



Report of the Rivers

STATE-WIDE RAPID HEALTH FACILITY ASSESSMENT



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

May 2013



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Foreword

The Rivers State Rapid Health Facility Assessment which was carried out in preparation for the elimination of mother-to-child transmission of HIV (eMTCT) marked the beginning of a new dawn in the drive towards zero new infections. It featured a practical collaborative effort in ensuring the engagement of all stakeholders and facilities to achieve set objectives. Indeed every activity geared towards the eMTCT is a welcome development and deserves encouragement and support. The result of the assessment is therefore cardinal to every intervention effort which aims to be all inclusive.

The document has afforded us clear opportunity for eMTCT and above all to also renew the spatial distribution of HIV services with a view to making improvements. It therefore represents not only an early planning stage but an objective review process and the gaps to be filled.

It may not be a model perfect document but it is a landmark foundation to begin the state eMTCT campaign and a platform for future reassessments and evaluation. This document is a welcome intervention effort towards eMTCT. Consequently, I recommend it to all stakeholders and researchers and further suggest that we utilize it in the forthcoming plan to achieve elimination status for the state.



Dr. Micheal Nyemenim

*T.A to the HCH on HIV/AIDS
Rivers State*

Acknowledgements

Very special thanks to the FHI 360 for wisdom and support in the control of HIV/AIDS in Rivers State. The partnership has been exemplary and filled with great milestones that will rail road a sustainable and successful control program. The state RHFA document represents one of the so many such achievements that remain an indelible and historic precipice for us to build upon.

We also very specially acknowledge the unwavering determination of his Excellency, the Executive Governor of Rivers State Rt. Hon. Chibuike Rotimi Amaechi (CON). Similarly, the commitment of the Hon. Commissioner for Health, Hon. T.S Parker and the Permanent Secretary, Rivers State Ministry of Health, has been very encouraging and steadfast. They have expressed their desire to support the eMTCT project as much as possible. This has strengthened the resolve of the diligent Rivers SASCP team especially Dr. Sibor Leelebari, Mrs Idoniboyeobu Frances and my humble self, Dr. Golden Owghonda to vigorously pursue the various control measures and most of all, engender ownership and accountability. We are certain that by his grace we will succeed.

We thank as well the Rivers State Primary and Secondary Health Care Boards, State Agency for the Control of AIDS, the RivNEPWAN and the 'Deep Dive' consultants of the SOML. You have all been a great backstop. Let's keep the team spirit.

Finally and most importantly, we humbly express our gratitude to GOD Almighty who has made all these possible.



Dr. Golden Owghonda, FWACP

*Deputy Director, Public Health Service
Program Manager, State AIDS/STI Control Program
River State Ministry of Health*

Acronyms

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



Executive Summary

Rivers State has the sixth highest HIV prevalence among the states of Nigeria and is one of the 12+1 states that contribute 70% of Nigeria's burden of mother-to-child transmission of HIV (MTCT). The HIV prevalence among pregnant women in the state rose initially from 1% in 1995 to a peak of 7.7% in 2001 and currently stands at 6% - consistently above the national prevalence since 2001. The 12+1 states have been earmarked 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 Rivers State. This cross-sectional survey utilized mixed (quantitative and qualitative) methods. All listed public and private health facilities in Rivers State which met defined criteria were assessed. The criteria included all facilities with ANC services while facilities with current implementing partner (IP) support for provision of antiretroviral drugs (ARVs) for prevention of mother-to-child transmission of HIV (PMTCT) or with plans for PMTCT services in 2013 were excluded.

Of the 413 health facilities providing ANC in the state, 66 were providing PMTCT services at the time of the assessment and 20 had plans for PMTCT services in 2013. The remaining 327 were assessed for their readiness to provide PMTCT services. Of these 327, 36.1% (118) were private and the others (209) were public. Approximately two-thirds of the facilities operated as primary level facilities.

There was a relatively better availability of human resource for health in assessed facilities with about 48% of the assessed facilities meeting the minimum national standard for PMTCT service provision. A total of 63 doctors, 73 nurses, 56 CHEWs/CHOs, 45 pharmacists or pharmacy technicians and 25 laboratory scientists or technicians are needed to bring all assessed public facilities to national standard for PMTCT service provision. With regard to private facilities, three doctors, six nurses, 100 CHEWs/CHOs, 38 pharmacists or pharmacy technicians and 10 laboratory scientists or technicians are needed.

There was a substantial drop between the average number of attendees for a first ANC visit the number of deliveries at both primary and secondary facilities suggesting a large dropout between ANC attendance and facility delivery. Results of key informant interviews with health providers also revealed that many 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 the uptake of ANC services and facility delivery should feature prominently in the design of eMTCT interventions. Thus, community engagement for demand creation should be improved.

SECTION

1

Background

Rivers State was created in 1967 with the split of the Eastern Region of Nigeria. It is one of the six states in Nigeria's South-South geopolitical zone. The old Rivers State comprised of the current Rivers State and what is now Bayelsa State which was carved out in 1996. It is bounded on the south by the Atlantic Ocean, to the north by Imo, Abia and Anambra States, to the east by Akwa Ibom State and to the west by Bayelsa and Delta states. With the capital in Port Harcourt, the state has a population of 5,198,716 according to the 2006 population census and – with a growth rate of 2.553% - the 2012 projected population is 6,202,042.

Rivers State has 23 local government areas (LGAs) and covers a land mass of 1,077 km². The inland section of Rivers State consists of tropical rainforest while towards the coast the typical river delta environment features many mangrove swamps. The

capital, Port Harcourt, is the nerve centre of the Nigerian oil industry and several other industries. Port Harcourt is the nation's second largest sea port with another sea port, the Onne Port Complex, in close proximity.

Marine agriculture is the main occupation of the people of Rivers State and the agricultural policy of the state government is anchored on food production. With enormous reserves of crude oil and natural gas, Rivers State accounts for more than 40% of Nigeria's crude oil production and the state also harbours the first petroleum refinery in Nigeria. In addition, the country's enormous liquefied natural gas project is located at Bonny in the state.

These and several other features of the state make it a preferred destination for businessmen and tourists from within and outside the country.

SECTION

2

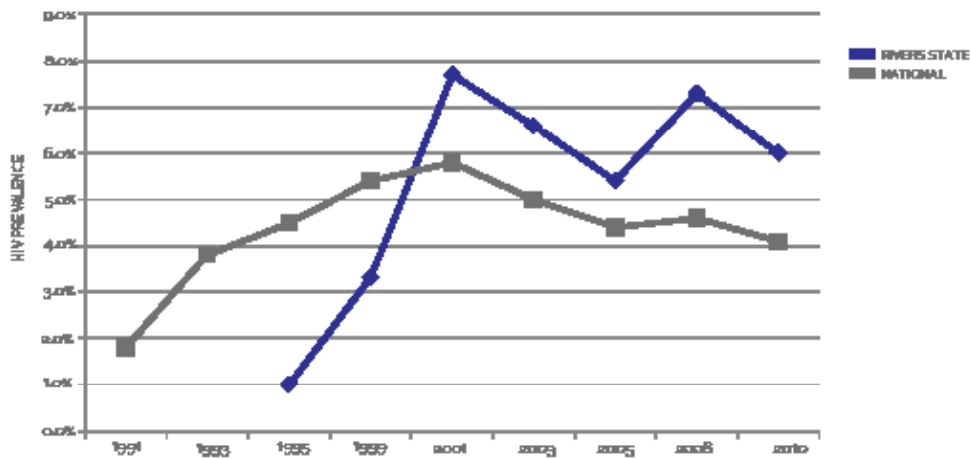
Rivers State HIV Profile

Rivers State HIV prevalence which currently stands at 6% has been rising and falling since 1999. Since 2001, HIV prevalence in Rivers State has been higher than the national prevalence which currently stands at 4.1% (see Figure 1 below). The state is one of the 12+1 states that contribute 70% of Nigeria's

PMTCT burden. These states have been earmarked for phase 1 of Nigeria's scale-up towards eMTCT.

Transactional sex and low condom use among female sex workers are two factors that have contributed to driving the epidemic in the state.

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



SOURCE: HSS 2010

Cultural factors and the state being a destination for long distance truck drivers and seamen are also thought to contribute to the epidemic.

2.1 MTCT PROFILE FOR RIVERS STATE

Using LGA-specific HIV prevalence data from the 2010 antenatal sero-prevalence survey, an estimated 10,680 pregnant women will be positive for HIV. Approximately one-third of these

women would infect their babies in the absence of any interventions to prevent mother-to-child transmission of HIV resulting in about 3,560 preventable HIV infections among infants in the State during that year alone. Table 1 shows that though Gokana, Ahoada East and Oyigbo LGAs have the highest HIV prevalence in the state, Oyigbo, Ahoada East and Etche rank highest when the MTCT burden and PMTCT service gap are considered.

