Report of the Akwa Ibom state-wide

RAPID HEALTH FACILITY ASSESSMENT

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

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Foreword

The Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) have constituted a major development and health challenge in Nigeria, including Akwa Ibom state. Available records indicate that the epidemic in Akwa Ibom state has increased in Prevalence from 8.0% in 2003 to 10.9% by the last sentinel survey in 2010. The implication of this on mother-to-child transmission of the infection was therefore a serious concern to the government and people of the state. Projections from the available information had shown that over 10,000 infants stood the risk of getting the infection from their infected mothers if the state does not intervene to avert this. Akwa Ibom state, in addition to 11 other states and the Federal Capital Territory (FCT) constituting the states with the highest burden of the infection in Nigeria, therefore had to have a situation analysis done to provide a baseline towards scaling up PMTCT and other care, treatment and support services in the state.

There have been concerted efforts in the past by the state and partners (UNICEF) at profiling the status of maternal and child health services in the state. However, this is the first time Akwa Ibom state will be conducting an assessment of all health facilities (public and private) specifically, in response to the need to make PMTCT services available to the people of the state.

In this document therefore, is the background information that is needed to guide the state in satisfying our desire to saturate Akwa Ibom state with PMTCT services. Our goal is in line with national and global goal of elimination of mother-to-child transmission of HIV by 2015. It is our strong believe that our partners and stakeholder will find it an inevitable tool in supporting us to achieve this goal.

I therefore have no hesitation in recommending it to all.

Dr Emem Abasi Bassey

Hon. Commissioner
State Ministry of Health

Acknowledgements

I am pleased to be associated with the Akwa Ibom State report of the rapid assessment of private and public health facilities for the purpose of scaling up PMTCT services. This document intends to guide us from where we are to where we have to be in the nearest future if our efforts at eliminating mother to child transmission from our state are to yield expected results.

The production of this document has been made possible through the financial and technical support of the United States Agency for International Development (USAID) working through the Family Health International (FHI 360) as a main implementing partner in our state. I therefore, on behalf of the Hon Commissioner and the entire staff of the Ministry of Health, hereby acknowledge this tremendous support and say thank you. I need to also appreciate the extra energy put in by staff of the state HIV/AIDS and sexually transmitted diseases programme (SASCP) unit of the Ministry of Health at ensuring we have this report.

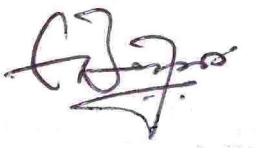
Our appreciation also goes to the Federal Ministry of Health, HIV and AIDS Division for their guidance and support. We cannot forget the support we received from our local and international partners. We thank you all.

We will not forget the support we have enjoyed and the partnership we have developed with the private facility proprietors as we begin this journey of eliminating infant HIV from our State. I am sure we will all be happy with ourselves at the end of it all.

To all those staff of the Local Government Service Commission, Hospital Management Board and the PHC departments of the 31 LGAs, I say thank you. I know I have not mentioned everybody that took part in this project. Please, rest assured that we appreciate you all.

I am convinced our collective efforts will pay off when in future we will remember our contributions in eliminating HIV from our state.

Thank You



Elder Esang Bassey

Permanent Secretary
State Ministry of Health

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care/Clinic
ARV	Antiretroviral
CHEW	Community Health Extension Worker
CSO	Civil Society Organisation
DOTS	Directly Observed Therapy Short course
eMTCT	Elimination of Mother-to-Child Transmission of HIV
FBO	Faith-Based Organisation
FHI 360	Family Health International
FSW	Female Sex Worker
GA	Gestational Age
HIV	Human Immunodeficiency Virus
HR	Human Resources
HTC	HIV Testing and Counselling
IP	Implementing Partner
IPTp	Intermittent Preventive Therapy for Malaria in pregnancy
JCHEW	Junior Community Health Extension Worker
LACA	Local Government Agency for the Control of HIV/AIDS
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MTCT	Mother-to-Child Transmission of HIV
NGO	Non-Governmental Organization
NPC	National Population Commission
OPD	Outpatient Department
PEPFAR	President's Emergency plan for AIDS Relief
PHC	Primary Health Centre
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
SACA	State Agency for the Control of HIV/AIDS
SASCP	State AIDS and STI Control Program
SMOH	State Ministry of Health
SURE-P	Subsidy Reinvestment and Empowerment Program
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WDC	Ward Development Committee

Executive Summary

Akwa Ibom State is ranked 2nd among the 12+1 states that contribute 70% of Nigeria's mother-to-child transmission of HIV (MTCT) burden. The HIV prevalence among pregnant women dipped to less than 8% in 2003 but has continued to rise to its current level of 10.9%. The 12+1 states have been earmarked by the Government of Nigeria for phase 1 of Nigeria's scale-up towards elimination of mother-to-child transmission of HIV (eMTCT).

In preparation for this scale-up, in February 2013, a rapid health facility assessment (R-HFA) was conducted in Akwa Ibom state. The goal of the assessment was to derive a baseline profile of antenatal care (ANC) services and thereby plan effective scale up of services to attain eMTCT in Akwa Ibom State.

A total of 408 facilities were visited, out of which 335 facilities were assessed. The 335 facilities were those found to provide antenatal care but with no support from any implementing partner for PMTCT services (ARVs). This report presents data from these facilities that constitute the majority of facilities with potential for PMTCT scale-up in Akwa Ibom State. Almost all the clinical and laboratory services which could serve as a platform for PMTCT services were available in most facilities assessed. Overall, the secondary facilities and private facilities were better staffed and had better outpatient department (OPD) and ANC attendance than primary level facilities. Findings revealed that many women in the state still prefer to deliver with traditional birth attendants (TBAs) and churches even though the women may attend ANC.

In order to scale-up PMTCT services efficiently in the state, the human resource gaps in the state need to be addressed. In addition, the community systems around primary level facilities must be fully utilized.

SECTION

1 Background

Akwa Ibom State is located in Nigeria's Niger Delta, in the coastal South-Southern part of the country with a population of 3,920,051 according to the 2006 census figures and a 2012 projected population of 4,655,127. The state was created in 1987 has a land area of 6,900 km2. Akwa Ibom State is made up of 31 Local Government Areas (LGAs) with Uyo as the state capital. Akwa Ibom shares a boundary on the North with Cross River and Imo States, on the south with the Atlantic Ocean, to the east with Cross River State and to the south-west with Akwa Ibom and Imo States. Major urban centres include Uyo, Eket, Ikot Ekpene, Abak, Ikot Abasi and Oron. Along with English, the main languages spoken are Ibibio, Annang, Eket, and Oron.

Akwa Ibom is an oil-producing state and more recently a tourist destination in Nigeria. The state is deeply religious and this shows not only in its name which translates to "The Great God of Heaven", but also in the rich relics of its traditional religion which have been preserved across the state. Akwa Ibom State is uni-cultural where the mores, taboos, customs and traditions are shared by the vast majority of the population.

SECTION

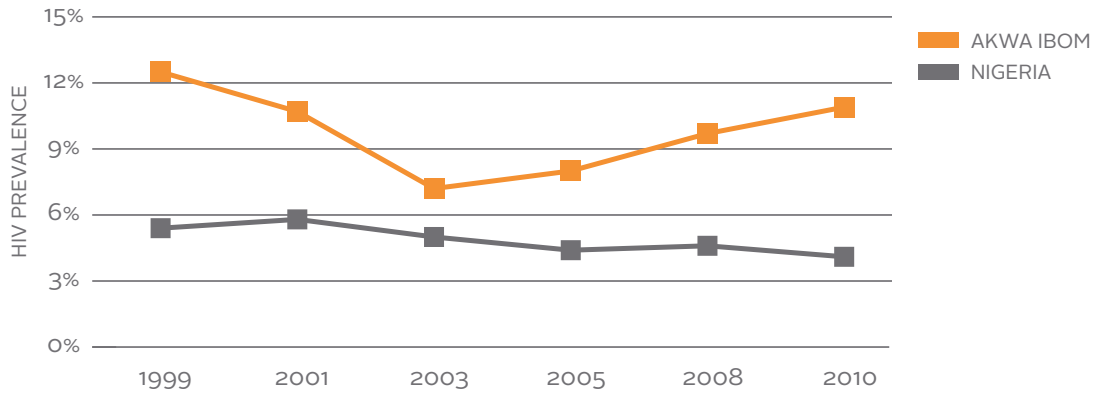
2 Akwa Ibom State HIV Profile

The Akwa Ibom State HIV prevalence has been rising steadily since 2003. The current HIV prevalence of 10.9% is far higher than the national prevalence of 4.8% (Figure 1).

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

There are about 3.14 million Nigerians living with HIV and about 154,920 new infections are in children. About 90% of HIV infections in children are as a result of MTCT. Nearly all of such infections can be prevented by effective PMTCT.

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



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

2.1 MTCT PROFILE FOR AKWA IBOM STATE

Estimates put the number of pregnant women in Akwa Ibom at 232,756 in 2012. Of these, approximately 22,115 (9.5%) were infected with HIV. Approximately one-third of whom would infect their babies in the absence of any intervention to prevent MTCT resulting in about 7,298 preventable HIV infections among infants in 2012 alone.

Table 1 presents the prevalence of HIV by LGA, MTCT burden and PMTCT coverage gap. Data revealed that Nsit Atai and Oron LGAs have the highest HIV prevalence in the state – 16.1% and 15.9%, respectively. The highest burden of HIV was in Eket. Other high burden LGAs were Ibiono Ibom, Mkpat Enin, Essien Udim and Uyo. There were 34 PMTCT sites in the state which are not equitably distributed; LGAs with the poorest coverage also include those with the highest HIV burden.

