Report of the Cross River

STATE-WIDE RAPID HEALTH FACILITY ASSESSMENT

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

March 2013

Report of the Cross River

STATE-WIDE RAPID HEALTH FACILITY ASSESSMENT

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

May 2013

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

The Cross River 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 Cross River 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.

Table of Contents

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

Foreword

Cross River State is one of the 12+1 states which together contribute nearly 70% of Nigeria's mother to child transmission of HIV (MTCT) burden. Its HIV prevalence of 7.1% ranks 9th 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 Cross River 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 488 public and private facilities covered all 18 local government areas (LGA) 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 Cross River State, the road to expanding PMTCT services is now wide open.

Prof Angela Oyo-Ita

Honourable Commissioner for Health

Cross River State Ministry of Health

Acknowledgements

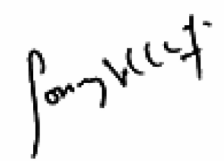
Our special thanks go to the United States Agency for International Development for financial assistance and FHI 360 for technical assistance during this rapid assessment. We really are indebted to them.

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 Cross River 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 the PHC Coordinators and LGA staff who utilized their in-depth knowledge of the terrain, making the accomplishment of this task so much easier.

Thank you all.



Dr Sonny Omini

Coordinator,
State AIDS/STIs Control Program,
Cross River State Ministry of Health

Acronyms

AIDS	Acquired Immuno-deficiency 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	Outpatients' 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

Cross River State is situated in the South-South geopolitical zone and administratively divided into 18 Local Government Areas (LGAs). From the national population census of 2006 the projected population of the State is estimated to be 3,438, 030 for 2012. The state's HIV prevalence is currently estimated at 7.1% and drivers of the epidemic in the state include a broad mix of socio cultural factors which include poor knowledge of the virus and its transmission, high risk sexual behaviours, limitations in health access and utilisation.

To address this situation and improve access to and coverage of PMTCT services, this state wide assessment was undertaken; its aim was to identify and document important features of facilities conducting Antenatal care which were currently not providing or planning to roll out PMTCT services in the state. All eligible facilities across the mix of public/private ownership and primary/secondary /tertiary levels of patient care were surveyed. The survey utilised qualitative and quantitative methods to assess facility service utilisation, human resources, infrastructure, community linkages, Maternal and Child Health support and consequently PMTCT eligibility.

Four hundred and eighty eight (488) facilities providing ANC services were assessed for PMTCT scale up.The findings of the assessment showed gaps in human resources, service delivery components including ANC utilisation/delivery ratios. The HR situation was found to be more challenging in primary/public than secondary/private institutions where about 70% and 50% of primary care institutions had no doctors or nurses respectively. These primary/public institutions however had better MCH support and closer functional community linkages. In-depth interviews of health care providers showed women commonly explore child delivery options outside the formal health system especially traditional birth attendants (TBAs) and churches. The reasons for this were related to community trust in these institutions, closer proximity to users and logistic challenges at health centres. Finding from the assessment also revealed that only 16 of the 488 assessed facilities were eligible for scale up based on current national human resource requirements for PMTCT service delivery.

Improving access to and coverage of PMTCT services in Cross River State will therefore require a series of broad ranging interventions to tackle human resource improvements and service utilisation. TBAs must be recognised as important providers of ANC and delivery services and should be constructively engaged to improve uptake of ANC services at the facility level.

SECTION

1 Background

Cross River State is one of the 36 States in the Federal Republic of Nigeria in the South -South geopolitical zone. It is located between latitude 4o 24', and 6o 53' North and longitude 7° 50' and 9° 28' East. It is bounded in the North by Benue State, South by the Atlantic ocean, south west – Akwa Ibom State, West by Ebonyi and Abia State, and East by the Republic of Cameroun. It has a total land mass of 23,000sq km. It has three major languages namely Efik, Bekwarra and Ejagam. From the national population census of 2006 the projected population of the State is estimated to be 3,438, 030 for 2012.

