FEDERAL MINISTRY OF HEALTH NIGERIA

National Operational Plan

for the

Elimination of Mother to Child Transmission (eMTCT) of HIV in Nigeria

2015–2016

NATIONAL AGENCY FOR THE CONTROL OF AIDS
NACA

National Operational Plan for the Elimination of Mother to Child Transmission (eMTCT) of HIV in Nigeria 2015–2016

HIV/AIDS Division, Federal Ministry of Health

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Foreword

The journey of preventing mother to child transmission of HIV in Nigeria started with 11 tertiary hospitals in 2002 but today we have successfully increased services to over 5000 sites including the tertiary, Secondary and Primary Health Centres. Accordingly, the number of women who have passed through the PMTCT intervention annually using the life-saving antiretroviral drugs for the prevention of Mother to Child transmission of HIV (PMTCT) has also increased from 13,000 in 2006 to 58,000 in 2013. Definitely there has been a decline in the prevalence of new HIV infections in Nigeria but a lot still needs to be done.

Nigeria still accounts for a significant proportion of paediatrics HIV infection globally. In response to this, the Government initiated a number of strategies to achieve it. These include the 2010-2015 National HIV Strategic Plan (NSP), 2010-2015 PMTCT scale-up plan, and more recently the 2013-2015 President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP).

Despite these efforts, a number of challenges have continued to hamper satisfactory progress, chief among which include inadequate political commitment at state and LGA levels, inadequate local funding and low community ownership and involvement.

This costed eMTCT operational plan has a two-year implementation time-line (2015-2016) to serve also as a stop gap operational plan for the period 2015-2016 that is neither covered by the 2010-2015 NSP nor by the yet-to-be developed 2016-2020 NSP. This is necessary to avoid a loss of implementation momentum during that period.

For successful implementation of this Plan, it is important that stakeholders at national, state and LGA levels play their roles to ensure that quality services are adequately provided in both public and private health facilities.

This document is recommended for Policy makers, Programme me Managers and healthcare givers. It is expected that proactive implementation of this 2-year operational plan will significantly contribute to the attainment of elimination of mother to child transmission of HIV by 2020.

Dr. Goodluck Ebele Jonathan GCFR
President and Commander In Chief of the Armed Forces
Federal Republic of Nigeria

Preface

Nigeria is committed to the eMTCT goal and has initiated a number of strategies to achieve it. These include the 2010-2015 National HIV Strategic Plan (NSP), 2010-2015 PMTCT scale-up plan, and more recently the 2013-2015 President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP).

Despite these efforts, a number of challenges have continued to hamper satisfactory progress, chief among which include poor implementation, inadequate local funding and low community ownership and involvement at the state and local government area levels.

Fortunately, His Excellency the President, Dr Goodluck Ebele Jonathan, in initiating the PCRP has undertaken to provide the needed political leadership and increase the local funding for the national HIV response.

Similar commitment at all levels of government is needed to achieve the eMTCT set goal all over Nigeria. Presented here is a costed Operational Plan (2015-2016) for the PMTCT component of the PCRP, designed to accelerate the PMTCT implementation towards achieving the eMTCT goal by 2020, if fully implemented.

The eMTCT operational plan was developed by stakeholders in the national PMTCT response. Relevant documents on the national HIV/AIDS response from the inception of the PMTCT programme were reviewed to understand the programme strategies, implementation targets, achievements, strengths and gaps. These included policy documents, guidelines, planning documents and reports. In particular, the UNAIDS Global Plan for eMTCT, the NSF and the 2010-2015 National Strategic Plan(NSP), the 2010-1015 PMTCT scale-up plan, the PCRP and the 2013 Mid Term Review/Joint Annual Review were reviewed for better understanding of recent policy direction, national ambitions and targets as well as to identify gaps and challenges in PMTCT implementation. Participants conducted these reviews individually and shared their findings with others for the next phase.

This eMTCT Operational Plan has a two-year implementation time-line (2015-2016) to serve also as a stopgap operational plan for the period 2015-2016 that is neither covered by the

2010-2015 NSP nor by the yet-to-be developed 2016-2020 NSP. This is necessary to avoid a loss of implementation momentum during that period.

The eMTCT Operational Plan basically has four Sections. Section one deals on the situation analysis and rationale for the document, Section Two; x-rayed fourteen Priority Areas and Activities that must be addressed including the three most important reasons that has been hindering the successful implementation of previous strategic Plans in Nigeria. Section Three and Four dealt with governance, implementation framework and detailed costing respectively.

It is expected that full implementation of this 2-year Operational Plan would significantly contribute to averting 240,000 vertical HIV infections between 2015 and 2020.

Dr Khaliru Alhassan

Hon. Minister of State for Health & Supervising Minister of Health

Acknowledgement

We acknowledge with gratitude the input of the representatives of the following organizations who carefully reviewed the necessary documents and provided invaluable contributions - NACA, NASCP, NPHCDA, UNAIDS, UNICEF, WHO, UNFPA, USG PEPFAR, ASWHAN, Department of Family Health (FMoH), FCT Ministry of Health, CHAI, APIN, FHI 360, MSH, and IHVN.

We wish to specifically acknowledge the support from UNICEF and UNAIDS for the Consultant who worked with the Plan Development Team and for some of the meetings held during the process of development of this Plan.

The available State Operational Plans for the prevention of MTCT provided significant insight to innovations that can be applied across the country and we are grateful to the respective State MoHs and their Lead IPs.

We also appreciate the financial and moral support of the Presidency and the National Agency for the Control of AIDS towards this process.

The excellent coordination effort of the PMTCT Unit of the National AIDS/STIs Control Programme under the Federal Ministry of Health is for sure going to represent one of the befitting legacies of the management of the Health Sector. It is hoped that this 2-year (2015-2016) Operational Plan will significantly reduce mother to child transmission of HIV infection in Nigeria.

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Acronyms and Abbreviations

AIDS	Acquired Immune-Deficiency syndrome
ANC	Antenatal Care/Antenatal Clinic
APIN	AIDS Prevention Initiative in Nigeria
ART	Antiretroviral Therapy
ARV	Antiretroviral Prophylaxis
ASWHAN	Association Women living with HIV/AIDS in Nigeria
AYP	Adolescent and Young People
BCC	Behavioural Change Communication
CHAI	Clinton Health Access Initiative
CORPS	Community Resource Persons
CSOs	Civil Society Organizations
DHCs	District Health Committees
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother to Child Transmission
FBOs	Faith Based Organizations
FCT	Federal Capital Territory
FHI 360	Family Health International
FLHE	Family Life Health Education
FMoH	Federal Ministry of Health
FP	Family Planning
GBV	Gender Based Violence
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IEC	Information Education and Communication
IHVN	Institute of Human Virology Nigeria
IP	Implementing Partner
IT	Implementing Team
JAR	Joint Annual Review
LACA	Local AIDS Control Agency
LGAs	Local Government Areas
LSS	Life Saving Skills
M&E	Monitoring and Evaluation
MNCH	Maternal Newborn and Child Health
MOT	Mode of Transmission
MSH	Management Sciences for Health
MTCT	Mother to Child Transmission
NACA	National Agency for the Control of AIDS
NARHS	National HIV&AIDS and Reproductive Health Survey
NASCP	National AIDS and STI Control Programme
NDHS	National Demographic and Health Survey
NGOs	Non-Governmental Organizations
NPHCDA	National Primary Health Care Development Agency
NSF	National Strategic framework
NSP	National Strategic Plan

NYSC	National Youth Service Corps
PCRP	Presidents Comprehensive Response Plan for HIV/AIDS in Nigeria
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PoA	Plan of Action
RH	Reproductive Health
SACA	State AIDS Control Agency
SASCP	State AIDS and STI Control Programme
SIT	State Implementation Team
SMoH	State Ministry of Health
SMT	State Monitoring Team
SOP	Standard Operating Procedures
SPHCDA	State Primary Health Care Development Agency
SRH	Sexual and Reproductive Health
SSP	State Strategic Plan
STIs	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
TOT	Training of Trainers
TWGs	Technical working group
UNAIDS	Joint United Nations Programme me on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children‘s Fund
VHWs	Volunteer Health Workers
WHCs	Ward Health Committees
WHCs/DHCs	Ward/District Health Committees
WHO	World Health Organization
YF	Youth Friendly

Process for Development of the eMTCT Operational Plan

The Elimination of Mother to Child Transmission (eMTCT) operational plan was developed by representatives of stakeholders in the National PMTCT response, including the National Agency for the Control of AIDS (NACA), HIV/AIDS Division of the Federal Ministry of Health (NASCP), National Primary Healthcare Development Agency (NPHCDA), Department of Family Health of FMOH, UNAIDS, UNICEF, UNFPA, WHO, United States Government President's Plan for AIDS Relief (USG-PEPFAR), Association of Women Living with HIV/AIDS in Nigeria (ASWHAN), Federal Capital Territory HIV/AIDS Division (FCT SASCP), lead implementing partners (AIDS Prevention Initiative Nigeria APIN, FHI360, Institute of Human Virology Nigeria IHVN, Management Sciences for Health MSH), and Clinton Health Access Initiative (CHAI). The entire process was coordinated by the PMTCT Unit with supervision from the Prevention Lead, FMOH/NASCP. One consultant worked with the team

Methodology

The development was carried out in two phases:

Desk Review of Existing Programme Documents and Programme

Relevant documents on the national HIV/AIDS response from the inception of the prevention of mother to child transmission (PMTCT) programme were reviewed to understand the programme strategies, implementation targets, achievements, strengths, and gaps. These included policy documents, guidelines, planning documents, and reports. In particular, the UNAIDS Global Plan for eMTCT, the National Strategic Framework (NSF) and the 2010-2015 National Strategic Plan (NSP), the 2010-1015 PMTCT scale-up plan, the President's Comprehensive Response Plan (PCRP), State 2014 Operational Plans for PMTCT and the 2013 Joint Annual Review and Mid-Term Review JAR/MTR. This helped in better understanding of the current policy direction, national ambitions and targets as well as in identifying gaps and challenges in PMTCT implementation. Contributors conducted these reviews individually and shared their findings with others for the next phase.

Planning Meetings

Seven planning meetings were held. Participants in the first four-day meeting identified the broad priority areas to be addressed in order to achieve the national eMTCT goal. A group of persons was assigned to identify the priority strategies needed to achieve the national target in each of the identified priority areas. These were reviewed and adopted in the plenary. Each of the groups was then assigned to identify priority activities required to implement each priority strategy. Their recommendations were reviewed and adopted in the plenary. Finally each group was tasked to rank the identified activities in the order of priority and to identify activities in a format that could be costed. This first meeting yielded the zero draft of the eMTCT operational plan, which was then used for costing.

Subsequent meetings were held to review, revise and adopt the final draft of the eMTCT operational plan.

Executive Summary

Nigeria has the second largest global burden of HIV/AIDS and also contributes the largest proportion of new vertically acquired HIV infections among children. The country has come a long way in the effort to control the HIV/AIDS epidemic, particularly in PMTCT.

Beginning with 11 tertiary health facilities in 2003, the country now has about 5,622 health facilities providing PMTCT services. The comprehensive package of PMTCT interventions includes HIV testing and counselling (HTC), infant feeding counselling, family planning counselling and services, ARV and cotrimoxazole prophylaxis for mother-infant pairs, early infant diagnosis (EID), screening of the mother for cervical cancer, and eligibility assessment of the mother for lifelong antiretroviral therapy (ART). The national coverage for each of these services ranges from less than 5% EID (at two months) to about 30% for maternal ARV prophylaxis.

Achieving a HIV-free generation is feasible with available technology, hence the United Nations' goal of eliminating new HIV infections among children and keeping their mothers alive (eMTCT) by 2015. Nigeria is committed to the eMTCT goal and has initiated a number of strategies to achieve it. These include the 2010–2015 National HIV Strategic Plan (NSP), 2010–2015 PMTCT scale-up plan, and more recently the 2013–2015 President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP).

In spite of these efforts, a number of challenges have continued to hamper satisfactory progress, chief among which are poor implementation as a result of inadequate political commitment at some lower levels, inadequate local funding, and low level community ownership and involvement at the state and local government area levels. Fortunately, His Excellency the President, Dr Goodluck Ebele Jonathan, in initiating the PCRP, had undertaken to provide the needed political leadership and increase the local funding of the national HIV response. Similar commitment at all levels of government is needed to achieve the eMTCT goal all over Nigeria.

Presented in this document is a costed operational plan (2015-2016) for the PMTCT component of the PCRP. The operational plan is designed to accelerate the PMTCT implementation towards achieving the eMTCT goal by 2020.

Section 1: Introduction

Background

1.1. HIV/AIDS Epidemic in Nigeria

Despite over two decades of fight against the HIV/AIDS epidemic, Nigeria still has a high burden of HIV/AIDS, second only to South Africa by global ranking[1]. Although Nigeria's current HIV prevalence rate among pregnant women is 4.1%[1], a decline from the peak of 5.8 in 2001, the number of new infections remains unacceptably high. Globally, Nigeria also contributes the highest number of vertically transmitted childhood HIV infections, accounting for 30% of the global burden[1]. The latter is partly due to the large number of people living with HIV (PLHIV) (3.4 million) in Nigeria of whom 57% are women. Most of these women do not know that they are HIV positive and therefore do not receive intervention during pregnancy, labour and breastfeeding to prevent vertical transmission of HIV to their infants.

Most married Nigerian women do not consider themselves at risk of HIV infection. However, results of the Mode of Transmission (MOT) study[2] shows that more new infections occur among this low-risk population (including married and cohabiting women). This implies that the entire population must be targeted with effective prevention interventions in order to achieve the desired reduction in incidence rate. Moreover, in spite of the relatively high public awareness of HIV/AIDS[3], high-risk sexual behaviours are still prevalent in the general population. These include high patronage of female sex workers by married men[2], early age of sexual debut[3], high rate of multiple sexual partnerships[2] and low prevalence of consistent and correct condom use[2], among others.

The low coverage of HIV counselling and testing (HCT)[3] means that many HIV-infected persons do not know their HIV status and may not receive secondary prevention interventions. Therefore, prevention interventions (turning off the tap) need to be intensified in order to contain the HIV/AIDS epidemic and achieve HIV-free generation in Nigeria.

