GOVERMENT OF ANAMBRA
NIGERIA

Report of the Anambra

STATE-WIDE RAPID HEALTH FACILITY ASSESSMENT

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

March 2013

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Citation: Anambra State Ministry of Health and FHI 360. 2013. *Anambra State-wide Rapid Health Facility Assessment,* Nigeria: Anambra State Ministry of Health and FHI 360.

The Anambra State-wide Rapid Health Facility Assessment was supported in part by the U.S. Agency for International Development (USAID). FHI 360 provided assistance to the Anambra State Government to conduct this assessment. Financial assistance was provided by USAID under the terms of the Cooperative Agreement AID-620-A-00002, of the Strengthening Integrated Delivery of HIV/AIDS Services Project. This report does not necessarily reflect the views of FHI 360, USAID or the United States Government.

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Foreword

Anambra state is one of the "12+1" states which together contribute nearly 70 percent of Nigeria's mother-to-child transmission of HIV (MTCT) burden. Its HIV prevalence, ranks fourth amongst all states.

In an attempt to improve the coverage of prevention of mother-to-child transmission (PMTCT) services and eliminate MTCT of HIV, the Anambra State Government embarked on a state-wide rapid facility assessment to assess the readiness of antenatal care facilities in the state to provide PMTCT services.

This exercise was done in collaboration with FHI 360, with financial support from the United States Agency for International Development (USAID).

The assessment of 634 public and private health facilities covered all local government areas (LGAs) in the state. The assessment also provided an opportunity for us to know the actual status of functionality and human resources for health in the state. In addition the quality and quantity of services rendered at various facilities is presented in this report.

Finally, having identified the gaps and challenges in the functionality of health facilities in Anambra state, the road to expanding PMTCT services is now wide open.

Dr Lawrence C. Ikeako

Honourable Commissioner for Health
Anambra State

Acknowledgements

Our special thanks go to the United States Agency for International Development for financial assistance and FHI 360 for technical assistance during this rapid assessment. We really are indebted to them.

The hard work and commitment demonstrated by everyone who contributed to the development of this document is acknowledged and appreciated.

We also thank the staff of the Anambra State ministry of health who contributed immensely to making this exercise a success. We also acknowledge the commitments of the consultants and volunteers who participated in this assessment.

We cannot thank the Ministry of Local Government enough; for releasing staff in their various health departments. We also appreciate LGA staff who utilized their in-depth knowledge of the terrain, making the accomplishment of this task so much easier.

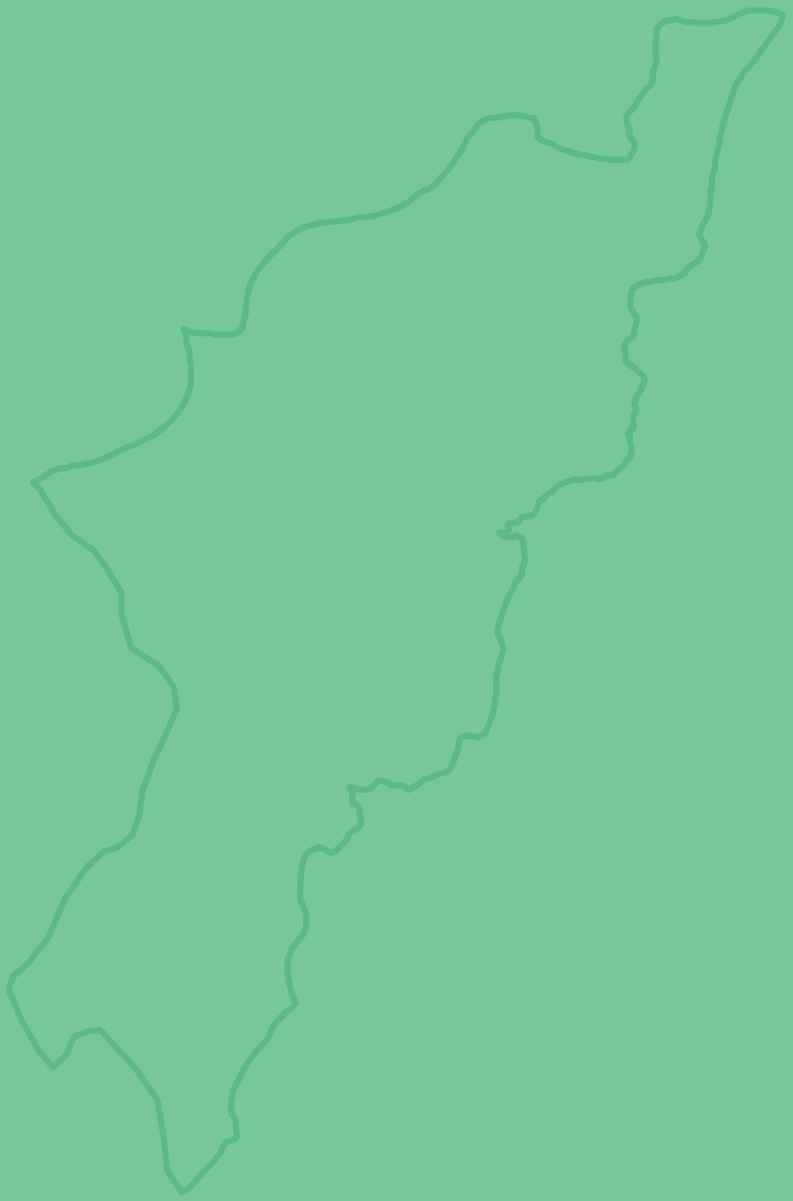
Thank you all.

Dr C. J. Okoye

Director of Public Health
Anambra State

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
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 Organisation
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 Re-investment and Empowerment Program
TB	Tuberculosis
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
VDC	Village Development Committee
WDC	Ward Development Committee



Executive Summary

Anambra State is one of the 12+1 states that contribute 70% of Nigeria's MTCT burden. The HIV prevalence among pregnant women is 8.7%, far above the national average of 4.1%, the highest in South East region and the fourth highest in the country. 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).

The goal of this assessment was to derive a baseline profile of antenatal care (ANC) services and thereby plan effective scale up of services to attain eMTCT in Anambra State. This survey utilized mixed (quantitative and qualitative) methods. All listed public and private health facilities in Anambra State which met defined criteria were assessed. All facilities with antenatal services were included while facilities with current implementing partner (IP) support providing antiretroviral drugs (ARVs) for prevention of mother-to-child transmission of HIV (PMTCT) or with plans for PMTCT services in 2013 were excluded.

A total of 829 facilities were visited; the assessment was fully conducted in 634 found to provide ANC services but with no support from an IP for PMTCT services (ARVs). Three hundred and sixty-eight were primary level facilities while the remaining were secondary facilities. Likewise, the majority (392) of the facilities were privately-owned while 242 were public facilities. On the average, the secondary facilities had a higher number of health workers across every category compared with the primary facilities.

Only 6.6% (41) of facilities met the national minimum HR standard for the provision of PMTCT services. Generally, there was a shortage of human resources for health in the facilities assessed. About 182 doctors, 89 nurses, 138 CHEWs/CHOs, 231 pharmacists or pharmacy technicians and 226 laboratory scientists are needed in the assessed public facilities to bring them to national standard for PMTCT service provision. The corresponding figures for private facilities are 75 doctors, 97 nurses, 304 CHEWs/CHOs, 318 pharmacists or pharmacy technicians and 184 laboratory technicians.

The gap between the average number pregnant women attending a first visit to the ANC and the number of deliveries at both primary and secondary facilities was substantial, suggesting a large dropout between ANC attendance and facility delivery. Results of key informant interviews (KIIs) with health providers also revealed that many of the women prefer to deliver with traditional birth attendants (TBAs) and churches.

Based on the results of this assessment, it is recommended that demand creation for uptake of ANC services and facility delivery needs to feature prominently in the design of eMTCT interventions. Thus, community engagement for demand creation should be improved.

SECTION

1 Background

Anambra State is located in south-eastern Nigeria and was created in 1991 with Awka as its capital. With a 2012 projected population of 4,984,127, Anambra has one of the highest population densities in Africa. Anambra is bounded by the Delta and Edo States to the west, Imo and Abia States to the south, Enugu State to the east and Kogi State to the north. The 21 Local Government Areas (LGAs) in Anambra State include: Aguata, Anambra East, Anambra West, Anaocha, Awka North, Awka South, Ayamelum, Dunukofia, Ekwusigo, Idemili North, Idemili south, Ihiala, Njikoka, Nnewi North, Nnewi South, Ogbaru, Onitsha North, Onitsha South, Orumba North, Orumba South and Oyi. The people of Anambra State are very industrious. Most of the industrial base of the state is private sector driven, spanning from agro-allied and automobile to manufacturing industries situated mostly in the Nnewi industrial belt. The Onitsha market is reputed to be the biggest in West Africa.