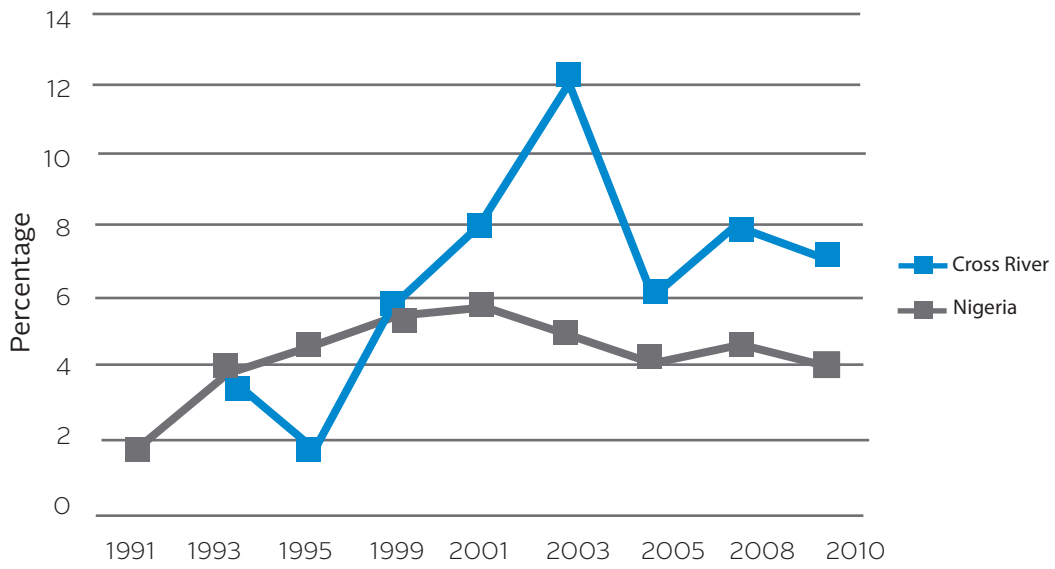
Cross River State is an agricultural state, its vegetation is made of mangrove and tropical rain forest in the south and central zones, and savannah woodlands in the north. About 75% of the people are engaged in subsistence farming. It is endowed with natural resources like limestone, clay, salt, kaolin, tin, uranium, crude oil, wood and aquatic products. Tourism development has been adopted to boost the economy of the State by the government. The main tourist attractions in the state include the Obudu cattle ranch resort, Christmas carnival, and Leboku new yam festival.

SECTION

2 Cross River State HIV Profile

HIV prevalence in Cross River State is 7.1% based on ANC sentinel surveillance figures (2010). This is one of the highest in the country. Factors that contribute to the HIV epidemic in Cross River State include: low condom use, high use of alcohol, use of psychoactive agents, early sexual exposure, high non marital and transactional sexual relationships (IBBSS Nigeria, 2010). The IBBSS study carried out in 2010included Cross River State among the other 6 states surveyed. The report showed that HIV infection is concentrated among the FSW with prevalence of 20.7% and 8.3% among brothel based and non-brothel based sex workers respectively. HIV prevalence among men who have sex with men (MSM) was 2.4%. Other most-at-risk persons (MARPS) identified in the state include transport workers, police, armed forces, IDUs, in and out of school youth and traders involved in cross border trade.

