ANAMBRA STATE

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

2013 – 2015

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The Anambra 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), United Nations Children's Fund (UNICEF) and United Nations Joint Programme on AIDS (UNAIDS). FHI 360, UNICEF and UNAIDS provided technical assistance to the Anambra State Government during development of the plan. Financial assistance was provided by USAID under the terms of the Cooperative Agreement AID-620-A-00002, of the Strengthening Integrated Delivery of HIV/AIDS Services Project. This report does not necessarily reflect the views of UNAIDS, UNICEF, FHI 360, USAID or the United States Government.

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Foreword

Globally, 20% of HIV positive pregnant women have access to antiretroviral therapy (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 ARVs for HIV positive women for prevention of mother-to-child transmission of HIV (PMTCT), Nigeria accounts for 30% of this 80% gap. In addition, Nigeria contributes to 15% if the children in need of ARVs. PMTCT is the most rewarding and cost effective intervention in HIV prevention. Nigeria is a signatory to the *"Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive"* which is the road map to ending new HIV infections in children worldwide by 2015.

Nigeria is unarguably a priority country for immediate and sustained scale-up of PMTCT services if the world is to achieve the elimination goal. Similarly, with a population of over four million, Anambra State is one of the priority states referred to as the 12+1 states believed to account for more than 60% of Nigeria's PMTCT gap. This clearly indicates the need for scaling up PMTCT services and the production of the eMTCT operational plan.

The Anambra State PMTCT scale-up plan is timely. The State Government under the able leadership of Mr. Peter Obi (Okwute) OON has worked tirelessly to upgrade services at all health care delivery points in the state. This he has dome by improving infrastructure, employing relevant staff, building the capacity of existing staff and purchasing consumables. The State Government has strengthened the Anambra State Agency for the Control of AIDS (ANSACA) and collaborates with donors and partners to ensure the identified gaps are closed.

Produced by key stakeholders, the Anambra State Elimination of Mother-to-Child Transmission of HIV eMTCT Operational Plan 2013-2015 is a comprehensive plan for the state. The document takes into consideration the four-pronged strategy to prevent HIV-Among infants and young children. This includes key interventions to be implemented as a component of the overall maternal newborn and child health (MNCH) services and is in line with the national/state PMTCT program.

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

Dr Lawrence C. Ikeako

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Acknowledgements

The Anambra State Ministry of Health (SMoH) and State Agency for the Control of AIDS hereby thank all persons involved in the development of the *"Anambra State Operational Plan for the Elimination of Mother to Child Transmission of HIV 2013-2015".* The level of commitment and hard work demonstrated by the staff of the State AIDS/STIs Control Program (SASCP) unit and the ANSACA staff in general is acknowledged.

In particular, the technical support provided by the National AIDS/STIs Control Program (NASCP), National Agency for the Control of AIDS (NACA), UNICEF, UNAIDS, FHI 360 and other partners in the state and the Deep Dive consultants is highly appreciated. They all reviewed our plan and ensured it aligned with the national eMTCT scale-up plan goal objectives and targets. We also acknowledge the development assistance provided to Anambra State by USAID, particularly HIV/AIDS programming over the years.

We express our profound gratitude to the State Government for the financial and moral support as well as the encouragement given to us in the course of producing this document.

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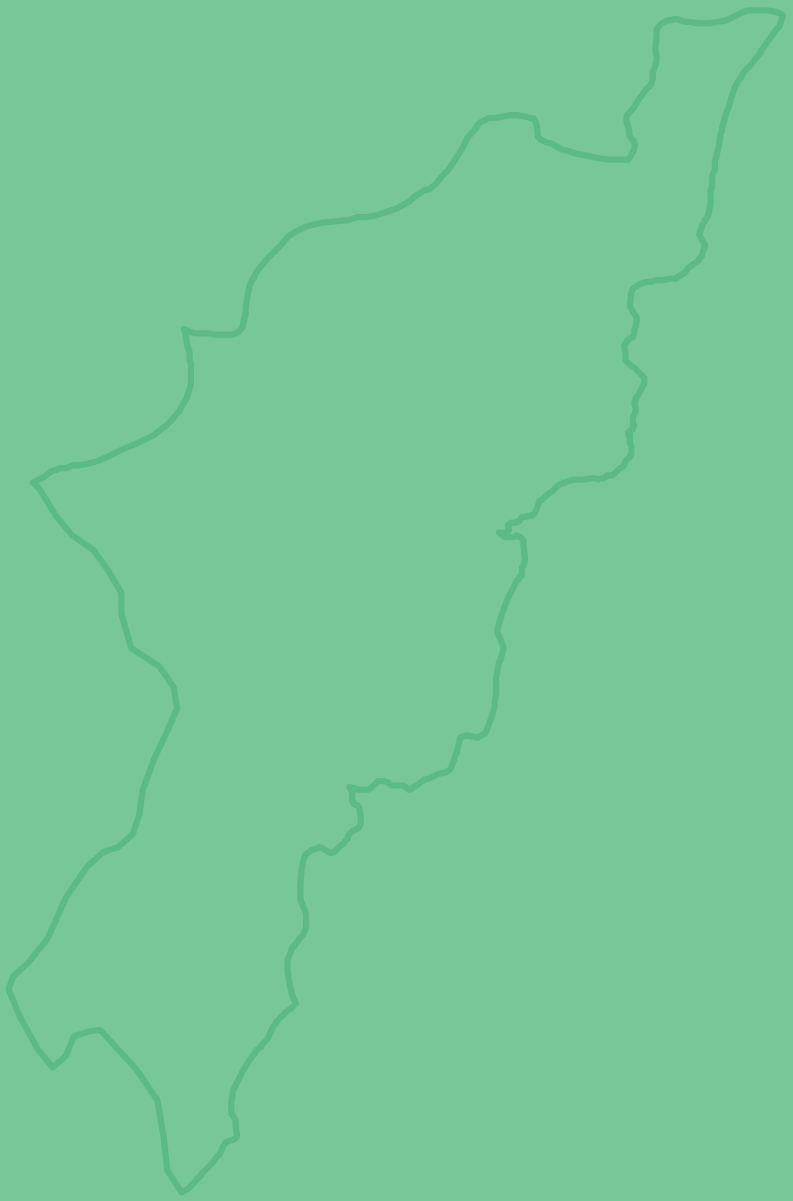
Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ANSACA	Anambra State AIDS Control Agency
ART	Artemisin Combination Therapy
ARVs	Anti-Retroviral Drugs
BNA	Bottleneck Analysis
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
DALYs	Disability Adjusted Life Years
DBS	Dried Blood Spot (Sample)
DFID	UK Department for International Development
DPRS	Department of Planning Research and Statistics
DQA	Data Quality 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
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
TBL	**T**uberculosis Laboratory
TOTs	Training Of Trainers
TOR	Terms of Reference
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VDRL	Venereal Diseases Research Laboratory
WHO	World Health Organization



Executive Summary

The sub-optimal coverage of prevention of mother-to-child transmission (PMTCT) of HIV services is evident in the fact that Nigeria has the highest burden of mother-to-child transmission of HIV (MTCT) in the world and is among the top ten countries with poor maternal and child health indices. In the light of the above, in June 2011, the President accented to the "Global plan to eliminate pediatric HIV and keep their mothers alive by 2015". In 2012, under the leadership of National Agency for Control of HIV/AIDS (NACA), 12 states plus the Federal Capital Territory (FCT), i.e. 12+1 states, which account for 70% of the PMTCT burden in Nigeria were identified for an increased focus.

HIV prevalence among pregnant women in the Anambra State was 8.7% based on the 2010 Antenatal Care (ANC) sentinel surveillance, ranking fourth in the country. Review of available data, the bottleneck analysis (BNA) and a rapid health facility assessment (RHFA) conducted in the state showed ANC attendance and delivery is high albeit occurring mostly in private facilities. Only 63 of the 1153 facilities providing antenatal services in Anambra State provide anti-retroviral drugs (ARVs) for PMTCT at the end of 2012. This translates to only 5% coverage rate. Of the 634 ANC facilities assessed in Anambra state, only 41 facilities (two public and 39 private) met the national human resource (HR) standard for PMTCT service provision. When applying the criteria of having at least four clinical staff to perform patient care duties (either nurses or community health workers), then 313 facilities can be upgraded to provide PMTCT services.

The findings from these efforts were used at a two-day planning workshop between June 26th and June 27th 2013. At the end of the meeting, a costed *"Anambra State Operational Plan for the Elimination of Mother-to-Child Transmission of HIV 2013-2015"* with an estimated cost of NGN 10,455,971,614 (USD 67,457,881) was developed. The *eMTCT Operational Plan 2013-2015* was disseminated to His Excellency, Peter Obi on June 28th 2013. He committed that the Anambra State Government would provide HIV rapid test kits (RTKs) for all facilities that would provide PMTCT in the state.

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

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

If implemented to scale, Anambra State's *eMTCT Operational Plan 2013-2015* would prevent, **8,306** infections among WRA, **7,196** pregnancies among HIV-positive women, **27,805** infections among HIV exposed infants (HEI), **4,157** infant deaths, and **58** maternal deaths will be prevented by meeting the PMTCT targets. Combined, this will result in **784,629** disability adjusted life years (DALYs) saved in Anambra State.

SECTION

1 Introduction

1.1 NIGERIA HIV SITUATIONAL ANALYSIS

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

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

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

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

1.2 NIGERIA PMTCT SITUATION ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.4 FUNDING OPPORTUNITIES

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

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

SECTION

2 Anambra State

2.1 STATE PROFILE

Anambra State is situated in South-East zone of the country. The capital of present day Anambra State is Awka. Ethnically, it is 98% of Igbo population and 2% Igalas. It is bounded in the northeast by Enugu state, in the east by Enugu and Abia states, in the west by Delta while in the south and northwest by Imo and Kogi states respectively.

Administratively Anambra is divided into 21LGAs, 235 health districts, 330 wards and 177 communities. With an annual growth rate of about 2.80 % the state was projected to have approximately 4,984,127 people at the end of 2012. It is a densely populated state with about 1,500 to 2,000 persons/km2.

There are 1,085,949 women of reproductive age (WRA) that is women ages 15-49, while the children under five years and below one year of age were 966,749 and 193,350, respectively. In 2012, 246,807 women were pregnant. The uptake of MCH services is relatively high in the state. The Multiple Indicator Cluster Survey (MICS) shows that in 2011 a high proportion of women in the state (93.6%) received antenatal care (ANC). More importantly most of these services were from a doctor or a nurse. Furthermore, most of these women delivered their babies by a skilled attendant (91.5%). The unmet need for contraception is 10.2% while 15.9% of women use a modern contraceptive method (50.5% use any contraceptive method). As is common in most South East States, most MCH services were accessed within the private sector.

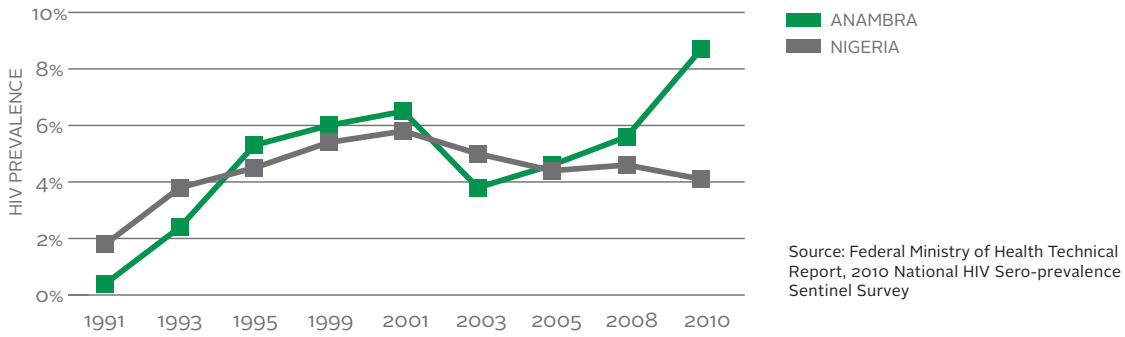
There are 1,485 health facilities in the state, 72% of which are private. Within the public sector, there is one tertiary health facility and 31 public secondary health care facilities. These hospitals are managed by the state government through the State Hospital Management Board of the State Ministry of Health (SMOH). The Ministry of Health's Department of Primary Health Care/Disease Control (PHC/DC) is the overall coordinator of PHC activities in the states. Critical cadres of service providers include 424 doctors, 567 registered nurses and mid wives, 96 pharmacists and pharmacy technicians, 256 laboratory scientist and technicians. Others include 1100 community health extension workers (CHEWs) and 131 record officers.

