**Country**
**Nigeria**

**Region**
Africa

**Title**
Proposal for PMTCT+ Centers of Excellence (Expansion of Current Prevention of Mother to Child Transmission of HIV Project)

| Agency | Type | ID |
|---|---|---|
| CCM Nigeria | CCM | 411 |

| Component | Year 1 | Total | Need Technical Support |
|---|---|---|---|
| HIV | 3.618.584 | 27.431.874 | |

**Comments**

BRIEF DESCRIPTION OF COMPONENT/PROPOSAL

Proposal to:

Strengthen 6 existing PMTCT+ Centers and establish operational VCT programs and care services;
Provide to 18,000 women attending ANC services with VCT
Provide ARV as prophylaxis for 912 HIV positive women and 912 babies
Give access to comprehensive care, including ARV and treatment of OI, to 912 HIV positive women and 456 HIV infected babies
Train 250 counselors
Launch education campaigns on PMTCT+

The program will run until 2010, but the proposal is requesting US$3,618,584 to run the phase for a period of one year. This amount will be supplemented with government contributions of US$1,231,563 to meet all the needs. The government contribution takes care of Human Resources. After a year, the initial centers will be assessed by the monitoring and evaluation team and the CCM, then the program will be scaled up out in tertiary, secondary and primary health care facilities.

Proposal addresses a real need, and the request fits in the national plan.

SPECIFIC OBSERVATIONS/COMMENTS

There is high political commitment, and that could be a guarantee that the program will continue beyond the pilot phase.

SEC 37

**Cover Letter to the GFATM Regarding Nigeria's Proposal**

**9 March 2002**

To the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria:

Dear Sirs,

It is with great pleasure that the Nigerian Country Coordinating Mechanism encloses its proposal to the GFATM for first round funding. Attached is a background document on Nigeria's Country Coordinating Mechanism. Further, please find Nigeria's five proposals – three for HIV/AIDS and one each for malaria and TB. Please feel free to contact me if you have any questions.

With best regards,

Dr. Abdulsalami Nasidi
Chairman

**Address:**
The Nigerian Country Coordinating Mechanism
Room 334, Federal Secretariat,
Shehu Shagari Way, Maitama,
Abuja
Tel: 00234 9 523 0573 Fax: +234 9 523 8362
e-mail: nasidia@hotmail.com

**Background**

The first meeting of Nigeria's CCM took place on 1st of February 2002. The CCM recognizes that the GFATM ideally wished for CCMs to be based on pre-existent groups and to have established processes well in advance of proposal submission. Nigeria has had a coordinating body drawn from a cross-section of society, which though not as comprehensive as the CCM, had an established process under the name of the Inter-Agency Coordinating Committee (ICC). Given the little time between distributing applications and the deadline for the first tranche, Nigeria upgraded the ICC to serve as the CCM. Nigerians recognized that there was the option of making the first deadline or waiting for a later opportunity. Thus, on 21st of January, members of what would become the CCM, the Minister of Health, His Excellency President Olusegun Obasanjo, and working groups on HIV/AIDS, Malaria, and Tuberculosis, decided to push forward with these proposals. Their view was that with Nigeria's state of health being increasingly dire, action had to be taken.

## CCP Process

The disease working groups had the choice of crafting comprehensive, all-inclusive proposals, or of proposing highly targeted expansions of current efforts. With the understanding that GFATM wishes to be a partner of countries and provide ongoing levels of support based on measurable outcomes, the teams chose extremely specific projects that met the following high-level criteria:

- Existing knowledge and experience in implementation
- Addressing critical areas of disease burden
- Super-scaleable results for the rest of the country
- Highly monitorable results and indicators
- Capacity for implementation in the next 12 months
- Urgent need for targeted action

The working groups, in consultation with the Minister of Health, partner NGOs and CBOs, international experts, Harvard University's Access Project for GFATM, decided to draft five highly detailed and inter-related proposals – three for HIV/AIDS and one each for malaria and tuberculosis. These proposals by no means represent the full range of need in Nigeria and UNAIDS, WHO and UNICEF played a key role in their development. The CCM intends to begin submitting additional proposals shortly.

The five projects contained herein are:

1. Improvement of Nigeria's anti retroviral pilot to fill in critical gaps identified by WHO and UNAIDS
2. Improvement of Nigeria's PMTCT program in order to create six Centres of Excellence for PMTCT+ which will serve as models for the nation
3. Capacity-building and assessment of HIV/AIDS NGOs to identify NGOs to be scaled up and coordinate ARV, PMTCT+, malaria, and tuberculosis initiatives in the communities
4. Expansion of Nigeria's DOTS tuberculosis program from 22 states to 31
5. Expansion of Nigeria's Roll-Back Malaria campaign and ITN distribution program from 10 states to 22 states

Each proposal is a cornerstone of the national fight against these three scourges and could make immediate and effective use of financing from GFATM. For example, the National ARV program has such enormous gaps in the range of drugs available that it, according to WHO experts, risks failure during the next year without funding for critical drugs and expanded services.

## Nigeria's CCM

Nigeria's CCM has begun with 38 members drawn from the private sector, civil society, NGOs, government ministries, people living with HIV/AIDS and TB, as well as

academics and medical practitioners. The CCM voted to have a rotating chairman of one year tenure, and elected its chairman for this year, Dr. A. Nasidi, a Director in the Ministry of Health and a former member of the GFATM Secretariat. The CCM follows democratic procedures with each member holding an equal vote. All parties involved in the fight against HIV/AIDS, TB and Malaria are represented on the CCM, as are Government, UN and Bilateral Agencies, NGOs, Civil Society and the Private Sector. The CCM has formed technical working groups for each of the three diseases, as well as a Finance Task Force and a TRP.

The kick-off of the CCM was an enormous success, with broad representation from a group of leaders who are committed to the highest levels of transparency and accountability in managing GFATM proposals, projects, and funds. The Minister of Health inaugurated the meeting and several proposals for submission were discussed, as were procedures for the CCM.

The CCM is responsible for the transparent and accountable distribution of funds to implementing partners, and for the monitoring and evaluation of all Global Fund-supported programs.

In the year to come, the CCM has the following key responsibilities, among others:

1) Develop, review and submit proposals to the GFATM
2) Manage funds
3) Monitor and evaluate all projects
4) Monitor and track all expenditures
5) Audit internal and project specific accounts
6) Write regular reports on performance of each project and the activities of the CCM in general

**CCM Membership List**

**A. PERSONS LIVING WITH HIV/AIDS AND TUBERCULOSIS**

| S/N | NAMES | ORGANIZATION | FORWARDING ADDRESS/E-MAIL | COMMENTS |
|---|---|---|---|---|
| 1. | Dr. Pat Matemilola (Chairman NPLWHAs) | People Living With HIV/AIDS (PLWHAs) | NNPLWHAs | President Network of PLWHAs |
| 2. | Mr. Mohammed F. Auwalu (Secretary NPLWHAs) | PLWHAs | NNPLWHAs | Secretary Network of PLWHAs |
| 3. | Mrs. Georgina Ahamefula | Persons with TB | C/o Nigerian AIDS Alliance, Lagos | A PLWHA with TB |

## B. NGOs AND COMMUNITY BASED ORGANIZATIONS

| S/N | Name | Organization | Address | Comments |
|---|---|---|---|---|
| 4. | Mohammed Y. Sanda | Society for the Prevention and eradication of TB | Maiduguri | Very Active in the fight against TB in Nigeria |
| 5. | Mr. N Nwosu | Teepac Research (NGO), Anambra | Teepac Research Unit, P O Box 312, Ihiala, Anambra State | Active NGO in TB Control in the Eastern part of Nigeria. |
| 6. | Dr. O J Ekanem | Malaria Society for Nigeria | National marketing control Office, Lagos. C/o | Main focus is Mass Awareness campaign on Malaria. |
| 7. | Prof. A H Abdulkareem | Malaria Care Organization | C/o LASU College of Medicine, Lagos | Promotion of the use of Bed nets, formation of Malaria Clubs in Schools and Environmental Activities |
| 8. | Mr. Smart Adeyemi | Nigerian Union of Journalist | NUJ HQ Abuja | President of the Abuja, |
| 9. | Dr. Ibrahim Atta | Civil Society Consultative Group on HIV/AIDS in Nigeria CISCGHAN. | C/o Action AIDS Abuja | President of the CISCGHAN |
| 10. | Lady B Onah | Civil Society Consultative Group on HIV/AIDS in Nigeria CISCGHAN | C/o Action AIDS Abuja | Member of the Civil Society Consultative Eastern Zone |
| 11. | Mrs. Patricia Nzegwu | Society of Women Against AIDS in Nigeria. | SWAN Lagos, C/o NACA | One of the most Active NGOs in Nigeria providing Care & Support to PLWHAs. It has a wide network in the Country |
| 12. | Dr. Mrs. Ketebu Nwakoroafor | National Council of Women Societies NCWS | NCWS HQ Abuja | The largest Umbrella Organization for all Women NGOs. Very Powerful and Influential. |

## C. PRIVATE SECTOR

| S/N | NAME | Organization | Address | Comments |
|---|---|---|---|---|
| 13 | Managing Director | Coca-cola Bottling Company, Ltd | Coca-Cola Bottling Company HQ, Lagos | Very wide Social Marketing network that can be harnessed for HIV/AIDS control |
| 14 | Managing Director | CHEVRON Oil | CHEVRON HQ Lagos | Carried out several AIDS Control Activities in the country at community level and with the FMOH |
| 15 | Alh. Aliko Dangote | Dangote Group of Companies | Dangote Group of Companies, Lagos | One of the Largest Land Transporters with a network |
| 16 | Mrs. Rosemary Okoli | Pharmaceutical Manufacturers Group (Manufacturers Association of Nigeria) PMGMAN (Pharma) | PMGMAN C/o Emzor Pharmaceutical Lagos | Network of Pharmaceutical Industry in Nigeria and active in the support of HIV/AIDS control |
| 17 | Mrs. Pricilla Kuye (President) | Nigeria Association for Chambers of Commerce & Industries and Agriculture NACCIMA | NACCIMA, Abuja | Covers a wide range of Sectors of the Economy and has a representation in all the States of the federation. |

## D. RELIGIOUS GROUPS

| S/N | NAME | Organization | Address | Comments |
|---|---|---|---|---|
| 18 | His Eminence Dr. Sunday Mbang | Christian Association of Nigeria | CAN HQ Lagos | Powerful Advocacy among the Christian Community |
| 19 | His Eminence The Sultan of Sokoto, Alh. Muhammadu Maccido | Supreme Islamic Council of Nigeria. | Sultan's Palace Sokoto | Powerful Advocacy among the Muslim Community |

## E. ACADEMIC/EDUCATIONAL SECTOR

| S/N | NAME | Organization | Address | Comments |
|---|---|---|---|---|
| 20 | Chief Alh. Babs Animashaun | National Parents/Teachers Association of Nigeria. | Plot No. 873 Babs Animashaun Street, Surulere, Lagos | Overseas an important network that can easily mobilize the education Sector |
| 21 | Prof. Anya O. Anya | Nigerian Academy of Sciences | C/o National Institute Of Medical Research, Lagos | Involved in verification of HIV Treatment Claims and very significant in the National Response to AIDS |
| 22 | Prof. John Idoko | Nigerian AIDS Research Network NARN | Jos University Teaching Hospital Jos | A very experienced Nigerian Clinician and Scientist and also Chairman of the NARN |
| 23 | Dr T.O. Harry | WHO Reference Laboratory | University of Maiduguri Teaching Hospital | A very experienced Virolgist and Scientist who has contributed immensely to the control of HIV/AIDS in Nigeria |
| 24 | Dr. Oni Idigbe | HIV/AIDS and TB National Laboratories | National Institute for Medical Research, Lagos | Experienced Bacteriologist who had worked immensely in HIV/AIDS and TB Research in Nigeria |
| 25 | Dr. A. Inyang | Drug and Vaccine Research and development | National Institute for Pharmaceutical Research and Development | Experienced pharmacologist who is heading a key Institue in this area. |

## F. GOVERNMENT SECTOR

| S/N | NAME | Organization | Address | Comments |
|---|---|---|---|---|
| 26 | Dr. Abdussalami Nasidi | Federal Ministry of Health | FMOH, Abuja | Director Special Projects |
| 27 | Prof. I Akinsete | National Action Committee on AIDS NACA | NACA, The Presidency | Chairman, NACA |
| 28 | Alh. S Kassim | Federal Ministry of Finance | Director, Multi-Laterals Fed. Min. of Finance, Abuja | Representing the Finance Ministry of NACA |

| | | | | |
|---|---|---|---|---|
| 29 | Mrs. Aisha U Umar | Federal Ministry of Education | Federal Ministry of Education, Abuja | Representing the Ministry of Education in NACA |
| 30 | Mr. Paul Okwulehie | Federal Ministry of Labor | Fed. Min. of Labor & Productivity. Abuja | Representing the Labor Ministry in NACA |
| 31 | Chief Economic Adviser | Nat. Planning Commission | National planning Commission, Abuja. | Representing the Planning Commission in NACA |
| 32 | Col E. O. Egbewunmi | Armed Forces AIDS Control program AFPAC | Military Hospital, Yaba Lagos | Representing the Military inn NACA |

## G. DEVELOPMENT PARTNERS

| S/N | Name | Organization | Address | Comments |
|---|---|---|---|---|
| 33 | Dr. Christian Voumard | UN Theme Group on AIDS of the UN Agencies (UNICEF) | UNICEF Lagos | The Umbrella Organization for the UN and Bilateral Agencies |
| 34 | Dr. Mrs. Lynn Gorton | United States Agency for International Development (USAID) | USAID Nigeria | A major Funding Agency in the HIV/AIDS Response |
| 35 | Dr. Abdul Moudi | World Health Organization (WHO) Nigeria | WHO Lagos | Major UN Agency in the Health Sector Response |
| 36 | Dr. Berhe Constantinos | United Nations Joint Program on HIV/AIDS (UNAIDS) in Nigeria | UNAIDS Abuja | UN System coordinating Program for AIDS |
| 37 | Dr. Claire More | Department For International Development (DFID) | DFID Abuja | A very Important Funding Development Partner in several Aspects of AIDS control |
| 38 | Mr. Klause Gilgen | International Federation of Anti-leprosy Associations | German Leprosy Relief Association Nigeria. Independent Layout, Enugu | Major Player in the funding of TB Treatment in many States of the federation |

## Independence

The CCM determined that it should be a partner of the Nigerian Government as well as of NGOs, donors, bilaterals, and multilaterals. However, it also decided that the CCM must function completely independently. For that reason, in spite of strong support from the Ministry of Health, the CCM decided that it would request bare bones funding for its first year of operations from GFATM until the CCM could obtain a pool of funds from multiple resources. In addition to the enclosed five proposals, the CCM requests a total amount of: $61,485 for its first year's activities. This budget is broken down as follows:

| | Number of Persons | Unit cost | Times per year | Total Cost |
|---|---|---|---|---|
| Transportation | 12 | 150 | 4 | 7200 |
| Per diems | 12 | 89 | 4 | 4285 |
| N Financial accountant | 1 | 50,000 | 1 | 50000 |
| Total | | | | 61,485 |

This budget ensures that CCM members from organizations lacking discretionary funds, as well as members who are PLWAs will not miss meetings due to a lack of resources. The vast majority of members will have their organizations or agencies cover their expenses for attendance at the four CCM meetings slated for the year to come. Meetings will take place in space donated by CCM member organizations, and members will pitch in for all incidental expenses.

## Transparency and Accountability

The members of the CCM believe that all GFATM funds must be disbursed in a timely, transparent manner. Projects funded are expected to have independent accountants and non-mingling accounts. All funds distributed must follow the CCM's financial regulations, which are in the process of being designed by the CCM's financial taskforce. Funds distributed to non-mingling accounts in the Federal Ministry of Health must follow the CCM's accounting rules, not the Ministry's. This will ensure the timely execution of activities and will also focus responsibility on the project heads.

## Submission of this Proposal

The members unanimously decided to submit five project proposals to GFATM for funding. Attached to this letter are the signatures of the CCM approving submission and the minutes of the meeting where such decision was taken. Additional signatures are contained, mainly drawn from the working groups addressing these three diseases and designing the proposals themselves.

CCM INAUGRATION & PROPOSAL ENDORSEMENT

| S/N | NAME | DESIGNATION | CONTACT ADDRESS | SIGNATURE |
|---|---|---|---|---|
| 1. | O. A. LAYADE [redacted] Miss O. Kuye | CONTROLLER OF [redacted] | NIGERIAN-AMERICAN CHAMBER OF COMMERCE 1, KINGSWAY ROAD IKOYI - LAGOS 01-2692088 01-2693041 | |
| 2 | [redacted] | Fed Min of Edu PPO. | 080 3310 5787 aLidan39@yahoo.com | |
| .. | [redacted] | INTERNATIONAL NETWORK FOR RATIONAL USE OF DRUGS (INRUD) NIGERIA & NIGERIAN COALITION FOR ESSENTIAL DRUGS & MEDICINES & ISLAMIC MEDICAL ASSOCIATION OF NIGERIA (IMAN | 3, ADENIKE MOYOSORE CLOSE GBAGADA PHASE II LAGOS 01-3422053 0802 310 0941 biolamab@linkserve.com.ng biolaab@hotmail.com | 08/03/02 |
| | [redacted] | Chairman: National Malaria Committee (RBM) ojekanem@Yahoo.com | House 5, AL Close 11.2 Road Festac Town LA 908 880520 480565 | |
| | Dr. Bassey Ebenso | ① Country Co-ordinator The Leprosy Mission ② Representing ILEP | Nigeria Co-ordinating office, 1 Lodi Kumoll Rd. P.M.B. 179 Minna 066-224840 -223433 (Fax) | |
| | Lucy Idoko | Desk Officer HIV/AIDS UNFPA | UNFPA, 11, Oyinkan Abayomi Drive Ikoyi Lagos 01-2693108 | |
| | Jude Edochie | Assistant Representative UNFPA | " | |
| 3 | Cyrilla BWAKIRA | Chief, Protection & Participation - UNICEF | 33, USUTA Street - HAITAMA Abuja | |
| | [redacted] (NAT) | [redacted] ASSISTANT IN NACA | 38A UMUEZEBI ST. NEW HAVEN ENUGU | |

| S/N | NAME | DESIGNATION | CONTACT ADDRESS | SIGNATURE |
|---|---|---|---|---|
| 10 ✓ | Jesa Kupfer | JPO UNAIDS | Aguiyi Ironsi Way MAITAMA, Abuja | |
| 11 | [redacted] | National Moderator Ciscghan | [illegible] Kumasi Crescent Abuja | |
| 12 ✓ | DR MARTINS OUBERETO | NATIONAL PROGRAMME MANAGER | NACA | |
| 13 | [redacted] | [redacted] | [redacted] | |
| 14 | Dr. N. Sani-Gwarzo | NE-NASCP FMOH | FMOH | |
| 15 | [redacted] | [redacted] | NACA | |
| 16 ✓ | Dr. M. E. Mosanya | Asst. Palliative Prog. Coordinator FMOH | FMOH | |
| 17 ✓ | John [redacted] | Harvard [redacted] | CDC | |
| 18 | Dr. M. Mustafa | NASCP | FMOH | |

| NAME | OFFICIAL DESIGNATION | CONTACT ADDRESS | SIGNATURE |
|---|---|---|---|
| Chief Bobs | National President National Parent Teacher Association of Nigeria | 14 Bobs Animashaun Road, Surulere | |
| [redacted] | [redacted] | Abuja | |
| Prof. T.O. Harry | Univ. of Maiduguri | Maiduguri | |
| Dr. Frank Mueke | WHO | WHO, Lagos | |
| Mrs Linda Humphrey | Dep Health Adviser DFID Nigeria | 14 Plot 607 Bobo St, Maitama Abuja | |
| Dr Nuj. Ogundiran | WHO | WHO LAGOS | |
| [redacted] | [redacted] | NHPLWHA, Ikeja, Lagos. | |
| Mr S.J. Simm | [redacted] | UNAIDS Abuja | |
| [redacted] | [redacted] | [redacted] | |
| Dr S. Fatunmbi | WHO | WHO, Ibadan | |
| Chioma Amajoh | PMWH/RBM | PMWH/RBM | |
| Dr B.I. Ogunade | UNICEF | UNICEF, Lagos | |

| | | | | |
|---|---|---|---|---|
| 31 | ORNTADOM B-AG | S.M.O | Roll Back Malaria Secretariat | ~~PMTCT~~ |
| 32 | A.L. ASUQUO | SMO | RBM Secretariat | |
| 33 | [redacted] | NARN Mng. D. | Dept of Medicine UNTH, Jos | |
| 34 | Mrs. O. JAJA | ACMLS Lab/Blood Safety | NASCP/FMOH | |
| 35 | Dr Fola Soetire | ARV Focal Person | NASCP/FMOH | |
| 36 | Dr. S.A. Kolo | AD Care & Support PMTCT Focal Person | NASCP/FMOH | |
| 37 | Mrs. C. Nwaobi | AD Development Mgt | NASCP/FMOH | |
| 38 | [illegible] | Videoman/HMH | Press Unit Fed. Min. of Health | |
| 39 | [illegible] | News Agency of Nig. | News Agency of Nigeria (NAN) | |
| 40 | Dr B.M. Afolabi | NPO/RBM/WHO | World Health Organization, Plot 1620 Maitama Sule Str Off Yakubu Gowon Crescent, Asokoro | |
| 41 | Mrs N.C. Nwaoriaku | FP Counselling | NASCP/FMOH | |
| 42 | Okoro P.O | P.A. NASCP | FMOH (NASCP) | |
| 43 | O.F. Awopegu | AOI/NASCP | FMOH | |
| 44 | Abiola Davies | Assistant Project Officer HIV/AIDS | UNICEF P.T.O | |