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



SOURCE: HSS 2010

2.1 CROSS RIVER STATE MTCT PROFILE

The number of HIV positive pregnant mothers was estimated projected LG population figures for 2012. Utilising site specific (for surveyed LGAs) and state average HIV prevalences as documented in the 2010 National HIV Sero-prevalence Sentinel Survey, this translated to 12,027 HIV positive pregnant women. In the absence of interventions to prevent HIV mother to child transmission, a third of these pregnancies are estimated to result in infant infection; 4,009 preventable cases of paediatric HIV which are the focus of the State's e-MTCT efforts. Table 1 shows HIV MTCT burdens and PMTCT coverage in the state. MTCT burden and PMTCT coverage are ranked with a higher rank assignment indicating a larger burden or poorer coverage respectively. Akpabuyo LGA has the highest HIV maternal burden and Bekwarra LGA the least. Bekwarra LGA also had the poorest PMTCT facility coverage while Ikom LGA obtained the highest rank sum for both maternal HIV burden and PMTCT coverage among the 18 LGAs in the state.

Table 1: LGA HIV burden and PMTCT Service Coverage Gap

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)	
ABI	7.1%	611	6	52	85%	11	17
AKAMKPA	2.6%	232	3	46	76%	5	8
AKPABUYO	7.1%	1153	18	37	73%	2	20
BAKASSI	7.1%	134	2	23	74%	3	5
BEKWARA	0.6%	38	1	61	97%	18	19
BIASE	7.1%	712	8	64	84%	10	18
BOKI	7.1%	790	11	61	82%	6	17
CALABAR SOUTH	7.1%	811	12	47	85%	11	23
CALABAR-MUNICIPAL	10.4%	1139	17	65	82%	6	23
ETUNG	7.1%	339	4	14	71%	1	5
IKOM	9.4%	918	16	76	92%	14	30
OBANLIKU	7.1%	464	5	46	93%	16	21
OBUBRA	7.1%	731	10	56	86%	13	23
OBUDU	7.1%	684	7	75	92%	14	21
ODUKPANI	7.1%	817	13	38	74%	3	16
OGOJA	7.1%	727	9	62	95%	17	26
YAKURR	7.1%	831	14	36	83%	9	23
YALA	7.1%	896	15	73	82%	6	21
TOTAL	**7.1%**	**12027**		**932**	**85%**		

SECTION

3 Response to the HIV Epidemic

The response from the State dates back to 1988 but was hindered by funding challenges. Non-governmental organizations (NGOs) soon thereafter commenced facilitated interventions among commercial sex workers, long distance truck drivers, and youths. In 2002 CRS government, through the State Action Committee on HIV/AIDS began to coordinate HIV/AIDS intervention programs in the state. In 2007, this committee was transformed to an agency – state agency for the control of HIV/AIDS (SACA). The function of SACA is complemented by that of LACA in the LGAs. The SMOH coordinates the health sector response. Other stakeholders in the response are civil society organizations (CSOs), faith-based organisations (FBOs), and NGOs. There are 183 CSOs, 25 FBOs, and 9 NGOs providing services at various levels.

The State response is guided by such policies asstate strategic plan, state M&E plan, state behavioural change policy, state AIDS priority plan, state workplace policy. A state scale-up plan was also prepared in 2011. The thematic areas provided for in the state response include Prevention, HCT, Treatment, PMTCT, Care and support. The State response is funded by the government and development partners.

The key strategies employed to control the pandemic in the state include mapping and rapid appraisals of at risk groups and the general population, bio-behavioural surveys, assessment of transmission dynamics, rapid scale up of HIV prevention programmes, increase accessibility and utilisation of PMTCT and developing other approaches to reducing HIV transmission

Coverage of PMTCT services in the state is still low with only 12% of health facilities providing PMTCT services and these are skewed in distribution toward urban and more developed areas of the state. In 2011, about 12.6% of pregnant women attending ANC received HTC services, 5.2% and 4.7% of infected pregnant women and HIV exposed infants received ARVs respectively. Response towards MARPs is poor; with no record on interventions for IDUs, MSMs and transport workers.

SECTION

4 Assessment Goal and Objectives

4.1 GOAL

The goal of this assessment is to derive a baseline profile of PMTCT services and thereby plan effective scale up of services in Cross River state.

