KANO STATE

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

2013 – 2015

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The Kano State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV was supported in part by the U.S. Agency for International Development (USAID) and United Nations Joint Programme on AIDS (UNAIDS). FHI 360, IHVN and UNAIDS provided technical assistance to the Kano State Government during development of the plan. Financial assistance was provided by USAID under the terms of the Cooperative Agreement AID-620-A-00002, of the Strengthening Integrated Delivery of HIV/AIDS Services Project and CDC under the terms of the cooperative agreement 5U2GGH000925-02-of the AIDS Care and Treatment in Nigeria (ACTION) Plus Up project. This report does not necessarily reflect the views of UNAIDS, FHI 360, IHVN, USAID or the United States Government.

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Foreword

Globally, only 20% of HIV positive pregnant women have access to antiretroviral therapy (ART) to prevent vertical transmission of HIV to their babies – this leaves a gap of 80%. Despite efforts made by the federal and state governments to expand access to antiretrovirals (ARVs) for HIV positive mothers for prevention of mother-to-child transmission (PMTCT), Nigeria accounts for 30% of the global 80% gap. In addition, Nigeria contributes 15% of the total number of children currently in need of ARVs. Nigeria is unarguably one of the priority countries for immediate and sustained scale up of PMTCT services if the world is to achieve the elimination goal.

The HIV prevalence in Kano State has been consistently below the national average. However, because of the state's large population, it is one of the priority HIV burdened states in the country. Similarly, the huge population coupled with a fertility rate estimated to be 8.1 as compared with national average of 5.7 and North West Zonal average 7.3, Kano State is one of the PMTCT priority states referred to as the "12+1". This clearly indicates the need for the production of this Kano State specific PMTCT Scale up Plan 2013 -15.

The gate way to PMTCT is antenatal care (ANC). It is instructive to note that the leading barrier to healthcare for Nigerian women and children is inability to afford treatment. This is what made the Kano state government in 2001 to make maternal and child healthcare (MCH) free in all secondary health care facilities of the state. It is gratifying to note that PMTCT is available in all but one of these facilities. To further demonstrate this government's commitment to the cause of women and children, free MCH will be extended to the primary health centers providing ANC services.

This document is timely and will further strengthen the already planned state ANC scale up, which is a key component of the elimination of mother-to-child transmission (eMTCT) continuum of care. Free MCH services remove the financial barrier to access ANC, hospital deliveries and postnatal care – all critical PMTCT service delivery points.

Produced by key PMTCT stakeholders, the Kano State eMTCT Operational Scale up Plan 2013 – 15 is a comprehensive plan for the state. The document takes in to consideration the recommended four-pronged strategy to prevent HIV among infants and young children. This includes key interventions to be implemented as a component of overall maternal, newborn and child health services and is in line with the national and state PMTCT program.

The Kano State Operational Plan 2013 – 15 is hereby recommended for use by all stakeholders with mandates to support PMTCT in Kano State. It is hoped that this document will guide our PMTCT partners on the support Kano State requires and plan accordingly while ensuring the implementation of quality services devoid of duplication as we work towards the goal of elimination of mother-to-child transmission and the Millennium Development Goals (MDGs) 4, 5 and 6 by 2015.

May 2014

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Finally, we express our profound gratitude to the Kano State Government and our lead USG partners FHI 360 and IHVN ably led by Drs. Hadiza Khamofu and Aaron Onah respectively for the logistics support as well as the encouragement given to us in the course of producing this document.

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Acronyms

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

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

Executive Summary

Kano State has an HIV prevalence of 3.4% and with its high population it is one of the "12+1" high burden, high priority states in Nigeria. Thus, Kano State will receive additional focus for 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 (eMTCT)" and the "President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP) 2013-2015." These plans will ensure that 90% of HIV positive pregnant women, their babies and families have access to services that will ensure zero new HIV infections amongst children and keep their mothers alive.

There were 2,542,045 women of reproductive age (WRA), i.e. aged 15-49 years, in Kano State at the end of 2012; out of these 577,738 were pregnant and at a prevalence of 3.4%, 19,643 of them were HIV positive. There is however poor access to maternal and child health (MCH) interventions particularly prevention of mother-to-child transmission of HIV (PMTCT) interventions. In 2011, only 55.5% of pregnant women accessed antenatal care (ANC) while 18.9% of women delivered in hospital. Data showed 11.4 % of eligible pregnant women received an HIV test in 2012. Furthermore, only 4% of eligible HIV positive pregnant women receive antiretroviral (ARV) drugs for PMTCT. Only 0.7% of WRA reported using a family planning (FP) method in a 2011 survey. Family planning interventions would potentially reduce MTCT by up to 13% and reduce maternal mortality by up to 30%.

As of June 2013, 106 facilities provided ARVs to HIV positive pregnant women. About 78% of ANC facilities which could provide comprehensive PMTCT services did not. These facilities were assessed in June 2013 and only 4% of these 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 assessment revealed shortfalls in the human resource and infrastructure capacity of the facilities.

The assessment findings were used in the development of a costed eMTCT scale up plan which took place during a three-day planning workshop on September 17th to 19th 2013. The plan aligns with the goals and targets contained in global and national eMTCT plans including the PCRP. A modelling exercise was completed to estimate the potential impact of meeting three eMTCT targets:

- Reduce by 50% HIV incidence among 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, 7,884 infections among WRA, 8,731 pregnancies among HIV-positive women, 12,559 infections among HIV exposed infants (HEI), 4,198 infant deaths, 70 maternal deaths will be prevented by meeting the PMTCT targets. Combined, this will result in 764,479 disability adjusted life years (DALYs) saved in Kano State by 2015 if the scale-up plan is implemented to scale.

The costed *"Kano State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV 2013-2015"* with an estimated cost of NGN 8,880,752,600 (USD 57,295,178) is presented in this document.

SECTION

1 Introduction

1.1 NIGERIA HIV SITUATIONAL ANALYSIS

Nigeria has a population of 162,265,000[1] and currently has one of the highest HIV burdens worldwide. It has a generalized epidemic with a prevalence of 4.1%[2] , an estimated 3.1 million persons living with HIV2, 215,130 AIDS related deaths[3] annually and 2,229,883 total AIDS orphans. By December 2012 only 491,021 out of an estimated 1.66 million people who require anti-retroviral drugs (ARV) were receiving [4].

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

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

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

1.2 NIGERIA PMTCT SITUATION ANALYSIS

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

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

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

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

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

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

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

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

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

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

The PMTCT Scale-up Technical Committee identified 12 states plus the FCT which account for 70% of the PMTCT burden in Nigeria for increased focus (see Table 1). 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, and HIV prevalence are expected to also guide prioritization of activities between LGAs and communities within the various states. Implementation is being carried out in a phased approach that will ensure better coordination of the response with all the states of the country benefiting by 2015.

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

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

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

1.4 FUNDING OPPORTUNITIES

Accelerating the scale up of PMTCT services requires additional efforts on resource mobilization 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[5] is timely as it challenges federal, state and local governments to significantly increase the resources allocated towards the HIV response in general and the PMTCT response in particular. The goal of the PCRP is to accelerate the implementation of key interventions over a two year period to bridge existing service access gaps, address key financial, health systems and coordination challenges and promote greater responsibility for the HIV response at federal, state and LGA 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 resources for PMTCT services in Nigeria. Other opportunities that are worthy of note include the provision of midwives at PHCs under the midwifery service scheme (MSS) funded by Millennium Development Goal (MDG) mechanism and Subsidy Re-investment and Empowerment Programme (SURE-P), coordinated by the NPHCDA. There are also opportunities for increasing coverage through working with private health practitioners and investment in MCH services including PMTCT through public-private partnerships (PPP).

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

SECTION

2 Kano State

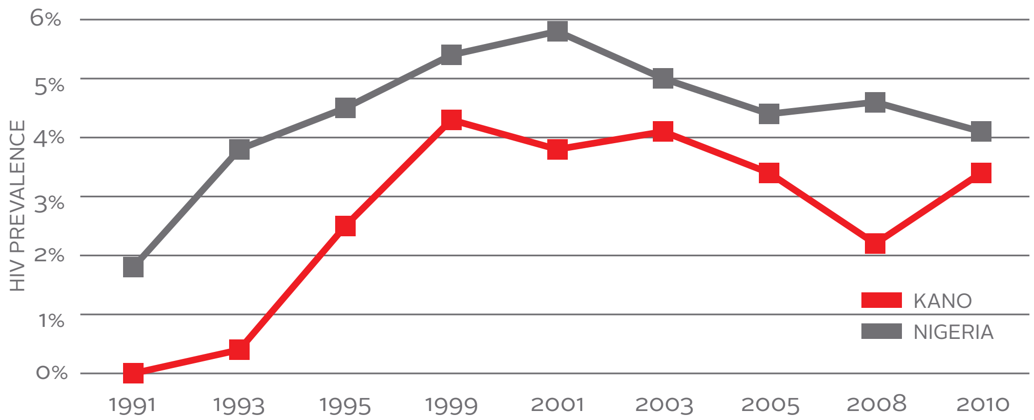
2.1 STATE PROFILE

Kano, one of the seven states in north-west Nigeria, is administratively divided into 44 LGAs. According to the 2006 Census, Kano has the highest population in Nigeria. In 2012, its population was estimated to be 11,554,751 based on a 3.3% annual growth rate. The capital, Kano City, is the third largest city in Nigeria and the largest in northern Nigeria. In addition, Kano City is a commercial hub attracting visitors from all over Nigeria and beyond.

At the end of 2012 there were an estimated 2,542,045 women of reproductive age (WRA), i.e.15-49 years old, in Kano State of whom 577,738 were pregnant during the same year. A 2011 survey showed contraceptive prevalence in the state was 0.7% while unmet need for contraception was 17.6%[6]. The same survey reported 55.5% of pregnant women received antenatal care from skilled personnel while 18.9% of deliveries were attended by a skilled birth attendant. Kano State reports a total of 1,132 health facilities, 638 (56%) of which provide ANC services.

2.2 HIV/AIDS IN KANO STATE

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



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

7 *Source: Federal MOH Technical Report 2010*

Kano state over the years has recorded varying 'dips' and 'peaks' in its HIV prevalence. From zero prevalence in 1991, the prevalence rose to 4.3% in 1999 and then dropped to 4.1% in 2003 and to a very low prevalence of 2.2% in 2008 only to rise again in 2010 to a prevalence of 3.4% signifying 1.2% increase . In addition, the Integrated Biological and Behavioral Surveillance Survey (IBBSS) conducted in 2007 showed the following prevalence amongst the various high risk groups in the state : brothel-based female sex workers (FSW) – 49.1%; non-brothel-based FSW – 44.1%; MSM – 11.7%; IDU– 10%; armed forces – 3.7%; police – 4.4%; and transport workers – 1.4%.

2.3 PMTCT IN KANO STATE

Based on a prevalence of 3.4%, an estimated 19,643 pregnant women are projected to be HIV positive out of an estimated population of 577,738 pregnant women within the state. About one third of HIV infected pregnant mothers would transmit the HIV virus to their babies in the absence of PMTCT which translates to an estimated 6,633 preventable HIV infections among infants in the state.