M INAUGURATION

| | NAMES | OFFICIAL DESIGNATION | CONTACT ADDRESS | SIGNATURES |
|---|---|---|---|---|
| 5 | DR. T.O. SOFOLA. | National Coordinator NTBLCP | FMOH | |
| 6 | ONIYEKWERE G.A. | PRESS. SEC. SJ3 | 09-5234590 | |
| 7 | Essen Cornelius | Bureau Chief | The Pioneer Akara Idom House, Abuja. | |
| 8 | Tony Akerele | Asst. Director (Press) FMOH | FMOH 5234590 | |
| 9 | COL [redacted] AGBEWUNMI | COORDINATOR ARMED FORCES PROG ON AIDS CONTROL | 17/27 Mobolaji St Lagos 01-2647584 | |
| 50 | Prof. A.B.C Nwosu | Hon. Minister of Health | FMOH 09-5234592 | |
| 51 | Dr. M.E. Anibueze | CSG II/TA to HMH | FMOH 09-5234590 | |
| 52 | Prof. H.A. ABDUL-KAREEM | MACOA LAGOS 08033088064 | LASU College of Medicine Ikeja E-mail akarim@onebox.com | |
| | | NACD | FMOH | |

| | | | |
|---|---|---|---|
| Dr. Edo J.J. | Dr | NIAS CP/Fmoh | |
| Mohd Yahya Sada | NGO | #3 Ibrahim Abacha Way Maiduguri Tel: 076-342752 | |
| Dr Oni Idigbe | DG | Nigerian Institute of Medical Research. 6 Edmond Crescent PMB 2013 Yaba Lagos 01-7744723 01-4705945 01-862865 (Fax) Oniidigbe@yahoo.com | 15/03/02 |
| Dr. Toyin Jolayemi | Associate | Ipas A1/A2 Bensima House Off Aguiyi Ironsi Maitama Abuja toyin.jolayemi@hotmail.com | TJolayemi |
| Ohikere Jerome | Students Representative (NIMSA). | C/(NIMSA Office) Assist Dean clinical ABUTH Zaria 069-33535 8 nimsapresident@yahoo.com | |

# MINUTES OF THE INAUGURAL MEETING OF THE COUNTRY COORDINATING MECHANISM HELD ON 5TH MARCH 2002 AT THE BENUE/PLATEAU MEETING ROOM, NICON-HILTON HOTEL, ABUJA.

## 1. Attendance List.

## Members:

| | |
|---|---|
| Prof. I. Akinsete | Chairman, NACA |
| Dr. A. Nasidi | DSP, FMOH. |
| Mr. Danjuma Yusuf Ali | Federal Ministry of Education |
| Prof. A. F. B. Mabadeje | International Network for Rational Use of Drugs, Nigeria. |
| Dr. O. J. Ekanem | Chairman, Nat'l Malaria Cntrl Cmtte |
| Prof. H. A. Abdulkareem | LASU, College of Medicine |
| Dr. Cyrilla Bwakira | Chief, Protection & Participation UNICEF |
| Lady Nkechi Onah | CiSCGHAN. |
| Dr. Ibrahim Atta | National Moderator CiSCGHAN |
| Mr. O. A. Layade | Representing President, Nig. / American Chamber of Comm. |
| Dr. Pat Matemilola | Coordinator, NNPLWHAs |
| Mohammed Farouk | Secretary, NNPLWHAs |
| Mr. B. S. Ajakasile | (Representing President, National PTA of Nig.) |
| Prof. J. A. Idoko | NARN President |
| Mr. Paul Okwulehie | Fed. Min. of Labour HIV/AIDS |
| Col. Wale Egbewunmi | Armed Forces Prog. AIDS Cntrl |

| | |
|---|---|
| Prof. T. O. Harry | University of Maiduguri |
| Dr. Oni Idigbe | Director General, NIMR, Lagos. |
| Dr. Frank Mueke | WHO |
| Dr. Linda Humphrey | Ag. Health Adviser DFID, Nigeria |
| Ms. Gesa Kupter | JPO UNAIDS |
| Dr. Bassey Ebenso | Country Coord. Leprosy Mission / ILEP |

The Honourable Minister of Health, Prof. A. B. C. Nwosu was also present with his Technical Adviser, Dr. M. Anibueze.

## In Attendance:

| | |
|---|---|
| Dr. T. O. Sofola | NTBLCP |
| Dr. M. E. Mosanya | RBM, FMOH |
| Dr. N. Sani-Gwarzo | NASCP, FMOH |
| Dr. Martins Ovberedjo | National Prog. Manager, NACA |
| Dr. Josh Ruxin | CID, Harvard University, USA |
| Mr. Jude Edochie | Assistant Rep. UNFPA |
| Mrs. Lucy Idoko | HIV/AIDS, UNFPA |
| Mr. S. J. Simon | UNAIDS |
| Dr. Niyi Ogundiran | WHO |
| Dr. Bayo S. Fatunmbi | WHO, Ibadan |
| Dr. B. M. Afolabi | WHO, Abuja |
| Dr. E. I. Gemade | UNICEF, Lagos |
| Dr. Abiola Davies | UNICEF, Lagos |
| Dr. Toyin Jolayemi | IPAS, Abuja |

| | |
|---|---|
| Mr. Jerome Ohikere | NIMSA, President |
| Dr. S. A. Kolo | NASCP, FMOH |
| Mrs. Chioma Amajoh | FMOH/RBM |
| Mr.Tony Aleyeke | FMOH |
| Mrs. N. C. R. Nwaneri | NASCP, FMOH |
| Dr. Fola Soretire | NASCP, FMOH |
| Dr. J. J. Edo | NASCP, FMOH |
| Dr. B. N. G.Ntadom | RBM, FMOH |
| Dr. Asadu | RBM, FMOH |
| Mrs. J. N. Etta | NASCP, FMOH |
| Mr. P. O. Okoro | NASCP, FMOH |
| Mr. G. A.Onyekwere | FMOH |
| Mr. Cornelius Essien | Bureau Chief, Akwa Ibom House |
| Ms. Olufunke Lawal | News Agency of Nigeria |

## Secretariat:

| | |
|---|---|
| Mr. B. C. Nwobi | NASCP, FMOH |
| Mrs. O. Jaja | NASCP, FMOH |
| Dr. M. Muktar | NASCP, FMOH |
| Mr. O. F. Awopeju | NASCP, FMOH |
| Mal. Salihu Mohammed | FMOH |

The meeting commenced at 1.30 pm, presided over by Dr. A. Nasidi.

2. The entire participants present unanimously adopted the agenda without amendment.

3. Dr. Nasidi made introductory remarks stating the purpose of the meeting.

A PowerPoint Presentation was used to introduce the GFATM identifying:

i. * What it is
* The need for it
* Beneficiaries
* Eligibility criteria

ii. **The Country Process**
- Establishment of a CCM as the apex Committee that is autonomous, independent and enjoys equity of membership status.
- Its functions as stated below were reviewed and adopted by the house.

**Major functions of the CCM**

- To develop and manage a coordinated response to the challenges posed by HIV/AIDS, TB and MALARIA;
- To ensure a sustainable national, state and local government area response based on empowered people's participation;
- To scale up the best practices already in place in communities where interventions have been initiated already;
- To enhance the effectiveness, and increase the efficiency, of responses by developing a systems perspective to social mobilization and public and private participation;
- To jointly and severally determine priorities for the government, development partners and civil society organization in the response to the pandemics.
- To allocate the necessary resources to scale up an effective and efficient response

## 4. Issues discussed under sustainability include:

- how the first year will be managed for now, but if well managed, most likely will be up to 5 years
- how Global Fund assistance and support could be maximally harnessed
- As long as there is accountability, countries may continue to draw from the fund
- The performance of the CCM will determine whether Nigeria would be able to draw from the fund next time

## 5. Issues discussed under eligibility include:

- GNP, Prevalence and others as presented in the Eligibility Criteria.
- Agencies not eligible include the UN systems like WHO etc
- Eligible agencies will include: NGOs, Private Sector Organizations, Government etc.

## 6. Procedures

- Proposals should be channeled through the CCM and be endorsed on behalf of Government.

## 7. Scope

- Proposals will be within the scope of the three diseases under consideration.

## 8. Guidelines

- Proposals must fit into country plan, clearly defined, fully justified and part of an ongoing process.

## 9. Inauguration by the Honourable Minister

Although the CCM (ICC) had some few meetings earlier, the Honourable Minister of Health officially inaugurated the CCM at this meeting.He congratulated all members and noted the good work done by the members. He expressed high expectations for a quality proposal document for Nigeria.

**The highlights of the remarks of the Honourable Minister include:**

- Assurance of Presidential support for the process;
- Proposals should be made to highly acceptable standard;
- Nigeria should not undergo a resubmission process;
- Acknowledge the hard work and in-put of the CCM so far;
- Shunned the denial and concealment by many sero-positive persons and wanton stigmatization of PLWAs.
- Denounced the pride and mannerism of some ***"high ranking"*** sero-positive individuals who attempt to enroll in the ARV initiative but ***'avoid'*** enlisting in the Network.
- Applauded the expansion of DOTS to all levels
- Inaugurated the CCM

## 10. Members then reviewed the structuring of the CCM namely:

- The CCM noted the Terms of Reference as basically: to work together in groups with interrelationship across programmes and provide the necessary feedback to the Fund.
- The establishment of independent financial accounting and fund management system.
- Determination of the frequency of meetings
- The Way Forward

Suggestions were made of other member-organizations to form part of the CCM e.g. NMA and Rotary. Any need for contribution from other organization will be co-opted to perform tasks as may be needed.

## 11. Chairmanship

After deliberations, members unanimously chose the person of Dr. A. Nasidi as Chairman for an initial period of one year with responsibilities being primarily to coordinate the business of the CCM including guidance to the selection of executive members of the CCM Secretariat. A one-year rotational period was agreed upon. This is in conformity with one of the requirements of the Fund that the members of the CCM should elect the Chairman.

## 12. Finance

Member requested and adopted

- the identification and utilization of a Finance/Accounting outfit to develop guidelines for management of the CCM funds.
- CCM to open its own accounts.

## 13. Budget

CCM should have budget for running its administration. This should be included in the proposals with funding sources such as:

- Private Sector
- Government
- GFATM

- Participating Organisations to fund themselves.

## 14. Presentations and Adoption of Proposals.

Dr. Ruxin, a consultant from Havard University, jointly with Dr. Nasidi, introduced The Guidelines for the presentation of draft proposals to the GFATM. They also acquainted the CCM with the various activities leading to the preparation of the draft proposals to be submitted to the GFATM through the CCM. The various presenters were then called upon to present their proposals to the CCM.

The presentations were made as follows:

### HIV/AIDS:

PMTCT Proposal.

Dr. S. A. Kolo presented the draft proposal on the *Expansion of the current PMTCT of HIV Project in Nigeria.*

ARV Proposal.

Dr. O.Soretire presented the draft proposal on the *Expansion of the ARV Programme in Nigeria.*

Civil Society Organisation Proposal.

Dr. M. Ovberedjo presented the draft proposal to *Assess and Promote the effective participation of Civil Society Organizations in the National Response to HIV/AIDS.*

### TUBERCULOSIS:

Dr. T. Sofola presented the draft proposal on *Accelerated DOTS expansion in Nigeria.*

### MALARIA:

Dr. M. Mosanya presented the draft proposal on *Scaling Up Roll Back Malaria in Nigeria: Promoting Use of Insecticide Treated Nets (ITNs); Improving Home Management of Malaria and Initiating; Intermittent Preventive Treatment (IPT) for Pregnant Women.*

Members reviewed and extensively discussed the presentations. Following observations made, amendments were recommended to each of the presenters,

and the proposal were all adopted for submission to the Fund as Nigeria Country Proposal, subject to the final amendments as recommended.

The respective working groups for the units of the proposal were enjoined to urgently effect the relevant amendments and provide the final copy of the entire proposal to the Chairman, Nigeria CCM, for onward transmission to the Fund by 10 March 2002.

## 15. Formation and endorsement of Sub-groups

The meeting deliberated on the formation of subgroup and Task Forces.
It was agreed the a working group for each of the diseases be formed in addition to one Task Force on Finance and a local Technical Review Panel

## 1. Adjournment

The meeting adjourned at 9.45 pm.

## Ulrik Tidestrom

**From:** Dr. Salma Anas Kolo [salma_anas@hotmail.com]
**Sent:** 20 March 2002 23:57
**To:** Ulrik Tidestrom
**Cc:** nasidia@hotmail.com
**Subject:** Re: Nigerian Proposal (PMTCT) to the Global Fund

**Importance:** High


List of submissions to GFATM w...


Nigeria PMTCT proposal Form to...

Dear Ulrik,

Thanks for your mail.

Please find attached:
1. The reviewed section C5 of the PMTCT proposal form, indicating resource
allocation to different implementing partners with activities.
2.List of all attachments.

Pls confirm receipt to me, and if there is any need for me to further improve on the proposal do not hesitate to let me know within the short time
period.

Looking forwrd to hear from you,

Salma
----- Original Message -----
From: "Ulrik Tidestrom" <Ulrik.Tidestrom@tss-twg.be>
To: <salma_anas@hotmail.com>
Cc: <nasidia@hotmail.com>
Sent: Tuesday, March 19, 2002 9:26 PM
Subject: Nigerian Proposal (PMTCT) to the Global Fund

Dear Dr. Anas-Kolo,

The Global Fund has recieved the proposal from the Nigerian CCM on HIV/AIDS (PMTCT). To ensure the completeness of the proposal, I kindly ask you to submit the following:

1) Specification of the allocation of money to different implementing partners, i.e. what amounts will be used by what partner. (As we interpret section C5 in your proposal, you only account for the planned contributions from different sources of funding.)

2) One list accounting for all the attachments, appendices etc. to your proposal.

We will appreciate your sending us this information no later that Thursday 21 March via e-mail or fax.

If we receive this information later than that time, we will need to postpone presentation to the Review Panel until the next round of this year.

With best regards,

Ulrik Tidestrom

The Global Fund
Interim Secretariat
Tel: +41 22 791 96 07
Fax:+41 22 791 94 61
e-mail: ulrik.tidestrom@tss-twg.be
www.globalfundatm.org

**C.4 Duration:** (provide an estimate)

Beginning and end dates:

From: February 2001 To: February 2010

Period to be covered by this request for financing:

From: 1st June 2002 To: 31st May 2003

**C.5 Implementation Plans including resource allocations to partners** *(Guidelines para. 40)*

(US$)

| | Budget Categories (please fill in according to your plan) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Implementing Partner** | *Human Resources* | *Logistics and supplies* | *Training & Supervision* | *Outreach Services* | *Commodities or Products** | *Data & information systems* | *Other (explain)* | *TOTAL* |
| Government | 105,995 | 503,161 | 953,220 | Nil | Nil | Nil | Operational research 329,500 | 1891876 |
| Civil Society | Nil | Nil | Nil | 66,965 | Nil | Nil | Nil | 66,965 |
| Private sector | Nil | Nil | Nil | 66,965 | 1,592,777 | Nil | Nil | 1659742 |
| Donors | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
| Other | Nil | Nil | Nil | Nil | Nil | | Nil | Nil |
| **TOTAL** | 105,995 | 503,161 | 953,220 | 133,930 | 1,592,777 | **Nil (fully comitted by government ) | 329,500 | 3618584 |

*Including drugs

SFL 36

(411)

**THE GLOBAL FUND**
**To Fight AIDS, Tuberculosis and Malaria**
**Interim Secretariat**

Geneva, 31 January 2002 GFATM/B1/6A

GUIDELINES FOR PROPOSALS

# PROPOSAL FORM

*Guidelines for Proposals* set out detailed conditions of support and criteria for review of proposals. Reference is made in this form to relevant sections of the Guidelines.

For the Use of the Global Fund Secretariat
Date Received:
Log No:

This form is divided into 3 sections:
SECTION A seeks summary information on the overall proposal, total funding sought and information related to general eligibility criteria, including details of the Country Coordinating Mechanism;
SECTIOB B seeks further detail on the overall proposal, its objectives, how it will be monitored and demonstration of additionality;
SECTION C seeks detail, including budgetary information, separately on each component of the proposal.

For additional pages, please mark clearly whether SECTION A, B or C.