4.2 OBJECTIVES

1. To document the proportion of health facilities in Cross River 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 for the 12 months preceding the assessment
3. To explore provider perspectives on barriers to uptake of PMTCT services
4. To map the physical location of health facilities using global positioning system (GPS) coordinates

SECTION

5 Assessment Design

This survey utilised mixed (quantitative and qualitative) methods.

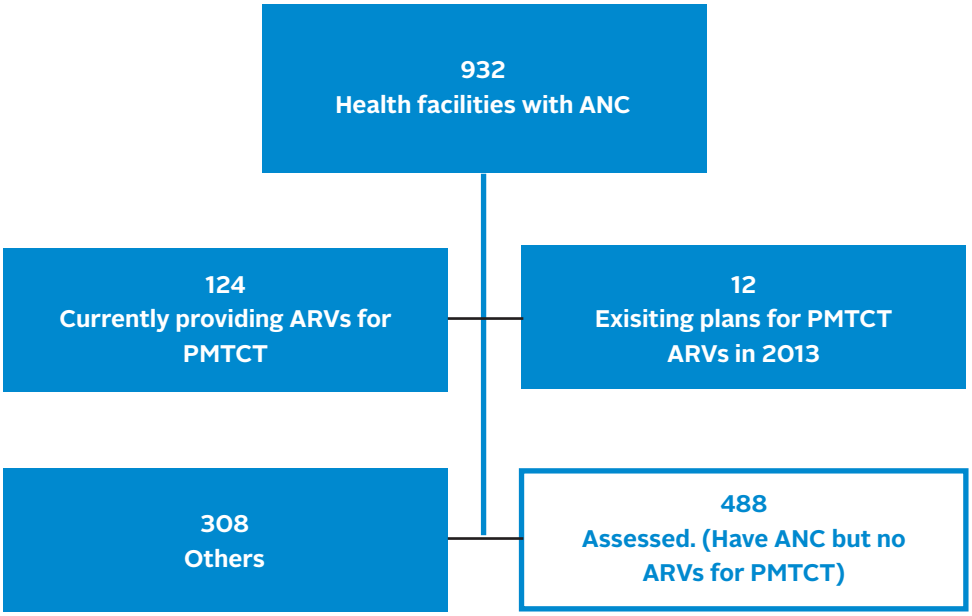
5.1 SAMPLING/SITE SELECTION

This assessment covered all listed public and private health facilities in Cross River State which met defined criteria. All facilities with antenatal services were included; excluded were non-functional facilities and any facility with current IP support providing ARVs for PMTCT. A total of 488 facilities provided ANC and at the time of the survey had no support to provide PMTCT ARVs these were subsequently assessed in full and the results are presented in sections which follow.

5.2 STUDY TOOL

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

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



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

5.3 ASSESSMENT PROCEDURE

The Cross River State Ministry of Health led this assessment exercise with technical support from FHI360 with funding from USAID. Following an orientation exercise, twenty-one (21) multidisciplinary teams (comprising staff from State Ministry of Health, SACA, LGA Health Departments and FHI360) 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 LIMITATIONS

1. A comprehensive listing of existing health facilities in the state was difficult to obtain. This made it difficult to determine if all eligible facilities had been identified and appropriately assessed.

2. A lack of operational definitions and criteria to establish functionality of health centres may have allowed nominally active facilities to be originally included in this sampling frame.

SECTION

6 Findings

Facility visits were conducted to 645 locations within the state. The results presented derived from 488 facilities which currently provide antenatal care services but not ARVs for PMTCT.

6.1 FACILITY OWNERSHIP AND HEALTH CARE LEVEL

Table 1 shows health system positioning and ownership of facilities. Public facilities are classified according to ownership by tiered government levels viz local, state and federal; private facilities as faith-based or profit oriented. The majority (over 90%) of facilities assessed in Cross River State are public owned and most of these are managed by the primary health care department of the ministry of the local government. Most public health facilities are categorised as primary health centres: conversely private health facilities are predominantly secondary health services. Almost all private health facilities operate on a for-profit basis with only 1 faith-based facility documented in this survey.