[1] ANC SENTINEL SURVEY (FMoH 2010)
[2] Nigerian mode of transmission report
[3] 2013 NDHS

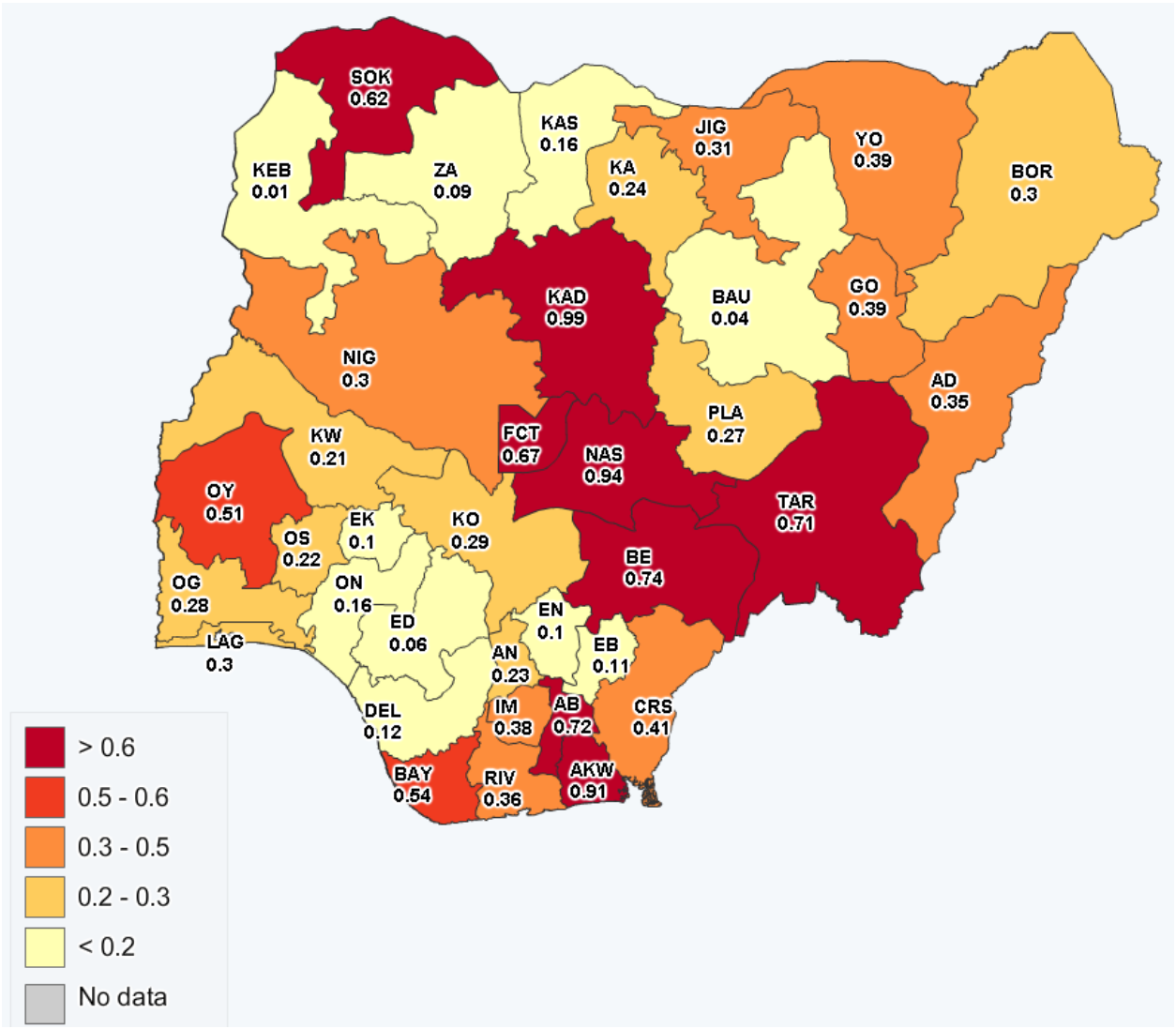

Figure 1: Distribution of HIV incidence among pregnant Nigerian women by state (spectrum estimate 2014)

1.1.1. PMTCT in Nigeria

In Nigeria, PMTCT services started in 11 pilot tertiary institutions in 2002 with less than 1% coverage. Recently, the number of PMTCT sites has increased to 5,622 out of the 22,726 public sector health facilities available in the country in December 2013[4]. To achieve the goal of eliminating MTCT, at least 90% of HIV-infected women should have access to comprehensive PMTCT services including ARV prophylaxis during pregnancy and the breastfeeding period. Between 2006 and 2013 the number of HIV positive pregnant women who received ARVs to reduce the risk of MTCT increased from 13,000 to 58,000 in 2013. However, this was still only 27%[1] of the 244,000 HIV-infected women who were estimated to have been pregnant in 2013.

[4] NACA 2014

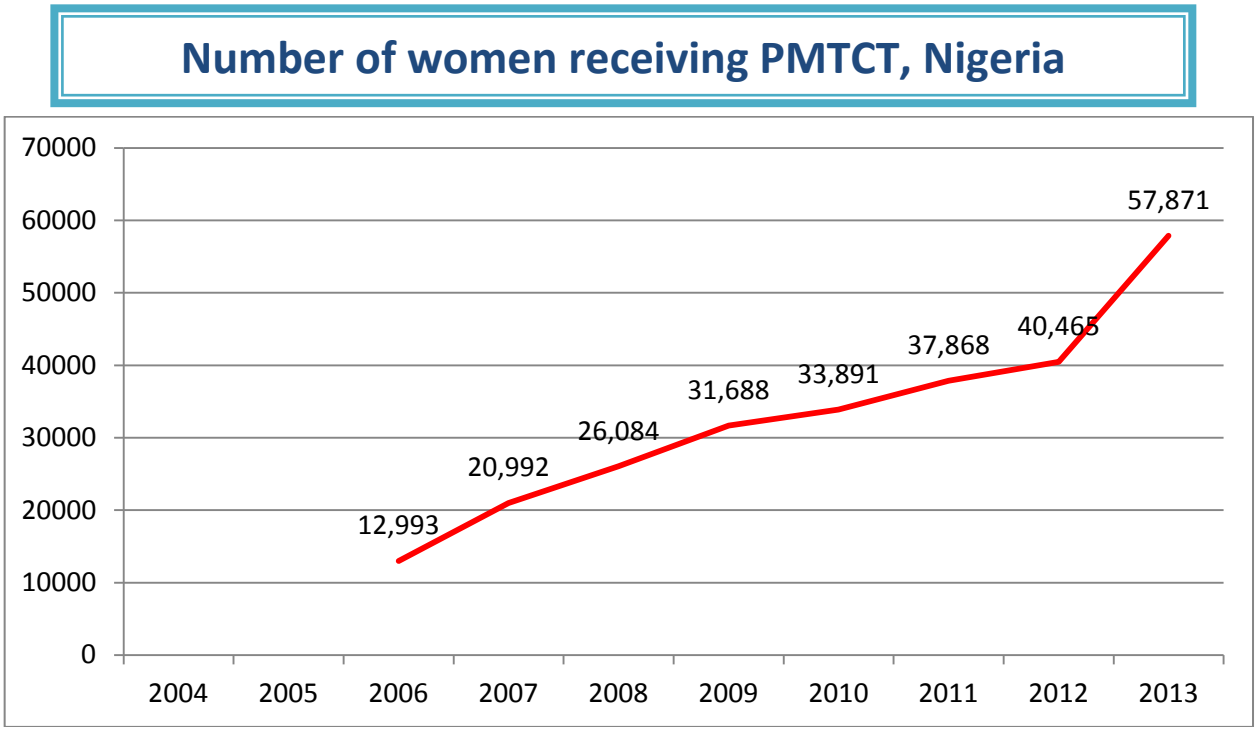

Figure 2: Yearly trend in the number of HIV+ women in Nigeria who received ARV to prevent MTC (2006-3013) (spectrum estimation 2014)

Overall, there is a geographic disparity in the PMTCT coverage. Unfortunately, with a change in the States that bear the highest MTCT burden as HIV prevalence increased markedly in some previously 'non-high burden' States not all the **current** high burden states have been adequately served (e.g. Oyo, Sokoto, and Taraba). A strategy to increase national focus on all the high burden states is therefore required to turn around the tide of the HIV epidemic among children in Nigeria. Services will also be scaled up in all the other States but at a different pace.

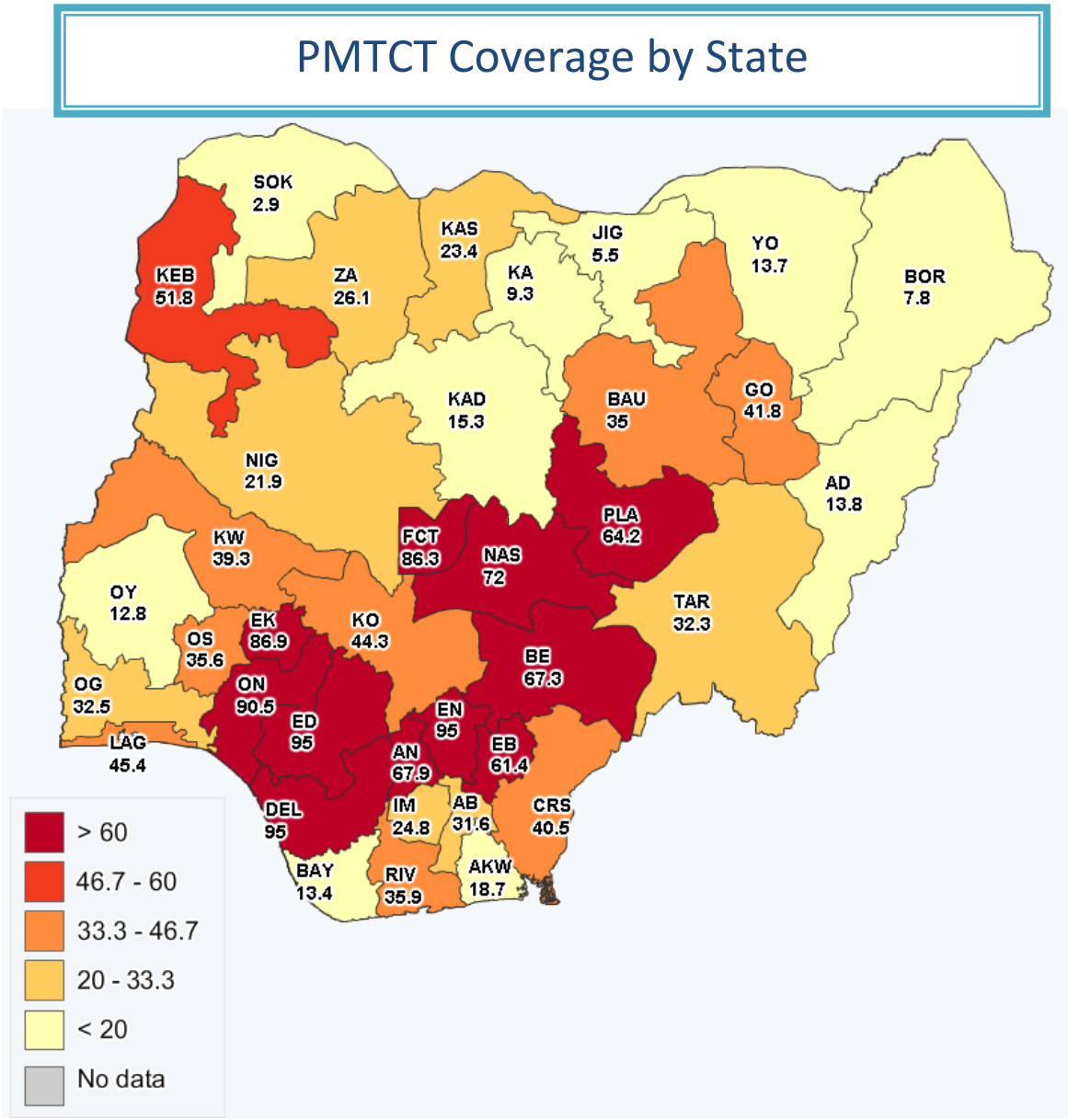

Figure 3: PMTCT coverage by state of residence, spectrum 2014

As most HIV-infected women in Nigeria are not aware of their HIV sero-status, routine HIV testing and counselling at the antenatal clinics (ANCs) offers the greatest opportunity to identify HIV-infected women and enrol them into the PMTCT programme. Only 61% of pregnant women in Nigeria attended ANC at least once during their pregnancy among the cohort of women who delivered between 2008 and 2013[3].

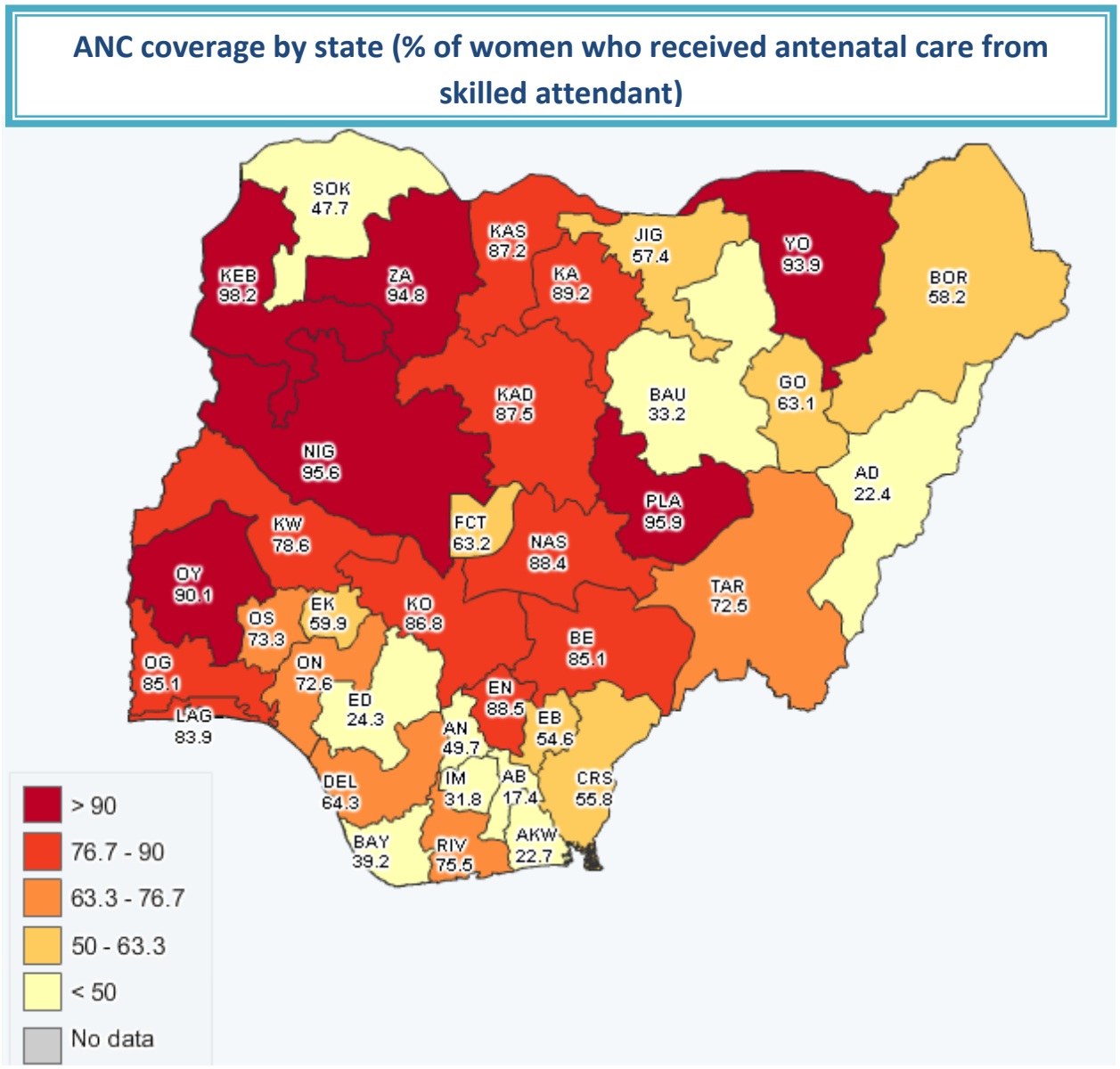

Figure 4: ANC coverage by State: % of women who received ANC from skilled attendants in Nigeria (NDHS 2013)

Long distance to health facilities and cost of services were some of the identified major barriers to ANC attendance[3]. Ensuring that there is at least one functional maternity clinic in each of the 9,522 wards in the country would be an effective step to remove the distance barrier to ANC attendance. Free maternal, neonatal and child health (MNCH) services and conditional cash transfer are other measures known to be effective for increasing access to ANC services. Effective comprehensive PMTCT interventions can reduce MTCT to as low as 0–2%[5]. On the other hand, without intervention, up to 45% of HIV-exposed infants could be infected from their mothers[5]. Providing PMTCT services in every ANC clinic as well as making ANC services universally accessible is the surest way of achieving the eMTCT goal in Nigeria. Most children are infected through MTCT (Figure 5).