2.2 HIV/AIDS IN ANAMBRA STATE

Figure 1 illustrates the trend in HIV prevalence among pregnant women in the State based on ANC sentinel surveillance from 1991 to 2010, compared to the national average during the same period. There was an increase in HIV prevalence from about 0.4% in 1991 to a peak of 6.5% in 2001 that was followed by a decline to 3.8% in 2003, but thereafter the trend was consistently upward to the highest proportion of about 8.7% in 2010, which was significantly higher than the national average of 4.1%. The high HIV prevalence is of particular relevance to vertical transmission of HIV within the state.

The Anambra Agency for the control of HIV/AIDS (ANSACA) was formed in 1997 and an AIDS Action Manager appointed to conduct programs for public awareness and care and support services. The Agency collaborates with development partners such as FHI 360, World Bank, UNICEF, AIDS Relief, NGOs, CBO and other individual philanthropists to support HIV/AIDS response in the State. ANSACA has improved the uptake of HTC at the community level, and also support orphans and other vulnerable children. ANSACA coordinates the multi-sectoral response to HIV/AIDS while the

Figure 1: Trend of State HIV Prevalence among Pregnant Women Compared to the National[6]



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

State AIDS and STIs Control Programme (SASCP) in responsible for implementation of health sector activities on HIV and AIDS.

2.3 PMTCT IN ANAMBRA STATE

Of the 1485 facilities in the state, 1153 offer ANC services out of which 63 facilities provide ARVs for PMTCT. Only one health facility provides polymerase chain reaction (PCR) testing for early infant diagnosis (EID) of HIV.

Based on the estimated 246,807 pregnant women within the state and a HIV prevalence of 8.7%, there were approximately 21,472 HIV infected pregnant mothers in Anambra State in 2012. In the absence of PMTCT interventions, 35% of HIV infected women would transmit the virus to their babies, translating to about 7,107 preventable HIV infections among infants in 2012 alone. Effective, comprehensive interventions for PMTCT can reduce the risk of transmission to less than 5%. The uptake of services and availability of interventions for PMTCT in the state has been summarized in Tables 2.

Table 2: Uptake of PMTCT Services in Anambra State in 2012

	Indicator	Number
1	Total number of pregnant women in the State	246,807
2	Total number of antenatal new cases reported (booking)	29,176
3	Total number of deliveries reported (in facilities booked and unbooked)	4,463
4	Number of pregnant women who were offered HCT for PMTCT and received their test results	28,838
5	Number of HIV positive women who received complete course of ARVs for PMTCT	927
6	Number of HIV positive mothers who received cotrimoxazole prophylaxis	N/A
7	Number of HIV exposed babies who received ARV prophylaxis	281
8	Number of HIV exposed babies who received cotrimoxazole prophylaxis	171
9	Number of HIV positive pregnant women who received infant feeding counseling	N/A
10	Number of HIV exposed babies who received PCR testing within 2 months of birth	169
11	1Number of HIV positive pregnant women whose CD4 was estimated in order to stage the HIV disease	54
12	Number of mothers who exclusively breast fed their babies at 3 months	57
13	Number of mothers who exclusively breast fed their babies at 6 months	N/A

SECTION

3 Process

This eMTCT operational plan was developed under the leadership of the Anambra SMOH and the State SACA. In February 2013, with support from the UNAIDS and HIV/AIDS Division FMOH, Anambra State developed the first draft of its eMTCT operational plan. This draft plan was however, not finalized.

In order to specifically identify the health system challenges to be addressed to meet Anambra State's eMTCT targets, FHI 360 with support from USAID, provided technical assistance to conduct a state-wide rapid health facility assessment (RHFA). The assessment was done in all facilities in all 21 LGAs identified as providing ANC services but not PMTCT services. The assessment covered seven domains: health human resource complement, client flow, scope of services provided, community support systems, facility health linkages, current infrastructure and future prospects for expansion. The results of this assessment (presented in Chapter 4) as well as a review of other relevant documents informed the priority areas chosen and scale-up targets required to meet the eMTCT goal. This was followed by a bottleneck analysis supported by UNICEF to identify the main gaps and disparities which are slowing the coverage of key PMTCT interventions the state.

The findings from these efforts were presented and discussed during a four-day planning workshop convened by the Anambra SMOH, on June 23rd -27th 2013. A wide range of stakeholders including representatives from HIV/AIDS Division of the FMOH and NACA were at the meeting which was co-funded by USAID, through FHI 360, and UNICEF. The initial draft eMTCT operational plan was reviewed in line with findings from the RHFA and BNA. The outcome of the meeting was a costed eMTCT scale up plan which aligned with the goals and targets contained in the national eMTCT scale up plan. State specific challenges identified informed the development of a comprehensive package with appropriate interventions to address the specific needs of the state.

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

With the completion of all of these processes, the Anambra SMOH and SACA disseminated *Anambra State's eMTCT Operational Plan 2013-2015* to His Excellency, Peter Obi on June 28th 2013. The dissemination meeting was attended by all major stakeholders in the HIV/AIDS response in Anambra state and beyond, including FHI 360 (lead PEPFAR implementing partner for Anambra State) and UNICEF.

SECTION

4 State-wide Rapid Health Facility Assessment

4.1 METHODOLOGY

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

The assessment covered all listed public and private health facilities in Anambra State which met defined criteria (see Box 1). A list of 1485 facilities was obtained from the Department of Planning, Research and Statistics (DPRS), State Ministry of Health. In total, 1153 had ANC services, 51 were currently providing ARVs for PMTCT while 12 had plans for PMTCT in 2013. Thus 634 facilities with antenatal services but no implementing partner (IP) support for PMTCT and did not have plans for PMTCT in 2013 were assessed.

Box 1: Site selection

Site Inclusion Criterion

- Providing ANC but no IP support for PMTCT services

Site Exclusion Criteria

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

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

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Faith-based	3	13	16
Private for profit	141	235	376
Sub-total (private)	144	248	392
Public			
LGA	220	1	221
State government	4	17	21
Sub-total	224	18	242
Overall total	**368**	**266**	**634**

4.2 FINDINGS

4.2.1 Characteristics of facilities

The majority of the facilities assessed were primary level and privately owned. Table 3 on the previous page summarizes characteristics of the facilities assessed.

4.2.2 Human resources and service utilization

The human resource for health complements and service utilization data for the 12 months preceding the assessment were assessed in each facility. On average the private hospitals were much better staffed (1.3 doctors per site) than the public hospitals (0.3 doctors per site). Secondary facilities had on average higher number of staff for each cadre compared with the primary facilities. Of all the health worker categories, the pharmacy technicians/pharmacists were the fewest per facility. The average number of OPD and ANC attendees as well as deliveries in the last 12 months also revealed a two to three times higher utilization of secondary facilities compared to the primary level health services.

4.2.3 Other domain summaries

Availability of clinical and laboratory services as well as infrastructure were assessed. Disaggregated by ownership, almost all the clinical and laboratory services were available in both private and public facilities assessed. TB services were the least available service in assessed facilities (obtainable in about 16% of the facilities), followed by family planning services (65.0%) and HTC services (65.9%). Among the primary level facilities there was space for laboratory (47.0%) and medical records (57.3%). In terms of enabling environment for PMTCT service provision, primary level facilities fared better compared with secondary health facilities, as they had more MDG support (25% vs. 3%), free ANC services (19% vs. 3.4%), regular monthly outreach (56.8% vs. 5.3%) and MSS midwives (8.7% vs. 5.3%). Findings also revealed better community systems supporting activities at primary level facilities as they have more linkages to ward development committees (56.3% vs. 22.2%) and village (48.9% vs. 22.6%) development committees.

4.2.4 Summary of qualitative findings

Health workers were interviewed as part of the assessment process. The key informant interviews (KIIs) conducted with health workers in Anambra State revealed that most women prefer accessing services through private clinics, traditional birth attendants (TBAs) and churches. Some reasons given for poor patronage of facility based services include, long distance, unavailability of staff, cost and insecurity. Respondents believed that some health facilities were well patronized due to the provision of free health services and drugs. Improved staffing and infrastructure will go a long way to improve service quality.

4.2.5 Scenarios for eligibility of PMTCT services

Only two (0.3%) public and 39 (6.3%) private facilities met the national prescribed HR standard for PMTCT service provision (one doctor, one nurse/midwife, two community workers, one pharmacy staff, one laboratory staff, one medical records officer). A less rigid criterion is required to ensure wider coverage of PMTCT services while the HR gaps are addressed. Some scenarios would be to include facilities with at least four health workers who could provide clinical care.

In light of scale-up constraints revealed by the assessment, and the wide PMTCT service gap across the state (95%), PMTCT service upgrades must be done equitably. Table 3 below shows the MTCT burden and PMTCT service coverage gap for the 21 LGAs in Anambra State. LGAs were ranked 1 to 21; those with larger MTCT burden and a wider PMTCT service coverage gap are ranked higher and should receive higher priority for scale up.

Aguata LGA with a prevalence of 8.5% has the greatest need for PMTCT scale-up. It has the highest burden of HIV positive women in Anambra state and a disproportionately low PMTCT coverage. Similar scenarios occur in Ihiala and Onitsha South LGAs. Anambra East, an urban LGA, has one of the lowest MTCT burden in the state but the highest PMTCT service coverage.

Table 4: LGA HIV burden and PMTCT Service Coverage Gap

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)	
Aguata	8.50%	1,876	21	80	99%	14	35
Ihiala	8.70%	1,569	20	96	99%	14	34
Onitsha South	13.10%	1,072	15	44	100%	16	31
Anambra West	8.70%	984	14	17	100%	16	30
Orumba South	8.70%	958	12	20	100%	16	28
Idemili South	8.70%	1,073	16	43	98%	10	26
Awka North	8.60%	858	9	14	100%	16	25
Ogbaru	8.70%	1,159	17	75	94%	6	23
Onitsha North	13.10%	984	13	186	98%	10	23
Ayamelum	8.70%	821	7	16	100%	16	23
Awka South	8.60%	1,458	19	58	87%	3	22
Nnewi South	8.70%	1,211	18	42	82%	2	20
Orumba North	8.70%	897	11	29	97%	8	19
Oyi	8.70%	873	10	32	97%	8	18
Dunukofia	8.70%	501	2	22	100%	16	18
Nnewi North	8.70%	807	6	104	98%	10	16
Njikoka	8.10%	717	4	37	98%	10	14
Ekwusigo	8.70%	822	8	45	91%	5	13
Anaocha	8.70%	790	5	45	87%	3	8
Idemili North	1.20%	309	1	120	94%	6	7
Anambra East	8.70%	582	3	26	81%	1	4
Ukwa West	7.30%	380	4	19	68%	1	5
STATE LEVEL		**21,472**		**1,153**	**95%**		

4.2.6 Summary of the Bottleneck Analysis

In order to inform PMTCT programming in Anambra State, UNICEF supported the Anambra SMOH to conduct a bottleneck analysis (BNA). The BNA identified and focused on four key areas that are priority for achieving comprehensive PMTCT services: antenatal care, HIV testing and counselling, maternal ARV for PMTCT, and skilled birth delivery. Table 5 presents key highlights of the analysis.

Table 5: Summary of bottleneck analysis and intervention areas

TRACE INTERVENTIONS	BOTTLENECKS	INTERVENTION AREAS
Focused antenatal care	• 35.5% of ANC facilities with sufficient healthcare providers trained on ANC facilities. • 4.9% of pregnant women attend ANC within the first trimester.	• Advocate for increase human resources for MNCH / PMTCT services in the State • Strengthen capacity of health staff in health facilities in PMTCT/ANC service provision • Increase the demand for ANC services through community mobilization and empowerment
HIV testing and counselling	• Only 26.6% of ANC facilities are providing HTC services. • Only 3.1% of pregnant women are screened for HIV in ANC	• Increase number of ANC facilities that provide HTC and PMTCT • Strengthen capacity of health staff in health facilities in HCT service provision • Increase the demand for HCT at ANC facilities through community mobilization and empowerment
Maternal ARV for PMTCT	• Only 8.2% ANC facilities that are providing PMTCT services • 0.6% of positive pregnant women received ARV for PMTCT • Only 0.1% of the HIV exposed infants born to pregnant women living with HIV received prophylaxis at birth. • Only 5.8% of facilities currently providing PMTCT with sufficient healthcare workers trained on ARV. • Only 12.6% of PMTCT facilities reporting no stock out of maternal ARV	• Increase number of ANC facilities that provide PMTCT and HTC • Strengthen implementation capacity of health facilities for PMTCT & HTC services • Increase the demand for maternal ARVs at ANC /PMTCT/HTC facilities through community mobilization and empowerment • Ensure linkages/referrals for comprehensive PMTCT service delivery • Implement innovative approaches on eMTCT/MCNH
Skilled birth attendance	• Only 30.1% of estimated health facilities providing basic obstetric care without stock out of commodities • Only 3.2% of live births were delivered by skilled birth attendants in health facilities	• Strengthen capacity of health facilities for institutional delivery services • Increase the demand for institutional delivery through community mobilization and empowerment
Coordination, monitoring and evaluation		• Strengthen implementation capacity for monitoring and evaluation for all interventions • Strengthen coordination and resource mobilization mechanisms

4.2.7 Recommendations

In order to eliminate MTCT in Anambra State, the 95% PMTCT service coverage gap must be closed. The scale-up efforts should address the inequities in access that exist in the state particularly between urban and rural areas. The comprehensive plan must address human resource gaps, increase service availability and ensure infrastructure upgrades within the public sector. With more than 70% of health facilities in the state being privately owned, engagement of private facilities in the state is critical to ensuring universal access to PMTCT services. Further, TBAs who are major stakeholders in maternal health services in the state should be engaged as part of a holistic demand creation strategy. Equally important is community involvement and ownership by mobilizing ward and village development committees, faith and community-based organizations as major players.