6.2 HUMAN RESOURCES AND SERVICE UTILIZATION

In Table 2, health human resource and service utilisation is presented, disaggregated by facility level. The average numbers in each facility shows a dearth of health human resources. In primary health centres, pharmacy staff were the least available staff cadre, followed by laboratory and record officers, nurses and doctors. Community health workers were the only cadre in which an average of over 1 staff member per facility was documented. Human resource gaps in secondary health centres follow a similar pattern with pharmacy and record staff available in only about 50% and 70% of facilities respectively. Facility staff average figures are about six times higher in secondary compared to primary centres except for trained community health workers for whom almost equal averages are observed. Only secondary facilities had average figures of more than one health worker in mostcadre per facility.

Service utilisation figures show higher indices for all three measures (OPD attendance, ANC utilisation and number of deliveries) in secondary compared to primary facilities. Average ANC attendance and number of deliveries in PHC is almost half that seen in SHC facilities. Multiple facilities (16 PHC and 4 SHC) had no records of OPD, new ANC or babies delivered.

Table 3 shows earlier presented human resources and service utilisation now disaggregated by facility ownership (public/private). Most PHC facilities are public and SHC, private. The data therefore follows the same general pattern as

Table 2: Characteristics of facilities providing ANC with no PMTCT ARVsupport

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Faith Based	1	0	1
Private for profit	4	33	37
Sub-total (private)	**5**	**33**	**38**
Public			
Federal government	4	1	5
State government	0	2	2
LGA	443	0	443
Sub-total (public)	**447**	**3**	**450**
Overall total	**452**	**36**	**488**

presented in Table 2 above. Private facilities show better work force ratios and utilisation figures compared to public. Wide disparities are however present; between and within both private and public groups.

6. 3 OTHER DOMAIN SUMMARIES

Findings related to the scope of services available in facilities, facility infrastructure, environmental enablement for MCH and community support/ participation are presented in Table 4, disaggregated by facility level. Importantly, less than 50% of facilities in the state reported having a laboratory service or support, a third provide TB related service and a tenth currently conduct HTC.

In comparing facility levels, it is noteworthy that only 92% of PHCs provide physical examinations to pregnant women compared to all SHCs; 46% of PHCs provide 24 hours delivery services as opposed to 85% of SHCs. In the wider MCH context, immunisation and child follow up are more frequently found at PHC compared to SHC.

The infrastructure domain assessed facilities present, as well as spaces in which these could be provided if currently absent. About three quarters of facilities had existing/ potential spaces for ANC rooms. The least frequentlyreported facility features were HTC/ Adherence counselling spaces (43%), laboratories (34%) and records/M&E room (31%).

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	Number of doctors	0.2*	78.3%	21.7%	2.3*	0.0%	100.0%	0.4*	72.5%	27.5%
	Number of registered nurse/ midwife	0.4	79.0%	21.0%	3.4	16.7%	83.3%	0.6	74.4%	25.6%
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	3.1	6.2%	93.8%	4.3	8.3%	91.7%	3.2	6.4%	93.6%
	Number of records officers	0.2	79.0%	21.0%	1.3	30.6%	69.4%	0.3	75.4%	24.6%
	Number of lab technician/ scientists	0.1	89.6%	10.4%	1.6	19.4%	80.6%	0.3	84.4%	15.6%
	Number of pharmacy technician/ pharmacists	0.06	96.7%	3.3%	1.1	52.8%	47.2	0.1	93.4%	6.6%
Service utilization	Number attended OPD in the last 12 months	406	5.1%	94.9%	3272	11.1%	88.9%	619	5.5%	94.5%
	ANC first attendees recorded in the last 12 months	83	6.9%	93.1%	139	36.1%	63.9%	87	23.2%	76.8%
	Deliveries taken in the last 12 months	23	22.8%	77.2%	62	27.8%	72.2%	26	9.0%	91.0%

