



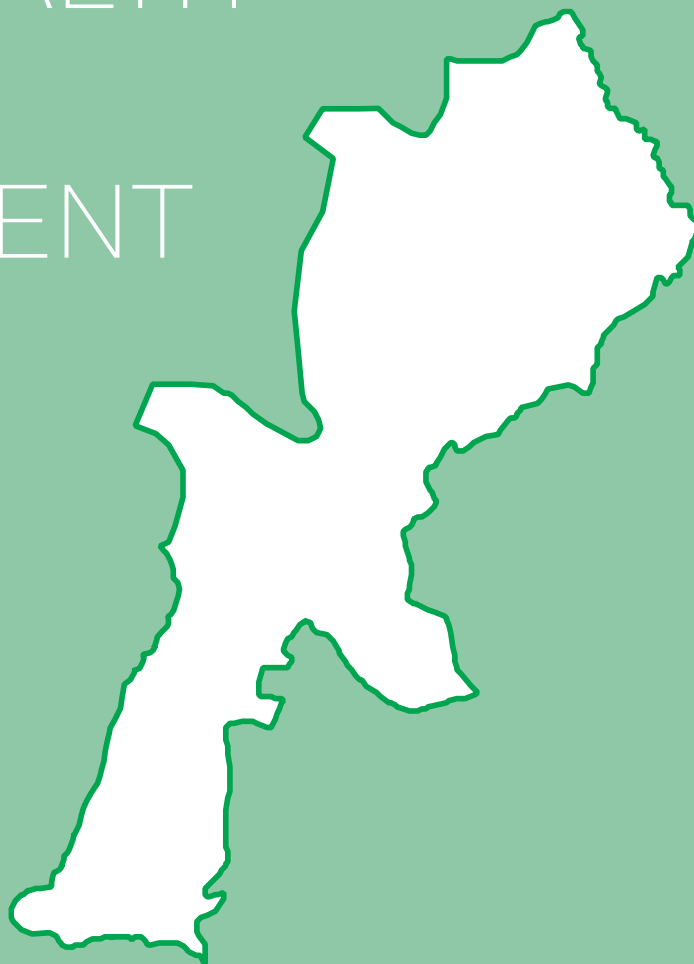
Report of the Abia

STATE-WIDE RAPID HEALTH FACILITY ASSESSMENT



In Preparation
for Elimination of
Mother-to-Child
Transmission of HIV

AUGUST 2013





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Table of Contents

Foreword	iii
Acknowledgements	iv
Acronyms	v
EXECUTIVE SUMMARY	1
1 BACKGROUND	2
2 ABIA STATE HIV PROFILE	2
2.1 MTCT Profile for Abia State.....	3
3 RESPONSE TO THE HIV EPIDEMIC	5
4 ASSESSMENT GOAL AND OBJECTIVES	6
4.1 Goal	6
4.2 Objectives.....	6
5 ASSESSMENT DESIGN	6
5.1 Sampling/Site Selection.....	6
5.2 Data collection.....	6
5.3 Assessment procedure	6
5.4 Challenges.....	6
6 FINDINGS	8
6.1 Characteristics of Facilities	8
6.2 Human Resources and Service Utilization.....	8
6.3 Domain-By-Domain Summary	11
6.4 Qualitative Findings	14
6.5 Scenarios for Eligibility for PMTCT Services.....	17
GEOSPATIAL REPRESENT-ATION OF FACILITIES	18
CONCLUSION	25
RECOMMENDATIONS	25
APPENDIX	26
GLOSSARY	36

LIST OF TABLES

Table 1: LGA ranking of MTCT burden and PMTCT coverage in Abia state	4
Table 2: Characteristics of facilities with ANC and no IP support for ARVs in PMTCT	8
Table 3: Human resources and service utilization disaggregated by level of facility – primary/secondary.	9
Table 4: Human resources and service utilization disaggregated by ownership of facility.....	10
Table 5: Domain-by-domain summary disaggregated by level of facility.....	12
Table 6: Domain-by-domain summary disaggregated by facility ownership.....	13
Table 7: Women prefer to patronize traditional birth attendants (TBAs), private clinics and churches.....	15
Table 8: Reasons why some health facilities are well patronized.....	16
Table 9: Respondents' suggestions on improving service quality.....	16
Table 10: Scenarios using different cut-offs – HR related.....	17

LIST OF FIGURES

Figure 1: Trend of HIV Prevalence in Nigeria and Abia State (1999-2010).	3
Figure 2: Sampling for state-wide rapid health facility assessment.....	6
Figure 3: Map showing currently existing PMTCT (ARVs) services.....	18
Figure 4: Map showing spread of assessed facilities (with ANC but no PMTCT)	19
Figure 5: Map showing spread of facilities meeting national HR criteria for PMTCT services	20
Figure 6: Map showing facilities meeting state-defined HR criteria for PMTCT services.....	21
Figure 7: Map showing 2014 coverage scenario with current PMTCT sites and scale-up to those meeting national HR criteria.....	22
Figure 8: Map showing 2014 coverage scenario with current PMTCT sites + scale-up to sites meeting state-defined HR criteria	23
Figure 9: Map showing coverage scenario with current PMTCT sites + sites earmarked for scale-up towards eMTCT	24

LIST OF APPENDICES

Appendix 1: Human resources and service utilization disaggregated by level of facility.....	26
Appendix 2: Human resources and service utilization disaggregated by facility ownership.....	27
Appendix 3: Human Resource Gap for Doctors by LGAs	28
Appendix 4: Coverage gap for Nurses by LGA.....	29
Appendix 5: Coverage Gap Community Workers in assessed facilities by LGAs (Trained Health Workers – CHOs, CHEWs etc.)	30
Appendix 6: Coverage gap for Records Officers by LGA	31
Appendix 7: Coverage gap for Laboratory Workers	32
Appendix 8: Coverage Gap Pharmacy Staff in assessed facilities by LGAs.....	33
Appendix 9: Staff requirements for all assessed facilities below national standard.....	34
Appendix 10: List of contributors.....	35

Foreword

As one of the “12+1” states which jointly contribute nearly 70 percent of Nigeria’s mother to child transmission of HIV (MTCT) burden Abia State is one of the priority states for PMTCT services scale up drive by Government of Nigeria. The state with HIV prevalence of 7.1%, ranks the 8th in the country and 2nd in the South-East zone.

Abia State Government, in collaboration with FHI 360, and with financial support from the United States Agency for International Development (USAID), embarked on a state-wide rapid health facility assessment to identify facilities and the needed resources for PMTCT services scale up. This is an important milestone towards the elimination of mother-to-child transmission of HIV (MTCT) in the state.

A total of 651 public and private health facilities located in all 17 local government areas (LGAs) in the state were assessed. This report contains details of findings in the 5 domains assessed per facility namely: available services, infrastructure, enabling environment for ANC, community delivery options and community health support systems. The report will surely be of immense help in the development of a state-specific, costed PMTCT scale-up plan.

Also, with the identification of gaps and challenges in the functionality of health facilities and lessons learned the road to expanding PMTCT services is now open in Abia State



Dr. Okechukwu S Ogah

*Honourable Commissioner for Health
Abia State*

Acknowledgements

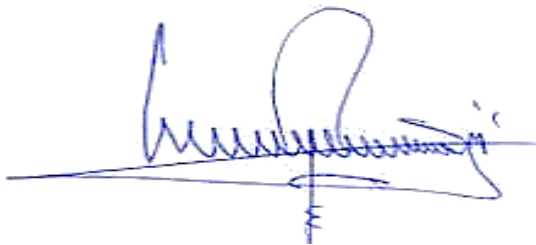
The Abia State Ministry of Health hereby thank all stakeholders whose commitment and hard work contributed to the successful production of this report. We are really indebted to the United States Agency for International Development for financial assistance and FHI 360 for technical assistance during this rapid assessment. Our special thanks go to them.

The hard work and commitment demonstrated by everyone who contributed to the development of the Rapid Health Facility Assessment Report for Abia State is acknowledged and appreciated.

Our gratitude goes to the staff of the Abia State Ministry of Health and the Hospitals Management Board who contributed immensely to making this exercise a success. We also acknowledge the commitments of the consultants and volunteers who participated in this assessment.

And for releasing staff in their various health departments, we cannot thank the Ministry of Local Government enough. We also appreciate the PHC Coordinators and LGA staff who utilized their in-depth knowledge of the terrain in making the accomplishment of the task a lot easier.