SECTION

5 Anambra State eMTCT Operational Plan

5.1 RATIONALE

MTCT is preventable, though 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 labour and while breastfeeding. Consequently, the prevention of vertical transmission of HIV is one of the critical pillars for attaining the Millennium Development Goals 4 (reduced child mortality), 5 (improved maternal health) and 6 (HIV and AIDS, malaria combated).

5.2 GOAL AND OBJECTIVES

This plan draws on the information generated from the health facility assessment and the bottleneck analysis in Anambra State.

In addition, it has been aligned to the *National Scale-up Plan towards Elimination of Mother to Child Transmission of HIV in Nigeria 2010 – 2015,* as well as the *National Health Sector Strategic Plan & Implementation Plan for HIV/AIDS 2010 – 2015.*

5.2.1 Goal

The goal of this operational plan is to improve maternal health and child survival by 2015 through the accelerated provision of comprehensive services for elimination of mother-to-child transmission of HIV.

5.2.2 Objectives

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

1. Reduce HIV incidence among 15-49 year old women by at least 50% by 2015;
2. Reduce the unmet need for family planning among women living with HIV by 90%;
3. Increase access to quality HIV counseling and testing to at least 90% of all pregnant women;
4. 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 the pregnant, infected women requiring treatment for their own health; and
7. Ensure effective management: coordination, resourcing, monitoring and evaluation, of the eMTCT elimination plan.

5.3 SCALE UP TARGETS

To facilitate the elimination of MTCT, the state has identified set targets for the process of scaling up PMTCT services. The parameters for measuring scale up include: ANC coverage, HTC coverage in ANC, the proportion of HIV positive women that are reached with services, ARV prophylaxis, EID coverage and access to lifelong ART for women of reproductive age (WRA) in 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 6: State Scale-up Targets for the Operational Plan

INDICATORS	BASELINE (2012)	YEAR 1 (2013)	YEAR 2 (2014)	YEAR 3 (2015)	DATA SOURCE
Estimated number of WRA (22% of the Total Population)	1,085,949	1116356	1147614	1179747	NPC 2006 Projections
Estimated number of pregnant WRA (5% of the Total Population)	246,807	252,261	257,836	263,534	NPC 2006 Projections
Projected ANC attendance (93.6 % of the Pregnant WRA)	231,011	236,116	241,334	246,668	MICS4 2011 Based Projections
Estimated number of HIV-positive pregnant women (based on state HIV prevalence of 8.7%)	21,472	21,947	22,432	22,927	NPC 2006 Projections
50% reduction in HIV incidence among 15-49 year old women	0.82%	0.68%	0.55%	0.42%	National HIV Sero-prevalence Sentinel Survey
90% reduction in unmet need for FP among all WRA (10.2%)	110,767	89,308 (8%)	57380.68 (5%)	11797.47 (1%)	MICS4 2011 Based Projections
90% of all pregnant women have access to quality HTC services	28,838 (12%)	75,678 (30%)	154,702 (60%)	237,181 (90%)	State Routine Health data on DHIS
90% of all HIV-positive pregnant women and breastfeeding infant-mother pairs have received ARV prophylaxis for eMTCT	927 (4%)	6,584 (30%)	13,459 (60%)	20,635 (90%)	State Routine Health data on DHIS
90% of all HIV-exposed infants have access to EID	169 (1%)	6,584 (30%)	13,459 (60%)	20,635 (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)	44 (0.4%)	3,292 (30%)	6,730 (60%)	10,317 (90%)	State Routine Health data on DHIS
33% of ANC facilities offer PMTCT services	51 (4%)	126 (11%)	314 (27%)	377 (33%)	State Routine Health data on DHIS

5.4 IMPLEMENTATION APPROACHES

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

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

5.4.1 PMTCT Service Supply Systems

Provision of comprehensive PMTCT services can significantly reduce the number of new pediatric infections and improve outcomes for HIV infected mothers. The PMTCT service supply systems include but are not limited to: (1) training of health care workers, (2) site activation for PMTCT service provision, (3) distribution of guidelines, standard operating procedures (SOPs), job aids and information, education 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 on the Integrated PMTCT curriculum, pharmacy best practice and laboratory service provision. Primary level health workers will learn Integrated Management of Pregnancy and Childbirth (IMPAC), adherence preparation and support as well as HIV counseling and testing, sample logging for CD4 and EID. Update trainings and step down trainings will further increase standards and the pool of health care providers. National guidelines and SOPs, job aids and IEC materials will be provided. Mentoring and supportive supervision will be an integral part of implementation. Joint mentoring and supportive supervision by the Joint State Implementation team (JSIT) will ensure program ownership and sustainability.

5.4.2 PMTCT Health Care Commodities supply

To ensure a successful and rapid scale up of PMTCT services, there is need for a strengthened supply chain management system for PMTCT commodities. This would ensure constant availability of rapid test kits (RTKs), ARVs, laboratory commodities as well as consumables. Existing state supply chain management systems will be strengthened and integrated with donor-supported systems to ensure a prompt and efficient supply chain management system for PMTCT in the State. Illustrative activities will include building the capacity of state and facility staff on supply chain processes, procurement and distribution of RTKs and ARVs amongst others.

5.4.3 PMTCT Demand Creation

Anambra's demand creation strategy is aligned with the national strategic approach, which involves positioning of PMTCT centers as places of "Confidence Building and Empowerment". The PMTCT centers would be branded with appropriate and acceptable logos/mascots– *friendly care, healthy babies*. The centers would be promoted as places to get trained and qualified 'friends' (facility workers) whom you can chat with about your life plans, especially your health and that of your baby, i.e. providing *'caring services tailored to your needs'*. Incentives such as 'happy birth packs' will be provided to mothers. Health workers will be trained for improved interpersonal skills and partnerships fostered between HCWs, TBAs and faith houses through orientation, trainings, dialogues and "be the best" campaign for healthcare workers (badges, etc.).This will address issues of HIV related stigma and disclosure by working with directly influencing audiences such as husbands, community and religious leaders to support and encourage pregnant women to seek ANC/PMTCT services.

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

5.4.5 Coordination and resource mobilization

The state HIV/AIDS response will be led by the state management team (SMT) chaired by the Honorable Commissioner for Health, with representation from government, CSO, private sector and partners, and the secretariat at SACA. The SMT will provide much needed oversight, governance and coordination of all effort within the state. The joint state implementation team (J-SIT) will develop and implement annual work plans as well as provide monitoring and supportive supervision to PMTCT sites. Site selection including all the processes related to their activation shall be presented to stakeholders drawn from the state, local government and selected facilities. Annual budgets shall be presented to stakeholders and counterpart funding shall be sourced from government (state and LGA) and the private sector to ensure ownership and sustainability of the activated sites. An annual resource mapping and gap analysis will inform targeted advocacy and resource mobilization activities. The state PMTCT task team will be created. The task team will be responsible for technical guidance and oversight of the state PMTCT program and will collaborate with the J-SIT in the provision of monitoring and supervision of all the activated sites.

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

SECTION

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

To estimate the potential impact of meeting PMTCT targets in Anambra, a modeling exercise was completed. In the exercise, the number of HIV infections averted in women of reproductive age and infants, the number of infant and maternal deaths averted, as well as the disability-adjusted life year (DALY) saved from meeting three of the four main PMTCT targets were estimated (targets listed below). The methods for estimation are described in below. Briefly, though, the infections and deaths that would result from maintaining current levels (maintaining the status quo) compared to meeting PMTCT targets were estimated. The difference between the two was taken as the estimate of programmatic impact (see Table 7).

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 7: Potential Impact of Meeting PMTCT Targets in Anambra State by 2015

TARGETS	2012	2013	2014	2015	TOTAL
1. Decrease HIV incidence among WRA	*0.82%*	*0.68%*	*0.55%*	*0.41%*	
2. Reduce unmet need for FP among HIV+ women	*10.20%*	*7.00%*	*4.00%*	*1.20%*	
3. Increase prophylaxis for HIV+ pregnant women	*4.00%*	*30.00%*	*60.00%*	*90.00%*	
OUTCOMES					
Status Quo Maintained: New HIV infections among WRA	7,961	8,117	8,276	8,438	32,793
Targets Achieved: New HIV infections among WRA	7,961	6,764	5,525	4,236	24,487
HIV infections averted among WRA	-	1,353	2,751	4,202	**8,306**
Status Quo Maintained: Pregnancies among HIV+ WRA	21,027	21,685	22,356	23,039	88,106
Targets Achieved: Pregnancies among HIV+ WRA	21,027	19,625	19,927	20,332	80,911
Pregnancies averted among HIV+ WRA	-	2,059	2,429	2,708	**7,196**
Status Quo Maintained: HIV infections among HEI	22,356	7,329	7,556	7,787	45,028
Targets Achieved: New HIV infections among HEI	7,107	5,103	3,388	1,627	17,224
HIV infections averted among HEI	15,248	2,227	4,169	6,161	**27,805**
Status Quo Maintained: Infant mortalities	3,184	3,283	3,385	3,488	13,341
Targets Achieved: Infant mortalities	3,184	2,508	2,003	1,489	9,183
Infant mortalities averted among HEI	-	776	1,382	1,999	**4,157**
Maternal mortalities averted among HIV+ women	-	16	19	22	**58**
DALYS saved	-	147,162	265,206	372,261	**784,629**

IN SUMMARY:

8,306
infections among WRA

7,196
pregnancies among HIV-positive women

27,805
infections among HIV exposed infants (HEI)

4,157
infant deaths

58
maternal deaths will be prevented by meeting the PMTCT targets.

Combined, this will result in

784,629
DALYs saved in Anambra State by 2015 if the scale-up plan is implemented to scale.

Impact Estimation Methodology and Assumptions

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

2. **The number of pregnancies prevented among HIV + women** was estimated by subtracting the number of pregnancies expected if unmet need was reduced by 90% from the number of expected pregnancies among HIV + women if unmet need was not reduced. The number of expected pregnancies in each scenario was based on a couple-years of protection (CYP) conversion factor produced by MSI[10]. CYPs in each scenario were estimated based on the current contraceptive

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

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

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

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

mix observed in each state[11] and assumed 1 year of use for new adopters. The CYPs for a minimum of year of use of each method were based on region-specific standards[12]. The World Health Organization estimates of HIV transmission from mother to child were also based on accepted standards: transmission with ARVs is expected be 5%, and without ARVs 35%[13].

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%)[14].