In total, 106 health facilities in Kano are supported to provide PMTCT services.

8 Federal Ministry of Health. (2010). National Sero-Prevalence Sentinel Survey. FMoH: Abuja.

SECTION

3 Process

This scale-up operational plan was developed under the leadership of the Kano State Agency for the Control of HIV and AIDS (KASACA).

In February 2013, with support from UNAIDS and HIV/AIDS Division FMOH, Kano 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 Kano's eMTCT targets, FHI 360 with support from USAID and IHVN with support from CDC, provided technical assistance to conduct a state-wide rapid health facility assessment (RHFA). The assessment was conducted in all facilities in all forty-four LGAs identified as providing ANC services but not PMTCT services. The assessment covered seven domains: facility health linkages, health human resource complement, client flow, scope of services provided, community support systems, current infrastructure and future prospects for expansion. The results of the assessment informed the priority areas chosen as well as scale-up targets required to meet the eMTCT goal.

From September 18th to 20th 2013, a three-day planning workshop was convened by the Kano 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 and CDC through IHVN. The initial draft plan earlier developed by the SMOH was reviewed in line with findings from the RHFA and deep dive. The outcome of the meeting was a costed eMTCT scale up plan which aligned with the goals and targets contained in the national eMTCT scale up plan. State specific challenges were identified and a comprehensive package with appropriate interventions to address the specific needs within the state developed.

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

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 all 44 LGAs of Kano State.

A complete list of all health facilities in the state was provided by the Department of Planning, Research and Statistics (DPRS) of the Kano SMOH. All public and private health facilities which met defined criteria were assessed. About 56% (638) of the 1,132 health facilities in Kano state provide ANC. Of those providing ANC, 499 (78%) had no support to provide ARVs for PMTCT at the time of the survey. These were fully assessed and the full *"Report of the Kano State-wide Rapid Health Facility Assessment: in preparation for the elimination of mother-to-child- transmission of HIV 2013"* is available as a separate document. A summary of assessment findings is presented below.

Box 1: Site selection

Site Inclusion Criterion

- Providing ANC

Site Exclusion Criteria

- Specialist hospitals such as neuropsychiatry, dental and maxillofacial hospitals.
- Facilities already providing ARVs for PMTCT or with plans to provide ARVs for PMTCT in 2013 (PEPFAR/Global Fund)

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

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Private for profit	5	49	54
Faith Based	3	0	3
Sub-total (private)	8	49	57
Public			
Federal Government	0	1	1
HMB	0	9	9
PHCMB	432	0	432
Sub-total (public)	432	10	442
Overall total	**440**	**59**	**499**

4.2 FINDINGS

4.2.1 Facility Ownership and Healthcare Level

Less than one-fifth of the facilities assessed (57) were privately owned while the rest of the facilities were publicly owned (442). A breakdown is presented in Table 2.

4.2.2 Human resources and service utilisation

Human resources for health and uptake of health services for the 12 months preceding the survey were assessed. The cadres assessed were doctors, nurses/midwives, trained community workers, laboratory, medical records and pharmacy staff. Findings revealed fewer staff and wider coverage gaps in primary compared to secondary health centers; only 22.0% of the primary facilities were covered by doctors and 17.0% by a registered nurse or midwife. Pharmacy technicians/pharmacists and laboratory technicians were the fewest per facility of all the health worker categories.

The mean outpatient department (OPD) and ANC attendance as well as deliveries in the 12 months preceding the survey was higher for secondary facilities compared to the primary level health services in the state.

4.2.3 Other domain summaries

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

Regarding the scope of services available, facility infrastructure, and environmental enablement for MCH and community support/participation disaggregated by facility level, almost all the clinical and laboratory services were available in most of the facilities assessed with the exception of tuberculosis (TB) services which were only available in 27.5% of the facilities- a greater proportion of which were in the secondary level (52.5%). Also, regarding identified structures, across all facility levels, spaces for TB microscopy were most commonly lacking (12.6%); with only 10.0% of primary level facilities having space for TB microscopy.

Furthermore, with respect to an enabling environment, primary level facilities seemed better off compared to secondary level facilities; as they had more MDG support (13.9% vs. 5.1%), free ANC services (89.1% vs. 11.9%) and regular monthly outreach (67.7% vs. 13.6%). Furthermore, primary level facilities were found having better community systems compared with the secondary facilities. However, it appeared a slightly higher proportion of secondary facilities (8.5%) had MSS midwives compared to primary level facilities (6.8%).

4.2.4 Summary of qualitative findings

Health workers were interviewed to give insight into issues that determined demand for health facility-based antenatal services in the state. Respondents were of the opinion that many women prefer traditional birth attendants (TBAs) and home delivery because it is perceived as a sign of bravery that can help improve their social standing even though these women usually attend ANC at the health facilities. Reasons advanced for this practice included a firm traditional belief in the abilities of the TBA, the presence of male health workers in facilities, poor condition of the facilities and lack of 24 hour services at the facilities. They also reported that costs of delivering at health centers are prohibitive – especially regarding transportation.

Reasons offered for why some facilities are well patronized included the good relationships health workers have with the community, availability of free drugs and services, availability of 24 hour service coupled with the engagement of consultants, the availability of highly motivated and dedicated clients.

Areas for improvement identified by health workers included better staffing, provision of free services including drugs, building capacity of staff to provide maternal and child health services as well as provision of better infrastructure and social amenities.

4.2.5 Scenarios for eligibility of PMTCT services

About 4% (22) of the assessed facilities met the minimum national standard *(one doctor, one nurse, two other health workers, one pharmacy staff, one lab staff, one records officer)* for PMTCT service provision. Of these, half were in the private sector. In order to ensure more equitable coverage of PMTCT services, a total of 440 doctors, 409 nurses, 327 community health extension workers(CHEWs)/community health officers(CHOs), 450 pharmacists or pharmacy technicians, 381 records officers and 383 laboratory scientists or technicians are needed to bring all assessed public facilities to national standards for PMTCT service provision.

Table 3: LGA ranking of MTCT burden and PMTCT coverage in Kano state

LGAS	MTCT BURDEN			PMTCT SERVICE COVERAGE GAP			RANK SUM [RANK 1 + RANK 2]
	HIV prevalence	Estimated number of HIV+ pregnant women	Rank 1 (number of HIV+ pregnant women)	Number of sites with ANC services	Proportion without PMTCT services	Rank 2 (service gap)	
BICHI	3.40%	564	37	19	95%	37	74
MAKODA	3.40%	446	29	14	100%	44	73
ROGO	3.40%	462	32	20	95%	37	69
SUMAILA	3.40%	508	35	16	94%	34	69
DAWAKIN KUDU	3.40%	457	31	17	94%	34	65
DAWAKIN TOFA	3.40%	499	34	22	91%	30	64
UNGOGO	3.40%	742	41	21	86%	23	64
DALA	3.40%	849	43	18	83%	20	63
BUNKURE	3.40%	354	18	5	100%	44	62
KUMBOTSO	3.40%	597	39	21	86%	23	62
GARKO	3.40%	328	15	15	100%	44	59
NASARAWA	3.40%	1,210	44	39	72%	13	57
TAKAI	3.40%	411	24	13	92%	33	57
GEZAWA	3.40%	573	38	17	82%	18	56
GWARZO	3.40%	372	19	17	94%	34	53
GAYA	3.40%	421	25	24	88%	27	52
GABASAWA	3.40%	428	27	14	86%	23	50
WARAWA	3.40%	267	5	16	100%	44	49
GARUM MALLAM	3.40%	241	4	9	100%	44	48
KURA	3.40%	290	9	25	96%	39	48
TUDUN WADA	3.40%	464	33	4	75%	15	48
KANO MUNICIPAL	3.40%	753	42	20	50%	4	46
KIRU	3.40%	542	36	11	64%	10	46
DAMBATTA	3.40%	427	26	11	82%	18	44
DOGUWA	3.40%	306	12	12	92%	32	44

Table 3: LGA ranking of MTCT burden and PMTCT coverage in Kano state *(contintinued)*

GWALE	3.40%	726	40	12	50%	4	44
BAGWAI	3.40%	328	15	10	90%	28	43
TARAUNI	3.40%	450	30	25	68%	12	42
ALBASU	3.40%	381	20	12	83%	20	40
FAGGE	3.40%	406	23	31	81%	17	40
BEBEJI	3.40%	389	22	11	73%	14	36
SHANONO	3.40%	282	8	10	90%	28	36
KABO	3.40%	311	13	13	85%	22	35
KUNCHI	3.40%	223	3	12	92%	31	34
RANO	3.40%	301	11	7	86%	23	34
AJINGI	3.40%	350	17	4	75%	15	32
MINJIBIR	3.40%	445	28	3	33%	1	29
WUDIL	3.40%	383	21	11	45%	3	24
TSANYAWA	3.40%	320	14	5	60%	6	20
KARAYE	3.40%	292	10	5	60%	6	16
MADOBI	3.40%	279	6	15	60%	6	12
TOFA	3.40%	200	1	18	67%	11	12
KIBIYA	3.40%	281	7	9	44%	2	9
RIMIN GADO	3.40%	210	2	5	60%	6	8
Total	**3.4%**	**19,067**		**638**			

While Nassarawa LGA has the highest MTCT burden, the lack of PMTCT services in Bichi and Makoda LGAs relative to their MTCT burdens shows they have the highest unmet need for PMTCT services.

4.2.6 Recommendations

Scale-up priority should be given to LGAs with the highest PMTCT service coverage gap and burden of HIV positive pregnant women. Scale-up efforts must attempt to close the gap in human resources in 96% of facilities without PMTCT services. In addition, infrastructure for safe delivery services should be provided in 60% of these facilities. Private sector involvement in PMTCT service provision is also another critical area which should be addressed to ensure universal coverage of PMTCT services. Community systems should be strengthened to improve community involvement and ownership by establishing and strengthening existing ward and village development committees as well as community-based organizations.

SECTION

5 Kano State eMTCT Operational Plan

5.1 RATIONALE

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

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

1. Reduce HIV incidence among 15-49 year old women by at least 50%;
2. Reduce the unmet need for family planning among women living with HIV by 90%;
3. Increase access to quality HIV counseling and testing to at least 90% of 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 infected pregnant women requiring treatment for their own health; and
7. Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT plan.

5.3 SCALE UP TARGETS

To facilitate eMTCT, Kano has selected indicators and set targets to monitor progress. The parameters for measuring scale up include: ANC coverage, HTC coverage in ANC, the proportion of HIV positive women reached with services, ARV prophylaxis, early infant diagnosis (EID) coverage and access to lifelong ART for women of reproductive age on need of ART for their own health. The baseline figures for these parameters and the targets for this plan are presented in the table below.