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

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	Number of doctors	0.3*	78.2%	21.8%	2.0	0.0%	100.0%	0.4*	72.5%	27.5%
	Number of registered nurse/ midwife	0.5	78.7%	21.3%	2.4	23.7%	76.3%	0.6	74.4%	25.6%
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	3.2	6.4%	93.6%	4.0	5.3%	94.7%	3.2	6.4%	93.6%
	Number of records officers	0.3	78.7%	21.3%	0.9	36.8%	63.2%	0.3	75.4%	24.6%
	Number of lab technician/ scientists	0.2	89.6%	10.4%	1.3	23.7%	76.3%	0.3	84.4%	15.6%
	Number of pharmacy technician/ pharmacists	0.1	96.0%	4.0%	0.7	63.2%	36.8%	0.1	93.4%	6.6%
Service utilization	Number attended OPD in the last 12 months	463	5.1%	94.9%	2456	10.5%	89.5%	619	5.5%	94.5%
	ANC first attendees recorded in the last 12 months	83	7.3%	92.7%	132	28.9%	71.1%	87	23.2%	76.8%
	Deliveries taken in the last 12 months	23	23.3%	76.7%	61	21.1%	78.9%	26	9.0%	91.0%

Table 5: Summary of domain responses disaggregated by facility level

		FACILITY TYPE		Total n =488
		Public n = 450	Private n = 38	
SERVICE AVAILABILITY	Physical Exam (including weight, assessing GA, blood pressure)	417 (92.3%)	36 (100.0%)	453 (92.8%)
	Laboratory services (onsite or by referral): Hb, Urinalysis	203(44.9%)	33 (91.7%)	236 (48.4%)
	Dispensing of haematinics and IPTp	402 (88.9%)	33 (91.7%)	93 (92.1%)
	Labour and delivery services (with 24 hour shifts)	365 (80.8%)	34 (94.4%)	399 (81.8%)
	Referrals for emergency obstetric and newborn care	409 (90.5%)	27 (75.0%)	436 (89.3%)
	Family Planning services (condoms, hormonal contraceptives)	331 (73.2%)	23 (63.9%)	354 (72.5%)
	Immunization services	423 (93.6%)	11 (30.6%)	434 (88.9%)
	Child follow up clinics	382 (84.5%)	19 (52.8%)	401 (82.2%)
	TB services (specify which - e.g. DOTS, microscopy)	49 (10.8%)	7 (19.4%)	56 (11.5%)
	HIV Testing and Counseling	157 (34.7%)	24 (66.7%)	181 (37.1%)
IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	OPD consulting room	320 (70.8%)	35 (97.2%)	355 (72.7%)
	Lab Room	133 (29.4%)	31 (86.1%)	164 (33.6%)
	Phlebotomy	128 (28.3%)	22 (61.1%)	150 (30.7%)
	ANC Space	326 (72.1%)	29 (80.6%)	355 (72.7%)
	ANC Room	282 (62.4%)	28 (77.8%)	310 (63.5%)
	Space that can be used for confidential counseling	263 (58.2%)	27 (75.0%)	290 (59.4%)
	Maternity Delivery Room	333 (73.7%)	34 (94.4%)	367 (75.2%)
	Pharmacy Store	180 (39.8%)	27 (75.0%)	207 (42.4%)
	Pharmacy Dispensary	183 (40.5%)	25 (69.4%)	208 (42.6%)
	Space for HTC/Adherence counseling	186 (41.2%)	23 (63.9%)	209 (42.8%)
	DOTS clinic	70 (15.5%)	8 (22.2%)	78 (16.0%)
	DOTS waiting area	76 (16.8%)	9 (25.0%)	85 (17.4%)
	Medical records/M&E	127 (28.1%)	26 (72.2%)	153 (31.4%)