Table 1: LGA ranking of MTCT burden and PMTCT coverage in Akwa Ibom 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)	
Mkpat Enin	10.9%	1153	28	8	100.0%	22	50
Obot Akara	10.9%	958	24	26	100.0%	22	46
Nsit Ubium	10.9%	826	20	6	100.0%	22	42
Ukanafun	9.7%	726	19	13	100.0%	22	41
Ibiono Ibom	10.9%	1226	30	11	90.9%	17	47
Itu	13.3%	1014	25	16	93.8%	19	44
Nsit Atai	16.1%	705	18	11	100.0%	22	40
Oruk Anam	10.9%	1117	26	12	91.7%	10	36
Ikot Abasi	10.9%	862	22	17	94.1%	12	34
Eket	13.3%	1371	31	21	90.5%	4	35
Oron	15.9%	827	21	11	90.9%	21	42
Ika	9.7%	421	7	9	100.0%	22	29
Uyo	6.3%	1150	27	36	86.1%	1	28
Etim Ekpo	10.9%	689	17	11	90.9%	6	23
Nsit Ibom	6.5%	419	6	9	100.0%	22	28
Essien Udim	10.0%	1153	29	17	76.5%	2	31
Onna	6.3%	463	10	15	93.3%	12	22
Eastern Obollo	10.9%	390	5	6	100.0%	22	27
Esit Eket	9.7%	367	3	9	100.0%	22	25
Abak	10.9%	904	23	17	82.4%	3	26
Okobo	10.9%	668	15	10	90.0%	19	34
Udung Uko	10.9%	345	2	8	100.0%	22	24
Urue Offong/ Oruko	10.9%	460	9	11	90.9%	8	17
Mbo	9.4%	573	14	9	88.9%	8	22
Ibesikpo Asutan	6.3%	515	12	10	90.0%	18	30
Etinan	6.7%	675	16	20	85.0%	5	21
Uruan	6.9%	482	11	10	90.0%	12	23
Ikot Ekpene	3.2%	270	1	14	92.9%	12	13
Ibeano	12.5%	558	13	16	87.5%	7	20
Ini	6.3%	372	4	11	90.9%	11	15
Ikono	5.8%	456	8	9	88.9%	12	20
Total		**22,115**		**409**			

* LGA based HIV prevalence sourced from unpublished state survey
* Estimated number of HIV+ pregnant women was derived by multiplying the 2012 LGA population projection (national population commission, 2006 census) by the LGA HIV prevalence (source as above)

SECTION

3 Response to the HIV Epidemic

Recognizing the role of comprehensive PMTCT services in reducing the vertical transmission of HIV, the Akwa Ibom State government set up the State HIV/AIDS and STIs Control Programme. The Control Programme is housed within the State Ministry of Health (SMOH) which is responsible for the state's health sector response. The Akwa Ibom State Agency for Control of AIDS (AKSACA) was set up and is responsible for coordinating the multi-sectoral response to HIV/AIDS.

Also, international donors such as the United States Government and the Global Fund through their implementing partners (IP) have invested technical and financial resources in the HIV programming in the state. Some of the program areas funded in Akwa Ibom State by international donors include HIV counseling and testing (HTC), provision of antiretroviral drugs (ARVs), laboratory equipment and capacity building for government and health facility staff amongst others.

In light of the global and national commitment toward elimination of mother-to-child transmission of HIV, we therefore set out to assess the readiness of the state to ensure zero mother to child transmission of HIV by 2015. This involved a state-wide rapid health facility assessment, the findings of which will inform the development of a state-specific, costed eMTCT plan.

SECTION

4 Assessment Goal and Objectives

4.1 GOAL

The goal of this assessment was to establish a baseline profile of antenatal care services as an entry point for PMTCT and thereby plan effective scale up of these services to attain eMTCT in Akwa Ibom State.

4.2 OBJECTIVES

1. Assess health facilities in Akwa Ibom State and document those which meet minimum criteria to provide ARVs for PMTCT
2. To document the HR, infrastructure, enabling environment, services available and their utilization in assessed health facilities for the 12 months preceding the assessment
3. To explore provider perspectives on barriers to uptake of PMTCT services
4. To map the physical location of health facilities using global positioning system (GPS) coordinates

SECTION

5 Assessment Design

This survey used mixed (quantitative and qualitative) methodologies to determine the status of the health system to deliver PMTCT services in Akwa Ibom State. The assessment took place in all 31 LGAs of the state.

5.1 SAMPLING/SITE SELECTION

A complete list of all health facilities in the state was obtained from the Department of Planning, Research and Statistics (DPRS) of the Akwa Ibom State Ministry of Health. All public and private health facilities which met defined criteria were and assessed. All facilities with antenatal services were included while facilities with current IP support providing ARVs for PMTCT or those with plans for PMTCT services in 2013 (Global Fund or PEPFAR) were excluded. Out of a total of 590 registered facilities in the state, 335 facilities with ANC services but with no support from any IP for PMTCT services (ARVs) were assessed (Figure 2).

Box 1: Site selection

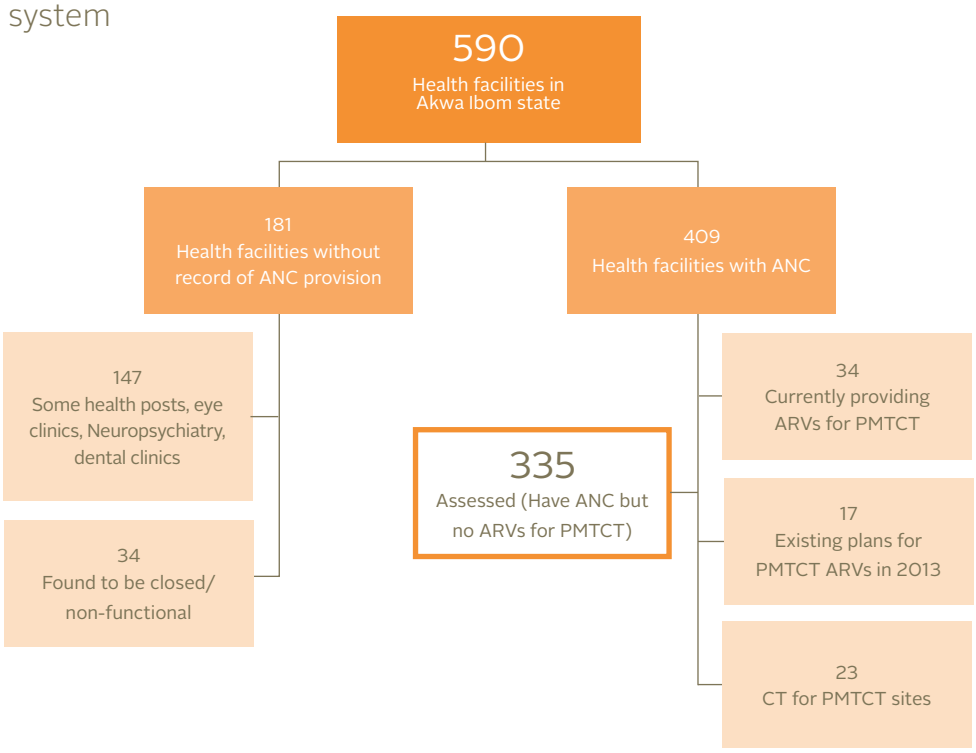
Site Inclusion Criterion

1. Providing ANC

Site Exclusion Criteria

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

Figure 2: Location of assessed health facilities within the Akwa Ibom state health system



5.2 STUDY TOOL

The Akwa Ibom State R-HFA tool consisted of both quantitative and qualitative components. The tool was divided into three sections: an assessment of facility characteristics including Global Positioning System (GPS) coordinates, domains necessary for service provision and a qualitative component. There were seven domains which covered PMTCT programmatic components for scale-up: linkages, human resources, client flow, and availability of maternal and child health (MCH) services, enabling environment, infrastructure and community systems.

The qualitative component of the survey consisted of key informant interviews with health workers 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 Akwa Ibom State Ministry of Health led this assessment exercise with technical support from FHI 360 and funding from USAID. A planning meeting was convened by the Ministry of Health with the State Agency for the Control of HIV/AIDS (SACA), LGA Health Department and FHI 360 to discuss logistics and mobilize stakeholders.

Fifteen teams comprised of three members each were deployed in February 2013 to conduct the assessment in all LGAs of the state. GPS devices were used to obtain location co-ordinates for facilities. Key informant interviews were conducted with the heads of facilities and where available, heads of laboratory and pharmacy units.

5.4 CHALLENGES

Access to facilities was limited in some communities along the river.

SECTION

6 Findings

A total of 408 facilities were visited, out of which 335 facilities were assessed. The 335 facilities were those found to provide ANC but did not receive support from an implementing partner to provide ARVs for PMTCT. The sections below present data from these facilities that constitute the bulk of facilities with potential for PMTCT scale-up in Akwa Ibom State.

6.1 CHARACTERISTICS OF FACILITIES

Table 2 shows the distribution of the assessed facilities disaggregated by their ownership and level of service delivery. Two hundred and eighty-nine were primary level facilities while the remaining were secondary facilities. Similarly, the majority of the facilities were public (282) while 53 were private facilities.