## SECTION A: OVERVIEW INFORMATION

| |
|---|
| A.1. Country (or region):<br>Nigeria |
| A.2. Proposal Title:<br>Proposal for PMTCT+ Centers of Excellence (Expansion of Current Prevention of Mother to Child Transmission of HIV Project) |
| A.3. Spell out which of the three health problems or combination of them this proposal aims to address (HIV/AIDS, TB and/or malaria) (*Guidelines para.4*) :<br>HIV/AIDS |
| A.4 What are the additional outcomes expected from this proposal? (*Guidelines, para. 8 and Annex 1, II 3*).<br>The six PMTCT+ Centers strenghtened and operational VCT programme and care services established |

VCT services provided to 18,000 pregnant women attending antenatal clinic services

14,400 women accept to be tested

Antiretroviral drugs provided as prophylaxis for 912 HIV positive pregnant women and to 912 babies

Access to comprehensive care services provided to 912 HIV positive women and 456 HIV infected babies which includes anti-retroviral therapy, management of opportunistic infections, STI management and access to family planning services

250 counsellors trained on HIV/AIDS and infant feeding counseling, 30 laboratory scientists trained on HIV testing

Education campaign on PMTCT+ established at the PMTCT+ sites with community members involved and committed

**A.4. Total Amount Requested from the Global Fund: (in US$, by year)**

| Components (described in Section C) | Year 1 (Budget) | Year 2 (Estimated . . . . . .) | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|
| Component 1<br>PMTCT+ Centers of Excellence | $3,618,584 | $5,090100 | $7,241520 | 6,300,230 | $5,181,440 |
| Component 2 | | | | | |
| Component 3 | | | | | |
| TOTAL (outlined in Section B) | | | | | |

**A.5. Disease burden** (Refer to official documentation or sources of epidemiological data on the prevalence and magnitude of HIV/AIDS, TB and/or malaria in the country/region/area) **or potential disease burden** (indicators such as incidence of new infections etc) *(Guidelines para.6)*

Nigeria is the most populous African nation with a population of 120 million and an annual growth rate of 2.8%. The country is divided into 6 geo-political zones with 36 states including the Federal Capital Territory, 774 local government areas and over 250 ethnic groups. The first case of AIDS was formally diagnosed in Nigeria in 1986 and since then there has been a consistent rise in the prevalence of the epidemic from 1.8% in 1993, to 3.8% in 1994 to 4.5% in 1996 and to 5.4% in 1999. The recent national HIV sero-prevalence survey conducted in Nigeria revealed that about 5.8% of women attending the ante-natal clinics were infected with HIV (NASCP-FMOH, December 2002). It is estimated that about 3.5 million Nigerians are already infected with HIV. The highest prevalence is in the age group 20 – 24. This translates to about 350,000 AIDS cases. AIDS is responsible for about 1.4 million cumulative deaths in 2002 in Nigeria. The group most affected are the productive, reproductive and economically viable segment of the society. The same survey estimates that the decrease in life expectancy in 2002 due to HIV/AIDS is 4.5 years. The Joint United Nations Programme on AIDS also estimates that about 750,000 paediatrics AIDS cases will occur in Nigeria in 2002.

The majority of the women infected are between 15 and 25 years of age. According to the National Planning Commission, women of childbearing age constitute about 25% of the

**population of 120 million (National Population Commission, Reports; 1991). The target groups are in dire need of appropriate information, HIV screening and counseling, in order to be able to make informed choices and decisions that will affect their lives and families.**

**Several studies have shown that paediatric AIDS cases are rising at an alarming rate. According to the Joint United Nations Programme on AIDS (UNAIDS), it is projected that about 755,000 paediatric AIDS cases will occur by the year 2002 in Nigeria (UNAIDS, 1999). Similarly, surveys indicate that more than 90% of HIV infections in children less than 15 years of age are acquired from their mothers. Between 14 and 40% of babies born to HIV mothers acquire the infection either during pregnancy, intra-partum or through breast feeding (Moemie and Reid T. E. 1995). The burden of mother to child transmission of HIV is much higher in sub-Saharan Africa compared to the rest of the world, because of higher levels of hetero-sexual transmission, high female:male ratio, high total fertility rate (TFR) and high rates of breast feeding.**
**There is a great need for Voluntary Counseling and Testing (VCT) in all PMTCT+ Centers in Nigeria to be made accessible to women of reproductive age and their partners, irrespective of social status or educational background.**

**Surveys conducted among university students in the USA (Anastasi et. al. 1999) have shown that 59% of the students seeking HIV antibody testing were women with average age of 22.6 years. Similarly, a survey conducted in Tanzania showed that 55.9% of people who volunteered for VCT were adult women (Killewo et al.1998)**

**A.6. Economic situation:** (Refer to official indicators such as GNP per capita, HDI or other information on resource availability) (*Guidelines para.6*)

**Nigeria's position in Africa is unique because of its multi-ethnic society, its federal structure and demographic composition. It is the largest country in Africa with a population of 120 million (NPC estimates of 1999). Roughly 50% of the population is between 15 and 49 years of age. The average population growth rate is 4.4%. The country ranks 146th on the Human Development Index because of highly adverse indicators like the rate of maternal mortality (948 per 100,000 live births), total fertility (5.1) and infant mortality (80 per 1,000 live births). The economy is dependent on oil but despite the rich oil resources, Nigeria is poor with an annual per capita income estimated at US$260.00. The foreign reserve and the entire economy depend on the oil market price. The fall in oil price in the 1980s led to trade arrears, inflation and unemployment. It is estimated that 48.5% of Nigeria's population lives below the poverty line.**

**A.7 Political commitment:** (government contribution to the financing of the proposal or public spending on health or existence of supportive national policies or presence of a national counterpart in the proposal, or other indicator) (*Guidelines para. 6*).

**The present democratic government under President Olusegun Obasanjo has taken steps to invigorate the fight against HIV/AIDS in the country. The President was quick to understand the deep socio-economic impact that the unchecked spread of HIV can cause. The President pledged to lead the campaign against AIDS personally and constituted a Presidential Committee on AIDS (PCA) with ministers as members. The National Action Committee on AIDS (NACA) was organized as a multi-sectoral body to coordinate the entire response through the relevant ministries and in cooperation with the donors and non-governmental partners. Political commitment has been demonstrated with the release of substantial funds by the President to combat HIV/AIDS in Nigeria.**

President Obasanjo also took the lead among African Heads of State by organizing the OAU Summit on HIV/AIDS in Abuja last year. Further political commitment has been demonstrated by the President by posing for photographs with PLWHAs for 2001 World AIDS Day with the 2001 WAD slogan [I Care.. do you?].

Barely a year after the OAU Summit, the Presidential Forum on HIV/AIDS will take place on Saturday, 9 March 2002. It is aimed at reviewing past efforts on HIV/AIDS, identifying the gaps and paving the way forward. The forum will also provide the opportunity to obtain political commitments at levels.

A national policy on HIV/AIDs exist, which is currently being reviewed, in order to address the emerging challenges posed by the disease. Similarly, there are national guidelines on syndromic management of STIs, home based care, PMTCT, AIDS case management and the use of ARVs. The federal government is collaborating with numerous partners towards implementing the proposal. They are: UNICEF, UNAIDS, UNFPA, WHO, APIN, FHI, CDC, USAID and DFID.

**A.8 Links with existing activities**: (What links are there between this proposal and other current activities supported, for example, through, national health strategies, Poverty Reduction Strategies and Sector-Wide Approaches? Provide copies of these as supporting documentation, noting them in Attachment 1)

The PMTCT programme implementation is well reflected in the National HIV/AIDS Emergency Action Plan (HEAP) for the country, which is part of the national health strategies.

Care and support as well as for people infected and affected by HIV/AIDS will be provided by the public and private sector and also NGOs. This component includes a pilot programme to prevent mother-to-child transmission with single dose Nevirapine and management of HIV/TB co-infection and treatment of opportunisitc infections. The continuum of care is linked to the communities through existing community networks.

This project will support and encourage voluntary counseling and confidential testing of expectant mothers and their partners. VCT has been integrated into reproductive health services (family planning services, antenatal sessions, STI management, adolescent reproductive health services etc.) The VCT component and provision of antiretroviral drugs for PMTCT+ is linked to the ARV initiative detailed in Nigeria's proposal to the GFATM.

Links with the Ministries of Women Affairs, Education and Information for awareness creation and community moblization have been established. Formative research was conducted at the six PMTCT+ Centers, which is aimed at developing comprehensive communication strategies to ensure community involvement, promote male involvement and participation of People Living with HIV/AIDS.

The PMTCT project has been linked to the National Poverty Eradication Programme (NAPEP) to ensure continuum of care for HIV positive mothers, their partners and babies by enhancing income generating activities and self reliance.

**A.9 Profile of the Country Coordinating Mechanism (CCM) – If not submitted by a CCM, please move directly to A.12.** *(Guidelines para. 9-14)*

*Various agencies and partners (including NGOs and Research Institutions) that are supporting this proposal are co-ordinated and organised through a country coordinating mechanism which is referred to in this document as CCM.*

1. Name of the CCM:
Country Coordinating Mechanism, Nigeria

2. Date of constitution of the current CCM:
21/01/2002

3. Organizational structure (e.g., secretariat, sub-committee, stand-alone):
The CCM will have a Secretariat, Technical Working groups on each of the diseases, Task Force on Finance and a Technical Review Panel

4. Frequency of meetings (e.g. monthly, quarterly):
**4times a year**

5. Major functions and responsibilities of the CCM:

1. Develop, review and submit proposals to the GF ATM
2. Manage funds
3. Monitor and evaluate all projects
4. Monitor and track all expenditures
5. Audit internal and poject specific accounts

6. Major strategies to enhance CCM's role and functions in the next 12 months:

SEE PROPOSAL COVER LETTER

**A.10. Please provide the total number and composition of members of CCM:**

| | |
|---|---|
| People living with HIV/TB/malaria | -2 |
| NGOs/Community-based organisation | -9 |
| Private Sector | -5 |
| Religious/Faith groups | -2 |
| Academic/Educational Sector | -6 |
| Government Sector | -7 |
| Other (explain) | -6 |
| TOTAL | -38 |

**A.10. Signatures:**

Members of the Country Coordinating Mechanism (CCM – see following page) sign below to endorse this proposal. Endorsement of this proposal does not imply any financial (or legal) commitment on the part of the partner agency or individual:

Signature,

**Chair of Country Coordination Mechanism:** Dr Abdulsalami Nasidi

**Chair Name and Contact Information:**
Address: Room 334, Federal Secretariat, Maitama, Abuja, Nigeria
Tel: +234 9 523 05 73, 234 9 670 1666
e-mail: nasidia@hotmail.com

**CCM Member Signatures**

Agency/Organization

Name/Title
Date
Signature

**SEE PROPOSAL COVER LETTER and attached endorsements**

**A.11.** In case the Global Fund Secretariat has queries on this submission, please contact:

Name:
Dr. Salma Anas-Kolo

Title/Address:
National PMTCT Focal Person
National HIV/AIDS STD Control Programme
Federal Ministry of Health
Federal Secretariat Complex
Abuja

Tel.No.: 234-9-5230950 - Office

234-9-2311507 - Home
234-80-44183653

Fax No.: 234-9-5230950

E-mail:
salma_anas@hotmail.com
salma_anas@yahoo.co.uk

**A.12.** If submitting not under a CCM, but as an individual or a partnership of non-governmental organizations (NGOs) or from private sector, please explain clearly the circumstances, conditions and/or reasons why not applying under a CCM.

**Not Applicable**

## SECTION B: OVERALL PROPOSAL

**B.1 Summary of overall proposal:** (Synopsis of proposal, describing overall objectives, who will be involved, the beneficiaries, listing the major health components and the synergies between the different components. [more detail on separate components is sought in section C]).

GOAL
To establish PMTCT+ Centers of Excellence in six health facilities in the six geopolitical zones of the country, where women of reproductive age groups, their partners and families will have access to effective PMTCT + and care services

SPECIFIC OBJECTIVES
1. To stengthen the recently launched PMTCT+ Centers with an operational VCT programme and care services.
2. To provide VCT services to 18,000 pregnant women attending antenatal clinical services in the centers.
3. To enable 14,400 women to know their status by the end of the period.
4. To provide antiretroviral drugs as prophylaxis for 912 HIV positive prgnant women and to 912 babies.
5. To provide access to comprehensive care services to 912 HIV positive women and 456 HIV infected babies within the period, which will include antiretroviral therapy,management of opportunistic infections, STI management and access to family planning services
6. To train at least 250 counselors on HIV/AIDS and infant feeding counseling from the six sites and 30 laboratory scientists on HIV testing.
7. To establish best practices and trained personnel who can replicate the lessons learned to the secondary and primary levels of care.
8. To establish an education campaign in the six project sites, so as to inform and mobilize the community, including People Living with HIV/AIDS about the overall objectives of the PMTCT programme

TARGET POPULATION
Women of reproductive age (15 to 49 years) their partners and babies are eligible to participate in the project, irrespective of their marital status and whether pregnant or not able to participate

PROJECT MANAGEMENT TEAM
The project is coordinated by Dr. Salma Anas-Kolo who is being supervised directly ythe NASCP programme manager, Dr. Nasir Sani-Gwarzo. The project site coordinators at the six sites are:

1. Dr. E. Emuveyan - Chairman PMTCT Taskforce and the coordinator, Lagos University Teaching Hospital
2. Dr. H. Onah - Coordinator, Uniersity of Nigeria Teaching Hospital, Enugu
3. Dr. C. Chamma - Coordinator, University of Maiduguri Teaching Hospital, Maiduguri
4. Dr. C. Agboghoroma- Coordinator, National Hospital, Abuja
5. Dr. C. Akani - Coordinator, University of Port Harocurt Teaching Hospital, Port Harcourt
6. Dr. Randawa - Coordinator, Ahmadu Bello University Teaching Hospital, Zaria

Two project zonal coordinators, project accountant and data manager will be recruited.

MAJOR HEALTH COMPONENTS
Voluntary counselling and confidential testing
Provision of nevirapine to expectant mothers and babies for PMTCT of HIV
Modification of obstetric practices
Modification of infant feeding practices

**B.2 Programmatic monitoring and evaluation:** (*Guidelines para. 34-37*) (The proposal needs to include an outline of the monitoring and evaluation process that will be followed in relation to the overall proposal, including timelines, and baseline data, responsibility for collection, proposed/anticipated use of the information to be collected and involvement of target population with monitoring and evaluation. [Section C requests monitoring and evaluation information on major components])

A comprehensive monitoring and evaluation system is built into the project to ensure that the project achieves the intended goal.

Monitoring:

A standard monitoring schedule was developed and will be applied to all six project sites. The monitoring schedule will be comprised of simple and precise information, so as to make it easy for completion and also to ensure compliance by the implementation team, the monitoring team and the CCM.

The project site coordinator supervises the project site, ensures that all forms are completed accurately at the end of each month. In the early stages of the project a coding system will be devised to provide confidentiality of information collected. The site will hold monthly meetings and write monthly reports to NASCP, who will subsequently report to NACA.

A taskforce on PMTCT+ of HIV has been set-up to monitor the project. The aim of the taskforce is to ensure that the project is implemented according to specifications as scheduled in the work plan. They are also expected to identify constraints during the conduct of the project and offer appropriate intervention measures. At the end of the project the team, including external facilitators, will evaluate the project.

The team of the taskforce comprise of experts on HIV/AIDS, project site co-ordinators, officials of FMOH (Reproductive Health, Baby Friendly Hospital Initiative, Nutrition, Foods and Drugs) and representatives of frontline stakeholders. They were trained for five days on PMTCT of HIV and the overall objective of the project.

Quarterly monitoring visits will be conducted by the taskforce to all project sites using the monitoring schedule designed and reported to NASCP for onward transmission to NACA. Thereafter, quarterly meetings will be held by the taskfore team to deliberate on the progress of the project and where necessary effect changes. A simple monitoring tool was also developed for use at the project site.

**B.3. Financial management** (*Guidelines para. 19-22, 38-40*) (Describe arrangements in place for financial management, including suggested disbursement mechanisms and plans)

**An accountant will be recruited from a private firm and will be responsible for all expenses/disbursement of funds. The project seeks to establish transparency and accountability in the project management. The project accountant will be based outside the Ministry of Health, but will report to the National PMTCT+ coordinator and the Country Coordinating Mechanism Financial Task Force. Funds will not flow through the Ministry's accounting mechanism. There will be three signatories to the account (CCM Chairman, NMCC Chairman and the NMCP Manager). Monthly financial reports will be submitted to the finance sub-committee of the CCM. The services of the CCM's independent accountant /auditor will be utilized.**

## B.4 Statement of Budget Requirements, Financial Commitments and Unmet Needs 2002 *(Guidelines para. 8, Annex III.2) (Demonstrate the additionality of the proposal)*

(US$)

### Budget Categories (please fill in according to plan)

*Human Resources*
*Logistics & supplies*
*Training & Supervision*
*Outreach Services*
*Commodities or products**
*Data & information systems*
*Other*
*(explain)*
*TOTAL*

**BUDGET REQUIREMENTS**

| | |
|---|---|
| TOTAL HUMAN RESOURCES | $1,063,849 |
| TOTAL LOGISTICS AND SUPPLIES | $503,161 |
| TOTAL TRAINING AND SUPERVISION | $1,110,245 |
| TOTAL OUTREACH SERVICES | $133,929 |
| TOTAL COMMODITIES OR PRODUCTS (ARVs, Infant formula, HIV reagents &consumables) | $1,592,777 |
| DATA AND INFO SYSTEMS | 20,936 |
| OTHERS- OPERATIONAL RESEARCH | $425,250 |
| TOTAL | $4,850,147 |

**Financial commitments, by source**

Government
$992,616

Civil Society
NIL

Private sector

NIL

Donors
UNICEF - $214,447
UNFPA - $6000
APIN - $18,500

Other
NIL

**TOTAL COMMITMENTS**

$1,231,563

**UNMET NEEDS**

$3,618,584

**including drugs*

**B.3 Duration** (provide an estimate):

Beginning and end dates:

From: February 2001 To: February 2010

Period to be covered by this request for financing:

From: 1st June 2002 To: 1st June 2003

## SECTION C: MAJOR COMPONENTS

**(separate Section C pages should be prepared for each major component of the proposal i.e. make more copies if needed.)**

**PROPOSAL COMPONENT** --- (Number separate components 1 to xx)

**C.1 Description:** (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

DISEASE SPECIFIC INTERVENTIONS
Voluntary counseling and confidential testing
Administration of nevirapine to mother and baby
Modification of obstetric practices
Modification of infant feeding practices, including administration of infant formula for HIV positive mothers who choose not to breast feed
Administration of ARV therapy to HIV positive mothers and HIV positive babies

WHAT IT SEEKS TO ACCOMPLISH
To establish PMTCT+ Centers of Excellence in six health facilities in six geopolitical zones of the country, where women of reproductive age groups, their partners and families will have access to effective PMTCTand care services

TARGET POPULATION
Women of reproductive age ( their partners and babies) are eligible to particpate in the project, irrespective of thei marital status and whether pregnant or not. Similarly, all women and their male partners attending the centers will be eligible to particpate.