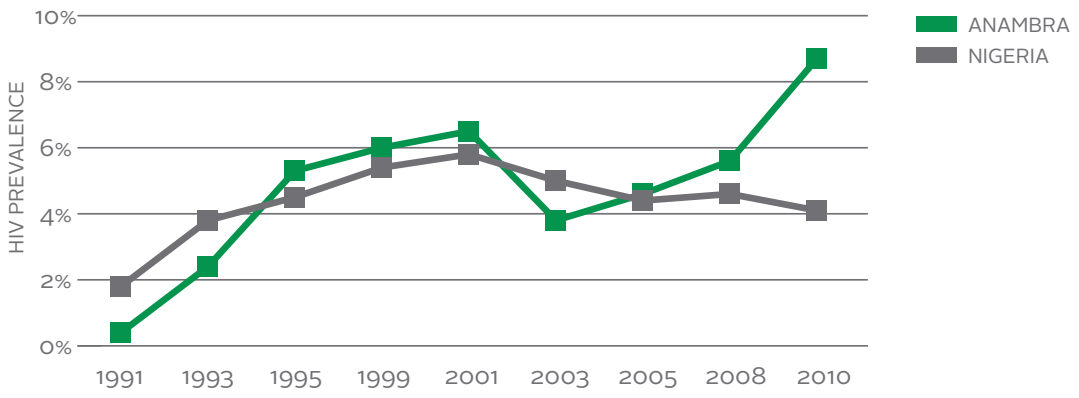
SECTION

2 State HIV Profile

HIV/AIDS is a major public health challenge in Anambra State. According to the 2010 sentinel survey, Anambra has an HIV prevalence of 8.7%, far above the national average of 4.1%, the highest in South East region and the fourth highest in the country (HSS 2010). The South East geopolitical zone has an average general HIV prevalence of 2.9%, ranging from 1.3% in Enugu State to 6.3% in Ebonyi State.

Over the last 10 years, the Anambra state HIV prevalence has risen steadily (HSS, 2010). 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 and knowledge of HIV/AIDS, stigma, discrimination and superstitious beliefs about HIV/AIDS.

Figure 1: Trend of HIV Prevalence in Nigeria and Anambra State (1991 -2010)



SOURCE: HSS 2010

2.1 MTCT PROFILE FOR ANAMBRA STATE

Anambra is one of the 12+1 states which contribute over 70% of Nigeria's MTCT burden. Based on 2012 population projections, there are about 249,206 pregnant women in the state. Site specific and average HIV prevalence in the state as documented in the 2010 sentinel survey, suggest about 20,328 pregnant women are infected with the virus. Approximately one-third of pregnancies in HIV infected women will culminate in HIV transmission to the baby without effective PMTCT interventions.

Table 1 shows a profile of MTCT burden and PMTCT coverage in Anambra LGAs. Maternal HIV burden and PMTCT service coverage for each LGA was determined using state HIV prevalence, LGA population, and number of facilities providing ANC and PMTCT services. The LGA rank score on each domain (maternal HIV burden and PMTCT coverage) was summed to derive a composite measure of LGA prioritization for scale-up. Higher rank scores indicate larger burden/lower coverage and consequently a higher priority for scale-up.

The LGAs with highest maternal HIV rank burdens are Aguata, Ihiala and Anaocha. PMTCT service coverage gaps were largest in Onitsha South, Orumba South, Anambra West, Ayamelum, Awka North and Dunukofia LGAs; all of which had no facilities providing PMTCT services. Onitsha South, Orumba South, Anambra West and Aguata LGAs were the most vulnerable based on the composite rank index (in decreasing rank order) and are the highest priority for scale-up efforts (See Table 1).

Table 1: LGA ranking of MTCT burden and PMTCT coverage in Anambra 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)	
Anambra West	8.7%	1149	14	17	100.0%	21	35
Orumba South	8.7%	1118	13	20	100.0%	21	34
Ihiala	8.7%	1831	19	96	99.0%	15	34
Aguata	8.5%	2241	20	80	98.8%	14	34
Awka North	8.6%	1014	10	14	100.0%	21	31
Ayamelum	8.7%	958	8	16	100.0%	21	29
Idemili South	8.7%	1253	15	43	97.7%	13	28
Idemili North	1.2%	2611	21	120	93.3%	7	28
Onitsha South	13.1%	831	4	44	100.0%	21	25
Ogbaru	8.7%	1353	16	75	93.3%	7	23
Dunukofia	8.7%	585	1	22	100.0%	21	22
Awka South	8.6%	1722	18	58	84.5%	4	22
Orumba North	8.7%	1047	12	29	96.6%	9	21
Oyi	8.7%	1019	11	32	96.9%	9	20
Nnewi South	8.7%	1414	17	42	78.6%	2	19
Njikoka	8.1%	899	5	37	97.3%	12	17
Nnewi North	8.7%	942	7	104	97.1%	10	17
Onitsha North	13.1%	763	3	186	97.3%	12	15
Ekwusigo	8.7%	960	9	45	88.9%	5	14
Anaocha	8.7%	922	6	45	84.4%	3	9
Anambra East	8.7%	680	2	26	76.9%	1	3
Total	**8.7%**	**20328**		**1153**	**95%**		

SECTION

3 Response to the HIV Epidemic

As part of the State Government's response to the HIV epidemic, The Anambra State Agency for the Control of AIDS was set up to coordinate the multi-sectoral response to HIV/AIDS. This is in addition to the function of the State Ministry of Health (SMOH) which is responsible for the state health sector response.

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 Anambra State by international donors include HIV testing and counselling (HTC), ARVs, laboratory equipment and capacity building for government and health facility staff.

However PMTCT coverage has been low. Consequently, Anambra 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 Anambra State Government with the support of the implementing partners has embarked on a scale up of PMTCT services. This drive involves a state-wide rapid health facility assessment (RHFA), the findings from which will be used to develop a state-specific, costed PMTCT scale-up plan that will guide expansion of services.

SECTION

4 Assessment Goal and Objectives

4.1 GOAL

The goal of this assessment is to contribute to Anambra State's efforts to eliminate mother-to-child transmission of HIV by 2015.

4.2 OBJECTIVES

1. To quickly identify health facilities in Anambra 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
4. To map the physical location of health facilities using global positioning system (GPS) coordinates

SECTION

5 Assessment Design

Both quantitative and qualitative methodologies were used in this rapid assessment to determine the status of the health system to deliver PMTCT services in Anambra State. The assessment took place in all 21 LGAs of the state.

5.1 SAMPLING/SITE SELECTION

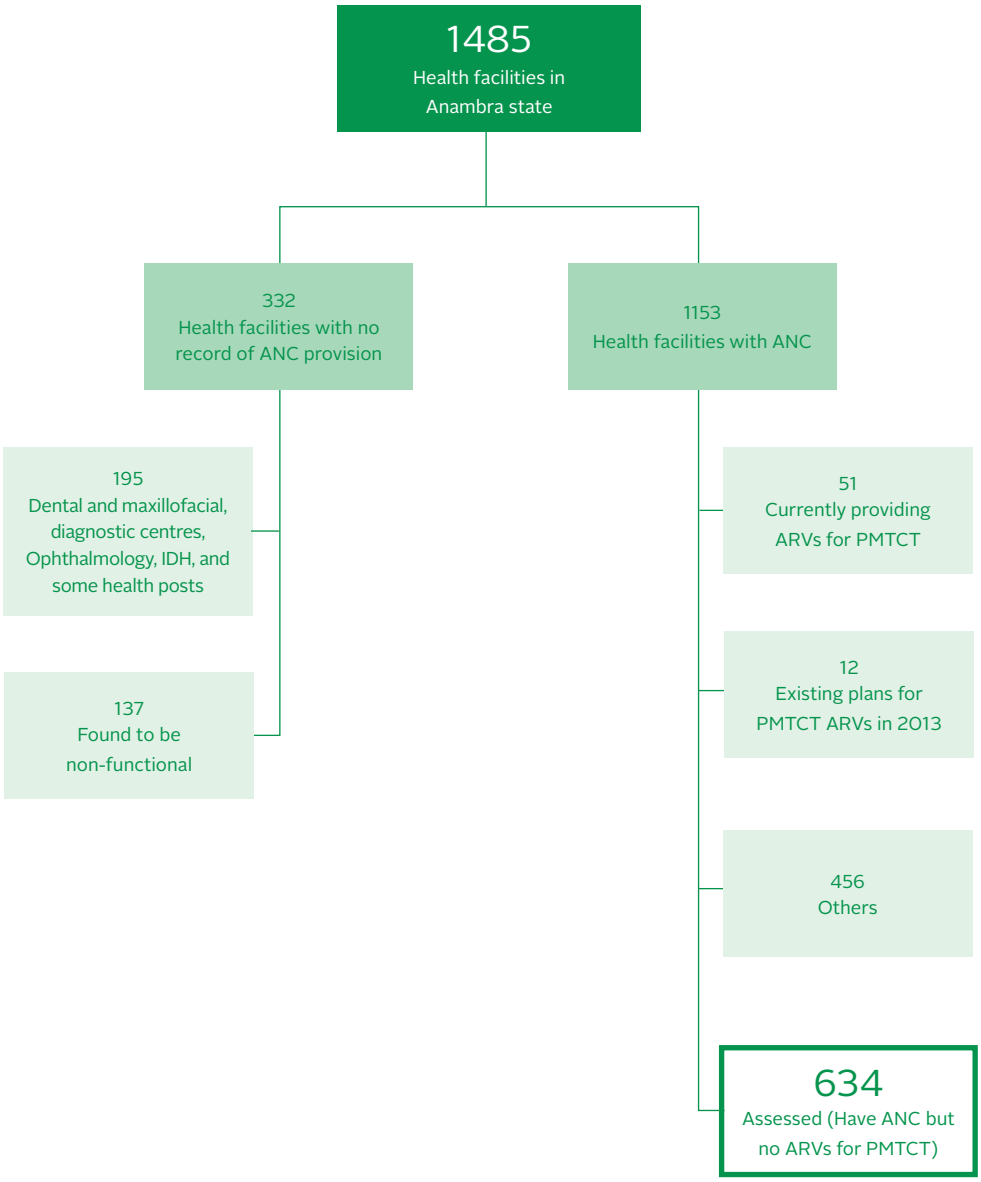
The sampling frame was a total listing of health facilities in the state. This comprised 1485 facilities. The inclusion criterion was facilities with ANC services as these were available to provide PMTCT services. Excluded from the assessment were 63 facilities that were already providing PMTCT services (ARVs for PMTCT). A total of 829 facilities were visited during the assessment exercise. Of these, 634 were found to provide ANC but did not receive support from an implementing partner to provide ARVs for PMTCT; these were the focus of the assessment activity (Figure 2).