6.2 HUMAN RESOURCES AND SERVICE UTILIZATION

Table 3 below presents the human resources and service utilization disaggregated according to facility level. Human resource shortages were measured by the average number of each cadre per facility and the proportion of facilities without any worker in the assessed cadre. Cadres assessed were doctors, nurses/midwives, trained community workers, laboratory, medical records and pharmacy staff. The data showed fewer staff and wider coverage gaps in primary facilities compared to secondary health centres. On average, the secondary facilities had a higher number of health workers across every category compared with the primary facilities; only 8% of the primary facilities were covered by doctors, whereas almost all (97.6%) facilities assessed had a nurse/midwife.

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	1	1	2
Private for profit	12	39	51
Sub-total (private)	13	40	53
Public			
LGA	213	0	213
State government	63	6	69
Sub-total	276	6	282
Overall total	**289**	**46**	**335**

Pharmacy technicians/pharmacists, laboratory technicians and records officers were the fewest per facility of all the health worker cadres. The average number of 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.

Table 4 below presents HR resources disaggregated according to ownership of facility.

The results show that on the average, private facilities had a higher number of health workers across all cadres when compred to public facilities. For example, almost all (94.3%) of private facilities had at least a doctor whereas only 6% of publicly owned facilities were covered by a physician. Similarly, the private facilities had a much higher rate of utilization compared with the public facilities in terms of OPD and ANC attendance, as well as deliveries occuring in the last 12 months.

Table 3: Human resources and service utilization disaggregated by level of facility

DOMAIN	Item	289 PRIMARY FACILITIES			46 SECONDARY FACILITIES			TOTAL (335)		
		Avg.	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Avg.	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Avg.	Proportion of facilities reporting zero	Proportion of facilities reporting at least one
HUMAN RESOURCES	Doctors	0.1	92.0%	8.0%	2.0	4.3%	95.7%	0.4	80.0%	20.0%
	Registered nurse/midwife	2.5	1.4%	98.6%	4.8	8.7%	91.3%	2.8	2.4%	97.6%
	Other trained health workers (Community Nurses, CHOs, CHEWs)	3.0	6.2%	93.8%	3.5	31.1%	68.1%	3.1	9.6%	90.4%
	Record officers	0.2	86.4%	13.6%	0.8	43.5%	56.5%	0.3	80.5%	19.5%
	Laboratory technician/ scientists	0.2	85.4%	14.6%	1.0	23.9%	76.1%	0.3	76.9%	23.1%
	Pharmacy technician/ pharmacists	0.1	93.7%	6.3%	0.7	50.0%	50.0%	0.2	87.7%	12.3%
SERVICE UTILIZATION	OPD attendance in the last 12 months	339.4	1.7%	98.3%	1256.6	0.0%	100.0%	465.4	1.5%	98.5%
	ANC first attendees recorded in the last 12 months	81.7	2.4%	97.6%	203.5	6.5%	93.5%	98.4	3.0%	97.0%
	Deliveries taken in the last 12 months	9.8	54.0%	46.0%	53.7	19.6%	80.4%	15.8	49.2%	50.8%

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

DOMAIN	Item	282 PUBLIC FACILITIES			53 PRIVATE FACILITIES			TOTAL (335)		
		Avg.	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Avg.	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Avg.	Proportion of facilities reporting zero	Proportion of facilities reporting at least one
HUMAN RESOURCES	Doctors	0.1	94.0%	6.0%	1.9	5.7%	94.3%	0.4	80.0%	20.0%
	Registered nurse/midwife	2.6	1.1%	98.9%	3.8	9.4%	90.6%	2.8	2.4%	97.6%
	Other trained health workers (Community Nurses, CHOs, CHEWs)	3.1	5.0%	95.0%	3.2	34.6%	65.4%	3.1	9.6%	90.4%
	Record officers	0.2	87.5%	12.5%	0.7	43.4%	56.6%	0.3	80.5%	19.5%
	Laboratory technician/ scientists	0.2	86.1%	13.9%	1.0	28.3%	71.7%	0.3	76.9%	23.1%
	Pharmacy technician/ pharmacists	0.1	93.9%	6.1%	0.7	54.7%	45.3%	0.2	87.7%	12.3%
SERVICE UTILIZATION	OPD attendance in the last 12 months	337.3	1.8%	98.2%	1146.9	0%	100%	465.4	1.5%	98.5%
	ANC first attendees recorded in the last 12 months	74.6	2.5%	97.5%	225.0	5.7%	94.3%	98.4	3.0%	97.0%
	Deliveries taken in the last 12 months	8.0	56.1%	43.9%	57.8	13.2%	86.8%	15.8	49.2%	50.8%

6.3 DOMAIN-BY-DOMAIN SUMMARY

Table 5 summarizes findings related to the scope of service available in facilities, facility infrastructure, environmental enablement for MCH and community support/participation disaggregated by facility level. Almost all the clinical and laboratory services were available in most facilities assessed. However TB services were available in only a few facilities (16%). A greater proportion of these facilities were secondary level. The structure identified to be deficient the most among primary level facilities was space for laboratory (55.6%).

The enabling environment seems to be better around the primary level facilities as they had more MDG support (16.1% vs. 2.2%), free ANC services (50.3% vs. 15.2%) and regular monthly outreaches (93.2% vs. 30.4%). None of the secondary facilities had MSS midwives. Furthermore, the results also show better community systems around the primary level facilities compared with the secondary facilities. These are presented in the tables on the next page.

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

		FACILITY TYPE		
		Primary level n = 289	Secondary level n = 46	Total n = 335
SERVICE AVAILABILITY	Physical Exam (including weight, assessing GA, blood pressure)	279 (95.5%)	46 (100%)	325 (96.2%)
	Laboratory services (onsite or by referral): Hb, Urinalysis	151 (51.7%)	45 (97.8%)	196 (58.0%)
	Dispensing of haematinics and IPTp	275 (94.2%)	44 (95.7%)	319 (94.4%)
	Labour and delivery services (with 24 hour shifts)	133 (45.5%)	43 (93.5%)	176 (52.1%)
	Referrals for emergency obstetric and new-born care	254 (87.0)	37 (80.4%)	291 (86.1%)
	Family Planning services (condoms, hormonal contraceptives)	225 (77.1%)	31 (67.4%)	256 (75.7)
	Immunization services	282 (96.6%)	18 (39.1%)	300 (88.8%)
	Child follow up clinics	250 (85.6%)	38 (82.6%)	288 (85.2%)
	TB services (specify which - e.g. DOTS, microscopy)	39 (13.4%)	14 (30.4)	53 (15.7%)
IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	Lab Room	145 (77.1%)	43 (93.5%)	188 (55.6%)
	ANC Space & Room	253 (86.6%)	44 (95.7%)	297 (87.9%)
	Space that can be used for confidential counseling	204 (69.9%)	42 (91.3%)	246 (72.8%)
	Maternity Room	194 (66.4%)	44 (95.7%)	238 (70.4%)
	Pharmacy, Store & Dispensary	164 (56.2%)	42 (91.3%)	206 (60.9%)
	Space for HTC/Adherence counseling	178 (61.0)	34 (73.9%)	212 (62.7%)
	Medical records/M&E	152 (52.1%)	37 (80.4%)	189 (55.9%)
ENABLING ENVIRONMENT	MDG Support for MCH services	47 (16.1%)	1 (2.2%)	48 (14.2%)
	Free ANC Services	147 (50.3%)	7 (15.2%)	154 (45.6%)
	Regular Monthly Community Outreaches	272 (93.2%)	14 (30.4%)	286 (84.6%)
	MSS Midwives	41 (14.0%)	0 (0%)	41 (12.1%)
COMMUNITY SYSTEMS (ARE THE FOLLOWING AVAILABLE?)	Other than health facilities where women deliver in this community	285 (98.6%)	44 (95.7%)	329 (98.2%)
	Ward development committee	252 (86.3%)	22 (47.8%)	274 (81.1%)
	Village development committee	197 (67.5%)	22 (47.8%)	219 (64.8%)
	Community development association	149 (51.0%)	23 (50.0%)	172 (50.9%)
	Community-based organization	151 (51.7%)	22 (47.8%)	173 (51.2%)

Table 6 has domain responses disaggregated by facility ownership. The patterns of availability of various service components are similar to those shown previously in Tables 4 and 5 on the previous page. Findings revealed that TB and laboratory services were available in the fewest facilities.