IMPLEMENTING PARTNERS
FEDERAL GOVERNMENT OF NIGERIA -Federal Ministry of Health - National HIV/AIDS and STD Control Programme, Reproductive Health, Nutrition, Baby Friendly Hospital Inititaitve, Foods and Drugs National Action on HIV/AIDS, Ministry of Information, Ministry of Women Affairs and Youth Development and Ministry of Education

DEVELOPMENTAL PARTNERS - UNICEF, UNFPA, WHO, UNAIDS

BILATERAL AGENCIES - FHI, CDC, APIN, USAID, DFID and LATH

NON-GOVERNMENTAL ORGANIZATIONS - SWAAN, FOWMAN, STOPAIDS, HALT AIDS
NETWORK OF PEOPLE LIVING WITH HIV/AIDS

STRATEGIES FOR IMPLEMENTATION

1.Strengthen PMTCT+ centers with VCT and care services, includiong ARV therapy to HIV positive mothers and their infected babies
2.Build capacity of health workers on PMTCT +, and laboratory skills.
3.Improve and create awareness of the community members, including women's groups, religious and community leaders, media groups and PLWHA through effective, appropriate and acceptable Information, Education and Communication materials.
4.Sensitize policy makers and leaders on PMTCT+ through advocacy.
5.Development standard training materials on PMTCT+ and VCT for health workers
6.Establish linkages with NGOs and community care providers

**C.2 Objectives and indicators** (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)

**To strengthen the recently launched PMTCT+ Centers with an operational VCT programme and to provide care services so that Centers of Excellence offer women and their famililes access to the spectrum of health services needed to address HIV issues**

- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets) (*Guidelines para. 34-37*)

**INDICATOR**
**Baseline**
**Targets**

**2001**
**2002**
**2003**
**2004**
**2005**
**2006**

**Since PMTCT was just launched in Nigeria, no baseline data per se are available. However, based on prevalence rates and current hospital admissions, we have estimated key measurements of success for the first year. These actuals will establish our baseline which will, through clinic scaleability and expansion, increase the targets by a high percentage every year. The chart for this estimate does not fit in this space. Please see: Table 3 on Page 12 of the main PMTCT+ Centers of Excellence proposal.**

**C.3 Programmatic monitoring and evaluation plans:** (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

**The project site coordinator supervises the project site, ensures that all forms are completed accurately by the end of each month, and provides leadership and insights about innovative strategies for improving programme management. In the early stages of the project a coding system will be devised to provide confidentiality of information collected. The site implementation will hold monthly meetings and reports monthly to National AIDS STD Control Programme (NASCP), who will subsequently write to the National Action Committee on AIDS (NACA).**

**A Task Force on PMTCT of HIV has been set-up to monitor the project. The aim of the taskforce is to ensure that the project is implemented according to specifications as scheduled in the work plan. They are also expected to identify constraints during the conduct of the project and offer appropraite intervention measures. The project will be evaluated twice annually by a team of experts.**

**Quarterly monitoring visits will be conducted by the Task Force at all project sites using the monitoring schedule designed and reported to NASCP for onward tranmission to NACA. Thereafter, quarterly meetings will be held by the taskforce team to deliberate on the progress of the project and where necessary effect changes**

**Two massive evaluations by teams of international experts twice per year who will submit reports to MOH, the CCM, and the Centres themselves.**

**C.4 Duration:** (provide an estimate)

Beginning and end dates:

From: February 2001 To: February 2010

Period to be covered by this request for financing:

From: 1st June 2002 To: 31st May 2003

**C.5 Implementation Plans including resource allocations to partners** *(Guidelines para. 40)*

(US$)

| | Budget Categories (please fill in according to your plan) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Implementing Partner** | *Human Resources* | *Logistics and supplies* | *Training & Supervision* | *Outreach Services* | *Commodities or Products** | *Data & information systems* | *Other (explain)* | ***TOTAL*** |
| Government | 957,852 | Nil | 30,300 | Nil | Nil | 4,464 | Operational research Nil | 992,616 |
| Civil Society | NIL | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
| Private sector | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
| Donors | Nil | Nil | 102,225<br>6000<br>18,500 | Nil | Nil | 16,472 | 95,750 | 238,947 |
| Other | | | | Nil | | | | |
| **TOTAL** | 957,852 | Nil | 157,025 | Nil | Nil | 20,936 | 95,750 | 1231563 |

**Including drugs*

**Attachment 1:** List of Supporting Documents

*Please note which documents are being included with your proposal by indicating a document number*

| **General documentation:** | **Attachment #** |
|---|---|
| 1. Poverty Reduction Strategy Paper (PRSP) | _____ |
| 2. Medium Term Expenditure Framework | _____ |
| 3. Sector strategic plans | _____ |
| 4. Any reports on performance | _____ |
| **HIV/AIDS specific documentation:** | **Attachment #** |
| 5. Situation analysis | I |
| 6. Baseline data for tracking progress[1] | II |
| 7. National strategic plan for HIV/AIDS, with budget estimates | III |
| 8. Results-oriented plan, with budget and resource gap indication (where available) | _____ |
| **TB specific documentation:** | **Attachment #** |
| 9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control | _____ |
| 10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents | _____ |
| 11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form) | _____ |
| 12. Most recent independent assessment/review of national TB control activities | _____ |
| **Malaria specific documentation:** | **Attachment #** |
| 13. Situation analysis | _____ |
| 14. Baseline data for the tracking of progress | _____ |
| 15. Country strategic plan to Roll Back Malaria, with budget estimates | _____ |
| 16. Result oriented plan, with budget and resource gap indication (where available) | _____ |
| **Crosscutting documents/activities** | **Attachment #** |

[1] Where baselines are not available, plans to establish baselines should be included in the proposal.

**List of submissions to GFATM with the PMTCT proposal form**

Attachments

1. National HIV/AIDS Seroprevalence survey report (2001)
2. HIVAIDS Emergency Action Plan (HEAP)
3. National guidelines for Prevention of Mother to Child Transmission (PMTCT) of HIV programme in Nigeria.
4. National manual for data collectors on PMTCT formative research
5. PMTCT main proposal
6. Detailed activity budget
7. Bibliography
8. Gantt chart for PMTCT implementation
9. List of acronyms
10. List of PMTCT Taskforce members
11. PMTCT + site monitoring form
12. Report of MTCT needs assessments visits to project sites
13. Report of PMTCT advocacy visits to project sites

# Country Proposal Document

# PROPOSAL FOR PMTCT+ PLUS CENTERS OF EXCELLENCE (EXPANSION OF CURRENT PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV PROJECT).

PROPOSAL SUBMITTED TO THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

BY

NIGERIAN COUNTRY COORDINATING MECHANISM
ABUJA, NIGERIA

MARCH 2002

## LIST OF DOCUMENTS ATTACHED TO THE PROPOSAL

| | |
|---|---|
| Attachment 1. | Needs Assessment Report to PMTCT project sites. |
| Attachment 2. | National HIV/AIDS surveillance report (2001). |
| Attachment 3. | HIV/AIDS Emergency Action Plan (HEAP). |
| Attachment 4. | National guidelines for the Implementation of PMTCT programme in Nigeria. |
| Attachment 5. | National manual for data collectors on PMTCT formative research |

# PROPOSAL FOR PMTCT+ PLUS CENTERS OF EXCELLENCE (EXPANSION OF CURRENT PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV PROJECT).

NIGERIAN COUNTRY COORDINATING MECHANISM
ABUJA, NIGERIA

MARCH 2002

## TABLE OF CONTENTS

## PROPOSAL OVERVIEW

Much of this attached proposal was prepared and submitted to be funded by the Federal Government of Nigeria in collaboration with other relevant stakeholders on Prevention of Mother to Child Transmission of HIV (PMTCT+) implementation in Nigeria namely UNICEF, WHO, UNAIDS, UNFPA and other bilateral donor agencies. However, as we begin implementation, a number of enormous financial gaps have emerged. This proposal to the GFATM seeks to fill these gaps, and link all existing and previously committed activities with activities which are vital but are currently under or non-funded. Without expanded financial assistance, the implementation of PMTCT in Nigeria will simply not succeed. The essential spectrum of services is seriously lacking, with the initial focus having been placed simply on lowering mother to child transmission, but not on the additional needs of mothers and their families.

We began the launching of the PMTCT project at the six sites for PMTCT services about a year ago (February 2001). Funding falls short of care and support needed and critical gaps, which have emerged, relate specifically to:

- Voluntary Counseling and HIV testing
- Breast milk substitute for babies born to HIV positive mothers who choose not to breast feed
- Development of communication strategies, including advocacy tools
- Development, production and dissemination of VCT guidelines and training manuals
- Anti-retroviral therapy for HIV positive mothers
- Management of opportunistic infections, especially tuberculosis (TB) for HIV positive mothers.
- Awareness creation and community mobilization/sensitization on PMTCT+
- Production and dissemination of Information, Education and communication (IEC) materials on PMTCT+/VCT

uptake, infant feeding practices in the light of HIV positive test, and community perceptions of the current programme implementation.

- Monitoring and supervision of the project implementation

The total cost for the PMTCT+ project in Nigeria at the six centers of Excellence is **$4,326,050** The Government of Nigeria and other stakeholders have already committed $1,210,627 since the beginning of the project implementation. A total of **$3,115,423** is required to fill the gap and move forward in the implementation of PMTCT+ at the six Centers of Excellence. We request that GFATM help us fill these gaps and thereby create Centers of Excellence to serve as models for the nation to be scaled out in the future.

We already started the basic PMTCT+ project at the six sites, but the GFTAM funds would allow us to address the inadequacies in that process and to establish true Centers of Excellence. Funding is currently provided by government, UNICEF, UNFPA, WHO and APIN. The details of areas supported and committed to the project are indicated in the detailed budget.

The pilot PMTCT+ project is being implemented in six reproductive in health facilities in the six geopolitical zones of Nigeria. It commenced in February 2001 with situational analysis of each of the sites and subsequently the sites were upgraded to standard specifications to provide basic antenatal, delivery and post-natal counselling and HIV screening. The project has involved the training of staff on all aspects of mother to child transmission of HIV, universal precautions and antiretroviral therapy, counselling and laboratory HIV screening procedures. Outreach care providers (Traditional Birth Attendants (TBAs, Voluntary Health Workers (VHWs), etc) within the selected environs will also be trained on PMTCT+ and counselling of People Living with HIV/AIDS (PLWHA).

In addition, advocacy visits have been conducted to the six sites, to sensitize and gain the support of the policy makers and other relevant stakeholders within the communities. Public enlightenment campaigns, and sensitization of women's groups and media organizations in the selected project sites are also an integral part of project implementation. Similarly, formative research on knowledge, attitudes, practices and expectations of the general population on PMTCT+ from the six sites are awaiting analysis and will subsequently be used for development of a communications strategy. Furthermore, operational research will be conducted from June 1$^{st}$ 2002 to 1$^{st}$ June 2002 during the period to identify factors within the communities that could mitigate the success of the PMTCT+ project.

The duration of this project proposal is expected to be one year from 1June 2002 to 30$^{th}$ June 2003. When the initial centers are assessed by the monitoring and evaluation team and the Country Coordinating Mechanism (CCM), we shall begin scaling the programme out in tertiary, secondary and primary health facilities. The Country Coordinating Mechanism will be submitting a proposal for expansion to the primary and secondary Health Care facilities. The lessons learned from the six PMTCT+ Centers of Excellence will be scaled up to 12 secondary levels of care and thereafter to 12 centers at the local government centers the next six months. We hope to expand the project nationwide to all levels of care within the next 4 years.

**GOAL**

To establish PMTCT+ Centers of Excellence in six health facilities in the six geopolitical zones of the country, where women of reproductive age groups, their partners and families will have access to effective PMTCT++ and care services.

**Specific Objectives**

1.To strengthen the recently launched PMTCT centers with operational VCT programme and care services

2. To provide VCT services to 18,000 pregnant women attending antenatal clinical services in the centers.

3.To enable 14,400 women know their status by the end of the period

4.To provide anti-retroviral drugs as prophylaxis for 912 HIV positive pregnant women and to 912 babies.

5.To provide access to comprehensive care services to 912 HIV positive women and 456 HIV infected babies within the period, which will include anti-retroviral therapy, management of opportunistic infections, STI management and access to family planning services.

6.To train at least 250 counselors on HIV/AIDS and infant feeding counseling from the six sites and 30 laboratory scientists on HIV testing.

7.To establish best practices and trained personnel who can replicate the lessons learned to the secondary and primary levels of care.

8.To establish an education campaign in the six project sites, so as to inform and mobilize the community, including People Living with HIV/AIDS about the overall objectives of the PMTCT+ programme.

The number of the population that will have access to the six PMTCT+ centers may appear small compared to the magnitude of HIV/AIDS problem in Nigeria. However, there is great need to pilot the PMTCT+ programme in the country at the six tertiary facilities, where a reasonable capacity already exist, so as to be able to gain experience thus the lessons learned will guide in the expansion of the programme nationwide.

The recent national HIV sero-prevalence survey conducted in Nigeria revealed that about 5.8% of women attending the antenatal clinic (ANC) were infected with HIV (NASCP-FMOH, December 2002). The majority of the women infected are young girls between 15 to 25 years. According to the National Planning Commission, women of childbearing age constitute about 25% of the population of 120 million people (National Population Commission, Reports; 1991). The target groups are in dire need of appropriate information, HIV screening and counseling on HIV/AIDS, in order to be able to make informed choices and decisions that will affect their lives and families.

Several studies have shown that pediatric AIDS cases are rising at an alarming rate. According to the Joint United Nations Programme on AIDS (UNAIDS), it is projected that about 755,000 pediatric AIDS cases will occur by the year 2002 in Nigeria (UNAIDS, 1999). Similarly, surveys indicate that more than 90% of HIV infections in children less than 15 years are acquired from their mothers. Between 14 and 40% of babies born to HIV mothers acquire the infection either during pregnancy, intra-partum or through breast-feeding (Moernle, E.H. et al 1995). The burden of mother to child transmission of HIV is much higher in sub-Saharan Africa compared to the rest of the world, because of higher levels of hetero-sexual transmission, high female: male ratio, high total fertility rate (TFR) and high levels of breast-feeding.

In view of the above, the Federal Government of Nigeria identified the need for urgent implementation of PMTCT+ interventions, which greatly reduce the transmission of HIV from infected mothers to their babies. In the interest of rapidly meeting that specific need, the Ministry of Health (MOH) began implementation. Unfortunately, that implementation falls short of meeting the needs of mothers long after giving birth, the needs of fathers, and the needs of siblings. These PMTCT+ Centers of Excellence will establish a benchmark for high quality care offered to the entire family.

The rising trend of HIV/AIDS among women could be a result of a combination of social and biological factors. The biological make up of the female vagina enhances HIV transmission from men to women more than the other way round. The common practice, whereby young girls indulge or are coerced into having sex with elderly men because of their financial difficulties greatly expose them to the risk of HIV and other STI's.

There is great need for Voluntary Counseling and Testing (VCT) in all P of Excellence in Nigeria to be made accessible for all women of reproductive age, irrespective of social status or educational background. Surveys conducted among university students in the USA (Anastasi et al. 1999) have shown that 59% of the students seeking HIV antibody testing were women with average age of 22.6 years. Similarly, a survey conducted in Tanzania showed that 55.9% of people who volunteered for VCT were adult women (Killewo, et al. 1998).

The aim of VCT is to help the woman take necessary action to ensure that they do not become infected with HIV. However, if a woman becomes infected the aim is to help her protect her own health, that of her sexual partner and that of her family. In addition to VCT, intervention strategies to reduce MTCT of HIV include the use of anti-retroviral drugs, replacement feeding, early weaning from breast-feeding and caesarean section.

A recent trial on reducing MTCT was conducted in Uganda using Nevirapine. It was found that two doses of Nevirapine could dramatically reduce the transmission of HIV from MTC. The trial showed that of the 300 women who took a single dose of the drug only 40 babies were infected with HIV. Their babies were given a single dose of Nevirapine at birth and the mothers also continue to breastfeed (Health/AIDS/CNN. 1999).

In Africa breast-feeding is responsible for a high proportion of mother to child transmission of HIV, where 1 in 7 children born to HIV positive mothers will be infected through breast milk (Fowler, et al. 1999). This project seeks to respond to the challenges through trained staff, availability of anti-retroviral drugs, voluntary and counseling services and continuum of care.

**Project sites**

The PMTCT+ Centers of Excellence will be implemented in all the six geopolitical zones of Nigeria. In each of the following centers, a PMTCT+ Center of Excellence has been established.

**Table 1: PMTCT+ Centers of Excellence by geographical distribution and HIV prevalence as at 1999.**

| Sino | PMTCT+ centers | Geographical zone | Prevalence in 15 – 49 years (%) |
|---|---|---|---|
| 1 | Ahmadu Bello University Teaching Hospital, Zaria, Kaduna state. | North West | 11.6 |
| 2 | National Hospital, Federal Capital Territory, Abuja. | North Central | 7.2 |
| 3 | University of Maiduguri Teaching Hospital, Maiduguri, Borno state. | North East | 4.5 |
| 4 | Lagos University Teaching Hospital, Lagos. | South West | 6.7 |
| 5 | University of Port Harcourt Teaching Hospital, Port Harcourt. | South South | 3.3 |
| 6 | University of Nigeria Teaching Hospital, Enugu. | South East | 4.7 |

The selection criteria were based on geopolitical location, high HIV prevalence rate of the state (1999 National seroprevalence survey data) and the availability of reasonably good antenatal and delivery services. The availability of functional laboratory and HIV screening facilities were considered as well as adequate and skilled manpower.

Women of reproductive age between 15 and 49 years (and their partners) are eligible to participate in the project, irrespective of their marital status and whether pregnant or not. They will be provided with adequate information on MTCT of HIV and VCT and the benefits of the project.

**Table 2: Number of HIV positive women expected at each site per year.**

| Project site | Number of ante-natal clinic attendees | HIV Prevalence in 15 to 49 year olds (%) | Number expected to be HIV positive |
|---|---|---|---|
| Ahmadu Bello University Teaching Hospital, Zaria, Kaduna state. | 3000 | 11.6 | 348 |
| National Hospital, Federal Capital Territory, Abuja (NHA). | 3000 | 7.2 | 216 |
| University of Maiduguri Teaching Hospital, Maiduguri, Borno state (UMTH). | 3000 | 4.5 | 135 |
| Lagos University Teaching Hospital, Lagos (LUTH). | 3000 | 6.7 | 201 |
| University of Port Harcourt Teaching Hospital, Port Harcourt (UPTH). | 3000 | 3.3 | 99 |
| University of Nigeria Teaching Hospital, Enugu (UNTH). | 3000 | 4.7 | 216 |
| Total | 18,000 | | 1140 |

The number of women attending the antenatal clinics at the six PMTCT+ Centers is consistent, because the populations in the catchment areas of the facility in the region and the population density are roughly equal.

The PMTCT+ project is coordinated by Dr Salma Anas Kolo who is being supervised directly by the National AIDS Control Programme manager Dr Nasir Sani-Gwarzo.

The project site coordinators are coordinating the six sites as follows:

1. Dr Ejiro Emueveya – Chairman PMTCT+ Taskforce and the coordinator, Lagos University Teaching Hospital, Lagos.
2. Dr H. Onah – Coordinator, University of Enugu Teaching Hospital, Enugu
3. Dr C. Akani- Coordinator, University of Port Harcourt Teaching Hospital, Port Harcourt.
4. Dr C. Chama – Coordinator, University of Maiduguri Teaching Hospital, Maiduguri.
5. Dr Randawa – Coordinator, Ahmadu Bello University Teaching Hospital, Zaria.
6. Dr C. Agboghoroma – Coordinator, National Hospital, Abuja.

Two consultants will be required to monitor the regional activities during the period and report back to the PMTCT+ coordinator. There is a also need to recruit the services of a full time accountant and a data analyst.

**Financial Management:**

An accountant will be recruited from a private firm who will be responsible for all expenses/disbursement of funds for perdiem, travels, drugs, equipment etc. The person will be based outside the Ministry of Health, but will report to the National PMTCT+ coordinator and the Country Coordinating Mechanism financial taskforce.

**Cascade of PMTCT+ programme**

All of the women attending ante-natal clinics at the Centers of Excellence will have access to pre-test group counseling as part of the routine ante-natal clinic talk and individual pre-test counseling for HIV testing.

Therefore, we can expect that of all women (18,000) who will have access to information on PMTCT+ and voluntary counseling at the six Centers of

[illegible] 80% (11,520) will come back for their results, assuming that HIV positive woman will return at the same rate as HIV negative ones. Using the state rate prevalence as shown on Table 2, a total of 1140 women will be HIV positive from the six Centers over the one year of which we can expect 80% (912) to receive the intervention (Nevirapine). Among these 912 HIV positive women, we anticipate that it should be possible to prevent at least 50% (456) of these HIV infections (refer to Table 3 for details).