Enabling environment for MCH/PMTCT was assessed based on MDG support for MCH, presence of MSS/SURE-P midwives, free ANC and community outreach services. About 90% of facilities conducted regular monthly outreach and 75% free ANC services. All the enabling environment features were higher in PHCs compared to SHCs. Almost half PHCs had MDG support for MCH and about 5% SURE-P or MSS supported midwives. Almost 90% of respondents stated women in their communities had other preferred sites (aside from health centres) for delivery. About 70% of facilities had ward committees, community development and community based organisations supporting service delivery. This community support was negligible among secondary level facilities.

Table 6: Summary of domain responses disaggregated by facility level (2)

		FACILITY TYPE		Total n =488
		Public n = 450	Private n = 38	
ENABLING ENVIRONMENT	MDG Support for MCH services	199 (44.0%)	4 (11.1%)	203 (41.6%)
	Free ANC Services	356 (78.8%)	4 (11.1%)	360 (73.8%)
	Regular Monthly Community Outreaches	416 (92.0%)	10 (27.8%)	426 (87.3%)
	MSS midwives	28 (6.2%)	0 (0.0%)	28 (5.7%)
	SURE-P midwives	23 (5.1%)	1 (2.8%)	24 (4.9%)
COMMUNITY BIRTHING PLACES	Places other than health facilities where women deliver in this community	401 (88.7%)	25 (69.4%)	426 (87.3%)
	Other Places – Churches	111 (24.6%)	13 (36.1%)	124 (25.4%)
	Other Places – Mosque	6 (1.3%)	1 (2.8%)	7 (1.4%)
	Other Places – TBA	373 (82.5%)	22 (61.1%)	395 (80.9%)
	Other Places – Maternity home of trained midwife	28 (6.2%)	2 (5.6%)	30 (6.1%)
COMMUNITY SYSTEMS (ARE THE FOLLOWING AVAILABLE?)	Ward development committee	339 (75.0%)	8 (22.2%)	347 (71.1%)
	Village development committee	376 (83.2%)	4 (11.1%)	380 (77.9%)
	Community development association	337 (74.6%)	3 (8.3%)	340 (69.7%)
	Community-based organization	194 (42.9%)	2 (5.6%)	196 (40.2%)

Table 6 has domain responses disaggregated by facility ownership. The patterns for availability of various service components are similar to those shown previously in Table 4. Findings inpublic facilities mirror primary health centres (for which these forma majority) and similarly private sites, the secondary health level. Surprisingly some public health facilities (8%) did not have facilities for basic physical examination. More private facilities had HTC (62% vs 36%), TB services (18% vs 11%) and 24 hour delivery service (94% vs 80%). Public facilities fared better at provision of immunisation; family planning and child follow up services.

The three least frequently reported infrastructure items were; medical record facility 31%, laboratory services 34% and HTC/Adherence counselling spaces 43.1%. Private facilities were twice as likely to report the presence of these infrastructure items as public facilities. Despite all the surveyed institutions being functional ANC centres, a quarter had neither dedicated spaces for ANC nor delivery rooms. This dearth was commoner in public health centres.