Table 1: LGA Ranking by MTCT Burden and PMTCT Service Coverage Gap in Rivers 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)	
OYIGBO	13.0%	540	18	27	96.3%	19	37
AHOADA EAST	12.5%	689	19	16	87.5%	14	33
ETCHE	8.8%	729	20	13	84.6%	11	31
PORT HARCOURT	7.8%	1393	22	70	81.4%	8	30
OGBA-EGBEMA-NDONI	5.2%	488	15	37	89.2%	15	30
OKRIKA	4.7%	346	11	14	92.9%	18	29
GOKANA	19.8%	1535	23	11	72.7%	4	27
BONNY	4.2%	299	10	11	90.9%	17	27
ABUAL/ODUAL	4.8%	449	14	7	85.7%	12	26
OBIO/AKPOR	3.2%	490	16	68	83.8%	10	26
ANDONI	2.8%	202	5	24	100.0%	20	25
OMUMA	5.8%	193	4	4	100.0%	20	24
ELEME	3.7%	233	8	10	90.0%	16	24
KHANA	8.0%	777	21	12	58.3%	1	22
AHOADA WEST	4.4%	364	13	11	81.8%	9	22
OPOBO/NKORO	3.2%	162	2	7	100.0%	20	22
DEGEMA	6.0%	496	17	8	75.0%	5	22
OGU/BOLO	2.2%	55	1	3	100.0%	20	21
TAI	5.8%	231	7	7	85.7%	12	19
EMUOHA	3.7%	247	9	14	78.6%	7	16
IKWERRE	5.7%	357	12	17	58.8%	2	14
ASARI-TORU	2.9%	211	6	14	71.4%	3	9
AKUKU TORU	3.6%	192	3	8	75.0%	5	8
Total	6.0%	10,680		413	84.0%		

SECTION

3 Response to the HIV Epidemic

Rivers State Agency for the Control of HIV/AIDS (SACA) was established in 2012 and is responsible for the overall management and coordination of HIV and AIDS programs within the state. The State AIDS and STI Control Program (SASCP) on the other hand, coordinates the health sector specific HIV and AIDS response and is responsible for monitoring HIV/AIDS programs; collaborating with key implementing partners (IPs) and other stakeholders in HIV and AIDS program management.

International donors such as the United States Government (USG) and the Global Fund (GF) through their implementing partners have invested technical and financial resources in the HIV programming in the state. Some of the program areas funded in Rivers State by the international donors include HIV Testing and Counselling (HTC), provision of antiretroviral drugs (ARVs), laboratory equipment and capacity building for government and health facility staff.

The present focus of programming in PMTCT in the country is to ensure that at least 90% of all pregnant women have access to quality HTC and

at least 90% of all HIV positive pregnant women have access to ARVs. This is in addition to ensuring that at least 90% of all HIV-exposed infants have access to ARV prophylaxis by 2015. This is to be achieved through the four prongs of PMTCT - primary prevention of HIV in girls/ women of reproductive age, prevention of unintended pregnancies in HIV positive women, preventing HIV transmission from infected women to their infants and providing appropriate treatment care and support to mothers living with HIV and their children and families.

However, PMTCT coverage in the state is low with only about 30% of antenatal facilities providing ARVs for PMTCT. In line with the focus of the Government of Nigeria on accelerating PMTCT coverage in the 12+1 states, the Rivers State government with the support the USG through the IPs and other donor agencies has embarked on a PMTCT service scale up drive. This drive includes the conduct of a state-wide rapid health facility assessment, the findings from which will be used to develop a state-specific, costed PMTCT scale-up plan.

SECTION

4

Assessment Goal and Objectives

4.1 GOAL

The goal of this assessment is to derive a baseline profile of antenatal care services and thereby plan effective scale up of services to attain elimination of mother-to-child transmission of HIV in Rivers State.

4.2 OBJECTIVES

1. Assess health facilities in Rivers State and document those which meet minimum criteria
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

to provide ARVs for PMTCT

SECTION

5

(GPS) coordinates

Assessment Design

The assessment utilised a cross-sectional design with mixed (quantitative and qualitative) methods.

5.1 SAMPLING/SITE SELECTION

This assessment covered all listed public and

Box 1: Site selection

Site Inclusion Criterion

- Providing ANC

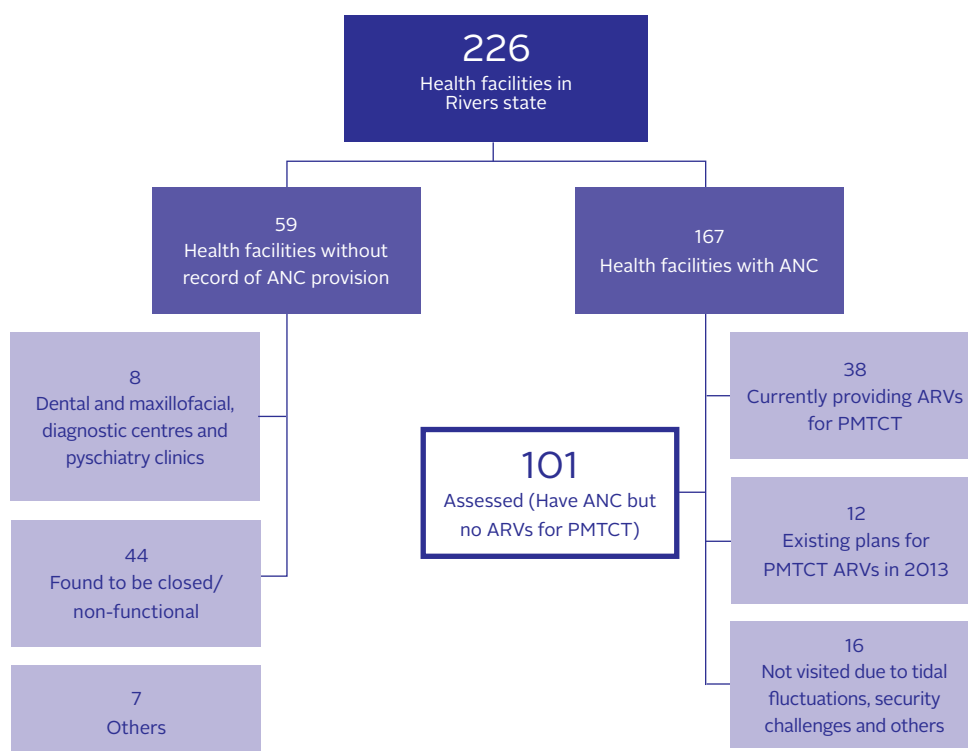
Site Exclusion Criteria

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

private health facilities in Rivers State which met defined criteria. A list of facilities was obtained from the Department of Planning, Research and

Statistics (DPRS), State Ministry of Health. All facilities with antenatal services were included; excluded were facilities with current IP support

Figure 2: Location of assessed health facilities within the Rivers State health system



providing ARVs for PMTCT or those with plans for PMTCT services in 2013 (supported through Global Fund or PEPFAR). In total, 101 facilities that had no support for PMTCT ARV provision were assessed as shown below (Figure 2).

5.2 STUDY TOOL

The Rivers State R-HFA tool included both quantitative and qualitative elements. The quantitative aspect used a semi structured

questionnaire to collect information from the facility head or officer about facility and service characteristics. Geospatial location of the facilities was ascertained as well facility ownership and current scope of PMTCT related services. There were seven domains which covered PMTCT programmatic components for scale-up: facility health linkages, health human resource complement, client flow, scope of services provided, community support systems, current infrastructure and future prospects for expansion.

The qualitative 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 Rivers State Ministry of Health led this assessment exercise with technical support from FHI 360 with funding from USAID. Following an orientation exercise, eight multidisciplinary teams (comprising staff from State Ministry of Health, SACA, 8 LGA Health Departments and FHI 360)

were mobilised to visit every health facility identified. 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

The two key challenges were 1) security concerns prevented access to some communities during the assessment exercise; and 2) difficult terrains and rising tides made access to some communities difficult.

SECTION

6

Findings

The results presented below were derived from the 101 facilities which currently provide ANC services but not ARVs for PMTCT.

6.1 FACILITY OWNERSHIP AND HEALTH CARE LEVEL

In Table 1, facilities are characterised based on the range of services provided; level of care (primary, secondary or tertiary) and ownership of the institution (public/private). Most of the assessed facilities were categorised as primary level centres; about a quarter were secondary level facilities. No tertiary institutions were assessed.

Similarly, there was a preponderance of public health facilities. All the 17 private health facilities were private for profit organisations; only one (a maternity centre) was a primary level facility. The majority of public health institutions were primary health facilities.

6.2 HUMAN RESOURCES AND SERVICE UTILIZATION

The human resource for health complement and service utilization data for the preceding 12 months were assessed in each facility and are presented disaggregated by facility level in Table 2.