5.2 DATA COLLECTION

The Anambra state-wide RHFA 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. The PMTCT programmatic components for scale-up were assessed under seven domains: linkages, human resources, client flow, availability of maternal and child health (MCH) services, enabling environment, infrastructure and community systems.

This tool was administered by a team comprised of local government and state government staff with technical assistance from FHI 360.

Figure 2: Location of assessed health facilities within Anambra State health system



SECTION

6 Findings

A total of 829 facilities were visited. Of those, 634 provided antenatal care but did not receive support from an implementing partner to provide ARVs for PMTCT. The sections below present data from these 634 facilities which were fully assessed. They constitute the bulk of facilities with potential for PMTCT scale-up in Anambra state.

6.1 CHARACTERISTICS OF FACILITIES

Table 2 below shows the distribution of the assessed facilities with respect to ownership and level of service delivery. Of the 634 facilities, close to two- third (368) were primary level while the remaining were secondary. Also, a majority of the facilities (392) were privately owned .

6.2 HUMAN RESOURCES AND SERVICE UTILIZATION

Human resources and service utilization disaggregated according by level of facility is presented in Table 3. 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. About a third (32.2%) of primary health facilities are covered by doctors whereas almost all (95.1%) of the secondary facilities had at least a doctor. The secondary facilities on the average had a higher number of health workers - across all categories - compared

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	3	13	16
Private for profit	141	235	376
Sub-total (private)	144	248	392
Public			
LGA	220	1	221
State government	4	17	21
Sub-total (public)	224	18	242
Overall total	**368**	**266**	**634**

with the primary facilities. Of all the health worker categories, the 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 two to three times higher utilization of secondary facilities compared to the primary level health services in the state.

Table 4 presents HR resources disaggregated according to facility ownership. The results show that on the average, private facilities had a higher number of health workers across all categories. Whereas about 81% of private facilities had at least a doctor, only 23% of public facilities were covered by doctors. Also, the private facilities had almost three times higher utilization rate than the public facilities. These results also show that the secondary facilities with higher utilization (see Table 2) are generally those that are privately owned.

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

DOMAIN	Item	368 PRIMARY FACILITIES			266 SECONDARY FACILITIES			TOTAL (634)		
		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	0.4	67.8%	32.2%	1.6	4.9%	95.1%	0.9	41.1%	58.9%
	Registered nurse/midwife	1.2	33.7%	66.3%	2.1	23.4%	76.6%	1.6	29.4%	70.6%
	Other trained health workers (Community Nurses, CHOs, CHEWs)	2.2	18.8%	81.2%	4.1	19.5%	80.5%	3.0	19.1%	80.9%
	Record officers	0.1	90.5%	9.5%	0.5	62.3%	37.7%	0.3	78.7%	21.3%
	Laboratory technician/ scientists	0.2	86.3%	13.7%	1.0	35.5%	77.4%	0.5	65.0%	35.0%
	Pharmacy technician/ pharmacists	0.04	96.4%	3.6%	0.4	74.0%	26.0%	0.2	87.0%	13.0%
SERVICE UTILIZATION	OPD attendance in the last 12 months	505	5.5%	94.5%	1692	1.5%	98.5%	1004	3.8%	96.2%
	ANC first attendees recorded in the last 12 months	157	4.1%	95.9%	333	7.9%	92.1%	231	5.7%	94.3%
	Deliveries taken in the last 12 months	76	9.5%	90.5%	160	6.8%	93.2%	111	8.4%	91.6%

*A FEW FACILITIES REPORTED ZERO ATTENDANCE ON THESE INDICATORS

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

DOMAIN	Item	242 PUBLIC FACILITIES			392 PRIVATE FACILITIES			TOTAL (634)		
		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	0.3	77.4%	22.6%	1.3	19.2%	80.8%	0.9	41.1%	58.9%
	Registered nurse/midwife	1.6	36.8%	63.2%	1.8	24.8%	75.2%	1.6	29.4%	70.6%
	Other trained health workers (Community Nurses, CHOs, CHEWs)	2.5	7.2%	92.8%	3.4	26.3%	73.7%	3.0	19.1%	80.9%
	Record officers	0.5	87.6%	12.4%	0.4	73.1%	26.9%	0.3	78.7%	21.3%
	Laboratory technician/ scientists	0.1	93.8%	6.2%	0.8	47.2%	52.8%	0.5	65.0%	35.0%
	Pharmacy technician/ pharmacists	0.3	95.9%	4.1%	0.3	81.5%	18.5%	0.2	87.0%	13.0%
SERVICE UTILIZATION	OPD attendance in the last 12 months	511.6	2.5%	97.5%	1310.3	4.6%	95.4%	1004.0	3.8%	96.2%
	ANC first attendees recorded in the last 12 months	113.9	3.3%	96.7%	303.9	7.1%	92.9%	231.4	5.7%	94.3%
	Deliveries taken in the last 12 months	49.3	14.1%	85.9%	150.0	4.8%	95.2%	111.6	8.4%	91.6%

*A FEW FACILITIES REPORTED ZERO ATTENDANCE ON THESE INDICATORS

6.3 DOMAIN-BY-DOMAIN SUMMARY

Table 5 summarizes the domain-by-domain disaggregation by level of facility. Almost all the clinical and laboratory services were available in most facilities assessed. TB services were the least available service in facilities (obtainable in less than a fifth of the facilities), followed by HTC services which were available in only two-thirds of facilities surveyed. A greater proportion of these facilities were secondary level. Similarly, the assessment found that common gaps in infrastructure among the primary level facilities were spaces for laboratory (47.0%) and medical records (57.3%).

In the same vein, the enabling environment seems to be better among primary level facilities compared with secondary health facilities, as they had more MDG support (25% vs. 3%), free ANC services (19% vs. 3.4%), regular monthly outreach (56.8% vs. 5.3%) and midwifes through the Midwives Service Scheme (MSS) (8.7% vs. 5.3%).

Furthermore, the results show better community systems around the primary level facilities as more of these facilities reported other facilities where women can deliver (60.1% vs. 56.4%), more ward development committees (56.3% vs. 22.2%) and village development committees (48.9% vs. 22.6%).

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

		FACILITY TYPE		
		Primary level n = 368	Secondary level n = 266	Total n = 634
SERVICE AVAILABILITY	Physical Exam (including weight, assessing GA, blood pressure)	366 (99.5%)	265 (99.6%)	631 (99.5%)
	Laboratory services (onsite or by referral): Hb, Urinalysis	302 (82.1%)	238 (89.5%)	540 (85.2%)
	Dispensing of haematinics and IPTp	353 (95.9%)	254 (95.5%)	607 (95.7%)
	Labour and delivery services (with 24 hour shifts)	315 (85.6%)	255 (95.9%)	570 (89.9%)
	Referrals for emergency obstetric and new-born care	341 (92.7%)	235 (88.3%)	576 (90.9%)
	Family Planning services (condoms, hormonal contraceptives)	230 (62.5%)	182 (68.4%)	412 (65.0%)
	Immunization services	292 (79.3%)	139 (21.9%)	431 (68.0%)
	Child follow up clinics	312 (84.8%)	197 (74.1%)	509 (80.3%)
	TB services (specify which - e.g. DOTS, microscopy)	47 (12.8%)	56 (21.2%)	103 (16.2%)
	HTC	199 (54.1%)	219 (82.3%)	418 (65.9%)

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

		FACILITY TYPE		
		Primary level n = 368	Secondary level n = 266	Total n = 634
IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	Lab Room	173 (47.0%)	217 (81.6%)	390 (61.5%)
	ANC Space & Room	338 (91.8%)	259 (97.4%)	597 (94.2%)
	Space that can be used for confidential counselling	312 (84.8%)	242 (91.0%)	554 (87.4%)
	Maternity Room	349 (94.8%)	262 (98.5%)	611 (96.4%)
	Pharmacy, Store & Dispensary	276 (75.0%)	238 (89.5%)	514 (81.1%)
	Space for HTC/Adherence counselling	283 (76.9%)	233 (87.6%)	516 (81.4%)
	Medical records/M&E	211 (57.3%)	203 (76.3%)	414 (65.3%)
ENABLING ENVIRONMENT	MDG Support for MCH services	92 (25.0%)	8 (3.0%)	100 (15.8%)
	Free ANC Services	70 (19.0%)	9 (3.4%)	79 (12.5%)
	Regular Monthly Community Outreaches	209 (56.8%)	14 (5.3%)	223 (35.2%)
	MSS midwives	32 (8.7%)	14 (5.3%)	46 (7.3%)
COMMUNITY SYSTEMS (ARE THE FOLLOWING AVAILABLE?)	Other than health facilities where women deliver in this community	221 (60.1%)	150 (56.4%)	371 (58.5%)
	Ward development committee	207 (56.2%)	59 (22.2%)	266 (42.0%)
	Village development committee	180 (48.9%)	60 (22.6%)	240 (37.9%)
	Community development association	174 (47.3%)	78 (29.3%)	252 (39.7%)
	Community-based organization	125 (34.0%)	55 (20.7%)	180 (28.4%)

Findings from each domain of the assessment disaggregated by facility ownership are presented in Table 6. Almost all the clinical and laboratory services were available in both private and public facilities assessed. TB services were the least available service in assessed facilities (obtainable in about 16% of the facilities), followed by family planning services (65.0%) and HTC services (65.9%). The assessment found that common gaps in infrastructure among the private facilities were spaces for laboratory (61.5%) and medical records (65.3%).