Table 6: Summary of domain responses disaggregated by facility ownership

		FACILITY TYPE		
		Public facilities n=282	Secondary level n = 53	Total n = 335
SERVICE AVAILABILITY	Physical Exam (including weight, assessing GA, blood pressure)	272 (96.5%)	53 (100%)	325 (97.0%)
	Laboratory services (onsite or by referral): Hb, Urinalysis	136 (48.2%)	3 (5.7%)	139 (41.5%)
	Dispensing of haematinics and IPTp	270 (95.7%)	49 (92.5%)	319 (95.2%)
	Labour and delivery services (with 24 hour shifts)	125 (44.3%)	51 (96.2%)	176 (52.5%)
	Referrals for emergency obstetric and newborn care	247 (87.6%)	44 (83.0%)	291 (86.9%)
	Family Planning services (condoms, hormonal contraceptives)	223 (79.1%)	33 (62.3%)	256 (76.4%)
	Immunization services	279 (98.9%)	21 (39.6%)	300 (89.6%)
	Child follow up clinics	244 (86.5%)	44 (83.0%)	288 (86.0%)
	TB services (specify which - e.g. DOTS, microscopy)	39 (13.8%)	14 (26.4%)	53 (15.8%)
IDENTIFIED STRUCTURE *(CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)*	Lab Room	141 (50.0%)	47 (88.7%)	188 (56.1%)
	ANC Space & Room	248 (87.9%)	49 (92.5%)	297 (88.7%)
	Space that can be used for confidential counseling	198 (70.2%)	48 (90.6%)	246 (73.4%)
	Maternity Room	189 (67.0%)	49 (92.5%)	238 (71.0%)
	Pharmacy, Store & Dispensary	160 (56.7%)	46 (86.8%)	206 (61.5%)
	Space for HTC/Adherence counseling	173 (61.3%)	39 (73.6%)	212 (63.3%)
	Medical records/M&E	146 (51.8%)	43 (81.1%)	189 (56.4%)

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

ENABLING ENVIRONMENT	MDG Support for MCH services	47 (16.7%)	1 (1.9%)	48 (14.3%)
	Free ANC Services	148 (52.5%)	6 (11.3%)	154 (46.0)
	Regular Monthly Community Outreaches	272 (96.5%)	14 (26.4%)	286 (85.4%)
	MSS midwives	36 (12.8%)	5 (9.4%)	41 (12.2%)
COMMUNITY SYSTEMS *(ARE THE FOLLOWING AVAILABLE?)*	Other than health facilities where women deliver in this community	279 (98.9%)	50 (94.3%)	329 (98.2%)
	Ward development committee	251 (89.0)	23 (43.4%)	274 (81.8%)
	Village development committee	196 (69.5%)	23 (43.4%)	219 (65.4%)
	Community development association	145 (51.4%)	27 (50.9%)	172 (51.3%)
	Community-based organization	147 (52.1%)	26 (49.1%)	173 (51.6%)

6.4 QUALITATIVE FINDINGS

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

6.4.1 Many women deliver with traditional birth attendants (TBAs) and churches

Results of the key informant interviews (KIIs) conducted with health workers in Akwa Ibom State revealed that many women still prefer to deliver with TBAs and churches even though they may attend ANC. Apart from the traditional trust in TBAs, other reasons proffered by respondents why health facilities delivery might not be popular with women include unavailability of health workers and women's fear for assisted delivery. Table 7 below presents verbatim quotes from respondents illustrating these themes.

Table 7: Some women prefer to patronize TBAs, private clinics and churches

THEMES	QUOTES
Why women prefer to deliver with TBAs	"They are more skilled." "Our mothers delivered with TBAs." "Mama Udoh has been doing this work since I was born and she has never had any problem and she can come to my house any time."
Reasons for poor patronage of the health facilities	"Most women don't come here for delivery, they said they are afraid that we do cut them with scissors if there is difficulties during delivery." "The staff here does not work at night." "Clients stopped coming because the staff are not always on ground." "The staff posted previously here did not treat clients well."

6.4.2 Role of Village Development Committees

Respondents were of the opinion that the village development committee can be both helpful and divisive. They can be very helpful in promoting a good relationship between the health facility and the community and also in providing security. The divergent views expressed by respondents are presented in Table 8 below.

Table 8: Reasons why some health facilities are well patronized

THEMES	QUOTES
Role of village/ward development committee	"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." "The grasses around the facility is being cleared by the community members." "Some of the equipment are donated by the community." "Some town hall officials told us to leave this place since; they instructed us to always leave the doors of the hall open to afford access to their hall any time." "In fact, one of them even pursued me in my dreams."

6.4.3 Perceived areas needing greatest improvement

In the opinion of health workers, better staffing, improved capacity building, provision of better infrastructure and better community participation 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	"We don't have enough staff and most times women come in the night and do not meet anyone." "We need the government to get us a better space to house the clinic and accommodate us."
Capacity building	"We need more staff to work better."
Provision of better structures	"Look at where we are staying. It's too small. We need a bigger space."
Community support	"We need the VDC/WDC to encourage their women to access/utilize the services we provide here."

6.5 SCENARIOS FOR ELIGIBILITY FOR PMTCT SERVICES

The number of facilities that meet different cut-offs in terms of eligibility to provide PMTCT services is presented in Table 7 disaggregated by ownership. The percentages use the total number of assessed facilities as the denominator. A simple addition of proportions of private and public facilities therefore gives the total proportion of facilities assessed in the state that met the particular criterion. More private facilities met the minimum HR complement while more public facilities met the composite criterion.

Table 10: Scenarios using different cut-offs

CRITERIA	CUT-OFF	OWNERSHIP	NUMBER OF FACILITIES ELIGIBLE	% OF TOTAL ASSESSED FACILITIES
Have ANC but no IP		Public	282	84.2
		Private	53	15.8
Availability of Doctors	At least 1	Public	17	5.1
		Private	50	14.9
Availability of Nurses/Midwives	At least 4	Public	43	12.8
		Private	23	6.9
Staff who can give nursing care	At least 4	Public	172	51.3
		Private	45	13.4
Clinical care (Nurses with health workers who can give nursing care)	At least 4	Public	175	52.2
		Private	45	13.4
ANC attendance in the last 12 months	Above state average	Public	60	17.9
		Private	21	6.3
Deliveries taken in the last 12 months	At least 1	Public	123	36.7
		Private	46	13.7
Minimum HR complement 1	At least 4 nursing care, 1 pharmacy, 1 lab, 1 records	Public	12	3.6
		Private	14	4.2
Minimum HR complement 2	At least 1 doctor, 4 nursing care, 1 pharmacy, 1 lab, 1 records	Public	9	2.7
		Private	14	4.2
Minimum HR complement 3 (National standard for PMTCT service)	1 doctor, 1 nurse, 2 other health workers, 1 pharmacy, 1 lab, 1 records officer	Public	9	2.7
		Private	16	4.8
Composite criterion	At least 4 nursing care, 1 pharmacy, 1 lab, 1 records, above average ANC attendance, at least 1 delivery	Public	7	2.1
		Private	6	1.8

SECTION

7 Geospatial representation of facilities

The maps below show the location of sites currently providing PMTCT services, assessed facilities, facilities which met the state-defined and national HR criteria for PMTCT service provision. It also presents the PMTCT landscape for different coverage scenarios by end of 2014.

Figure 3: Map illustrating current PMTCT sites in Akwa Ibom state

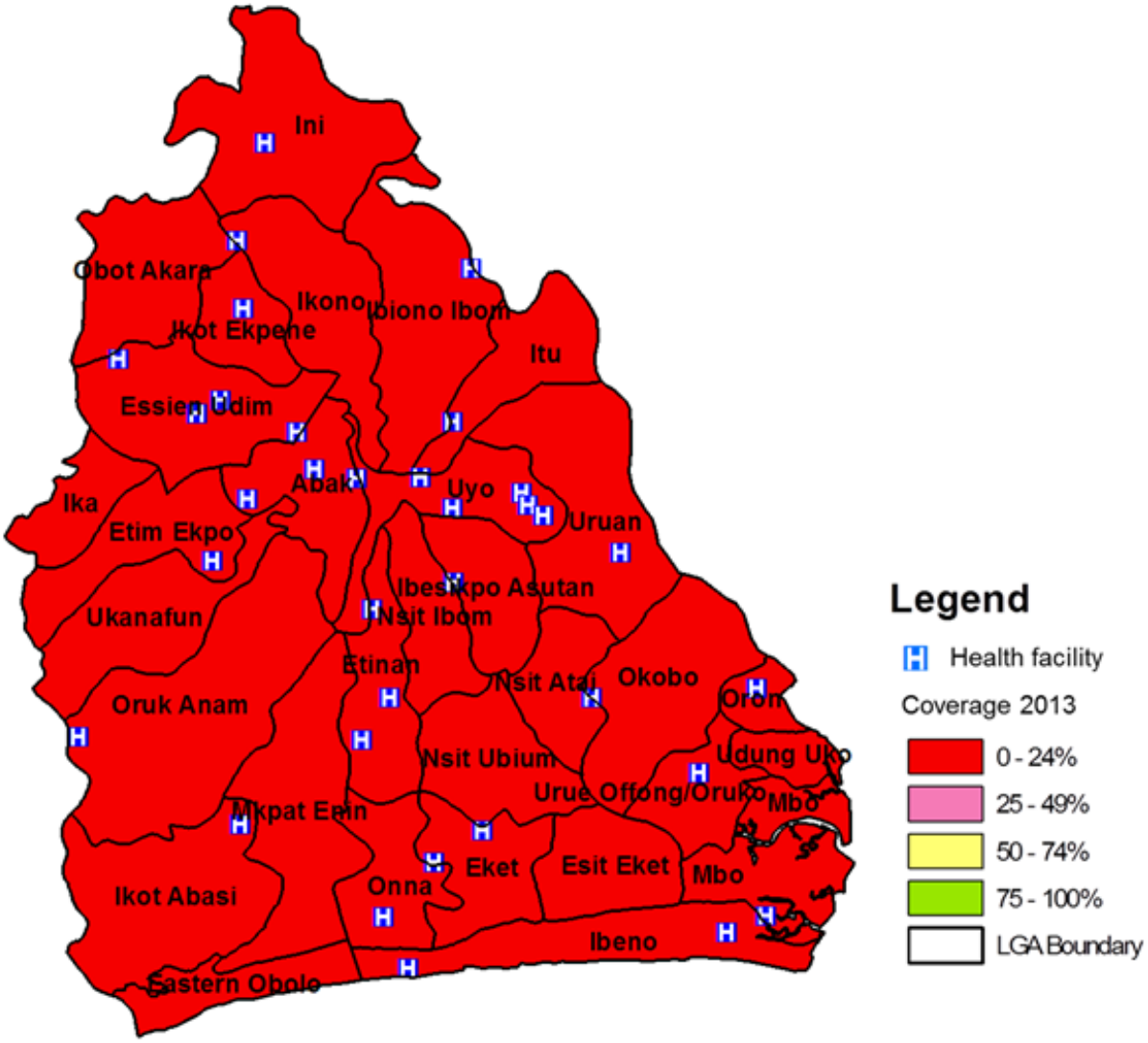


Figure 4: Map illustrating spread of 335 assessed facilities (with ANC but no PMTCT)