[5] Coutsouddis et.al 2001

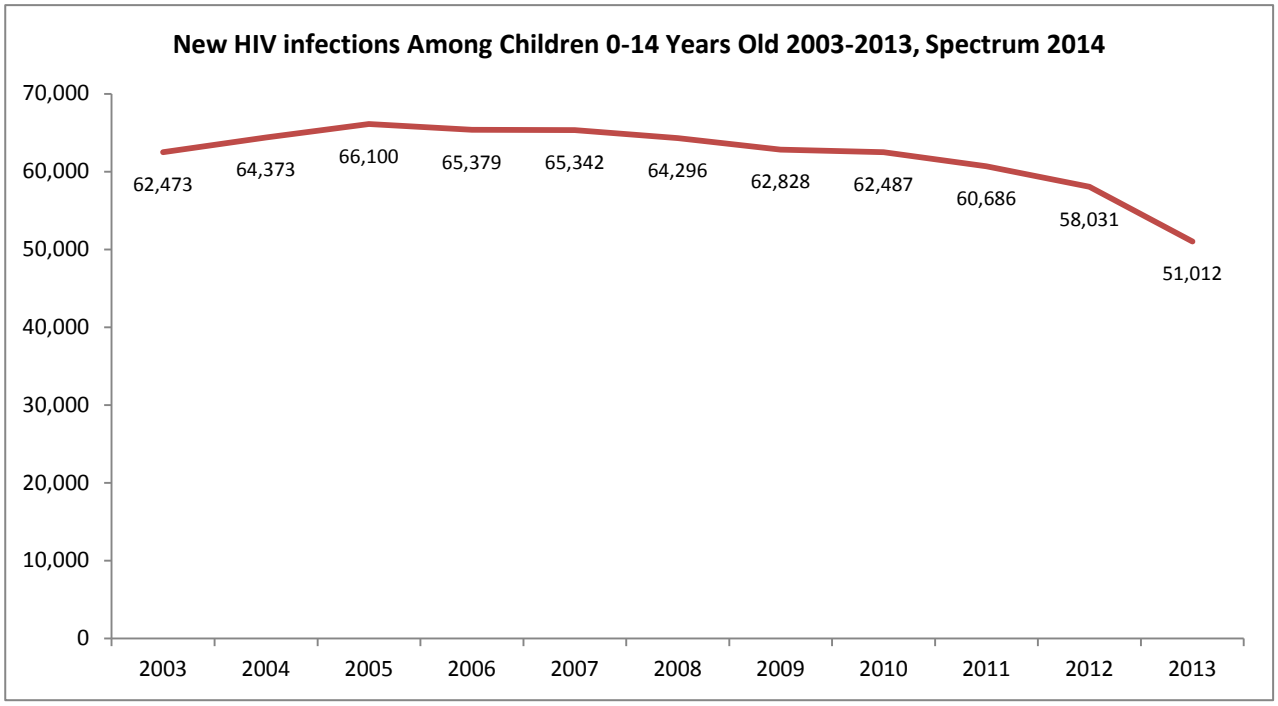

Figure 5: Trend of new HIV infections among children in Nigeria (Spectrum estimation)

1.1.2. PMTCT and the Health System in Nigeria

The health system in Nigeria could be conveniently divided into the formal and informal sectors. The formal sector is further sub-divided into public and private sectors, which is further stratified into primary, secondary and tertiary levels, according to the sophistication of services provided. The primary level is the most basic and is provided at the primary health care (PHC) facilities, which include health posts, health centres and maternity homes. The non-formal sector is much more heterogeneous and nebulous.

The public formal health sector has about 22,726 health facilities. Of these, only 63 out of 310 tertiary, 482 out of 972 secondary and 493 out of 21,431 primary health facilities (totalling 1,018) were providing PMTCT or HCT services in 2009[6,7]. The total number of PMTCT sites by the end of 2013 was 5,622.

The PHC system is the main channel of providing health services, including MNCH services, to the grassroots population. The National Health Policy stipulates that local government areas (LGAs) are in charge of the PHC system. According to the national minimum health care package, a population of not more than 20,000 is expected to be served by at least one primary health care centre[8]. Equipping and staffing one PHC clinic in each of the 9,522 wards to provide comprehensive MNCH, including PMTCT, services would go a long way in getting health care closer to the people.

Recently, the involvement of private sector health facilities has been prioritised with the sector now playing an increasing role in PMTCT service provision. Data from the 2013 NDHS revealed

[6] National Strategic Health Development plan 2010-2015
[7] Nigeria Health System Assessment 2010
[8] National Ward Minimum Health Care Package

that about 15% of all child births occurred in private hospitals[3]. Increasing private health facilities involvement in the national PMTCT programme presents a huge opportunity for achieving the national eMTCT goal. Scale up of PMTCT services to the private hospitals and clinics is one of the planned priority strategies in the 2010–2015 PMTCT scale-up plan[9]. It was recommended for implementation by the mid-term review of the NSP. Scaling up of PMTCT services to all PHC and private healthcare facilities would significantly increase the national PMTCT coverage.

1.1.3. Coordination and Funding of PMTCT programme

The NSF, NSP and PCRP place the responsibilities of multi-sectoral coordination and resource mobilization for the national HIV/AIDS response with NACA, SACA and LACA at the federal, state and LGAs respectively while the Ministry of Health (MOH) at the federal and lower levels coordinates the implementation. Coordination of multi-sectoral response is the role of NACA while the coordination of implementation in health settings lies with the Federal Ministry of Health (FMOH). Coordination efforts should be harmonized for efficient use of resources. An identified challenge to rapid scale up of PMTCT is the existence of parallel PMTCT coordinating structures at NACA and NASCP, leading to duplication of duties

Poor political commitment at most levels and inadequate funding are arguably the greatest challenges to achieving the eMTCT goal.

Funding is largely donor-dependent. The highest component of local funding for the response in recent years is about 25% at the national level. The highest state contribution is 0.3%.

1.2. Rationale for the eMTCT Operational Plan

Nigeria is a signatory to the United Nations Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive[10]. Yet, up to 60,000 infants are estimated to acquire HIV infection from their mothers annually at the current level of PMTCT coverage. Currently, only about 30% of HIV positive pregnant women receive ARV for PMTCT[1]. Access to comprehensive PMTCT services could reduce the number of infected infants to 0–2% depending on the scope of service coverage[7]. Low political commitment and poor funding, particularly at the subnational level, have been identified as the greatest challenges to attaining the eMTCT goal[6]. Therefore, in order to increase the momentum of the PMTCT programme towards achieving the eMTCT targets, there is a need to enhance political commitment at all levels of government.

The President has demonstrated a practical commitment to the elimination agenda through the launch of the PCRP in 2013 as well as the other efforts by the Federal Government to promote political and funding commitment at sub-national levels. The PCRP was nested in the current 2010–2015 NSP. The eMTCT operational plan has been developed to address the implementation gaps of the 2010–2015 NSP and the PCRP and to increase the momentum of PMTCT implementation towards the elimination goal.

The eMTCT operational plan has a two-year implementation timeline (2015–2016). It will also serve as a stopgap operational plan for the period 2015–2016 that is covered neither by the 2010–2015 NSP nor by the yet-to-be developed 2016–2020 NSP. This is necessary to avoid a loss of

[9] 2011-2015 NSP
[10] UNAIDS 2011

implementation momentum during that period. *The eMTCT operational plan assists the country to accelerate its response towards achieving the elimination of MTCT target by 2020.*

A modelling of the impact of such programme acceleration for achieving eMTCT has been conducted. In the baseline scenario it is assumed that, between 2013 and 2020, *coverage and thus expenditures remain at 2013 levels*. In the second scenario, it is assumed that *coverage increases to reach all HIV-positive pregnant women by 2020.* This scenario also includes significantly scaling up of treatment coverage, increasing coverage of HIV prevention interventions among women aged between 15 and 49 years and increasing contraceptive prevalence to reduce unplanned pregnancies among HIV positive women.

When compared to the baseline scenario, the estimates show that the increased coverage would avert 240,000 vertical infections between 2015 and 2020 (Figure 6). Some 93% (225,000) of vertical infections averted are solely as a result of scaling up PMTCT services while an additional 17,000 vertical infections would be averted as a result of the combination of prevention, family planning and treatment programmes.

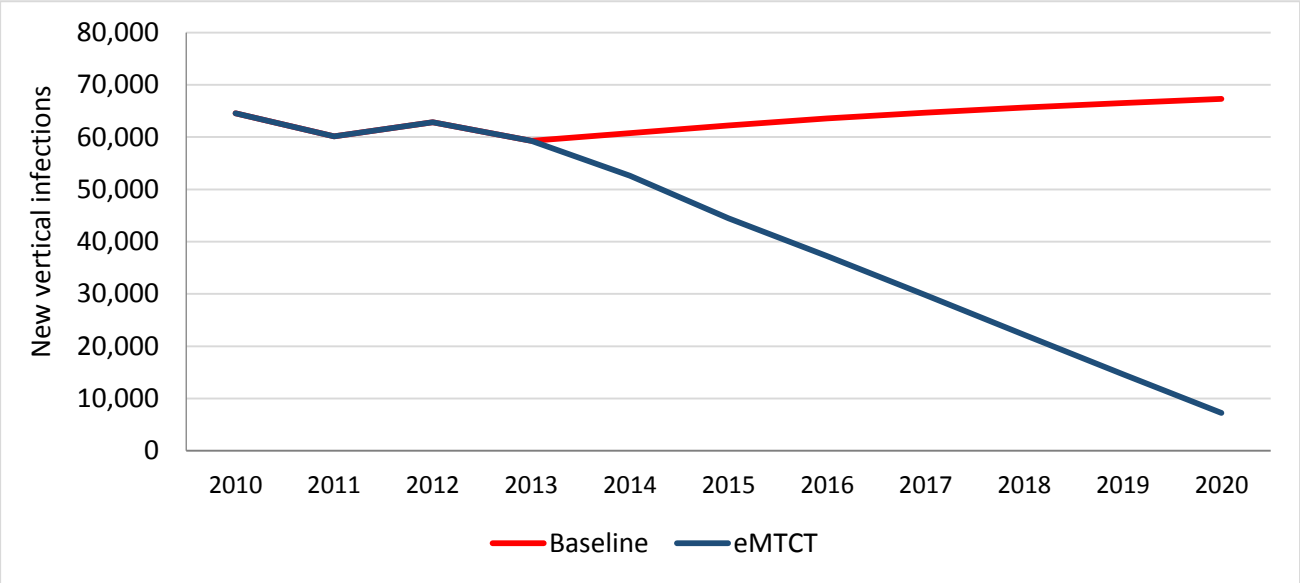

Figure 6: New vertical infections by scenario 1, 2010–2020

The combination of these interventions can produce substantial benefits beyond vertical HIV infections. For instance, more than 350,000 additional infections among adults (non-vertical infections) could be averted (Figure 7).

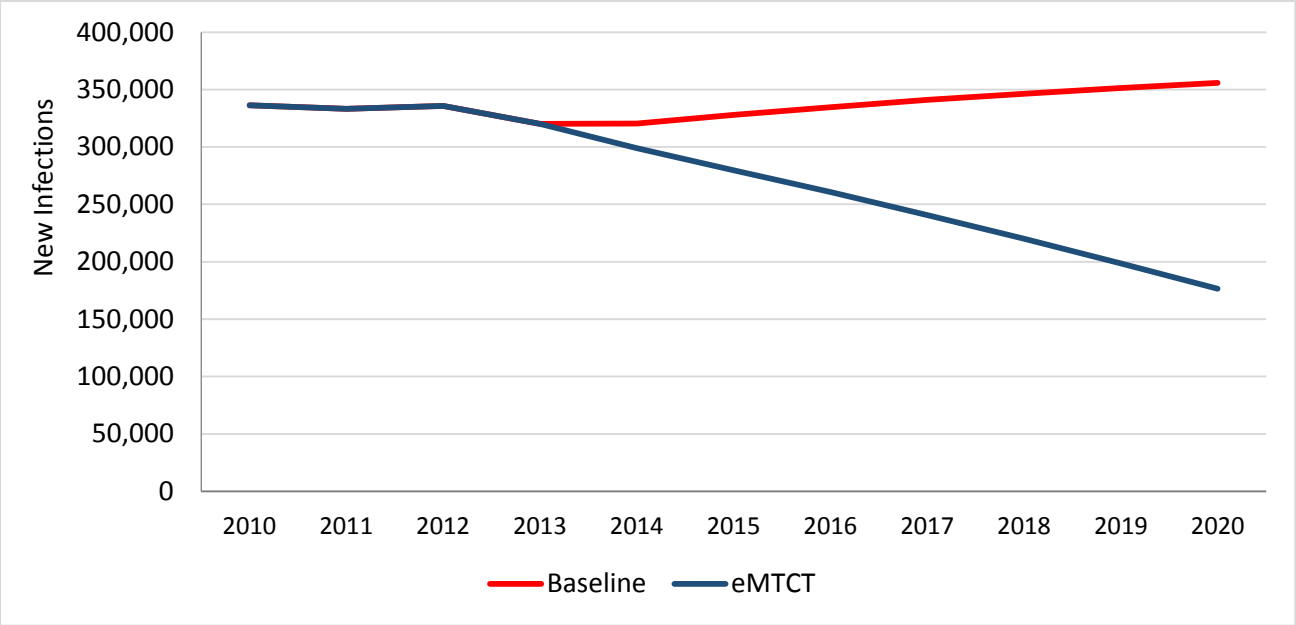

Figure 7: Trend of total new infections by scenario 2010–2020

1.2.1. Goal of the eMTCT Operational Plan

The goal of the eMTCT operational plan is to contribute to the elimination of new HIV infections among children and keep their mothers alive by 2020.