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

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

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

   b. reduced unmet need for family planning,

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

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

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

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

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

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

SECTION

7 Implementation Plan

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Staffing					
Recruit and deploy HCWs (doctors/midwives/nurses/ CHEWs, lab and pharmacy staff) for service provision at SHCs and PHCs	1184	Q3-4	Q1-4		SMOH
Training & capacity					
Conduct 10-day training for HCWs (doctors/midwives/ nurses/CHEWs, lab and pharmacy staff) on HCT	626	Q3-4	Q1-4		SMOH
Sensitize HCWs (doctors/midwives/nurses/CHEWs, lab and pharmacy staff) on PITC and multi-point HIV testing at health facilities (no cost- on-site sensitization)	All HCWs	Q3-4	Q1-4		SMOH
Train community volunteers and pharmacists on HCT and referrals in PMTCT	63	Q1	Q1		SMOH
Print STI syndromic management IEC materials	500		Q!-3		
Monitoring and supervision					
Conduct quarterly feedback meeting between community leaders, community resource persons (CORPs) and HCWs		Q3-4	Q1-4		LACA/PHC Coordinators
Conduct quarterly meeting with the trained TBAs, CORPs and HCWs at the ward level		Q3-4	Q1-4		LACA/Ward Focal Person/HCW
Hold quarterly meeting of JAPIN, SACA, SAPAC, SMOI, CiSHAN, NEPWHAN and IPS			Q1-4		SMoH, SPHCDA/ SMoI
Community services					
Engage community volunteers and pharmacists to conduct community outreach for HCT for general population	63		Q1-4		SMOH
Conduct 1-day sensitization for CORPs (including TBAs and VHWs) on HCT and PMTCT	630	Q3	Q1		SMOH
Support the trained CORPS (including TBAs and VHWs) to educate and mobilize communities on HCT and referrals for PMTCT	630	Q3-4	Q1-4		SMOH
Print and distribute 50,000 booklets of referral forms to TBAs	Pregnant women	Q4			SMoH/SACA/IPs

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Drugs					
Procure ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r)- already costed			Q1-4		SIT, SACA, SASCP
Consumables					
Procure male condoms for HIV prevention	211,760,055	Q4	Q3		NACA
Procure female condoms for HIV prevention	10,588,003	Q4	Q3		NACA
Procure consumables		Q3-4	Q1-4		USAID; GF
Procure and distribute HIV test kits (determine) - targeting 1,085,949 for 3 years	3,257,847	Q4	Q3		USAID, SACA, SASCP
Confirmatory tests (Unigold)	63	Q4	Q3		USAID, SACA, SASCP
Tie breaker (star pack)	6	Q4	Q3		USAID, SACA, SASCP
Equipment					
Procure ANC equipment (autoclave and sterilization, etc.)	313		Q1-4		SASCP
Distribution					
Distribute drugs (TDF, 3TC, AZT, EFV, LPV/r) - already costed	0		Q1-4		SIT, SACA, SASCP
Distribution of commodities	313	Q3	Q1-4		SIT, SACA, SASCP
Transport logistics for accessing ELISA screened blood					SACA, SASCP
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS					
Training & capacity					
Conduct a 10-day training for 46 selected communication officers in social & behaviour change communication at state and LGA levels	46	Q4			SMoH/SACA/IPs
Train 50 TBAs and FBOs/LGA in 21 LGAs on PMTCT, FP, MNCH and providing referrals to new PHCs	1050	Q4	Q1		LACA/PHC Coordinators/HCW
Conduct a 3-day non-residential training for 210 ward development committee members as advocates for PMTCT services (10 wards per LGA)	210	Q4	Q1		LACA/Ward Focal Person/HCW

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS *(continued)*					
Community mobilization					
Conduct 1-day sensitization meeting for 210 stakeholders on the importance of PMTCT and FP services	210	Q4			SMoH/SACA/IPs
Conduct 1 FGD session in each PMTCT site community		Q4	Q3		LACA/HCW
Conduct quarterly community dialogue sessions in the PMTCT site communities for community leaders women group leaders religious and youth leaders PLWHIV and pregnant women		Q4	Q1-4		LACA/PHC Coordinators
Conduct 210 quarterly community outreaches to carry out HCT and generate demand for PMTCT and FP services	10 communities/LGA	Q3-4	Q1-4		LACA/PHC Coordinators/HCW
Hold a 1-day advocacy meeting for key stakeholders (at the state and LGA levels) to support PMTCT implementation		Q4			SMoH, SACA, HMB, SPHCDA, LACA
Conduct a 2-day workshop at the state level to develop/adapt PMTCT advocacy pack	40 participants	Q4			SMoH,SACA, IPs
Develop/adapt and translate PMTCT IEC materials into local languages		Q3			SMoH, SPHCDA,SMoI
Media engagement					
Develop 4 radio and TV jingles to generate demand for PMTCT service uptake		Q3-4			SMoH, SPHCDA,SMoI
Air 120 jingles and 60 TV jingles per month		Q4	Q1-4		SMoH, SPHCDA,SMoI

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 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 MCH/FP/FH coordinators on SRH/HIV Integration	25	Q1	Q1		SMoH
Conduct 21-day onsite training on family planning technology for HCW in SHC	186	Q3-4	Q1-4	Q1-4	SMoH
Monitoring & supervision					
Conduct monthly mentoring visits and joint supervisory visits on SRH/HV integration to PMTCT sites (link with routine mentoring visits)	313	Q3-4	Q1-4	Q1-4	SMoH
Print and distribute the SRH/HIV guidelines, service providers' curriculum and manual to all facilities	313	Q4	Q1-4	Q1-4	SMoH
Print and distribute FP service protocols and job aids to all facilities	313	Q4	Q1-4	Q1-4	SMoH
Linkages & referrals					
Link clients to emergency contraceptives and psychosocial support		Q4	Q1-4	Q1-4	SIT, SACA, SASCP
FOCUS AREA: HEALTH CARE SERVICES					
Procurement(quantification forecasting)					
Consumables					
Procurement of FP commodities (condoms, COC, POP (Exluton), injectibles-Depo, noristerat (needles & syringes), implants-Jadelle, implanon, IUCD)	113,215	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of FP consumables (cotton wool, gloves, methylated spirit, detergent, bleach)	113,215	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procure emergency contraceptives	11,322	Q4	Q1-4	Q1	SIT, SACA, SASCP
Equipment					
Procure equipment for family planning (clinic couches, angle lamp, sterilization units, IUCD, insertion kits, weighing scale, BP apparatus, stethoscope, Jadelle insertion kits, sharps boxes, furniture etc)		Q4	Q1-4	Q1	SIT, SACA, SASCP
FP models e.g penile, pelvis, gynecological models	313	Q4	Q1-2		SIT, SACA, SASCP
Distribution					
Distribution of commodities through cluster review and resupply meeting	313	Q4	Q1-4	Q1-4	SIT, SACA, SASCP
Stock management					
Capacity building on Contraceptive Logistic Management System (CLMS) for nurses and CHEWS	30	Q4	Q1-4	Q1-4	SIT, SACA, SASCP

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 reduced by 90% *(continued)*

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS					
Training& capacity					
Conduct 2-day training for 5 CORPS on PMTCT/HCT & FP (5 per ward in 21 LGAs, 50/LGA)	Support groups	Q4			SMoH, SPHCDA
Community mobilization					
Conduct ward level community sensitization for community members on PMTCT quarterly	210 (members)	Q3-4	Q1-4	Q1-4	SMoH, SPHCDA

Prong 3: Prevention of mother to child transmission of HIV

Objective 3: Increase access to quality HIV counseling and testing to at least 90% of pregnant women by 2015

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Staffing					
Recruit and decoy HCWs (doctors/midwives/nurses/ Chews, lab and pharmacy staff) for service provision at SHCs and PHCs	0	Q4	Q1-4	Q1-4	SMoH
Training & capacity					
Conduct TOT in Integrated PMTCT for master trainers in Anambra	42	Q4	Q1		SMoH
Conduct TOT in Integrated Management of Pregnancy and Childbirth (IMPAC) for master trainers in Anambra					SMoH
Conduct 6-day Integrated PMTCT training for HCWs (doctors, nurses and midwives) in 186 SHCs	930	Q4	Q1-4	Q1-4	SMoH
Conduct 6-day Integrated LGA-based IMAI/IMPAC training for HCWs (nurses/CHEWs) in 126 PHCs	254	Q4	Q1-4	Q1-4	SMoH
Print and distribute the national guidelines and SOPs for PMTCT, HCT, laboratory, pharmacy	1252	Q4	Q1-4	Q1-4	SMoH
Print and distributed job-aids to all health facilities	313	Q4	Q1-4	Q1-4	SMoH
Print and distribute IMPAC training materials for PHCs (training manuals and modules)	126	Q4	Q1-4	Q1-4	SMoH
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Drugs					
Procurement of ARVs for triple prophylaxis (TDF + 3TC + EFV)90%	36,345	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of ARVs for triple prophylaxis (AZT + 3TC + EFV) 5%	2,019	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of ARVs for triple prophylaxis (other regimen) 5%	2,019	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of OI medication (CTX)	40,383	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of hematinic	40,383	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of other commodities (antibiotics, antifungals, etc.)	3,634	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of NVP syrup for babies	3,634	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of CTX for babies	3,634	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of ITNs, SP and drugs for treatment of malaria	2,019	Q4	Q1-4	Q1	SIT, SACA, SASCP

Prong 3: Prevention of mother to child transmission of HIV

Objective 3: Increase access to quality HIV counseling and testing to at least 90% of pregnant women by 2015 *(continued)*

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: HEALTH CARE COMMODITIES *(continued)*					
Procurement *(continued)*					
Consumables					
Procure laboratory reagents and consumables	21	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of DBS kits	0	Q4	Q1-4	Q1-4	SIT, SACA, SASCP
Procurement of RTKs	0	Q4	Q1-4	Q1	SIT, SACA, SASCP
Equipment					
Procurement of safe delivery kit	0	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of air conditioners & refrigerators for 20 Labs and Pharmacy	21	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of lab equipment for 30 PHCs (POC, CD4 and accessories)	30	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement of lab ancillary equipment, starter reagents and consumables for secondary health facilities (CD4, chemistry and hematology)	21	Q4	Q1-4	Q1	SIT, SACA, SASCP
Procurement and distribution of SMS printers	68	Q4	Q1-4	Q1	SIT, SACA, SASCP
Lab equipment maintenance	20	Q4	Q1-4	Q1	SIT, SACA, SASCP
Distribution					
Distribution of ARV and OIs	313	Q4	Q1-4	Q1	SIT, SACA, SASCP
Distribution of DBS kits (all distribution pooled)	0	Q4	Q1-4	Q1-4	SIT, SACA, SASCP
Sample transfer for logging (DBS, CD4, hematology, chemistry & blood for Elisa)	313	Q4	Q1-4	Q1-4	SIT, SACA, SASCP
Sample processing at central lab	313	Q4	Q1-4	Q1	SIT, SACA, SASCP
Stock management(CLMS)					
Upgrade & maintenance of central medical store	1				SIT, SACA, SASCP
Training of store personnel on good warehouse practices	10				SIT, SACA, SASCP

Prong 3: Prevention of mother to child transmission of HIV

Objective 3: Increase access to quality HIV counseling and testing to at least 90% of pregnant women by 2015 *(continued)*

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT DEMAND CREATION					
Training & capacity					
Conduct 3-day training on IPC & couple counseling for 3 HCW each in 251 PHCs of 21 LGA (i.e. 36 HCW/LGA)	756 HCW at PHC level	Q3-4			SMoH/SPHCDA/ SACA
Community mobilization					
Conduct sensitization seminars for HCWs on stigma and discrimination and importance of ARV initiation before site activation	756 HCW	Q4			SMoH/SPHCDA/ SACA

Prong 4: Family centered care and support

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

Objective 6: Increase provision of life-long ART received by at least 90% of the pregnant infected women requiring treatment for their own health

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS					
Training& capacity					
Conduct 2-day onsite training on adherence counseling for HCWs	1000	Q4	Q1-4	Q1-4	SMoH
Conduct 5-day state-based pharmaceutical care trainings for facility pharmacists and CP preceptors in PMTCT sites including LMIS	372	Q4	Q1-4	Q1-4	SMoH
Conduct 2-day LGA based ART dispensing and documentation training for HCW in PHCs	127	Q4	Q1-4	Q1-4	SMoH
Conduct 5-day onsite pharmacy best practices training for HCWs in 186 SHCs	313	Q4	Q1-4	Q1-4	SMoH
Conduct 5-day laboratory training for HCWs in 186 SHCs	372	Q4	Q1-4	Q1-4	SMoH
Conduct 3-day training for HCWs at SHCs and PHCs on EID	626	Q1-4	Q1-4	Q1-4	SMoH
Site activation					
Activate 313 sites for PMTCT/EID service provision	313	Q4	Q1-4	Q1-4	SMoH
Monitoring and supervision					
Conduct monthly mentoring visits and joint supervisory visits to PMTCT sites	313	Q4	Q1-4	Q1-4	SMoH
Conduct quarterly technical supportive supervisory visits to PMTCT sites	313	Q4	Q1-4	Q1-4	SMoH
Conduct monthly cluster coordination meetings with HCW, support groups, CBOs and FBOs (32 clusters of 10 facilities each)	32	Q4	Q1-4	Q1-4	SMoH
Support mother support groups (MSGs) to provide mentorship to women living with HIV through health talks at ANC, community-based adherence support, and tracking of HIV positive pregnant women and their infants after delivery (30 women per LGA)	630	Q1 & 3-4	Q1-4	Q1-4	SMoH
Conduct bi-monthly orientation of PLHIV support groups in each LGA on PMTCT including infant feeding counseling, treatment adherence counseling (10 persons per LGA)	210	Q1-4	Q1-4	Q1-4	SMoH
Patient tracking					
Provide appointment diaries to treatment supporters for weekly reports tracking reports	313	Q3	Q1-4	Q1-4	SMoH
Provide appointment diaries for HCWs to schedule visits for each HIV+ mother	313	Q3-4	Q1		SMoH