**Table 3: Number of HIV positive pregnant women expected to receive the intervention in each PMTCT+ Centers by the end of June 2003**

| PMTCT+ Centers | # to be tested for HIV | Number of women returning for results | Number of HIV positive pregnant women | Number expected to receive the ARV (Nevirapine) | Number of HIV infections averted in children |
|---|---|---|---|---|---|
| NHA, Abuja | 2,400 | 1,920 | 216 | 172.8 | 86.4 |
| UNTH, Enugu | 2,400 | 1,920 | 141 | 112.8 | 56.4 |
| LUTH, Lagos | 2,400 | 1,920 | 201 | 160.8 | 80.4 |
| UMTH, Maiduguri | 2,400 | 1,920 | 135 | 108 | 54 |
| UPTH, Port Harcourt | 2,400 | 1,920 | 99 | 79.2 | 39.1 |
| ABUTH, Zaria | 2,400 | 1,920 | 348 | 278.4 | 139.2 |
| TOTAL for 2002-2003 | 14,400 | 11,520 | 1140 | 912 | 456 |
| 2003-2004 | 43,200 | 34,560 | 3,420 | 2,736 | 1,368 |
| 2004-2005 | 72,000 | 57,600 | 5,700 | 4,560 | 2,280 |
| 2005 – 2006 | 144,000 | 115,200 | 11,400 | 9,120 | 4,560 |

**1. Stakeholder analysis**

The stakeholder analysis was an important activity towards the successful implementation of the project. It includes identification of the relevant stakeholders to the project: eligible women of reproductive age groups, the policy makers, community leaders, women's groups, and PLWHA. Other relevant stakeholders were involved in the management of the selected project sites including project site coordinators and representatives of the FMOH. The international agencies, donor agencies, private sectors, NGOs and the CBOs working on HIV/AIDS are also be involved in the stakeholder analysis. The NGOs and CBOs will be actively involved in the community outreach activities. The basic aim of the analysis was to inform all the relevant stakeholders on the current ideas about PMTCT+ of HIV, its importance and the need for implementing the project in Nigeria. The analysis also mobilizes resources within the communities involved, and also to achieve their overall support, involvement and participation for the project.

**2.Problem analysis**

2.1 Each of the six health facilities in the country was assessed in terms of the availability of basic and essential antenatal, delivery, post-natal and laboratory services. The information on the number of skilled staff, annual deliveries, and women screened voluntarily and counseled for HIV and pediatric AIDS cases were gathered. A questionnaire was designed to cover all the required information and analyzed to provide baseline information about the sites that may require strengthening before the take off of the project. Please see appendix VII for a detailed report of the needs assessment of the six centers.

**Output related activities**

**1. PMTCT+ Centers of Excellence strengthened and operational PMTCT+ programme established.**

1.1The selected PMTCT+ centers were strengthened to standard specifications to be able to provide basic antenatal, delivery, laboratory and HIV counseling services. Based on the outcome of the needs assessment, the center that required equipment, renovation or more staff was strengthened. All the sites

December 2001.

1.2 Train counselors on PMTCT+

A total of 40 qualified nurses and social workers working in the ante-natal, delivery, post-natal and social welfare units were selected from the P of Excellence and trained on HIV/AIDS counseling. The training covered all aspects of PMTCT+ of HIV, including infant feeding, modified obstetrics practices, FP, ARV and counseling male partners.

Similarly, we wish to expand the training program in order to ensure that all learning is diffused among the workers at each site. We have therefore planned six counseling training workshops, which are scheduled for the six sites, to include at least 35 participants per site. Three resource persons (drawn from operational sites and experts from Lagos, Kano, Jos, and Abuja), two facilitators (from the MOH) and three support staff (from the MOH) will conduct each of the training. Materials required for the training will include stationer, training modules, flip charts, TV, VCR, video films, pamphlets and posters. APIN has already committed funding for the trainings.

1.3 Train laboratory scientists and technicians

Laboratory technicians and scientists will be trained on HIV screening to improve their skills and standardize their procedures, in order to be able to provide counseling, accurate HIV confidential testing in the selected sites. A total of 30 laboratory scientists and technicians will be trained for five days at one site, in Zaria. Two experts (from MOH in Abuja and from National Institute of Medical Research in Lagos), one facilitator (from the MOH) and one support staff (from MOH) will be required to conduct the training. Also stationer, flip charts, posters, reagents and equipment will be required for the training workshop. No funds are currently committed.

1.4 Train women's groups on PMTCT+

Five day Training workshop will be organized for representative of women groups at each site. These workshops are aimed at providing appropriate and adequate knowledge on PMTCT+/VCT to women. NGOs and CBOs which have experience in counseling such as Society for Women and AIDS in Nigeria (SWAAN), Federation for Muslim Women Association of Nigeria (FOMWAN), Network of People Living with HIV/AIDS (NNPLWHA), STOPAIDS, HALTAIDS, Christian Health Association of Nigeria (CHAN), Islamic Medical Association of

the workshop. Two staff from the Ministry of Women Affairs will facilitate the workshop. In addition to writing materials, posters, pamphlets and flip charts, two resource persons, two facilitators and two support staff will be required for the workshop. Funds have not been committed yet.

1.5 Train Community outreach care providers on PMTCT+

The training of 30 community out-reach care providers on PMTCT+, will target mainly community based care providers, such as Traditional Birth Attendants (TBAs), Village Health workers (VHW) and Voluntary Health workers within the catchment area of the project sites. A five-day training workshop will be conducted at each site. Three facilitators and three support staff from the MOH will carry out the training. Materials such as film charts, and IEC materials will be required for the training workshop. No funds committed to the training.

**2. Information Education and Communication (IEC) programme on the transmission of HIV from mother to child developed and functional at the six Centers.**

2.1 Organize public awareness campaigns

The Ministries of Health, Education and Information in collaboration with NGOs will organize IEC campaigns at the selected states to enlighten the general public on PMTCT+. The public campaigns will include public lectures and rallies. Schools, barracks, male clubs and associations and work places will be targeted. IEC interventions will be sustained throughout the project implementation period, which will include production and distribution of IEC materials, use of traditional theaters and appropriate channels of communications, such as town criers and praise singers. No funds have been committed for the IEC campaigns.

2.2 Conduct advocacy visits to policy makers and community leaders

Advocacy visits were conducted to the six sites targeting policy makers and community leaders, including religious leaders, youth groups and PLWHAs. A fact sheet on PMTCT+ was developed to enlighten the target groups. The advocacy visits were conducted by stakeholders from the MOH namely; National AIDS Control Programme (NASCP), Baby Friendly Hospital Initiative (BFHI) and Reproductive Health. National Action Committee Action on AIDS (NACA) and UNICEF were also represented. The government, through NACA, sponsored the advocacy visits. For details, please see appendix VII.

Posters and pamphlets with simple, clear and acceptable messages on PMTCT+ will be produced and distributed to the general public. It will also be made available at the centers for everybody in need of information on PMTCT++ and during training and sensitization workshops. The posters will be field tested in the six pilot sites and, based on the outcome, a final version will be produced that will be acceptable and sensitive to the cultural settings of the people. Funds are not allocated.

2.4 Development of PMTCT+ guidelines for health workers

Experts from institutions and members of the taskforce on PMTCT+ have developed comprehensive guidelines. It provides update information to health workers working in the relevant departments and actively involved in providing care for pregnant women, during labour/delivery and post-partum. These guidelines have been finalized, but we wait funds for production and dissemination.

2.5. Development, production and dissemination of VCT guidelines and training manual.

VCT is a critical part of the PMTCT+ implementation programme. Thus, we to developed a comprehensive VCT guideline for health workers and facilitators, and also training manual. A draft guideline was developed, but yet to be finalized. Technical assistants will be drawn both from local and international sources to finalize the training guide and to develop a draft training manual. This will later be field tested among health workers and finalized at a 2 day critique workshop, which will involve experts on HIV/AIDS counseling, infant feeding counseling and ARV therapy. Funds are not committed.

2.6 Sensitize mass media organizations

The Ministries of Health and Information will organize two batches of one-day sensitization workshop for 35 senior representatives of media organizations from the six project sites in Maiduguri, Borno State. The aim of this is to provide them with adequate and appropriate messages on PMTCT+ for dissemination to the general public. Two facilitators, two resource persons and a member of support staff will be required to conduct the workshop. They will be drawn from the Ministry of Information and MOH. Writing materials, flip charts, media kits, posters and leaflets will be required. No funds committed.

2.7 Sensitize women in the media

mobilize women of reproductive age groups to access PMTCT+ services. A total of 30 media women will be identified and sensitized in a one-day workshop. The workshop will be held in Enugu, Enugu State. Two resource persons, two facilitators and two support staff drawn from the Ministries of Information, Women Affairs and Health will conduct the sensitization workshop. Media kits will be required for the workshop. No funds are currently committed.

2.8 Sensitize NGOs

The Ministries of Health and Information in collaboration with NACA will organize two batches of one-day sensitization workshops for NGOs actively involved in PMTCT+ and VCT. About 70 NGOs will be sensitized on PMTCT+ and VCT. No funds committed.

2.9 Arrange monthly Radio and TV programmes

Radio and Television programmes will run for a week at monthly intervals in the six sites over the one-year period. The programmes will be broadcast in English and the local languages of the areas. Funds are not committed.

**3.PMTCT+ training programme developed and operational in the selected six centers.**

3.1 Integrate VCT into Family Planning services

The trained health workers and counselors provide information on PMTCT+ to clients attending Family Planning clinics. VCT has been incorporated into Family Planning sessions and the trained health workers will adequately sensitize all staff working in Family Planning clinics.

3.2 Organize antenatal clinic sessions to include PMTCT+

The trained health workers of the facility will train all staff of the antenatal clinic on PMTCT+. The aim of integrating VCT into antenatal sessions in each of the project sites is to ensure that all women attending antenatal clinics have access to adequate information on how to prevent transmission of HIV.

3.3 Promote male involvement

All males will have access to adequate information on the PMTCT+ at the centers and from the public awareness campaigns. As part of the counseling training, the health workers will also acquire skills on counseling the male partner and significant others.

3.4 Provide confidential testing

partners using the HIV rapid test technique. All positive tests shall be repeated using another rapid test that has a different antigenic property. The counselor will disclose the HIV status of participants and will offer on going counseling thereafter. Infants will be screened for HIV at 18 months of age. We request funds for free HIV testing.

3.5 Provide pre and post-test counseling for consenting women and their partners

Counseling will be provided to all consenting women and their partners by trained counselors in a confidential environment in the center. All information collected will be strictly confidential. The counseling will include pre, post and on-going HIV counseling. All pregnant women attending the PMTCT+ Centers of Excellence will have access to the PMTCT+ services.

**4. Improved health worker practices on PMTCT+ and VCT**

4.1Train and update heath workers (clinicians) on PMTCT+

Improved health worker attitudes and practices on PMTCT+ will be established and functional in the project sites through sensitization and training workshop. A five-day training workshop was organized for 40 health workers from the project sites at two sites to update them on current PMTCT+ practices and the universal procedures. The health workers were drawn from both public and private sectors, including NGOs. Three resource persons, three facilitators and two support staff will be required for the conduct of each workshop. The training has taken place in Abuja. UNICEF sponsored the workshop in collaboration with Government.

4.2 Train clinicians on universal precaution

Same group of health workers (4.1) have been trained on universal precautions, in order to reduce their risk of exposure to HIV and also to reduce the risk of transmitting HIV to patients.

4.3 As above (4.1) same group of health workers (clinicians) were also trained on the appropriate use of ARVs including monitoring the progress of patients on ARV and the side effects.

4.4. Train communities care providers on PMTCT+. Trainees include: (Community Health Officers, Community Health Extension Workers), and Junior Community Health Extension Workers) on PMTCT+ and counseling on infant

voluntary Health workers. About 180 (about 30 per site) health workers will be trained in each of the selected sites. Experts on nutrition, Reproductive Health and HIV/AIDS will be drawn from the institutions and MOH to conduct the training. No funds available.

4.5. Thirty PLWHAs (at least 5 per site) will be identified and trained on PMTCT+ for five days in Kaduna by officials from NGOs and MOH.

4.6 A national training of counselors was conducted by the Ministry of Health in collaboration with UNICEF where, 40 nurse/midwives were trained as counselors. Similarly, a five-day regional training will be organized by the MOH in collaboration with the APIN project at the six sites. About 40 participants will be trained per site. Funds have already been committed for the training of counselors at the six project sites by UNICEF and the APIN project.

4.7 Competence based supervision of the trained health workers practices will be instituted to ensure adequate practice on PMTCT+ issues, including universal precautions. The supervision will be built into the project monitoring system and conducted on an on-going basis. Experts will be drawn internationally and locally to monitor the project implementation. Currently, no funds have been committed for the monitoring exercise.

**5. Provision of Nevirapine**

A single dose of antiretroviral drug (Nevirapine), as a prophylaxis will be administered to consenting HIV positive mothers during labour. Similarly, a single dose of Nevirapine will be administered to their babies at birth. Boehringer Ingelheim has committed itself to provide free Nevirapine for PMTCT+ for the project sites over the period.

**6. Provide Breast milk substitute**

Infant feeding:

All consenting mothers will be counseled on available infant feeding options. This will enable them to make informed decision on a specific infant feeding option, depending on the individual's socio-economic status and cultural background. However, mixed feeding will be strongly discouraged at any time.

The infant feeding options will include:

- Exclusive breast feeding 6 months (EBF)

- Pasteurization of expressed milk ( $60^{0C}$ for 30 minutes)
- Heat treatment of expressed breast milk
- Home prepared infant formula e.g. Cow, camel or goat milk

However, breast milk substitutes in the form of infant formula will to be provided to babies born to HIV positive mothers, who choose not to breast-feed. Such babies will be on exclusive infant formula for the first six months of life, while complementary feeds will commence after six months. However, the baby will continue with the infant formula up to one year. There are no funds for the procurement of infant formulae.

**7. Involve Community members, including PLWHA.**

7.1 Prepare advocacy package on PMTCT+

Comprehensive advocacy tools will be prepared at national and a central training to be conducted for relevant community members, including PLWHAs and Persons Affected By AIDS. Experts will be drawn from the institutions, Ministry of Information, UNICEF and MOH to develop the tools, when funds are available.

**8. Evaluation reports including situational analysis report, pre and post test intervention surveys and operational research on factors constraining PMTCT+ implementation.**

8.1 Provide quarterly monitoring visits to project sites

A quarterly monitoring visit will be conducted to each of the centers by the monitoring team, to ensure that the project is implemented according to the stated plan. The project monitoring will commence on the 1st June 2002. Monitoring commenced with funds provided by government. However, funds are not available to continue monitoring. The monitoring team comprised of external experts and local experts from the institutions and some members of the PMTCT+ taskforce.

8.2 Conduct situation analysis of the six selected sites

A situational analysis of the project sites was conducted prior to the commencement of the project. The purpose of this analysis was to provide baseline information about the sites with regard to the equipment, infrastructure and staff available. Please see appendix VI for detailed report of the needs

planning and the institutional strengthening processes.

8.3 Conduct pre-test of knowledge, attitudes, practices and expectations (KAPE) of women with regard to PMTCT+. A questionnaire will be designed testing these areas with regard to PMTCT+. The questionnaire will be structured and self-administered to randomly selected women attending the centers. The data generated will be analyzed to determine their levels with regard to PMTCT+ prior to intervention. UNICEF has already committed funds for this research.

8.4 Conduct pre-test of knowledge and practices of health workers on PMTCT+. A questionnaire was designed and administered to randomly selected health workers in the project sites. The information collected will be analyzed to assess their knowledge and practices on PMTCT+ and to inform the content of future training. UNICEF has sponsored the activity.

8.5 Operational research in the form of key informant in-depth interviews on factors influencing the implementation and sustainability of PMTCT+ will be conducted. A cross section of men, including PLWHAs in all the selected sites will be targeted. The operational research will also, be conducted on the VCT uptake, ARV uptake infant feeding practices and community perceptions on PMTCT+/VCT. No funds committed.

8.6 Conduct post test on men, women and health workers with regard to knowledge and practices on PMTCT+. No funds committed.

8.7 Post-intervention questionnaire will be designed in June 2002 to test health workers and community members with regard to PMTCT+. The questionnaire will be administered to men, women and health workers in the selected project sites. The data will be collected and analyzed to determine the extent to which they have changed or improved as a result of the intervention. The project will be fully evaluated in December 2002 and June 2003 by the evaluation team using appropriate tools (See table 2 for details on evaluation). The evaluation team will be comprised of experts from within and outside the country. The overall project report including situational analysis, pre and post intervention surveys will be made available by the end of the project (31$^{st}$ June 2003). There will be quarterly monitoring of the project by the monitoring team and reports will be made to the CCM. No funds committed for the post intervention surveys, evaluation of the project, report writing and dissemination of findings.

**PMTCT+ Taskforce meetings:**

PMTCT+ taskforce meetings will be held quarterly, in order to review the progress of the PMTCT+ implementation. It will also provide an opportunity to all members to discuss and share experiences on current updates on PMTCT+/VCT.

Members of the Taskforce comprised of experts on HIV/AIDS, PMTCT+, reproductive Health and Nutrition. They are drawn from institutions, Ministries of Health, Information, Women affairs, Education, and also the international agencies, such as UNICEF, UNFPA, WHO, UNAIDS, CDC, DFID, APIN-Harvard, FHI, Policy project. Please see appendix V for the names of members of the PMTCT+ Taskforce in Nigeria.

## MONITORING AND EVALUATION

A comprehensive monitoring and evaluation system will be built into the project to ensure that the project is implemented according to the required standards, in order to achieve the set goal.

**Monitoring:**

A standard monitoring schedule was developed and will applied to all the six-selected project sites. The monitoring schedule will comprise of simple and precise information required, so as to make it easy for completion and also to ensure compliance by the implementation team, the monitoring team and the CCM.

The project site coordinator supervises the project site, ensure that all forms are completed accurately and all completed forms at the end of each month. In the early stages of the project a coding system will be devised to provide confidentiality of information collected and the PC cleanse the data and enter accurately into the computer. The site implementation will hold monthly meetings and reports monthly to NASCP, who will subsequently report to NACA.

A taskforce on PMTCT+ of HIV has been set-up to monitor the project. The aim of the taskforce is to ensure that the project is implemented according to specifications as scheduled in the work plan. They are also expected to identify constraints during the conduct of the project and offer appropriate intervention measures. At the end of the project the team including external facilitators will evaluate the project.

The team of the taskforce comprise of experts on HIV/AIDS, project site co-ordinators, officials of FMOH (Reproductive Health, BFHI, Nutrition Foods and Drugs) and representative of frontline stakeholders. They were trained for five days on PMTCT+ of HIV and the overall objective of the project.

Quarterly monitoring visits will be conducted by the taskforce to all project sites using the monitoring schedule designed and reported to NASCP for onward transmission to NACA. Thereafter, quarterly meetings will be held by the taskforce team to deliberate on the progress of the project and where necessary effect changes.

A simple monitoring tool was also developed for use at the project site. Please see Appendix V.