1.2.2. Objectives

The specific objectives are to have at least:

a. 50% of adolescents and young people have access to prevention interventions by 2016
b. 20% of all HIV positive women have access to contraceptive by 2016
c. 70% of all pregnant women receive quality HIV testing and counselling and receive their result by 2016
d. 70% of all HIV positive pregnant women and breastfeeding mothers receive ARVs by 2016
e. 55% of all HIV-exposed infants receive ARV prophylaxis by 2016*
f. 45% of all HIV-exposed infants have early infant diagnosis services by 2016*
g. 55% of all HIV-exposed infants receive CTX prophylaxis by 2016*

**(Baseline for e, f and g were 9%, 5% and 5% respectively in GARPR 2013*

Section 2: Priority Areas and Priority Activities

2.1.1. Priority Area 1: Adolescents and Young People

Background

Young people are at the centre of the HIV epidemic in terms of vulnerability, transmission, impact and potential for change. Adolescents and youth are increasingly recognized as a priority on the global agenda as well as in national HIV policies because young people make up a segment of the population that is particularly vulnerable to HIV. Globally, 50% of HIV transmission takes place among those aged 15–24 years, and 5,000–6,000 young people become infected every day. In 2011, young people accounted for 40% all new adult HIV infections, and 80% of those new infections occurred in sub-Saharan Africa. However, in Nigeria lack of specific data on adolescents HIV/PMTCT incidence rate is a barrier to proper planning.

In Nigeria, the estimated number of new HIV infections occurring among young people age 14 years and less dropped from 66,000 in 2010 to 60,000 in 2012. The 2012 NARHS shows that HIV prevalence was 2.5% for males and 3.7% for females (compared to the national average of 3.5% for 15-49-year-olds).

At the same time, analysis of the mid-term review of the implementation of the 2010–2015 national HIV/AIDS strategic plan, disaggregated data by age and gender, shows that HCT access was skewed to adults, with very few adolescents and children accessing HCT services. Of those tested in 2012, 191,161 (6.7%) were less than 15 years of age (FMOH, 2013). Between the last two NDHS, Nigeria's teenage pregnancy rate has remained high at 23%. This continued high teenage pregnancy rate underscores the need to revitalize prevention efforts (prongs 1 and 2) for young people and adolescents in Nigeria.

Objective

To increase HIV prevention services to 50% of adolescents and young people by 2016

Priority Activities

Federal

- Organise refresher training of trainers (TOT) on family life and HIV/AIDS education (FLHE) for out-of-school peer educators in 36 states and FCT.

State/LGA

- Conduct training of out-of-school peer educators on FLHE in 774 LGA.
- Support one youth PLHIV support group per LGA to implement HIV prevention activities.

LGA

- Implement peer education activities in each of the 774 LGAs.

2.1.2. Priority Area 2: Condom Programming

Background

Of the 3.4 million adults living with HIV in Nigeria, 58% are female. The inability of females to negotiate safer sex with their male partners exacerbates their vulnerability to HIV infections and hence increases their risk of infecting their children during and after pregnancy. Correct and consistent use of condom is an effective HIV prevention strategy. Despite government support for condom programming, social and cultural resistance to its use persists because of the misconceptions associating condom use with sexual promiscuity. The current effort of government in promoting and supporting condom programming needs to be strengthened.

Objectives

To increase condom use among women of reproductive age in order to reduce exposure to HIV infection and unintended pregnancies.

Priority activities

Federal/state/LGAs

- Train 3,700 male and female volunteers on how to demonstrate the use of condoms using models (penile and vaginal).
- Conduct condom awareness generation activities and distribution in public places such as offices, markets and hospitals throughout the federation.

Facility level

- Discuss family planning at ANC/PMTCT clinics, laying more emphasis on the dual protection advantages of condom (protection against unwanted pregnancy and STIs and HIV).
- Provide condoms to breastfeeding mothers during postnatal and child immunization visits.

2.1.3. Priority Area 3: Provider Initiated Counselling and Testing (PICT)

Background

HIV counselling and testing is the entry point to HIV prevention, treatment, care and support services. It is particularly important for identifying pregnant HIV-positive women so that they could be enrolled into the PMTCT programme.

The country data at the end of 2013 showed that the cumulative number of persons accessing HCT services was far below the national targets. The recently developed PCRP aims to test 80 million Nigerians within two years. However, at the end of 2013, only 4,077,663 were tested and counselled and a cumulative number of about 23 million have been tested since the commencement of these services in 2002.

Recent evidence reveals a high unmet need for HCT services. According to the 2012 NARHS, 77% of those surveyed actually desired to have an HIV test, with majority of those who wanted a test residing in the rural areas. Several challenges affect the national HCT programme. These include the limited number of HCT service delivery points, frequent commodity stock-outs, poor commodity logistics for storage and distribution, and poor funding of the HCT programme.

There are many opportunities in clinic and facility settings which have not been used to full advantage in providing testing and counselling and increasing access to these services to pregnant mothers and women in the reproductive age group.

Objectives

To increase access to testing and counselling services and linkages to HIV prevention and care services to pregnant women and women in the reproductive age group attending health care facilities in Nigeria.

Priority Activities

Federal

- Distribute guidelines, training tools and educational materials for PITC to the 37 states Ministry of Health.
- Conduct one TOT on PITC for two persons per 36 states and FCT.
- Integrate HCT into the national MNCH week initiative at the policy level.

State

- Conduct PITC training for health workers.
- Provide routine testing and counselling with "Opt out approach" in all public, private and non-formal facilities providing ANC services.
- Provide routine testing and counselling with "Opt out approach" in all family planning, STI and infant welfare clinics in all facilities where they exist.
- Plan and provide tools for integrating HCT into bi-annual MNCH weeks at the LGA level.

LGA

- Provide routine testing and counselling with "Opt out approach" in all PHC facilities and private and non-formal facilities providing ANC services.
- Conduct community preparedness and social mobilization for HCT services.
- Conduct HCT during bi-annual MNCH weeks.

2.1.4. Priority Area 4: Integration of PMTCT and MNCH/FP Interventions

Background

Integration of interventions for PMTCT and MNCH is essential as clients seek both related services and share many common needs and concerns that make service integration appropriate. This provides opportunity to accelerate the elimination agenda. A significant proportion of mothers and their children have contact with the health system during their antenatal and postnatal periods through maternal health, well baby, immunization and pediatrics clinics, as well as inpatient paediatric wards during acute illness without receiving HIV/PMTCT services. These cascades of missed opportunities and poor linkages exist between points of service delivery, beginning from the first ANC visit, through childbirth, and during postnatal maternal and child visits.

Weak coordination, parallel planning, lack of funding for supervision and structural healthcare system limitations such as irregular supply of essential commodities are major challenges. In

addition, inadequate number of health care providers, irregular technical support and inadequate basic working conditions also militate against effective integration.

The states Ministry of Health will create at all levels a coherent policy environment, spearhead strategic planning and ensure availability of resources for implementing integration at lower levels of the health system. Health facility staffing norms, technical support, cost-sharing policies, clinical reporting procedures, salary and incentive schemes, clinical supply chains, and resourcing of health facility physical space upgrades, all require attention.

Objectives

- To increase one-stop access to PMTCT, family planning (FP) and related services at health facilities providing care for women and children.
- To strengthen coordination of MNCH/FP and HIV/ PMTCT programmes at all levels.
- To build the capacity of health workers to provide integrated MNCH/FP and HIV/PMTCT services.
- To promote integrated data reporting and supportive supervision of MNCH-FP/HIV/PMTCT programmes.
- To strengthen integrated logistics for MNCH/FP and HIV supplies and commodities.

Priority Activities

To strengthen coordination of MNCH/FP and HIV/ PMTCT programme s at all levels

Federal

- Conduct joint annual planning meeting of MNCH/RH and HIV/ PMTCT programmes.
- Support joint planning for integrated MNCH/FP and HIV/PMTCT interventions during MNCH weeks.

State/LGA

- Support implementation of integrated MNCH/FP/PMTCT services during MNCH weeks nationwide.
- Support joint bi-annual progress review and coordination meetings between MNCH/RH and HIV/PMTCT programmes.

To build the capacity of health workers to provide integrated MNCH-FP/HIV PMTCT services

Federal/State

- Print 50,000 copies each of revised National Guidelines, standard operating procedures (SOPs) on integration models and RH/HIV integration training manuals.
- Disseminate the revised National Guidelines and SOPs on integration models and RH/HIV integration training manuals in all 36 states and the FCT.
- Conduct orientation of 10 (LSS, FP, PMTCT and HIV) master trainers/state on revised RH/HIV integration modules.
- Incorporate training on RH/HIV integration into existing HIV/PMTCT and RH trainings.
- Support training of NYSC health workers on RH/HIV integration.
- Conduct two targeted advocacy visits annually to SMOH, SMOLG, and LGA service commission on recruitment and retention of health workers.

To promote integrated data reporting and supportive supervision of MNCH-FP/HIV/PMTCT programme

Federal

- Support quarterly generation of District Health Information System (DHIS) reports as feedback to states.
- Support bi-annual performance review meetings with states.
- Conduct quarterly Data Quality Assessment exercise.

State

- Support quarterly generation of LGA DHIS report as feedback to LGAs.
- Provide technical and financial resources for quarterly integrated supportive supervision and mentoring for MNCH/HIV/PMTCT services.
- Conduct quarterly Data Quality Assessment.

To strengthen integrated logistics for MNCH and HIV supplies and commodities

Federal

- Train 100 RH/MNCH and HIV/PMTCT officers on LMIS.
- Support joint annual planning for RH/HIV commodities forecasting, procurement and distribution in 36 states and FCT.
- Support quarterly joint stock taking and reporting on availability of MNCH and HIV supplies and commodities in 36 states and FCT.

State/LGA

- Support LGAs to conduct monthly supervision mentoring visits to health facilities.

2.1.5. Priority Area 5: Scale-up of Service Delivery

Background

Efforts at scaling up PMTCT service delivery in Nigeria are faced with challenges such as inadequate numbers and mal-distribution of public and private service delivery points, poor ANC attendance, inequity of access, poor quality of PMTCT services, poor drug adherence and retention of mother-baby pair, poor laboratory monitoring, and weak linkages to comprehensive HIV care.

Elimination of MTCT requires substantially increasing the demand and supply aspects of the PMTCT care continuum. Therefore, rapid investments towards increasing the number of service delivery points, the scope and quality of services and innovative approaches to increasing the demand for HIV services are vital for achieving universal access, and retention within the service continuum.

Objectives

To make PMTCT services accessible to at least 70% of HIV positive pregnant women by 2016

Priority Activities

Federal

- Distribute PMTCT guidelines, SOPs and reporting tools to states.
- Procure and distribute ARV prophylaxis and treatment for all HIV positive pregnant women.
- Review the minimum package for eMTCT services in the country to include basic requirements for immunological monitoring for pregnant women on ARVs.
- Update and circulate directory of facilities providing PMTCT service (public, private, federal, state, local)

State

- Institutionalize state level supervisory visits and QI/QA monitoring to facilities.
- Distribute PMTCT guidelines, SOPs and reporting tools to public and private health facilities.
- Activate 1500 additional sites to provide PMTCT services.

LGA

- Appoint and train a dedicated M&E officer responsible for M&E at the LGA level.
- Facilitate the institutionalization of PMTCT peer support (Mentor Mothers) at PMTCT facilities.

Facility

- Provide multiple testing points in every facility to reach pregnant women and women of reproductive age.
- Provide comprehensive PMTCT services.
- Conduct facility QA/QI activities.

2.1.6. Priority Area 6: Increased Involvement of Formal and Non-formal Private Health Service Providers in PMTCT

Background

Nigeria has a relatively high number of private health facilities, which represent nearly 34% of all healthcare facilities in the country (National Health Facility Directory, 2012). Provision of health services through the non-formal providers is also thought to be significant. Such providers include traditional healers, traditional birth attendants (TBAs) and spiritual healing institutions. According to DHS 2013, only 35% of deliveries take place in health facilities; 20% in public health facilities and 15% in private health facilities. The rest of the deliveries take place at homes and at the non-formal settings.

Engagement of the non-formal and private facilities has been low and linkages remain rudimentary resulting in little or no information about their activities. There is the need for an improved mechanism for the engagement of private health service providers at the formal and non-formal settings.

Challenges include non-reporting of data from these facilities, quality issues and inadequate supervision.

Objectives

To increase the involvement of private and the non-formal healthcare providers in the PMTCT programme.

Priority Activities

Federal

- Facilitate the involvement of more private health facilities in the National Health Insurance Scheme (NHIS).
- Advocate to and engage the leadership of the private health providers to buy-in to the PMTCT programme.
- Conduct TOT for private health care practitioners.

State

- Sensitize informal service providers on PMTCT, provision of intervention and prompt referral.
- Conduct periodic mentorship and supervisory visits to SDPs of the non-formal sectors.
- Sensitize professional bodies of various private health service providers on PMTCT and prompt referral
- Conduct HCT and PMTCT training for service providers in all the private health sectors.
- Provide commodities, data and referral tools, and job aids to the trained private health workers.
- Facilitate periodic supervisory visits to SDPs of the private health sectors.
- Facilitate quarterly review meetings with representatives of service providers from private health sectors.

LGA/Community

- Sensitize TBAs and other community resource persons (CORPs) on PMTCT and on mobilization of pregnant women in their communities for ANC.
- Conduct HCT outreaches to TBAs and other appropriate CORPs service delivery points.
- Provide commodities, data collection tools, and job aids to the trained TBAs and appropriate community-based organizations (CBOs)/CORPs.
- Utilize the hub and spoke model, map out catchment areas and assign or designate trained TBAs and appropriate CBOs/CORPs for ease of referral.
- Conduct regular supervisory visits to trained TBAs and CORPs.
- Convene monthly review meetings with trained TBAs and CORPs.