Prong 4: Family centered care and support

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

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS *(continued)*					
Linkages & referrals					
Engage CBOs for identification and referral of pregnant women from community to facility for PMTCT services and client tracking (2 CBOs per LGA)	42	Q1 &3-4	Q1-4	Q1-4	SMoH
Contact cellphone providers to set up SMS systems		Q3-4			SMoH
Provide integrated SMS system phone to treatment supporters and HCW for client follow up (one phone per facility)	313	Q3-4	Q1-4	Q1-4	SMoH
Link active EID sites to the National PCR Lab	313	Q1-4	Q1-4	Q1-4	SMoH
Support referral and linkages of HIV positive pregnant women on lifelong ART and infected infants to comprehensive treatment sites	313	Q3-4	Q1-4	Q1-4	SMoH
Support linkages between the PMTCT and TB clients for IPT	313	Q3-4	Q1-4	Q1-4	SMoH
Conduct monthly tracking/referral focal persons meeting	313	Q3-4	Q1-4	Q1-4	SMoH
Community services					
Identify and train mentor mothers on adherence counseling, referrals and client tracking PMTCT (30 women per LGAs)	630	Q1-4	Q1-4	Q1-4	SMoH
FOCUS AREA: HEALTH CARE COMMODITIES					
Procurement					
Procure ARVs for treatment of HIV positive mothers	20,192	Q4	Q1-4	Q1	NACA
Procure ARVs for treatment of HIV positive babies	75	Q4	Q1-4	Q1	NACA
Procure OIs for HIV positive mothers	20,192	Q4	Q1-4	Q1	NACA
Procure OIs for HIV positive babies	75	Q4	Q1-4	Q1	NACA
Procurement of internet modems and airtime	38	Q4	Q3		SIT, SACA, SASCP
Procurement of basic care kit	40,383		Q1-4	Q1-2	SIT, SACA, SASCP
Stock management(CLMS)					
Supportive supervision for LMIS reporting	38	Q4	Q1-4	Q1-4	SIT, SACA, SASCP
Others					
Nutritional support (plumpy nuts)	0	Q4	Q1-4	Q1-4	SIT, SACA, SASCP
Conduct logistics meetings (bi-monthly)	15	Q4	Q3	Q2	SIT, SACA, SASCP

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PROJECT MANAGEMENT					
Coordination and Research Mobilization					
Conduct 2-day meeting for key stakeholders (national, state, development and implementing partners) to develop eMTCT operational work plan for 2013 - 2015	65 stakeholders	Q3			SMoH
Conduct one-day meeting to disseminate Anambra State eMTCT operational work plan	300 stakeholders	Q3			SMoH
Print and distribute costed state eMTCT operational plan through a dissemination meeting	1500 copies	Q4			FHI 360
Print facility assessment and bottleneck analysis reports	1500 copies				FHI 360 & UNICEF
Support quarterly state PMTCT TWG meetings	20 participants	Q4	Q1-4	Q1-4	SMoH
Conduct quarterly Steering Committee (State Management Team) meetings to review progress of PMTCT programs	11 participants (SMoH and HMB)	Q4	Q1-4	Q1-4	SMoH
Conduct quarterly Joint Implementing Partners' meeting (SMoH, SACA, FHI 360, PPFN, UNICEF) to discuss and review program performance	30 participants	Q4	Q1-4	Q1-4	SMoH/SACA
Annual progress review meetings with all stakeholders including private and public health facilities	100 participants		Q2	Q2	SMoH
Print and circulate annual progress report	500		Q2	Q2	SACA/FHI 360
Conduct 1-day quarterly SACA/LACA Managers forum in the state	35 participants (SMoH, SACA, LGA and partners)	Q4	Q1-4	Q1-4	SACA
Conduct 1-day quarterly PHC forum with the Director of PHC/ Disease Control and LGA HOD Health	40 participants	Q4	Q1-4	Q1-4	SMoH
Conduct onthly meeting of 21 LGA teams	10 per LGA	Q4	Q1-4	Q1-4	MoLG
Develop advocacy tool kit for resource mobilization	60 participants	Q4			FHI 360/SACA
Hold monthly PMTCT program coordination meeting					SMoH
Conduct bi-monthly 1-day meeting of the PMTCT TWG					SMoH
Conduct quarterly cluster coordination meetings	2 LGAs				SMoH
Support the state-level Health Sector coordination meeting		Q3		Q1	SMoH
Support bi-monthly M&E meeting for data collection					SMoH
Print and disseminate registers and HMIS tools for monitoring the program					SMoH

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PROJECT MANAGEMENT *(continued)*					
Bottleneck analysis					
UNICEF Staff travel to support the BNA process	UNICEF staff	Q2-3			UNICEF
Conduct 5-day workshop on Bottleneck Analysis on LGA operational plan for 21 LGAs and state HIV/AIDS program	80 participants	Q2-3			SMoH / UNICEF
Conduct 2-day workshop for the validation of the LGA BNA operational plan with LGAs, SMOH and SACA	80 participants	Q3			SMoH / UNICEF
Conduct 2-day sensitization meeting on bottleneck analysis	7 people SMOH and SACA	Q2			UNICEF
Infrastructure					
Conduct a 10-day rapid state-wide health facility assessment with 85 assessors from SMoH, SACA, HMB, LGA and FHI 360	313 health facilities	Q2-3			SMoH
Conduct infrastructural assessment and develop BOQs	313 health facilities	Q4	Q2-3	Q2-3	SMoH/LG/FHI 360
Carry out infrastructural upgrade for selected health facilities	313 health facilities	Q4	Q1-4	Q1-3	SMoH/LG/FHI 360
Procure and supply furniture and office equipment for upgraded health facilities	313 health facilities	Q4	Q1-4	Q1-3	FHI 360
Procure 2 vehicles (four-wheel drive Toyota Hilux/Ford Ranger Pickups) for monitoring and supervision by SMoH and GoN SIT	2 vehicles		Q2-3	Q2--3	SMoH/SACA
Fuelling and routine maintenance of 2 four-wheel drive vehicle	2 vehicles	Q2-4	Q1-4		SMoH
Procure office equipment for health facilities	20 PHCs	Q1 &Q3	Q2	Q1	SMoH
Conduct general upgrade of PHCs and SHCs to facilitate provision of PMTCT services	20 PHCs		Q2	Q1	SMoH
HR & Staffing					
Conduct an assessment to define human resources gaps		Q2-3			SMoH
Recruit relevant personnel based on identified HR gaps		Q1			SMoH/HMB/CSC & LGSC
Conduct a 1-day orientation and deployment of recruited personnel	All new recruits	Q1-2			SMoH/HMB/CSC & LGSC
Engage volunteer HCWs/interns (eg. SURE-P, NMCN 1 year midwife service) and NYSC doctors, pharmacists, laboratory scientists to complement HR needs in health facilities	At least 150 (at 50 # a year) across the various health workers cadres	Q4	Q1-4	Q1-4	SMoH/HMB & MoLG
Engagement of Consultant for BNA Process	one consultant	Q2-3			UNICEF

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: PROJECT MANAGEMENT *(continued)*					
Advocacy and Community Mobilization					
Conduct two batches of a 5-day Program Management and Advocacy Skills Training including adaptation of advocacy tool kit for relevant LGA and State officials					SMoH
Printing of advocacy took kits	500 copies	Q4	Q1		FHI 360/SACA
Conduct advocacy visit to the state Executive Governor (State Executive Council) for recruitment of adequate health personnel with relevant skill mix, increased funding and timely release funds.	20 state officials and IP staff	Q4	Q1-4	Q1-4	SMoH & Implementing Partners
Conduct 1-day advocacy meeting (buy into monthly fund allocation meetings at state) for LGA Chairmen and MLoG for recruitment of retired HCWs (doctors) to support clusters of health facilities within their LGAs (50 persons)	20 state officials and IP staff	Q4	Q1		SMoH & Implementing Partners
Conduct advocacy visits to the State Gov. and the State House of Assembly Committee on Health	20 (SMoH, SACA & IP)	Q4	Q1-4	Q1-4	SMoH & Implementing Partners
Hold semi- annual public-private sector forum to engender private sector participation and support	50 persons		Q1 & Q3	Q3	SMoH /SACA
Conduct a 1-day annual sensitization meeting with the leadership of Anambra state chapter of NMA, NANNM, PSN, AGPMPN, ACPN AMLSN, Civil Service Doctor Forum, Medical & Health Workers' Union, Community Health Practitioners' Association and CHAN to foster improvement in health workers' attitude to work	55 (5 per groups and 5 state and IP) participants	Q4	Q3	Q3	SMoH
Conduct annual 1-day sensitization workshop for private sector and other business enterprises to secure their commitment and funding support for the roll out of the eMTCT operational plan in Anambra State	50 persons	Q4	Q3	Q3	SMoH /SACA
FOCUS AREA: MONITORING AND EVALUATION					
Finalize and operationalize the state costed health M&E work plan.	One state level costed M&E work plan	Q4	Q1-4	Q1-4	ANSMoH/DPRS
Central Database					
Conduct assessment of M&E capacity, process and systems for all health programs (e.g. HIV, malaria, TB, RH/FP, nutrition, NPI) in the state	Assessment completed for all health programs	Q4			ANSMoH/DPRS
Conduct 2-day state-level meeting to harmonize M&E systems and process for all health Programs (e.g. HIV, malaria, TB, RH/FP, nutrition, NPI) and develop the costed work plan for health programs	One state level costed M&E work plan for health developed	Q4			ANSMoH/DPRS

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: MONITORING AND EVALUATION *(continued)*					
Central Database *(continued)*					
Form integrated health data management & supportive supervision teams at the state & LGA level (M&E persons from various health programs)	1 state and 21 LGAs team constituted	Q3-4			ANSMoH/DPRS
LGAs and State Ministry of Health (ANSMoH) to incrementally budget for the printing and supply of harmonized M&E Tools from 2014 onwards	ANSMoH to supply from 2014		Q4	Q1-4	ANSMoH
FHI 360 to advocate to NACA and FMoH/DPRS to harmonize the 2 DHIS 2.0 instance into a single platform for ease of data management effective from January 2014	Reporting commenced	Q3-4			FHI 360
Advocacy to Honorable Commissioner of Ministry of Local Government to ensure printing and supply of harmonized NMHIS tools for all PHCs in the 21 LGAs	All PHCs in the 21 LGAs tools from 2014	Q3			ANSMoH/DPRS
Data Reporting					
Conduct a meeting to update the state health facilities list (private, public & mission)		Q2-3			DPRS & SACA
Engage 25 Youth Corpers (NYSC) as LGA M&E assistants to support M&E reporting and data management at LGA-level		Q3	Q2	Q2	ANSMoH/DPRS
Notify registered private health facilities in the state and LGAs about their health data reporting obligation to the governments	100% of registered private health facilities	Q2-3			DMS and DPRS at ANSMoH
Print and supply M&E tools to secondary and tertiary health facilities in the state through World Bank Malaria Booster grant	All secondary and tertiary health facilities receive supply through state RBM Office	Q3-4	Q1-4		SACA State Roll-back program
Strategic Information					
State MoH to produce bi-annual PMTCT coverage analysis for 2013, 2014 and 2015.	3 publications	Q3	Q3	Q3	ANSMoH/DPRS
Produce and disseminate quarterly health information products (such as: LGA Health Factsheets) using her analyzed LGA data for health planning and decision making	14 quarterly health factsheets per LGA LOP	Q3-4	Q1-4	Q1-4	LGA NMHIS Officer
Routine Data Management					
Institute monthly LGA health M&E meetings in 21 LGAs in the state	252 monthly health M&E meeting at the LGAs per year	Q2-4	Q1-4	Q1-4	ANSMoH/DPRS
Institute and conduct monthly state health M&E meetings with LGAs' M&E Officers	12 monthly health M&E meetings at the state-level every year	Q2-4	Q1-4	Q1-4	ANSMoH/DPRS

Cross Cutting Areas

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

Key interventions and activities	Target	Timeline			Responsible party
		2013	2014	2015	
FOCUS AREA: MONITORING AND EVALUATION *(continued)*					
Routine Data Management *(continued)*					
Conduct routine DQA, integrated mentoring and supportive supervision visits to low reporting rate and poor data quality reporting facilities by LGA teams	Each team makes at least 1 visit per facility per month	Q3-4	Q1-4	Q1-4	LGA Data Management Team
Conduct routine DQA, integrated mentoring and supportive supervision visits to low reporting rate and poor data quality reporting LGAs by state teams	Each team makes at least 1 visit per LGA per month	Q3-4	Q1-4	Q1-4	State Data Management Team
Organize state-level annual Health Data Producer and User (HDPU) Meeting	3 meetings	Q4	Q4	Q4	ANSMoH/DPRS
Organize state-level Bi-Annual Health Data Consultative Committee (DHDCC) Meetings	3 meetings	Q3	Q3	Q3	ANSMoH/DPRS
Capacity Building					
Capacity building on integrated data collection & management for facility M&E officers	1200 facility staff	Q4			ANSMoH/DPRS & LGA Dept. of Health
Capacity building on integrated data collection & management for LGAs M&E officers (2-day training)	60 LGAs M&E officers	Q4			ANSMoH/DPRS
Capacity building on Integrated data collection & management for State M&E officers (2-day training)	30 state M&E officers	Q4			FHI 360
Training of State and LGA-level M&E Teams on Integrated Health Data Management and Supportive Supervision (5-day training)	90 state and LGAs M&E officers		Q1		ANSMoH/DPRS
Conduct 1-day sensitization on integrated health data management and dataflow for all state-level health program managers and their M&E officers	30 persons	Q3			ANSMoH/DPRS
Conduct 1-day step-down sensitization on integrated health data management and dataflow for all LGA-level health program managers and their M&E officers	252 LGA-level program managers and their M&E officers	Q4			ANSMoH/DPRS
Incorporate data demand and data use into the training and capacity building for the health facility, LGAs and state M&E officers	See all the M&E-related training				ANSMoH/DPRS
Special studies					
Conduct operational research and special studies on identified relevant subjects					

SECTION

8 Monitoring and Evaluation Plan

The existing Information Management System will be utilised for routine collection of programme data using the registers and reporting forms at implementing health facilities. The reporting will follow the established channels through the Local Government Areas to the State level where data will be compiled and shared for use in planning and policy decision making processes. The core indicators are summarized in Table 8 below.