Thank you all,

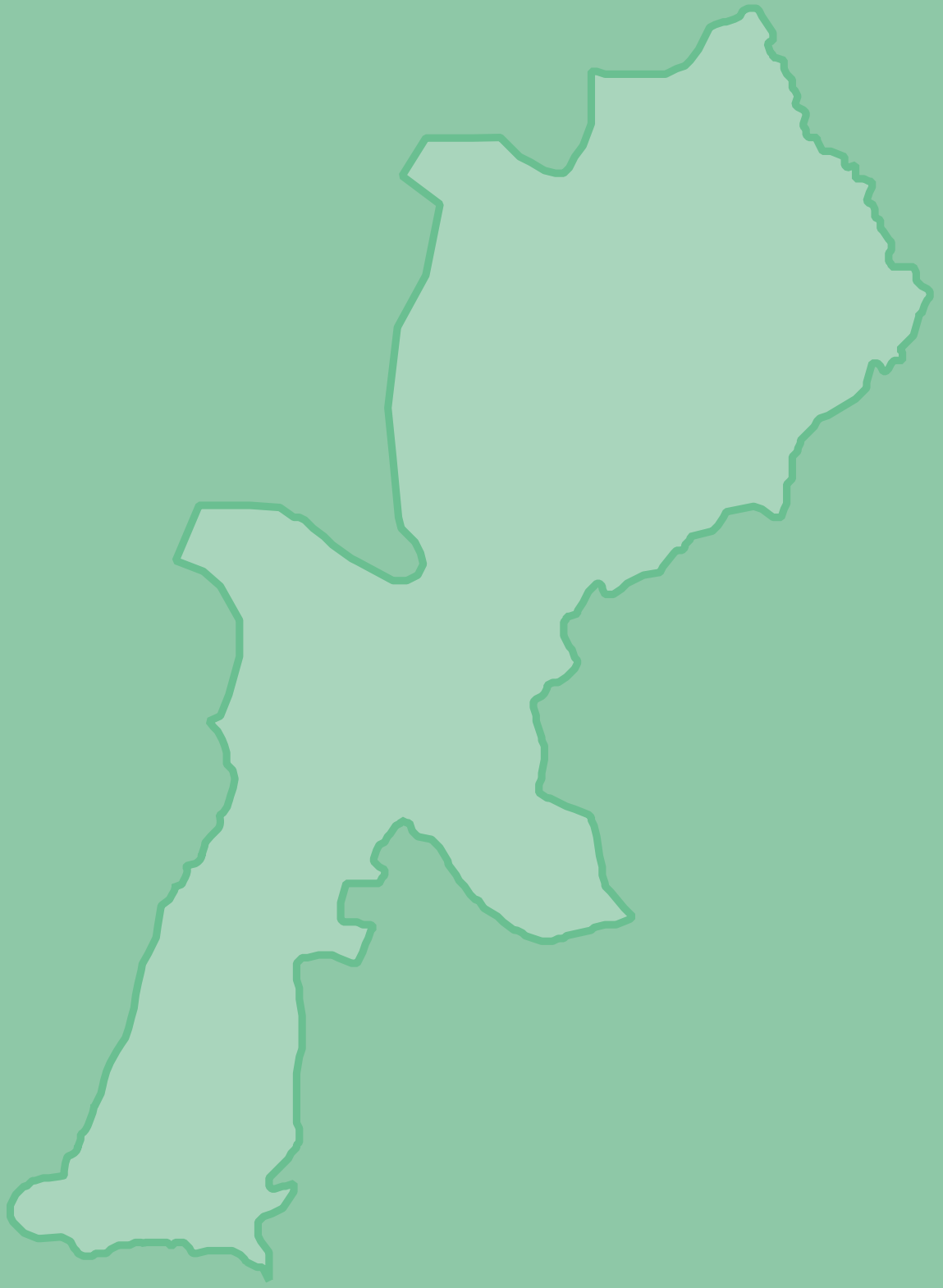


Chief Franklin Enyinnaya Orji

*Director of Public Health/Disease Control
Abia State Ministry of Health*

Acronyms

ARV	Anti-retroviral
CHEW	Community Health Extension Worker
CHO	Community Health Officer
DOTS	Directly Observed Therapy, Short-course
DPRS	Director Planning Research and Statistics
eMTCT	Elimination of Mother-to-Child Transmission of HIV
FHI 360	Family Health International
GPS	Global Positioning System
HR	Human Resource
IP	Implementing Partner
KII	Key Informant Interview
LACA	Local Government Agency for Control of HIV/AIDS
LGA	Local Government Area
MDG	Millennium Development Goal
MTCT	Mother-to-Child Transmission of HIV
MSS	Midwives Services Scheme
OPD	Outpatient Department
PHC	Primary Health Care/Centre
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission of HIV
R-HFA	Rapid Health Facility Assessment
SACA	State Control Agency for Control of AIDS
SAPC	State AIDS Programme Coordinator
SASCP	State AIDS and STI Control Programme
SMOH	State Ministry of Health
SURE-P	Subsidy Reinvestment and Empowerment Program
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
VDG	Village Development Committee



Executive Summary

Abia State in Nigeria's South Eastern geopolitical zone is an important state to target for eliminating mother-to-child transmission of HIV in Nigeria. The HIV prevalence in the state has shown an upward trend from surveillance reports and now stands at 7.3% which is higher than the regional and national average. It is one of the 12+1 states accounting for 70% the national burden of mother-to-child transmission of HIV (MTCT). The Government of Nigeria is committed to eradicating MTCT by 2015. To achieve this objective, PMTCT service coverage and access is being scaled up in these priority states.

This state wide facility assessment was conducted to identify health facilities which provide antenatal care (ANC) but not antiretrovirals (ARVs) for the prevention of mother-to-child transmission (PMTCT). It aimed to document human health resource, service provision and utilization indices in order to engage these facilities in scale up efforts to boost PMTCT coverage and access. Health workers in all eligible facilities across the mix of public/private ownership and primary/secondary/tertiary levels of patient care were surveyed using qualitative and quantitative methods. In total, 651 eligible facilities were identified and surveyed. Geospatial coordinates of these facilities were collected and are mapped to show site spread and aid decisions to maximize PMTCT coverage.

Wide gaps in current PMTCT coverage were seen; only five LGAs had PMTCT sites on record at the time of this survey. Human resource (HR) deficiencies were observed for all cadres of staff necessary for optimal delivery of PMTCT and maternal and child health (MCH) services with only 44 facilities meeting national minimum human resource complements for PMTCT service provision. Some facilities also lacked necessary infrastructure for PMTCT. Health workers report that deliveries occur outside the health facility, in maternity homes and with TBAs. Reasons adduced for this included cultural beliefs, logistic problems with efficient health service delivery, health care costs and poor staff attitudes.

To improve PMTCT access and coverage, a broad based range of interventions incorporating health systems strengthening, health demand creation and community engagement must be undertaken. Mechanisms to engage traditional birth attendants (TBAs) which increase HIV testing and counseling (HTC), ANC and PMTCT use should also be explored.

SECTION

1 Background

Abia State is located in south-eastern Nigeria; its capital is Umuahia. The state became a political entity in 1991 when it was formed out of Imo State; subsequently in 1996 four local governments were transferred to the newly created Ebonyi State. The state has 17 Local Government Areas (LGAs) namely: Aba North, Aba South, Ukwa East and West, Ukwunagbo, Obingwa, Osisioma, Isiala Ngwa North and South, Umuahia North and South, Ikwuano, Bende, Isiukuwato, Ohafia, Nneochi, Arochukwu. The state shares common boundaries to the north with Ebonyi State; to the south and southwest with Rivers State; and to the east and southeast with Cross River and Akwa Ibom States, respectively. To the west is Imo State, and to the northwest is Anambra State. It covers an area of about 5,243 km² which is approximately 5.8% of the total land

area of Nigeria. The topography is mainly flat and low lying, with existing highlands averaging 150m above sea level in elevation.

National projections from the 2006 census estimate a current population of 3,394,524 with a slight majority of females in most LGAs. The main ethnic group is Igbo. Abia State has two principal urban centres – the administrative capital of Umuahia and the commercial centre of Aba. The mainstays of the economy are crude oil production and agriculture. These account for 39% and 27% of the State's Gross Domestic Product (GDP), respectively. The main crops produced are yams, maize, potatoes, rice, cashews, plantains, and cassava.

The prevalence of HIV in Abia State has shown a steady increase since the onset of community surveillance using Antenatal Sentinel Surveys in

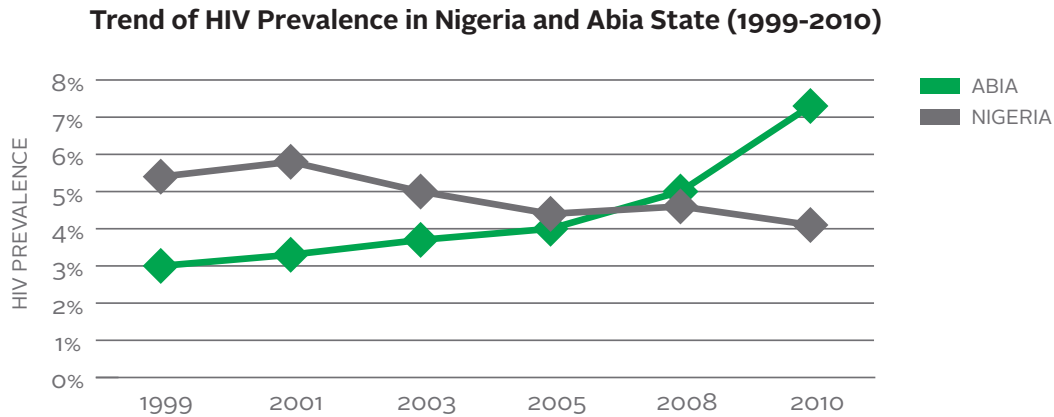
SECTION

2 Abia State HIV Profile

1999. At that time the state HIV prevalence was 3.0%, almost half the national average of 5.4%. However while the national prevalence has reduced fairly consistently to the current 2010 estimate of 4.1%, the Abia State prevalence has risen steadily and now stands at 7.3%. This is above the South Eastern regional average (3%) and Abia is second only to Anambra (8.7%) in the region.

The major route of HIV transmission, like for the rest of Nigeria, is heterosexual intercourse. The main drivers of the epidemic include multiple concurrent sexual partners, low perception of risk and knowledge levels, stigma and discrimination and superstitious beliefs about HIV/AIDS.

Figure 1: Trend of HIV Prevalence in Nigeria and Abia State (1999-2010).



SOURCE: HSS 2010

2.1 MTCT PROFILE FOR ABIA STATE

Abia is one of 12+1 states which contribute to over 70% of maternally acquired HIV infections in Nigeria. These states are the current focus of Nigeria’s elimination of mother-to-child transmission (eMTCT) efforts. Based on projected population figures, Abia is estimated to have 12,377 pregnant women living with HIV. With a third of maternal infections resulting in paediatric transmission without PMTCT interventions, over 4,000 children are at risk of prenatal HIV infection in the state.

To understand the relative burden of maternal HIV and provision of PMTCT service in the various

LGAs, a profile of the situation was conducted. This profile ranks the LGAs according to maternal HIV burden (based on number of affected women) and PMTCT service coverage gap (proportion of ANC facilities which do not provide PMTCT) with higher ranks indicating higher burden/larger coverage gaps. The individual and summed ranks are shown below in Table 1. Abia South, Umuahia North and South LGAs have the highest maternal HIV population burden. Ikwuano, Ukwa East, Ugwunagbo, and Umuahia South LGAs had no PMTCT centres and consequently a service coverage gap of 100%. Combining both indices Umuahia South, Ikwuano and Obingwa the most affected LGAs.

Table 1: LGA ranking of MTCT burden and PMTCT coverage in Abia state

LGAS	MTCT BURDEN			PMTCT SERVICE COVERAGE GAP			RANK SUM [RANK 1 + RANK 2]
	HIV prevalence	Estimated number of HIV+ pregnant women	Rank 1 (number of HIV+ pregnant women)	Number of sites with ANC services	Proportion without PMTCT services	Rank 2 (service gap)	
Aba North	7.0%	446	5	60	97%	9	14
Aba South	7.0%	1785	17	64	88%	6	23
Arochukwu	7.3%	737	11	49	98%	12	23
Bende	7.3%	839	13	62	95%	8	21
Ikwuano	7.3%	600	8	39	100%	17	25
Isiala Ngwa North	1.3%	119	1	44	86%	5	6
Isiala Ngwa South	7.3%	595	7	39	97%	9	16
Isuikwuato	7.3%	504	6	44	84%	3	9
Obingwa	7.3%	792	12	51	98%	12	24
Ohafia	4.7%	690	9	44	82%	2	11
Osioma	7.3%	961	14	65	97%	9	23
Ugwunagbo	7.3%	372	3	52	100%	17	20
Ukwa East	7.3%	253	2	20	100%	17	19
Ukwa West	7.3%	380	4	19	68%	1	5
Umuahia North	12.0%	1597	16	64	89%	7	23
Umuahia South	12.0%	995	15	37	100%	17	32
Nneochi	7.3%	710	10	37	84%	3	13
Total	7.30%	12,377		790	93%		

SECTION

3 Response to the HIV Epidemic

As part of the government's response to the HIV epidemic, the Abia State HIV/AIDS/STI Control Programme (SASCP) was created as a division under the Directorate of the State Public Health Department located at Umuahia.. While the overall management of HIV and AIDS programmes within the State is coordinated by the State Agency for Control of AIDS (SACA), the SASCP on the other hand, coordinates the health sector HIV and AIDS response. It also monitors the sector's (HIV/AIDS) programmes and collaborates with key partners and other stakeholders in HIV and AIDS programming and management.

Also, international donors such as the United States Government and the Global Fund through their implementing partners have invested technical and financial resources in the HIV

programming in the state. Some of the program areas funded in Abia State by the international donors include (HTC), provision of ARVs, laboratory equipment and capacity building for government and health facility staff.

However PMTCT coverage has been low. Consequently, Abia is one of the 12+1 states that contribute 70% to the national PMTCT burden. In line with the focus of the Government of Nigeria on accelerating PMTCT coverage in these 12+1 states, the Abia state government with the support of the implementing partners has embarked on a drive to scale up PMTCT services. This drive involves a state-wide rapid health facility assessment, the findings from which will be used to develop a state-specific, costed PMTCT scale-up plan.

SECTION

4 Assessment Goal and Objectives

4.1 GOAL

The goal of this assessment is to contribute to Abia state efforts to eliminate mother-to-child transmission of HIV by 2015.