See table 4 for detailed information on monitoring.

| Activities | Indicators | Results | Responsibl e | Date |
|---|---|---|---|---|
| 1.1Provide basic equipment's facilities and staff | -Types and # of equipment provided<br>-No of staff identified/deployed | P of Excellence records | FMOH<br>PCs | 30//01/02 |
| 1.2 Training of counselors on PMTCT+ | -Type of training conducted<br>- Cadre and No of staff trained | Training records | FMOH<br>NASCP<br>PCs | 30/01/02 |
| 1.3 Training of lab. Scientists and technicians | -Type of training<br>-Cadre and No of staff trained | Report of workshop | NASCP<br>PCs | 30/01/02 |
| 1.4 Sensitize women groups on PMTCT+ | -Categories and # of women groups sensitized<br>-No of women sensitized | Report of workshop | NASCP,<br>SAPC<br>SMWA<br>PCs | 31/03/02 |
| 1.5 Train CHOs, CHEWS and JCHEWs on PMTCT+ | - Cadre and # Trained | Training records | NASCP<br>SAPCs<br>PCs | 31/03.02 |
| 1.6 Train TBAs, VHW's on counseling and infant feeding options | -Cadre and # trained | Training records | NASCP<br>PCs<br>SAPC<br>MCH coordinators | 31/04/02 |
| 1.7 Train PLWHA on PMTCT+ | -No of PLWHA trained<br>-Types of training conducted | Training records | FMOH | 31/06/02 |
| | | | | |
| 2.1 Develop and produce IEC materials | - # and types of IEC materials developed and produced | Records and inventory of IEC materials produced | NASCP<br>NACA<br>SAPCs<br>PCs | 31/03/02 |
| 2.2Organise IEC campaigns | -Types of IEC channels used<br>-# of people reached<br>- # of agencies involved<br>-# of activities and places | Activity report<br>Recorded programme | NASCP<br>SAPC<br>SMWA<br>SMI<br>PCs | 01/04/01 to 31/01/02 |
| 2.3 Conduct advocacy visits | -# of policy makers committed<br>-# of policy statements made<br>-# of commitments made | Reports of advocacy visits conducted<br>Reports of statement/co mmitments made | NASCP<br>SAPC<br>PCs | 30/04/01 |
| 2.4 Arrange monthly radio/TV programmes | -# of radio/TV stations involved<br>-# of slots ( per month and total)<br>-Type of messages aired | Recorded programmes<br>Slots chart record | NASCP<br>SAPC<br>SMI<br>PCs | 01/08/01 to 31/01/02 |
| 2.5 Sensitize and mobilize media groups | - # of media groups sensitized/mobilized<br>-# of media personnel sensitized/mobilized | Report of workshop | NASCP<br>SAPC<br>PCs | 30/08/01 |
| 2.6 Sensitize media women | - Types and # of media women sensitized | Report of workshop | NASCP<br>SAPC<br>PCs | 30/04/02 |

| | | | | |
|---|---|---|---|---|
| | | | | |
| 3.1 Set-up VCT in FP services | -No of FP-Clinics providing VCT services<br>-# of women offered VCT in FP clinic<br>-No of women accepting VC<br>-# of women accepting CT<br>-# of women collecting test result | FP records | PC | 30/04/02 |
| 3.2 Organize VCT during ANC services or delivery | -# of women attending ANC services<br>-# women offered VCT during ANC<br>-# of women offered at delivery<br>-# of women accepting VC<br>-# of women accepting CT<br>-# of women collecting test results | ANC records | PC | 30/08/01 |
| 3.3 Promote male involvement | -# of men accompanying their partners to ANC or FP clinics<br>-# of men offered VCT<br>-# of men accepting VC<br>-# of men accepting CT<br>-# of men collecting test results | Monthly reports | PC | 30/04/01 |

| Outputs/Activities | Data needed | How | By whom | When |
|---|---|---|---|---|
| | | | | |
| 4.1 Sensitize health workers (clinicians) on PMTCT+ | - Cadre and # of health workers sensitized on PMTCT+ | Report of workshop | NASCP SAPC PCs | 01/01/02 |
| 4.2 Sensitize health workers on universal precautions | - cadre and # of health workers sensitized on universal precautions | Report of workshop | NASCP PCs | 01/01/02 |
| 4.3 Train clinicians on appropriate use of ARV | - No of clinicians trained on ARVs | Report of workshop | NASCP PCs | 01/03/02 |
| 4.4. Promote safer obstetrics practices | - # of deliveries<br>- # of invasive ANC procedures<br>- # of ARMs done<br>- # of episiotomies done<br>- # of elective Caesarian sections performed for PMTCT+ | Hospital records<br>Project records | NASCP PCs | 01/03/02 |
| 4.5Institute competence based supervision of health workers practices | -# of Supervisory visits | Monitoring report | Monitoring team | 01/01/02 |

| | | | | |
|---|---|---|---|---|
| Nevirapine | Nevirapine<br>-# of women accepting Nevirapine<br>-# of infants who received Nevirapine | Project records<br><br>Monthly reports | UNICEF<br>FMOH | |
| | | | | |
| 5.1 Conduct operational research | -Constraints to large scale programming identified<br>-Prospects of large scale programming identified | -Researh findings | NASCP<br>SAPC<br>PC | 01/06/02 to 01/06/02 |
| 5.2 Dissemination of survey report | -# of reports disseminated<br>-# of forums of dissemination | Survey reports, seminars, conferences, meetings and workshops | FMOH<br>NACA<br>PCs<br>SAPC<br>UNICEF<br>UNAIDS<br>WHO<br>UNFPA<br>CDC | 31/06/03 |
| | | | | |
| 6.1Conduct needs assessment of project sites | -# of sites assessed | Reports of needs assessment conducted | FMOH<br>TF | 01/02/01 |
| 6.2Develop pre and post test questionnaire and apply | -# and type of pre and post intervention Questionnaire developed and applied | Reports of pre- and post intervention survey | FMOH<br>TF | 01/03/01 |
| 6.3 Conduct monitoring visits | -# of monitoring visits to sites conducted | Quarterly reports | FMOH<br>TF | 01/06/02 to 31/06/03 |
| 6.4 Evaluation of project | -Needs assessment report<br>-PC's monthly reports<br>-Quarterly reports<br>-Biannual reports<br>-Mid-term review<br>-Pre and post intervention surveys reports<br>- End of project review | Survey report<br>Project report | NACA<br>FMOH<br>TF<br>SAPC<br>PCs<br>UNAIDS<br>UNICEF<br>WHO<br>UNFPA<br>CDC | 01/06/03 |
| 6.5 Dissemination of project report | -# of evaluation reports produced<br>-# of evaluation reports disseminated<br>-# of forums utilized | Records of reports disseminated | UNAIDS<br>UNICEF<br>UNFPA<br>WHO<br>CDC<br>NACA<br>FMOH<br>TF<br>PCs<br>SAPCs | 31/08/02 |

**EVALUATION:**

Evaluation is an essential part of the project integrated at the initial stage, commencing with problem analysis, situation analysis and pre intervention surveys, which was done by the officials of the MOH, UNICEF and UNICEF consultant. The basic aim of evaluation is to determine the importance and relevance of PMTCT+ programme in reducing the transmission of HIV from mothers to their babies. Thus, lessons learnt from the project will be replicated nation wide.

Pre and post intervention surveys have been built into the project to assess the extent to which the project will achieve its intended goal and purpose. An epidemiologist will assist in the design, coding, data entry and analysis to ensure accuracy and quality of information generated and disseminated. A summary evaluation including needs assessment, the end of the project would have conducted pre/post intervention surveys and operations research findings. The evaluators will comprise the taskforce and external persons.

**Table 5: Evaluation plan**

| Indicators | Data needed | How | By whom | When |
|---|---|---|---|---|
| [illegible] | | | | |
| 1.1.# of Women of reproductive age attending antenatal clinic over the time period.<br>1.2.% antenatal clinic attendees accepting VC.<br>% of antenatal clinic attendees accepting CT | -# of women of reproductive age attending antenatal clinic<br><br># of antenatal clinic attendees counseled<br># of antenatal attendees tested | P records | M&E team | 01/06/03 |
| 2.1 # of Males accepting VC services<br>2.2 # of males accepting CT. services | -No of males counseled<br>- # of males tested | P records | M&E team | 30/06/02 |
| 3.1. % 0f women of reproductive age knowledgeable about PMTCT+.<br>3.2. % of women of reproductive age knowledgeable about PMTCT+<br>3.3 % of women of reproductive age knowledgeable about PMTCT+ | - # of women aware of the modes of transmission of HIV<br>-# of women aware of MTCT of HIV<br>- # of women aware of the benefits of VCT<br>-No of women counseled voluntarily<br># of women voluntarily tested. | Conduct FGD's and interviews<br>Post survey reports<br>PMTCT+ Centers records | M&E team | 30/06/03 |
| 4.1 % of health workers knowledgeable about PMTCT+ | -# of health workers aware of modes of PMTCT+<br>-# of health workers aware of the benefits of VCT<br># of health workers who have offered VCT | Survey report | M&E team | 30/06/03 |

| | | | | |
|---|---|---|---|---|
| 1.1 # of centers upgraded, equipped and staffed | _No of functional equipment's supplied<br>-# of staff trained. | Inventory of PMTCT+ centers | FMOH, PC SAPC | 31/06/03 |
| | | | | |
| 2.1 # Media organization sensitized | - # and type of media organization sensitized<br>-# of media organization participating in PMTCT+ | Training reports<br>Media reports | NASCP, SAPC | 01/08/03 |
| 2.2 # of Media women and women groups sensitized | -# and type of organisation sensitised<br>-# of media women org. participating.<br>-# of women groups sensitized and participating | Training reports<br>Institutional report. | NASCP, SAPC | 01/06/03 |
| 2.3 # of IEC activities organized in each project site | - # of IEC activities<br>-Locations of IEC campaigns<br>-Types of messages | -Activity report | M&E team | 01/06/03 |
| 2.4 Monthly radio/TV programmes prepared and broadcast | -# of radio/TV Programme.<br>-Issues discussed<br>-Time of broadcasting programmes<br>_People approached | -Reviewing record of programme | M&E team | 01/06/02 to 31/06/03 |
| 2.5 # of articles in Newspapers | -# of print media involved<br>-# of articles developed | Review of articles in Newspapers | | 31/07/02 |
| | | | | |
| 3.1 social workers nurses and trained as counselors | _No of people trained<br>- # of counsellors working | -Training report<br>- Hospital records (administrative) | NASCP, PC | 31/04/02 |
| 3.2 Laboratory scientists trained | -# of lab. Scientists trained<br>- # of Laboratory scientists functional | -Training report | NASCP PC | 31/07/02 |
| 3.3 VCT integrated into FP and ANC services | - # of VCT providers per site<br>- Schedule of VCT in FP<br>- Schedule of VCT in FP<br>- Schedule of antenatal clinic sessions | -Review of ANC and FP records<br>- Institutional training records. | M&E team | 01//01/02 |
| | | | | |
| 4.1 # doctors trained on MTCT | -# of doctors trained<br>- # of doctors functional | Review of workshop report<br>- Center reports Intuitional administrative reports | NASCP PC | 30/06/02 |

| | | | | |
|---|---|---|---|---|
| 4.2 30 doctors and 60 nurses sensitized on universal precautions | - No of doctors trained and nurses observing universal precautions | Review of workshop report | NASCP ,PC | 31/01/02 |
| 4.3 # of doses Nevirapine given to mothers and their babies | -# of mothers receiving Nevirapine<br>-# of babies receiving Nevirapine | Review of ARV treatment records | NASCP, PC | 31/06/02 |
| | | | | |
| 5.1Questionaire designed and applied | - Type of data collection tools designed and applied | Samples of tool | | 31/03/02 |
| 5.2 Analysis of survey data | - Data collected | Databank | | 01/06/03 |
| 5.3 Survey report disseminated | - Summative project reports | - Summative project report | FMOH<br>NASCP<br>SAPC<br>UNICEF<br>UNAIDS | 31/06/03 |
| | | | | |
| 6.1 Situation analysis conducted, pre-test questionnaire designed and applied | -Accuracy, appropriateness and timeliness of survey<br>-# of questionnaire distributed and collected<br>-Orderly and accurate data analysis | Review pre-intervention, situation analysis and post-intervention survey reports | M&E team | 31/03/02 |
| 6.2 Post-intervention questionnaire designed and applied | - Accuracy, appropriateness and timeliness of survey<br>- # of questionnaire distributed and collected<br>- Orderly and accurate data analysis | Review post-intervention | | 01/06/02 |
| 6.3 Situation analysis and pre and post intervention, including monitoring reports are compiled and analyzed | - Accuracy, appropriateness and timeliness of survey<br>- # of questionnaire distributed and collected<br>- Orderly and accurate data analysis | Review pre-intervention, situation analysis and Post-intervention survey reports | | 01/06/03 |
| 6.4 Summary evaluation report disseminated to relevant stakeholders | -# of reports distributed<br>-External feedback, including inputs | Feedback | | 31/06/03 |

## APPENDIX 1: BIBLIOGRAPHY


1. Anastasi, M.C. et al. (1999) 'Descriptive analysis of students seeking HIV antibody testing at a university health service. 'Journal of American College of Health, 48 (1): 13-9.

2. Centers for Disease Control and Prevention. (1995)'AIDS Surveillance Report'. CDC Report, 7:2-36.

3. Fowler, M.G. et al. (1997) 'Transmission of HIV –1 from on mother to child'. Journal of Obstetrics and Gynaecology, 6:343-348.

4. Fowler. et al.(1997) 'Progress in prevention of perinatal HIV-1'. Paediatrics Supplement, 1:97-103.

5. Health/AIDS. (1999)'Affordable drugs reduce mother the child transmission of HIV'. CNN Report, 4: 4.

6. Hermione, L. (1997) 'Breastfeeding and HIV/AIDS'. Seminar, AIDS consortium.

7. Hubley, J. (1995) 'A guide to the understanding of HIV/AIDS'. AIDS Care Handbook. 2nd Edition fully revised.

8. 'Comparing the cost-effectiveness of various interventions for perinatal HIV transmission in Thailand'.

9. Marx, R.et al. (1999)' Linking clients from Counseling and Testing to preventive services'. Journal of Community Health, 24(3): 201-214.

10. Moernla, E.H. et al. (1995) 'Human Immuno-Deficiency virus in children'. American Medical Journal of Health System and Pharmacology, 1:52(9): 961-979

11. NASCP-FMOH, Nigeria. (1999)'HIV/ Syphilis seroprevalence survey'. FMOH Reports.

12. NASCP-FMOH, Nigeria. (1999)'Fact Sheet on HIV/AIDS in Nigeria'. Federal Ministry of Health Reports.

13. National Population Commission Program. (1991). Nigeria Population Commission Reports.

14. Ruff, A.J et al. (1994) 'Prevalence of HIV DNA and P24 antigen in the breast milk and correlation with maternal factors'. Journal of Acquired Immune Deficiency Syndrome, 7: 68-78.

15. Shaffer, N. et al. (1991) 'Short course Zidovidine for perinatal HIV-1 transmission in Bangkok, Thailand, A randomised controlled trial'. Lancet, 353/915:773-780.

16. The HIV/AIDS Collaboration, Thailand (1998-1999). Annual Reports.

17. UNAIDS /WHO Update (1998). UNAIDS Reports.

18. UNAIDS Episode; Projections. (1999). UNAIDS Reports.

19. UNAIDS/WHO. (1999)'HIV/AIDS epidemic update'. UNAIDS Reports.

20. Van Peer, P. et al. (1991) 'Post-natal transmission of HIV-1 from mother to infant'. England Journal of Medicine, 325:593.

21. Vangese, B. et al. (1997) 'Cost-effectiveness of counseling and testing and partner notification: a decision analysis'. CDC, Atlanta Georgia 30333,USA.

23. Weirhardt, L.S. et al. (1999) 'Effects of HIV counseling and testing on sexual behaviour: a mata-analytic review of published research, 1985-1997'. American Medical Journal of Health, 89(9): 1397-1

# Proposal Timelines

# Appendices

**APPENDIX II: GANTT CHART FOR THE IMPLEMENTATION OF THE MTCT+ PILOT PROJECT IN NIGERIA FROM 1ST JUNE 2002 TO 31ST JUNE 2003.**

| Activities | 2001 | | | | | | | | | | | | 2002 | | | | | | | | | | | | Responsibilities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | F | M | A | M | J | J | A | S | O | N | D | | J | F | M | A | M | J | J | A | S | O | N | D | |
| Project related | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.Finalization of draft proposal | | | | | | | | | | | | | | | | | | | | | | | | | FMOH |
| 2. Stakeholder analysis | | | | | | | | | | | | | | | | | | | | | | | | | FMOH |
| 3. Problem analysis | | | | | | | | | | | | | | | | | | | | | | | | | FMOH, UNICEF, UNAIDS |
| 4. Secure funding | | | | | | | | | | | | | | | | | | | | | | | | | FMOH, NACA |
| Register nevirapine, clarify requirements for donation and make request | | | | | | | | | | | | | | | | | | | | | | | | | FMOH, UNAIDS |
| 6. Nevirapine available at the six sites | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6.Building modifications | | | | | | | | | | | | | | | | | | | | | | | | | UNICEF |
| 7. Review national policies/guidelines on key issues, revise/develop as necessary | | | | | | | | | | | | | | | | | | | | | | | | | UNICEF UNAIDS WHO UNFPA FMOH, CDC, NAC |
| 8. Finalize and distribute PMTCT+ guidelines | | | | | | | | | | | | | | | | | | | | | | | | | TF, FMOH UNICEF, WHO, UNAIDS |
| 9. Develop, produce and disseminate VCT guidelines and training manuals | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9.Study tour for key taskforce members | | | | | | | | | | | | | | | | | | | | | | | | | UNAIDS, UNICEF WHO, CD |
| 10. Focal points attend PMTCT+ conference in Uganda | | | | | | | | | | | | | | | | | | | | | | | | | UNAIDS UNICEF, CDC FMO WHO |
| 11. Develop scaling- | | | | | | | | | | | | | | | | | | | | | | | | | FMOH |

| | |
|---|---|
| up plan | |
| Output related activities | |
| 1.PMTCT+ strengthened and operational VCT programme established and functional | |
| .0 Provide basic equipment, facilities and staff. | UNICEF, FMOH |
| 1.1 Train nurses and social workers on counselling and infant feeding options | UNICEF, WHO, UNAIDS, FMOH |
| 1.2 Train laboratory scientists/technologists | FMOH |
| 1.3 Organize laboratory quality control | FMOH |
| 1.4 Sensitise 30 women groups on MTCT+ | NACA FMOH NGO PSC |
| 1.5 Train 30 community care providers (TBA's, VHW's) on counselling and infant feeding options | NACA, NGO FMOH PSC |
| IEC Programme developed and functional | |
| 2.0 Develop communication plan and messages (including long term advocacy) | UNICEF, FMOH WHO CDC |
| .1 Organise public awareness campaigns | FMOH, NACA, PSC TF |
| 2.2 Produce and distribute IEC materials on PMTCT+ | UNAIDS UNICEF FMOH NACA WHO CDC |
| 2.3 Develop site manuals | UNAIDS WHO UNICEF CDC |

| | |
|---|---|
| | FMOH<br>UNFPA |
| 2.4 Arrange monthly ıdio and TV programmes | PSC<br>NACA<br>FMOH |
| 2.5 Sensitise 30 media women on PMTCT+ | NACA<br>PSC<br>FMOH |
| VCT programme developed and operational | |
| 3.0 Integrate VCT into FP services | PSC<br>FMOH<br>TF |
| 3.1 Integrate VCT into ANC sessions | PSC<br>TF<br>FMOH |
| 3.2 Ensure male involvement | NACA<br>FMOH<br>NGO<br>PLWA |
| 3 Provide pre-test ıd post test counselling for consenting women and their partners | PSC |
| 3.4 Provide confidential testing for consenting women and their partners | PSC |
| Improved Health workers practices with regard to PMTCT+ of HIV | |
| 4.1Train 60 medical doctors VCT, infant-feeding options, appropriate use of ARV's and monitoring the side fects. | FMOH<br>PSC<br>TF<br>UNCEF<br>WHO<br>UNAIDS |
| 5. Provide ARV drugs | |
| | UNAIDS<br>FMOH |
| 6.Community members involved and committed to PMTCT+, including PLW's | |
| 6.1 Develop advocacy package | UNCEF<br>FMOH<br>NACA |
| 6.2 Conduct advocacy visits to policy makers, community leaders/religious leaders | NACA<br>FMOH |
| 6.3Implement | CDC |

| | |
|---|---|
| to mobilise support in communities | NACA<br>FMOH<br>PSC<br>TF<br>NGO |
| 6.4 Train 60 PLWA's on VCT and infant feeding options | CISGHAI<br>PLWA<br>FMOH<br>NACA |
| 7. Evaluation reports, including situation analysis's, pre and post test surveys and operational research factors militating against PMTCT, reports disseminated | |
| | FMOH |
| 7.1 Design pre and post test questionnaires and apply to selected sites | FMOH |
| 7.2 Design questionnaire for operational research and apply to all the sites | FMOH |
| 7.3. Develop, M&E plan, and produce monitoring tools, recruit and train data managers | FMOH<br>UNCEF<br>WHO<br>UNAIDS<br>NACA |
| 7.4 Conduct quarterly monitoring visits to project sites | FOMH<br>TF |
| 7.5 Organise quarterly meetings of taskforce members | FMOH |
| 7.5 Evaluation of project, including evaluation analysis and surveys. | UNAIDS<br>WHO<br>UNICEF<br>NACA<br>FMOH<br>CDC |
| 7.6 Dissemination of project reports | UNAIDS<br>WHO<br>UNICEF<br>UNFPA<br>FMOH<br>NACA<br>CDC<br>USAID,<br>DFID, JHU |