Table 8: Targets of the Indicators for Anambra State

Indicator	Baseline (2012)	Year 1 (2013)	Year 2 (2014)	Year 3 (2015)
Number of health facilities that provide ANC plus PMTCT services	51	126	314	377
Number of females age 15 – 49 yrs tested HIV positive	7,961	6,764	5,525	4,236
Number of HIV infected women aged 15 – 49 years who accessed comprehensive family planning services	N/A	91,016	58,993	13,915
Number of pregnant women counseled tested and given HIV results	28,838	75,678	154,702	237,181
Number of pregnant women reached with antiretroviral drugs for PMTCT according to the national guidelines	927	6,584	13,459	20,635
Number of HIV positive pregnant women in need of treatment initiated on ART for their own health (50% of total)	44	5,926	6,057	6,190
Number of HIV exposed infants offered first PCR test from 6 – 8 weeks of age	169	6,584	13,459	20,635

8.1 ANAMBRA STATE PMTCT M&E FRAMEWORK

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

SECTION

9 Summary Budget

The summary of the budget for the plan is highlighted in the table below. Please see Appendix 1 for detailed budget

Table 9: Budget Summary Table

THEMATIC AREAS	Year 1 Budget (NGN)	Year 2[17] Budget (NGN)	Year 3[18] Budget (NGN)	Total Budget(NGN)	Total Budget (USD)
PMTCT service supply systems	170,128,760	491,801,130	167,913,610	829,843,500	5,353,829
Health care commodities	1,634,672,095	3,760,605,680	1,255,908,482	6,651,186,256	42,910,879
PMTCT demand creation system	99,029,000	58,932,000	58,932,000	216,893,000	1,399,310
Monitoring & evaluation	788,653,600	206,952,000	187,372,000	1,182,977,600	7,632,114
Program management	360,982,858	898,532,600	315,555,800	1,575,071,258	10,161,750
Grand total	**3,053,466,313**	**5,416,823,410**	**1,985,681,892**	**10,455,971,614**	**67,457,881**

17 Less one-off activities

18 Less one-off activities

SECTION

10 Appendix- Detailed Budget

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Staffing	Recruit and deploy HCWs (doctors/midwives/nurses/CHEWs, lab and pharmacy staff) for service provision at SHCs and PHCs	-	-
Training & capacity	Conduct 10-day training for HCWs (doctors/midwives/nurses/ CHEWs, lab and pharmacy staff) on HCT	33,537,400	100,612,200
	Sensitize HCWs (doctors/midwives/nurses/CHEWs, lab and pharmacy staff) on PITC and multi-point HIV testing at health facilities (no cost-on-site sensitization)	-	-
	Train the community volunteers and pharmacists on HCT and referrals in PMTCT	-	8,728,250
Community Mobilization	Engage community volunteers and pharmacists to conduct community outreaches for HCT for general population	-	2,268,000
	Conduct 1-day sensitization for community resource persons (CORPs) (including TBAs and VHWs) on HCT and PMTCT	390,600	1,171,800
Linkages/ Referrals	Support the trained CORPS (including TBAs and VHWs) to educate and mobilize communities on HCT and referrals for PMTCT	5,670,000	17,010,000
PMTCT service supply systems sub-total		**39,598,000**	**129,790,250**
FOCUS AREA: HEALTH CARE COMMODITIES			
Procurement (quantification, forecasting)	Procure ARVs for post exposure prophylaxis (TDF, 3TC, AZT, EFV, LPV/r)- already costed	-	-
	Procure male condoms for HIV prevention	169,408,044	508,224,132
	Procure female condoms for HIV prevention	393,873,712	1,181,621,135
	Procure gloves, goggles, sharps boxes, biohazard bags, color coded bins, jik, methylated spirit, cotton wools, lancets, absorbent pad, tissue wipes, sharp containers, bin liners, etc.	18,780,000	56,340,000
	Procure and distribute HIV test kits (determine) - targeting 1,085,949 for 3 years	156,376,656	469,129,968
	Procure ANC equipment (autoclave and sterilization, etc.)	32,717,890	98,153,670

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	-	-	ANSG
33,537,400	167,687,000	1,081,852	FHI 360 and PPFN
-	-	-	FHI 360 and PPFN
8,728,250	17,456,500	112,623	PPFN
2,268,000	4,536,000	29,265	PPFN
390,600	1,953,000	12,600	PPFN
5,670,000	28,350,000	182,903	PPFN
50,594,250	**219,982,500**	**1,419,242**	
-	-	-	State Govt., Donor Partners
169,408,044	847,040,220	5,464,776	USAID
393,873,712	1,969,368,558	12,705,604	USAID
18,780,000	93,900,000	605,806	SACA, SASCP
156,376,656	781,883,280	5,044,408	USAID
32,717,890	163,589,450	1,055,416	USAID

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: HEALTH CARE COMMODITIES *(continued)*			
Distribution	Distribute drugs (TDF, 3TC, AZT, EFV, LPV/r) - already costed	-	-
	Distribution of commodities	124,000	624,000
	Confirmatory tests (Unigold)	58,641,210	175,923,630
	Tie breaker (Starpack)	5,864,130	17,592,390
	Transport logistics for accessing ELISA screened blood	-	-
others	Print STI syndromic management IEC materials		-
Health care commodities sub-total		**835,785,642**	**2,507,608,925**
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS			
Training on IPC	Conduct 10-day training for 46 selected communication officers in social & behaviour change communication at State and Local government levels	12,475,000	-
	Train 50 TBAs and FBOs/LGA in 21 LGAs on PMTCT, FP, MNCH and providing referrals to new PHCs	5,880,000	-
	Conduct 3-day non residential training for 210 ward development committee members as advocates for PMTCT services (10 wards per LGA)	2,289,000	-
Community Mobilization	Conduct 1-day sensitization meeting for 210 stakeholders on the importance of PMTCT and FP services	840,000	-
	Conduct 1 FGD session in each PMTCT site community	840,000	840,000
	Conduct quarterly community dialogue sessions in the PMTCT site communities	1,680,000	3,360,000
	Conduct 210 quarterly community outreaches to carry out HCT and generate demand for PMTCT and FP services	6,770,000	13,440,000
	Print and distribute 50,000 booklets of referral forms to TBAs	5,000,000	-
	Hold a 1-day advocacy meeting for key stakeholders (at the state and LGA levels) to support PMTCT implementation	355,000	-
	Conduct a 2-day workshop at the state level to develop/adapt PMTCT advocacy pack	1,333,000	-

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	-	-	State Govt., Donor Partners
1,128,000	1,876,000	12,103	State Govt., Donor Partners
58,641,210	293,206,050	1,891,652	USAID
5,864,130	29,320,650	189,165	USAID
-	-	-	State Govt., Donor Partners
-	-	-	State Govt., Donor Partners
836,789,642	**4,180,184,208**	**26,968,930**	
-	12,475,000	80,484	SMOH/FHI 360
-	5,880,000	37,935	SMOH
-	2,289,000	14,768	SMOH/FHI 360
-	840,000	5,419	SMOH
840,000	2,520,000	16,258	SMOH
3,360,000	8,400,000	54,194	SMOH
13,440,000	33,650,000	217,097	SMOH
-	5,000,000	32,258	SMOH
-	355,000	2,290	SMOH
-	1,333,000	8,600	SMOH

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS *(continued)*			
Media engagement	Develop 4 radio and TV jingles to generate demand for PMTCT service uptake	1,800,000	-
	Air 120 jingles and 60 TV jingles per month	12,600,000	25,200,000
Mentoring & supervision	Conduct quarterly feedback meeting between community leaders, CORPs and HCWs	1,680,000	3,360,000
	Conduct quarterly meeting with the trained TBAs, CORPs and HCWs at the ward level	5,880,000	11,760,000
	Hold quarterly meeting of JAPIN, SACA, SAPAC, SMOI, CiSHAN, NEPWHAN and Ips	-	300,000
Others	Develop/adapt and translate PMTCT IEC materials into local languages	219,000	-
PMTCT demand creation systems sub-total		**59,641,000**	**58,260,000**
Objective 1 sub-total		**935,024,642**	**2,695,659,175**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	1,800,000	11,613	SMOH
25,200,000	63,000,000	406,452	SMOH
3,360,000	8,400,000	54,194	SMOH
11,760,000	29,400,000	189,677	SMOH
300,000	600,000	3,871	SMOH
-	219,000	1,413	SMOH
58,260,000	**176,161,000**	**1,136,523**	
945,643,892	**4,576,327,708**	**29,524,695**	

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Training & capacity	Conduct 5-day training MCH/FP/FH coordinators on SRH/HIV integration	-	3,414,400
	Conduct 21-day onsite training on family planning technology for HCW in SHC	2,877,660	8,632,980
Mentoring & supervision	Conduct monthly mentoring visits and joint supervisory visits on SRH/HV integration to PMTCT sites (link with routine mentoring visits)	-	-
	Print and distribute the SRH/HIV guidelines, service providers' curriculum and manual to all facilities	939,000	-
	Print and distribute FP service protocols and job aids to all facilities	1,095,500	-
PMTCT service supply systems sub-total		**4,912,160**	**12,047,380**
FOCUS AREA: HEALTH CARE SERVICES			
Procurement (quantification, forecasting)	Procurement of FP commodities (condoms, COC, POP(Exluton), Injectible- Depo, noristerat(needles & syringes), implants-Jadelle, implanon, IUCD)	-	-
	Procurement of FP consumables (cotton wool, gloves, methylated spirit, detergent, bleach)	807,660	2,422,980
	Procure emergency contraceptives	679,290	2,037,870
	Procure equipment for family planning (clinic couches, angle lamp, sterilization units, IUCD, insertion kits, weighing scale, BP apparatus, stethoscope, jadelle insertion kits, sharps boxes, furniture etc) - already costed under equipment procurement & maintenance		-
	FP models e.g. penile, pelvis, gynecological models	939,000	-
Distribution	Distribution of commodities through cluster review and resupply meeting	3,540,000	7,080,000
Stock management (CLMS)	Capacity building on Contraceptive Logistic Management System (CLMS) for nurses and CHEWS	3,516,000	-
Linkages	Link clients to emergency contraceptives and psychosocial support	-	-
Health care commodities sub-total		**9,481,950**	**11,540,850**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	3,414,400	22,028	PPFN
2,877,660	14,388,300	92,828	PPFN
-	-	-	ANSG
-	939,000	6,058	FHI 360
-	1,095,500	7,068	FHI 360
2,877,660	**19,837,200**	**127,982**	
-	-	-	FMOH / UNFPA
807,660	4,038,300	26,054	State Govt., Donor Partners
679,290	3,396,450	21,913	State Govt., Donor Partners
-	-	-	State Govt., Donor Partners
-	939,000	6,058	State Govt., Donor Partners
7,080,000	17,700,000	114,194	State Govt., Donor Partners
-	3,516,000	22,684	State Govt., Donor Partners
-	-	-	State Govt., Donor Partners
8,566,950	**29,589,750**	**190,902**	