4.2 OBJECTIVES

1. To quickly identify health facilities in Abia State that meet a minimum set of criteria for provision of PMTCT services;
2. To document the HR, infrastructure, enabling environment, services available and their utilization in assessed health facilities (12 months preceding the assessment);
3. To explore provider perspectives on barriers to uptake of PMTCT services; and
4. To map the physical location of health facilities using global positioning system (GPS) coordinates.

SECTION

5 Assessment Design

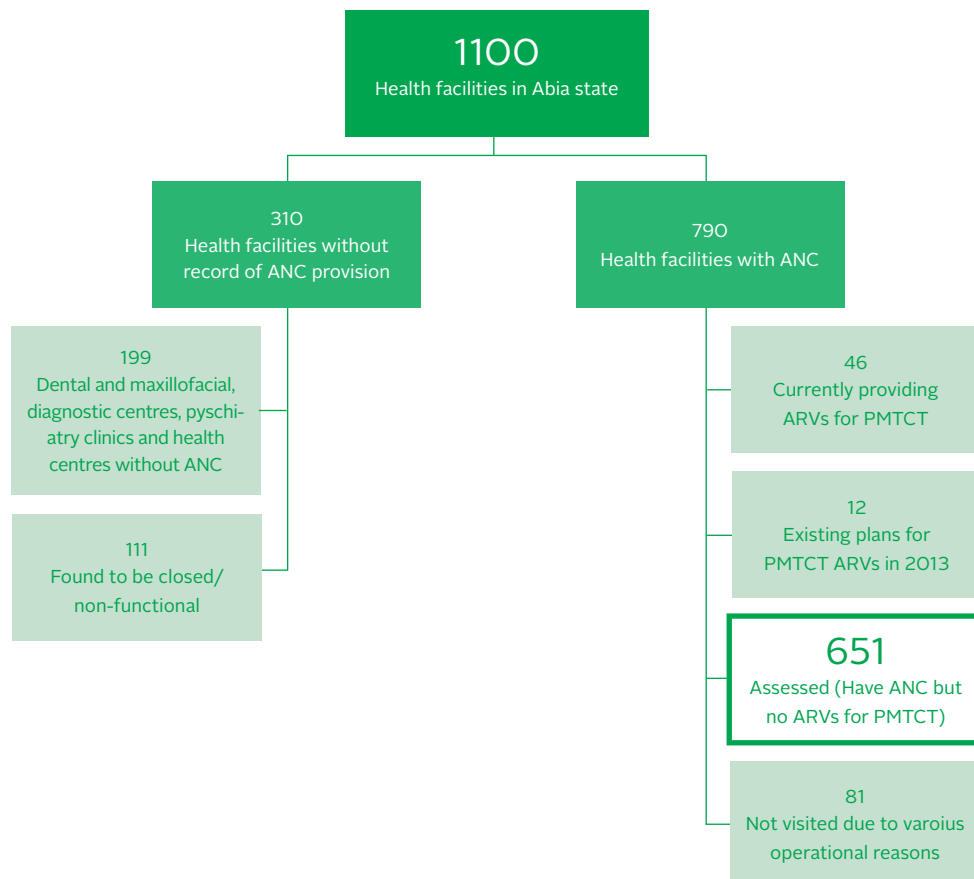
This cross-sectional survey utilized mixed (quantitative and qualitative) methods. The assessment took place in all 17 Local Government Areas of the state.

5.1 SAMPLING/SITE SELECTION

The sampling frame was a total listing of the 1100 health facilities in the state. The inclusion criterion was all facilities with ANC services as these could

in principle provide PMTCT services if equipped with the proper technical and human expertise. Excluded from the assessment were 58 facilities that were already providing PMTCT services (ARVs for PMTCT or had plans to commence this service in 2013). A total of 651 facilities which provided antenatal care but had no implementing partner support for PMTCT services (ARVs) were assessed in this exercise. A breakdown of facilities depicting sampled institutions is shown below (Figure 2).

Figure 2: Sampling for state-wide rapid health facility assessment



5.2 DATA COLLECTION

The Abia State Rapid Health Facility Assessment (R-HFA) tool included both quantitative and qualitative elements. The quantitative aspect used a semi structured questionnaire to collect information from the facility head or officer about facility and service characteristics. Geospatial location of the facilities was ascertained as well facility ownership and current scope of PMTCT related services. The review covered seven domains which included: facility health linkages, health human resource complement, client flow, scope of services provided, community support systems, current infrastructure and future prospects for expansion.

The qualitative section was a key informant interview of the same officer to explore community birth site options, perceived reasons for preferred choice, factors influencing facility patronage and the extent of community participation in service delivery.

5.3 ASSESSMENT PROCEDURE

The Abia State Ministry of Health and the Abia State Agency for the Control of AIDS led this assessment exercise with technical support from FHI 360 with funding from USAID. Following an orientation exercise, multidisciplinary teams (comprising staff from State Ministry of Health, SACA, Hospitals Management Board, Primary Health Care Management Board and FHI 360) were mobilized to visit health facilities. GPS devices were used to obtain location coordinates for facilities. Key informant interviews were conducted with the heads of facilities and where available, heads of laboratory and pharmacy units.

5.4 CHALLENGES

It was difficult to accurately identify all health centres in the state. Two rounds of data collection were therefore conducted. The supplemental/second assessment was required to reach facilities which were eligible but not identified or located in the first round.

SECTION

6 Findings

A total of 651 facilities were found to provide antenatal care but did not receive support from an implementing partner to provide ARVs for PMTCT. The sections below present data from these facilities which constitute the majority of facilities with potential for PMTCT scale-up in Abia State.

6.1 CHARACTERISTICS OF FACILITIES

In Table 2 below, the distribution of the assessed facilities with respect to ownership and level of service delivery is presented. Over 80% of the facilities (541) were primary level while the remaining were secondary facilities. Similarly, about two-thirds of the facilities were publicly owned (426) while the rest were private facilities.

6.2 HUMAN RESOURCES AND SERVICE UTILIZATION

Human resources and service utilization disaggregation according to facility level is presented in Table 3. The secondary facilities on the average have a higher number of health workers – across all categories- compared with the primary facilities. Of all the health worker categories, the records officer and pharmacy technicians/pharmacists are the fewest per facility. The average number of outpatient department (OPD) and ANC attendees as well as deliveries in the last 12 months also revealed a much higher utilization of secondary facilities compared to the primary level health services in the state. Notably, the average number of deliveries is almost half

Table 2: Characteristics of facilities with ANC and no IP support for ARVs in PMTCT

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Faith-based	6	7	13
Private for profit	115	98	213
Sub-total (private)	121	105	226
Public			
Federal government	1	1	2
State government	1	3	4
LGA	418	1	419
Sub-total (public)	420	5	425
Overall total	541	110	651

the number of new ANC attendees. This should however not be interpreted to mean only half of registered mothers deliver in a health facilities due to fact that 1) registration and delivery may be separated by up to 9 months but the R-HFA data was collected for the same reference period; 2) unregistered mothers may deliver in a facility; and 3) pregnancies may terminate in other end points besides delivery of an infant. The foregoing notwithstanding, the finding might suggest a significant proportion of deliveries occur outside the formal health system.

Table 4 presents HR resources and facility utilization now disaggregated according to facility level. The results show that on the average, private facilities have a higher number of every category of health worker. Also, the private facilities have OPD and ANC utilization figures which are about 5 to 8 times than seen in public facilities. This highlights the importance of proper private health sector engagement in reaching the target population of pregnant women.

Table 3: Human resources and service utilization disaggregated by level of facility – primary/secondary

DOMAIN	Item	541 PRIMARY FACILITIES			110 SECONDARY FACILITIES			651 TOTAL FACILITIES		
		Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one
HUMAN RESOURCES	Doctors	0.2	83.2%	16.8%	2.0	4.5%	95.5%	0.5	69.9%	30.1%
	Registered nurse/midwife	1.1	47.5%	52.5%	3.0	16.4%	83.6%	1.4	42.2%	57.8%
	Other trained health workers (Community Nurses, CHOs, CHEWs)	2.4	12.8%	87.2%	5.2	17.3%	82.7%	2.8	13.5%	86.5%
	Record officers	0.2	86.1%	13.9%	0.7	60.9%	39.1%	0.3	81.9%	18.1%
	Laboratory technician/scientists	0.3	78.6%	21.4%	1.4	25.5%	74.5%	0.5	69.6%	30.4%
	Pharmacy technician/pharmacists	0.1	90.9%	8.1%	0.5	62.7%	37.3%	0.2	86.2%	13.8%
SERVICE UTILIZATION	OPD attendance in the last 12 months	291	4.3%	95.7%	1325	4.5%	95.5%	466	4.3%	95.7%
	ANC first attendees recorded in the last 12 months	80	5.2%	94.8%	717	7.3%	92.7%	188	5.5%	94.5%
	Deliveries taken in the last 12 months	46	14.6%	85.4%	428	5.5%	94.5%	110	13.1%	86.9%

Table 4: Human resources and service utilization disaggregated by ownership of facility

DOMAIN	Item	541 PRIMARY FACILITIES			110 SECONDARY FACILITIES			651 TOTAL FACILITIES		
		Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one
HUMAN RESOURCES	Doctors	0.1	96.9%	3.1%	1.4	19.0%	81.0%	0.5	69.9%	30.1%
	Registered nurse/midwife	0.9	53.4%	46.6%	2.4	21.2%	78.8%	1.4	42.2%	57.8%
	Other trained health workers (Community Nurses, CHOs, CHEWs)	2.1	10.8%	87.2%	4.2	18.6%	81.4%	2.8	13.5%	86.5%
	Record officers	0.2	89.4%	10.6%	0.4	67.7%	32.3%	0.3	81.9%	18.1%
	Laboratory technician/scientists	0.2	86.8%	13.2%	1.0	37.2%	62.8%	0.5	69.6%	30.4%
	Pharmacy technician/pharmacists	0.1	92.9%	7.1%	0.3	73.5%	26.5%	0.2	86.2%	13.8%
SERVICE UTILIZATION	OPD attendance in the last 12 months	186	4.2%	95.8%	992	4.4%	95.6%	466	4.3%	95.7%
	ANC first attendees recorded in the last 12 months	50	5.2%	94.8%	446	6.2%	93.8%	188	5.5%	94.5%
	Deliveries taken in the last 12 months	22	17.2%	82.8%	277	5.3%	94.7%	110	13.1%	86.9%

6.3 DOMAIN-BY-DOMAIN SUMMARY

Table 5 summarizes findings from each domain of the assessment. The domains assessed are services available, infrastructure, enabling environment for ANC, community delivery options and community health support systems. Findings are disaggregated by level of facility and type of ownership.

Basic clinical services were available in most of the facilities with the percentage of facilities providing assessed facilities generally exceeding 70%. The notable exceptions to this general rule were HTC and TB services. HTC services were available in less than half of facilities surveyed. Where available, HTC services are a good platform on which to build PMTCT services. TB services were the least frequently available service (obtainable in less than a fifth of the facilities). As expected the range of services provided is wider in secondary level facilities.

Infrastructure assessment focused on availability of space for critical functions related to ANC and PMTCT care components. About 70% and 90% of facilities had spaces which could be utilized for Adherence and Confidential Counselling respectively. Less than 15% of facilities had the necessary infrastructure to use for phlebotomy or drug dispensing services. The previous trend is observed with secondary health facilities having richer infrastructure allowances than primary health centers.