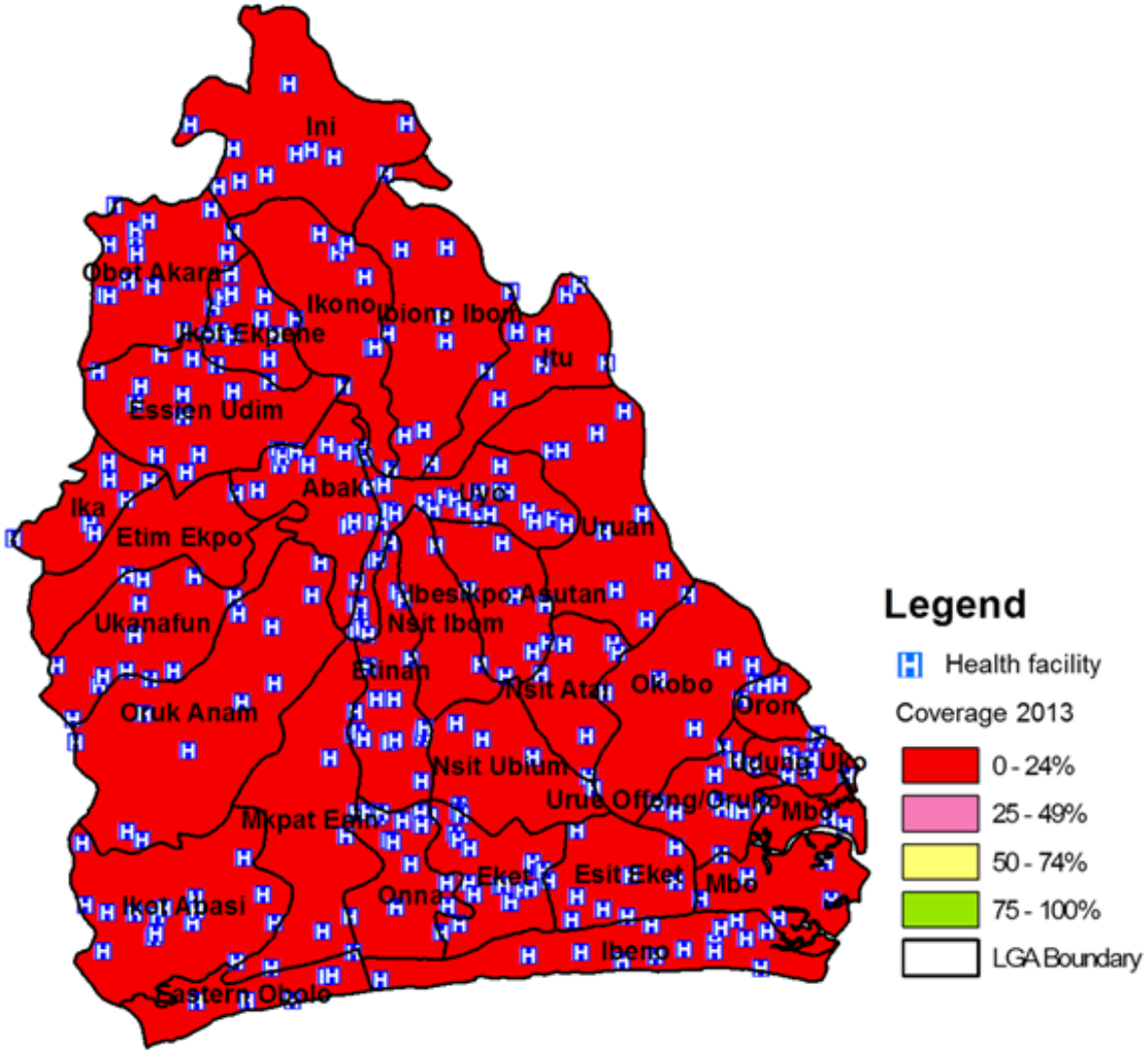


Figure 5: Map illustrating the spread of facilities which meet the national HR criteria for PMTCT services

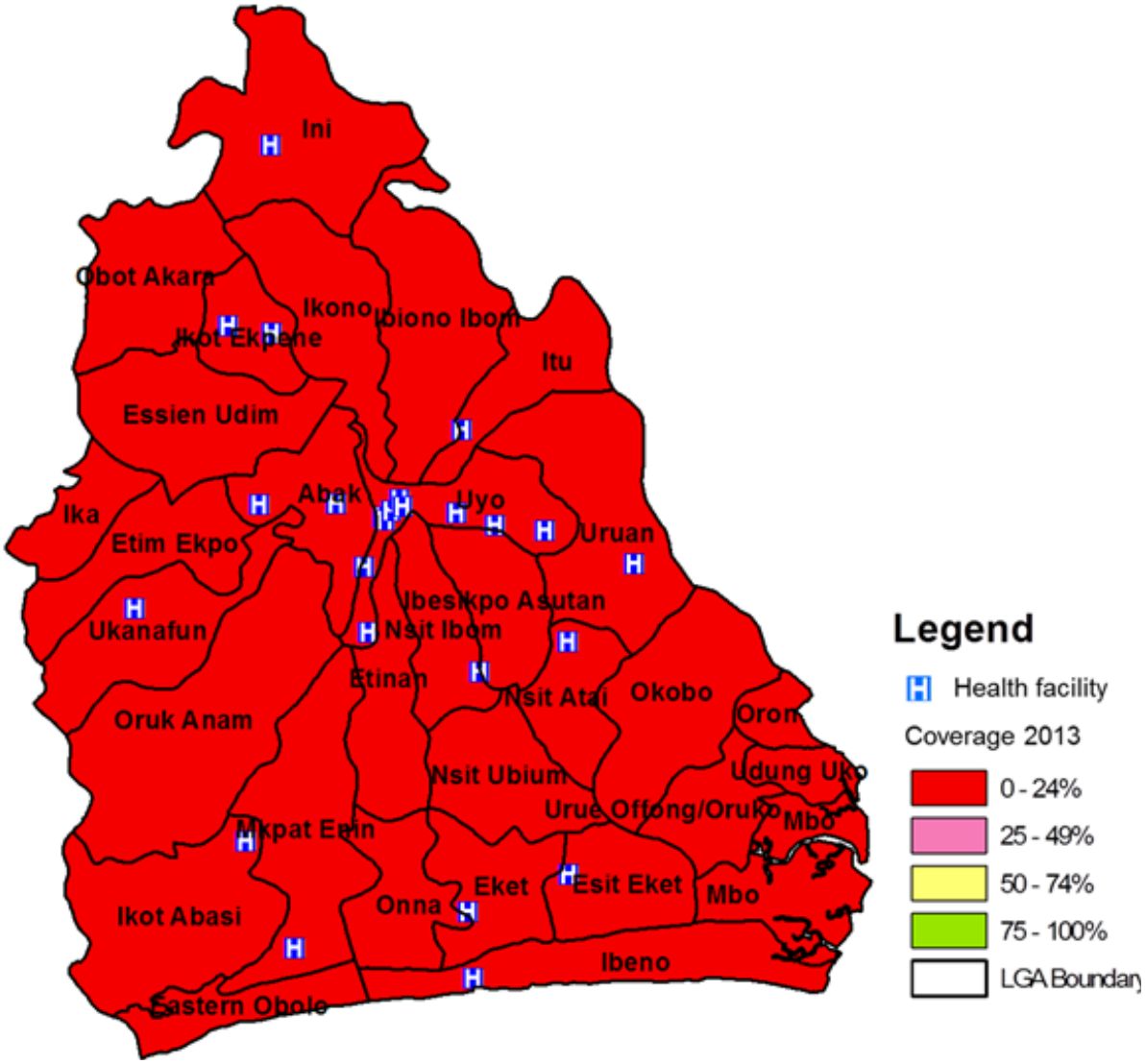


Figure 6: Map illustrating facilities which meet the state-defined HR criteria for PMTCT services