Likewise, the enabling environment seems to be better around the public facilities as they have more MDG support (2.3% vs. 37.6%), free ANC services (3.1% vs. 27.7%), regular monthly outreach (5.9% vs. 82.6%) and MSS midwives (4.3% vs. 12.0%). Furthermore, the results show better community systems around public facilities except for "other facilities where women can deliver" which is higher for private facilities.

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

		FACILITY TYPE		
		Primary level n = 242	Secondary level n = 392	Total n = 634
SERVICE AVAILABILITY	Physical Exam (including weight, assessing GA, blood pressure)	265 (99.6%)	366 (99.5%)	631 (99.5%)
	Laboratory services (onsite or by referral): Hb, Urinalysis	195 (80.6%)	345 (88.0%)	540 (85.2%)
	Dispensing of haematinics and IPTp	235 (97.1%)	372 (94.9%)	607 (95.7%)
	Labour and delivery services (with 24 hour shifts)	190 (78.5%)	380 (96.9%)	570 (89.9%)
	Referrals for emergency obstetric and new-born care	235 (88.3%)	341 (92.7%)	576 (90.9%)
	Family Planning services (condoms, hormonal contraceptives)	173 (71.5%)	239 (61.0%)	412 (65.0%)
	Immunization services	231 (95.5%)	200 (51.0%)	431 (68.0%)
	Child follow up clinics	221 (91.3%)	288 (73.5%)	509 (80.3%)
	TB services (specify which - e.g. DOTS, microscopy)	56 (21.1%)	47 (12.8%)	103 (16.2%)
IDENTIFIED STRUCTURE *(CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)*	Lab Room	112 (46.3%)	278 (70.9%)	390 (61.5%)
	ANC Space & Room	226 (93.4%)	371 (94.6%)	597 (94.2%)
	Space that can be used for confidential counselling	207 (85.5%)	347 (88.5%)	554 (87.4%)
	Maternity Room	227 (93.8%)	384 (98.0%)	611 (96.4%)
	Pharmacy, Store & Dispensary	185 (76.4%)	329 (83.9%)	514 (81.1%)
	Space for HTC/Adherence counselling	187 (77.3%)	329 (83.9%)	516 (81.4%)
	Medical records/M&E	139 (57.4%)	275 (70.2%)	414 (65.3%)
ENABLING ENVIRONMENT	MDG Support for MCH services	91 (37.6%)	9 (2.3%)	100 (15.8%)
	Free ANC Services	67 (27.7%)	12 (3.1%)	79 (12.5%)
	Regular Monthly Community Outreaches	200 (82.6%)	23 (5.9%)	223 (35.2%)
	MSS midwives	29(12.0%)	17(4.3%)	46 (7.3%)
COMMUNITY SYSTEMS *(ARE THE FOLLOWING AVAILABLE?)*	Other than health facilities where women deliver in this community	161 (66.5%)	210 (53.6%)	371 (58.5%)
	Ward development committee	193 (79.8%)	73 (18.6%)	266 (42.0%)
	Village development committee	172 (71.1%)	68 (17.3%)	240 (37.9%)
	Community development association	138 (57.0%)	114 (29.1%)	252 (39.7%)
	Community-based organization	94 (38.8%)	86 (21.9%)	180 (28.4%)

6.4 QUALITATIVE FINDINGS

In order to plan for scale-up, a decision is to be made on the number of facilities that will be scaled-up to increase the facility coverage of PMTCT services. The scenarios presented in Table 7 apply different cut-off points and the number of assessed facilities that met these criteria. These cut-offs are related to the prescribed national standards for PMTCT sites. Fifty three of the 242 (21.9%) of public facilities and 315/394 (79.9%) of private facilities assessed had at least one doctor. The next criterion was the availability of at least four nurses/midwives, which was chosen with the assumption that a minimum of four nurses/midwifes are necessary to ensure round-the-clock provision of services. Only 26 public (10.7%) and 43 private facilities (11.0%) met this criterion. A relaxed criterion was defined by the state to include facilities with at least four health workers who could give clinical care. Staff who could give clinical care were defined as nurses, community health extension workers and community health officers. More facilities met this criterion than those that met the 'nurse/midwife' criterion.

Two minimum human resource (HR) criteria were set to include different combinations of HR-related criteria. These are presented as 'Minimum HR complement 1' and 'Minimum HR complement 2'. Minimum HR complement 1 included at least four nursing staff, one pharmacist/pharmacy technician, one lab technician, and one records officer. Minimum HR complement 2 included at least one doctor, four nursing staff, one pharmacist/pharmacy technician, one lab technician, and one records officer. Only 33 facilities met both criteria, while merely 6.6% (41) of facilities met the national minimum standard for the provision of PMTCT service provision.

Only one public facility and 18 private facilities met the composite criteria for having at least four health workers to provide nursing care, one pharmacy, one lab, one records, above average ANC attendance and at least one delivery per month.

Table 7: Scenarios using different cut-offs – HR related

CRITERIA	CUT-OFF	OWNERSHIP	NUMBER OF FACILITIES ELIGIBLE	% OF TOTAL FACILITIES
Have ANC but no IP (total assessed)		Public	242	38.2
		Private	392	61.8
Availability of Doctors	At least 1	Public	53	8.5
		Private	315	50.4
Availability of Nurses/ Midwives	At least 4	Public	26	4.1
		Private	43	6.8
Staff who can give nursing care	At least 4	Public	52	8.3
		Private	143	22.8
Clinical care (Nurses with health workers who can give nursing care)	At least 4	Public	94	15.0
		Private	219	34.9
ANC attendance in the last 12 months	Above state average	Public	39	6.2
		Private	116	18.3
Deliveries taken in the last 12 months	At least 1	Public	207	32.7
		Private	373	58.9
Minimum HR complement 1	At least 4 nursing care, 1 pharmacy, 1 lab, 1 records	Public	2	0.3
		Private	31	5.0
Minimum HR complement 2	At least 1 doctor, 4 nursing care, 1 pharmacy, 1 lab, 1 records	Public	2	0.3
		Private	31	5.0
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	2	0.3
		Private	39	6.3
Composite criterion	At least 4 nursing care, 1 pharmacy, 1 lab, 1 records, above average ANC attendance, at least 1 delivery	Public	1	0.2
		Private	18	2.9

6.5 QUALITATIVE FINDINGS

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

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

The KIIs conducted with health workers in Anambra State revealed that many women prefer the services of TBAs, private clinics and churches. Respondents provided the following reasons for this observation: reliability, friendliness and availability of TBAs. Whereas, long distance, unavailability of staff, cost and insecurity are some of the reasons respondents believe are responsible for the low patronage of health facilities. Table 8 below captures these themes as well as quotes from respondents.

Table 8: Women prefer to patronize traditional birth attendants (TBAs), private clinics and churches

THEMES	QUOTES
Women prefer to patronize traditional birth attendants (TBAs), private clinics and churches	"In this place, for example out of these 246 women that came for ANC last year, only about 31 of them delivered here. They all will want to deliver with the TBAs in the community." "They attend ANC clinics but prefer going to the TBAs for deliveries." "We do not know if they are charmed because they pay more there than what we take from them." "They believe it is cheaper since they pay in installments; the mothers are given special attention; no such privilege is given to the patients in the PHCs and General Hospitals."
Why women prefer to deliver with TBAs	"They see the TBAs to be more reliable and friendly than we the health workers." "They are more skilled and available at all times, our mothers delivered there."
Reasons for poor patronage of the health facilities	"Sometimes they refuse to come back just like that." "This place is far from the village. We even find it difficult coming to work because of the distance." "We don't have enough staff and most times women come in the night and do not meet anyone." "Most pregnant women ended up not paying their bills completely especially when they are very close to delivery, hence they visit the TBAs." "Because of insecurity here, thieves do visit us and so we cannot keep our patient here for 24 hours services for the fear of being attacked by thieves."

6.5.2 Some health facilities are well patronized

Respondents believe reasons why some health facilities are well patronized include the provision of free health services and regular community outreach. The availability of functional village and ward development committees also help to ensure that facilities are well utilized. These themes are summarized in Table 9.

Table 9: Reasons why some health facilities are well patronized

THEMES	QUOTES
Reasons for good patronage of health facility	"They are just coming because the free things they get here." "We do carry out community outreach twice in a month." "We always go to the people to talk to them and to encourage them on the importance of visiting the hospital."
Role of village/ward development committee	"Last time the town officials invited me to their meeting ...I also told them that this clinic is their own, they should patronize it first." "In most PHCs, some of the equipment are donated by the community." "They have been up and doing to ensure that women come to this clinic." "The grasses around the facility is being cleared by the community members."