The 'enabling environment' domain assessed facility access to support for ANC such as Millennium Development Goal (MDG) funds for MCH services, presence of midwives supported by the Midwives Service Scheme (MSS) or Subsidy Reinvestment Program (SURE-P), and provision of subsidized ANC services to the community and conduct of regular community outreaches. Community outreach was the most frequently observed activity in this domain. Over 60% of facilities

engaged in community outreach although only 8% of secondary facilities participated. Few facilities (14%) provide free/subsidized ANC in the state, less than a quarter had access to MDG support for MCH and less than 10% had access to midwife staffing support programs

A majority of respondents' opined women utilized birthing facilities outside the formal health care system. The most popular option in the view of respondents were maternity homes or traditional birth attendants (TBAs). More respondents in primary health facilities were aware of existing community support systems such as ward and village development committees, community development and community based organizations. This reflects a closer integration into the community at the primary health level compared to secondary. Nonetheless only about half of facilities reported the existence of ward or village development committees.

Domain findings are disaggregated by facility ownership (public/private) and presented in Table 6. The majority of public facilities are primary health facilities, while private facilities encompass both primary and secondary level institutions as previously seen in Table 2. The results are therefore similar to those shown above in Table 5.

The range of services provided was similar in most respects across public and private facilities except for a few important exceptions. Private facilities were twice as likely to have HTC or TB treatment services compared with public owned health centres. Less than 70% and 20% of assessed private facilities had HTC or TB treatment services, respectively. More public facilities however conducted provided immunisation and child clinic follow up services.

Public facilities generally fared better on items related to enabling environment and awareness of community support systems.

Table 5: Domain-by-domain summary disaggregated by level of facility

		FACILITY TYPE		
		Primary level n = 541	Secondary level n = 110	Total n = 651
SERVICE AVAILABILITY	Physical Exam (including weight, assessing GA, blood pressure)	534 (98.7%)	109 (99.1%)	643 (98.8%)
	Laboratory services (onsite or by referral): Hb, Urinalysis	379 (70.1%)	104 (94.5%)	483 (74.2%)
	Dispensing of haematinics and IPTp	507 (93.7%)	96 (87.3%)	610 (93.7%)
	Labour and delivery services (with 24 hour shifts)	502 (92.8%)	108 (98.2%)	610 (93.7%)
	Referrals for emergency obstetric and new-born care	520 (96.1%)	98 (89.1%)	618 (94.9%)
	Family Planning services (condoms, hormonal contraceptives)	413 (76.3%)	83 (75.5%)	496 (76.2%)
	Immunization services	479 (88.5%)	59 (53.6%)	538 (82.6%)
	Child follow up clinics	491 (90.8%)	88 (80.0%)	579 (88.9%)
	TB services (specify which - e.g. DOTS, microscopy)	55 (10.2%)	27 (24.5%)	82 (12.6%)
	HTC	216 (39.9%)	85 (77.3%)	301 (46.2%)
IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	Lab Room	349 (64.5%)	99 (90.0%)	448 (68.8%)
	Phlebotomy	33 (6.1%)	40 (36.4%)	73 (11.2%)
	ANC Space	87 (16.1%)	53 (48.2%)	140 (21.5%)
	ANC Room	487 (90.0%)	93 (84.5%)	580 (89.1%)
	Space for Confidential Counselling	425 (78.6%)	93 (84.5%)	518 (79.6%)
	Maternity Room	507 (93.7%)	103 (93.6%)	610 (93.7%)
	Pharmacy Store	386 (71.3%)	83 (75.5%)	469 (72.0%)
	Pharmacy Dispensary	50 (9.2%)	36 (32.7%)	86 (13.2%)
	HIV Adherence Counselling	388 (71.7%)	83 (75.5%)	471 (72.4%)
	Medical Records	321 (59.3%)	84 (76.4%)	405 (62.2%)
	DOTS Clinic	5 (0.9%)	7 (6.4%)	12 (1.8%)
	DOTS waiting area	5 (0.9%)	6 (5.5%)	11 (1.7%)
	ENABLING ENVIRONMENT	MDG Support for MCH services	132 (24.4%)	3 (2.7%)
Free ANC Services		88 (16.3%)	3 (2.7%)	91 (14.0%)
Regular Monthly Community Outreaches		397 (73.4%)	9 (8.2%)	406 (62.4%)
MSS Midwives		44 (8.1%)	5 (4.5%)	49 (7.5%)
SURE-P Midwives		38 (7.0%)	2 (1.8%)	40 (6.1%)

Table 5: Domain-by-domain summary disaggregated by level of facility (*continued*)

DELIVERY SITES	Other than health facilities where women deliver in this community	470 (86.9%)	82 (74.5%)	552 (84.8%)
	Other Places - Church	39 (7.2%)	10 (9.1%)	49 (7.5%)
	Other Places - Mosque	3 (0.6%)	2 (1.8%)	5 (0.8%)
	Other Places – TBA/Maternity home	88 (16.3%)	26 (23.6%)	114 (17.5%)
COMMUNITY SYSTEMS	Ward development committee	372 (68.8%)	14 (12.7%)	386 (59.3%)
	Village development committee	326 (60.3%)	8 (7.3%)	334 (51.3%)
	Community development association	321 (59.3%)	21 (19.1%)	342 (52.5%)
	Community-based organization	172 (31.8%)	7 (6.4%)	179 (27.5%)

Table 6: Domain-by-domain summary disaggregated by facility ownership

		FACILITY TYPE		
		Primary level n = 425	Secondary level n = 226	Total n = 651
SERVICE AVAILABILITY	Physical Exam (including weight, assessing GA, blood pressure)	419 (98.6%)	224 (99.1%)	643 (98.8%)
	Laboratory services (onsite or by referral): Hb, Urinalysis	292 (68.7%)	191 (84.5%)	483 (74.2%)
	Dispensing of haematinics and IPTp	392 (92.2%)	211 (93.4%)	603 (92.6%)
	Labour and delivery services (with 24 hour shifts)	387 (91.1%)	223 (98.7%)	610 (93.7%)
	Referrals for emergency obstetric and new-born care	413 (97.2%)	205 (90.7%)	618 (94.9%)
	Family Planning services (condoms, hormonal contraceptives)	332 (78.1%)	164 (72.6%)	496 (76.2%)
	Immunization services	416 (97.9%)	122 (54.0%)	538 (82.6%)
	Child follow up clinics	403 (94.8%)	176 (77.9%)	579 (88.9%)
	TB services (specify which - e.g. DOTS, microscopy)	40 (9.4%)	42 (18.6%)	82 (12.6%)
	HTC	143 (33.6%)	185 (69.9%)	301 (46.2%)
IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	Lab Room	277 (65.2%)	171 (75.7%)	448 (68.8%)
	Phlebotomy	16 (3.8%)	57 (25.2%)	73 (11.2%)
	ANC Space	38 (8.9%)	102 (45.1%)	140 (21.5%)
	ANC Room	402 (94.6%)	178 (78.8%)	580 (89.1%)
	Space for Confidential Counselling	359 (84.5%)	159 (70.4%)	518 (79.6%)
	Maternity Room	401 (94.4%)	209 (92.5%)	610 (93.7%)
	Pharmacy Store	315 (74.1%)	154 (68.1%)	469 (72.0%)
	Pharmacy Dispensary	22 (5.2%)	64 (28.3%)	86 (13.2%)
	HTC Adherence Counselling	334 (78.6%)	137 (60.6%)	471 (72.4%)
	Medical Records	265 (62.4%)	140 (61.9%)	405 (62.2%)
	DOTS Clinic	2 (0.5%)	10 (4.4%)	12 (1.8%)
	DOTS waiting area	2 (0.5%)	9 (4.0%)	11 (1.7%)

Table 6: Domain-by-domain summary disaggregated by facility ownership (*continued*)

ENABLING ENVIRONMENT	MDG Support for MCH services	130 (30.6%)	5 (2.2%)	135 (20.7%)
	Free ANC Services	85 (20.0%)	6 (2.7%)	91 (14.0%)
	Regular Monthly Community Outreaches	380 (89.4%)	26 (11.5%)	406 (62.4%)
	MSS Midwives	39 (9.2%)	10 (4.4%)	49 (7.5%)
	SURE-P Midwives	35 (8.2%)	5 (2.2%)	40 (6.1%)
DELIVERY SITES	Other than health facilities where women deliver in this community	368 (86.6%)	184 (81.4%)	552 (84.8%)
	Other Places - Church	12 (2.8%)	37 (16.4%)	49 (7.5%)
	Other Places - Mosque	2 (0.5%)	3 (1.3%)	5 (0.8%)
	Other Places – TBA/Maternity home	35 (8.2%)	79 (35.0%)	114 (17.5%)
COMMUNITY SYSTEMS	Ward development committee	349 (82.1%)	37 (16.4%)	386 (59.3%)
	Village development committee	309 (72.7%)	25 (11.1%)	334 (51.3%)
	Community development association	298 (70.1%)	44 (19.5%)	342 (52.5%)
	Community-based organization	60 (37.6%)	19 (8.4%)	179 (27.5%)

6.4 QUALITATIVE FINDINGS

Health workers were interviewed as part of the assessment process. The findings represent health worker perspectives and give an insight into issues that determine demand for health facility-based PMTCT services.

6.5.1 Most women prefer to deliver with TBAs, private clinics and churches

In the key informant interviews (KIIs) conducted with health workers in Abia State, indicated that many

women prefer the services of TBAs and churches during deliveries even though these women usually attend ANC at the health facilities. Some of the reasons provided for this observation include a firm traditional belief in the abilities of the TBA, perceived cost of services at the health facilities, the long distance to the facilities and unavailability of staff especially at night. Table 7 below captures all of these themes as well as the verbatim quotes from respondents supporting these themes.

Table 7: Women prefer to patronize traditional birth attendants (TBAs), private clinics and churches

THEMES	QUOTES
<p>Women prefer to patronize traditional birth attendants (TBAs), private clinics and churches</p>	<p>“You see all these women? You won’t see them here during delivery at all. They will all want to deliver at home.”</p> <p>“They prefer to come here (facility), some of them go to their churches to deliver.”</p>
<p>Why women prefer to deliver with TBAs</p>	<p>“Even though they come back here with bleeding and complete weakness, yet they will believe that it was for a different reason.”</p> <p>”They believe TBAs charge lower than PHCs.”</p> <p>“The staff here does not work at night.”</p> <p>“When they go to TBAs, often times there are complications and they had to run to us. It is safer for them to come here and deliver their babies to avoid such complications.”</p>
<p>Reasons for poor patronage of the health facilities</p>	<p>“Clients stopped coming because the staff are not always on ground.”</p> <p>“This clinic was supposed to be sited here, but because of the present Counselor, he took it to his own community which is out of the community.”</p> <p>“Look at where we are staying. It’s too small. We need a bigger space.”</p> <p>“We don’t have enough staff and most times women come in the night and do not meet anyone.”</p> <p>“This place is far from the village. We even find it difficult coming to work because of the distance.”</p>

6.5.2 Some health facilities are well patronized

Perceived reasons why some facilities were well patronized included a good relationship with the

community including the Village Development Committee (VCD) as well as security in the neighbourhood. These themes with verbatim quotes are summarized in Table 8 below.