2.1.7. Priority Area 7: Adherence Support and Surveillance of ARV Drug Toxicity

Introduction

Long use of ARV drugs during pregnancy and throughout MTCT risk period as recommended by the national guidelines has necessitated the need to establish and strengthen the existing systems for ARV adherence support and for surveillance of ARV drug toxicity. These systems will ensure effective and efficient treatment planning and ongoing support to ensure increased adherence and early detection of drug toxicity during pregnancy and the breastfeeding period.

Strategies to facilitate adherence support and surveillance for ARV drug toxicity will include patient education and information, use of ICT, and establishment of facility-linked community support groups. The use of mobile text messages for supporting adherence and health care delivery in general has increased as access to phone technology expands. Emphasis on the use of mobile phone technology will be supported as a convenient reminder mechanism to engage HIV+ pregnant women on ARV and throughout the period of MTCT risk. Surveillance for toxicity will be conducted at every point of contact from the first antenatal clinic visit, to delivery and until the end of the breastfeeding period, to collect data on the toxicity of ARVs (or lack thereof) in mothers and infants.

Objectives

- To strengthen ARV adherence support system.
- To build capacity for surveillance of ARV toxicity at all levels.

Priority Activities

Federal Level

- Develop and disseminate standard patient information and education leaflets on ARVs use during pregnancy and breastfeeding period.
- Support implementation of mobile phone technology for SMS reminders.
- Develop simple job aids for early identification of ARV toxicity.

State

- Establish and engage mother mentors/peer support groups/counsellors to support education and adherence counselling and track/follow-up mother-baby pair in health facilities.
- Sensitize health care professionals providing PMTCT on reporting of ARV toxicity and adverse reactions.

Community/Facility

- Implement mother mentors/peer support groups/counsellors providing education and adherence counselling and tracking/follow-up of mother-baby pair in the community.
- Implement the use of mobile phone technology for providing SMS reminders.

2.1.8. Priority Area 8: Early Infant Diagnosis (EID)

Background

Currently not all the facilities offering ARVs for PMTCT provide EID services even though the programme goal is for every PMTCT facility to also offer DBS sample collection and transport for EID. Among the key strategic objectives of the national scale-up plan is ensuring that at least 90% of all HIV-exposed infants have access to EID services. With this ambitious target, the requirement for EID is increased even as Nigeria targets to test more than 158,000 HIV-exposed infants by

2020. So far, EID coverage has remained low with only 5% of HIV-exposed infants receiving a virological test within two months of birth (FMOH 2013).

The EID programme is critical to assessing outcomes of PMTCT interventions and is important for early initiation of HIV-infected infants on ART because without ART, a HIV-infected infant has a 35% chance of dying by the age of one year and a 53% chance of dying by the age of two years. To ensure zero new HIV infections, therefore, there is a need to greatly improve timely access to EID services for all HIV exposed infants.

Challenges with the EID programme in Nigeria include inadequate number of health facilities providing services, erratic supply of EID commodities, long turnaround time for EID result retrieval, inadequate capacity of health care providers, poor dried blood spot (DBS) sample logistic systems, and weak coordination of EID activities at the national and state levels.

Objectives

To increase EID service coverage by scaling up EID services and strengthening EID logistics to improve turnaround time for result retrieval.

Priority Activities

Federal

- Establish two additional automated polymerase chain reaction (PCR) machines.
- Procure and distribute EID commodities to health facilities.
- Integrate EID training into the PMTCT curriculum.
- Develop and distribute SOPs and job aids for EID service delivery.
- Engage with chief medical directors (CMDs) of tertiary institutions where PCR laboratories are located to advocate for a facility budget for equipment maintenance and fuelling of generators needed for EID services.

State

- Map PMTCT sites not providing EID services.
- Provide EID services to all PMTCT sites on-site or by referral.
- Procure and install SMS printers to facilitate EID result retrieval (two each per LGA).
- Train and engage additional laboratory personnel to support PCR laboratories (one each per high volume laboratory).
- Provide funding for active tracking of defaulting mother-baby pairs and ensure their linkage to care (use of mentor mother/other CORPs).

Facility

Train health workers on DBS collection and handling.

2.1.9. Priority Area 9: Human Resources for Health

Background

Effective delivery of quality HIV services requires adequate number and skill mix of health care workers at the federal, state, local government, and health facility levels. However, the HIV

epidemic has put further pressure on an overburdened health care system. The mal-distribution of limited human resources for health in favour of the urban areas is another major challenge. Task shifting, which involves transfer of skills to lower cadres of staff to perform specific tasks, is an effective strategy to address this challenge.

The capacity of the health worker for optimal performance is best developed through training and providing trained workers the means to carry out interventions. That means coupling increased technical knowledge with improved motivation and supervision and with functional systems.
At the same time health facilities should have the basic tools and equipment to support the provision of high quality eMTCT services.

Objectives

- To provide PMTCT training for relevant health workers.
- To implement task-shifting for the scale-up and decentralization efforts of the PMTCT/HIV response.
- To institutionalize effective mentoring and coaching as part of the task shifting strategy.

Priority Activities

Federal

- Develop, produce and distribute national training documents, SOPs and job aids.
- Conduct TOT for PMTCT trainers based on the PMTCT training documents to produce PMTCT national master trainers.

State

- Conduct rapid needs assessment of PHCs and private health facilities with minimum staff requirement for PMTCT service delivery (in yet to be assessed states).
- Conduct state level PMTCT TOT to produce trainers to cascade PMTCT training at LGA/facility levels.
- Conduct mentoring and supervisory visits to facilities.

Facility

- Conduct PMTCT and RH step-down training at the facility level.
- Implement task shifting to include eMTCT services and RH integration.

2.1.10. Priority Area 10: Monitoring and Evaluation System for eMTCT

Background

Monitoring and evaluation (M&E) is critical to the success of any programme. The Nigeria National Response Information Management System (NNRIMS) is the platform for tracking the national HIV/AIDS response. The current focus on use of HMIS tools at the PHC level further helps to strengthen integration and minimize verticalization of HIV M&E system at the lowest level of PMTCT service provision.

PMTCT management information system has standardized tools, and FMOH maintains the central database and provides technical assistance to the PMTCT sites for monitoring and evaluation of the PMTCT activities.

Reporting should be both vertical and horizontal within the states with well-defined M&E organizational structures at the state, LGA and SDP levels.

It is pertinent to strengthen other periodic non-routine sources of data and information in the HIV M&E systems, which are used to track the trend in the HIV prevalence rate and other outcome and impact indicators of the HIV response among the general population and key target groups. These include: data quality audit, surveillance (HSS, NARHS, IBBSS, MICS), programme reports, and operational researches. Regular DQAs and surveys need to be conducted and should be coordinated by an agreed body such as NACA or NASCP with the involvement of relevant stakeholders. Regular data quality audit should be conducted at all levels.

Objectives

To provide accurate, complete and timely PMTCT data for progress tracking and evidence based planning of PMTCT services.

Priority Activities

Federal

- Ensure the use of DHIS ICT platform by the SMOH (SASCP + HPRS) and HIV implementing partners.
- Convene annual review meeting for PMTCT programme evaluation.
- Support zonal quarterly PMTCT M&E review meetings.

State

- Distribute the harmonized HMIS and PMTCT DCTs to facilities.
- Convene monthly state level PMTCT data collection and collation meetings.
- Conduct quarterly DQA exercise to PMTCT sites.
- Conduct capacity building of SMOH, LGA and facility health workers on harmonized PMTCT M&E tools.
- Conduct capacity building of SMOH, LGA and facility health workers on computer use of DHIS2 platform.
- Convene quarterly PMTCT data verification, validation and feedback meeting.

LGA

- Attend monthly state level PMTCT data collection and collation meetings.
- Conduct monthly data collection and collation from all public and private facilities providing PMTCT services.
- Transmit data to SASCP and maintain updated PMTCT data on the DHIS2 database.

Facility

- Implement real time and accurate data collection using the approved national data management tools.
- Transmit data using the national monthly summary report form to the LACA officer.

2.1.11. Priority Area 11: Procurement and Supply Chain Management

Background

The Nigerian HIV/AIDS logistics system is designed to operate as a two-tier system – central and facility. It is a 'forced ordering maximum-minimum inventory control system'. As such, orders are placed at a fixed time interval (two months) and the order quantities are determined by the responsible person at the facility level using consumption data. Additional financing and training at the state level has already been identified in the PCRP as a critical necessity at the state level for improved monitoring and supervision of facilities that receive HIV commodities. At the moment, over 90% of funds for eMTCT commodities in Nigeria are provided by PEPFAR and the Global Fund for AIDS, TB and Malaria (GFATM); these commitments are managed by government as well as non-governmental stakeholders. With increased resource commitment of the Government of Nigeria (GoN) to eMTCT in the coming years, an efficient national PSCM system will require co-ordination among all funding streams to eliminate the potential for stock outs and wastages. Potential expansion of DHIS functionalities to cover commodities logistics data will improve forecasting and contribute to moving towards just in time delivery.

Objectives

- To reduce stock-outs and expiry of HIV commodities for eMTCT/EID by improving forecasting and moving towards just-in-time delivery.
- To improve data visibility and consistent quality up through LGAs, states, and at the national level.
- To strengthen PSCM system to enable adaptation to changing funding arrangements and co-ordination of multiple commodity sources.

Priority Activities

National Level

- Support national quantification for eMTCT commodities (2015-2018).
- Conduct bi-annual supply plan review exercises.
- Conduct annual procurement audits of all partners, and sharing of best practices information on pricing.
- Consolidate all HIV commodities to axial warehouses as entry point for supply chain.
- Develop third party logistics arrangements to move commodities from axial warehouses to facilities.

State Level

- Develop state level commodity consumption data gathering capacity in the health system through the SMOH (State Logistics Management Coordination Units - LMCUs).
- Strengthen the SPHCDA to increase accountability by service providers through improved logistics data management, effective feedback mechanisms, and consistent monitoring and supportive supervisory visits.
- Include SMOH and SPHCDA in site activation and PSCM network inclusion activities, with focus on transferring this responsibility to them.

LGA

- Operate task shifting where necessary capacity is lacking for data collection and logistics management at facility level.

- Support LGA HIV coordinators to engage in task shifting when necessary to gather data from facilities.

Facility

- Build the capacity of all facilities to submit basic consumption data on a bimonthly basis to designated reporting channel.
- Develop mobile feedback methods at facilities for improved commodities management and capability of early stock-out warnings.

2.1.12. Priority Area 12: Referral System Strengthening for PMTCT

Background

In order to achieve eMTCT, GoN is scaling up PMTCT services through decentralization to PHCs and private health facilities. However, in line with current national standards, PHCs and private facilities do not have the capacity to provide all the required services. These services include laboratory tests and management of complicated cases and as such must refer. A cluster model referral system is already operational to facilitate DBS samples transportation and logistics. Such a model is recommended for the entire PMTCT programme.

Objectives

To scale-up the cluster model of referral to cover all PMTCT service areas (HIV clients/laboratory specimens' referral, professional/mentorship support, client tracking and logistics support) by 2016.

Priority Activities

Federal

- NASCP to review and institutionalize the cluster model of referral for the national HIV/PMTCT programme.
- NASCP to provide guidance and tools to states to establish the cluster model of referral at the state level.

State/LGA

- States to support health facilities that serve as cluster hubs to plan for and provide mentorship visits, referral feedback and to facilitate completion of the referral cycle for patients and laboratory investigations.
- LGAs with assistance from states to sensitize all HIV service delivery sites focal persons on the cluster model network and its expected functionality for client/patient referral, professional/mentorship support and logistics support.
- LGAs with assistance from states to support all HIV service delivery sites to enter into arrangement with transport associations and to actively facilitate patient referral.

2.1.13. Priority Area 13: Community Leadership and Action for eMTCT

Background

Community leadership and participation has become increasingly recognized as an important element in improving health status particularly among poor and underserved populations in developing countries. Some of the challenges documented in the review of HIV/AIDS prevention, treatment, care and support services in Nigeria include low utilization and uptake of services especially by the hard-to-reach communities, lack of awareness on PMTCT/eMTCT services and stigma/discrimination amongst others. If any noticeable improvement in the utilization/uptake of eMTCT services is to be effected, communities must be fully involved. This means that community members must participate in the planning, implementation, monitoring and evaluation of eMTCT programmes. This level of participation will ensure programme ownership and sustainability.

Objectives

- To increase advocacy for service availability and access.
- To strengthen community groups and organizations in resourcing community interventions for sustainability.
- To strengthen social communication approaches to create demand and increase uptake of PMTCT services.
- To increase mass mobilization efforts through targeted use of mass media.

Priority Activities

Federal

- Convene a national dialogue with traditional and religious leaders on PMTCT for awareness creation and engagement in the national eMTCT agenda.

State

- Conduct advocacy visits to traditional and religious leaders on eMTCT services to sensitize and request their engagement in eMTCT services in their wards and communities.
- Engage traditional and religious leaders to create awareness, and give terms of reference for community ownership and their participation in eMTCT services.

LGA

- Conduct advocacy visits to traditional and religious leaders on eMTCT services to sensitize them and request their engagement in eMTCT services in their wards and communities.
- Engage traditional and religious leaders to create awareness, get their buy-in and give terms of reference for their participation in eMTCT services.
- Conduct training and re-training of CBOs, CDAs, VDC/WDC members, CORPs, TBAs, etc.

Community Level

- Traditional rulers to conduct awareness and mobilize CBOs, CORPS for PMTCT demand creation.
- CORPS to mobilize the pregnant women for uptake of PMTCT services.

2.1.14. Priority Area 14: Ownership and Coordination

Background

Country ownership and coordination is critical for reaching the goal of effective, efficient and sustainable national AIDS response in which systems and resources are enhanced and put to optimal use. The national response architecture in Nigeria is designed to ensure that all facets of the HIV/AIDS response including PMTCT are adequately coordinated from the federal level down to the LGA and community levels.

However, a systemic review of the national response has identified key challenges, which include mainly limited domestic financing of the response and weak coordination at the state level.

Strong political engagement and leadership at the national and subnational levels is an absolute prerequisite for ownership and effective coordination. Committed political leadership is at the centre stage where policies, legislations and allocation of resources are determined.

Objectives

- To increase political commitment and leadership at all levels of government for achieving the eMTCT goal.
- To increase domestic funding for the HIV response to 50% by 2016 through an active involvement of the various tiers of government and the private sector.

Priority Activities

National

- Support states to conduct a resource mapping exercise and develop a resource mobilization strategy.
- Develop a score card that will track states' funding for HIV/AIDS.

State

- Develop a comprehensive state level advocacy package.
- Constitute and ensure functionality of state PMTCT working group.
- Support the convening of state level HIV stakeholders meeting similar to the presidential parley at national level.
- Support the SMOH to perform its oversight and coordination functions.

LGA

- Coordinate the activities of CBOs and CORPS.