Table 4: State Level Targets for the Kano State eMTCT Operational Plan

INDICATORS	BASELINE (2012)	YEAR 1 (2013)	YEAR 2 (2014)	YEAR 3 (2015)	DATA SOURCE
Estimated number of WRA	2,542,045	2,627,332	2,715,481	2,806,586	NPC 2006 projections
Estimated number of pregnant WRA (5% of total population)	577,738	597,121	617,155	637,861	NPC 2006 projections
Projected ANC attendance (55.5% of pregnant women)	320,644	331,402	342,521	354,013	MICS 4 2011 based projections
Estimated number of HIV-positive pregnant women (3.4% prevalence: 2010 sentinel survey)	19,643	20,302	20,983	21,687	National HIV Sero-prevalence Sentinel Survey
50% reduction in HIV incidence among 15-49 year old women	0.30%	0.25%	0.20%	0.15%	Prevalence based estimates
90% reduction in unmet need for family planning among women living with HIV (based on 17.6% unmet needs)	17.60%	15.00%	7.50%	1.70%	MICS4 2011 based projections
90% of all pregnant women have access to quality HIV testing and counseling services	66,083 (11.40%)	179,136 (30%)	493,724 (80%)	574,074 (90%)	State routine health data on DHIS
90% of all HIV-positive pregnant women and breastfeeding infant-mother pairs have received ARV prophylaxis for PMTCT	780 (4.10%)	6,091 (30%)	16,787 (80%)	19,519 (90%)	State routine health data on DHIS
90% of all HIV-exposed infants have access to EID services	NA	6,091 (30%)	16,787 (80%)	19,519 (90%)	State routine health data on DHIS
90% of HIV-infected women pregnant requiring treatment for their own health will have access to lifelong ART (based on 50% of HIV positive pregnant women requiring ART)	NA	3,045 (30%)	8,393 (80%)	9,759 (90%)	State routine health data on DHIS
84% of ANC facilities offer PMTCT services	106 (17%)	328 (51%)	538 (84%)	538 (84%)	State routine health data on DHIS

5.4 IMPLEMENTATION APPROACHES

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

- PMTCT guidelines, manuals and related standards produced and widely disseminated;
- Advocacy for PMTCT with gatekeepers and influential people within the community strengthened;
- Community education on PMTCT including promoting the utilization of the available services enhanced;

- Social mobilization at community level for PMTCT strengthened;
- The human resource capacity for delivery of quality PMTCT services strengthened;
- Medicines, related commodities and supplies as well as the procurement supplies management system strengthened;
- Physical infrastructure and equipment for provision of quality PMTCT services rehabilitated;
- PMTCT program coordination, management and resource mobilization strengthened; and
- PMTCT program monitoring and evaluation as well as operational research strengthened.

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

5.4.1 PMTCT Service Supply Systems

In order to ensure universal access to PMTCT services Kano State adopted a number of approaches. These are based on the unique socio-cultural structure of the state:

- Strengthening the human resource capacity in the state to deliver PMTCT services at health facilities;
- Increasing demand for HTC services in the general population and pregnant women by strengthening community based services:
    - Use of the Kwankwasiya Medical Team for HTC and STI outreaches,
    - Working with CBOs to test and refer pregnant women + general population,
    - Working with community pharmacists,
    - Providing TBAs with incentives to ensure TBA refer clients for HTC; and
- Building the capacity of selected health facilities to provide lifelong treatment and care to women and their families.

Health workers will have their technical and infrastructural capacity strengthened through: (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 and communication (IEC) materials and (4) providing support to PMTCT sites through routine mentoring and technical supportive supervision. Health care workers in secondary health facilities will be trained using the Integrated PMTCT curriculum and the IMAI/IMPAC curriculum will be used for training health care workers in primary health care facilities. Update trainings and step down trainings will further increase standards and the pool of health care providers. National guidelines and SOPs, job aids and IEC materials will be provided. Mentoring and supportive supervision will be an integral component 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.

Novel approaches will be implemented, such as the use of the eleven Kwankwasiya Medical Teams, which already provide a number of services through monthly outreach. Team members will be trained to offer HIV counseling, testing and referrals as part of their outreach services. Community based organizations will also have their capacity built to provide HTC services and refer clients on a regular basis. Linkages between facilities and community pharmacists will be strengthened. TBAs will be supported to provide facilitated referrals for HTC. This will involve payment of a referral incentive and provision of referral booklets to TBAs. Completed referrals will be verified by LGA M&E during monthly meetings.

The PMTCT continuum of care emphasizes the provision of a comprehensive range of treatment and care services for pregnant women and their infants beyond labor and delivery. The Kano state government will ensure that all HIV infected women and their families have access to ARVs as well as care and support services at both the facility and community levels.

5.4.2 PMTCT Health Care Commodities supply

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

5.4.3 PMTCT Demand Creation

The Kano State eMTCT demand creation intervention is based on the multi-pronged social and behavior change communication (SBCC) strategy which involves systematic application of interactive and research driven communication process that addresses key elements for social and behavior change at the individual level, community level, and broader social context. The state will create demand through three major approaches: advocacy to persuade policy change and action; social and community mobilization for promotion of new norms and wider participation, and behavior change communication to increase knowledge, and 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 based 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 (men that care) forum, women leaders and health care providers within the primary health structures.

Key recommended activities include advocacy and sensitization meetings with policy makers, 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 the government an opportunity to make a formal announcement of its commitment to eMTCT. This event will also be conducted in all the LGAs where the chairmen and community paramount leaders will confirm their commitment. This is supported with broad base 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 partnership with community institutions and establish ownership among community members. Communication and behaviour 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.

In order to ensure that PMTCT interventions achieve the best outcomes for the state, KSACA will empower key frontline providers and mobilizers through trainings on interpersonal communication, and community dialogue facilitation skill so as to enable them provide sustainable quality service.

5.4.4 Monitoring and Evaluation

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

To this end, the M&E system proposed for the scale-up will address identified deficiencies in the areas of increasing awareness and support for M&E activities in the state, improving human resource capacity to support integrated M&E activities, strengthening structures for coordination and implementation of HIV/AIDS M&E activities and increasing completeness of reporting with of health data within approved timelines.

At the inception phase, the major key players in implementing program M&E system and HMIS at both the state and LGA level will be engaged to agree on the seamless way of strengthening M&E coordination and assignment of roles & responsibilities. Monthly program coordination and data review meetings will be established to facilitate strategic direction for the scale up. A central database, standard data management protocol and relevant HR will be put in place to facilitate the process of obtaining up-to-date routine service statistics and LMIS reports across the state. The capacity of medical records and M&E/HMIS officers at community, health facility, LGA and state levels will be built. M&E tools shall be procured and distributed amongst them. Systems for routine mentoring and supportive supervision and data quality auditing will be instituted to ensure that high quality data is generated for analysis and use in decision making.

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

The rapid health facility assessment and scale-up plans will be disseminated to state and LGA level stakeholders to ensure buy-in to eMTCT. The budget for implementing the operational will be presented and the required funding will be sourced (government agencies-SURE-P, NACA etc., development partners- Bill and Melinda Gates, UNICEF and individuals like Dangote) to ensure ownership and sustainability of the activated sites. The state PMTCT task team will be inaugurated to work with the Sidhas team and other implementing partners (IPs) and ensure ongoing monitoring and supervisison. There is a need to disseminate the baseline assessment report, build consensus for the finalization of Kano state eMTCT scale up plan. In addition, the Kano state PMTCT task team/SMT comprising of government (SMoH, KSACA, LACAs, hospital heads and IPs (lead IPs, CSOs and networks) will be inaugurated.

SECTION

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

To estimate the potential impact of meeting PMTCT targets in Kano State, a modeling exercise was completed. In the exercise, the number of HIV infections averted in women of reproductive age and infants, the number of infant and maternal deaths averted, as well as the disability-adjusted life year (DALY) saved from meeting 3 of the 4 main PMTCT targets were estimated (targets listed below). The methods for estimation are described in below. Briefly, though, the infections and deaths that would result from maintaining current levels (maintaining the status quo) compared to meeting PMTCT targets were estimated. The difference between the two was taken as the estimate of programmatic impact (see table below).

TARGETS:

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

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

TARGETS	2012	2013	2014	2015	TOTAL
1. Decrease HIV incidence among WRA	*0.30%*	*0.25%*	*0.20%*	*0.15%*	
2. Reduce unmet need for FP among HIV+ women	*17.6%*	*12.0%*	*7.0%*	*2.0%*	
3. Increase prophylaxis for HIV+ pregnant women	*4.0%*	*30.0%*	*80.0%*	*90.0%*	
OUTCOMES					
Status Quo Maintained: New HIV infections among WRA	7,367	7,587	7,814	8,048	30,816
Targets Achieved: New HIV infections among WRA	7,367	6,323	5,212	4,030	22,931
HIV infections averted among WRA	-	1,265	2,602	4,018	**7,884**
Status Quo Maintained: Pregnancies among HIV+ WRA	-	(228)	(237)	(247)	(712)
Targets Achieved: Pregnancies among HIV+ WRA	-	2,601	2,708	2,710	8,019
Pregnancies averted among HIV+ WRA	-	2,829	2,946	2,957	**8,731**
Status Quo Maintained: HIV infections among HEI	6,633	6,711	6,791	6,874	27,009
Targets Achieved: New HIV infections among HEI	6,633	4,490	1,914	1,412	14,449
HIV infections averted among HEI	-	2,220	4,877	5,462	**12,559**
Status Quo Maintained: Infant mortalities	2,972	3,007	3,043	3,080	12,103
Targets Achieved: Infant mortalities	2,972	2,207	1,433	1,292	7,904
Infant mortalties averted among HEI	-	800	1,610	1,788	**4,198**
Status Quo Maintained: Maternal mortalities	-	(2)	(2)	(2)	(6)
Targets Achieved: Maternal mortalities	-	21	22	22	64
Maternal mortalities averted among HIV+ women	-	23	24	24	**70**
DALYS saved	-	144,777	281,598	338,104	**764,479**

IN SUMMARY:

7,884

infections among WRA

8,731

pregnancies among HIV-positive women

12,559

infections among HIV exposed infants (HEI)

4,198

infant deaths

70

maternal deaths will be prevented by meeting the PMTCT targets.

Combined, this will result in

764,479

DALYs saved in Kano 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%)[9], 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[10] (state prevalence – national prevalence /100). Estimates of population growth[11] 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 couples years of protection (CYP) conversion factor produced by MSI[12]. CYPs in each scenario were estimated based on the current contraceptive mix observed in each state[13] and assumed 1

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

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

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

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

13 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

year of use for new adopters. The CYPs for a minimum of year of use of each method were based on region-specific standards[14]. 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%[15].

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

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

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

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

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

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

   b. the reduction in HIV infections among HIV exposed infants (in step 2), as well as expected mortality among infected children in the first year of life (35.2%) compared to un-infected infants (4.9%)[16].

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)[17]** 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.