Table 8: Reasons why some health facilities are well patronized

THEMES	QUOTES
Reasons for good patronage of health facility	“We don’t have any problem with anybody, we are all safe and free among ourselves in this community.”
Role of village/ward development committee	<p>“The VDC has been very helpful. They always invite us for meetings to give health talks, they encourage the community to patronize us and they donate materials sometimes.”</p> <p>“We always go to the people to talk to them and to encourage them on the importance of carrying out their deliveries here.”</p> <p>“Some of the equipment are donated by the community.”</p>

6.5.3 Perceived need of the facility in order to improve service quality

Health workers interviewed were of the opinion that better staffing of facilities, improved capacity building for

staff as well as provision of better structures and social amenities will go a long way to improve service quality in the state (see Table 9).

Table 9: Respondents’ suggestions on improving service quality

THEMES	QUOTES
Improved staffing	<p>“The government should bring more qualified staff and supply drugs regularly to the facilities.”</p> <p>“We need doctors in our facility.”</p>
Capacity building	<p>“We need to go for more training”.</p> <p>“We need more hands to assist us to work better.”</p>
Provision of better structures	<p>“We need the government to get us a better space to house the clinic.”</p> <p>We want government to help construct better facilities that are closer to the people (village).”</p> <p>“We need the government to get us better houses to live and work in.”</p>

6.5 SCENARIOS FOR ELIGIBILITY FOR PMTCT SERVICES

To plan scale up of PMTCT services, a decision is to be made on the number of facilities meeting important eligibility criteria. Table shows the number of assessed facilities which met these criteria when applying different cut-offs. The criteria relate specifically to basic health manpower requirements for PMTCT. Percentages are calculated based on all 651 facilities assessed.

National standards for PMTCT stipulate centres must have at least one doctor, a nurse, two other clinical health

staff in addition to one each of a pharmacy, laboratory and record officer. Only 44 of the 651 facilities met this standard. This number falls well short of that required to saturate Abia State with PMTCT services. Considering staff who can provide clinical care to include nurses and trained community health workers such as Community Health Officers (CHOs) and Community Health Extension Workers (CHEWs), 259 facilities have at least 4 such clinical care providers out of which 113 are public and 146 private corresponding to almost 40% of surveyed health facilities.

Table 10: Scenarios using different cut-offs – HR related

CRITERIA	CUT-OFF	OWNERSHIP	NUMBER OF FACILITIES ELIGIBLE	% OF TOTAL (N=651) FACILITIES
Have ANC but no PMTCT		Public	425	65.3
		Private	226	34.7
Availability of Doctors	At least 1	Public	13	2.0
		Private	183	28.1
Availability of Nurses/Midwives	At least 4	Public	26	4.0
		Private	50	7.7
Staff who can give clinical care	At least 4	Public	113	17.4
		Private	146	22.4
Minimum HR complement 1	At least 4 clinical care, 1 pharmacy, 1 lab, 1 records	Public	8	1.2
		Private	37	5.7
Minimum HR complement 2	At least 1 doctor, 4 nursing care, 1 pharmacy, 1 lab, 1 records	Public	4	0.6
		Private	36	5.5
Minimum HR complement 3 (National standard for PMTCT)	1 doctor, 1 nurse, 2 other health workers, 1 pharmacy, 1 lab, 1 records officer	Public	5	0.8
		Private	39	6.0
ANC attendance	Above state average	Public	21	3.2
		Private	74	11.4

SECTION

7 Geospatial representation of facilities

The maps below show the location of sites currently providing PMTCT services, assessed facilities, facilities meeting state-defined criteria for PMTCT service provision and the PMTCT landscape if facilities meeting state-defined criteria are added to existing sites providing PMTCT services.

Figure 3: Map showing currently existing PMTCT (ARVs) services

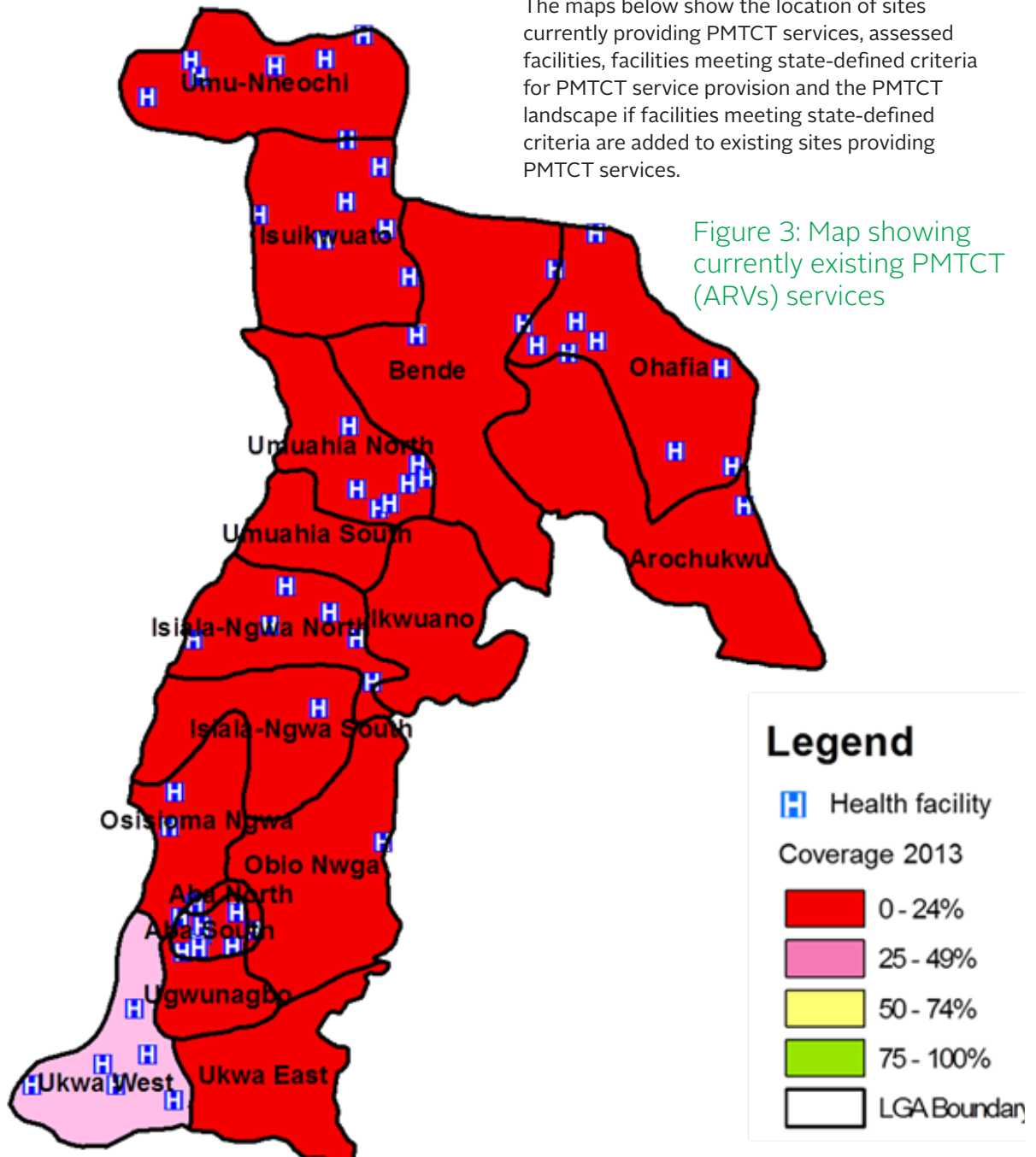


Figure 4: Map showing spread of assessed facilities (with ANC but no PMTCT)

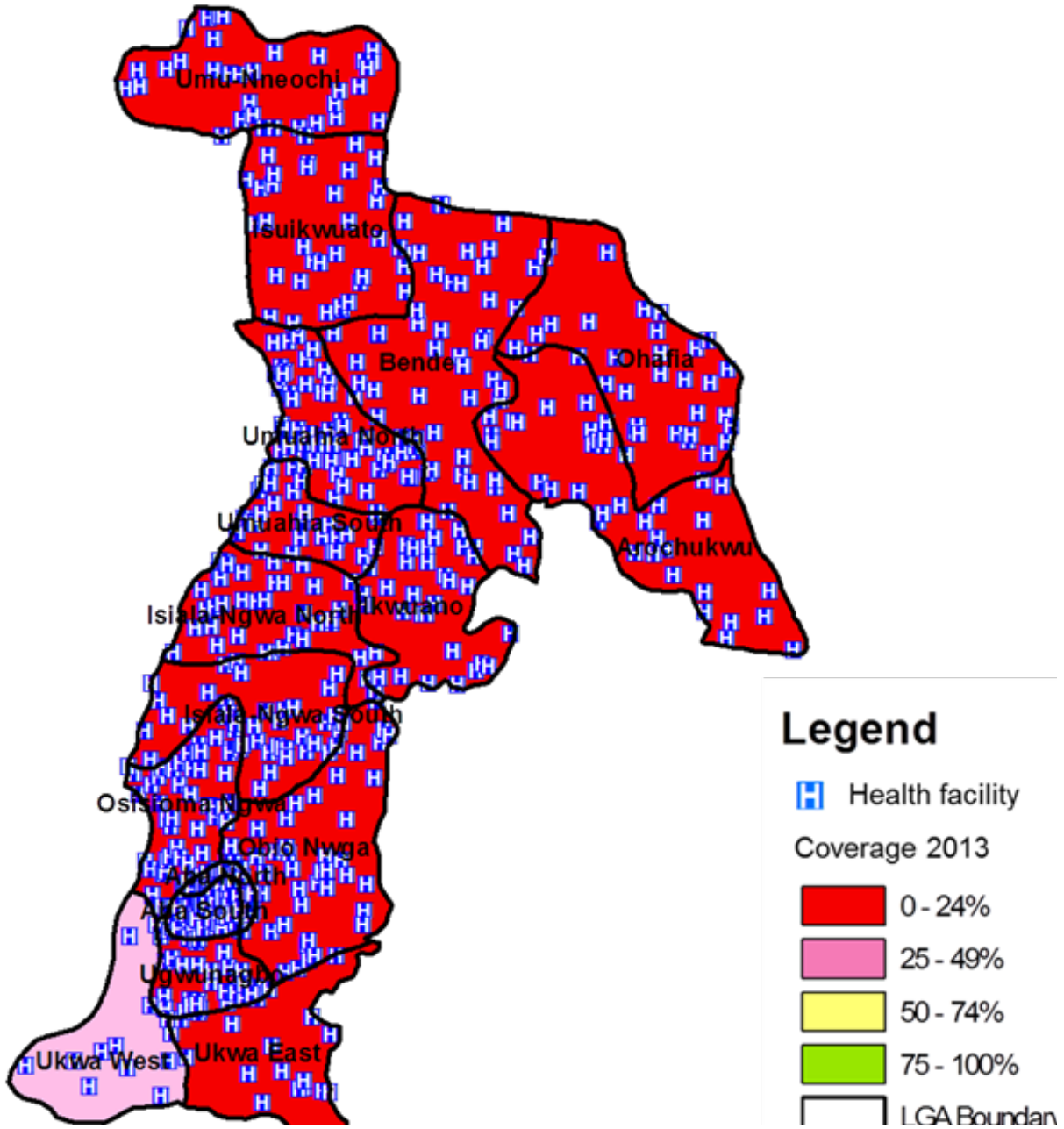


Figure 5: Map showing spread of facilities meeting national HR criteria for PMTCT services