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

Health workers interviewed were of the opinion that the provision of free health services and drugs, as well as improved staffing and provision of better structures will help to improve service quality in the state (see Table 10).

Table 10: Respondents' suggestions on improving service quality

THEMES	QUOTES
Provision of free health services and drugs	"It is good if the government should provide everything free for the pregnant women."
Improved staffing	"We need doctors in our facility."
Provision of better structures	"We want government to help us build new facilities that are closer to the people (village)."

SECTION

7 Geospatial representation of facilities

The maps below show the location of sites currently providing PMTCT services, assessed facilities, facilities which meet the state-defined and national criteria for PMTCT service provision. The PMTCT landscape for different coverage scenarios is also presented.

Figure 3: Map illustrating PMTCT sites in Anambra State as at the time of this assessment

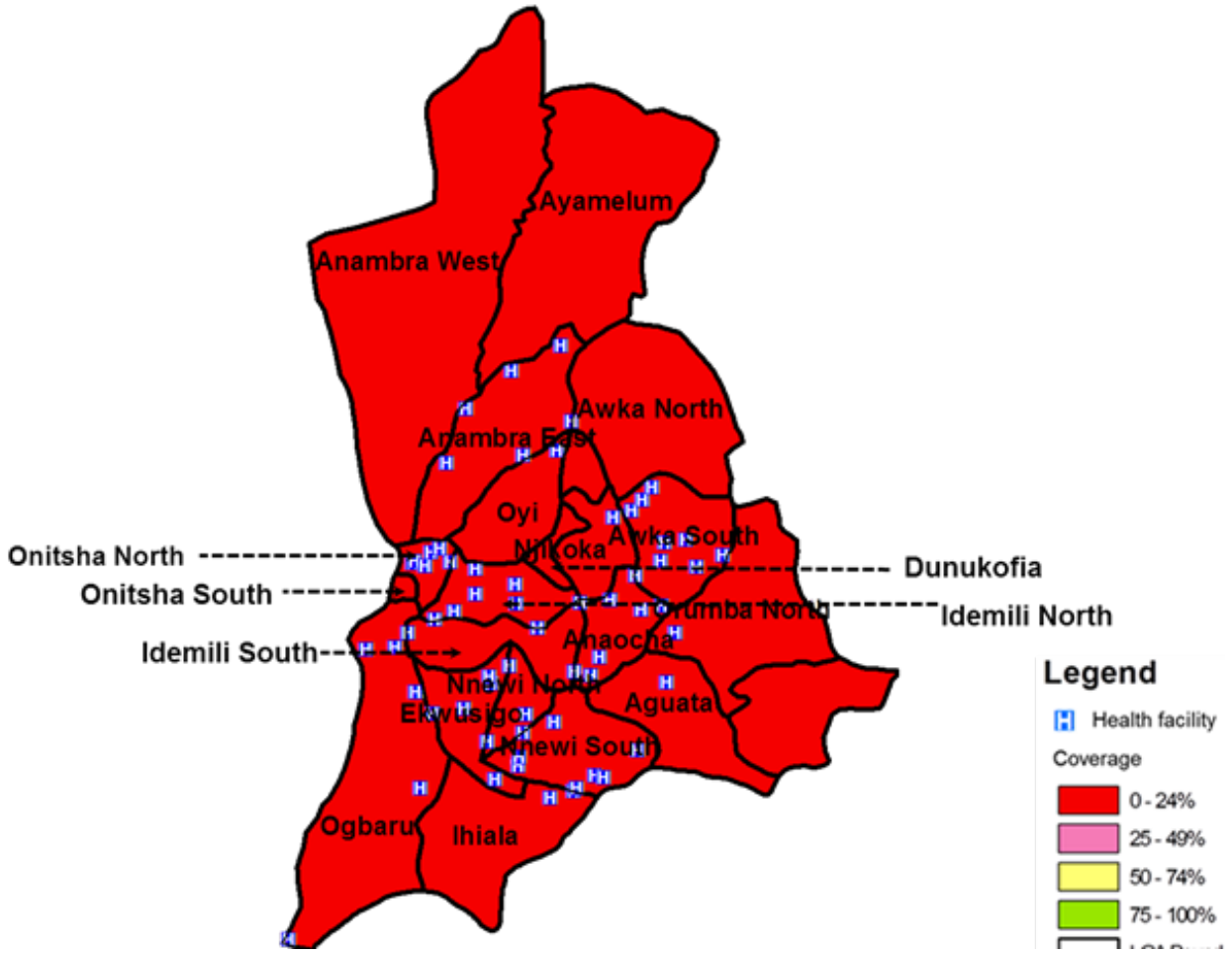


Figure 4: Map illustrating spread of assessed facilities (with ANC but no PMTCT)

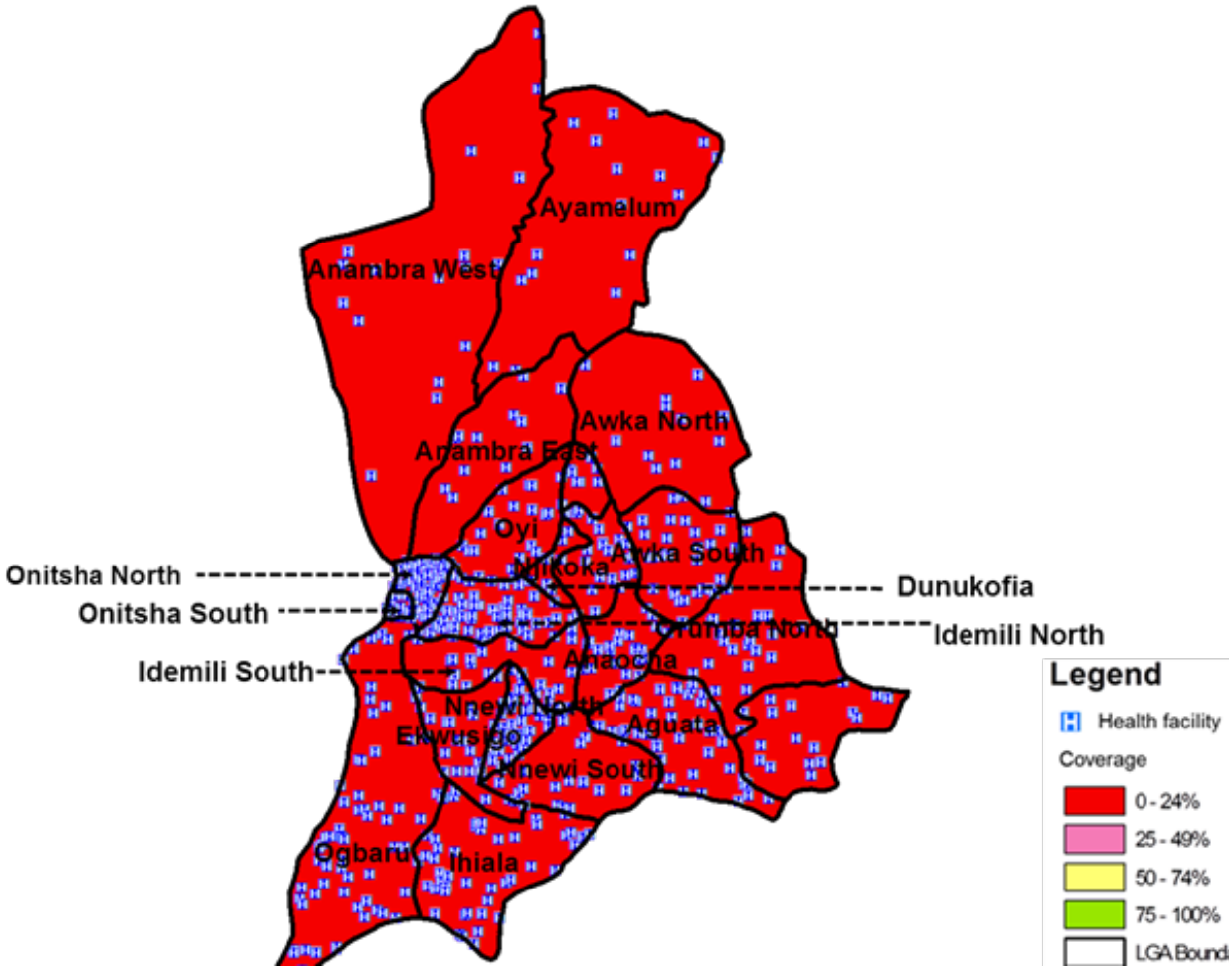


Figure 5: Map showing the spread of facilities which met the national HR criteria for PMTCT services