14 Measure Evaluation. Couple Years Protection. Website accessed October 25th 2013

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

16 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

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

SECTION

7 Implementation Plan

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Staffing					
Recruit and deploy HCWs (nurses/midwives/CHEWs, lab and pharmacy staff) for HTC service provision at SHCs at no cost (3 per facility)	6 HCWs to be deployed	Q3-Q4	Q1-Q4		SMOH
Recruit and deploy HCWs (nurses/midwives/CHEWs, lab and pharmacy staff) for HTC service provision at PHCs at no cost (3 per facility)	1,209 HCWs to be deployed	Q3-Q4	Q1-Q4		SMOH
Sensitization					
Sensitize HCWs on PITC and multi-point HIV testing at health facilities by LGA/state team (on-site sensitization)	All HCWs in the facility	Q3-Q4	Q1-Q4		SMOH
Mentoring & supervision					
Conduct monthly LGA-level mentoring and supportive supervisory visits on HTC and syndromic management of STIs to all sites (by MCH+LACA+HIV FP+ M&E)	176 persons (4 persons per team in 44 LGAs)				SACA/SIT
Conduct quarterly state-level joint mentoring and supportive supervisory visits on HTC and syndromic management of STIs to all sites (SACA/SIT)	12 persons (3 teams of 4 persons each)				SACA/SIT
Conduct state-level joint integrated supportive supervisory visits to all sites + Kwankwasiya medical outreach (costed on state ISS budget); support monthly HTC outreach by CBOs					SACA/SIT
Support monthly HTC outreach by CBOs	1 per month per CBO				SFH
Conduct quarterly HTC outreach at adult literacy schools in collaboration with Agency for Mass Education	1 per quarter per LGA				SACA
Conduct monthly mentoring and supervisory visits for CBOs, PMVs, CVs, community pharmacists and TBAs by LGA with support from KSACA and PHCMB (cost linked to monthly mentoring visits)	176 persons (4 persons per team in 44 LGAs)				SACA/SIT
Linkages/referrals					
Identify and train CBOs on a family centered HTC and referrals (in collaboration with Kano state PHCMB)	2 CBOs per LGA	Q3-Q4	Q1-Q4		SMOH/GF

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS *(Continued)*					
Training& capacity					
Conduct 10-day training for HCWs on HTC at private and public PHCs and SHCs (840 in 21 batches + 5 facilitators per batch)	840 HCWs trained	Q1	Q1&Q3		SMOH/GF/FHI 360/ IHVN/JHPIEGO
Conduct 10-day HTC/STI training for Kwankwasiya Medical Outreach (60 persons in 2 batches + 5 facilitators per batch)	60 persons trained				SACA/SMOH
Conduct 3-day training on syndromic management of STIs for HCWs at private and public PHCs and SHCs (420 in 10 batches + 2 facilitators per batch)	420 HCWs trained				SACA/SMOH
Support facility based step-down trainings for HTC and syndromic management of STIs	1,000 HCWs trained				SACA/SMOH
Condom promotion					
Engage community volunteers, community pharmacists and PMVs through Association of Community Pharmacists and Nigerian Association of Patent Proprietary Medicine Dealers (NAPPMED) to conduct community outreach for condom promotion and HTCHTC	10 CVs per LGA, 10 PMVs per LGA in the rural areas and 30 PMVs and 30 CPs per 6 metropolitan LGAs				
Conduct 2-day ToT for community volunteers, community pharmacists and PMVs on condom promotion, HTC and referrals in PMTCT	2 CVs per LGA				
Conduct 1-day step down training for community volunteers, community pharmacists and PMVs on condom promotion, HTC and referrals in PMTCT	10 CVs per LGA, 10 PMVs per LGA in the rural areas and 30 PMVs and 30 CPs per 6 metropolitan LGAs				
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Consumables					
Procurement of RTKs (Determine = 1,224,688)	1,224,688	Q4	Q1-Q4	Q1-Q4	PEPFAR/USAID
Procurement of confirmatory test kit (Stat pack = 244,938)	244,938	Q4	Q1-Q4	Q1-Q4	PEPFAR/USAID
Procurement of tie breaker test kit (Unigold = 24,494)	24,494	Q4	Q1-Q4	Q1-Q4	PEPFAR/USAID
Procurement of laboratory consumables	1,494,120 tests	Q4	Q1-Q4	Q1-Q3	KSACA/ FUNDING PARTNERS
Procurement of male condoms (135,665 carton (100x30))	406,994,933 units	Q4	Q1-Q4	Q1-Q3	KSACA/ FUNDING PARTNERS
Procurement of female condoms	4,069,950 units	Q4	Q1-Q4	Q1-Q3	KSACA/ FUNDING PARTNERS
Procurement of lab reagents and lab consumables for S TI diagnosis	44 facilities				KSACA/ FUNDING PARTNERS

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: HEALTH CARE COMMODITIES *(Continued)*					
Procurement *(continued)*					
Equipment					
Procurement of ANC equipment and sterilization equipment to promote infection control	420 facilities	facilities			
Drugs					
Procurement of drugs for STI treatment {Cotrimoxazole,Doxycycline,Ciprofloxacin,Metronidazole,Fluconazole,Clotrimazole V. tabs and cream, Ampicillin/Cloxacillin, Acyclovir); Dispensing envelopes and bags for 106,773 clients	106,773 doses	Q4	Q1-Q4	Q1-Q3	KSACA/ FUNDING PARTNERS
Distribution					
Drugs					
Distribution of commodities to sites	420 sites	Q4	Q1-Q4	Q1-Q3	
Training and capacity building					
LMIS trainings (TOT for 88 person for 5 days X 2 batches + 2 facilitators)	88 trainers	Q4	Q2		KSACA/ FUNDING PARTNERS
LMIS step down training (2-day for 2 persons per facility) + 2 trainers	420 facilities	Q4	Q1-Q3		KSACA/ FUNDING PARTNERS
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS					
Training on IPC					
Conduct 2-day training on community mobilization on PMTCT for CSOs (CBOs and support groups)	3 participants per ward x 44 LGAs (1452)		Q1		KSACA/IPS/Line Ministries
1-day training for frontline peer educators on interpersonal communication (IPC) techniques for mobilization and to support dialogues at "Majalis" levels (Male Care Forum)	6 per ward x 484 (2904)		Q1		KSACA/IPS/Line Ministries
Conduct a 5-day training for community health workers on IPC	1 participant per PHC x 403 PHCs (403)		Q2		KSACA/IPS/Line Ministries
Conduct a 3-day training for media practitioners to mainstream ANC/HTC/PMTCT/RH/FP messages into their programs	30 journalists		Q2		KSACA/IPS/Line Ministries
Train local drama groups & Kanywood to mainstream ANC/HTC/PMTCT/RH/FP messages into their activities	30 participants		Q2		KSACA/IPS/Line Ministries

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS *(Continued)*					
Community mobilization					
Sensitization					
Conduct a 1-day sensitization meeting for Imams	484 Imams (1 per ward)	Q4			KSACA/IPS/Line Ministries
Conduct a 1-day sensitization meeting for Pastors	100 Pastors	Q4			KSACA/IPS/Line Ministries
Advocacy					
Conduct advocacy to the state executive council & state house of assembly to Implement free Maternal and Child Health Services (MCH) at all facilities in Kano State	Biannually	Q4	Q1-Q4		KSACA/IPS/Line Ministries
Conduct advocacy to the local government Chairman to provide infrastructure at ANC service points	44 LGA Chairmen	Q4	Q1-Q4		KSACA/IPS/Line Ministries
Conduct advocacy to gatekeepers (traditional/religious leaders) to reach their community/congregation with targeted PMTCT messages	2,200 community/ traditional leaders	Q4	Q1-Q4		KSACA/IPS/Line Ministries
Conduct advocacy to the National Union of Road Transport Workers to facilitate access to facilities in times of emergency	44 LGAs + State HQ	Q4	Q1-Q4		KSACA/IPS/Line Ministries
Media engagement					
Produce PMTCT home videos for local audience and "Majigi" locations/viewing centers	Men & women of reproductive age				KSACA/IPS/Line Ministries
Mentoring & supervision					
Conduct quarterly TBA network coordination meeting	30 TBAs per LGA x 44 LGAs monthly (1320)		Q1-Q4		KSACA/IPS/Line Ministries
IEC materials					
Conduct a 5-day workshop to adapt and pretest materials (print and electronic messages/ materials) for all four PMTCT prongs	15 persons including technical experts		Q1		KSACA/IPS/Line Ministries
Review and finalize BCC messages	Two meetings	Q4	Q1		KSACA/IPS/Line Ministries
Produce SBCC materials posters, pamphlets, fliers, pens, t-shirts, Hijabs etc.)	Posters - 80,000; flyers - 80,000; t shirts - 5000; hijabs -5000 (170,000)	Q4	Q1		KSACA/IPS/Line Ministries

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS *(Continued)*					
IEC materials *(continued)*					
Produce radio messages and programs	2 messages x 2 languages (4)		Q1		KSACA/IPS/Line Ministries
Broadcast radio messages	2 messages x 2 languages x thrice daily x 365 days		Q1-Q4		KSACA/IPS/Line Ministries
Produce & Broadcast 52 episodes enter-educate radio programs	enter-educate programs x 52 episodes		Q1-Q4		KSACA/IPS/Line Ministries
Distribute SBCC materials (at no cost)	500,000		Q1-Q4		KSACA/IPS/Line Ministries
Brand PMTCT service centers as user- friendly centers	2,132 sign posts	Q4			KSACA/IPS/Line Ministries
Community services					
Launch Kano State eMTCT Implementation Plan at state level	20 persons per LGA x 44 (880)	Q4			KSACA/IPS/Line Ministries
Provide grants to CBOs/support groups and frontline workers to implement integrated community PMTCT programs	Transport & communication allowance twice a month		Q1-Q4		KSACA/IPS/Line Ministries
Training of facilitators of community dialogue	1 per ward x 484 wards (484)				KSACA/IPS/Line Ministries
Conduct community dialogues with all stakeholders including TBA/traditional healers	5 TBA/TH per ward x 484 wards monthly (2,420)		Q1-Q4		KSACA/IPS/Line Ministries

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SYSTEM SUPPLY SERVICES					
Training & capacity					
Conduct 5-day training for LGA MCH/RH coordinators + SIT on SRH/ HIV integration (in 2 batches, 1 per LGA and SIT)	60 persons to be trained	Q4			SMOH/GF
Service Provision					
Print and disseminate the SRH/HIV guidelines, service providers' curriculum and manual to all facilities (distribution linked to mentoring visits)	1 each for 420 HFs	Q2			SMOH/FMOH/GF
Conduct monthly community level outreaches for family planning service provision	Monthly	Q4	Q1-Q4	Q1-Q3	SFH
Sensitization					
Conduct regular community level sensitization on FP	Quarterly	Q4	Q1-Q4	Q1-Q3	
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Consumables					
Procurement of family planning commodities	Quarterly	Q4	Q1-Q4	Q1-Q3	FMOH/UNFPA
Procurement of family planning consumables	Quarterly	Q4	Q1-Q4	Q1-Q3	KSACA/ FUNDING PARTNERS
Drugs					
Procure Emergency contraceptives	463 persons (1% of 46266)				KSACA/ FUNDING PARTNERS
Equipment					
Procurement of family planning equipment (examination couch, weighing balance, lamp)	420 facilities				KSG
Distribution					
Consumables					
Distribution of family planning commodities	420 facilities				KSACA/ FUNDING PARTNERS
Stock management (CLMS)					
Capacity building for service providers (CLMIS) 3-day TOT training for 44 persons (1 per LGA)	44 persons (1 per LGA)		Q1-Q2		KSACA/ FUNDING PARTNERS
Capacity building for service providers (CLMIS) 3-day TOT training for 44 persons (1 per LGA)	44 persons (1 per LGA)				