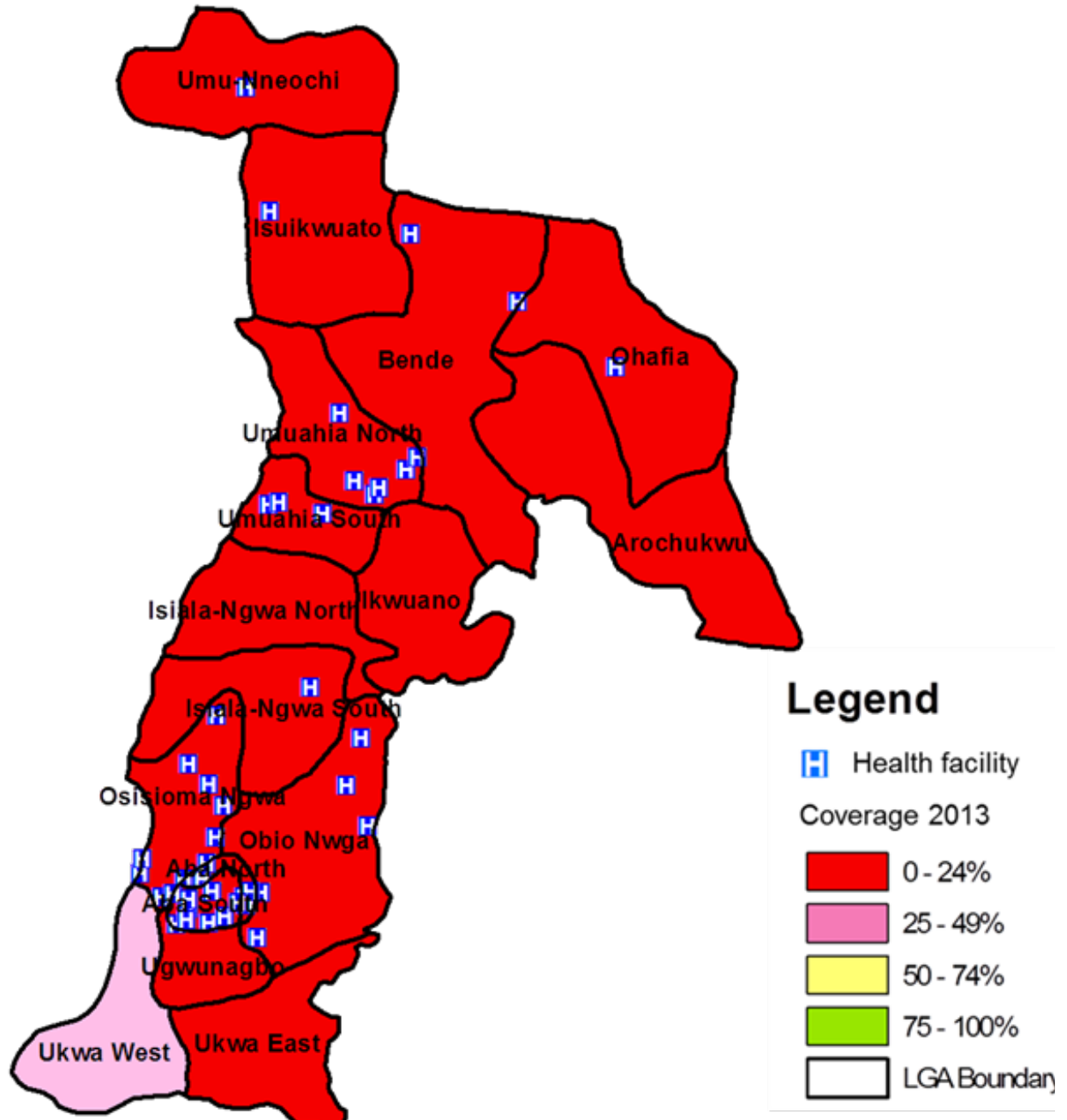


Figure 6: Map showing facilities meeting state-defined HR criteria for PMTCT services

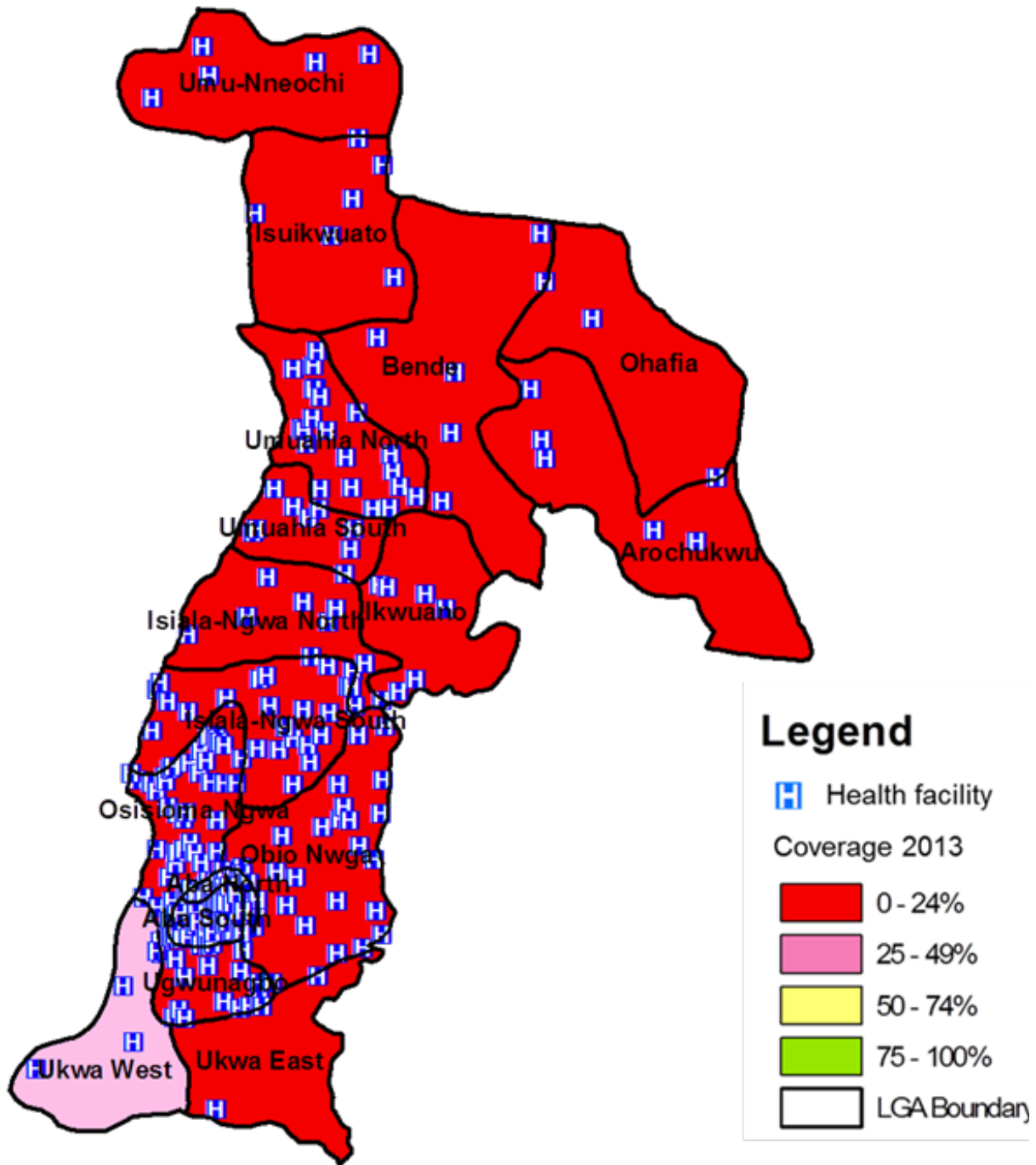


Figure 7: Map showing 2014 coverage scenario with current PMTCT sites and scale-up to those meeting national HR criteria

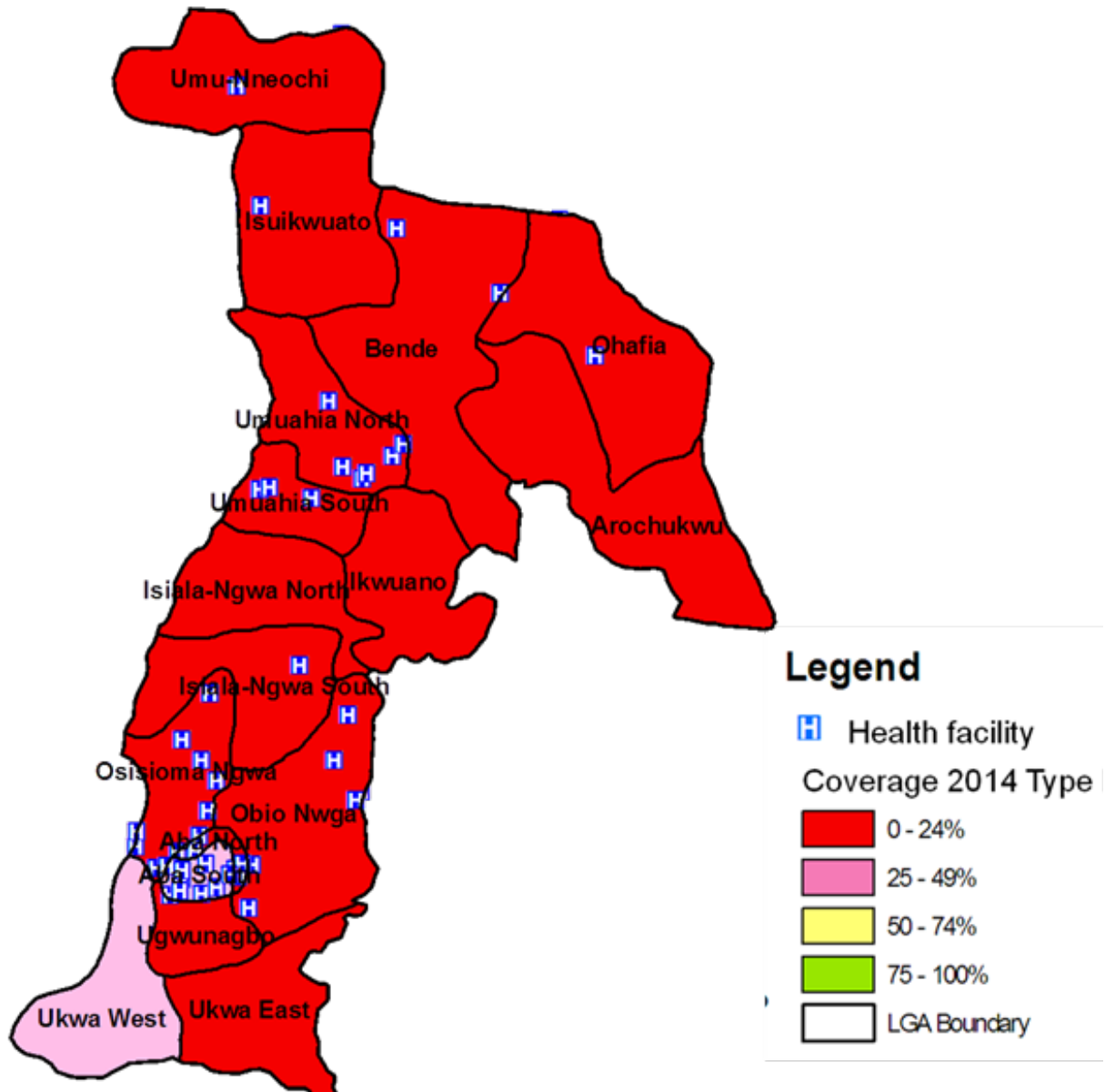


Figure 8: Map showing 2014 coverage scenario with current PMTCT sites + scale-up to sites meeting state-defined HR criteria