## APPENDIX III: LIST OF ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Clinic |
| ARV | Anti retroviral |
| BF | Breastfeeding |
| CDC | Centres for Disease Control |
| CBO's | Community Based Organizations |
| DFID | Department for International Development |
| FMOH | Federal Ministry of Health |
| FP | Family Planning |
| FOMWAN | Federation of Muslim Women Association in Nigeria |
| HIV | Human Immunodeficiency Virus |
| IF | Infant Formula |
| MTCT | Mother to Child Transmission |
| MOH | Ministry of Health |
| NACA | National Action Committee on AIDS |
| NASCP | National AIDS/STD Control Programme |
| NNPLWHA | Network of People Living with HIV/AIDS |
| NCWS | National Council on Women Society |
| NPC | National Population Commission |
| NGO | Non Governmental Organization |
| PC | Programme Coordinator |
| PMTCT+ | Prevention of Mother to Child Transmission of HIV |
| PLWA | People Living With HIV/AIDS |
| SAPC | State AIDS Control Programme |
| STDs | Sexually Transmitted Diseases |
| SWAAN | Society for Women and AIDS in Nigeria |
| TF | Taskforce |
| TBAs | Traditional Birth Attendants |
| UNAIDS | United Nations Joint Programme on HIV/AIDS |
| UNFPA | United Nation's Funds for Populations Activities |
| UNICEF | United Nation's Children's Funds |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counselling Testing |
| VHW | Village Health Worker/Voluntary Health Worker |
| WHO | World Health Organization |

**APPENDIX IV: Members of the PMTCT+ Taskforce are as follows:**

1. Dr E. Emueveyan - Chairman.
2. Dr S Anas-Kolo - Secretary
3. Dr H. Onah - UNTH, Enugu Coordinator
4. Dr C. Akani - UPTH, Port Harcourt coordinator
5. Dr C. Chama - UMTH, Maiduguri coordinator
6. Dr Randawa - ABUTH, Zaria coordinator
7. Dr C. Agbohoroma - National Hospital, Abuja, Coordinator
8. Dr N. Sani-Gwarzo - NASCP/FMOH Programme Manager
9. Dr E A. Abebe - Director Public Health/FMOH
10. Dr A. Adeyemi - Coordinator Reproductive Health, FMOH
11. Dr N. Njepuome - Coordinator BFHI, FMOH
12. Dr Omojokun - Coordinator Nutrition, FMOH
13. Prof. I Akinsete -Chairman, National Action Committee on AIDS
14. Dr Abosede - Special Assistant to Chairman NACA
15. Dr N. Grange - Consultant Pediatrician
16. Dr Grace Masha - Social Scientist
17. Prof. J. Idoko - JUTH, JOS, Coordinator
18. Prof. Adewole - UCH, Ibadan, Coordinator
19. Representative of UNAIDS
20. ,, of UNICEF'
21. ,, of WHO
22. Representative of UNFPA
23. Representative of FHI
24. Representative of Policy project
25. Representative of DFID
26. Representative of APIN- Harvard
27. Representative of PAN
28. Representative of SOGON
29. Representative of IMAN

30. Representative of CHAN
31. Representative of SWAAN
32. Representative of FOMWAN
33. Representative of PLWHA
34. Representative of Ministry of Women affairs
35. Representative of Ministry of Information
36. Representative of Ministry of Education affairs
37. Representative of Ministry of Justice
38. Representative of the AFPAC
39. Representative of STOPAIDS
40. Representative of HALTAIDS

**APPENDIX V: PMTCT++ SITE MONITORING FORM:**

***APPENDIX VI: JOINT REPORT OF ADVOCACY VISIT TO PMTCT+ CENTERS IN NIGERIA* HELD FROM 27TH JANUARY TO 1ST FEBRUARY 2002.**

**Introduction:**

The first phase of the PMTCT+ advocacy visit was conducted from 27th January to 1st February 2002. Three PMTCT+ model project sites in the three states of the three geopolitical zones of the country were visited over the period. The states are:

1. Borno State - North East
2. Enugu State - South East
3. Rivers state - South South

**Participants:**

The visiting team comprised of relevant stakeholders on PMTCT+ in the country, which were represented as follows:

- Dr Abosede –National Action Committee on AIDS
- Dr Abiola Davies –UNICEF, Abuja
- Dr E. Emueveyan - Chairman, PMTCT+ taskforce
- Dr N. Adeyemi - Reproductive Health, FMOH
- Dr N. Njepuome - BFHI, FMOH
- Dr S. Anas-Kolo - NASCPO, FMOH

**Specific objectives:**

- To sensitize and create awareness about mother to child transmission of HIV and ways of prevention.
- To inform the policy makers and influential groups within the project sites about the PMTCT+ project in their states
- To gain their support and commitment towards implementing the PMTCT+ model project in their state
- To gain commitments of the state governments towards scaling up the project in the states and local governments and also, sustaining the PMTCT+ interventions in the future.
- To assess the level of preparedness of the PMTCT+ project sites towards service delivery.

**Target groups:**

The groups targeted for the advocacy included policy makers, influential groups and the management of the PMTCT+ project sites. They are as follows:

- Policy makers – The state governor, the commissioners of Health, women affairs, information and Education. Similarly, the director/coordinators of the Primary Health Care (PHC) were aimed for the advocacy.

- Influential groups within the communities were targeted, such as the religious leaders, community leaders, and women and youth leaders.
- Relevant stakeholders working within the state on HIV/AIDS were also, targeted, such as NGOs, CBOs, and People Living with HIV/AIDS (PLWHA).

**Sites visited:**

**A. Borno state**

The team visited Maiduguri, the Borno state capital on the 27th January and departed on the 29th January 2002. In Maiduguri, a meeting was held with the officials of the Ministry of Health, with the commissioner, the director Disease control, deputy director, disease control, assistant director, disease control and the state ADIS programme coordinator. The team discussed with them the aim of the mission. Thereafter, team visited the ministries of women affairs and information and local government affairs. Issues relating to PMTCT+ were discussed and their roles and responsibilities in the project implementation discussed in details.

The team and the relevant stakeholders had a meeting with Borno state governor. In attendance at the meeting were the deputy Governor, the Secretary to the government, members of the executive council, chairmen of boards and parastatal, community leaders The mission briefed the governor and his team about the overall objectives of the project, the interventions and the need for scaling up, their commitments and support for the project. We also, seized the opportunity to request the governor to inaugurate the State AIDS Committee on AIDS, in order to access the funds for the State AIDS control activities.

The government of Borno pledged their support and commitment to fight against HIV/AIDS and also for the PMTCT+ Project.

In addition, the met with Emir of Borno, the community leaders and religious leaders in the Emirs' palace. The Emir on behalf of the people of Borno, pledged to support the project and ensure that the community will be mobilized and the good intentions will not be mis-interpreted.

Please see appendix 1 for list names of people met in Maiduguri, Borno state.

**Key findings:**

- The policy makers are supportive and committed to ensure an AIDS free society.
- The community leaders were supportive and willing to mobilize the community to prevent MTCT of HIV in the state.
- The State Action Committee on HIV/AIDS (SACA) is not yet inaugurated.

- The PMTCT+ site committee is functional and had had two meetings, so far. However, the committee is yet to involve other stakeholders, such as the ministries of women affairs, education, PLWH/AIDS, NGOS and community members.
- There is collaboration between the State Ministry of Health and the Project site located in the University of Maiduguri.

B. **Enugu State**

The team arrived Enugu on the 29th January and departed for Port Harcourt on the 31st February 2002. While in Enugu, the team visited the University of Enugu Teaching Hospital, where we met with the Chief Medical Director, the Chairman Medical advisory committee, the State AIDS programme coordinator, The Project site coordinator and some of the PMTCT+ key implementers. The group was informed of the teams' mission in the stage and the CMD appreciated the inclusion of his institution as one of the PMTCT+ pilot sites for South East. He indicated his commitment to support the project.

The State AIDS programme coordinator led the team to the governors' office, where we met with the Deputy Governor of the state, members of the executive council, the chief protocol officer and the pressmen. They were briefed about the aim of our mission; the need to support the project and also support the pilot sits. Then deputy governor responded on behalf of the state governor, who was unavoidably absent. He pledged the support of the state government for the new initiative and informed us that the SACA has already been inaugurated.

A meeting was held in the office of the permanent secretary Ministry of Health, with the officials of the Ministry of Health, women affairs, information, NGO's (SWAAN) and religious leaders. The UNICEF zonal office was also represented at the meeting. During the meeting, there was an extensive discussion on PMTCT+, the roles and responsibilities of relevant stakeholders, including PLWHA. Issues regarding the scaling up of the project and the responsibilities of partners and communities were clarified.

We also, seized the opportunity to assess the level of preparedness of the PMTCT+ project site, by interacting with the key implementers and also, reviewing the flow of the ANC, delivery and the labour room, in order to enhance smooth PMTCT+ flow of activities without causing stigma to consenting women and their partners.

The team also, visited the state General hospital, which is the next site for the PMTCT+ project in the state. The chief Medical Director of the hospital is very eager to commence the PMTCT+ services in his hospital, considering the fact

that the site has been used for the sentinel survey, since the beginning of the HIV sero prevalence survey in the country.

**Key findings:**

- The state government is supportive and committed to fight the scourge of HIV/AIDS in the state.
- All the stakeholders met have agreed to support and mobilize resources for PMTCT+ within the state.
- The SACA is inaugurated, however the State Programme Team (SPT) is yet to be in place.
- The PMTCT+ committee in the state is not functional.
- Inadequate counselors on HIV/AIDS and infant feeding counseling prior to commencement of service delivery.

Please see appendix ii the list of persons met in Enugu.

**Rivers state:**

Port Harcourt, the Rivers state capital, is one of the PMTCT+ proposed model project sites in the country. The team arrived on the 31st January and departed on the 1st February 2002.

The Chief Medical Director and the PMTCT+ coordinator, received the team at the University of Port Harcourt Teaching Hospital, where we met with the management team. They were informed of our mission and the need to commence the project at the teaching hospital in the state.

Thereafter, the CCMD led us to the office of the commissioner of health, who represented the governor of the state. A meeting was held with the commissioner of health, in attendance also, were the sate AIDS coordinator, the Director, Primary Health Care and other ministry officials. They were informed about the PMTCT+ initiative in the country, the need to support the intervention and the responsibilities of the state and relevant stakeholders in scaling up the project and ensuring sustainability.

The commissioner responded by pledging the commitment of the state government and also, briefed us on the state's plan to commence PMTCT+ and ARV as part of their initiative of improving access to care and support for the increasing number of PLWJHA in the state. He further discussed the efforts of his state in curtailing the spread of HIV/AIDS through massive awareness campaigns, one of which was the million-man march that took place in January.

The team appreciated the efforts of the state government, however, cautions that there is great need for the state to harmonize their efforts in line with the Federal government guidelines on PMTCT+ and ARV therapy.

The level of preparedness of the project site, i.e. the teaching hospital was assed. The CMD, the PMTCT+ coordinator and some management staff took the

team around the relevant departments of obstetrics and pediatrics. The management indicated their commitments and full to support for the project. More counseling rooms will be made available and more staff to be redeployed to the ANC clinic.

**Key findings:**

- There is high level political commitment towards combating the HIV/AIDS epidemic in the state
- The state government is making efforts to commence PMTCT+ project and ARV therapy.
- Approval has already been given to purchase AZT for PMTCT+ from Glaxo SmithKline and ARVs (Lamuvudine, Stavudine, and Nevirapine) from CIPLA of India.
- The State PMTCT+ committee is functional
- A sensitization workshop was conducted in the teaching hospital for senior staff of the relevant departments.
- The SACA has already been inaugurated, but the state action team is yet to be functional.

Appendix iii shoes the names of people met in Port Harcourt.

**Recommendations**

Based on the one-week interactions, field experiences and findings at the three PMTCT+ project sites in the country, the following recommendations were made:

1. There is need for sustained efforts to translate the high level political commitments on HIV/AIDS control at the state levels to action.
2. The state governments to adopt and implement the PMTCT+ interventions at the state levels and local government levels, including the private sectors.
3. The state to be committed and mobilize local resources towards implementing the PMTCT+ interventions at all levels of health care.
4. Encourage more collaboration between the Federal institutions and the state ministries, as well as other stakeholders on HIV/AIDS activities, such as the NGOs, community members and PLWHA.
5. State governments should be encouraged to establish the SACA, and also ensure that the state programme Team are functional, in order to access the world bank funs for HIV/AIDS control activities.

6. The PMTCT+ committees should include all stakeholders within the communities, PLHA and relevant ministries, namely women, affairs, information and education.
7. There is need for training of counselors on HIV/AIDS and infant feeding counseling at the six sites in the departments of Pediatrics and Obstetrics/Gynecology, social work and the laboratory.
8. Redeployment and or recruitment of more nurses/midwives to the ANC, labour and the child welfare clinics, in order to cope with the increase workload as a result of HIV and infant feeding counseling.
9. States to harmonize their efforts on HIV prevention, Care and support to be in line with the Federal Government guidelines in the respective areas; such as PMTCT+ and access to anti-retroviral therapy.