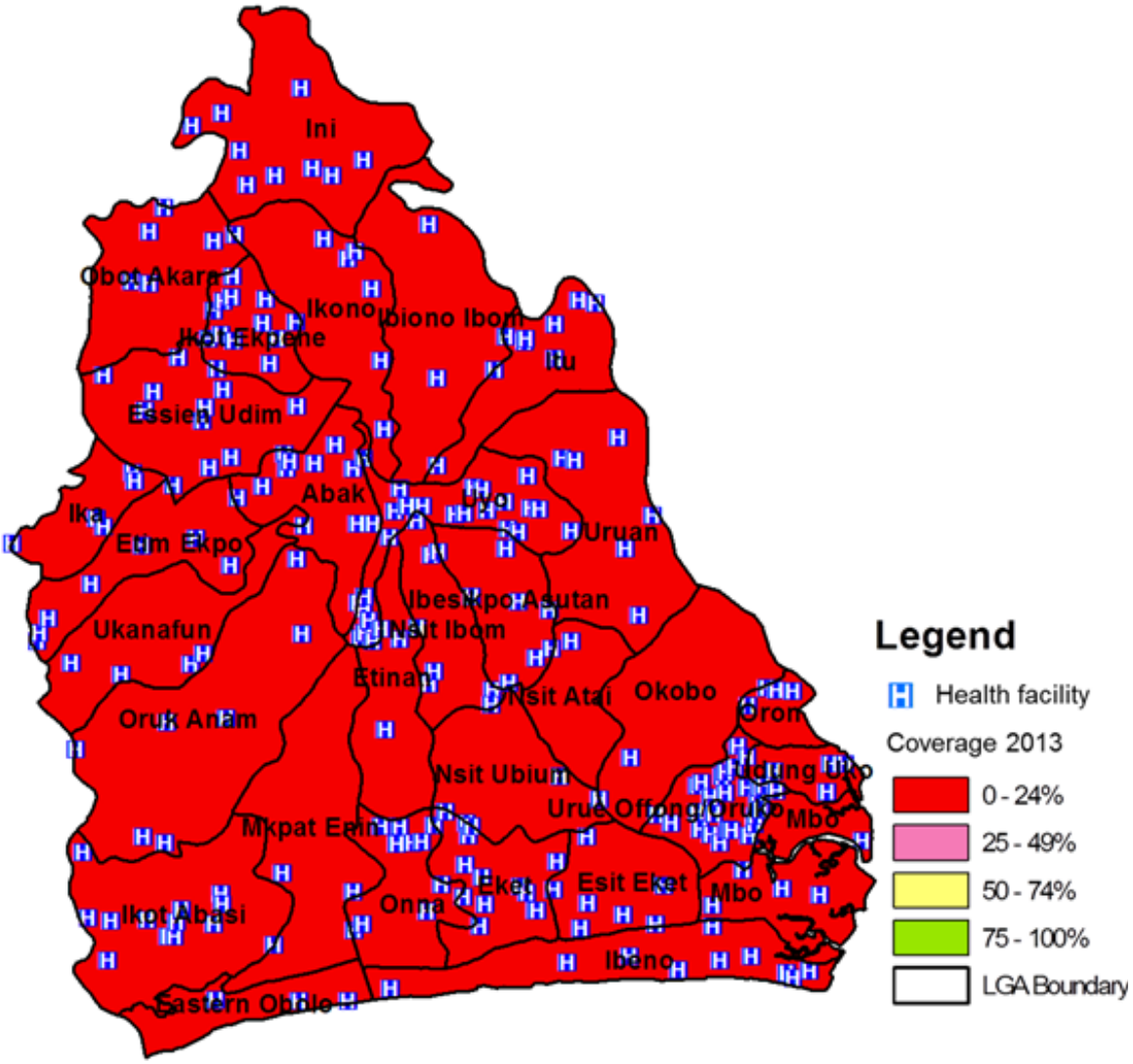


Figure 7: Map illustrating scenario for 2014 coverage (current PMTCT sites + scale-up limited to sites meeting national HR criteria)

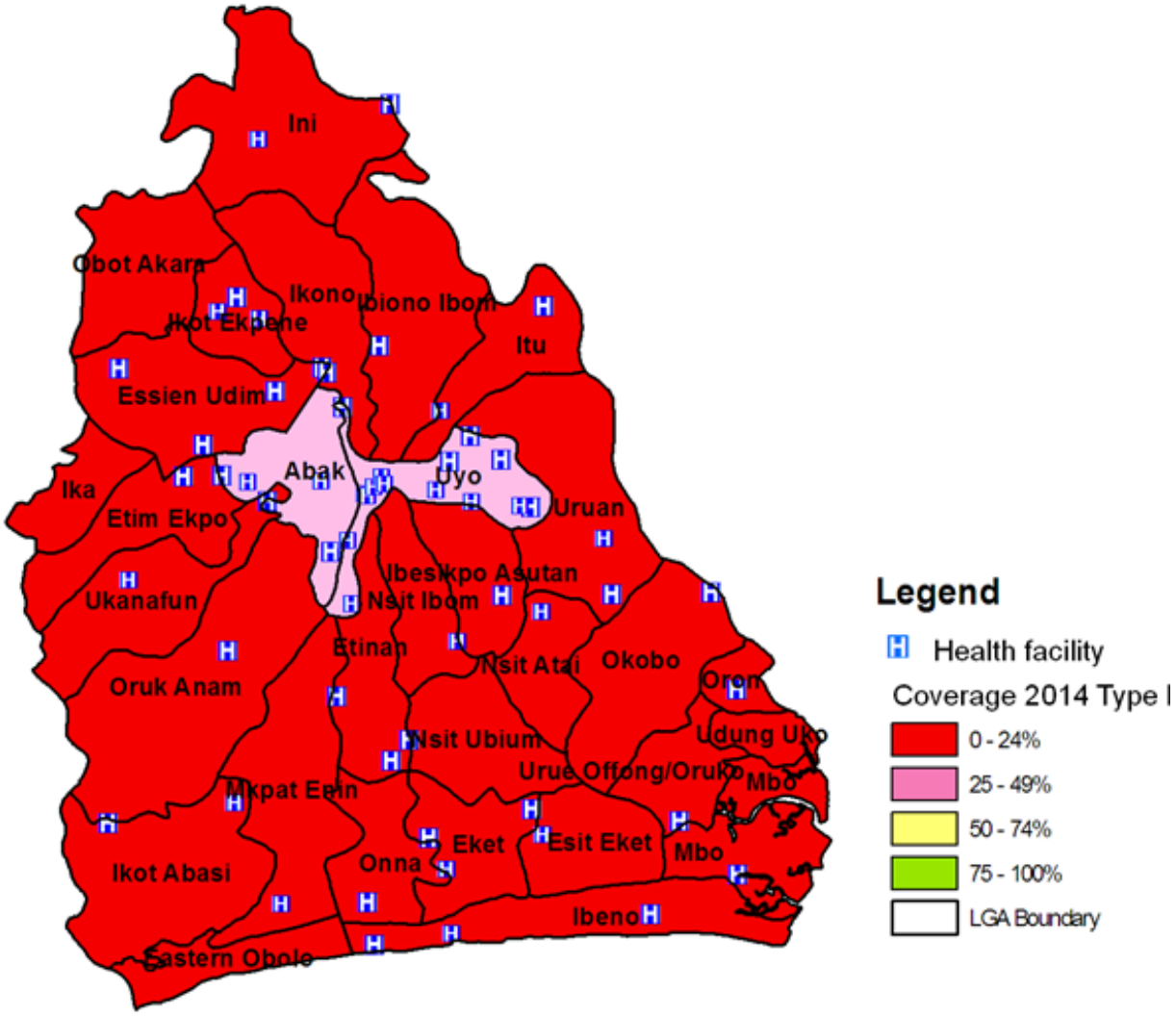


Figure 8: Map illustrating scenario for 2014 coverage (current PMTCT sites + scale-up limited to sites meeting state-defined HR criteria)