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

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Private for profit	1	16	17
Sub-total (private)	1	16	17
Public			
LGA	72	0	72
State government	0	12	12
Sub-total (public)	72	12	84
Overall total	73	28	101

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 shows fewer staff and large coverage gaps in primary compared to secondary health facilities. About 70% of primary level facilities had no doctors; almost 50% had no nurses or medical records officer, over 60% lacked pharmacy and laboratory staff. The cadre best represented were community health workers who were absent in only 13% of primary level facilities and 11% of secondary level health facilities. Despite staff shortages it is encouraging to note the average number of nurses or community staff in each PHC exceeds one. The average number of all assessed cadres at secondary level exceeds one.

Service utilization figures are higher for all indices (outpatient department [OPD] attendance, ANC

utilization and number of deliveries) in secondary compared to primary facilities. This is unsurprising as more advanced facilities are found in larger urban populations and secondary health facilities are commonly used as referral centres for PHC. Though the ANC and deliveries data do not refer to the same cohort, the data suggests less than a third of ANC bookings result in a facility delivery.

Table 4 shows human resources and service utilization data disaggregated by facility ownership (public/private). Private facilities show better work force ratios and utilization figures compared to public ones. However, public centre averages for nurses and community health workers exceed two per centre. The rarest cadre is pharmacy staff who are only present in 30% of primary level facilities and 67% of secondary level facilities. Almost a quarter of primary level facilities reported no deliveries in the preceding year.

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

DOMAIN	Item	73 PRIMARY FACILITIES			28 SECONDARY FACILITIES			TOTAL 101 FACILITIES		
		Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one
HUMAN RESOURCES	Doctors	0.2	73.8%	26.2%	2.5	5.9%	94.1%	0.8	62.4%	37.6%
	Registered nurse/midwife	1.6	48.8%	51.2%	5.9	5.9%	94.1%	2.8	41.6%	58.4%
	Other trained health workers (Community Nurses, CHOs, CHEWs)	3.9	13.1%	86.9%	2.8	11.8%	88.2%	3.6	12.9%	87.1%
	Record officers	0.6	47.6%	52.4%	1.5	35.3%	64.7%	0.9	45.5%	54.5%
	Laboratory technician/scientists	0.5	61.9%	38.1%	1.6	41.2%	58.8%	0.8	58.4%	41.6%
	Pharmacy technician/pharmacists	0.4	60.7%	39.3%	1.3	47.1%	52.9%	0.7	58.4%	41.6%
SERVICE UTILIZATION	OPD attendance in the last 12 months	412	7.1%*	92.9%	1626	5.9%*	94.1%	749	6.9%	93.1%
	ANC first attendees recorded in the last 12 months	143	21.4%*	78.6%	229	11.8%*	88.2%	167	4.0%	96.0%
	Deliveries taken in the last 12 months	31	21.4%*	78.6%	57	11.8%*	88.2%	38	19.8%	80.2%

*SOME CENTRES REPORTED ZERO FOR THESE DATA ELEMENTS. THESE COULD BE DUE RECENT FLOODING AND RENOVATION WORK IN THESE FACILITIES.

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

DOMAIN	Item	84 PUBLIC FACILITIES			17 PRIVATE FACILITIES			TOTAL 101 FACILITIES		
		Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one	Average	Proportion of facilities reporting zero	Proportion of facilities reporting at least one
HUMAN RESOURCES	Number of doctors	0.3	84.9%	15.1%	3.2	3.6%	96.4%	0.8	62.4%	37.6%
	Number of registered nurse/midwife	2.3	54.8%	45.2%	4.8	7.1%	92.9%	2.8	41.6%	58.4%
	Number of other trained health workers (community nurses, CHOs, CHEWs)	3.8	5.5%	94.5%	2.8	32.1%	67.9%	3.6	12.9%	87.1%
	Number of records officers	0.8	54.8%	45.2%	1.3	21.4%	78.6%	0.9	45.5%	54.5%
	Number of lab technician/scientists	0.7	67.1%	32.9%	1.6	35.7%	64.3%	0.8	58.4%	41.6%
	Number of pharmacy technician/pharmacists	0.5	68.5%	31.5%	1.3	32.1%	67.9%	0.7	58.4%	41.6%
SERVICE UTILIZATION	Number attended OPD in the last 12 months	497	6.8%*	93.2%	1992	7.1%*	92.9%	749	6.9%	93.1%
	ANC first attendees recorded in the last 12 months	171	1.4%*	98.6%	149	10.7%*	89.3%	167	4.0%	96.0%
	Deliveries taken in the last 12 months	32	23.3%*	76.7%	69	10.7%*	89.3%	38	19.8%	80.2%

* SOME CENTRES REPORTED ZERO FOR THESE DATA ELEMENTS. THESE COULD BE DUE RECENT FLOODING AND RENOVATION WORK IN THESE FACILITIES.

6.3 SUMMARIES OF OTHER DOMAINS

Findings related to the scope of service available in facilities, facility infrastructure, enabling environment for MCH and community support/participation are presented in Table 5, disaggregated by facility level. All facilities provided basic physical examinations for pregnant women. At the time of the assessment only 35% of primary level health facilities and 60% of secondary level health facilities had HTC services. The range of services provided was wider in secondary level health facilities; however more PHCs provided haematinics and intermittent preventive therapy for malaria in pregnancy (IPTp), Immunization and child follow up clinic services compared to secondary level health facilities. Assessments of infrastructure

documented dedicated spaces for outpatient and antenatal consultations, phlebotomy and laboratory services, delivery, counselling and TB services among others. It is important to note that almost 20% of primary level health facilities reported not having delivery rooms. Only about a third of primary or secondary facilities had spaces dedicated for phlebotomy, although about two thirds of each facility type had laboratories.

Tuberculosis is an important disease to consider in planning HIV treatment services due to the issues of comorbidity and increased susceptibility for people living with HIV (PLHIV). At present less than a fifth of PHCs had TB treatment facilities; this proportion is marginally lower in secondary level health facilities.

Table 5: Summary of domain responses disaggregated by facility level

		FACILITY TYPE		
		Primary level n = 73	Secondary level n = 28	Total n = 101
SERVICE AVAILABILITY	Physical exam (including weight, assessing GA, blood pressure)	73 (100.0%)	28 (100.0%)	101 (100.0%)
	Laboratory services (onsite or by referral): Hb, urinalysis	41 (56.2%)	22 (78.6%)	63 (62.4%)
	Dispensing of haematinics and IPTp	70 (95.9%)	23 (82.1%)	93 (92.1%)
	Labour and delivery services (with 24 hour shifts)	53 (72.6%)	26 (92.9%)	79 (78.2%)
	Referrals for emergency obstetric and newborn care	63 (86.3%)	23 (82.1%)	86 (85.1%)
	Family planning services (condoms, hormonal contraceptives)	38 (52.1%)	21 (75.0%)	59 (58.4%)
	Immunization services	71 (97.3%)	15 (53.6%)	86 (85.1%)
	Child follow up clinics	58 (79.5%)	20 (71.4%)	78 (77.2%)
	TB services (specify which - e.g. DOTS, microscopy)	18 (24.7%)	6 (21.4%)	24 (23.8%)
	HIV testing and counselling	26 (35.6%)	17 (60.7%)	43 (42.6%)

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

	FACILITY TYPE			
	Primary level n = 73	Secondary level n = 28	Total n = 101	
IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	OPD consulting room	65 (89.0%)	28 (100.0%)	93 (92.1%)
	Lab Room	45 (61.6%)	19 (67.9%)	64 (63.4%)
	Phlebotomy	18 (24.7%)	10 (35.7%)	28 (27.7%)
	ANC space	58 (79.5%)	25 (89.3%)	83 (82.2%)
	ANC room	40 (54.8%)	22 (78.6%)	62 (61.4%)
	Space that can be used for confidential counselling	45 (61.6%)	22 (78.6%)	67 (66.3%)
	Maternity delivery room	60 (82.2%)	28 (100.0%)	88 (87.1%)
	Pharmacy store	44 (60.3%)	18 (64.3%)	62 (61.4%)
	Space for adherence counselling	36 (49.3%)	18 (64.3%)	54 (53.5%)
	DOTS clinic	12 (16.4%)	6 (21.4%)	18 (17.8%)
	DOTS waiting area	7 (9.6%)	6 (21.6%)	13 (12.9%)
	Medical records/M&E	25 (34.2%)	19 (67.9%)	44 (43.6%)

Enabling environment for MCH takes into account whether facilities have support to provide maternal health services, conduct outreach or subsidise ANC. The primary level health facilities generally appeared better oriented towards providing free MCH services or through outreaches. Almost half the surveyed primary level health facilities had MDG support for MCH and provided free components of ANC with 60% engaged in community outreach services. More respondents from primary level health facilities also reported awareness of community based support systems such as village and community development associations.

Almost all respondents reported a preference for delivering their babies in the community (not within health facilities). This reinforces the earlier finding of low delivery numbers compared to ANC attendance. The most favoured birth option (according to the healthcare providers surveyed) was with the assistance of traditional birth attendants. Other important options included at churches and maternity homes.