Prong 3: Prevention of mother to child transmission of HIV

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEM					
Staffing					
Recruit and deploy HCWs (doctors/nurses/ midwives/CHEWs, lab and pharmacy staff) for PMTCT service provision at SHCs (3 per facility)	1209 HCWs to be deployed	Q3-Q4	Q1-Q4	Q1-Q3	SMOH
Recruit and deploy HCWs (doctors/nurses/midwives/ CHEWs, lab and pharmacy staff) for PMTCT service provision at PHCs (3 per facility)	1209 HCWs to be deployed	Q3-Q4	Q1-Q4	Q1-Q3	SMOH
Training & capacity					
Conduct facility level HTCHTC for all pregnant women at ANC	Y1= 173753 (30% of pregnant women) Y2= 478540 (80% of pregnant women) Y3= 556016 (90% of pregnant women) Total = 1,208,309	Q3			SMOH/PEPFAR/ JHPIEGO
Conduct 6-day training in Integrated PMTCT for secondary health facilities in 3 batches	5 per facility * 17 SHC (85)	Q3			SMOH/PEPFAR/ JHPIEGO
Conduct 5-day training on Integrated Management of Pregnancy and Childbirth (IMPAC) for PHCs and LGA staff (in 20 batches)	2 per facility * 403 (806) + LGA participants (4 per LGA)	Q3-Q4	Q1-Q4	Q1	SMOH/PEPFAR/GF
Conduct 2-day onsite training on adherence counseling for HCWs	5 per facility * 17 SHC (85)	Q3-Q4	Q1		SMOH
Conduct 5day pharmaceutical care trainings for HCWs in PMTCT sites (secondary health facilities and CP preceptors) including LMIS (51 persons in 2 batches)	51 persons to be trained in 17 SHC				SMOH
Conduct 3-day ART dispensing and documentation training for HCW in PHCs (in 20 batches)	982 persons to be trained (2 persons per facility *403 and 4 from the LGA*44)	Q3-Q4	Q1-Q4	Q1	SMOH
Conduct 5-day onsite pharmacy best practices training for HCW for 17 SHC	All HCWs in the facility	Q3-Q4	Q1-Q4	Q1	SMOH
Conduct 5-day medical laboratory services training for HCWs in 17 SHCs	34 persons to be trained (2 persons per facility *17)	Q3-Q4			SMOH

Prong 3: Prevention of mother to child transmission of HIV

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEM *(continued)*					
Linkages/referrals					
Conduct 2-day orientation meeting for TBAs as community resource persons on HTC and referrals for pregnant women (by state in 10 batches)	10 TBAs per LGA	Q2-Q4	Q1-Q2		SMOH
Support TBAs to offer facilitated referrals to pregnant women for HTC	30 referrals per TBA per month	Q2-Q4	Q1-Q4	Q1-Q4	SMOH
Support PHC staff to conduct twice monthly HTC and condom distribution through outreaches in the community (link routine immunization outreach services + Kwankwasiya medical team outreaches	403 PHCs * 24 outreaches per annum (9,672)	Q2-Q4	Q1-Q4	Q1-Q4	SMOH
Engage CBOs for identification and referral of pregnant women from community to facility for PMTCT services and client tracking	2 CBOs per month targeting 60 pregnant women (120)	Q2-Q4	Q1-Q4	Q1	KSACA
Support monthly meetings for CBOs and TBAs (for data collection, payment for referrals)	1 per month	Q2-Q4	Q1-Q4	Q1-Q4	KSACA
Mentoring & supervision					
Support facility level partner counseling and testing (HTC) (linked to LGA mentoring visits)	302,077				SMOH/GF
Conduct monthly LGA-level mentoring visits and joint supervisory to PMTCT sites (link cost to prong 1 mentoring)	Monthly	Q2-Q4	Q1-Q4	Q1-Q4	SMOH
Conduct quarterly state-level service quality improvements in PMTCT sites (link cost to prong 1 mentoring)	Quarterly				FMOH/SMOH/GF/FHI 360/IHVN/JHPIEGO
Print and disseminate national guidelines, job aids and SOPs for PMTCT/EID, IYCF and HTC (distribution linked to activation or mentoring visits)	2 of each tool for 420 sites(840)				
Site activation					
Activate 420 sites for PMTCT/EID service provision 2 HCW per facility over 2 days each	420 sites to be activated (2 days each for SHCs and PHC)	Q3-Q4	Q1-Q4	Q1	SMOH/PEPFAR/GF
IEC materials					
Print and distribute IMPAC training materials for PHCs (training manuals and modules)	403				FMOH/SMOH/GF/FHI 360/IHVN

Prong 3: Prevention of mother to child transmission of HIV

Objective 3: Increase access to quality HIV counseling and testing to at least 90% of pregnant women *(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: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Drugs					
Procurement of ARVs for triple prophylaxis (TDF+3TC+EFV) for 90% infected pregnant women	41,640	Q4	Q1-Q4	Q1-Q3	PEPFAR/USAID
Procurement of ARVs for triple prophylaxis (alternative regimen - AZT+3TC+EFV) 5%	2,082	Q4	Q1-Q4	Q1-Q3	PEPFAR/USAID
Procurement of ARVs for HIV exposed infants (NVP suspension)	36,652	Q4	Q1-Q4	Q1-Q3	PEPFAR/USAID
Procurement of co-trim for HIV infected pregnant women	41,640	Q4	Q1-Q4	Q1-Q3	PEPFAR/USAID
Procurement of co-trim for HIV exposed infants	36,652	Q4	Q1-Q4	Q1-Q3	PEPFAR/USAID
Procurement of essential ANC drugs (e.g. haematinics, IPT)					KSG
Consumables					
Procurement of DBS kits	367 bundle kits				
Equipment					
Procurement of lab equipment, starter reagents and consumables for Secondary Health facilities (CD4, chemistry and haematology)	44 facilities		Q1&Q2		KSACA/ Funding Partners
Procurement of POC machine	44 (1 per LGA)		Q1		KSACA/ Funding Partners
Procurement of SMS printer	2 per LGA (approximately) $800 per printer)		Q1		KSACA/ Funding Partners
Logistics					
Laboratory equipment maintenance	44 facilities				KSACA/ Funding Partners
Sample transfer (CD4, haematology, chemistry) for primary health care centers	420 facilities - transportation - N6,000 per facility per month	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners
Sample transfer for DBS	420 facilities - transportation - N6,000 per facility per month	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners

Prong 4: Family centered care and support

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Linkages/referral					
Print and distribute job-aids on EID to the laboratory and clinics (SHCs and PHCs) (Linked to PMTCT printing)					
Support referral and linkages of HIV positive pregnant women on lifelong ART and infected infants to comprehensive treatment sites through cluster coordination meetings	12 meetings per annum				
Service Provision					
Support DBS sample transfer from PHCs and SHCs to National PCR labs	12 per annum				SMOH/GF/FHI 360/ IHVN/ JPHIEGO
Support monthly mother support groups (MSGs) meetings	12 per annum				
Support mother support groups (MSGs) to provide community based adherence support and tracking of HIV positive pregnant women and their infants	437 persons (1 person per PHC MSG * 403; 2 person per SHC MSG * 17)	Q4	Q1-Q4		SMOH
Support HCW to conduct client tracking	12 per annum				
Training					
Conduct 3-day training for HCWs at SHCs and PHCs on EID in 20 batches	982 persons to be trained (2 persons per facility *403 and 4 from the LGA*44)	Q4	Q1-Q4		SMOH/GF/FHI 360/ IHVN/JPHIEGO
Conduct 6-day ART training for 44 secondary health facilities + model PHCs in 6 batches	5 staff per site	Q4	Q1-Q4		KSACA/ Funding Partners
Conduct 5-day medical laboratory services training for HCWs in 44 SHCs + model PHCs	2 Lab staff per site	Q4	Q1-Q4		KSACA/ Funding Partners
Site activation					
Activate 44 sites for ART service provision	10 HW per site over 3 days (30)	Q4	Q1-Q4		KSACA/ Funding Partners
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement (quantification, forecasting)					
Drugs					
Procurement of ARVs for lifelong ART	18,326	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners
Procurement of RTK for couple counseling	1,246,934	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners

Prong 4: Family centered care and support

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: HEALTH CARE COMMODITIES *(continued)*					
Procurement (quantification, forecasting) *(continued)*					
Consumables					
Procurement of state specific basic care kits (LLIN, water treatment, buckets with lid and spigot etc.)	41,640	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners
Procurement of nutritional supplement for HIV pregnant women	46,266	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners
Procurement of nutritional supplement for HIV infected/exposed babies (malnourished children)	36,652	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners
Procurement of RTKs for family care	46,266	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners
Procurement of modem and airtime for submission of logistic reports	44 (1 per LGA)	Q4	Q1-Q4	Q1-Q3	KSACA/ Funding Partners
Distribution					
Consumables					
Distribution of basic care kits	46,266	Q4	Q1-Q4	Q1-Q4	KSACA
Stock management LMIS					
Supportive supervision for LMIS reporting (3 persons per LGA, for 3 days bimonthly)	Bimonthly	Q4	Q1-Q4	Q1-Q4	KSACA

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: MONITORING AND EVALUATION					
Data Quality Assurance					
Conduct 6-day training on M&E (tools refresher, data quality and supportive supervision) for 100 selected state and LGA M&E officers (residential)	100		Q1-Q2		DPME, SACA
Conduct 6-day Data Management training for 10 state M&E Officers (non-residential)	10		Q2		DPME, SACA
Conduct 5-day DHIS (eNNRIMS) training for 46 selected Data officers/managers (34 record officers from secondary health facilities, 6 zonal M&E officers and 4 SACA and 2 SMoH M&E officers)	46	Q4			DPME, SACA
Conduct state led quarterly M&E supportive supervision to LGAs and Health facilities	Quarterly	Q4	Q1-Q4	Q1-Q4	DPRS, SMoH
Procure and distribute Data collection and reporting tools (NHMIS and Harmonized HIV data collection tools) for 700 health facilities including private	All health facilities (public and private)	Q4	Q1-Q4	Q1-Q4	DPME, SACA
Routine monitoring					
Conduct state quarterly M&E review meetings	55 participants	Q4	Q1-Q4	Q1-Q4	M&E Officer, SMoH
Conduct LGA monthly M&E review meetings (1,332 Participants)	44 LGA M&E officers, 1,288 facility M&E officers	Q4	Q1-Q4	Q1-Q4	LGA M&E Officers
Conduct quarterly M&E TWG meetings	55 participants	Q4	Q1-Q4	Q1-Q4	DPH, SMoH
Participate in the Quarterly Partner Coordination Forum	20 participants	Q4	Q1-Q4	Q1-Q4	DAGS, SMoH
Deploy 6 SACA zonal M&E officers for monitoring HIV M&E activities	Once		Q1		Director Monitoring and Planning, SPHCMB
Conduct LGA led monthly M&E supportive supervision to health facilities	Monthly	Q4	Q1-Q4	Q1-Q4	DPME, SACA
Conduct mid-term evaluation of eMTCT program	Once		Q4		DPME, SACA
Capacity building					
Conduct service availability mapping survey and establish an up to date PMTCT facility list (including private facilities)	Once	Q4			DPME, SACA
Conduct annual performance review meeting	44 PHCCs, 6 zonal M&E officers, 10 SACA officers, 10 SMoH officers and 10 partners (80)		Q4	Q4	DG, SACA
Deploy 2 additional M&E assistants to support SACA M&E unit	Once	Q4	Q4	Q4	DAGS, SMoH
Conduct M&E staffing needs assessment	Annually	Q4	Q4	Q4	DPME, SACA