2.2. Implementation of the eMTCT Operational Plan

The eMTCT operational plan became necessary in order to further increase the pace of PMTCT implementation as indicated in the 2010–2015 scale-up plan and PCRP. Like the PCRP, the eMTCT operational plan is guided by the goals and objectives of the 2010–2015 NSP in the area of PMTCT with the expansion of the targets towards the global goal of elimination of MTCT. The implementation framework for the eMTCT operational plan, as described previously, was derived from the 2010–2015 NSP and the PCRP.

The three most important areas that Nigeria has to address in order to meet the HIV/AIDS response targets are strong political commitment at all levels, adequate local funding, and strong community ownership and involvement.

2.2.1. Increasing Community Involvement and Ownership

Nigeria has a clear path of engagement between the government and the community leadership through the appropriate ministries (Ministry of Local Government or of Social Development, etc) at national, state and LGA levels. When desirable, the community leadership could be actively engaged and held accountable. Lessons learnt from community engagement for polio eradication should be leveraged on for the successful implementation of the eMTCT operational plan.

2.2.2. Financing the eMTCT Operational Plan

The following section of the NOP contains a summary of the costing done to estimate the total financial need of the country to meet the PMTCT goals outlined for the 2015–2016 period. The costing was done according to the 14 identified priority areas; with individual priority activities in each priority area costed to generate the total cost for each priority area. When possible, activities were costed explicitly with all of their cost elements. For activities that are complex but already have established costs outlined in previous national documents or partner documents, those costs were utilized here upon consensus of stakeholders that selected the activities. Service delivery components heavily utilized these established costs, which allowed for the consolidation of the multiple activities necessary to deliver a service (such as ART), into a single activity.

The majority of activities, that are not service delivery, will be taking place in the first year of the operational plan. Those that are ongoing, such as quarterly meetings, have an indication of their repetition within the detailed costing annex. The total amount required for the costed activities is **N118,183,338,846.40 or $726,150,671.14** over the two-year period. This amount is intended to cover all PMTCT related costs for the duration of the operational plan, including PMTCT programmatic contributions to wider HIV service/system strengthening activities. The distribution of the cost according to the costed 14 priority areas is shown in Table 1 while details of the cost according to individual activities is attached as Annex 1.

Table 1: Distribution of cost according to priority areas

S/No.	Priority area	Cost in Naira (N)	Cost in USD ($)
1.	Adolescent and young people	3,071,309,227.20	19,195,682.67
2.	Condom programming	426,934,180.80	2,668,338.63
3.	Provider initiated counselling and testing	40,286,919,211.20	251,793,245.07
4.	Integration of PMTCT and MNCH/FP Interventions	3,470,828,704.00	21,692,679.40
5.	Scale-up of service delivery	30,331,123,542.40	189,569,522.14
6.	Engagement of formal and informal private sector	399,456,278.40	2,496,601.74
7.	Adherence	14,161,141,289.60	88,507,133.06
8.	Early infant diagnosis (EID)	4,717,619,225.60	29,485,120.16
9.	Human resources	4,480,608,592.00	28,003,803.70
10.	Monitoring and evaluation	14,447,241,401.60	90,295,258.76
11.	PSCM	1,227,489,360.00	7,671,808.50

12.	Referral	110,739,430.40	692,121.44
13.	Community leadership and action	795,133,528.00	4,969,584.55
14.	Ownership and coordination	256,794,875.20	1,604,967.97
	Grand Total	**118,183,338,846.40**	**726,150,671.14**

Section 3: Policies and Implementation Framework for the eMTCT Operational Plan

3.0. Policy, Governance and Implementation Environment

3.1. Policy

The operational plan is based on the PCRP, which was developed in order to accelerate the implementation of the 2010–2015 NSP. The overall PMTCT goal in the 2010–2015 NSP is virtual elimination of MTCT by 2015. The PMTCT guidelines and training documents, which provide the implementation tools for the national PMTCT programme, will also be used for the implementation of eMTCT operational plan.

3.2. Governance and Implementation Framework

3.2.1. Governance

NACA, SACA and LACA have the statutory responsibilities to mobilize resources and coordinate the multi-sectoral HIV/AIDS response at the federal, state and local government levels respectively. The line ministries in turn coordinate the responses that are domiciled in their respective ministries. Hence, the ministries of health at the federal and state levels and the health departments at the local government level, implement and coordinate the health sector response at the respective levels. Technical working groups for each thematic area should provide technical guidance at the level of the implementing ministries for such thematic areas.

3.2.2. Implementation Framework and Agencies

The following agencies are expected to play their statutory complementary roles as detailed in the 3013 PCRP and other policy documents to achieve optimal implementation of the eMTCT operational plan.

3.2.2.1. NACA

- Plan and coordinate the HIV/AIDS activities of the various sectors in the country in line with existing policy guidelines including the National Strategic Framework.
- Facilitate the engagement of all tiers of government and all relevant sectors on the issues of HIV/AIDS prevention, care and support.
- Advocate for the mainstreaming of HIV/AIDS interventions into all sectors of the society.
- Mobilize resources (foreign and local) and coordinate equitable application for HIV/AIDS activities.
- Facilitate the development and management of the policies and strategies of all sectors to ensure sustained human, financial and organizational resources to support the successful implementation of the eMTCT operational plan.
- Support and promote training programmes for the human resources required to implement the eMTCT operational plan.
- Support PMTCT related research in collaboration with other research-based institutions in Nigeria.

3.2.2.2. Federal Ministry of Health

The Federal Ministry of Health through NASCP is responsible for the coordination of the health sector component of the national HIV/AIDS response, including PMTCT. FMoH will:

- Develop policies and guidelines for the health sector response to HIV/AIDS including PMTCT.
- Develop training curricula for all cadres of personnel involved in service delivery for HIV/AIDS including PMTCT.
- Establish linkages to the National Technical Working Groups and other established FMoH platforms that can support the implementation of the eMTCT operational plan.
- Coordinate the training of all cadres of health personnel for effective provision of PMTCT services.
- Provide technical support in the state level development of the eMTCT operational plan as well as in the revision of other health sector response documents.
- Provide technical oversight to the state level PMTCT service delivery activities for quality assurance and equitable distribution of services to key populations.
- Serve as the data warehouse for the national PMTCT data.
- Support states in quantification for commodities required for state level implementation of the eMTCT operational plan.
- In collaboration with NACA, generate policy briefs on the eMTCT operational plan and other components of the national HJV/AIDS response for policy makers.
- Be represented on technical review panels for review of grant applications to states and local implementing partners.
- In collaboration with relevant stakeholders, coordinate efforts to strengthen the supply chain management systems determined in the eMTCT operational plan.
- In collaboration with other research institutions and other relevant bodies, conduct operational research to improve implementation of PMTCT programme in Nigeria.

3.2.2.3. National Primary Health Care Development Agency

NPHCDA has a key role to play in eMTCT in general through the routine delivery of primary health care services and specifically through the integration of eMTCT during the MNCH Week. NPHCDA is improving access to care and sustainable delivery of quality services. In furtherance to this goal the NPHCDA will:

- Participate at the national level in developing eMTCT modalities.
- Train zonal and state personnel to adapt existing planning template (microplan) to incorporate plan for scaled up eMTCT delivery during MNCH week and for routine services.
- Adapt protocols, guidelines and tools to incorporate new components.
- Mobilize resources (foreign and local) for improving focused ANC services, family planning, etc.
- Participate in TWGs at the national and state levels, providing leadership for MNCH Week activities at PHC sites.
- Develop partnership for strengthening broader eMTCT components that are domiciled at the PHC levels, including family planning and HCT.
- Implement scaled up MNCH Week, which will incorporate eMTCT.
- Monitor service delivery, review and provide necessary feedback for programming.
- Collaborate on integrated eMTCT platform social mobilization activities and drive community leadership activities for scaled up routine service delivery.
- Conduct needed formative and operational research for improved programme delivery.

3.2.2.4. SACAs

The roles and responsibilities of the SACAs as defined by the national governance guidelines by NACA are applicable to the implementation of the eMTCT operational plan as follows:

- Plan and coordinate HIV/AIDS activities of the various sectors and stakeholders in the state in line with state HIV/AIDS strategic plan.
- Facilitate the engagement of all sectors and stakeholders on the issues of HIV/AIDS prevention, care and support at state level.
- Mobilize adequate resources and coordinate equitable application for HIV/AIDS activities.
- Promote training programmes for human resources for health required for the successful implementation of the eMTCT operational plan at the state level.
- Be the coordinating secretariat of the State HIV/AIDS Management Team (SMT).
- Hold all state HIV/AIDS partners accountable transparently.

3.2.2.5. States Ministry of Health

- Review and cost priority interventions in the states HIV/AIDS plans in line with applicable local context and disease epidemiology.
- Constitute and lead the SMT primarily responsible for the general health sector response to HIV/AIDS in the state. The SMT comprises relevant stakeholders in the HIV/AIDS response in the state with secretariat responsibilities housed under the state SACA. The membership includes, but not limited to, the SASCP, lead IPs, civil society, the private sector, and representatives of development partners and the academia.
- Hold all state level PMTCT partners accountable especially in areas of resource allocation, services provision and data management.
- Coordinate all eMTCT activities of the IPs working in the state.
- Lead the conduct of facility assessment for PMTCT service scale-up.
- Mobilize resources (financial, human and material) to cater for the health sector response including implementation of the state level eMTCT operational plan.
- Develop and implement capacity building plans for all cadres of health workers involved in the state level HIV/AIDS response, including implementing the eMTCT operational plan.
- Develop with support from the technical partners and FMoH, grant applications to the special HIV/AIDS funds for matching grants for implementation of the state level eMTCT operational plan and other priority interventions in line with the tenets of the PCRP fund granting model.
- Generate, collate and share state level programme activity data with the SACA and FMoH.

3.2.2.6. State Primary Health Care Development Board

The roles and responsibilities of the SPHCDA as defined by the National Guidelines for Development of Primary Health Care System in Nigeria are applicable to eMTCT operational plan as follows:

- Promote and monitor implementation of integrated eMTCT/MNCH Week activities and routine eMTCT services at PHC facilities.
- Provide strategic technical support for new components of integration of eMTCT/MNCH Week activities and routine PMTCT services at PHC facilities by the state.
- Mobilize resources within the state, nationally and internationally to support integration of eMTCT services into PHC facility services.
- Ensure effective implementation and supervision of all integrated eMTCT/MNCH services.

- Ensure effective community involvement and participation in the integrated services from inception to implementation stage.
- Strengthen referrals and linkages with other branches of health sector especially with regards to eMTCT/MNCH services.
- Ensure effective training, retraining and manpower deployment for integrated eMTCT/MNCH activities.
- Develop sound database for effective planning, implementation and supervision for eMTCT/MNCH.

3.2.2.7. Local government PHC Coordinator

- Coordinate all PMTCT activities at the LGA level.
- Coordinate training and posting of healthcare personnel.
- Deploy and supervise the local government M&E officer.
- Be accountable for all PMTCT activities at the LGA level including service delivery resources and data management.

3.2.2.8. Non-governmental organizations (NGOs), Faith-based Organizations (FBOs) and Civil Society Organizations (CSOs)

These organizations are expected to be engaged in demand creation for PMTCT services, advocacy for resource allocation and quality service provision where appropriate. Other specific roles in the PCRP and eMTCT operational plan implementation include:

- Membership of the SMT.
- Active involvement in advocacy for resource mobilization for the state level HIV/AIDS response including PMTCT.
- Providing a civil society perspective score card for resource performance at the national, state and local government levels.
- Introduction of innovative approaches to increase service availability, demand creation and service utilization at the state and local government levels.

3.2.2.9. Private Sector

The private sector is expected to be involved in the eMTCT operational plan through the corporate platform and through PMTCT service provision. As corporate entities, the roles of the private sector would include:

- Financial and other contributions to improve the resource envelop of the eMTCT operational plan at all levels.
- Private sector organizations with skills in financial management, costing and resource mobilization could provide in-kind services to improve the capacity of the eMTCT programme managers at all levels.
- The involvement and active engagement of the private health sector in the PMTCT service delivery is a necessity for achieving the national eMTCT targets. The private health care providers are expected to be involved in the implementation of the eMTCT operational plan by:
  - ✓ Making their hospitals and clinics available for facility assessment, staff training and facility upgrade (if necessary) and provision of PMTCT services.

- ✓ Proper management of eMTCT programme activity data by using the national programme data collection tools and reporting generated data through the approved route of national data flow.

3.2.2.10. Community Gate-keepers and Community Resource Persons

All cadres of community leaders would be actively engaged to ensure that all pregnant women in their communities register for antenatal care and receive available preventive health services including PMTCT services. A system of accountability would be established to ensure that no pregnant woman is missed out.

Community resource persons including HIV-related CBOs, TBAs, volunteer health workers (VHWs) and members of ward/district health committees (WHCs or DHCs) would be engaged in demand creation for PMTCT services.

3.2.2.11. Development Partners

The roles of development partners in the national HIV/AIDS response would continue to be leveraged on in the implementation of the eMTCT operational plan. They are expected to provide requisite resources and technical assistance as well as support capacity development of programme managers and service providers. They are expected to be members of the TWGs at the national level and the SMT at the state level.