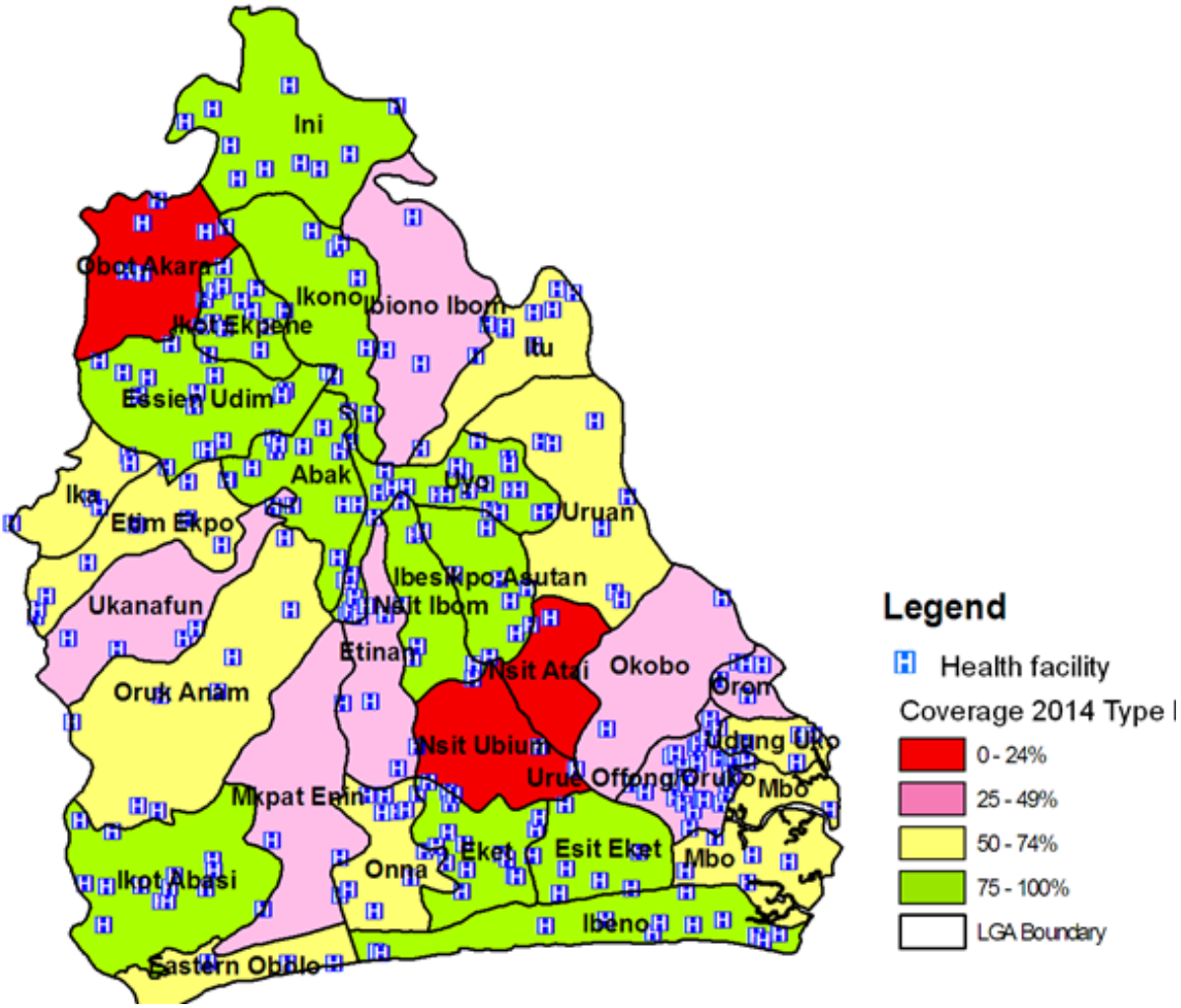
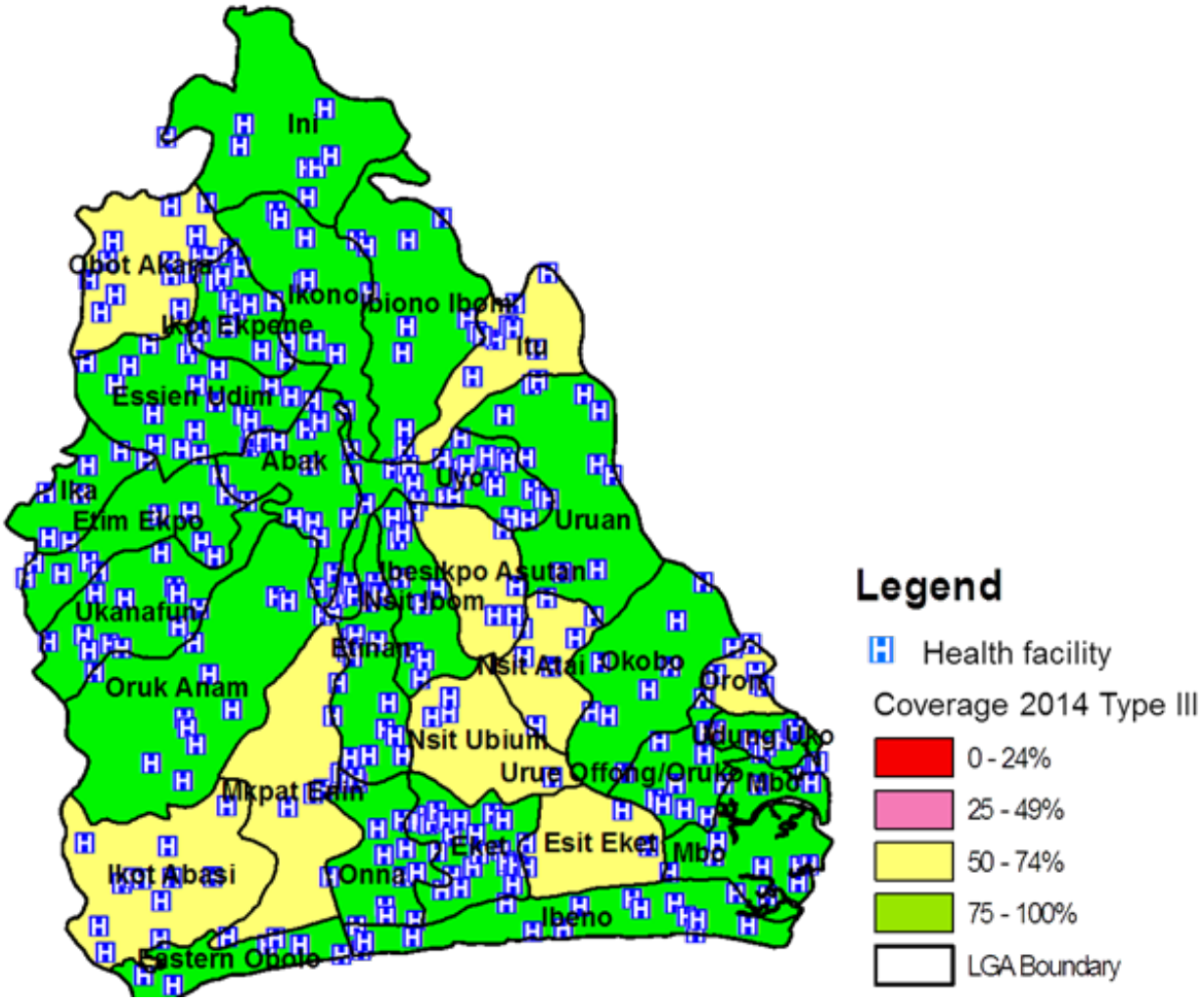


Figure 9: Map illustrating scenario for 2014 PMTCT coverage (current + sites earmarked for scale-up towards eMTCT)



SECTION

8 Conclusion

Akwa Ibom State has more public than private facilities. The infrastructure available for PMTCT is generally inadequate in the state although private facilities seem to fare better than public ones as well as secondary facilities when compared to primary level facilities. Improvements in community involvement and ownership are necessary. Furthermore, only a few health facilities (most of which are private) met the minimum HR complement or the composite criterion for PMTCT services. Scale-up will therefore need to go beyond these criteria in order to attain eMTCT.

SECTION

9 Recommendations

A comprehensive plan to improve PMTCT coverage and access must address all facets of the identified poor facility utilization, human resource and infrastructure gaps. The state government will need to engage staff to bring assessed facilities up to the national minimum HR standard. Another option to address HR challenges is a redistribution of staff from facilities that are well or overstaffed to some other facilities with acute HR shortages by the State Ministry of Health/Hospitals Management Board.

The implementing partners may need to work with both the private and public health facilities for the proposed PMTCT scale-up, while the challenges of infrastructure and HR in public facilities are being resolved.

There is also the need to improve community involvement and ownership by establishing and strengthening existing ward and village development committees as well as community-based organizations to provide community based PMTCT services. These efforts must embrace strong ANC demand creation strategies which recognise and include TBAs as central stakeholders.

Appendix

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

DOMAIN	ITEM	289 PRIMARY FACILITIES					46 SECONDARY FACILITIES					TOTAL 335 FACILITIES				
		Median	Mean	Min	Max	Total	Median	Mean	Min	Max	Total	Median	Mean	Min	Max	Total
HUMAN RESOURCES	Number of doctors	0	0	0.1	4	33	0	2	2.0	7	90	0	0	0.4	7	123
	Number of registered nurse/ midwife	0	2	2.5	25	725	0	3.5	4.8	20	222	0	2	2.8	25	947
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	0	2	3.0	18	869	0	3	3.5	21	162	0	2	3.1	21	1031
	Number of records officers	0	0	0.2	4	58	0	0	0.8	4	35	0	0	0.3	4	93
	Number of lab technician/ scientists	0	0	0.2	5	65	0	1	1.0	3	47	0	0	0.3	5	112
	Number of pharmacy technician/ pharmacists	0	0	0.1	4	23	0	0.5	0.7	3	32	0	0	0.2	4	55
SERVICE UTILIZATION	Number attended OPD in the last 12 months	0	132	339.4	6429	98098	26	728	1256.6	10000	57804	0	166	465.4	10000	155902
	ANC first attendees recorded in the last 12 months	0	38	81.7	1920	23605	0	64	203.5	3600	9363	0	40	98.4	3600	32968
	Deliveries taken in the last 12 months	0	0	9.9	273	2834	0	15.5	53.7	600	2470	0	1	15.9	600	5304

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

DOMAIN	ITEM	282 PUBLIC					53 PRIVATE					TOTAL 335 FACILITIES				
		Median	Mean	Min	Max	Total	Median	Mean	Min	Max	Total	Median	Mean	Min	Max	Total
HUMAN RESOURCES	Number of doctors	0	0	0.1	2	21	0	2	1.9	7	102	0	0	0.4	7	123
	Number of registered nurse/midwife	0	2	2.6	25	744	0	3	3.8	16	203	0	2	2.8	25	947
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	0	2	3.1	18	862	0	2	3.2	21	169	0	2	3.1	21	1031
	Number of records officers	0	0	0.2	4	54	0	1	0.7	4	39	0	0	0.3	4	93
	Number of lab technician/ scientists	0	0	0.2	5	57	0	1	1.0	40	55	0	0	0.3	5	112
	Number of pharmacy technician/ pharmacists	0	0	0.1	2	20	0	0	0.7	4	35	0	0	0.2	4	55
SERVICE UTILIZATION	Number attended OPD in the last 12 months	0	134.5	337.3	6429	95117	4	600	1146.9	10000	60785	0	166	465.4	10000	155902
	ANC first attendees recorded in the last 12 months	0	36.5	74.6	1141	21043	0	60	225.0	3600	11925	0	40	98.4	3600	32968
	Deliveries taken in the last 12 months	0	0	8.0	273	2242	0	16	57.8	600	3062	0	1	15.9	600	5304

Appendix 3: Human Resource Gap in Akwa Ibom State assessed facilities by LGAs (Doctors)