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

		FACILITY TYPE		
		Primary level n = 73	Secondary level n = 28	Total n = 101
ENABLING ENVIRONMENT	MDG support for MCH services	33 (45.2%)	6 (21.4%)	39 (38.6%)
	Free ANC services	33 (45.2%)	3 (10.7%)	36 (35.6%)
	Regular monthly community outreach	45 (61.6%)	3 (10.7%)	48 (47.5%)
	MSS midwives	18 (24.7%)	6 (21.4%)	24 (23.8%)
	SURE-P midwives	19 (26.0%)	4 (14.3%)	23 (22.8%)
COMMUNITY SYSTEMS (ARE THE FOLLOWING AVAILABLE?)	Other than health facilities where women deliver in this community	72 (98.6%)	26 (92.9%)	98 (97.0%)
	Other places – churches	14 (19.2%)	6 (21.4%)	20 (19.8%)
	Other places – mosque	1 (1.4%)	1 (3.6%)	2 (2.0%)
	Other places – TBA	81 (96.4%)	15 (88.2%)	96 (95.0%)
	Other places – maternity home of trained midwife	7 (8.3%)	1 (5.9%)	8 (7.9%)
COMMUNITY SYSTEMS	Ward development committee	72 (98.6%)	26 (92.9%)	98 (97.0%)
	Village development committee	43 (58.9%)	6 (21.4%)	49 (48.5%)
	Community development association	42 (57.5%)	9 (32.1%)	51 (50.5%)
	Community-based organization	36 (49.3%)	9 (32.1%)	45 (44.6%)

Tables 7 and 8 below have domain responses disaggregated by facility ownership. The patterns for availability of various service components are similar to those shown previously in Table 5. Findings in public facilities mirror primary level health facilities (for which these form a majority) and similarly private sites, the secondary health level. The earlier observations of a broader range of services and more diverse infrastructural capabilities are noted in private compared to public facilities. Public facilities however have

better support in terms of enabling environment and awareness of community support systems.

More public facilities provided immunization services (92% vs 47%), haematinics and malaria prophylaxis in pregnancy (96% vs 71%) and child follow-up clinics (80% vs 65%). In considering services provided, the percentage of centres providing TB treatment and HTC services were almost even at 20 and 40 percent, respectively, for both public and private facilities.

Table 7: Summary of domain responses disaggregated by facility ownership

		FACILITY TYPE		
		Primary level n = 84	Secondary level n = 17	Total n = 101
SERVICE AVAILABILITY	Physical exam (including weight, assessing GA, blood pressure)	84 (100.0%)	17 (100.0%)	101 (100.0%)
	Laboratory services (onsite or by referral): Hb, urinalysis	50 (59.5%)	13 (76.5%)	63 (62.4%)
	Dispensing of haematinics and IPTp	81 (96.4%)	12 (70.6%)	93 (92.1%)
	Labour and delivery services (with 24 hour shifts)	63 (75.0%)	16 (94.1%)	79 (78.2%)
	Referrals for emergency obstetric and new-born care	72 (85.7%)	14 (82.4%)	86 (85.1%)
	Family planning services (condoms, hormonal contraceptives)	47 (56.0%)	12 (70.6%)	59 (58.4%)
	Immunization services	78 (92.9%)	8 (47.1%)	86 (85.1%)
	Child follow up clinics	67 (79.8%)	11 (64.7%)	78 (77.2%)
	TB services (specify which - e.g. DOTS, microscopy)	20 (23.8%)	4 (23.5%)	24 (23.8%)
	HIV testing and counselling	35 (41.7%)	8 (47.1%)	43 (42.6%)
IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	OPD consulting room	76 (90.5%)	17 (100.0%)	93 (92.1%)
	Lab Room	55 (65.5%)	9 (52.9%)	64 (63.4%)
	Phlebotomy	22 (26.2%)	6 (35.3%)	28 (27.7%)
	ANC space	68 (81.0%)	15 (88.2%)	83 (82.2%)
	ANC room	46 (54.8%)	16 (94.1%)	62 (61.4%)
	Space that can be used for confidential counselling	53 (63.1%)	14 (82.4%)	67 (66.3%)
	Maternity delivery room	71 (84.5%)	17 (100.0%)	88 (87.1%)
	pharmacy store	50 (59.5%)	12 (70.6%)	62 (61.4%)
	Space for HTC/adherence counselling	40 (47.6%)	14 (82.4%)	54 (53.5%)
	DOTS clinic	15 (17.9%)	3 (17.6%)	18 (17.8%)
	DOTS waiting area	10 (11.9%)	3 (17.6%)	13 (12.9%)
	Medical records/M&E	31 (36.9%)	13 (76.5%)	44 (43.6%)

Enabling environment and awareness of community support were much lower for private health facilities. More public facility respondents

were aware of the existence of potential community support groups like ward and village community development groups.

Table 8 Summary of domain responses disaggregated by facility ownership

		FACILITY TYPE		
		Primary level n = 84	Secondary level n = 17	Total n = 101
ENABLING ENVIRONMENT	MDG Support for MCH services	39 (46.4%)	0 (0.0%)	39 (38.6%)
	Free ANC Services	35 (41.7%)	1 (5.9%)	36 (35.6%)
	Regular Monthly Community Outreaches	48 (57.1%)	0 (0.0%)	48 (47.5%)
	MSS midwives	21 (25.0%)	3 (17.6%)	24 (23.8%)
	SURE-P midwives	23 (27.4%)	0 (0.0%)	23 (22.8%)
COMMUNITY BIRTHING PLACES	Other than health facilities where women deliver in this community	83 (98.8%)	15 (88.2%)	98 (97.0%)
	Other Places – Churches	16 (19.0%)	4 (23.5%)	20 (19.8%)
	Other Places – Mosque	2 (2.4%)	0 (0.0%)	2 (2.0%)
	Other Places – TBA	81 (96.4%)	15 (88.2%)	96 (95.0%)
	Other Places – Maternity home of trained midwife	7 (8.3%)	1 (5.9%)	8 (7.9%)
COMMUNITY SYSTEMS	Ward development committee	46 (54.8%)	3 (17.6%)	49 (48.5%)
	Village development committee	49 (58.3%)	2 (11.8%)	51 (50.5%)
	Community development association	44 (52.4%)	1 (5.9%)	45 (44.6%)
	Community-based organization	36 (42.9%)	1 (5.9%)	37 (36.6%)

6.4 QUALITATIVE DATA 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 Community preference for delivery outside health facilities

The key informant interviews (KIIs) conducted with health workers in Rivers State revealed that

many women prefer the services of traditional birth attendants (TBAs) and to a lesser degree churches during deliveries even though they may receive early ANC at health facilities. Some of the reasons suggested for this development include a firm traditional belief in the abilities of the TBA, perceived higher cost of services at the health facilities, difficulties reaching health facilities due to distance and unavailability of staff especially at night. Table 9 below summarises these themes as well as the verbatim quotes from respondents supporting these themes.

Table 9: Preferred community delivery options

THEMES	QUOTES
<p>Women prefer to patronize traditional birth attendants (TBAs), private clinics and churches</p>	<p>“It has been in their system for long, so they are used to it.”</p> <p>“You see all these women? You won’t see them here during delivery at all. They will all want to deliver at home.”</p> <p>“They prefer to come here(facility), some of them go to their churches to deliver.”</p>
<p>Why women prefer to deliver with TBAs</p>	<p>“No one to take delivery in the hospital at night.”</p> <p>“It is a very traditional community. The TBAs are their people, they believe in them.”</p> <p>“They believe the hospital will do a CS for them if they come here.”</p> <p>“They are more closer to the TBA.”</p>
<p>Reasons for poor patronage of the health facilities</p>	<p>“This place is far from the village. We even find it difficult coming to work because of the distance.”</p> <p>“The environment is not conducive for health workers and patients.”</p> <p>“For 5 years, this place was closed, the patients stopped coming.”</p> <p>“The facility was taken over by the flood of last year.”</p>

6.4.2 Some health facilities are well patronized

Key informants provided several reasons for why some facilities are well patronized: those facilities have a good relationship with the community

including the Village Development Committee, and the neighbourhood is perceived as safe. These themes with verbatim quotes are summarized in Table 10 below.

Table 10: Reasons why some health facilities are well patronized

THEMES	QUOTES
Reasons for good patronage of health facility	"We give them good service. They like us here."
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 WDC help us with community mobilisation. They are very useful."

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

provision of better structures and social amenities will go a long way to improve service quality in the state (see Table 11).

Key informants felt that better staffing of facilities, improved capacity building for staff as well as

Table 11: Respondents' suggestions on improving service quality

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

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 12 disaggregated by ownership. Percentages use the total number of facilities assessed as the denominator, which explains any differences from reporting of similar criteria in Table 3. About 40% of assessed facilities were covered on a full time or part time basis by doctors. Also about 30% and 40% of public and private facilities respectively, were staffed with up

to four nurse/midwives or community health workers. The criterion most frequently met was having four clinical staff that could perform patient care duties (either nurses or community health workers); about 60% of facilities qualified in this regard. Few facilities qualified on examination of multiple components which was primarily due to the shortages of pharmacy, laboratory and record staff. Only 19 facilities met requirements of above average ANC utilization when combined with requirements for clinical staff and other support cadres. Only 12 (11.8%) of the assessed facilities met the National HR standard for PMTCT service provision.