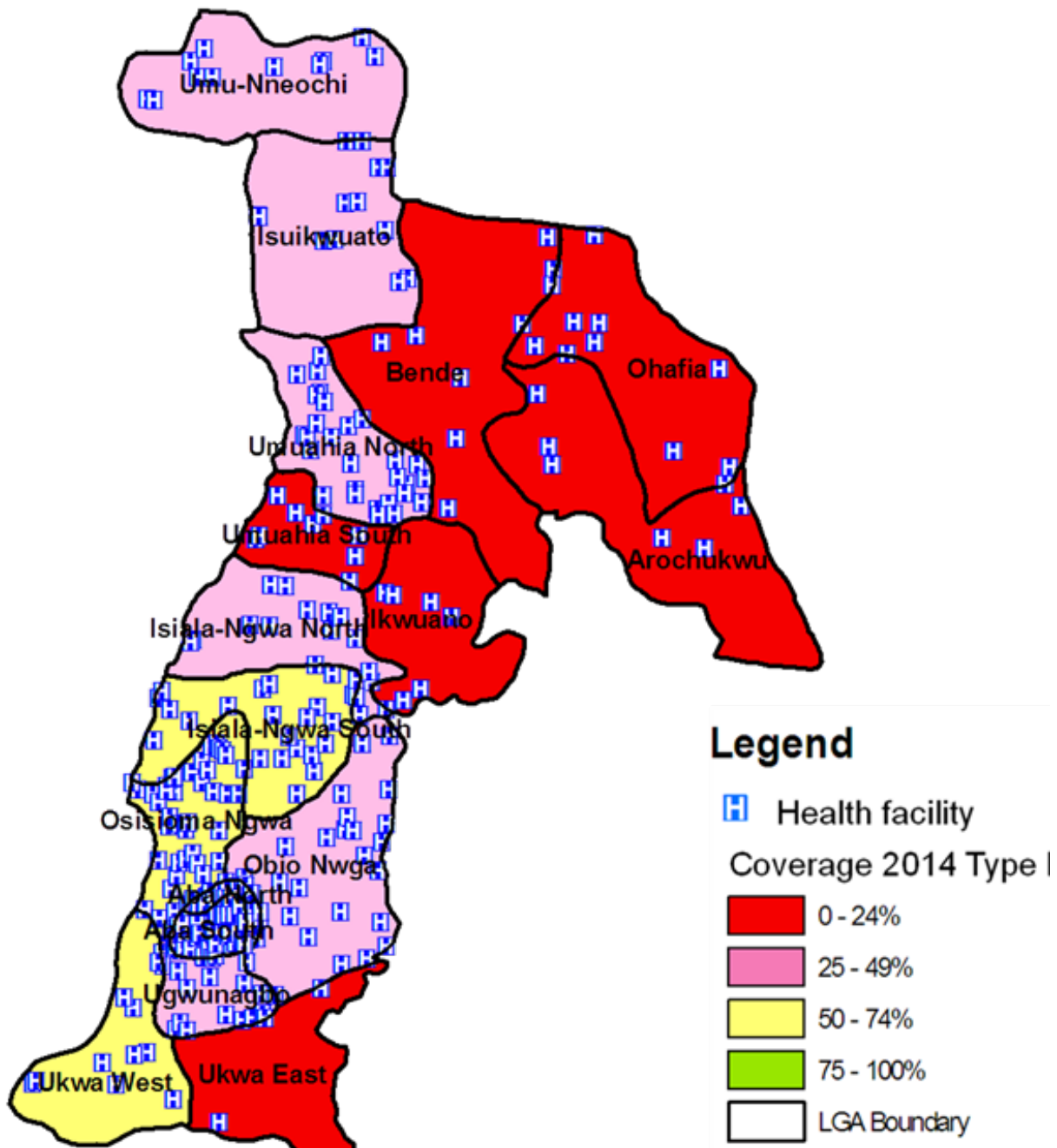
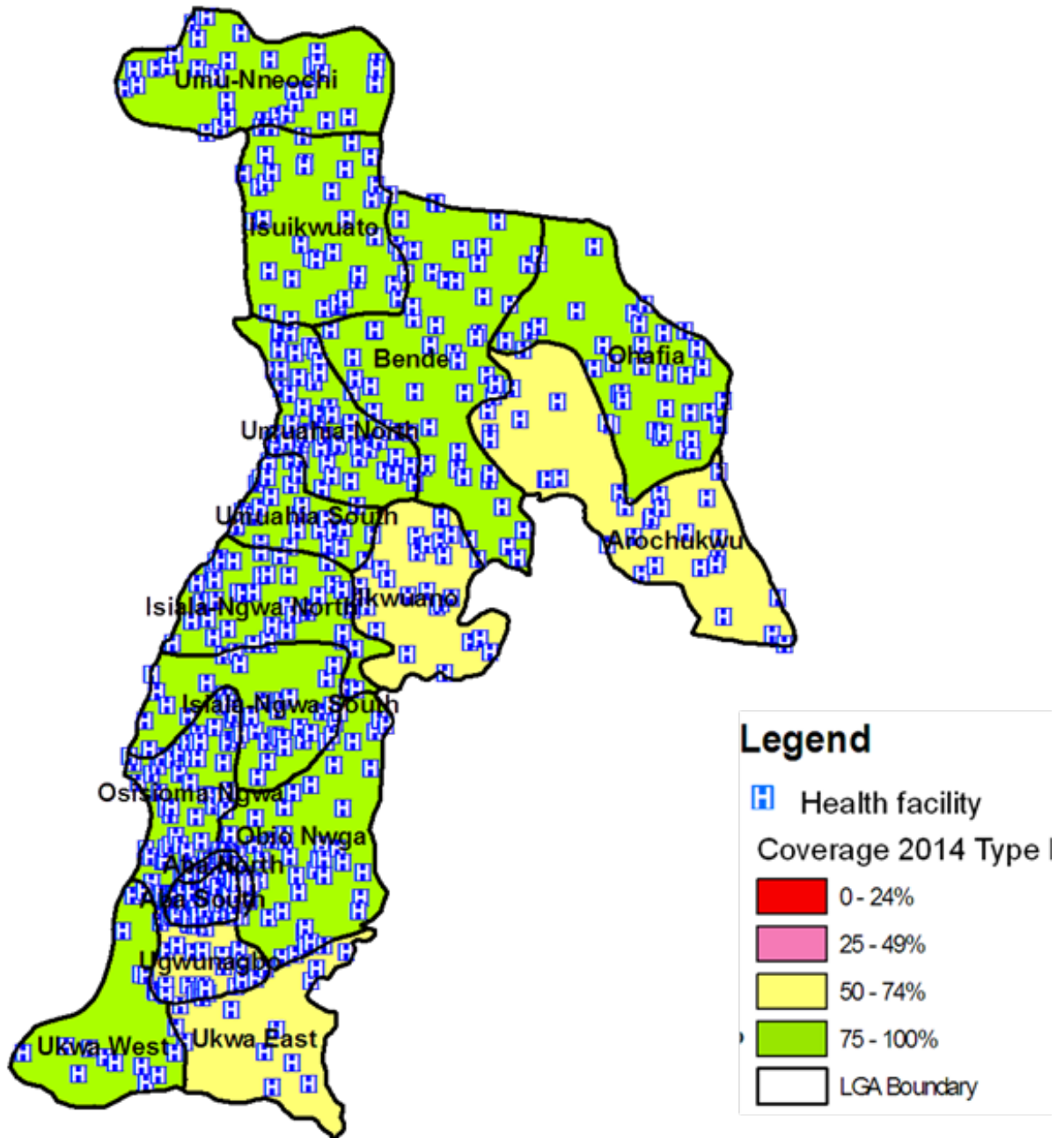


Figure 9: Map showing coverage scenario with current PMTCT sites + sites earmarked for scale-up towards eMTCT



SECTION

8

Conclusion

The findings of this assessment provide crucial information for effective scale up of PMTCT services in Abia state. PMTCT service coverage in the state is poor with wide coverage gaps. There are human and infrastructural gaps which currently limit HTC and would potentially threaten successful PMTCT scale up in the state. The state

is experiencing dual challenges of poor health facility utilisation and preference for births outside the health system should be addressed.

Private health facilities and the informal health sector play an important role in the delivery of MCH services.

SECTION

9

Recommendations

A comprehensive PMTCT plan based on collaborative efforts between the Government of Abia, donor organisations, implementing partners, civil society and other health system stakeholders should be developed to aid the achievement eMTCT in the state.

Facilities must be supported to provide ANC and delivery services to the population. This should include short and long term measures to address

the human resource gaps identified for PMTCT and the wider MCH service provision.

The state PMTCT plan must engage communities and important health service providers such as TBAs to expand access to HTC. Demand creation and other strategies are necessary to encourage facility delivery. These will be necessary to ensure optimal utilisation of scale-up services for eMTCT.

Appendix

Appendix 1: Human resources and service utilization disaggregated by level of facility

DOMAIN	ITEM	541 PRIMARY FACILITIES					110 SECONDARY FACILITIES				
		Median	Mean	Min	Max	Total	Median	Mean	Min	Max	Total
HUMAN RESOURCES	Number of doctors	0	0.2	0	5	129	2.0	2.0	0	15	224
	Number of registered nurse/midwife	1	1.1	0	13	590	2.0	3.0	0	24	335
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	3	2.3	0	15	1288	4.0	5.2	0	44	567
	Number of records officers	0	0.2	0	5	89	0	0.7	0	8	74
	Number of lab technician/scientists	0	0.3	0	8	163	1.0	1.6	0	7	44
	Number of pharmacy technician/pharmacists	0	0.1	0	6	64	1.0	1.3	0	7	151
SERVICE UTILIZATION	Number attended OPD in the last 12 months	291	105	0	8000	157525	720	1325	0	10000	145750
	ANC first attendees recorded in the last 12 months	30	80	0	2000	43332	129	716	0	29000	78868
	Deliveries taken in the last 12 months	13	46	0	5000	24892	67	428	0	14500	47055

Appendix 2: Human resources and service utilization disaggregated by facility ownership

DOMAIN	ITEM	541 PRIMARY FACILITIES					110 SECONDARY FACILITIES				
		Median	Mean	Min	Max	Total	Median	Mean	Min	Max	Total
HUMAN RESOURCES	Number of doctors	0	0.1	0	15	43	2.0	1.4	0	7	310
	Number of registered nurse/midwife	0	0.9	0	24	389	2.0	2.4	0	12	536
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	2	2.1	0	45	909	3.0	4.1	0	44	946
	Number of records officers	0	0.2	0	8	67	0	0.4	0	5	96
	Number of lab technician/scientists	0	0.2	0	7	88	1.0	1.0	0	8	226
	Number of pharmacy technician/pharmacists	0	0.1	0	8	45	0	0.3	0	6	77
SERVICE UTILIZATION	Number attended OPD in the last 12 months	86	186	0	2300	79089	376	992	0	10000	224186
	ANC first attendees recorded in the last 12 months	25	50	0	800	21400	100	446	0	29000	100800
	Deliveries taken in the last 12 months	10	22	0	744	9312	67	428	0	14500	52635