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS			
Training on IPC	Conduct 2-day training for 5 CORPS on PMTCT/HCT & FP (5 per ward in 21 LGAs; 50/LGA)	4,830,000	-
	Conduct 3-day training for 15 selected journalists from JAPIN Anambra state chapter on reporting of PMTCT issues	831,000	
Community Mobilization	Conduct ward level community sensitization on PMTCT quarterly	336,000	672,000
	Produce 1 million IEC materials on PMTCT, HCT & family planning (fliers, posters, pamphlets, wrist bands, t-shirts, apron, etc)	27,750,000	
Media engagement			
PMTCT demand creation systems sub-total		**33,747,000**	**672,000**
Objective 2 sub-total		**48,141,110**	**24,260,230**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	4,830,000	31,161	SMOH/FHI 360
	831,000	5,361	
672,000	1,680,000	10,839	SMOH
	27,750,000	179,032	
672,000	**35,091,000**	**226,394**	
12,116,610	**84,517,950**	**545,277**	

SECTION

10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Staffing	Recruit and deploy HCWs (doctors/midwives/nurses/CHEWs, lab and pharmacy staff) for service provision at SHCs and PHCs	-	-
Training & capacity	Conduct TOT in integrated PMTCT for master trainers in Anambra	3,319,200	3,319,200
	Conduct TOT in Integrated Management of Pregnancy and Childbirth (IMPAC) for master trainers in Anambra	3,319,200	3,319,200
	Conduct 6-day integrated PMTCT training for HCWs (doctors, nurses and midwives) in 186 SHCs	8,934,600	26,803,800
	Conduct 6-day integrated LGA-based IMAI/IMPAC training for HCWs (Nurses/CHEWs) in 126 PHCs	4,676,800	14,030,400
	Print and distributed the national guidelines and SOPs for PMTCT, HCT, laboratory, pharmacy	2,504,000	-
	Print and distributed job-aids to all health facilities	626,000	-
	Print and distribute IMPAC training materials for PHCs (training manuals and modules)	939,000	-
PMTCT service supply systems sub-total		**24,318,800**	**47,472,600**
FOCUS AREA: HEALTH CARE COMMODITIES			
Procurement (quantification, forecasting)	Procurement of ARVs for triple prophylaxis (TDF + 3TC + EFV) 90%	92,330,076	276,990,228
	Procurement of ARVs for triple prophylaxis (AZT + 3TC + EFV) 5%	7,811,688	23,435,063
	Procurement of ARVs for triple prophylaxis (other regimen) 5%	16,049,820	48,149,459
	Procurement of OI medication (CTX)	4,845,960	14,537,880
	Procurement of haematinics	2,422,980	7,268,940
	Procurement of other commodities (antibiotics, antifungal, etc)	1,453,788	4,361,364
	Procurement of NVP syrup for babies	4,603,662	13,810,986
	Procurement of CTX for babies	1,918,193	5,754,578
	Procurement of ITNs, SP and drugs for treatment of malaria	16,153,200	48,459,600
	Procure laboratory reagents and consumables	-	5,354,508

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	-	-	ANSG
-	6,638,400	42,828	ANSG
8,934,600	44,673,000	288,213	ANSG +FHI 360
4,676,800	23,384,000	150,865	ANSG +FHI 360
-	2,504,000	16,155	FHI 360 + UNICEF
-	626,000	4,039	FHI 360 + UNICEF
-	939,000	6,058	FHI 360
13,611,400	**78,764,400**	**508,157**	
92,330,076	461,650,379	2,978,390	State Govt., Donor Partners
7,811,688	39,058,438	251,990	State Govt., Donor Partners
16,049,820	80,249,098	517,736	State Govt., Donor Partners
4,845,960	24,229,800	156,321	State Govt., Donor Partners
2,422,980	12,114,900	78,161	USAID, UN, GF
1,453,788	7,268,940	46,896	USAID, UN, GF
4,603,662	23,018,310	148,505	USAID, UN, GF
1,918,193	9,590,963	61,877	USAID, UN, GF
16,153,200	80,766,000	521,071	USAID, UN, GF
5,354,508	10,709,015	69,090	State Govt., Donor Partners

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: HEALTH CARE COMMODITIES *(continued)*			
Procurement (quantification, forecasting)	Procurement of safe delivery kit	16,153,200	48,459,600
	Procurement of air conditioners & refrigerators for 20 labs and pharmacy	15,120,000	15,120,000
	Procurement of lab equipment for 30 PHCs (POC, CD4 and accessories)	25,499,250	25,499,250
	Procurement of lab ancillary equipment, starter reagents and consumables for secondary health facilities (CD4, chemistry and hematology)	340,313,081	-
	Procurement of DBS kits	5,042,790	-
	Procurement and distribution of SMS printers	3,570,000	3,570,000
	Procurement of RTKs (already costed in prong 1)	-	-
Distribution	Distribution of ARV and OIs	-	-
	Distribution of DBS kits (all distribution pooled)	-	-
Stock management (CLMS)	Upgrade & maintenance of central medical store	5,000,000	500,000
	Training of store personnel on good warehouse practices	1,502,000	-
Others	Lab equipment maintenance	-	11,340,000
	Sample transfer for logging (DBS, CD4, hematology, chemistry & blood for Elisa)	37,560,000	112,680,000
	Sample processing at central lab	5,700,000	17,100,000
Health care commodities sub-total		**603,049,686**	**682,391,454**
FOCUS AREA: PMTCT DEMAND CREATION SYSTEMS			
Training on IPC	Conduct 3-day training on IPC & couple counseling for 3 HCW each in 251 PHCs of 21 LGA (i.e. 36 HCW/LGA	5,055,000	-
Community Mobilization	Conduct sensitization seminars for HCWs on stigma and discrimination and importance of ARV initiation before site activation	586,000	-
Media engagement			
PMTCT demand creation systems sub-total		**5,641,000**	**-**
Objective 3 sub-total		**633,009,486**	**729,864,054**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
16,153,200	80,766,000	521,071	USAID, UN, GF
-	30,240,000	195,097	USAID, State Govt.
-	50,998,500	329,023	State Govt., Donor Partners
-	340,313,081	2,195,568	State Govt., Donor Partners
-	5,042,790	32,534	State Govt., Donor Partners
-	7,140,000	46,065	State Govt., Donor Partners
-	-	-	State Govt., Donor Partners
-	-	-	State Govt., Donor Partners
-	-	-	State Govt., Donor Partners
500,000	6,000,000	38,710	USAID, State Govt.
-	1,502,000	9,690	State Govt., Donor Partners
11,340,000	22,680,000	146,323	State Govt., Donor Partners
37,560,000	187,800,000	1,211,613	State Govt., Donor Partners
5,700,000	28,500,000	183,871	State Govt., Donor Partners
224,197,073	**1,509,638,213**	**9,739,601**	
-	5,055,000	32,613	SMOH/FHI 360
-	586,000	3,781	SMOH/LGA
-	**5,641,000**	**36,394**	
237,808,473	**1,594,043,613**	**10,284,152**	

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Training	Conduct 2-day onsite training on adherence counseling for HCWs	1,235,600	3,706,800
	Conduct 5-day state-based pharmaceutical care trainings for facility pharmacists and CP preceptors in PMTCT sites including LMIS	9,868,040	29,604,120
	Conduct 2-day LGA based ART dispensing and documentation training for HCW in PHCs	551,300	1,653,900
	Conduct 5-day onsite pharmacy best practices training for HCW for SHC and PHCs	11,612,300	34,836,900
	Conduct 5-day laboratory training for HCWs in 186 SHCs	9,868,040	29,604,120
Site activation	Activate 313 sites for PMTCT/EID service provision	8,508,700	25,526,100
Mentoring & supervision	Conduct monthly mentoring visits and joint supervisory visits to PMTCT sites	11,268,000	33,804,000
	Conduct quarterly technical supportive supervisory visits to PMTCT sites	5,634,000	16,902,000
	Conduct monthly cluster coordination meetings with HCW, support groups, CBOs and FBOs (32 clusters of 10 facilities each)	7,776,000	23,328,000
	Support the PLHIV groups to conduct meetings every 2 months for 10 persons per support group for 1 day for 32 clusters	2,400,000	7,200,000
	Support mother support groups (MSGs) to provide mentorship to women living with HIV through health talks at ANC, community-based adherence support, and tracking of HIV positive pregnant women and their infants after delivery (30 women per LGA)	18,780,000	56,340,000
	Conduct bi-monthly orientation of PLHIV support groups in each LGA on PMTCT including infant feeding counseling, treatment adherence counseling (10 persons per LGA)	1,575,000	4,725,000
Linkages/ Referrals	Engage CBOs for identification and referral of pregnant women from community to facility for PMTCT services and client tracking (2 CBOs per LGA)	2,016,000	6,048,000
	Contact cell phone providers to set up SMS systems	-	-
	Provide integrated SMS system phone to treatment supporters and HCW for client follow up (one phone per facility)	243,500	730,500
PMTCT service supply systems sub-total		**91,336,480**	**274,009,440**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
1,235,600	6,178,000	39,858	ANSG +FHI 360
9,868,040	49,340,200	318,324	ANSG +FHI 360
551,300	2,756,500	17,784	ANSG +FHI 360
11,612,300	58,061,500	374,590	ANSG +FHI 360
9,868,040	49,340,200	318,324	ANSG +FHI 360
8,508,700	42,543,500	274,474	ANSG +FHI 360
11,268,000	56,340,000	363,484	ANSG +FHI 360
5,634,000	28,170,000	181,742	ANSG +UNICEF
7,776,000	38,880,000	250,839	FHI 360 + PPFN
2,400,000	12,000,000	77,419	
18,780,000	93,900,000	605,806	UNICEF
1,575,000	7,875,000	50,806	UNICEF
2,016,000	10,080,000	65,032	FHI 360
-	-	-	UNICEF
243,500	1,217,500	7,855	UNICEF
91,336,480	**456,682,400**	**2,946,338**	

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: HEALTH CARE COMMODITIES			
Procurement (quantification, forecasting)	Procure ARVs for treatment of HIV positive mothers	128,239,392	384,718,176
	Procure ARVs for treatment of HIV positive babies	22,009,050	66,027,150
	Procure OI's for HIV positive mothers	5,819,700	17,459,100
	Procure OI's for HIV positive babies	359,625	1,078,875
	Procurement of internet modems and airtime	501,600	1,504,800
	Procurement of basic care kit	12,114,900	36,344,700
Stock management (CLMS)	Supportive supervision for LMIS reporting	5,594,400	16,783,200
Others	Nutritional support (Plumpy nuts)	11,639,400	34,918,200
	Conduct logistics meetings (bi-monthly)	76,750	230,250
Health care commodities sub-total		**186,354,817**	**559,064,451**
Objective 4 sub-total		**277,691,297**	**833,073,891**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
128,239,392	641,196,960	4,136,755	USAID, State Govt.
22,009,050	110,045,250	709,969	USAID, State Govt.
5,819,700	29,098,500	187,732	USAID, State Govt.
359,625	1,798,125	11,601	USAID, State Govt.
501,600	2,508,000	16,181	USAID, State Govt.
12,114,900	60,574,500	390,803	USAID, State Govt.
5,594,400	27,972,000	180,465	USAID, State Govt.
11,639,400	58,197,000	375,465	USAID, State Govt.
76,750	383,750	2,476	USAID, State Govt.
186,354,817	**931,774,085**	**6,011,446**	
277,691,297	**1,388,456,485**	**8,957,784**	

SECTION

10 APPENDIX-DETAILED BUDGET

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	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PMTCT SERVICE SUPPLY SYSTEMS			
Training	Conduct 3-day training for HCWs at SHCs and PHCs on EID	1,352,160	4,056,480
	Identify and train mentor mothers on adherence counseling, referrals and client tracking PMTCT (30 women per LGAs)	315,000	945,000
Linkages/ referrals	Link active EID sites to the National PCR Lab	-	-
	Print and distribute job-aids on EID to the laboratory and clinics (SHCs and PHCs)	469,500	
	Conduct monthly tracking/referral focal persons meeting	7,812,000	23,436,000
	Support referral and linkages of HIV positive pregnant women on lifelong ART and infected infants to comprehensive treatment sites	-	-
	Support linkages between the PMTCT and TB clients for IPT	-	-
Monitoring and supervision	Provide appointment diaries to treatment supporters for weekly reports tracking reports	9,780	29,340
	Provide appointment diaries for HCWs to schedule visits for each HIV+ mother	4,880	14,640
PMTCT service supply systems sub-total		**9,963,320**	**28,481,460**
Objective 5 and 6 sub-total		**9,963,320**	**28,481,460**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
1,352,160	6,760,800	43,618	UNICEF
315,000	1,575,000	10,161	UNICEF
-	-	-	ANSG+ FHI 360
	469,500	3,029	
7,812,000	39,060,000	252,000	UNICEF
-	-	-	UNICEF
-	-	-	ANSG
9,780	48,900	315	UNICEF
4,880	24,400	157	UNICEF
9,493,820	**47,938,600**	**309,281**	
9,493,820	**47,938,600**	**309,281**	