Table 12: Human resource-related cut-offs

CRITERIA	CUT-OFF	OWNERSHIP	NO. OF FACILITIES ELIGIBLE	% OF TOTAL (N = 101) FACILITIES
Have ANC but no IP		Public	84	83.2
		Private	17	16.8
Availability of doctors	At least 1	Public	22	21.8
		Private	16	15.8
Availability of nurses/midwives	At least 4	Public	28	27.7
		Private	6	5.9
Other trained staff – CHEWs, JCHEWs	At least 4	Public	33	32.7
		Private	6	5.9
Clinical care staff (nurses, CHOs, CHEWs, JCHEWs)	At least 4	Public	49	48.5
		Private	12	11.9
ANC attendance in the last 12 months	Equal or above state mean (167)	Public	24	23.8
		Private	4	4.0
Deliveries taken in the last 12 months	At least 1	Public	66	65.3
		Private	15	14.9
National PMTCT HR complement	1 doctor, 1 nurse/midwife, 2 community workers, 1 pharmacy, 1 lab, 1 records	Public	6	5.9
		Private	6	5.9
Minimum HR complement 1	At least 4 clinical care, 1 pharmacy, 1 lab, 1 records	Public	18	17.8
		Private	6	5.9
Minimum HR complement 2	At least 1 doctor, 4 clinical, 1 pharmacy, 1 lab, 1 records	Public	10	9.9
		Private	6	5.9
Composite criterion	At least 4 nursing care, 1 pharmacy, 1 lab, 1 records, above average ANC attendance, at least 1 delivery	Public	14	13.9
		Private	5	5.0

SECTION

7 Geospatial representation of facilities

The maps below show the location of sites currently providing PMTCT services, assessed facilities, facilities meeting state-defined criteria for PMTCT service provision and the PMTCT

landscape if facilities meeting state-defined criteria are added to existing sites providing PMTCT services.

Figure 3: Map showing currently existing PMTCT services

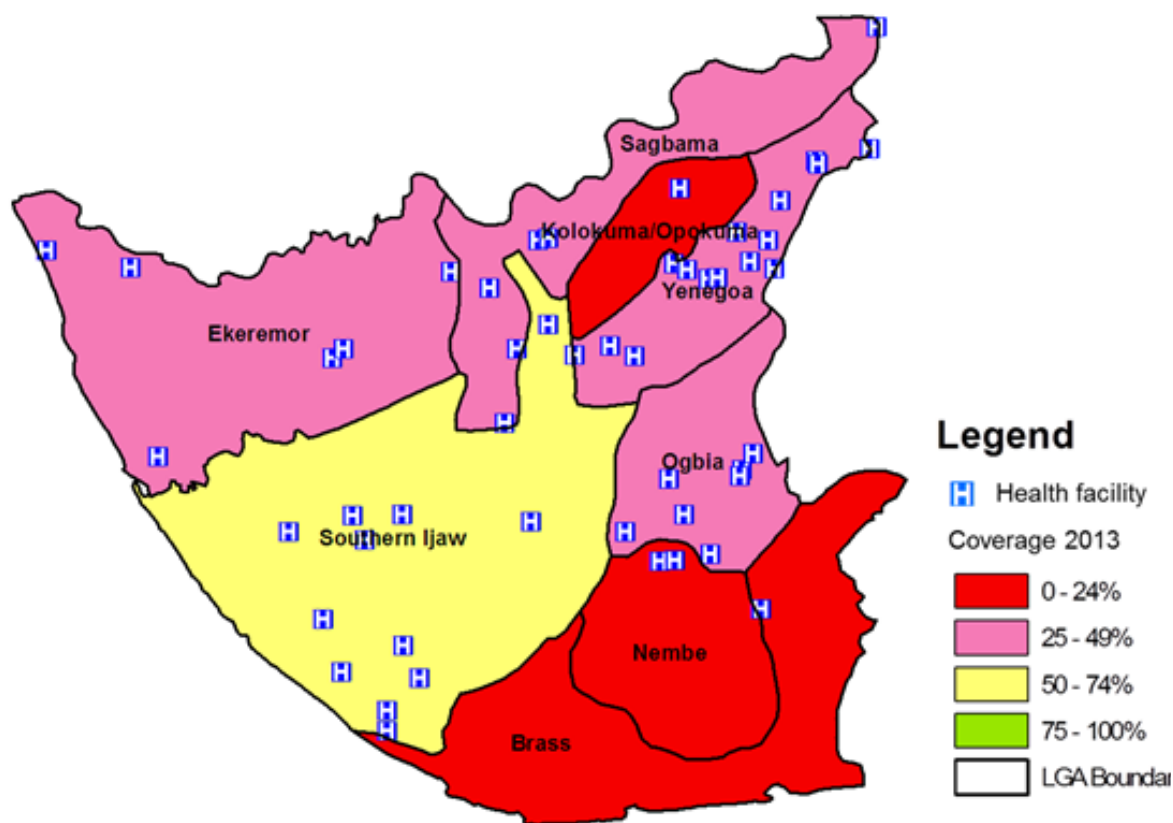


Figure 4: Map showing spread of assessed facilities (with ANC but no PMTCT)

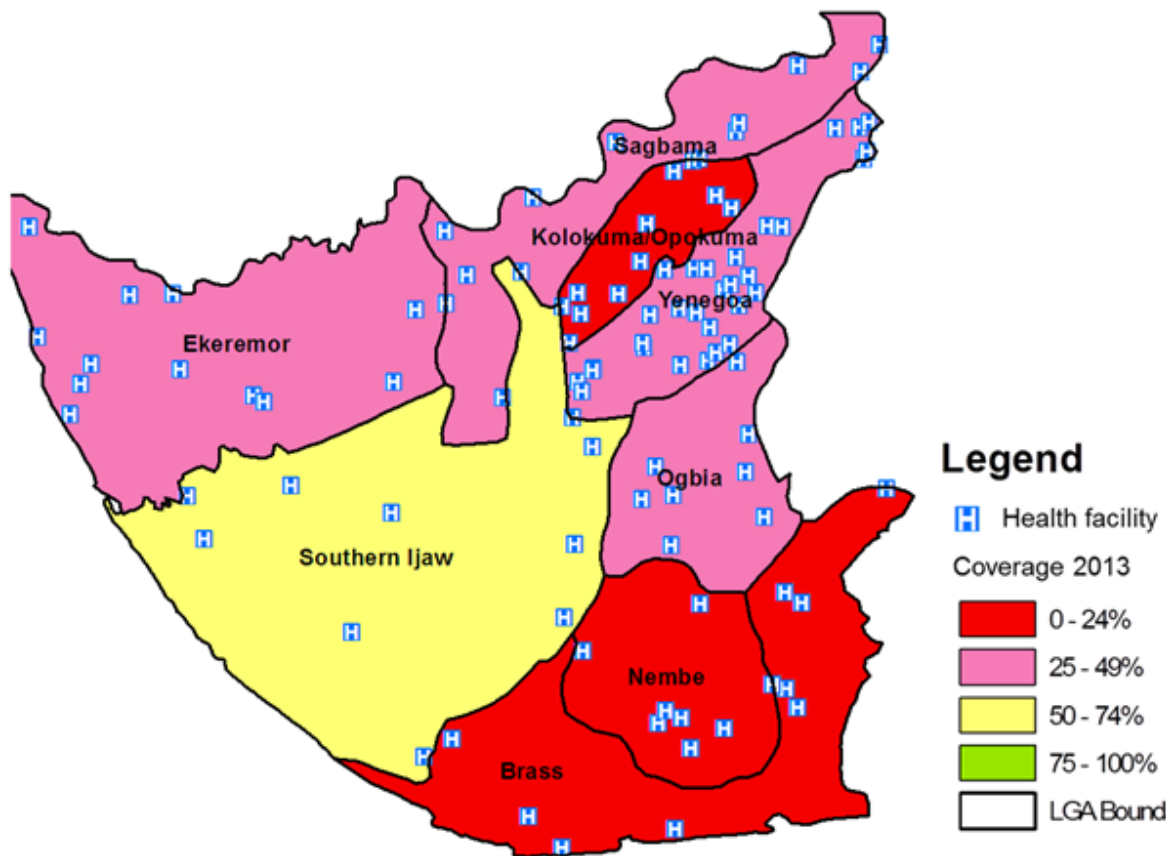


Figure 5: Map showing spread of facilities meeting national HR criteria for PMTCT services