Appendix 3: Human Resource Gap for Doctors by LGAs

S/N	LGAS	PUBLIC (N = 425)			PRIVATE (N = 226)		
		Total no of facilities	Facilities with at least one doctor	Number of doctors needed to meet national standard	Total no of facilities	Facilities with at least one doctor	Number of doctors needed to meet national standard
1	Aba North	7	0	7	51	46	5
2	Aba South	6	1	5	46	40	6
3	Arochukwu	34	1	33	4	4	0
4	Bende	48	1	47	5	4	1
5	Ikwuano	31	2	29	3	1	2
6	Isiala-Ngwa North	27	0	27	11	4	7
7	Isiala-Ngwa South	27	1	26	9	2	7
8	Isiukwuato	33	1	32	4	3	1
9	Obi Ngwa	30	1	29	10	8	2
10	Ohafia	27	1	26	5	4	1
11	Osioma Ngwa	25	2	23	29	24	5
12	Ugwunagbo	22	0	22	12	8	4
13	Ukwa East	16	0	16	1	1	0
14	Ukwa West	11	0	11	0	0	0
15	Umuahia North	26	0	26	28	28	0
16	Umuahia South	26	1	25	6	5	1
17	Umu-Nneochi	29	1	28	2	1	1
Total		425	13	412	226	183	43

Appendix 4: Coverage gap for Nurses by LGA

S/N	LGAS	PUBLIC (N = 425)			PRIVATE (N = 226)		
		Total no of facilities	Facilities with at least one doctor	Number of nurses needed to meet national standard	Total no of facilities	Facilities with at least one doctor	Number of nurses needed to meet national standard
1	Aba North	7	7	0	51	47	4
2	Aba South	6	4	2	46	37	9
3	Arochukwu	34	6	28	4	3	1
4	Bende	48	15	33	5	3	2
5	Ikwuano	31	20	11	3	1	2
6	Isiala-Ngwa North	27	7	20	11	2	9
7	Isiala-Ngwa South	27	10	17	9	7	2
8	Isiukwuato	33	14	19	4	3	1
9	Obi Ngwa	30	17	13	10	8	2
10	Ohafia	27	10	17	5	2	3
11	Osioma Ngwa	25	14	11	29	23	6
12	Ugwunagbo	22	10	12	12	9	3
13	Ukwa East	16	9	7	1	1	0
14	Ukwa West	11	5	6	0	0	0
15	Umuahia North	26	16	10	28	25	3
16	Umuahia South	26	20	6	6	5	1
17	Umu-Nneochi	29	14	15	2	2	0
Total		425	198	227	226	178	48

Appendix 5: Coverage Gap Community Workers in assessed facilities by LGAs
(Trained Health Workers – CHOs, CHEWs etc.)

S/N	LGAS	PUBLIC (N = 425)			PRIVATE (N = 226)		
		Total no of facilities	Facilities with at least two community health staff	Number of community workers needed to meet national standard	Total no of facilities	Facilities with at least two community health staff	Number of community workers needed to meet national standard
1	Aba North	7	7	0	51	47	8
2	Aba South	6	6	0	46	44	4
3	Arochukwu	34	15	21	4	4	0
4	Bende	48	24	28	5	4	2
5	Ikwuano	31	17	22	3	0	5
6	Isiala-Ngwa North	27	20	7	11	5	9
7	Isiala-Ngwa South	27	27	0	9	6	5
8	Isiukwuato	33	22	12	4	3	2
9	Obi Ngwa	30	30	0	10	8	4
10	Ohafia	27	11	20	5	2	5
11	Osisioma Ngwa	25	24	1	29	28	1
12	Ugwunagbo	22	20	2	12	10	3
13	Ukwa East	16	13	4	1	1	0
14	Ukwa West	11	10	1	0	0	0
15	Umuahia North	26	13	23	28	28	0
16	Umuahia South	26	18	16	6	4	4
17	Umu-Nneochi	29	19	11	2	2	0
Total		425	296	412	226	196	52

Appendix 6: Coverage gap for Records Officers by LGA

S/N	LGAS	PUBLIC (N = 425)			PRIVATE (N = 226)		
		Total no of facilities	Facilities with at least one record officer	Number of one records officers needed to meet national standard	Total no of facilities	Facilities with at least one record officer	Number of one records officers needed to meet national standard
1	Aba North	7	2	5	51	14	37
2	Aba South	6	1	5	46	16	30
3	Arochukwu	34	2	32	4	0	4
4	Bende	48	3	45	5	3	2
5	Ikwuano	31	1	30	3	0	3
6	Isiala-Ngwa North	27	1	26	11	2	9
7	Isiala-Ngwa South	27	3	24	9	4	5
8	Isiukwuato	33	2	31	4	1	3
9	Obi Ngwa	30	5	25	10	6	4
10	Ohafia	27	5	22	5	2	3
11	Osisioma Ngwa	25	6	19	29	14	15
12	Ugwunagbo	22	3	19	12	0	12
13	Ukwa East	16	1	15	1	0	1
14	Ukwa West	11	0	11	0	0	0
15	Umuahia North	26	6	20	28	9	19
16	Umuahia South	26	3	23	6	2	4
17	Umu-Nneochi	29	1	28	2	0	2
Total		425	45	380	226	178	48

Appendix 7: Coverage gap for Laboratory Workers

S/N	LGAS	PUBLIC (N = 425)			PRIVATE (N = 226)		
		Total no of facilities	Facilities with at least one Lab worker	Number of Lab workers needed to meet national standard	Total no of facilities	Facilities with at least one Lab worker	Number of Lab workers needed to meet national standard
1	Aba North	7	5	2	51	37	14
2	Aba South	6	4	2	46	32	14
3	Arochukwu	34	2	32	4	3	1
4	Bende	48	1	47	5	3	2
5	Ikwuano	31	3	28	3	0	3
6	Isiala-Ngwa North	27	1	26	11	2	9
7	Isiala-Ngwa South	27	7	20	9	4	5
8	Isiukwuato	33	2	31	4	2	2
9	Obi Ngwa	30	5	25	10	8	2
10	Ohafia	27	3	24	5	4	1
11	Osisioma Ngwa	25	5	20	29	23	6
12	Ugwunagbo	22	4	18	12	3	9
13	Ukwa East	16	2	14	1	1	0
14	Ukwa West	11	1	10	0	0	0
15	Umuahia North	26	3	23	28	14	14
16	Umuahia South	26	7	19	6	6	0
17	Umu-Nneochi	29	1	28	2	0	2
Total		425	56	369	226	178	84

Appendix 8: Coverage Gap Pharmacy Staff in assessed facilities by LGAs

S/N	LGAS	PUBLIC (N = 425)			PRIVATE (N = 226)		
		Total no of facilities	Facilities with at least one Lab worker	Number of Lab workers needed to meet national standard	Total no of facilities	Facilities with at least one Lab worker	Number of Lab workers needed to meet national standard
1	Aba North	7	6	1	51	16	35
2	Aba South	6	2	4	46	15	31
3	Arochukwu	34	1	33	4	0	4
4	Bende	48	0	48	5	2	3
5	Ikwuano	31	0	31	3	0	3
6	Isiala-Ngwa North	27	0	27	11	2	9
7	Isiala-Ngwa South	27	2	25	9	1	8
8	Isiukwuato	33	1	32	4	1	3
9	Obi Ngwa	30	4	26	10	5	5
10	Ohafia	27	1	26	5	0	5
11	Osisioma Ngwa	25	1	24	29	9	20
12	Ugwunagbo	22	4	18	12	0	12
13	Ukwa East	16	1	15	1	0	1
14	Ukwa West	11	1	10	0	0	0
15	Umuahia North	26	2	24	28	7	21
16	Umuahia South	26	3	23	6	2	4
17	Umu-Nneochi	29	1	28	2	0	2
Total		425	30	395	226	60	166

Appendix 9: Staff requirements for all assessed facilities below national standard

S/N	HEALTH WORKER CADRE	NUMBER NEEDED TO MEET NATIONAL STANDARD IN PUBLIC FACILITIES	NUMBER NEEDED TO MEET NATIONAL STANDARD IN PRIVATE FACILITIES
1	Doctors	412	43
2	Nurses	227	48
3	Trained Health Workers – CHOs, CHEWs etc.	412	52
4	Record Officers	380	48
5	Lab. Scientist/ technicians	369	84
6	Pharmacist/pharmacy technicians	395	166

Appendix 10: List of contributors

ABIA STATE GOVERNMENT

Dr Christy Nwogwugwu	Dr Ukoha	Obike Sunday
Dr. Rock Hemuka	Elder Emenike Ibe	Obioma Anosike Ugonma
Chief Franklin Orji	I C Egwuogu	Ogbuehi Uzma
Rev. P C Nwabuko	Ihuoma Odoemena	Oyidiya Kalu
C C Eke	Jerry Imaga	Pharm C.C Chimaraoke
Charity Agwu	Mr Chidiebere Nwogwugwu	Rachael Iwezor
Chijioke Udeogu	Mr Solomon Offor	Rose Otutubuike
Chisom Ogbasugo	Mr. Itiba C.	Sis Jovita Nwoko Solomon Offor
Dr Azubuike Ikonke	Mrs Ada Nwuche	Theresa Nwafor
Dr Mrs Egwuekwe	Mrs Akunna	Uche Nwankwo
Dr Nwodondo	Mrs Augustina Nwachukwu	Ugochukwu Nwoke Oji
Dr Odoemelam	Mrs Elizabeth Adiele	Ugochukwu Onuoha
Dr Okey Okoroafor	Mrs May Madukwe	Victoria Nwakanma
Dr Okorie Onoka	Mrs Ngozi Chiege	
Dr Omende Kelechi	Mrs Nnenna Okorocho	
Dr Orikara	Ngozi Eke	
Dr Ugochukwu	Nkechi Anuriegbe	

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Phyllis Jones-Changa	Ngozi Ezema	Garba Walong
Dr Kwasi Torpey	Dr Justina Ifeora	Dr Layi Jaiyeola
Dr Robert Chiegil	Samsu Gombwer Olamide	Dr Akin Fasanmi
Dr Hadiza Khamofu	Agbaje Williams Ojo	Ugoh Emmanuel Ikechukwu
Dr Edward 'Kola Oladele	Dr Tunde Olaiya	Mahmud Khaled
Dr Mariya Saleh	Mrs Okache Adama	Chris Obominuru
Dr Uche Ralph-Opara	Dr Herbert Onuoha	Yoila S. Raymond
Dr Seun Asala	Joseph Okoegwale	Evelyn Ngige
Dr Maurice Ekanem	James Gba	Aisha Yusuf
Simpson Tumwikirize	Tony Idu Dr Olujide	Kunle Lawal
Olufunso Adebayo	John Ojo	Rebecca Dirks
	Angela Uche Eze	Jill Vitick

CONSULTANTS

Dr Oluwafemi Popoola
Dr Oluwaseun Akinyemi

Glossary

Acquired Immune Deficiency Syndrome (AIDS)

– This is a disease of the human immune system caused by HIV infection.

Antiretroviral drugs (ARVs) – Drugs used to treat HIV/AIDS.

Epidemic – The occurrence of a disease or health-related event above what is normally expected for the location and the period.

Human Immunodeficiency Virus (HIV) – The virus that causes AIDS.

Key Informant Interview (KII) – A qualitative research method in which individuals that are knowledgeable about an issue of interest are interviewed in order to obtain pertinent information.

Primary Health Care (PHC) – This is defined as “essential health care based on practical,

scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”.

Prevalence – The proportion of a population found to have a condition. It is arrived at by comparing the number of people found to have the condition with the total number of people studied, and is usually expressed as a fraction, as a percentage or as the number of cases per 10,000 or 100,000 people.

Sexually Transmitted Infections – These are illnesses that have a significant probability of transmission between humans by means of sexual behaviour e.g. gonorrhoea, syphilis etc.

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