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: MONITORING AND EVALUATION *(continued)*					
Advocacy					
Conduct advocacy visits to relevant decision-makers on M&E: State Commissioner of Health, HMB, DPRS, SACA, Ministry of Planning and Budget (MPB), Office of the Head of Service (HoS), State Legislature and PHCMB	Biannually	Q4	Q1		DG, SACA
IEC materials					
Produce and distribute M&E newsletter, factsheet, magazine, IEC and other information products (monthly, quarterly, bi-annually, annually etc)	monthly, quarterly, bi-annually, annually	Q1-Q4	Q1-Q4		DPME, SACA
FOCUS AREA: PROGRAM MANAGEMENT					
Situation analysis					
Develop and distribute state and LGA score cards on key performance indicators quarterly)	400 copies * 9 (3,600)	Q4	Q1-Q4	Q1-Q4	SACA/SMOH (DPRS)/lead IPs
Conduct resource mapping and gap analysis	2 facilitators for 5days	Q4			SACA, IPs
Coordination and resource mobilization					
Conduct state-wide rapid health facility assessment	Once	Q2			SACA, Lead IPs
Conduct Kano State PMTCT diagnostic	Once	Q2			SACA, NACA, FMoH
Conduct site selection for PMTCT scale-up activities	420 health facilities (17 Secondary & 403 Primary HFs)	Q4			SACA, Lead IPs
Develop costed state PMTCT operational plan	Once	Q3			SACA, Lead IPs
Print and distribute the costed operational plan	500 copies	Q4			SACA, Lead IPs
Convene a stakeholders forum/dissemination of operational plan	1 meeting (200 participants)	Q4			SACA/Lead IPs
Conduct monthly mentorship to the implementing sites	11 teams of 5 members each, to visit 4 LGAs per team each month (27 months)	Q4	Q1-Q4	Q1-Q4	SACA, Lead IPs
Conduct quarterly supportive supervision visits	11 teams of 3 members to visit 4 LGAs per team each quarter (9 quarters)		Q1&Q3	Q1&Q3	SACA, Lead IPs
Conduct bi-annual partners/stakeholders Forum on HIV/AIDS	50 participants * 4 meetings (200)		Q4	Q4	SACA
Conduct annual summit on HIV/AIDS	250 participants * 2 meetings (500)	Q4	Q1-Q3		SACA

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PROGRAM MANAGEMENT *(continued)*					
Coordination and resource mobilization *(continued)*					
Provide a framework for the Governor's Award (for the best performing LGA) during annual summit on HIV/AIDS for 3 years	3 Awards	Q4			SACA, Lead IPs
SACA to liaise with the HMB and PHCMB to address human resource gap for PMTCT scale-up	Annually	Q4	Q1-Q4	Q1-Q4	SACA/PHMB/HMB
Inaugurate a State Management Team (SMT)	1 event (30 participants)	Q4			SACA
Hold quarterly review meetings of SMT	9 meetings * 15 participants (135)	Q4	Q1-Q4	Q1-Q4	SACA
Review membership and TOR of the current State Implementation Team	1 meeting (25 participants)	Q4	Q1-Q4	Q1-Q4	SACA, SMoH
Hold monthly State Implementation Team meetings	27 meetings * 20 participants (540)	Q4	Q1-Q4	Q1-Q4	SACA
Hold monthly cluster coordination meetings (50 clusters in 44 LGAs)	15 participants x 50 clusters / monthly x 27 meetings (20,250)	Q4	Q1-Q4	Q1-Q4	SACA, IPs
Hold quarterly PMTCT technical working group meetings (TWG)	20participants x 9 meetings (180)	Q4	Q1-Q4	Q1-Q4	SACA, IPs
Capacity building					
Build the capacity of PHC team/LACAs to effectively monitor and coordinate the implementation of PMTCT scale up plan	7participants per LGA (308 participants)	Q4			SACA, IPs
Build capacity of SMT on leadership and program management	15participants		Q1		SACA, SMoH, IPs
Build capacity of SIT on supervision, mentoring and monitoring	20participants from 10 CSOs		Q1&Q2		SACA
Enhance the participation of private health facilities within the state	100 participants (1 meeting)	Q4			SACA, SMoH
Infrastructure					
Assess infrastructure needs and develop BOQ	420 HFs	Q4	Q1		SACA/PHHMB
Carry out infrastructural upgrades	420 HFs		Q1-Q3		HMB, PHCMB
Procure & maintain 3 vehicles for supervision and monitoring (1 bus and 2 4x4 wheel drive vehicles)	3 vehicles (1 in 2014, 2 in 2015)	Q4	Q2	Q1	SACA

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PROGRAM MANAGEMENT *(continued)*					
Community mobilization					
Advocacy					
Develop advocacy package (to State Executive Council; State House of Assembly; philanthropists and private sectors)	5 persons for 3 days	Q4			SACA, IPs
Conduct advocacy visits to State Executive Council; State House of Assembly; philanthropists and private sectors	10 persons for 7 visits	Q4			SACA, IPs

SECTION

8 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 summarised in Table 6 below.

Table 6: Targets of the Core Indicators for Kano State

Indicator	Baseline (2012)	2013	2014	2015
Number of health facilities that provide ANC plus PMTCT services	118	338	538	538
Number females age 15 – 49 years newly tested HIV positive	7,367	6,323	5,212	4,030
Number of pregnant women counselled tested and given HIV results	66,083	179,136	493,724	574,074
Number of HIV infected women aged 15 – 49 years who accessed comprehensive family planning services	N/A	4,555	4,743	4,747
Number of pregnant women reached with antiretroviral drugs for PMTCT according to the national guidelines	780	6,091	16,787	19,519
Number of HIV positive pregnant women in need of treatment initiated on ART for their own health (50% of total)	983	3,045	8,393	9,759
Number of HIV exposed infants offered first PCR test from 6 – 8 weeks of age	86	6,091	16,787	19,519

8.1 KANO STATE PMTCT M&E FRAMEWORK

GOAL

Improved maternal health and child survival by 2015 through the accelerated provision of comprehensive services for elimination of mother-to-child transmission of HIV

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

SECTION

9 Summary Budget

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

Table 7: Budget Summary Table

THEMATIC AREAS	Year 1 (NGN)	Year 2 (NGN)	Year 3 (NGN)	Total (NGN)	Total (USD)
PMTCT service supply systems	111,446,709	504,632,780	133,998,380	750,077,868	4,839,212
Health care commodities	612,028,007	3,223,039,956	1,812,383,869	5,647,451,832	36,435,173
PMTCT demand creation system	292,047,100	251,222,000	-	543,269,100	3,504,962
Monitoring & evaluation	43,632,900	150,713,900	148,258,600	342,605,400	2,210,357
Program management	171,442,108	1,387,026,292	38,880,000	1,597,348,400	10,305,474
Grand total	**1,230,596,824**	**5,516,634,928**	**2,133,520,848**	**8,880,752,600**	**57,295,178**

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	
Staffing	Recruit and deploy HCWs (nurses/midwives/CHEWs, lab and pharmacy staff) for HTC service provision at SHCs (no cost)
	Recruit and deploy HCWs (nurses/midwives/CHEWs, lab and pharmacy staff) for HTCHTC service provision at PHCs (no cost)
Training & capacity	Conduct 10-day training for HCWs on HTCHTC at private and public PHCs and SHCs (840 in 21 batches + 5 facilitators per batch)
	Conduct 10-day HTCHTC/STI training for Kwankwasiya Medical Outreach (60 persons in 2 batches + 5 facilitators per batch)
	Conduct 3-day training on syndromic management of STIs for HCWs at private and public PHCs and SHCs (420 in 10 batches + 2 facilitators per batch)
	Support facility based step-down trainings for HTC and syndromic management of STIs
Sensitization	Sensitize HCWs on PITC and multi-point HIV testing at health facilities by LGA/state team (onsite sensitization)
Linkages/referrals	Identify and train CBOs on a family centered HTC and referrals (in collaboration with Kano state PHCMB)
Mentoring & supervision	Conduct monthly LGA-level mentoring and supportive supervisory visits on HTC and syndromic management of STIs to all sites (by MCH+LACA+HIV FP+ M&E)
	Conduct quarterly state-level joint mentoring and supportive supervisory visits on HTC and syndromic management of STIs to all sites (SACA/SIT)
	Conduct state-level joint integrated supportive supervisory visits to all sites + Kwankwasiya medical outreach (costed on state ISS budget)
	Support monthly HTCHTC outreach by CBOs
	Conduct quarterly HTC outreach at adult literacy schools in collaboration with Agency for Mass Education
	Conduct monthly mentoring and supervisory visits for CBOs, PMVs, CVs, Community Pharmacists and TBAs by LGA with support from KSACA and PHCMB (cost linked to monthly mentoring visits)
Condom promotion	Engage community volunteers, community pharmacists and PMVs through Association of Community Pharmacists and Nigerian Association of Patent Proprietary Medicine Dealers (NAPPMED) to conduct community outreaches for condom promotion and HTC
	Conduct 2-day ToT for community volunteers, community pharmacists and PMVs on condom promotion, HTC and referrals in PMTCT
	Conduct 1-day step down training for community volunteers, community pharmacists and PMVs on condom promotion, HTC and referrals in PMTCT
PMTCT service supply systems sub-total	

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
			-	-
			-	-
41,195,700	164,782,800	-	205,978,500	1,328,894
3,042,400	12,169,600	-	15,212,000	98,142
6,820,000	27,280,000	-	34,100,000	220,000
1,000,000	4,000,000	-	5,000,000	32,258
300,000	1,200,000	-	1,500,000	9,677
594,000	2,376,000	-	2,970,000	19,161
1,395,821	4,940,179	4,940,179	11,276,179	72,750
898,824	3,181,176	3,181,176	7,261,176	46,846
			-	-
1,832,015	6,483,985	6,483,985	14,799,985	95,484
-	616,000	616,000	1,232,000	7,948
			-	-
140,000	-	-	140,000	903
-	1,054,000	-	1,054,000	6,800
-	1,680,000	-	1,680,000	10,839
57,218,760	**229,763,740**	**15,221,340**	**302,203,840**	**1,949,702**