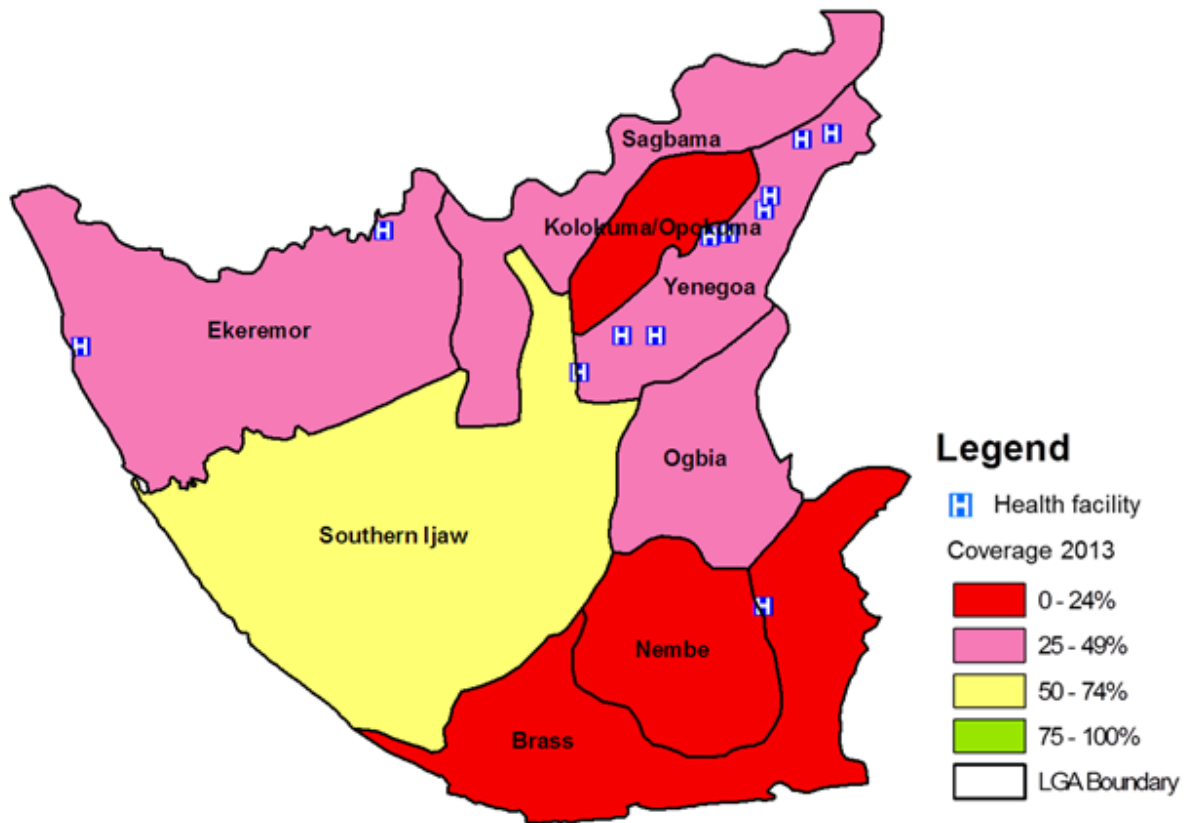


Figure 6: Map showing spread of facilities meeting state-defined HR criteria for PMTCT services

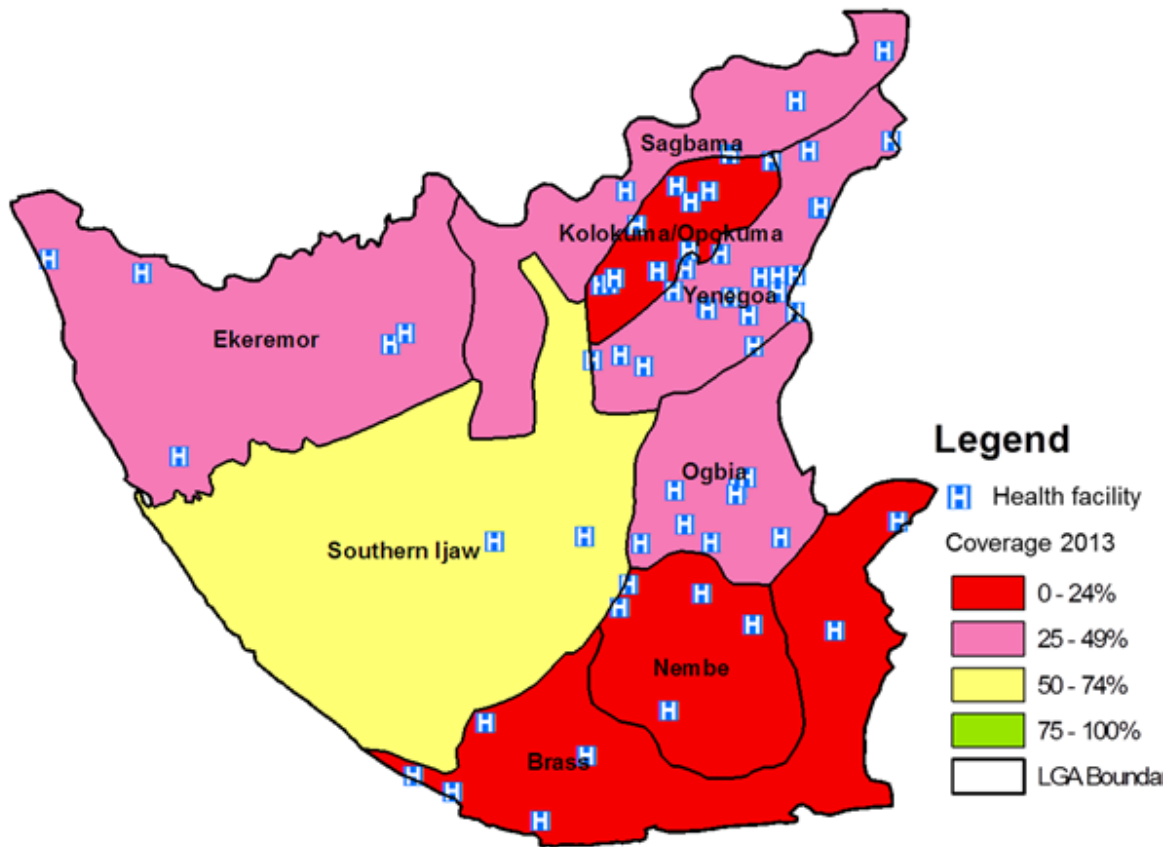


Figure 7: Map showing scenario for 2014 (current PMTCT sites + facilities meeting national HR criteria for PMTCT services)

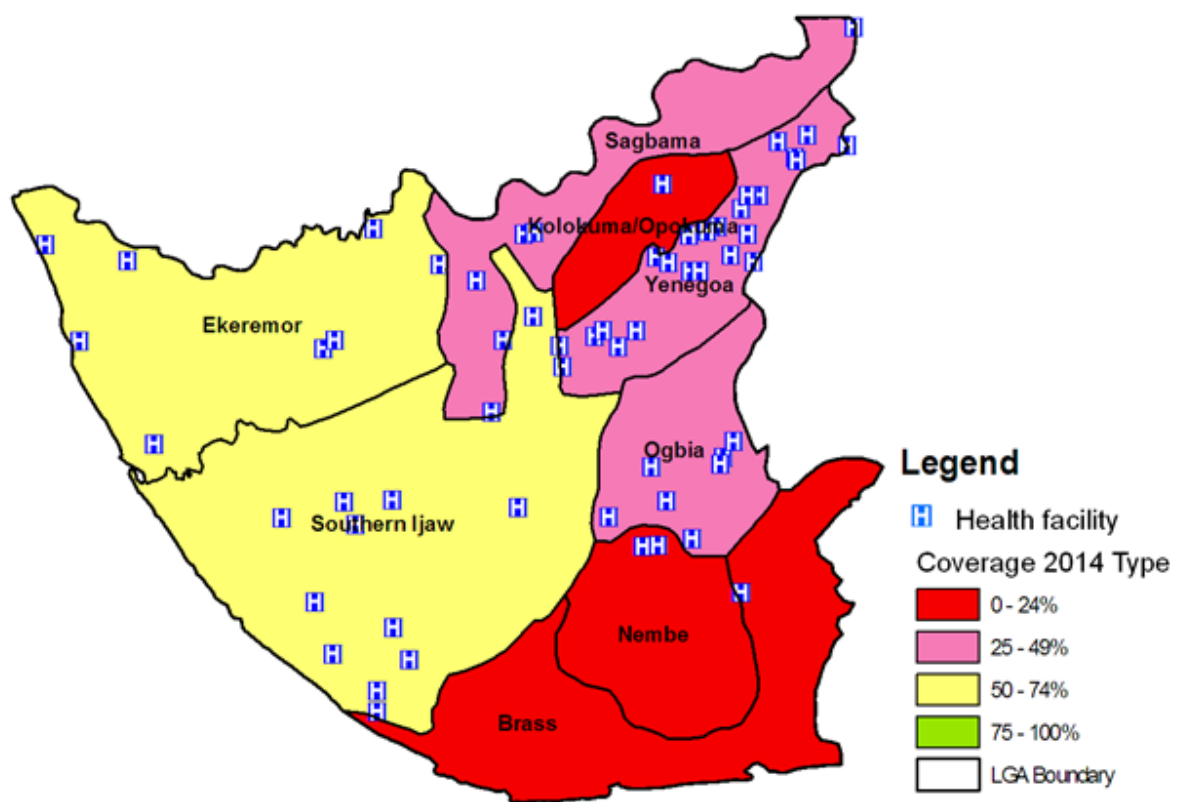


Figure 8: Map showing scenario for 2014 (current PMTCT sites + facilities meeting state-defined HR criteria for PMTCT services)