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: MONITORING & EVALUATION			
Data Quality Assurance	Update the state health facilities list (Private, Public & Mission)	-	-
	Engage 25 NYSC as LGA M&E assistants to support M&E reporting and data management at LGA-level	7,500,000	7,500,000
	Strengthen the public-private Sector partnership to facilitate improved M&E data reporting by the private sector facilities	-	-
Strategic Information	State MoH to produce bi-annual PMTCT coverage analysis for 2013, 2014 and 2015.	-	-
	LGAs to produce and disseminate quarterly health Information products (such as: LGA Health Factsheets) using her analyzed LGA data for health planning and decision making	-	-
Central Database	Assessment of M&E capacity, process and systems for all Health Programs (e.g. HIV, malaria, TB, RH/FP, nutrition, NPI) in the state	-	-
	Conduct 2-day state-level meeting to harmonize M&E systems and process for all health programs (e.g. HIV, malaria, TB, RH/FP, nutrition, NPI) and develop the costed work plan for health programs	16,950,000	
	FHI 360 to advocate to NACA and FMoH/DPRS to harmonize the 2 DHIS 2.0 instance into a single platform for ease of data management	-	-
	Formation of integrated health data management & supportive supervision teams at the state & LGA level (M&E persons from various health program)	-	-
	LGAs and State Ministry of Health (ANSMoH) to incrementally budget for the printing and supply of harmonized M&E Tools from 2014 onwards	-	-
Routine Monitoring	Institute monthly LGAs health M&E meetings in 21 LGAs in the state	15,487,500	36,582,000
	Institute monthly state health M&E meetings with LGA M&E officers	737,500	1,742,000
	Routine DQA, integrated mentoring and supportive supervision visits to low reporting rate and poor data quality reporting facilities by LGA Teams	240,000	576,000
	Routine DQA, integrated Mentoring and supportive supervision visits to low reporting rate and poor data quality reporting LGAs by state teams	240,000	576,000
	Organize state-level annual Health Data Producer and User (HDPU) Meeting	576,000	576,000
	Organize state-level bi-annual Health Data Consultative Committee (DHDCC) Meetings	240,000	240,000

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	-	-	Not Applicable
7,500,000	22,500,000	145,161	State Health Budget
-	-	-	DPRS
-	-	-	Not Applicable
-	-	-	Not Applicable
-	-	-	State Health Budget
	16,950,000	109,355	SACA & DPRS
-	-	-	Not Applicable
-	-	-	eMTCT Scale up Plan
45,000,000	45,000,000	290,323	State Health Budget
36,582,000	88,651,500	571,945	eMTCT Scale up Plan
1,742,000	4,221,500	27,235	eMTCT Scale up Plan
576,000	1,392,000	8,981	eMTCT Scale up Plan
576,000	1,392,000	8,981	eMTCT Scale up Plan
576,000	1,728,000	11,148	eMTCT Scale up Plan
240,000	720,000	4,645	eMTCT Scale up Plan

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: MONITORING & EVALUATION *(continued)*			
Capacity Building	Capacity building on integrated data collection & management for facility M&E officers	682,026,000	-
	Capacity building on Integrated data collection & management for LGA M&E officers	36,500,000	-
	Capacity building on Integrated data collection & management for state M&E officers	280,000	-
	Training of state and LGA-level M&E teams on integrated health data management and supportive supervision	7,982,000	-
	Conduct 1-day sensitization on integrated health data management and dataflow for all state-level health program managers and their M&E officers	179,000	-
	Conduct 1-day step-down sensitization on integrated health data management and dataflow for all LGA-level health program managers and their M&E officers	1,713,600	-
	Incorporate data demand and data use into the training and capacity building for the health facility, LGAs and state M&E officers	-	-
Advocacy	Advocacy to Honorable Commissioner of Ministry of Local Government to ensure printing and supply of harmonized NMHIS tools for all PHCs in the 21 LGAs	12,000	-
Site activation	SACA to print and supply harmonized M&E tools to secondary and tertiary health facilities in the state through World Bank grant	17,990,000	79,580,000
	State Roll-Back Malaria Program to print and supply M&E tools to secondary and tertiary health facilities in the state through World Bank Malaria Booster grant	-	79,580,000
other	Finalize and operationalize the state costed health M&E work plan	-	-
Monitoring & evaluation sub-total		**788,653,600**	**206,952,000**
FOCUS AREA: PROGRAM MANAGEMENT			
Situation analysis	Conduct a 10 -day rapid state-wide health facility assessment	24,127,000	-
	Conduct an assessment to define human resources gaps (linked to activity 1.1)	-	-
Coordination & Resource mobilisation	Conduct 2-day meeting to develop eMTCT operational work plan for 2013 - 2015	2,939,000	-
	Conduct 1-day meeting to disseminate Anambra State eMTCT operational work plan	1,708,100	-
	Print and distribute costed state eMTCT operational plan	3,000,000	-
	Print facility assessment and bottleneck analysis reports	3,000,000	-

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	682,026,000	4,400,168	eMTCT Scale up Plan
-	36,500,000	235,484	eMTCT Scale up Plan
-	280,000	1,806	eMTCT Scale up Plan
-	7,982,000	51,497	eMTCT Scale up Plan
-	179,000	1,155	eMTCT Scale up Plan
-	1,713,600	11,055	eMTCT Scale up Plan
-	-	-	Not Applicable
-	12,000	77	G-SIT Budget
-	97,570,000	629,484	World Bank HIV/ AIDS Fund
94,580,000	174,160,000	1,123,613	World Bank Malaria Booster Program
-	-	-	Not Applicable
187,372,000	**1,182,977,600**	**7,632,114**	
-	24,127,000	155,658	PEPFAR
-	-	-	PEPFAR
-	2,939,000	18,961	PEPFAR
-	1,708,100	11,020	PEPFAR/State Govt
-	3,000,000	19,355	PEPFAR
-	3,000,000	19,355	PEPFAR & UNICEF

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PROGRAM MANAGEMENT *(continued)*			
Coordination & Resource mobilisation *(continued)*	Support quarterly State PMTCT TWG meetings	304,000	608,000
	Conduct quarterly Steering Committee (State Management Team) meetings to review progress of PMTCT programs	68,200	136,400
	Conduct quarterly Joint Implementing Partners' meeting to discuss and review program performance	346,000	692,000
	Annual progress review meetings with all stakeholders including private and public health facilities	-	1,512,000
	Print and circulate annual progress report	-	1,000,000
	To conduct one day quarterly SACA/LACA Managers forum in the state	1,756,200	3,512,400
	To conduct one day quarterly PHC forum with the Director of PHC/ Disease Control and LGA HOD Health	1,827,200	3,654,400
	Monthly meeting of 21 LGA teams	3,780,000	7,560,000
	Develop advocacy tool kit for resource mobilization (activity linked to 2.2)	-	-
	UNICEF Staff travel to support the BNA process	1,500,000	-
	Hold monthly PMTCT program coordination meeting		
	Conduct bi-monthly 1-day meeting of the PMTCT TWG		
	Conduct quarterly cluster coordination meetings	GF	
	Support the state-level health sector coordination meeting	GF	
	Support bi-monthly M&E meeting for data collection		
	Print and disseminate registers and HMIS tools for monitoring the program		
Infrastructure	Conduct infrastructural assessment and develop BOQs	5,909,404	17,634,400
	Carry out infrastructural upgrade for selected health facilities	252,000,000	752,000,000
	Procure and supply furniture and office equipment for upgraded health facilities	33,579,000	100,204,000
	Procure 2 vehicles for monitoring and supervision by SMoH and GoN SIT	-	6,000,000
	Fuelling and routine maintenance of 2 four-wheel drive vehicle	-	1,920,000
	Procure office equipment for health facilities	GF	
	Conduct general upgrade of PHCs and SHCs to facilitate provision of PMTCT services	GF	

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
608,000	1,520,000	9,806	PEPFAR
136,400	341,000	2,200	SMoH/SACA
692,000	1,730,000	11,161	SACA/WB
1,512,000	3,024,000	19,510	SACA/WB
1,000,000	2,000,000	12,903	SACA/WB/PEFPAR
3,512,400	8,781,000	56,652	SACA/WB
3,654,400	9,136,000	58,942	PEPFAR/ UNICEF
7,560,000	18,900,000	121,935	MoLG
-	-	-	PEPFAR /SACA/WB
-	1,500,000	9,677	UNICEF
5,815,600	29,359,404	189,416	PEPFAR
248,000,000	1,252,000,000	8,077,419	PEPFAR
33,046,000	166,829,000	1,076,316	PEPFAR
6,000,000	12,000,000	77,419	SMoH/SACA/ WB
1,920,000	3,840,000	24,774	

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PROGRAM MANAGEMENT *(continued)*			
HR & Staffing	Conduct an assessment to define human resources gaps (linked to activity 1.1)		-
	Recruit relevant personnel based on identified HR gaps from activity 1.1.	-	-
	Conduct a 1-day orientation and deployment of recruited personnel	-	-
	Engage volunteer HCWs/interns (e.g. SURE-P, NMCN 1 year Midwife Service) and NYSC doctors, pharmacists, laboratory scientists to complement HR needs in health facilities	-	-
	Engagement of consultant for BNA Process	1,666,956	-
Community Mobilization	Printing of advocacy took kits	1,000,000	-
	Conduct Advocacy visit to the state Executive Governor (State Executive Council) for recruitment of adequate health personnel with relevant skill mix, increased funding and timely release funds.	120,000	240,000
	Conduct 1-day advocacy meeting (buy into monthly fund allocation meetings at State) for LGA Chairmen and MLoG for recruitment of retired HCWs (doctors) to support clusters of health facilities within their LGAs (50 persons)	-	-
	Conduct advocacy visits to the State Gov and the State House of Assembly Committee on Health (linked to activity 2.4)	-	-
	Hold semi- annual public-private sector forum to engender private sector participation and support	480,000	960,000
	Conduct 2-day sensitization meeting on bottleneck analysis	-	-
	Conduct a 1-day annual sensitization meeting with the leadership of Anambra state chapter of NMA, NANNM, PSN, AGPMPN, ACPN AMLSN, Civil Service Doctor Forum, Medical & Health Workers' Union, Community Health Practitioners' Association and CHAN to foster improvement in health workers' attitude to work	419,000	419,000
	Conduct annual 1-day sensitization workshop for private sector and other business enterprises to secure their commitment and unding support for the roll out of the eMTCT operational plan in Anambra State.	480,000	480,000

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	-	-	PEPFAR
-	-	-	State Govt
-	-	-	State Govt
-	-	-	State Govt
-	1,666,956	10,755	UNICEF
-	1,000,000	6,452	PEPFAR /SACA/WB
240,000	600,000	3,871	SMoH/SACA
-	-	-	SMoH /SMoLG
-	-	-	SMoH/SACA
960,000	2,400,000	15,484	SACA/WB
-	-	-	UNICEF
419,000	1,257,000	8,110	SMoH/SACA
480,000	1,440,000	9,290	SACA/WB

SECTION
10 APPENDIX-DETAILED BUDGET

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

Strategic intervention	Activities	Year 1 Budget (Naira)	Year 2 Budget less one-off activities (Naira)
FOCUS AREA: PROGRAM MANAGEMENT *(continued)*			
Capacity Building	Conduct 5-day workshop on Bottleneck Analysis on LGA operational plan	5,748,488	-
	Conduct a 2-day workshop for the validation of the LGA BNA operational plan.	4,954,310	-
	Conduct 4 day training of state and LGA officers on M&E		
	Conduct 3-day training of HCWs at PHCs and SHCs on data management		
	Conduct bi-monthly DQA, and mentorship to the implementing sites		
	Conduct two batches of a 5-day program management and advocacy skills training including adaptation of advocacy tool kit for relevant LGA and state officials	10,270,000	
	Conduct operational research and special studies on identified relevant subjects		
Program management sub-total		**360,982,858**	**898,532,600**
Objective 7 sub-total		**1,149,636,458**	**1,105,484,600**
Grand total		**3,053,466,313**	**5,416,823,410**

Year 3 Budget Less One-off activities (Naira)	Total Budget (Naira)	Total Budget (Dollar)	Funding Source
-	5,748,488	37,087	UNICEF
-	4,954,310	31,963	UNICEF
		-	
315,555,800	**1,575,071,258**	**10,161,750**	
502,927,800	**2,758,048,858**	**17,793,864**	
1,985,681,892	**10,455,971,614**	**67,457,881**	

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