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% *(continued)*

Strategic intervention	Activities
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Drugs***
	Procurement of drugs for STI treatment {Cotrimoxazole,Doxycycline, Ciprofloxacin, Metronidazole, Fluconazole, Clotrimazole V. tabs and cream, Ampicillin/Cloxacillin, Acyclovir, dispensing envelopes and bags for 106,773 clients)
	Consumables
	Procurement of RTKs (Determine= 1,224,688)
	Procurement of confirmatory test kit (Stat pack= 244,938)
	Procurement of tie breaker test kit (Unigold=24,494)
	Procurement of laboratory consumables
	Procurement of male condoms (135,665 carton(100x30))
	Procurement of female condoms
	Procurement of lab reagents and lab consumables for STI diagnosis
	Equipment
	Procurement of ANC equipment and sterilization equipment to promote infection control
Distribution	***Consumables***
	Distribution of commodities to sites
Training & capacity building	LMIS trainings (TOT for 88 person for 5 days X 2 batches + 2 facilitators)
	LMIS step down training (2 day for 2 persons per facility) + 2 trainers
Health care commodities sub-total	
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS	
Training on IPC	Conduct 2-day training on community mobilization on PMTCT for CSOs (CBOs and support groups)
	1 -day training for frontline peer educators on interpersonal communication (IPC) techniques for mobilization and to support dialogues at Majalis levels (Male Care forum)
	Conduct a 5-day training for community health workers on IPC
	Conduct a 3-day training for media practitioners to mainstream ANC/HTC/PMTCT/RH/FP messages into their programs
	Train local drama groups & KANYWOOD to mainstream ANC/HTC/PMTCT/RH/FP messages into their activities (cost as defined in PM worksheet
Community mobilization	***Sensitization***
	Conduct a 1-day sensitization meeting for Imams.
	Conduct a 1-day sensitization meeting for pastors

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
6,673,313	26,693,250	20,019,938	53,386,500	344,429
22,963,125	91,852,500	68,889,375	183,705,000	1,185,194
13,777,875	55,111,500	41,333,625	110,223,000	711,116
1,378,125	5,512,500	4,134,375	11,025,000	71,129
9,689,525	38,758,100	29,068,575	77,516,200	500,105
203,497,500	813,990,000	610,492,500	1,627,980,000	10,503,097
17,806,250	71,225,000	53,418,750	142,450,000	919,032
5,338,650	10,677,300	10,677,300	26,693,250	172,215
			-	-
2,370,000	9,480,000	7,110,000	18,960,000	122,323
4,264,500	4,264,500	-	8,529,000	55,026
1,856,000	5,568,000	-	7,424,000	47,897
289,614,863	**1,133,132,650**	**845,144,438**	**2,267,891,950**	**14,631,561**
35,068,000	35,068,000	-	70,136,000	452,490
32,648,000	32,648,000	-	65,296,000	421,265
18,780,000	18,780,000	-	37,560,000	242,323
2,927,000	-	-	2,927,000	18,884
2,927,000	-	-	2,927,000	18,884
6,798,000	6,798,000	-	13,596,000	87,716
5,808,000	5,808,000	-	11,616,000	74,942

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% *(continued)*

Strategic intervention	Activities
THEMATIC AREA: PMTCT DEMAND CREATION SYSTEMS *(continued)*	
Community mobilization *(continued)*	***Advocacy***
	Conduct advocacy to the state executive council & state house of assembly to Implement free MCH at all facilities in Kano state.
	Conduct advocacy to the Local Government Chairman to provide infrastructure at ANC service points
	Conduct advocacy to gatekeepers (traditional/religious leaders) to reach their community/ congregation with targeted PMTCT messages
	Conduct advocacy to the National Union of Road Transport Workers to facilitate access to facilities in times of emergency
Media engagement	Produce PMTCT Home videos for local audience and "Majigi" locations/viewing centers
Mentoring & supervision	Conduct quarterly TBA network coordination meeting
IEC materials	Conduct a 5-day workshop to adapt and pretest materials (print and electronic messages/ materials) for all four PMTCT prongs
	Review and finalize BCC messages
	Produce SBCC materials - posters, pamphlets, fliers, pens, t-shirts, hijabs etc.
	Produce radio messages and programs
	Broadcast radio messages
	Produce & broadcast 52 episodes enter-educate radio programs
	Distribute SBCC materials (at no cost)
	Brand PMTCT service centers as user- friendly centers
Community services	Launch Kano State eMTCT Implementation Plan at state level
	Provide grants to CBOs/support groups and frontline workers to implement integrated community PMTCT programs
	Training of facilitators of community dialogue
	Conduct community dialogues with all stakeholders including TBA/traditional healers
PMTCT demand creation systems 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)
1,486,100	-	-	1,486,100	9,588
4,796,000	4,796,000	-	9,592,000	61,884
-	-	-	-	-
2,376,000	2,376,000	-	4,752,000	30,658
4,000,000	4,000,000	-	8,000,000	51,613
11,880,000	11,880,000	-	23,760,000	153,290
2,370,000	-	-	2,370,000	15,290
-	-	-	-	-
7,050,000	7,050,000	-	14,100,000	90,968
1,700,000	1,700,000	-	3,400,000	21,935
10,950,000	10,950,000	-	21,900,000	141,290
18,000,000	18,000,000	-	36,000,000	232,258
-	-	-	-	-
21,320,000	-	-	21,320,000	137,548
9,795,000	-	-	9,795,000	63,194
72,600,000	72,600,000	-	145,200,000	936,774
8,604,000	8,604,000	-	17,208,000	111,019
10,164,000	10,164,000	-	20,328,000	131,148
292,047,100	**251,222,000**	**-**	**543,269,100**	**3,504,962**
638,880,722	**1,614,118,390**	**860,365,778**	**3,113,364,890**	**20,086,225**

SECTION

10 APPENDIX-DETAILED BUDGET

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training & capacity	Conduct 5-day training for LGA MCH/RH coordinators + SIT on SRH/ HIV integration (in 2 batches)
Service provision	Print and disseminate the SRH/HIV guidelines, service providers' curriculum and manual to all facilities (distribution linked to mentoring visits)
	Conduct monthly community level outreaches for family planning service provision
Sensitization	Conduct regular community level sensitization on FP
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Drugs***
	Procure Emergency contraceptives
	Consumables
	Procurement of family planning commodities
	Procurement of family planning consumables
	Equipment
	Procurement of family planning equipment (Examination couch, weighing balance, lamp)
Distribution	***Consumables***
	Distribution of family planning commodities
Stock management (CLMS)	Capacity building for service providers (CLMIS) 3 day TOT training for 44 persons (1 per LGA)
Health care commodities sub-total	
Objective 2 sub-total	

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
-	8,116,000	-	8,116,000	52,361
-	5,040,000	-	5,040,000	32,516
4,871,494	44,226,000	44,226,000	93,323,494	602,087
			-	-
4,871,494	**57,382,000**	**44,226,000**	**106,479,494**	**686,964**
17,363	69,450	52,088	138,901	896
-	-	-	-	-
1,156,650	4,626,600	3,469,950	9,253,200	59,698
-	-	-	-	-
832,500	3,330,000	2,497,500	6,660,000	42,968
-	2,564,000	-	2,564,000	16,542
2,006,513	**10,590,050**	**6,019,538**	**18,616,101**	**120,104**
6,878,007	**67,972,050**	**50,245,538**	**125,095,594**	**807,068**

SECTION

10 APPENDIX-DETAILED BUDGET

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

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Staffing	Recruit and deploy HCWs (doctors/nurses/midwives/CHEWs, lab and pharmacy staff) for PMTCT service provision at SHCs
	Recruit and deploy HCWs (doctors/nurses/midwives/CHEWs, lab and pharmacy staff) for PMTCT service provision at PHCs
Training & capacity	Conduct facility level HTC for all pregnant women at ANC
	Conduct 6-day training in Integrated PMTCT for secondary health facilities in 3 batches
	Conduct 5-day training on Integrated Management of Pregnancy and Childbirth (IMPAC) for PHCs and LGA staff (in 20 batches)
	Conduct 2-day onsite training on adherence counseling for HCWs
	Conduct 5-day pharmaceutical care trainings for HCWs in PMTCT sites (secondary health facilities and CP preceptors) including LMIS (51 persons in 2 batches)
	Conduct 3-day ART dispensing and documentation training for HCW in PHCs (in 20 batches)
	Conduct 5-day onsite pharmacy best practices training for HCW for 17 SHC
	Conduct 5-day medical laboratory services training for HCWs in 17 SHCs
Linkages/referrals	Conduct 2-day orientation meeting for TBAs as community resource persons on HTC and referrals for pregnant women (by state in 10 batches)
	Support TBAs to offer facilitated referrals to pregnant women for HTC.
	Support PHC staff to conduct twice monthly HTC and condom distribution through outreach in the community (link routine immunization outreach services + Kwankwasiya medical team outreach)
	Engage CBOs for identification and referral of pregnant women from community to facility for PMTCT services and client tracking
	Support monthly meetings for CBOs and TBAs (for data collection, payment for referrals)
Mentoring & supervision	Support facility level partner counseling and testing (HTC) (linked to LGA mentoring visits)
	Conduct monthly LGA-level mentoring visits and joint supervisory to PMTCT sites (link cost to prong 1 mentoring)
	Conduct quarterly state-level service quality improvements in PMTCT sites (link cost to prong 1 mentoring)
	Print and disseminate national guidelines, job aids and SOPs for PMTCT/EID, IYCF and HTC (distribution linked to activation or mentoring visits)
Site activation	Activate 420 sites for PMTCT/EID service provision 2 HCW per facility over 2 days each
IEC materials	Print and distribute IMPAC training materials for PHCs (training manuals and modules)
PMTCT service supply systems sub-total	

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
2,968,600	11,874,400	-	14,843,000	95,761
6,571,200	26,284,800	-	32,856,000	211,974
622,800	2,491,200	-	3,114,000	20,090
1,579,200	6,316,800	-	7,896,000	50,942
4,052,400	16,209,600	-	20,262,000	130,723
1,230,800	4,923,200	-	6,154,000	39,703
909,600	3,638,400	-	4,548,000	29,342
-	3,980,000	-	3,980,000	25,677
-	8,910,000	8,910,000	17,820,000	114,968
-	-	-	-	-
-	1,782,000	1,782,000	3,564,000	22,994
-	5,940,000	5,940,000	11,880,000	76,645
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
571,200	2,284,800	-	2,856,000	18,426
2,016,000	8,064,000	-	10,080,000	65,032
630,000	2,520,000	-	3,150,000	20,323
21,151,800	**105,219,200**	**16,632,000**	**143,003,000**	**922,600**

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

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Procurement (quantification, forecasting)	***Drugs***
	Procurement of ARVs for triple prophylaxis (TDF+3TC+EFV) for 90% infected pregnant women
	Procurement of ARVs for triple prophylaxis (alternative regimen - AZT+3TC+EFV) 5%
	Procurement of ARVs for HIV exposed infants (NVP suspension)
	Procurement of co-trim for HIV infected pregnant women
	Procurement of co-trim for HIV exposed infants
	Procurement of essential ANC drugs (e.g. haematenics, IPT)
	Consumables
	Procurement of DBS kits
	Equipment
	Procurement of lab equipment, starter reagents and consumables for secondary health facilities (CD4, chemistry and haematology)
	Procurement of POC machine
	Procurement of SMS printer
Logistics	Laboratory equipment maintenance
	Sample transfer (CD4, haematology, chemistry) for primary health care centers
	Sample transfer for DBS
Health care commodities sub-total	
Objective 3&4 sub-total	