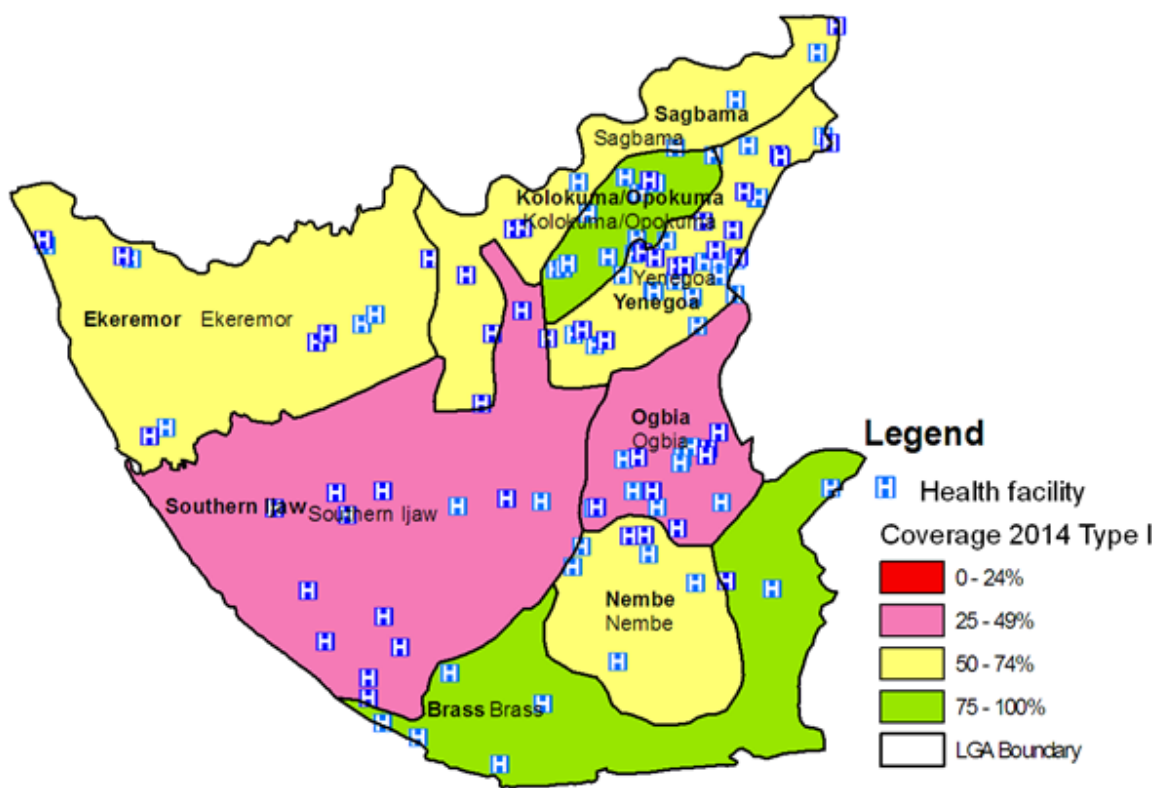
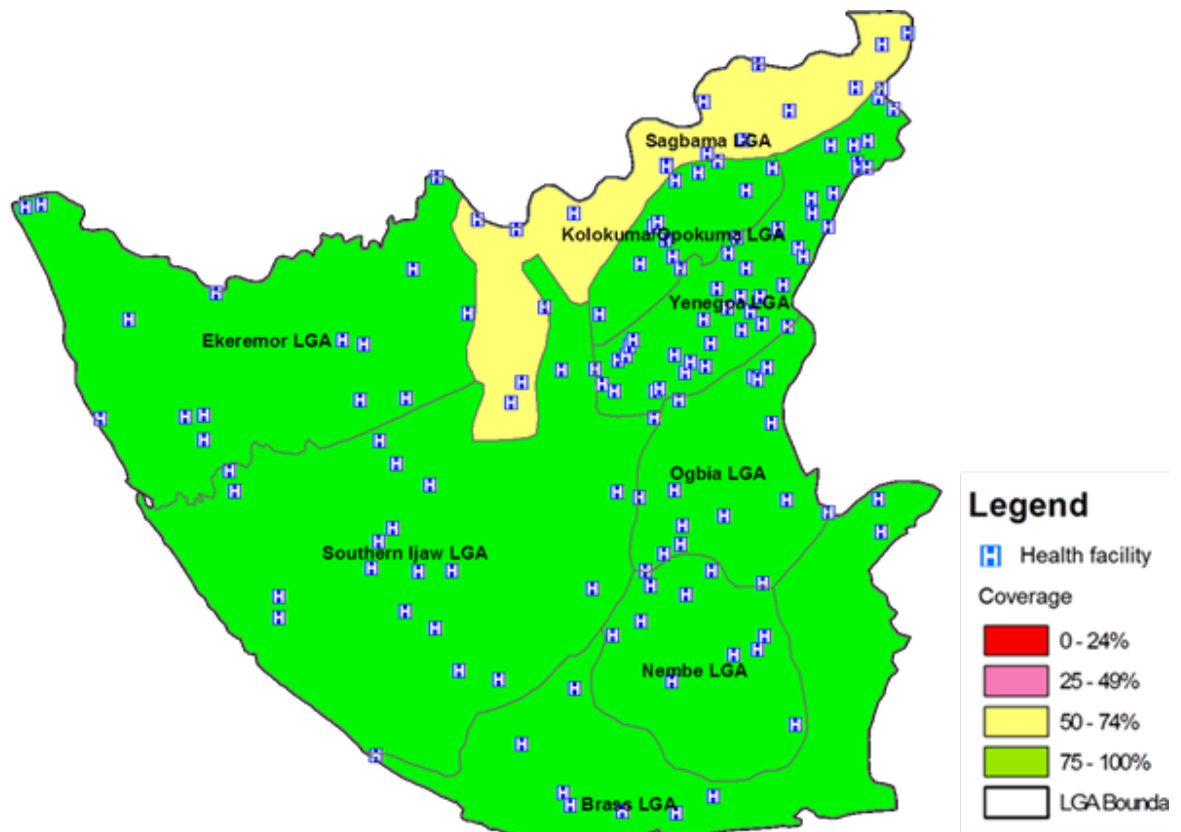


Figure 9: Map showing scenario for 2014 (current PMTCT sites + sites earmarked for scale-up)



SECTION

8

Conclusion

This findings of this assessment will inform scale-up of services towards elimination of mother-to-child transmission of HIV in Rivers State. Thirteen facilities met national minimum human resource standard for PMTCT service delivery. The key findings of human resource and infrastructure gaps among the facilities included in the assessment will require targeted intervention by the state.

Facility utilization for ANC and delivery is relatively poor. Traditional birth attendants are major stakeholders in maternal health services in the state and as such should be engaged as part of a holistic approach towards provision of PMTCT services.

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 in collaboration with donor agencies, implementing partners and other stakeholders should engage staff to bring assessed facilities up to the national minimum HR standard.