# Proposal Budget

| Key Activity | Number | % Time contributed | Unit cost | Total cost | Funding Committed (Federal Government) | Funding Committed (UNICEF) | Funding Committed (UNFPA) | Funding Committed (APIN) | Funding Committed (Boerhinger Ingelheim) | Funding Committed | Total Uncommitted (Gap) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Service Delivery** | | | | | | | | | | | |
| **Center A (National Hospital Abuja)** | | | | | | | | | | | |
| Gynaecologist/Site coordinator | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Gynaecologist | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Paediatrician | 2 | 1 | 16,071 | 32,142 | 32,142 | | | | | 32,142 | 0 |
| Social workers | 2 | 1 | 5,357 | 10,714 | 10,714 | | | | | 10,714 | 0 |
| Nurses and/midwives | 15 | 1 | 5,357 | 80,357 | 80,357 | | | | | 80,357 | 0 |
| Record clerks | 2 | 1 | 2,143 | 4,286 | 4,286 | | | | | 4,286 | 0 |
| **Sub-Total** | | | | **159,642** | **159,642** | | | | | **159,642** | **0** |
| **Center B (LUTH, Lagos)** | | | | | | | | | | | |
| Gynaecologist/Site coordinator | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Gynaecologist | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Paediatrician | 2 | 1 | 16,071 | 32,142 | 32,142 | | | | | 32,142 | 0 |
| Social workers | 2 | 1 | 5,357 | 10,714 | 10,714 | | | | | 10,714 | 0 |
| Nurses and/midwives | 15 | 1 | 5,357 | 80,357 | 80,357 | | | | | 80,357 | 0 |
| Record clerks | 2 | 1 | 2,143 | 4,286 | 4,286 | | | | | 4,286 | 0 |
| **Sub-Total** | | | | **159,642** | **159,642** | | | | | **159,642** | **0** |
| **Center C (UNTH, Enugu)** | | | | | | | | | | | |
| Gynaecologist/Site coordinator | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Gynaecologist | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Paediatrician | 2 | 1 | 16,071 | 32,142 | 32,142 | | | | | 32,142 | 0 |
| Social workers | 2 | 1 | 5,357 | 10,714 | 10,714 | | | | | 10,714 | 0 |
| Nurses and/midwives | 15 | 1 | 5,357 | 80,357 | 80,357 | | | | | 80,357 | 0 |
| Record clerks | 2 | 1 | 2,143 | 4,286 | 4,286 | | | | | 4,286 | 0 |
| **Sub-Total** | | | | **159,642** | **159,642** | | | | | **159,642** | **0** |
| **Center D (UPTH, Port Harcourt)** | | | | | | | | | | | |
| Gynaecologist/Site coordinator | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Gynaecologist | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Paediatrician | 2 | 1 | 16,071 | 32,142 | 32,142 | | | | | 32,142 | 0 |
| Social workers | 2 | 1 | 5,357 | 10,714 | 10,714 | | | | | 10,714 | 0 |
| Nurses and/midwives | 15 | 1 | 5,357 | 80,357 | 80,357 | | | | | 80,357 | 0 |
| Record clerks | 2 | 1 | 2,143 | 4,286 | 4,286 | | | | | 4,286 | 0 |
| **Sub-Total** | | | | **159,642** | **159,642** | | | | | **159,642** | **0** |
| **Center E (ABUTH, Zaria)** | | | | | | | | | | | |
| Gynaecologist/Site coordinator | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Gynaecologist | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |
| Paediatrician | 2 | 1 | 16,071 | 32,142 | 32,142 | | | | | 32,142 | 0 |
| Social workers | 2 | 1 | 5,357 | 10,714 | 10,714 | | | | | 10,714 | 0 |
| Nurses and/midwives | 15 | 1 | 5,357 | 80,357 | 80,357 | | | | | 80,357 | 0 |
| Record clerks | 2 | 1 | 2,143 | 4,286 | 4,286 | | | | | 4,286 | 0 |
| **Sub-Total** | | | | **159,642** | **159,642** | | | | | **159,642** | **0** |
| **Center F (UMTH, Maiduguri)** | | | | | | | | | | | |
| Gynaecologist/Site coordinator | 1 | 1 | 16,071 | 16,071 | 16,071 | | | | | 16,071 | 0 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Gynaecologist | 1 | 1 | 16,071 | 16,071 | 16,071 | | | 16,071 | 0 |
| Paediatrician | 2 | 1 | 16,071 | 32,142 | 32,142 | | | 32,142 | 0 |
| Social workers | 2 | 1 | 5,357 | 10,714 | 10,714 | | | 10,714 | 0 |
| Nurses and/midwives | 15 | 1 | 5,357 | 80,357 | 80,357 | | | 80,357 | 0 |
| Record clerks | 2 | 1 | 2,143 | 4,286 | 4,286 | | | 4,286 | 0 |
| Sub-Total | | | | 159,642 | 159,642 | | | 159,642 | 0 |
| Non Government Human Resources | | | | | | | | | |
| Two coordinators of Centers of Excellence | 2 | 1 | 24,000 | 48,000 | | | | 0 | 48,000 |
| One data analyst | 1 | 1 | 12,000 | 12,000 | | | | 0 | 12,000 |
| Part-time PMTCT expert consultant | 1 | 0 | 120,000 | 30,000 | | | | 0 | 30,000 |
| Full-time Project Accountant | 1 | 1 | 16,000 | 16,000 | | | | 0 | 16,000 |
| Sub-Total | | | | 106,000 | | | | 0 | 106,000 |
| | | | | | | | | | |
| and five trainers | 43 | | 250 | 10,750 | | 10,750 | | 10,750 | 0 |
| Five-day training workshop for medical laboratory scientists 35 participants and 4 trainers | 39 | | 250 | 9,750 | | | | 0 | 9,750 |
| Six batches of one-day sensitization workshop for women groups in each of the six sites and 4 trtrainers to six sites | 234 | | 74 | 17,411 | | | | 0 | 17,411 |
| One-day sensitization workshop for media women groups( 35 participants and 4 trainers) | 39 | | 250 | 9,750 | | | | 0 | 9,750 |
| Two batches of one-day sensitization workshops for media organizations (each 35 persons) and 4 trainers to two sites | 78 | | 250 | 19,500 | | | | 0 | 19,500 |
| Two batches of one-day sensitization workshop for Non-Governmental Organizations (each 35 persons) and 4 trainers t two sites | 78 | | 250 | 19,500 | | | | | |
| Five-day training workshop for 66 research team and 4 trainers | 72 | | 250 | 18,000 | | 18,000 | | 18,000 | 0 |
| Five-day training workshops for 40 pmtct key implementers and 4 trainers | 44 | | 250 | 11,000 | | 11,000 | | 11,000 | 0 |
| Two-day training workshops for 35 Traditional Birth Attendants and Voluntary Health Workers and 4 trainers | 39 | | 250 | 9,750 | | | | 0 | 9,750 |
| Two-day training workshop for 35 PLWHAs and 4 trainers | 39 | | 250 | 9,750 | | | | 0 | 9,750 |
| Advocacy visits to six PMTCT sites | 12 | | 600 | 7,200 | 7,200 | | | 7,200 | 0 |
| IEC campaigns to six sites | 48 | | 250 | 12,000 | | | | 0 | 12,000 |
| Needs assessments of project site | 12 | | 600 | 7,200 | | 7,200 | | 7,200 | 0 |
| Stakeholder analysis meetings | 35 | | 250 | 8,750 | | | | 0 | 8,750 |
| Monitoring visits (12 people making 24 site visits per year) | 12 | | 6,000 | 72,000 | | | | 0 | 72,000 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Five-days training workshops for record clerks | 16 | | 250 | 4,000 | | | | | 0 | 4,000 |
| Travel for two coordinators of Centers (6 visits per year, each to 3 sites) | 36 | | 250 | 9,000 | | | | | 0 | 9,000 |
| Travel for PMTCT accountant to PMTCT sites ( 4 visits to each site) | 24 | | 250 | 6,000 | | | | | 0 | 6,000 |
| Travel for two National officials (PMTCT and AIDS programme coordinators) with expert consultant to six sites (24 visits) twice a year for 10 days each. | 24 | | | | | | | | | |
| Travel for data analyst (4 visits to each site per year) | 24 | | 250 | 6,000 | | | | | 0 | 6,000 |
| Travel for PMTCT expert consultant local travel (twice per year to each site) | 12 | | 250 | 3,000 | | | | | 0 | 3,000 |
| Travel for PMTCT expert consultant from overseas (twice per year) | 2 | | 2,500 | 5,000 | | | | | | |
| Travel for 30 resource persons to six sites for counseling training | 30 | | 250 | 7,500 | 7,500 | | | | | |
| Travel for nurses, midwives, and social workers to site for counselling training (at six sites -- 35 per site; local travel) | 210 | | 10 | 2,100 | 2,100 | | | | 2,100 | 0 |
| Sub-Total | | | | 284,911 | 15,600 | 46,950 | 0 | 0 | 53,750 | 231,161 |
| | | | | | | | | | | |
| National five-day training workshop for 38 counselors | 5 | | 80 | 400 | | 400 | | | 400 | 0 |
| Five-day training workshop for medical laboratory scientists by 4 trainers (5 days at $80 per day) | 4 | | 400 | 1,600 | | | | | 0 | 1,600 |
| Six batches of one-day sensitization workshop for women's groups in each of the six sites (four trainers conducting six days of training at $80/day) | 4 | | 480 | 1,920 | | | | | 0 | 1,920 |
| One-day sensitization workshop for media women groups | 4 | | 80 | 320 | | | | | 0 | 320 |
| Two batches of one-day sensitization workshops for media organizations | 4 | | 160 | 640 | | | | | 0 | 640 |
| Two batches of one-day sensitization workshop for Non-Governmental Organisation | 4 | | 160 | 640 | | | | | 0 | 640 |
| Five-day training workshop for PMTCT research team (four trainers for five days at $80/day) | 4 | | 400 | 1,600 | | 1,600 | | | 1,600 | 0 |
| Five-day training workshops for PMTCT key implementers (4 trainers for five days @$80/day) | 4 | | 400 | 1,600 | | 1,600 | | | 1,600 | 0 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Two-day training workshops for Traditional Birth Attendants and Voluntary Health Workers (five trainers for 2 days at six sites at $80/day) | 5 | | 960 | 4,800 | | | | | 0 | 4,800 |
| 5 personnel to complete five day IEC campaign at six sites (30 total days per person per year at $80 per day) | 5 | | 2,400 | 12,000 | | | | | 0 | 12,000 |
| Five day training workshop for record clerks (4 trainers for five days @ $80/day) | 4 | | 400 | 1,600 | | | | | 0 | 1,600 |
| Two-day training workshop for PLWHAs (4 trainers for two days @ $80/day) | 4 | | 160 | 640 | | | | | 0 | 640 |
| Regional five-day counseling training workshop at six sites | 5 | | 2,400 | 12,000 | | | 12,000 | | 12,000 | 0 |
| Quarterly six-day monitoring/supervision visits at six sites by 12 monitors (each monitor spends 24 days per year conducting monitoring) | 12 | | 1,920 | 23,040 | | | | | 0 | 23,040 |
| Sub-Total | | | | 62,500 | 0 | 3,600 | 0 | 12,000 | 0 | 15,600 | 47,200 |
| [illegible] | | | | | | | | | | |
| Counseling training for 38 participants and 5 trainers ($65 per day for five days) | 43 | | 325 | 13,975 | | 13,975 | | | | 13,975 | 0 |
| Laboratory Training (5 days) for 35 participants by 4 trainers | 39 | | 325 | 12,675 | | | | | | 0 | 12,675 |
| Two day sensitization workshops for media women groups (35 participants) by 4 trainers for 5 days @ $65 | 39 | | 325 | 12,675 | | | | | | 0 | 12,675 |
| Two day sensitization workshops for 35 media groups by 4 trainers @ $65 per day. | 39 | | 325 | 12,675 | | | | | | 0 | 12,675 |
| Two day sensitization workshops for 35 PLWHA by 4 trainers @ $65 per day. | 39 | | 325 | 12,675 | | | | | | 0 | 12,675 |
| Training of PMTCT research team (66 participants) by 6 trainers for 5 days @ $65 per day | 72 | | 325 | 23,400 | | 23,400 | | | | 23,400 | 0 |
| Training of PMTCT key implementers ( participants) by 4 trainers for 5 days @ $65 per day. | 44 | | 325 | 14,300 | | 14,300 | | | | 14,300 | 0 |
| Personnel (5) for IEC campaigns for 5 days in each of the six sites ( total of 30 days) @ $65 per day | 5 | | 1,950 | 9,750 | | | | | | 0 | 9,750 |
| Training of 16 record clerks by 4 trainers for 5 days @ $65 per day | 20 | | 325 | 6,500 | | | | | | 0 | 6,500 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Counseling training at six sites fro 35 participants per site ( total 210 ) by 5 trainers per site (20 trainers), thus; total is 230) @ $65 per day | 20 | 325 | 6,500 | | | 6,500 | | 6,500 | 0 |
| PMTCT accountant to visit six sites 6 times a year for six days at each site ( total days is 144) @ $65 per day. | 1 | 9,360 | 9,360 | | | | | | 9,360 |
| Data analyst to visit six sites 6 times a year for six days at each site ( total days is 144) aa2 $65 per day. | 1 | 9,360 | 9,360 | | | | | | 9,360 |
| Monitoring/supervision visits at six sites( quarterly for 6 daysper site) by 12 experts ( total working days is 24 days) @ $65 per day | 12 | 18,720 | 224,640 | | | | | | 224,640 |
| Monitoring/supervision visits at six sites( quarterly for 6 days per site) by regional coordinators ( total working days is 24 days) @ $65 per day | 2 | 18,720 | 37,440 | | | | | | 37,440 |
| Monitoring/supervision visits at six sites( quarterly for 6 daysper site) by 2 national officials ( NASCprograme coordinator and PMTCT focal person) ( total working days is 24 days) @ $65 per day | 2 | 18,720 | 37,440 | | | | | | 37,440 |
| Monitoring/supervision visits at six sites( quarterly for 6 daysper site) by 1 experts ( total working days is 24 days) @ $65 per day | 1 | 18,720 | 18,720 | | | | | | 18,720 |
| Sub-Total | | | 462,065 | 0 | | 51,675 | 0 | 6,500 | 0 | 55,175 | 403,910 |
| [redacted] | | | | | | | | | |
| One day Stakeholder analysis meeting in Abuja | 40 | 338 | 13,500 | 13,500 | | | | | 13,500 | 0 |
| Development of a draft guideline by consultant | 1 | 6,000 | 6,000 | | | 6,000 | | | 6,000 | 0 |
| Development of VCT draft guidelines by two consultants | 2 | 12,500 | 25,000 | | | | | | 0 | 25,000 |
| Review workshop to adopt draft guidelines and manuals (40 participants all expenses included) | 40 | 781 | 31,240 | | | | | | 0 | 31,240 |
| Field testing of guidelines and training manuals (six sites) | 6 | 3,500 | 21,000 | | | | | | 0 | 21,000 |
| Finalization /adoption of draft guidelines and manuals (40 participants in workshop all expenses included) | 40 | 781 | 31,240 | | | | | | 0 | 31,240 |
| Production of VCT guidelines and training manuals | 10,000 | 5 | 50,000 | | | | | | 0 | 50,000 |
| Dissemination of VCT guidelines and training manual (all 37 states) | 37 | 405 | 14,985 | | | | | | 0 | 14,985 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Sub-Total | | | 192,965 | 13,500 | 0 | 6,000 | 0 | 0 | 19,500 | 173,465 |
| [illegible] | | | | | | | | | | |
| Capillus | 180 | 313 | 56,250 | | | | | | 0 | 56,250 |
| Gene 11 | 480 | 179 | 85,714 | | | | | | 0 | 85,714 |
| Pipettes | 6 | 89 | 536 | | | | | | 0 | 536 |
| Syringes and needles | 6 | 18 | 107 | | | | | | 0 | 107 |
| Medical wipes | 12 | 9 | 107 | | | | | | 0 | 107 |
| Latex gloves | 12 | 9 | 107 | | | | | | 0 | 107 |
| Disinfectants (Sodium Hyochlorite) | 2 | 18 | 36 | | | | | | 0 | 36 |
| Methylated spirit | 2 | 18 | 36 | | | | | | 0 | 36 |
| Cotton wool | 2 | 9 | 18 | | | | | | 0 | 18 |
| Disposal jars (plastic) | 2 | 2 | 4 | | | | | | 0 | 4 |
| Collection tubes (plain) | 72 | 804 | 57,857 | | | | | | 0 | 57,857 |
| Serum vial 2-3ml with screw lap (cined rubber) | 72 | 804 | 57,857 | | | | | | 0 | 57,857 |
| Sub-Total | | | 256,629 | 0 | 0 | 0 | 0 | 0 | 0 | 256,629 |
| [illegible] | | | | | | | | | | |
| 400G infant formula for 45 babies per year | 27,000 | 7 | 192,780 | | | | | | | 192,780 |
| Sub-Total | | | 192,780 | | | | | | 0 | 192,780 |
| [illegible] | | | | | | | | | | |
| Nevirapine tablets for HIV positive mothers for PMTCT | 912 | 1 | 912 | | | | | 912 | 912 | 0 |
| Nevirapine syrup for babies born to HIV positive mothers for PMTCT | 456 | 1 | 456 | | | | | 456 | 456 | 0 |
| Triple therapy antiretrovirals for PMTCT+ (HIV+ mothers) | 912 | 500 | 456,000 | | | | | | | 456,000 |
| Combivir syrup for 277 HIV+ babies | 456 | 1,500 | 684,000 | | | | | | | 684,000 |
| Sub-Total | | | 1,141,368 | | | | | | 0 | 1,141,368 |
| [illegible] | | | | | | | | | | |
| **Formative research** | | | | | | | | | | |
| Development of research tools | 1 | 3,500 | 3,500 | | 3,500 | | | | 3,500 | 0 |
| Training of PMTCT research team | 1 | 31,250 | 31,250 | | 31,250 | | | | 31,250 | 0 |
| Production of instruments | 1 | 4,000 | 4,000 | | 4,000 | | | | 4,000 | 0 |
| Data collection | 1 | 35,000 | 35,000 | | 35,000 | | | | 35,000 | 0 |
| Data management/report writing by two consultants | 2 | 6,000 | 12,000 | | 12,000 | | | | 12,000 | 0 |
| **Development of communication strategies for PMTCT** | | | | | | | | | | 0 |
| Technical assistant | 1 | 10,000 | 10,000 | | 10,000 | | | | 10,000 | 0 |
| Review workshop to develop communication strategy | 1 | 31,250 | 31,250 | | | | | | 0 | 31,250 |
| Field testing of tools | 6 | 6,000 | 36,000 | | | | | | 0 | 36,000 |
| Critique workshop to finalize communication strategy for 35 participants | 1 | 31,250 | 31,250 | | | | | | 0 | 31,250 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Operational research** | | | | | | | | | | | 0 |
| VCT uptake per site for six sites | 6 | | 8,500 | 51,000 | | | | | | 0 | 51,000 |
| Nevirapine uptake per site for six sites | 6 | | 5,000 | 30,000 | | | | | | 0 | 30,000 |
| Infant feeding practices per site than for six sites | 6 | | 15,000 | 90,000 | | | | | | 0 | 90,000 |
| Community perceptions of PMTCT per site for six sites | 6 | | 10,000 | 60,000 | | | | | | 0 | 60,000 |
| Sub-Total | | | | 425,250 | 0 | 95,750 | 0 | 0 | 0 | 95,750 | 329,500 |
| | | | | | | | | | | | |
| Awareness/sensitization on PMTCT in the communities | 6 | | 1,339 | 8,036 | | | | | | 0 | 8,036 |
| Sensitization seminars for community care provider, public and private sectors | 6 | | 5,357 | 32,143 | | | | | | 0 | 32,143 |
| Sensitization of NGOs, CBOs, PLWHAs | 6 | | 2,232 | 13,393 | | | | | | 0 | 13,393 |
| Media campaigns | 6 | | 1,339 | 8,036 | | | | | | 0 | 8,036 |
| advocacy to community /religious leaders, women and youth groups | 6 | | 5,357 | 32,143 | | | | | | 0 | 32,143 |
| Production and dissemination of IEC materials | 6 | | 4,464 | 26,786 | | | | | | 0 | 26,786 |
| Sensitization and involvement of men (clubs etc) | 6 | | 2,232 | 13,393 | | | | | | 0 | 13,393 |
| | | | | | | | | | | 0 | 0 |
| Sub-Total | | | | 133,929 | 0 | 0 | 0 | 0 | 0 | 0 | 133,929 |
| | | | | | | | | | | | |
| PMTCT Taskforce meeting in Abuja | 4 | | 16,071 | 64,284 | | | | | | 0 | 64,284 |
| Sub-Total | | | | 64,284 | 0 | 0 | 0 | 0 | 0 | 0 | 64,284 |
| | | | | | | | | | | | |
| Five-day study tour for 12 key implementers to Uganda | 12 | | 3,600 | 43,200 | | | | | | | |
| Sub-Total | | | | 43,200 | | | | | | 0 | 43,200 |
| | | | | | | | | | | | |
| 1. Desktop computers @ 130,000 per set | 6 | | 1,161 | 6,964 | | 6,964 | | | | 6,964 | 0 |
| 2.Laptop computer @ 160,000 per unit | 2 | | 1,607 | 3,214 | | 3,214 | | | | 3,214 | 0 |
| 3.Printers @ 40,000 per set | 8 | | 357 | 2,857 | | 2,857 | | | | 2,857 | 0 |
| 4. 21 inches color TV set @ 35,000 per set | 7 | | 312 | 2,187 | | 2,187 | | | | 2,187 | 0 |
| 5.Video player @ 20,000 per set | 7 | | 179 | 1,250 | | 1,250 | | | | 1,250 | 0 |
| 6. Communications (telephones, fax, internet services, courier services) | 7 | | 638 | 4,464 | 4,464 | | | | | 4,464 | 0 |
| Sub-Total | | | | 20,936 | 4,464 | 16,472 | 0 | 0 | 0 | 20,936 | 0 |
| | | | | | | | | | | | |
| 1. Vehicle ( 4 wheel drive Toyota Jeep) one per zone and one at national level | 7 | | 62,500 | 437,500 | | | | | | 0 | 437,500 |
| 2. Distribution of drugs, materials and HIV reagents | 6 | | 5,000 | 30,000 | | | | | | 0 | 30,000 |
| 3. Storage facilities (one per site) | 6 | | 1,000 | 6,000 | | | | | | 0 | 6,000 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 4. Freezers | 6 | 1,339 | 8,036 | | | | | | 0 | 8,036 |
| 5. Maintenance (electricity, and general services) | 6 | 1,000 | 6,000 | | | | | | 0 | 6,000 |
| 7. Fuelling and maintenance of vehicle | 7 | 2,232 | 15,625 | | | | | | 0 | 15,625 |
| Sub Total | | | 503,161 | 0 | 0 | 0 | 0 | 0 | 0 | 503,161 |
| GRAND TOTALS | | | 4,850,147 | 992,616 | 214,447 | 6,000 | 18,500 | 0 | 1,231,563 | 3,618,584 |

| | |
|---|---|
| TOTAL COST OF PMTCT+ CENTERS OF EXCELLENCE | 4,850,147 |
| TOTAL FUNDS CURRENTLY COMMITTED | 1,231,563 |
| TOTAL REQUESTED OF GFATM | 3,618,584 |

| | TOTAL COST | | | | | | |
|---|---|---|---|---|---|---|---|
| TOTAL HUMAN RESOURCES | 1,063,849 | 957,852 | 0 | 0 | 0 | 0 | 957,852 |
| TOTAL LOGISTICS | 503,161 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL TRAINING AND SUPERVISION | 1,110,245 | 30,300 | 102,225 | 6,000 | 18,500 | 0 | 157,025 |
| TOTAL OUTREACH SERVICES | 133,929 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL COMMODITIES OR PRODUCTS | 1,592,777 | 0 | 0 | 0 | 0 | 0 | 0 |
| DATA AND INFO SYSTEMS | 20,936 | 4,464 | 16,472 | 0 | 0 | 0 | 20,936 |
| OPERATIONAL RESEARCH | 425,250 | 0 | 95,750 | 0 | 0 | 0 | 95,750 |
| | 4,850,147 | 992,616 | 214,447 | 6,000 | 18,500 | 0 | 1,231,563 |