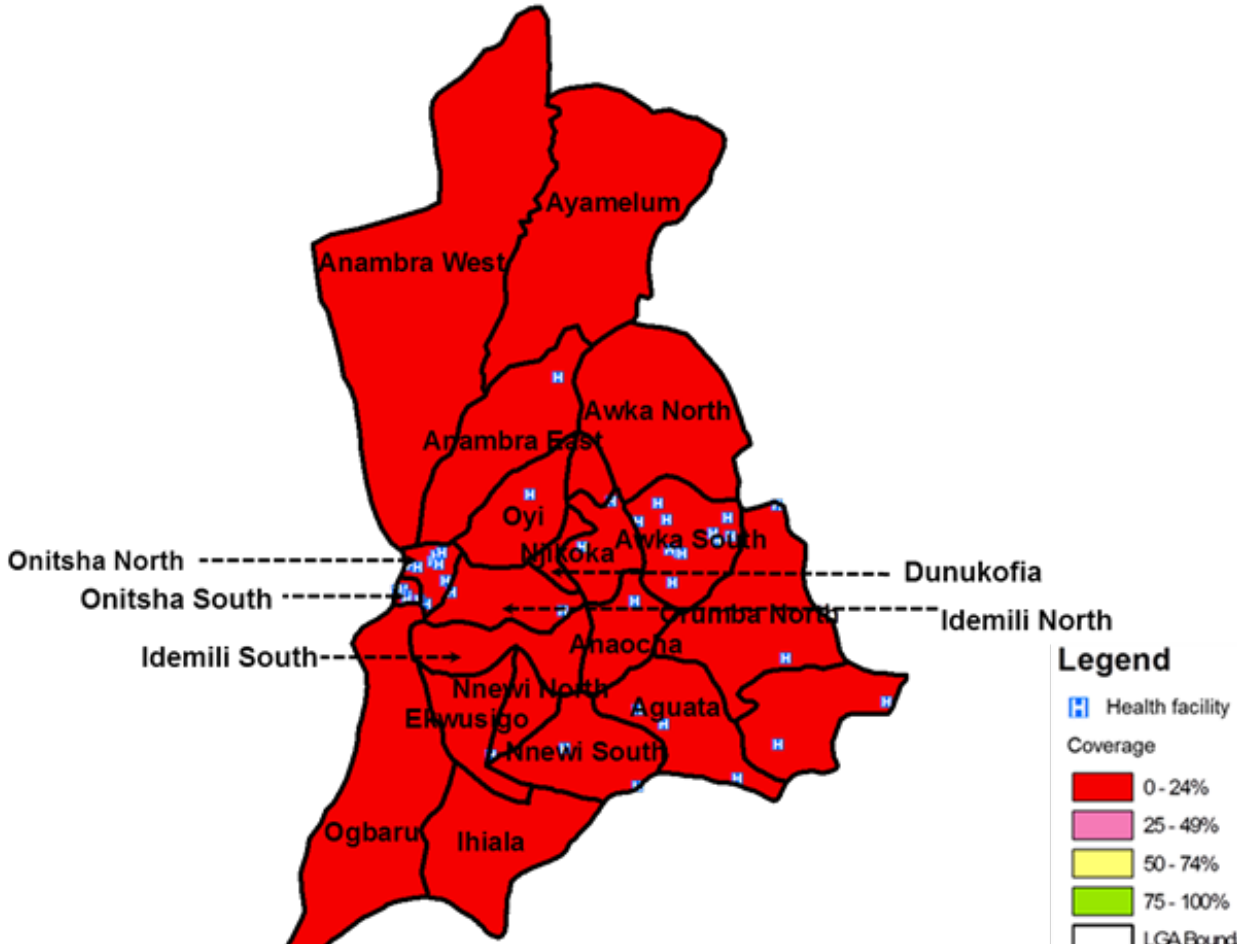


Figure 6: Map showing facilities which met the state-defined HR criteria for PMTCT services

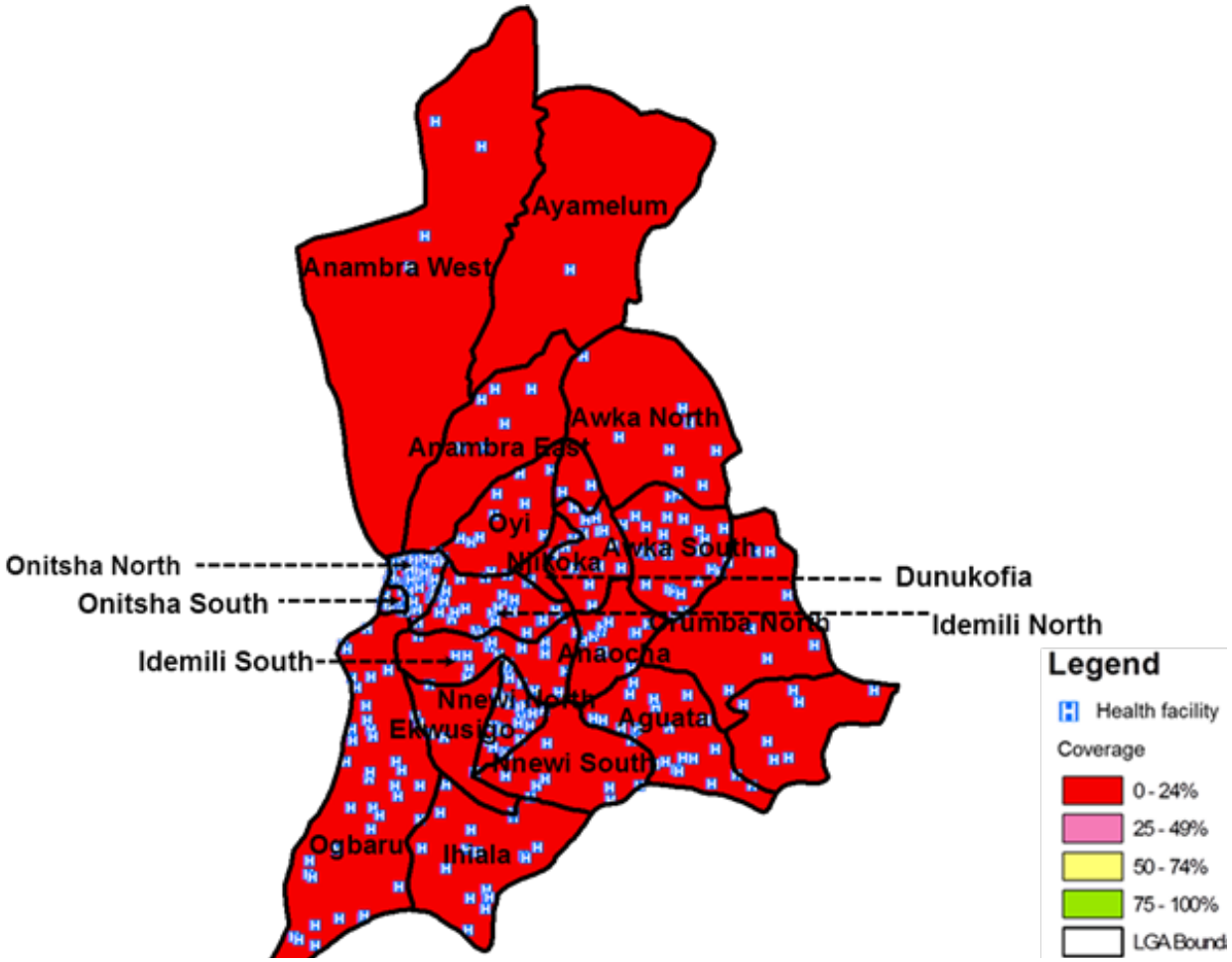


Figure 7: Map illustrating scenario for 2014 coverage with current PMTCT sites and scale-up limited to sites which met national HR criteria