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
141,055,500	564,222,000	423,166,500	1,128,444,000	7,280,284
10,748,325	42,993,300	32,244,975	85,986,600	554,752
8,250,000	33,000,000	24,750,000	66,000,000	425,806
4,465,000	17,860,000	13,395,000	35,720,000	230,452
25,427,344	101,709,375	76,282,031	203,418,750	1,312,379
-	-	-	-	-
660,600	2,642,400	1,981,800	5,284,800	34,095
-	713,036,931	-	713,036,931	4,600,238
-	74,797,800	-	74,797,800	482,566
-	9,856,000	-	9,856,000	63,587
-	-	-	-	-
7,560,000	30,240,000	22,680,000	60,480,000	390,194
7,560,000	30,240,000	22,680,000	60,480,000	390,194
205,726,769	**1,620,597,806**	**617,180,306**	**2,443,504,881**	**15,764,548**
226,878,569	**1,725,817,006**	**633,812,306**	**2,586,507,881**	**16,687,148**

SECTION

10 APPENDIX-DETAILED BUDGET

Prong 4: Family centered care and support

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

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

Strategic intervention	Activities
THEMATIC AREA: PMTCT SERVICE SUPPLY SYSTEMS	
Training	Conduct 3-day training for HCWs at SHCs and PHCs on EID in 20 batches
	Conduct 6-day ART training for 44 secondary health facilities + model PHCs in 6 batches
	Conduct 5-day medical laboratory services training for HCWs in 44 SHCs + model PHCs
Site activation	Activate 44 sites for ART service provision
Service provision	Support DBS sample transfer from PHCs and SHCs to national PCR labs
	Support monthly mother support groups (MSGs) meetings
	Support mother support groups (MSGs) to provide community based adherence support and tracking of HIV positive pregnant women and their infants
	Support HCW to conduct client tracking
Linkages/referrals	Print and distribute job aids on EID to the laboratory and clinics (SHCs and PHCs) (linked to PMTCT printing)
	Support referral and linkages of HIV positive pregnant women on lifelong ART and infected infants to comprehensive treatment sites through cluster coordination meetings
PMTCT service supply systems sub-total	
THEMATIC AREA: HEALTH CARE COMMODITIES	
Procurement (quantification, forecasting)	***Drugs***
	Procurement of ARVs for lifelong ART
	Procurement of RTK for couple counseling
	Consumables
	Procurement of state specific basic care kits (LLIN, water treatment, buckets with lid and spigot etc.)
	Procurement of nutritional supplement for HIV pregnant women
	Procurement of nutritional supplement for HIV infected/exposed babies (malnourished children)
	Procurement of RTKs for family care
	Procurement of modem and airtime for submission of logistic reports
Distribution	***Consumables***
	Distribution of basic care kits
Stock management LMIS	Supportive supervision for LMIS reporting (3 persons per LGA, for 3 days bimonthly)
Health care commodities sub-total	
Objective 5&6 sub-total	

Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)	Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)
4,052,400	16,209,600	-	20,262,000	130,723
6,529,600	26,118,400	-	32,648,000	210,632
2,134,000	8,536,000	-	10,670,000	68,839
871,200	3,484,800	-	4,356,000	28,103
3,747,303	13,262,697	13,262,697	30,272,697	195,308
649,830	2,299,920	2,299,920	5,249,670	33,869
649,830	13,441,638	13,441,638	27,533,106	177,633
5,198,639	13,441,638	13,441,638	32,081,915	206,980
-	-	-	-	-
4,371,854	15,473,147	15,473,147	35,318,147	227,859
28,204,656	**112,267,840**	**57,919,040**	**198,391,535**	**1,279,945**
-	-	-	-	-
-	-	-	-	-
10,410,000	41,640,000	31,230,000	83,280,000	537,290
42,951,563	171,806,250	128,854,688	343,612,500	2,216,855
60,475,800	241,903,200	181,427,400	483,806,400	3,121,332
-	-	-	-	-
599,500	2,398,000	1,798,500	4,796,000	30,942
-	-	-	-	-
243,000	972,000	729,000	1,944,000	12,542
114,679,863	**458,719,450**	**344,039,588**	**917,438,900**	**5,918,961**
142,884,518	**570,987,290**	**401,958,627**	**1,115,830,435**	**7,198,906**

SECTION

10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities
THEMATIC AREA: MONITORING & EVALUATION	
Data quality assurance	Conduct 6-day training on M&E (tools refresher, data quality and supportive supervision) for 100 selected state and LGA M&E officers (residential)
	Conduct 6-day data management training for 10 state M&E officers (non-residential)
	Conduct 5-day DHIS (eNNRIMS) training for 46 selected data officers/managers (34 record officers from secondary health facilities, 6 zonal M&E officers and 4 SACA and 2 SMoH M&E officers)
	Conduct state led quarterly M&E supportive supervision to LGAs and health facilities
	Procure and distribute data collection and reporting tools (NHMIS and harmonized HIV data collection tools) for 700 health facilities including private
Routine monitoring	Conduct state quarterly M&E review meetings (55 participants)
	Conduct LGA monthly M&E review meetings (1,332 participants)
	Conduct quarterly M&E TWG meetings (55 participants)
	Participate in the Quarterly Partner Coordination Forum (20 participants)
	Deploy 6 SACA zonal M&E officers for monitoring HIV M&E activities
	Conduct LGA led monthly M&E supportive supervision to health facilities
	Conduct mid-term evaluation of eMTCT program
Capacity building	Conduct service availability mapping survey and establish an up to date PMTCT facility list (including private facilities)
	Conduct annual performance review meeting (44 PHCCs, 6 zonal M&E officers, 10 SACA officers, 10 SMoH officers and 10 partners)
	Conduct M&E staffing needs assessment
Advocacy	Conduct advocacy visits to relevant decision-makers on M&E: State Commissioner of Health, HMB, DPRS, SACA, Ministry of Planning and Budget (MPB), Office of the Head of Service (HoS), State Legislature and PHCMB
IEC materials	Print and distribute the 2013-2015 Kano State eMTCT scale up plan document
	Produce and distribute M&E newsletter, factsheet, magazine, IEC and other information products (monthly, quarterly, bi-annually, annually etc)
Other	Deploy 2 additional M&E Assistants to support SACA M&E unit
Monitoring & 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)
14,757,000			14,757,000	95,206
	303,000		303,000	1,955
	723,800		723,800	4,670
480,000	1,920,000	1,920,000	4,320,000	27,871
9,187,500	73,500,000	73,500,000	156,187,500	1,007,661
122,800	491,200	491,200	1,105,200	7,130
6,654,000	26,616,000	26,616,000	59,886,000	386,361
122,800	491,200	491,200	1,105,200	7,130
70,300	281,200	281,200	632,700	4,082
			-	-
10,560,000	42,240,000	42,240,000	95,040,000	613,161
	1,370,000		1,370,000	8,839
			-	-
	469,000	469,000	938,000	6,052
1,120,000			1,120,000	7,226
58,500	58,500		117,000	755
			-	-
500,000	2,250,000	2,250,000	5,000,000	32,258
-	-	-	-	-
43,632,900	**150,713,900**	**148,258,600**	**342,605,400**	**2,210,357**

SECTION

10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities
THEMATIC AREA: PROGRAM MANAGEMENT	
Situation analysis	Develop and distribute state and LGA score cards on key performance indicators (quarterly)
	Conduct resource mapping and gap analysis
Coordination & resource mobilization	Conduct state-wide rapid health facility assessment
	Conduct Kano State PMTCT Diagnostic
	Conduct site selection for PMTCT scale-up activities
	Develop costed state PMTCT operational plan
	Print and distribute the costed operational plan
	Convene a stakeholders forum/dissemination of operational plan
	Conduct monthly mentorship to the implementing sites
	Conduct quarterly supportive supervision visits
	Conduct bi-annual partners/stakeholders Forum on HIV/AIDS
	Conduct annual summit on HIV/AIDS
	Provide a framework for the Governor's Award (for the best performing LGA) during annual summit on HIV/AIDS for 3 years
	SACA to liaise with the HMB and PHCMB to address human resource gap for PMTCT scale-up
	Inaugurate a State Management Team (SMT)
	Hold quarterly review meetings of SMT
	Review membership and TOR of the current State Implementation Team
	Hold monthly State Implementation Team meetings
	Hold monthly cluster coordination meetings (50 clusters in 44 LGAs)
	Hold quarterly PMTCT technical working group meetings (TWG)
Infrastructure	Assess infrastructure needs and develop BOQ
	Carry out infrastructural upgrades
	Procure & maintain three vehicles for supervision and monitoring (1 bus and 2 4x4 wheel drive vehicles)
Community Mobilization	***Advocacy***
	Develop advocacy package (to State Executive Council; State House of Assembly; philanthropists and private sectors)
	Conduct advocacy visits to State Executive Council; State House of Assembly; philanthropists and private sectors

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)
346,000	1,384,000	1,384,000	3,114,000	20,090
285,000	-	-	285,000	1,839
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
1,750,000	-	-	1,750,000	11,290
720,000	-	-	720,000	4,645
1,320,000	5,280,000	5,280,000	11,880,000	76,645
264,000	1,056,000	1,056,000	2,376,000	15,329
-	640,000	640,000	1,280,000	8,258
-	1,100,000	1,100,000	2,200,000	14,194
250,000	250,000	250,000	750,000	4,839
-	-	-	-	-
90,000	-	-	90,000	581
45,000	180,000	180,000	405,000	2,613
-	-	-	-	-
120,000	480,000	480,000	1,080,000	6,968
4,500,000	18,000,000	18,000,000	40,500,000	261,290
40,000	160,000	160,000	360,000	2,323
1,680,000	1,680,000	-	3,360,000	21,677
141,999,708	1,338,000,292	-	1,480,000,000	9,548,387
10,350,000	10,350,000	10,350,000	31,050,000	200,323
165,000	-	-	165,000	1,065
525,000	-	-	525,000	3,387

SECTION

10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities
THEMATIC AREA: PROGRAM MANAGEMENT *(continued)*	
Capacity Building	Build the capacity of PHC team/ LACAs to effectively monitor and coordinate the implementation of PMTCT scale up plan
	Build capacity of SMT on leadership and program management
	Build capacity of SIT on supervision, mentoring and monitoring
	Build capacity of HMTs on leadership and coordination
	Enhance the participation of private health facilities within the state
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)
6,472,400	-	-	6,472,400	41,757
-	1,133,000	-	1,133,000	7,310
-	1,133,000	-	1,133,000	7,310
-	6,200,000	-	6,200,000	40,000
520,000	-	-	520,000	3,355
171,442,108	**1,387,026,292**	**38,880,000**	**1,597,348,400**	**10,305,474**
215,075,008	**1,537,740,192**	**187,138,600**	**1,939,953,800**	**12,515,831**
1,230,596,824	**5,516,634,928**	**2,133,520,848**	**8,880,752,600**	**57,295,178**

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