Annexes

Annex 1: Costing of individual activities of the eMTCT operational plan (2015–2016)

Annex 2: Costing of individual priority activities of the eMTCT operational plan (2015-2016)

eMTCT Costed Activities

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
1. Adolescent and young people							
1.1 Organise refresher TOT for out-of-school peer educators in 36+1 states on FLHE							
	Venue <50	37	1	3	54,636	6,064,634.85	**37,903.97**
	Facilitator's Fee	37	1	3	32,782	3,638,780.91	**22,742.38**
	Lunch	37	21	3	2,530	5,897,281.25	**36,858.01**
	Tea Break	37	21	3	1,897	4,422,960.94	**27,643.51**
	Inter-city Travel	37	20	2	12,650	18,721,528	**117,009.55**
	Total		1			38,745,186	**242,157.41**
1.2 Conduct training of out-of-schools peer educators on FLHE in 774LGA							
	Venue <50	774	1	5	54,636	211,442,674.50	1,321,516.72
	Facilitator's Fee	774	1	5	32,782	126,865,604.70	792,910.03
	Lunch	774	36	5	2,530	352,470,709.54	2,202,941.93
	Tea Break	774	36	5	1,897	264,353,032.15	1,652,206.45
	Total		2			**1,910,264,042**	**11,939,150.26**
1.3 Support one youth PLHIV group per LGA to implement HIV prevention activities							
	LGA Grant	774	1	1	100000	77,400,000	483,750.00
	Total					**77,400,000**	**483,750.00**
1.4 Implement peer education activities in each of the 774 LGAs							
	Stipend	774	5	12	2,000	92,880,000.00	580,500.00
	Refreshments	774	205	12	500	952,020,000.00	5,950,125.00
	Total		2			**1,044,900,000**	**6,530,625.00**

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
2. Condom programming							
2.1 Volunteer generation of awareness and knowledge of condom use							
	Volunteer Stipend	37	100	12	4,000	177,600,000.00	1,110,000.00
	Supervisor	37	1	4	5,000	740,000.00	4,625.00
	Training Material/Manual	37	101	0.5	200	373,700.00	2,335.63
	Total		2			**357,427,400.00**	**2,233,921.25**
2.2 Training of 3,700 male and female volunteers (100 per state+FCT) on demonstration of male and female condoms using anatomical models							
	Facilitator's Fee	37	1	1	32,782	1,212,927	7,580.79
	Venue 100	37	1	1	109,273	4,043,090	25,269.31
	Inter-city Travel	37	100	1	12,650	46,803,819	292,523.87
	Lunch	37	100	1	2,530	9,360,764	58,504.77
	Stationary	37	100	1	2,185	8,086,180	50,538.62
	Total					**69,506,780**	**434,417.38**
3. Provider Initiated Testing and Counselling (PITC)							
3.1 Print and distribute, SOPs, training tools and educational materials for PITC to the 37 State Ministries of health							
	Printing	37	2000	4	300.0	88,800,000.00	555,000.00
	Distribution	37	1	1		-	-
	Total					**88,800,000**	**555,000.00**
3.2 Build capacity of service providers in all facilities providing ANC on PITC							
	PITC Training-Public	9952	2	3	32,000	1,910,784,000.00	11,942,400.00
	PITC Training-Private	37	20	3	32,000	71,040,000.00	444,000.00
	Total					**1,981,824,000**	**12,386,400.00**

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
3.3 Integrate HCT into national MNCH week initiative at the policy level							
	Venue <50	1	1	3	54,636	163,909.05	1,024.43
	Lunch	1	20	3	2,530	151,796.17	948.73
	Stationary	1	20	3	2,185	131,127.24	819.55
	DSA	1	20	3	22,769	1,366,165.54	8,538.53
	Total					**1,812,998**	**11,331.24**
3.4 Provide routine testing and counselling in all public tertiary, secondary, and primary care facilities providing ANC. Also including private PHCs							
	RTKs		20,000,000	1	792	15,840,000,000.00	99,000,000.00
	Total					**15,840,000,000**	**99,000,000.00**
3.5 Train volunteers/groups of lay counsellors for training							
	Venue <50	9952	1	5	54,636	2,718,704,776.00	16,991,904.85
	Lunch	9952	5	5	2,530	629,448,123.26	3,934,050.77
	Tea Break	9952	5	5	1,897	472,086,092.45	2,950,538.08
	Facilitator's Fee	9952	1	5	32,782	1,631,222,865.60	10,195,142.91
	Inter-City Travel	9952	1	2	12,650	251,779,249.31	1,573,620.31
	Total		2			**11,406,482,213**	**71,290,513.83**
3.6 Provide stipend for lay counsellors							
	Stipend	22850	2	12	10,000	5,484,000,000.00	34,275,000.00
	Total		2			**10,968,000,000**	**68,550,000.00**
4. Integration of PMTCT and MNCH/FP Interventions							
4.1 Conduct joint annual planning meeting of RH and HIV/ PMTCT programmes							
	Venue <50	1	1	2	54,636	109,272.70	682.95
	DSA	1	40	2	22,769	1,821,554.05	11,384.71

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Tea Break	1	40	2	1,897	151,796.17	948.73
	Stationary	1	40	2	2,185	174,836.32	1,092.73
	Lunch	1	40	2	2,530	202,394.89	1,264.97
	Total		2			2,459,854	**15,374.09**
4.2 Support implementation of integrated MNCH/PMTCT services during MNCH weeks nationwide							
	State Grant	37	1	2	20,000,000.0	1,480,000,000.00	9,250,000.00
	Total		2			**2,960,000,000.00**	**18,500,000.00**
4.3 Support joint bi-annual progress review and coordination meetings between MNCH and HIV/PMTCT programmes and state representatives							
	Venue 50-100	1	1	4	76,491	305,963.56	1,912.27
	Lunch	1	80	4	2,530	809,579.58	5,059.87
	Tea Break	1	80	4	1,897	607,184.68	3,794.90
	Flight	1	72	2	74,263	10,693,872.00	66,836.70
	Intra-city Travel	1	72	2	6,325	910,777.03	5,692.36
	DSA	1	72	4	22,769	6,557,594.60	40,984.97
	Stationary	1	80	4	2,185	699,345.28	4,370.91
	Total		2			**41,168,633**	**257,303.96**
4.4 Print 50,000 copies each of revised National Guidelines, SOPs on integration models and RH/HIV integration training manuals							
	Printing (N300 per copy)	1	150000		300.0	45,000,000.00	281,250.00
	Total		1			**45,000,000**	**281,250.00**
4.5 Disseminate revised National Guidelines, SOPs on integration models and RH/HIV integration training manuals in all 36 states + FCT							
	State Distribution Cost	37	1		150,000.0	5,550,000.00	34,687.50
	Total		1			**5,550,000**	**34,687.50**

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
4.6 Conduct orientation of 10 (LSS, FP, PMTCT and HIV) master trainers/state on revised RH/HIV integration modules							
	Venue <50	37	1	1	54,636	2,021,544.95	12,634.66
	Tea Break	37	12	1	1,897	842,468.75	5,265.43
	Lunch	37	12	1	2,530	1,123,291.67	7,020.57
	Intra-city Travel	37	10	1	6,325	2,340,191	14,626.19
	DSA	37	12	1	22,769	10,109,625.00	63,185.16
	Stationary	37	12	1	2,185	970,342	6,064.63
	Total		1			17,407,463	**108,796.64**
4.7 Incorporate training on RH/HIV integration into existing HIV/PMTCT and RH trainings							
	No Extra Cost					-	-
	Total					**-**	**-**
4.8 Support training of NYSC health workers on RH/HIV integration							
	Lunch	779	2	3	2,530	11,824,921.74	73,905.76
	Tea Break	779	2	3	1,897	8,868,691.30	55,429.32
	Stationary	779	2	3	2,185	10,214,812	63,842.57
	DSA	774	2	3	22,769	105,741,212.86	660,882.58
	Facilitator's Fee	1	5	**3**	32,782	491,727	3,073.29
	Total					137,141,365	**857,133.53**
4.9 Conduct 2 targeted advocacy visits annually to SMOH, SMOLG, LGA service commission on recruitment and retention of health workers							
	No additional cost					**-**	**$ -**
	Total					-	**$ -**
4.10 Support quarterly generation of DHIS reports as feedback to states and LGAs							
	No additional cost					-	-
	Total					-	-

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
4.11 Provide technical and financial resources for quarterly integrated supportive supervision inlcluding MNCH/RH/FP /PMTCT commodities stock taking and mentoring at state and LGA level							
	DSA	37	5	5	22,769	21,061,718.75	**131,635.74**
	Inter-city Travel	37	5	5	12,650	11,700,954.86	**73,130.97**
	Total		8			262,101,389	**1,638,133.68**
5. Service Delivery							
5.1 Activation of an additional 1500 PMTCT sites to increase total number of PMTCT sites from 5622 to 7122							
	Facility Upgrade	1500	1	1	4,800,000.0	7,200,000,000.00	45,000,000.00
	Total					**7,200,000,000**	**45,000,000.00**
5.2 Provide HCT to 5,164,369 which is 70% of the National target by 2016							
	RTKs	1	9166128	1	792	7,259,573,376.00	45,372,333.60
	Total					**7,259,573,376**	**45,372,333.60**
5.3 Provide support to increase the number of HIV infected pregnant women who receive ARVs to 133,937 which is 70% of the National target (from 57,871 {30% achievement} in 2013) to reduce the risk of MTCT.							
	Triple Prophylaxis+Support Services		250214	1	34,608.0	8,659,406,112.00	54,121,288.20
	Total					**8,659,406,112**	**54,121,288.20**
5.4 Provide support to increase the number of HIV infected pregnant women who receive Cotrimoxazole prophylaxis							
	Cotrimoxazole prophylaxis		250214	1	1,184.0	296,253,376.00	1,851,583.60
	Total					**296,253,376**	**1,851,583.60**
5.5 Provide support to increase the number of infants born to HIV-infected women (HIV-exposed infants) receiving antiretroviral prophylaxis to 105,236 by 2016 which is 70% of the National target. (Which was 10198 {5% achievement} in 2013) to reduce the risk of mother-to-child transmission							
	Antiretroviral prophylaxis		210542	1	3,964.8	834,756,921.60	5,217,230.76

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Total					**834,756,922**	**5,217,230.76**
5.6 Provide support to increase the number of infants born to HIV-infected women (HIV-exposed infants) receiving Cotrimoxazole prophylaxis							
	Cotrimoxazole prophylaxis		210542	1	1,184.0	249,281,728.00	1,558,010.80
	Total					**249,281,728**	**1,558,010.80**
5.7 Print and circulate PMTCT guidelines, SOPs							
	Printing		22928	1	300.0	6,878,400.00	42,990.00
	Distribution	37	1	1	150,000.0	5,550,000.00	34,687.50
	Total					**12,428,400**	**77,677.50**
5.8 To Institutionalize State level supportive supervisory visits and QI/QA monitoring.							
	Facilitator's Fee	37	1	5	32,782	6,064,634.85	37,903.97
	Inter-city Travel	37	85	2	12,650	79,566,493.07	497,290.58
	Tea Break	37	85	5	1,897	29,837,434.90	186,483.97
	Venue 50-100	37	1	5	76,491	14,150,814.65	88,442.59
	Lunch	37	85	5	2,530	39,783,246.54	248,645.29
	Stationary	37	85	5	2,185	34,366,264.15	214,789.15
	DSA	37	85	5	22,769	358,049,218.83	2,237,807.62
	Supervisory Visit Stipend	7122	8	4	20,000	4,558,080,000.00	28,488,000.00
	Total					**5,119,898,107**	**31,999,363.17**
5.9 Advocacy to institutionalize free ANC and deliveries services for HIV infected pregnant women.							
	Intra-city Travel	37	20	1	6,325	4,680,381.95	29,252.39
	Venue <50	37	1	1	54,636	2,021,544.95	12,634.66
	Lunch	37	20	1	2,530	1,872,152.78	11,700.95
	Stationary	37	20	1	2,185	1,617,235.96	10,107.72
	Total					**10,191,316**	**63,695.72**

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
5.10 Institutionalize regular facility QA/QI activities on PMTCT.							
	No Additional Cost					-	-
	Total					**-**	**-**
5.11 To conduct a mapping of antenatal care and delivery service providers and classify them into public, formal private and informal private as well as to identify service providers that can be trained for HCT and PMTCT - focus on private and non-formal, perhaps under service delivery to link with other mapping							
	Consultant's Fee	1	1	30	64,000.0	1,920,000.00	12,000.00
	Training & Field Testing	1	80	3	80,000.0	19,200,000.00	120,000.00
	Inter-city Travel	7122	2	1	12,650	180,182,055.22	1,126,137.85
	Stipend	7122	2	1	20,000	284,880,000.00	1,780,500.00
	Venue <50	1	1	2	54,636	109,272.70	682.95
	Lunch	1	30	2	2,530	151,796.17	948.73
	Stationary	1	30	2	2,185	131,127.24	819.55
	DSA	1	30	2	22,769	1,366,165.54	8,538.53
	Printing	1	1000	1	300.0	300,000.00	1,875.00
	Total					**488,240,417**	**3,051,502.61**
5.12 Syphilis testing for mothers, and penicillin for infants born to positive mothers							
	Syphilis Testing for Pregnant Mothers	1	250214	1	750.4	187,760,585.60	1,173,503.66
	Penicillin for Infants	1	2105.42	1	6,332.8	13,333,203.78	83,332.52
	Total					**201,093,789**	**1,256,836.18**
6. Formal & Non-Formal							
6.1 Print and disseminate guidance materials, tools and job aids for increasing the involvement of formal and non-formal private healthcare provider facilities in provision of PMTCT services (Federal Government)							
	Venue <50	1	2	3	54,636	327,818.10	2,048.86

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Venue 100	1	1	1	109,273	109,272.70	682.95
	Stationary	1	93	3	2,185	611,926.90	3,824.54
	Lunch	1	93	3	2,530	708,381.88	4,427.39
	Printing	1	6000	1	300	1,800,000.00	11,250.00
	DSA	1	93	3	22,769	6,375,436.91	39,846.48
	Total					**9,932,836**	**62,080.23**
6.2 LGAs with assistance from States to conduct a sensitization/orientation meetings; one with formal private service providers and other with non-formal service providers; on PMTCT.							
	Venue <50	37	40	2	54,636	161,723,596.00	1,010,772.48
	Lunch	37	40	2	2,530	7,488,611.11	46,803.82
	Inter-city Travel	37	30	2	12,650	28,082,291.67	175,514.32
	Stationary	37	40	2	2,185	6,468,943.84	40,430.90
	Total					**203,763,443**	**1,273,521.52**
6.3 Facilities to conduct periodic mentorship and supervisory visits to all private service delivery points with trained service providers							
	Mentor Stipend	774	1	12	10,000	92,880,000.00	580,500.00
	Total		2			**185,760,000**	**1,161,000.00**
7. Adherence							
7.1 Develop standard patient information and education leaflets on ARVs use during pregnagcy and breastfeeding period and job aid for identifying toxicity for health workers							
	Venue <50	1	1	3	54,636	163,909.05	1,024.43
	Lunch	1	40	3	2,530	303,592.34	1,897.45
	Tea Break	1	40	3	1,897	227,694.26	1,423.09
	Flight	1	27	1	74,263	2,005,101.00	12,531.88
	Intra-city Travel	1	13	3	6,325	246,668.78	1,541.68
	DSA	1	27	3	22,769	1,844,323.48	11,527.02
	Total					**4,791,289**	**29,945.56**

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
7.2 Print and disseminate PMTCT drug information and education leaflets in English, Ibo , Yoruba and Hausa languages , 30,000 copies of each							
	Printing	1	30000	1	200.0	6,000,000.00	37,500.00
	Total		4			**24,000,000**	**150,000.00**
7.3 Establish and engage Mother Mentors /Peer support groups/counselors to support education and adherence counseling and track/follow-up mother baby pair							
	Venue <50	11464	1	12	50,000	6,878,400,000.00	42,990,000.00
	Total		2			**13,756,800,000**	**85,980,000.00**
7.4 Use of SMS reminders							
	State Grant	37	1	1	10,000,000.0	370,000,000.00	2,312,500.00
	Total					**370,000,000**	**2,312,500.00**
7.5 Distribution of job aids on ARV toxicity and adverse reactions to health care professionals							
	State Distribution Cost	37	1	1	150,000.0	5,550,000.00	34,687.50
	Total					**5,550,000**	**34,687.50**
7.6 Sensitization of health care professionals providing PMTCT on reporting of ARV toxicity and adverse reactions							
	No Cost (on the job)					-	-
	Total					**-**	**-**
8. EID							
8.1 Purchase of 2 new automated PCR Machines							
	PCR Machines (Installation inc.)	2	0.5	1	24,000,000.0	24,000,000.00	150,000.00
	Lab Technicians	2	3	12	150,000.0	10,800,000.00	67,500.00
	Lab Renovation	2	0.5	1	3,200,000.0	3,200,000.00	20,000.00
	Total		2			**76,000,000**	**475,000.00**