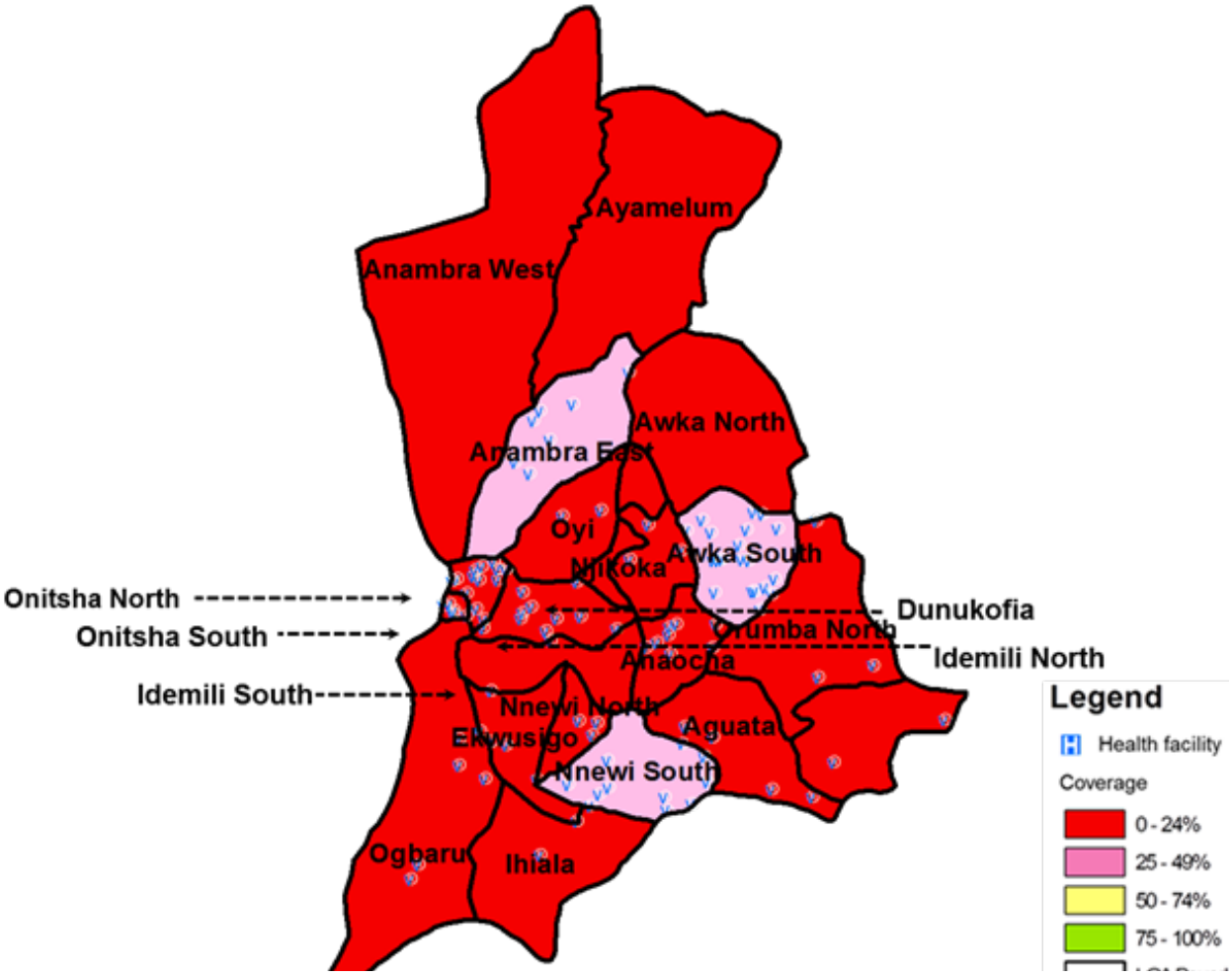


Figure 8: Map illustrating scenario for 2014 coverage (current PMTCT sites + scale-up to sites which met the state-defined HR criteria)

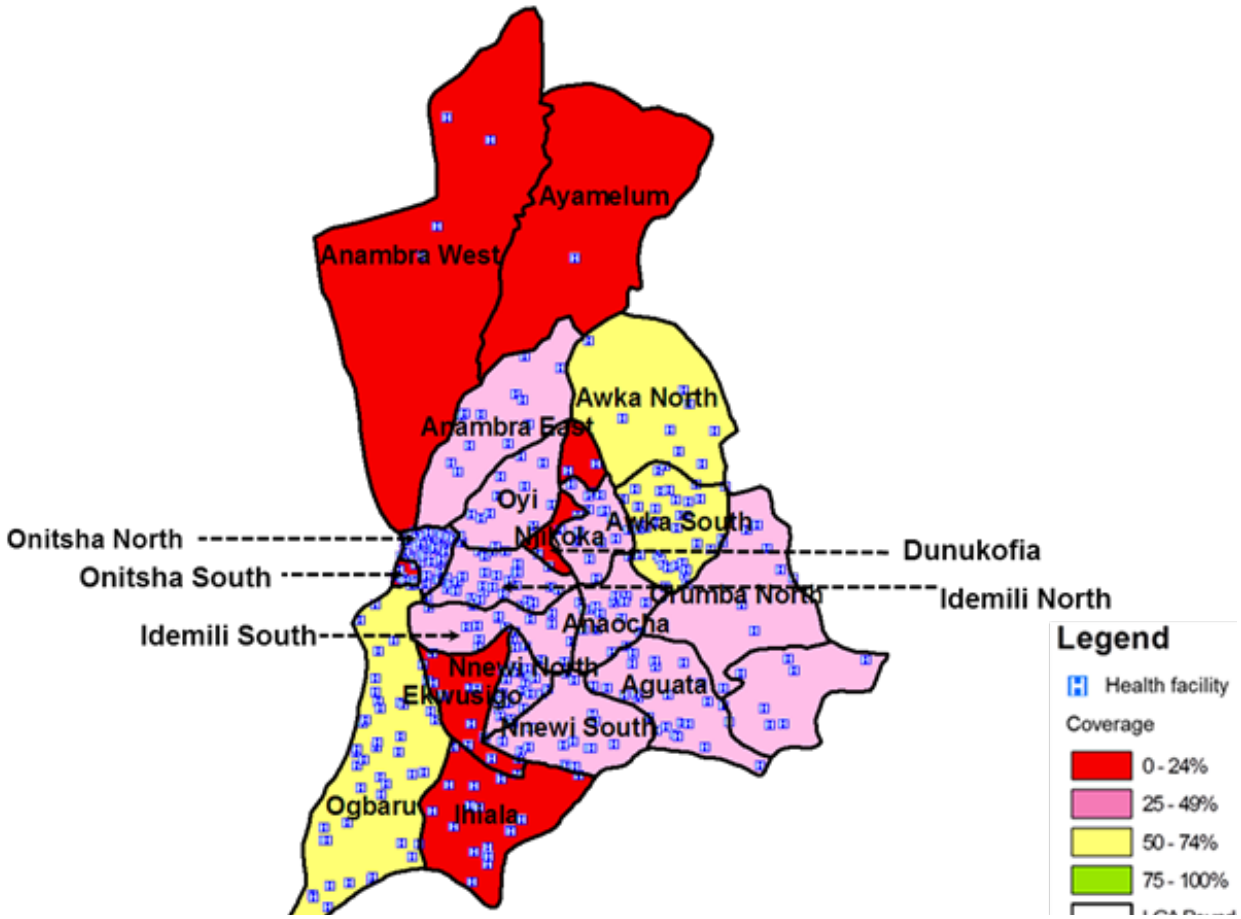
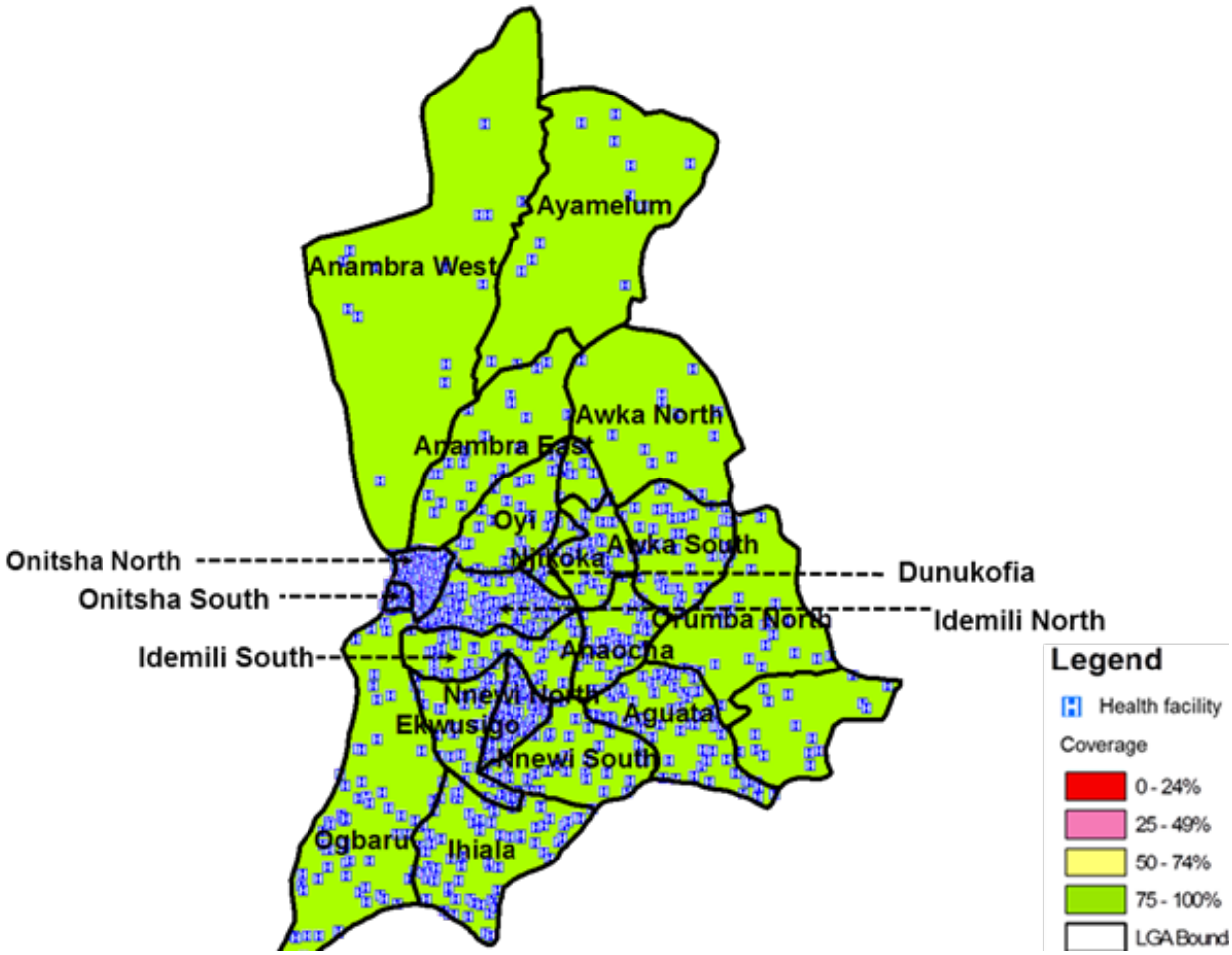


Figure 9: Map illustrating scenario for 2014 coverage (current PMTCT sites + scale-up to 80% of ANC facilities without PMTCT)



SECTION

8 Conclusion

Infrastructure for PMTCT services is poor at the primary level facilities although there is a better enabling environment and better community systems around these primary facilities. Generally however, there is poor community involvement and ownership as many of the facilities did not have functioning community systems. Additionally, only 6.6% of health facilities providing ANC services in the state met the national HR complement for PMTCT services with private health facilities faring far better with regards to HR availability.