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 conduct 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	73 PRIMARY FACILITIES					28 SECONDARY FACILITIES				
		Median	Mean	Min	Max	Total	Median	Mean	Min	Max.	Total
HUMAN RESOURCES	Number of doctors	0	0.2	0	2	11	2.0	2.5	0	8	70
	Number of registered nurse/midwife	0	1.6	0	10	114	4.0	5.9	0	20	164
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	3	3.9	0	15	285	2.0	2.8	0	15	79
	Number of records officers	0	0.6	0	5	44	1.0	1.5	0	5	42
	Number of lab technician/scientists	0	0.5	0	5	39	1.0	1.6	0	7	44
	Number of pharmacy technician/pharmacists	0	0.4	0	4	30	1.0	1.3	0	5	36
SERVICE UTILIZATION	Number attended OPD in the last 12 months	254	412	0	1890	30089	757	1626	0	8431	45545
	ANC first attendees recorded in the last 12 months	60	143	0	1015	10470	142	229	0	804	6413
	Deliveries taken in the last 12 months	12	31	0	633	2282	35	57	0	414	1589

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

DOMAIN	ITEM	84 PUBLIC					17 PRIVATE				
		Median	Mean	Min	Max	Total	Median	Mean	Min	Max.	Total
HUMAN RESOURCES	Number of doctors	0	0.3	0	2	27	2	3.2	0	8	54
	Number of registered nurse/midwife	1	2.3	0	14	196	3	4.8	0	20	82
	Number of other trained health workers (community nurses, CHOs, CHEWs)	3	3.8	0	15	316	2	2.8	0	7	48
	Number of records officers	1	0.8	0	5	64	1	1.3	0	5	22
	Number of lab technician/scientists	0	0.7	0	6	55	1	1.6	0	7	28
	Number of pharmacy technician/pharmacists	0	0.5	0	4	44	1	1.3	0	5	22
SERVICE UTILIZATION	Number attended OPD in the last 12 months	303	497	0	2401	41772	720	1992	0	8431	33862
	ANC first attendees recorded in the last 12 months	81	171	0	1015	14352	86	149	0	577	2531
	Deliveries taken in the last 12 months	14	32	0	633	2694	37	69	0	414	1177

Appendix 3: Human Resource Gap for Doctors in Rivers State by LGAs in assessed facilities

S/N	LGAS	PUBLIC (N=84)			PRIVATE (N=17)		
		Total no of facilities	Facilities with at least one doctor	Number of doctors needed to meet national standard	Total no of facilities	Facilities with at least one doctor	Number of doctors needed to meet national standard
1	Brass	9	3	6	N/A	N/A	N/A
2	Ekeremor	12	3	9	N/A	N/A	N/A
3	Kolokuma/Opokuma	11	3	8	N/A	N/A	N/A
4	Nembe	8	1	7	N/A	N/A	N/A
5	Ogbia	7	1	6	1	1	0
6	Sagbama	12	3	9	1	1	0
7	Southern Ijaw	9	1	8	N/A	N/A	N/A
8	Yenegoa	16	7	9	15	14	1
Total		84	22	62	17	16	1

Appendix 4: Coverage gap for Nurses by LGA

S/N	LGAS	PUBLIC (N=84)			PRIVATE (N=17)		
		Total no of facilities	Facilities with at least one nurse	Number of nurses needed to meet national standard	Total no of facilities	Facilities with at least one nurse	Number of nurses needed to meet national standard
1	Brass	9	7	2	N/A	N/A	N/A
2	Ekeremor	12	4	8	N/A	N/A	N/A
3	Kolokuma/Opokuma	11	8	3	N/A	N/A	N/A
4	Nembe	8	4	4	N/A	N/A	N/A
5	Ogbia	7	3	4	1	1	0
6	Sagbama	12	5	7	1	1	0
7	Southern Ijaw	9	2	7	N/A	N/A	N/A
8	Yenegoa	16	10	6	15	14	1
Total		84	43	41	17	16	1

Appendix 5: Coverage gap for Community Workers by LGA

S/N	LGAS	PUBLIC (N=84)			PRIVATE (N=17)		
		Total no of facilities	Facilities with at least two comm workers	Number of comm workers needed to meet national standard	Total no of facilities	Facilities with at least two comm workers	Number of comm workers needed to meet national standard
1	Brass	9	7	3	N/A	N/A	N/A
2	Ekeremor	12	9	5	N/A	N/A	N/A
3	Kolokuma/Opokuma	11	10	1	N/A	N/A	N/A
4	Nembe	8	7	1	N/A	N/A	N/A
5	Ogbia	7	7	0	1	1	0
6	Sagbama	12	8	5	1	0	2
7	Southern Ijaw	9	5	7	N/A	N/A	N/A
8	Yenegoa	16	14	4	15	11	5
Total		84	67	26	17	12	7

Appendix 6: Coverage gap for Records Officers by LGA

S/N	LGAS	PUBLIC (N=84)			PRIVATE (N=17)		
		Total no of facilities	Facilities with at least one records officer	Number of one records officers needed to meet national standard	Total no of facilities	Facilities with at least one records officer	Number of one records officers needed to meet national standard
1	Brass	9	5	4	N/A	N/A	N/A
2	Ekeremor	12	4	8	N/A	N/A	N/A
3	Kolokuma/Opokuma	11	8	3	N/A	N/A	N/A
4	Nembe	8	4	4	N/A	N/A	N/A
5	Ogbia	7	4	3	1	0	1
6	Sagbama	12	6	6	1	0	1
7	Southern Ijaw	9	5	4	N/A	N/A	N/A
8	Yenegoa	16	8	8	15	11	4
Total		84	44	40	16	15	1

Appendix 7: Coverage gap for Laboratory workers by LGA

S/N	LGAS	PUBLIC (N=84)			PRIVATE (N=17)		
		Total no of facilities	Facilities with at least one Lab worker	Number of Lab workers needed to meet national standard	Total no of facilities	Facilities with at least one Lab worker	Number of Lab workers needed to meet national standard
1	Brass	9	4	5	N/A	N/A	N/A
2	Ekeremor	12	1	11	N/A	N/A	N/A
3	Kolokuma/Opokuma	11	4	7	N/A	N/A	N/A
4	Nembe	8	4	4	N/A	N/A	N/A
5	Ogbia	7	4	3	1	0	1
6	Sagbama	12	4	8	1	0	1
7	Southern Ijaw	9	3	6	N/A	N/A	N/A
8	Yenegoa	16	8	8	15	10	5
Total		84	32	52	17	10	7

Appendix 8: Coverage gap for Pharmacy Staff by LGA

S/N	LGAS	PUBLIC (N=84)			PRIVATE (N=17)		
		Total no of facilities	Facilities with at least one Pharmacy Staff	Number of Pharmacy Staff needed to meet national standard	Total no of facilities	Facilities with at least one Pharmacy Staff	Number of Pharmacy Staff needed to meet national standard
1	Brass	9	6	3	N/A	N/A	N/A
2	Ekeremor	12	1	11	N/A	N/A	N/A
3	Kolokuma/Opokuma	11	7	4	N/A	N/A	N/A
4	Nembe	8	3	5	N/A	N/A	N/A
5	Ogbia	7	2	5	1	0	1
6	Sagbama	12	3	9	1	0	1
7	Southern Ijaw	9	3	6	N/A	N/A	N/A
8	Yenegoa	16	8	8	15	9	6
Total		84	32	52	17	9	8

Appendix 9: Summary of Human Resource Gap in Rivers 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	62	1
2	Nurses	41	1
3	Trained Health Workers – CHOs, CHEWs etc.	17	5
4	Record Officers	40	6
5	Lab. Scientist/ technicians	52	7
6	Pharmacist/pharmacy technicians	51	8

Appendix 10: List of contributors

RIVERS STATE GOVERNMENT

Dr. Wakiente O. Omubo	Omungu Emmanuel	Beauty B. Ikoni
Dr. Jones Stow	Apriefe G.	Gana Modibo
Iyoyo Muna	Dr. Abule David	Monica Ayabina
Obom E. A.	Lili Ebutu	Suam Morowei
Ochayi James	Patience Inogula	Benjamin Obhesi
Adulphus Enezigha	Asas Yomo Ebi	Ginah Barasin-Opre.
Tabowei Churchill	Maria Asalagha	Moses Ouseibai
Jones-Kekebou Ebiemi	Philo Okolo	Obubo Timi
Ogbogi Blessing	Memory Augustine	Benson Simon
Agbana Edwin	Elizabeth Egerike	Igbans Salvation
Collins Elizabeth	Matthias Azini	Neriessa Saniyigha
Kenneth Zifa Wei	Sam David	Zibai Florence
Ogonodi Beredugo	Azini Mathins	Christopher N. Aporoko
Alagha Chris	Evans Imienmokumo	Igbogi Blessing
Diepreye Alagoa	Meli Ebinipre	Obiene Ruth
Kingsley Eze	Stanley Gabriel	Kunle Lawal
Okpatu Monica	Batowei Okuboere	Rebecca Dirks
Zige Amapomom	Fanny Stephens	Jill Vitick
Douye Bigbo	Memory Augustine	
Legimokuma Reuben	Stella Reuben	

TECHNICAL ASSISTANCE

Phyllis Jones-Changa	Dr Akinlolu Fasanmi	Emmanuel Ugo
Dr Kwasi Torpey	Simpson Tumwikirize	Ifeoluwa Ibirogba
Dr Robert Chiegil	Olufunso Adebayo	Jibola Erogbogbo
Dr Hadiza Khamofu	Williams Ojo	Mandu Etim
Dr Edward 'Kola Oladele	Julius Chinedu	Stanley Ezenwankwo
Dr Mariya Saleh	Joseph Okoegwale	Suleiman Gbadamasi
Dr Uche Ralph-Opara	Mrs Okache Adama	Walong Garba
Dr Seun Asala	Chris Obominuru	
Dr Maurice Ekanem	Daniel Henry	

CONSULTANTS

Dr Oluwafemi Popoola
Dr Oluwaseun Akinyemi

Glossary

Acquired Immune Deficiency Syndrome (AIDS)

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

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

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

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

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

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

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

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

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

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