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
8.2 Procurement of EID commodities, and supporting of sample transport							
	Reagents, DBS kits, and consumables	1	144241	1	4,404.8	635,352,756.80	3,970,954.73
	Total					**635,352,757**	**3,970,954.73**
8.3 Scale-up EID services to all PMTCT sites							
	PMTCT service training	1	2000	3	400,000	2,400,000,000.00	15,000,000.00
	Total					**2,400,000,000**	**15,000,000.00**
8.4 Hiring and Training of additional Staff for the PCR labs							
	Lab Technician	1	26	12	150,000.0	46,800,000.00	292,500.00
	Training	1	26	5	80,000.0	10,400,000.00	65,000.00
	Total					**57,200,000**	**357,500.00**
8.5 Procurement and Installation of SMS printers							
	SMS Procurement & Install	1548	1	1	172,663.0	267,282,324.00	1,670,514.53
	GSM Modem	23	1	1	118,423.0	2,723,729.00	17,023.31
	Total					**267,282,324**	**1,670,514.53**
8.6 Conduct quarterly supportive supervision and mentorship exercise to all EID sites							
	Stipend	2000	4	4	20,000.0	640,000,000.00	4,000,000.00
	Total		2			**1,280,000,000**	**8,000,000.00**
8.7 Purchase 25 KVA generator for the 10 high volume PCR labs + 2 new PCR labs							
	25 KVA Generator	2	1	1	892,072.0	1,784,144.00	11,150.90
	Total					**1,784,144**	**11,150.90**
9. Human Resources							
9.1 Rapid needs assessment of existing PHCs with minimum staff requirement for MNCH to identify the gaps and opportunities for scaling up.							

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Per-State Assessment Cost	24	1	1	1600000	38,400,000.00	240,000.00
	Total					**38,400,000**	**240,000.00**
9.2 Implement Task shifting at the health facilities to include eMTCT services and RH integration							
	Task Shifting Training	37	100	1	400,000.0	1,480,000,000.00	9,250,000.00
	Total		2			**2,960,000,000**	**18,500,000.00**
9.3 Four batches of TOT to increase the pool of PMTCT master trainers							
	Venue <50	1	2	4	54,636	437,090.80	2,731.82
	Facilitator's Fee	1	4	4	32,782	524,508.96	3,278.18
	Lunch	1	64	4	2,530	647,663.66	4,047.90
	Tea Break	1	64	4	1,897	485,747.75	3,035.92
	DSA	1	60	4	22,769	5,464,662.16	34,154.14
	Total		4			**30,238,693**	**188,991.83**
9.4 Training of HWs in Public and Private HFs							
	Training for PMTCT Service Delivery	1500	3	1	320,000.0	1,440,000,000.00	9,000,000.00
	Total					**1,440,000,000**	**9,000,000.00**
9.5 Revision of national training documents, SOPs and Job Aids							
	Venue <50	1	1	5	54,636	273,181.75	1,707.39
	Lunch	1	40	5	2,530	505,987.24	3,162.42
	Tea Break	1	40	5	1,897	379,490.43	2,371.82
	Intra-city Travel	1	25	5	6,325	790,605.06	4,941.28
	Flight	1	25	1	74,263	1,856,575.00	11,603.59
	Stationary	1	40	5	2,185	437,090.80	2,731.82
	Total					**4,242,930**	**26,518.31**

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
9.6 Develop a capacity building strategy for eMTCT - cascade training, mentoring and supervision							
	Venue <50	1	1	3	54,636	163,909.05	1,024.43
	Lunch	1	30	3	2,530	227,694.26	1,423.09
	Tea Break	1	30	3	1,897	170,770.69	1,067.32
	Flight	1	20	1	74,263	1,485,260.00	9,282.88
	Intra-city Travel	1	20	2	6,325	252,993.62	1,581.21
	Stationary	1	30	3	2,185	196,690.86	1,229.32
	DSA	1	20	3	22,769	1,366,165.54	8,538.53
	Total		2			**7,726,968**	**48,293.55**
10. M&E							
10.1 Convene Zonal quarterly PMTCT M&E review meeting							
	Venue <50	6	1	2	54,636	655,636.20	4,097.73
	Lunch	6	25	2	2,530	758,980.86	4,743.63
	Tea Break	6	25	2	1,897	569,235.64	3,557.72
	DSA	6	25	3	22,769	10,246,241.56	64,039.01
	Inter-city Travel	6	25	2	12,650	3,794,904.28	23,718.15
	Total		8			**128,199,988**	**801,249.93**
10.2 Convene monthly state level PMTCT data collection and collation meeting							
	Venue <50	37	1	1	54,636	2,021,544.95	12,634.66
	Lunch	37	46	1	2,530	4,305,951.39	26,912.20
	DSA	37	13	2	22,769	21,230,212.50	132,688.83
	Inter-city Travel	37	13	2	12,650	12,168,993.06	76,056.21
	Intra-city Travel	37	33	1	6,325	7,722,630.21	48,266.44
	Tea Break	37	46	1	1,897	3,229,463.54	20,184.15
	Total		24			**1,216,291,096**	**7,601,819.35**
10.3 Convene Quarterly PMTCT data verification, validation and feedback meeting							

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Venue <50	37	1	1	54,636	2,021,544.95	12,634.66
	Lunch	37	46	1	2,530	4,305,951.39	26,912.20
	DSA	37	13	2	22,769	21,230,212.50	132,688.83
	Inter-city Travel	37	13	2	12,650	12,168,993.06	76,056.21
	Intra-city Travel	37	33	1	6,325	7,722,630.21	48,266.44
	Tea Break	37	46	1	1,897	3,229,463.54	20,184.15
	Total		8			**405,430,365**	**2,533,939.78**
10.4 Conduct capacity building of SMOH, LGA and Facility HWs on harmonized PMTCT M&E tools							
	HW Training	2000	2	4	80,000	1,280,000,000.00	8,000,000.00
	Total					**1,280,000,000**	**8,000,000.00**
10.5 Conduct capacity building of SMOH, LGA and Facility HWs on computer use of DHIS2 platform							
	HW Training	2000	2	4	80,000	1,280,000,000.00	8,000,000.00
	Total					**1,280,000,000**	**8,000,000.00**
10.6 Reprinting and distribution of the Harmonized HMIS and PMTCT DCTs							
	Printing	1	50000	1	1,000.0	50,000,000.00	312,500.00
	Total		32			**1,600,000,000**	**10,000,000.00**
10.7 Ensure the use of DHIS ICT platform by the PMTCT sites, all LGA (LACA + M&E), SMOH (SASCP + HPRS) and HIV Implementing Partners							
	Not Costable					-	-
	Total					**-**	**-**
10.8 Ensure regular transmission of PMTCT data and scorecard/feedback report in accordance with the national data flow and protocols							
	Internet Router/Modem (Procure & Install)	7659	0.5	1	20000	76,590,000.00	478,687.50
	Internet Bandwidth	7659	1	12	5000	459,540,000.00	2,872,125.00

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Total		2			**1,072,260,000**	**6,701,625.00**
10.9 Conduct quarterly DQA exercise to PMTCT sites							
	Stipend	6500	5	5	5,000.0	812,500,000.00	5,078,125.00
	Total		8			**6,500,000,000**	**40,625,000.00**
10.10 Support Quarterly meeting of M&E TWG at National, and State Levels							
	Venue <50	38	1	4	54,636	8,304,725.20	51,904.53
	Intra-city Travel	38	35	4	6,325	33,648,151.28	210,300.95
	Lunch	38	35	4	2,530	13,459,260.51	84,120.38
	Tea Break	38	35	4	1,897	10,094,445.39	63,090.28
	Total		8			**524,052,659**	**3,275,329.12**
10.11 Convene annual review meeting for PMTCT Programme evaluation							
	Venue 100	38	1	4	109,273	16,609,450.40	103,809.07
	Intra-city Travel	38	100	4	6,325	96,137,575.10	600,859.84
	Lunch	38	100	4	2,530	38,455,030.04	240,343.94
	Tea Break	38	100	4	1,897	28,841,272.53	180,257.95
	Stationary	38	100	4	2,185	33,218,900.80	207,618.13
	PMTCT Score-Card Printing	38	500	1	250	4,750,000.00	29,687.50
	PAS+Projector	38	1	4	16,391	2,491,417.56	15,571.36
	Total		2			**441,007,293**	**2,756,295.58**
11. PSCM							
11.1 PMTCT Contribution to Nigeria Integrated SC Plan							
	Contribution Proportion (15%)		1	1		1,227,489,360.00	7,671,808.50
	Total					**1,227,489,360**	**7,671,808.50**
12. Referral							

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
12.1 NASCP to review the cluster model, existing client/patient referral systems, professional/mentorship support and logistics support systems							
	Venue <50	37	1	1	54,636	2,021,544.95	12,634.66
	Lunch	37	20	1	2,530	1,872,152.78	11,700.95
	Inter-city Travel	37	1	3	12,650	1,404,114.58	8,775.72
	DSA	37	2	3	22,769	5,054,812.50	31,592.58
	Communication	37	2	3	1000	222,000.00	1,387.50
	Total					**10,574,625**	**66,091.41**
12.2 NASCP to provide guidance and tools to states for strengthening client/patient referral systems, professional/mentorship support and logistics support systems using the cluster model							
	Venue <50	1	2	3	54,636	327,818.10	2,048.86
	Venue 100	1	1	1	109,273	109,272.70	682.95
	Stationary	1	93	3	2,185	611,926.90	3,824.54
	Lunch	1	93	3	2,530	708,381.88	4,427.39
	Printing	1	10000	1	300	3,000,000.00	18,750.00
	DSA	1	37	3	22,769	2,527,406.25	15,796.29
	Total					**7,284,806**	**45,530.04**
12.3 States to support health facilities that serve as cluster hub to plan for and provide mentorship visits							
	Stipend	774	1	12	10000	92,880,000.00	580,500.00
	Total					**92,880,000**	**580,500.00**
13. Community Leadership and Action							
13.1 Convene a National dialogue with traditional and religious leaders on eMTCT							
	Venue 50-100	1	2	1	76,491	152,981.78	956.14
	Stationary	1	185	1	2,185	404,308.99	2,526.93
	DSA	1	185	2	22,769	8,424,687.50	52,654.30
	Flight	1	180	1	74,263	13,367,340.00	83,545.88
	Intra-city Travel	1	180	2	6,325	2,276,942.57	14,230.89

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Total					**24,626,261**	**153,914.13**
13.2 Develop, Produce and disseminate advocacy tools , BCC and demand creation materials on eMTCT							
	Venue <50	1	1	2	54,636	109,272.70	682.95
	Lunch	1	30	2	2,530	151,796.17	948.73
	Tea Break	1	30	2	1,897	113,847.13	711.54
	DSA	1	30	2	22,769	1,366,165.54	8,538.53
	Stationary	1	30	2	2,185	131,127.24	819.55
	Printing	1	2000	1	300	600,000.00	3,750.00
	Flight	1	16	1	74,263	1,188,208.00	7,426.30
	Intra-city Travel	1	16	2	6,325	202,394.89	1,264.97
	Total					**3,862,812**	**24,142.57**
13.3 Conduct Orientation and advocacy visit to Traditional and Religious leaders - State/LGAs. Develop Traditional leaders action plan							
	Representative Stipend	37	20	12	5,000.0	44,400,000.00	277,500.00
	Total		2			**100,769,084**	**629,806.77**
13.4 Conduct orientation workshop for CORPs (inlc VDC/WDC, TBA) on active mobilisation of pregnant women for ANC attendance - State/LGA							
	Lunch	774	10	1	2,530	19,581,706.09	122,385.66
	Tea Break	774	10	1	1,897	14,686,279.56	91,789.25
	Facilitator's Fee	774	1	1	32,782	25,373,120.94	158,582.01
	Intra-city Travel	774	10	1	6,325	48,954,265.21	305,964.16
	Total					**108,595,372**	**678,721.07**
13.5 Active Engagement of Traditional and Religious leaders to create demand for PMTCT services(including HCT) in their respective wards and communities. Federal/state/LGA. Support implementation of their plan							
	Volunteer Stipend	774	10	12	3000	278,640,000.00	1,741,500.00

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Total		2			**557,280,000**	**3,483,000.00**
14. Ownership and Coordination							
14.1 Develop state specific advocacy package							
	Consultant's Fee	37	1	14	49,440	25,609,920.00	160,062.00
	Venue <50	37	1	2	54,636	4,043,089.90	25,269.31
	Lunch	37	20	2	2,530	3,744,305.56	23,401.91
	Tea Break	37	20	2	1,897	2,808,229.17	17,551.43
	Total					**36,205,545**	**226,284.65**
14.2 Production of advocacy packs							
	Printing	37	250	1	300	2,775,000	17,343.75
	Total					**38,980,545**	**243,628.40**
14.3 Conduct high level Advocacy visit							
	DSA	37	3	2	22,769	5,054,812.50	31,592.58
	Flight	24	3	1	74,263	5,346,936.00	33,418.35
	Total		4			**41,606,994**	**260,043.71**
14.4 Operationalize and Ensure functionality of PMTCT Technical working group (TWG) to manage HIV response							
	Venue <50	37	1	1	54,636	2,021,544.95	12,634.66
	Lunch	37	30	1	2,530	2,808,229.17	17,551.43
	Tea Break	37	30	1	1,897	2,106,171.88	13,163.57
	Stationary	37	30	1	2,185	2,425,853.94	15,161.59
	Total		8			**74,894,399**	**468,090.00**
14.5 Support the SMOH to perform coordination function							
	Venue <50	37	1	1	54,636	2,021,544.95	12,634.66
	Lunch	37	25	1	2,530	2,340,190.97	14,626.19
	Tea Break	37	25	1	1,897	1,755,143.23	10,969.65

		No. of states/LGAs	Units	No. of days/times	Unit cost (N)	Cost (N)	Cost ($)
	Stationary	37	25	1	2,021,544.95	12,634.66	
	Total		8			**65,107,393**	**406,921.21**
							726,150,671.14

Exchange Rate (N/$): US$1 = NGN160.00