SECTION

9 Recommendations

Data from this assessment should be used to develop a comprehensive state PMTCT scale-up plan. Implementing partners and other stakeholders need to work with the state government to improve infrastructure and HR availability at the primary level facilities especially those that are publicly owned.

A comprehensive scale-up plan will include private health facilities as the findings show that there are many facilities in the private sector that are available to provide PMTCT services with the proper resources. Service utilization data also shows that these facilities are well utilized.

There is also need to improve the community involvement and ownership by facilitating the establishment of ward and village development committees as well as community-based organizations.

Appendix

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

DOMAIN	ITEM	368 PRIMARY FACILITIES					266 SECONDARY FACILITIES					TOTAL 634 FACILITIES				
		Min	Median	Average	Max	Total	Min	Median	Average	Max	Total	Min	Median	Average	Max	Total
HUMAN RESOURCES	Number of doctors	0	0	0.4	5	138	0	1	1.6	6	424	0	1	0.9	6	562
	Number of registered nurse/midwife	0	1	1.2	13	423	0	1	2.1	40	567	0	1	1.6	40	990
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	0	2	2.2	11	795	0	3	4.1	20	1100	0	2	3.0	20	1895
	Number of records officers	0	0	0.1	6	42	0	0	0.5	8	131	0	0	0.3	8	173
	Number of lab technician/ scientists	0	0	0.2	3	56	0	1	1.0	7	256	0	0	0.5	7	312
	Number of pharmacy technician/ pharmacists	0	0	0.04	3	15	0	0	0.4	4	96	0	0	0.2	4	111
SERVICE UTILIZATION	Number attended OPD in the last 12 months	0	264	505.2	6850	184914	0	656	1692.8	23212	448583	0	378	1004	23212	633497
	ANC first attendees recorded in the last 12 months	0	72.5	157.5	2604	57949	0	120	333.6	8205	88739	0	88.5	231	8205	146688
	Deliveries taken in the last 12 months	0	31	76.7	1416	28158	0	60	159.7	3410	42481	0	40	112	3410	70639

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

DOMAIN	ITEM	242 PUBLIC					392 PRIVATE					TOTAL 634 FACILITIES				
		Min	Median	Average	Max	Total	Min	Median	Average	Max	Total	Min	Median	Average	Max	Total
HUMAN RESOURCES	Number of doctors	0	0	0.3	6	63	0	1	1.3	6	499	0	1	0.9	6	562
	Number of registered nurse/midwife	0	1	1.3	0	302	0	1	1.8	40	688	0	1	1.6	40	990
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	0	2	2.5	9	582	0	2	3.4	20	1313	0	2	3.0	20	1895
	Number of records officers	0	0	0.2	6	38	0	0	0.4	8	135	0	0	0.3	8	173
	Number of lab technician/ scientists	0	0	0.1	3	17	0	1	0.8	7	295	0	0	0.5	7	312
	Number of pharmacy technician/ pharmacists	0	0	0.1	2	12	0	0	0.3	4	99	0	0	0.2	4	111
SERVICE UTILIZATION	Number attended OPD in the last 12 months	0	289	511.6	6850	123804	0	480	1310	23212	509693	0	378	1004	23212	633497
	ANC first attendees recorded in the last 12 months	0	52	114	1200	27573	0	112	304	8205	119115	0	89	231	8205	146688
	Deliveries taken in the last 12 months	0	20	49	1140	11880	0	60	150	3410	58759	0	40	112	3410	70639

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

S/N	LGAS	PUBLIC (N=242)		PRIVATE (N=392)	
		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	Aguata	4	15	22	3
2	Awka North	0	8	3	1
3	Awka South	0	6	23	3
4	Anambra East	5	3	3	1
5	Anambra West	10	6	0	1
6	Anaocha		12	9	5
7	Ayamelum	1	11	2	2
8	Dunukofia	0	10	5	0
9	Ekwusigo	2	13	5	1
10	Idemili North	3	4	39	16
11	Idemili South	2	10	11	0
12	Ihiala	5	20	13	12
13	Njikoka	7	5	8	1
14	Nnewi North	1	14	31	4
15	Nnewi South	1	9	8	3
16	Ogbaru	1	5	50	8
17	Onitsha North	2	7	53	6
18	Onitsha South	1	0	12	3
19	Orumba North	1	18	4	2
20	Orumba South	5	5	7	0
21	Oyi	0	8	7	5
Total		**53**	**189**	**315**	**77**

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

S/N	LGAS	PUBLIC (N=242)		PRIVATE (N=392)	
		Facilities with at least one nurse	Number of nurses needed to meet national standard	Facilities with at least one nurse	Number of nurses needed to meet national standard
1	Aguata	11	8	20	5
2	Awka North	5	3	4	0
3	Awka South	6	10	1	0
4	Anambra East	9	5	5	9
5	Anambra West	4	4	1	3
6	Anaocha	4	2	17	9
7	Ayamelum	7	5	1	3
8	Dunukofia	7	3	4	1
9	Ekwusigo	9	6	5	1
10	Idemili North	5	2	46	9
11	Idemili South	12	0	9	2
12	Ihiala	16	9	13	12
13	Njikoka	9	3	4	5
14	Nnewi North	8	7	25	10
15	Nnewi South	8	2	8	3
16	Ogbaru	4	2	51	7
17	Onitsha North	7	2	49	10
18	Onitsha South	0	1	14	1
19	Orumba North	9	10	5	1
20	Orumba South	7	3	5	2
21	Oyi	6	2	7	5
Total		**153**	**89**	**294**	**98**

Appendix 5: Human Resource Gap in Anambra State assessed facilities by LGAs (Trained Health Workers – CHOs, CHEWs etc.)

S/N	LGAS	PUBLIC (N=242)		PRIVATE (N=392)	
		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	Aguata	14	10	19	12
2	Awka North	5	6	3	2
3	Awka South	12	8	0	2
4	Anambra East	10	8	5	18
5	Anambra West	8	0	1	6
6	Anaocha	6	0	25	2
7	Ayamelum	5	14	2	4
8	Dunukofia	3	2	2	6
9	Ekwusigo	10	10	3	6
10	Idemili North	5	4	19	72
11	Idemili South	6	12	8	6
12	Ihiala	18	14	5	40
13	Njikoka	12	0	5	8
14	Nnewi North	13	4	24	22
15	Nnewi South	3	14	8	6
16	Ogbaru	5	2	42	32
17	Onitsha North	8	2	43	32
18	Onitsha South	0	2	10	10
19	Orumba North	11	16	5	2
20	Orumba South	5	10	6	2
21	Oyi	8	0	5	14
Total		**167**	**138**	**240**	**304**

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

S/N	LGAS	PUBLIC (N=242)		PRIVATE (N=392)	
		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	Aguata	1	18	4	21
2	Awka North	0	8	1	3
3	Awka South	0	16	0	1
4	Anambra East	2	12	1	13
5	Anambra West	0	8	0	4
6	Anaocha	0	6	14	12
7	Ayamelum	0	12	0	4
8	Dunukofia	0	10	1	4
9	Ekwusigo	2	13	1	5
10	Idemili North	1	6	8	47
11	Idemili South	0	12	0	11
12	Ihiala	1	24	2	23
13	Njikoka	2	10	2	7
14	Nnewi North	0	15	3	32
15	Nnewi South	0	10	3	8
16	Ogbaru	0	6	5	53
17	Onitsha North	0	9	14	45
18	Onitsha South	0	1	7	8
19	Orumba North	1	18	2	4
20	Orumba South	0	10	2	5
21	Oyi	0	8	2	10
Total		**10**	**232**	**72**	**320**

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

S/N	LGAS	PUBLIC (N=242)		PRIVATE (N=392)	
		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	Aguata	2	17	21	4
2	Awka North	0	8	2	2
3	Awka South	0	16	0	1
4	Anambra East	1	13	2	12
5	Anambra West	0	8	1	3
6	Anaocha	1	5	19	7
7	Ayamelum	1	11	1	3
8	Dunukofia	0	10	2	3
9	Ekwusigo	1	14	5	1
10	Idemili North	1	6	26	29
11	Idemili South	0	12	4	7
12	Ihiala	2	23	10	15
13	Njikoka	2	10	6	3
14	Nnewi North	1	14	16	19
15	Nnewi South	0	10	6	5
16	Ogbaru	1	5	22	36
17	Onitsha North	1	8	40	19
18	Onitsha South	0	1	12	3
19	Orumba North	0	19	3	3
20	Orumba South	0	10	4	3
21	Oyi	1	7	4	8
Total		**15**	**227**	**206**	**186**

Appendix 8: Summary of Human Resource Gap in Anambra 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	189	77
2	Nurses	89	98
3	Trained Health Workers – CHOs, CHEWs etc.	138	304
4	Record Officers	232	320
5	Lab. Scientist/ technicians	227	186
6	Pharmacist/pharmacy technicians	395	166

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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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