S/N	LGAS	PUBLIC (N=282)		PRIVATE (N=53)	
		Facilities with at least one doctor	Number of doctors needed to meet national standard	Facilities with at least one doctor	Number of doctors needed to meet national standard
1	ABAK	0	11	3	0
2	EASTERN OBOLLO	0	6	N/A	N/A
3	EKET	1	10	8	0
4	ESIT EKET	1	8	N/A	N/A
5	ESSIEN UDIM	0	13	N/A	N/A
6	ETIM EKPO	0	9	1	0
7	ETINAN	0	17	N/A	N/A
8	IBEANO	2	10	2	0
9	IBESIKPO ASUTAN	0	8	N/A	N/A
10	IBIONO IBOM	0	9	N/A	N/A
11	IKA	0	7	N/A	N/A
12	IKONO	0	8	N/A	N/A
13	IKOT ABASI	0	11	5	0
14	IKOT EKPENE	1	8	2	2
15	INI	1	9	N/A	N/A
16	ITU	2	7	1	0
17	MBO	0	7	1	0
18	MKPAT ENIN	1	3	N/A	N/A
19	NSIT ATAI	1	5	N/A	N/A
20	NSIT IBOM	1	8	N/A	N/A
21	NSIT UBIUM	0	4	N/A	N/A
22	OBOT AKARA	0	13	N/A	N/A
23	OKOBO	0	7	N/A	N/A
24	ONNA	1	10	3	0
25	ORON	0	5	N/A	N/A
26	ORUK ANAM	0	10	N/A	N/A
27	UDUNG UKO	1	6	1	0
28	UKANAFUN	1	10	1	1
29	URUAN	1	8	N/A	N/A
30	URUE OFFONG/ORUKO	0	10	N/A	N/A
31	UYO	2	8	21	0
Total		**17**	**265**	**50**	**3**

Appendix 4: Human Resource Gap in Akwa Ibom State assessed facilities by LGAs (Nurses)

S/N	LGAS	PUBLIC (N=282)		PRIVATE (N=53)	
		Facilities with at least one nurse	Number of nurses needed to meet national standard	Facilities with at least one nurse	Number of nus needed to meet national standard
1	ABAK	11	0	3	0
2	EASTERN OBOLLO	6	0	N/A	N/A
3	EKET	11	0	8	0
4	ESIT EKET	9	0	N/A	N/A
5	ESSIEN UDIM	13	0	N/A	N/A
6	ETIM EKPO	9	0	0	1
7	ETINAN	17	0	N/A	N/A
8	IBEANO	12	0	2	0
9	IBESIKPO ASUTAN	8	0	N/A	N/A
10	IBIONO IBOM	9	0	N/A	N/A
11	IKA	6	1	N/A	N/A
12	IKONO	8	0	N/A	N/A
13	IKOT ABASI	11	0	3	2
14	IKOT EKPENE	9	0	4	0
15	INI	10	0	N/A	N/A
16	ITU	9	0	1	0
17	MBO	7	0	1	0
18	MKPAT ENIN	4	0	N/A	N/A
19	NSIT ATAI	6	0	N/A	N/A
20	NSIT IBOM	9	0	N/A	N/A
21	NSIT UBIUM	4	0	N/A	N/A
22	OBOT AKARA	13	0	N/A	N/A
23	OKOBO	7	0	N/A	N/A
24	ONNA	11	0	2	1
25	ORON	4	1	N/A	N/A
26	ORUK ANAM	10	0	1	0
27	UDUNG UKO	7	0	1	0
28	UKANAFUN	10	1	2	0
29	URUAN	9	0	N/A	N/A
30	URUE OFFONG/ORUKO	10	0	N/A	N/A
31	UYO	10	0	20	1
Total		**279**	**3**	**48**	**5**

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

S/N	LGAS	PUBLIC (N=282)		PRIVATE (N=53)	
		Facilities with at least two trained HWs	Number of HWs needed to meet national standard	Facilities with at least two trained HWs	Number of HWs needed to meet national standard
1	ABAK	10	2	1	4
2	EASTERN OBOLLO	4	4	N/A	N/A
3	EKET	8	6	8	0
4	ESIT EKET	7	4	N/A	N/A
5	ESSIEN UDIM	12	2	N/A	N/A
6	ETIM EKPO	6	6	0	2
7	ETINAN	2	30	N/A	N/A
8	IBEANO	10	4	2	0
9	IBESIKPO ASUTAN	7	2	N/A	N/A
10	IBIONO IBOM	6	6	N/A	N/A
11	IKA	7	0	N/A	N/A
12	IKONO	7	2	N/A	N/A
13	IKOT ABASI	10	2	3	4
14	IKOT EKPENE	8	2	4	0
15	INI	9	2	N/A	N/A
16	ITU	8	2	1	0
17	MBO	6	2	1	0
18	MKPAT ENIN	1	6	N/A	N/A
19	NSIT ATAI	5	2	N/A	N/A
20	NSIT IBOM	7	4	N/A	N/A
21	NSIT UBIUM	2	4	N/A	N/A
22	OBOT AKARA	7	12	N/A	N/A
23	OKOBO	3	8	N/A	N/A
24	ONNA	10	2	1	4
25	ORON	4	2	N/A	N/A
26	ORUK ANAM	9	2	1	0
27	UDUNG UKO	5	4	1	0
28	UKANAFUN	6	10	1	2
29	URUAN	5	8	N/A	N/A
30	URUE OFFONG/ORUKO	8	4	N/A	N/A
31	UYO	9	2	9	24
Total		**208**	**148**	**33**	**40**

Appendix 6: Human Resource Gap in Akwa Ibom State assessed facilities by LGAs (Pharmacists or Pharmacy technicians)

S/N	LGAS	PUBLIC (N=282)		PRIVATE (N=53)	
		Facilities with at least one pharm./ pharm. tech.	Number of pharm. needed to meet national standard	Facilities with at least one pharm./ pharm. tech.	Number of pharm. needed to meet national standard
1	ABAK	0	11	2	1
2	EASTERN OBOLLO	0	6	N/A	N/A
3	EKET	0	11	2	6
4	ESIT EKET	1	8	N/A	N/A
5	ESSIEN UDIM	0	13	N/A	N/A
6	ETIM EKPO	0	9	0	1
7	ETINAN	2	15	N/A	N/A
8	IBEANO	1	11	0	2
9	IBESIKPO ASUTAN	0	8	N/A	N/A
10	IBIONO IBOM	1	8	N/A	N/A
11	IKA	0	7	N/A	N/A
12	IKONO	0	8	N/A	N/A
13	IKOT ABASI	1	10	2	3
14	IKOT EKPENE	1	8	1	3
15	INI	1	9	N/A	N/A
16	ITU	2	7	1	0
17	MBO	1	6	0	1
18	MKPAT ENIN	1	3	N/A	N/A
19	NSIT ATAI	1	5	N/A	N/A
20	NSIT IBOM	1	8	N/A	N/A
21	NSIT UBIUM	0	4	N/A	N/A
22	OBOT AKARA	1	12	N/A	N/A
23	OKOBO	0	7	N/A	N/A
24	ONNA	0	11	1	2
25	ORON	1	4	N/A	N/A
26	ORUK ANAM	0	10	1	0
27	UDUNG UKO	0	7	0	1
28	UKANAFUN	0	11	2	0
29	URUAN	1	8	N/A	N/A
30	URUE OFFONG/ORUKO	0	10	N/A	N/A
31	UYO	0	10	12	9
Total		**17**	**265**	**24**	**29**

Appendix 7: Human Resource Gap in Akwa Ibom State assessed facilities by LGAs (Laboratory scientists or technicians)

S/N	LGAS	PUBLIC (N=282)		PRIVATE (N=53)	
		Facilities with at least one Lab tech	Number of Lab tech needed to meet national standard	Facilities with at least one Lab tech	Number of Lab tech needed to meet national standard
1	ABAK	1	10	3	0
2	EASTERN OBOLLO	1	5	N/A	N/A
3	EKET	2	9	4	4
4	ESIT EKET	2	7	N/A	N/A
5	ESSIEN UDIM	2	11	N/A	N/A
6	ETIM EKPO	1	8	1	0
7	ETINAN	2	15	N/A	N/A
8	IBEANO	1	11	1	1
9	IBESIKPO ASUTAN	1	7	N/A	N/A
10	IBIONO IBOM	1	8	N/A	N/A
11	IKA	0	7	N/A	N/A
12	IKONO	2	6	N/A	N/A
13	IKOT ABASI	0	11	4	1
14	IKOT EKPENE	3	6	2	2
15	INI	1	9	N/A	N/A
16	ITU	3	6	1	0
17	MBO	1	6	0	1
18	MKPAT ENIN	1	3	N/A	N/A
19	NSIT ATAI	1	5	N/A	N/A
20	NSIT IBOM	2	7	N/A	N/A
21	NSIT UBIUM	0	4	N/A	N/A
22	OBOT AKARA	1	12	N/A	N/A
23	OKOBO	1	6	N/A	N/A
24	ONNA	2	9	1	2
25	ORON	0	5	N/A	N/A
26	ORUK ANAM	1	9	1	0
27	UDUNG UKO	0	7	0	1
28	UKANAFUN	1	10	2	0
29	URUAN	2	7	N/A	N/A
30	URUE OFFONG/ ORUKO	1	9	N/A	N/A
31	UYO	2	8	18	3
Total		**39**	**243**	**38**	**15**

Appendix 8: Summary of Human Resource Gap in Akwa Ibom State assessed facilities by Cadre

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	265	3
2	Nurses	3	5
3	Trained Health Workers – CHOs, CHEWs etc.	148	40
4	Pharmacist/pharmacy technicians	263	29
5	Lab. Scientist/ technicians	241	15

Appendix 9: List of contributors

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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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