Table 7: Summary of domain responses disaggregated by facility ownership

		FACILITY TYPE		Total n =488
		Public n = 450	Private n = 38	
Service availability	Physical Exam (including weight, assessing GA, blood pressure)	415 (92.2%)	38 (100.0%)	453 (92.8%)
	Laboratory services (onsite or by referral): Hb, Urinalysis	202(44.9%)	34 (89.5%)	236 (48.4%)
	Dispensing of haematinics and IPTp	401 (89.1%)	34(89.5%)	435 (89.1%)
	Labour and delivery services (with 24 hour shifts)	363 (80.7%)	36 (94.7%)	399 (81.8%)
	Referrals for emergency obstetric and newborn care	407 (90.4%)	29 (76.3%)	436 (89.3%)
	Family Planning services (condoms, hormonal contraceptives)	331 (73.6%)	23 (60.5%)	354 (72.5%)
	Immunization services	423 (94.0%)	11 (28.9%)	434 (88.9%)
	Child follow up clinics	383 (85.1%)	18 (47.4%)	401 (82.2%)
	TB services (specify which - e.g. DOTS, microscopy)	49 (10.9%)	7 (18.4%)	56 (11.5%)
	HTC	157 (34.9%)	24 (63.2%)	181 (37.1%)
Identified Structure (Can space be identified for the following?)	OPD consulting room	318 (70.7%)	37 (97.4%)	355 (72.7%)
	Lab Room	134 (29.8%)	30 (78.9%)	164 (33.6%)
	Phlebotomy	128 (28.4%)	22 (57.9%)	150 (30.7%)
	ANC Space	326 (72.4%)	29 (76.3%)	355 (72.7%)
	ANC Room	282 (62.7%)	28 (73.7%)	310 (63.5%)
	Space that can be used for confidential counseling	264 (58.7%)	26 (68.4%)	290 (59.4%)
	Maternity Delivery Room	331 (73.6%)	36 (94.7%)	367 (75.2%)
	Pharmacy Store	181 (40.2%)	26 (68.4%)	207 (42.4%)
	Pharmacy Dispensary	183 (40.7%)	25 (65.8%)	208 (42.6%)
	Space for HTC/Adherence counseling	186 (41.3%)	23 (60.5%)	209 (42.8%)
	DOTS clinic	70 (15.6%)	8 (21.1%)	78 (16.0%)
	DOTS waiting area	77 (17.1%)	8(21.1%)	85 (17.4%)
	Medical records/M&E	128 (28.4%)	25 (65.8%)	153 (31.4%)

Assessed indices of an enabling environment to support were; facility conducting community outreach, free ANC, program support (MDG, MSS, SURE-P) for MCH. All indices of an enabling environment were commoner among public facilities. Almost three quarters of health facilities offered free antenatal services. Only a few facilities had support from program for their MCH activity, 42% from MDG, 6% MSS and 5% SURE-P.

Almost all facilities receiving this support were in the public category. Similarly community support systems were reported almost exclusively by public facilities; 26% private vs 75% public facilities had ward development committees. Less than 10% of private facilities had a community development association or a community based organisation supporting their activity.

Table 8: Summary of domain responses disaggregated by facility ownership (2)

		FACILITY TYPE		Total n =488
		Public n = 450	Private n = 38	
Enabling environment	MDG Support for MCH services	200 (44.4%)	3 (7.9%)	203 (41.6%)
	Free ANC Services	359 (79.8%)	1 (2.6%)	360 (73.8%)
	Regular Monthly Community Outreaches	419 (93.1%)	7 (18.4%)	426 (87.3%)
	MSS midwives	28 (6.2%)	0 (0.0%)	28 (5.7%)
	SURE-P midwives	23 (5.1%)	1 (2.6%)	24 (4.9%)
Community birthing places	Places other than health facilities where women deliver in this community	397 (88.2%)	29 (76.3%)	426 (87.3%)
	Other Places - Churches	108 (24.0%)	16 (42.1%)	124 (25.4%)
	Other Places - Mosque	6 (1.3%)	1 (2.8%)	7 (1.4%)
	Other Places - TBA	369 (82.0%)	26 (68.4%)	395 (80.9%)
	Other Places – Maternity home of trained midwife	28 (6.2%)	2 (5.6%)	30 (6.1%)
Community Systems (Are the following available?)	Ward development committee	337 (74.9%)	10 (26.3%)	347 (71.1%)
	Village development committee	375 (83.3%)	5 (13.2%)	380 (77.9%)
	Community development association	336 (74.7%)	4 (10.5%)	340 (69.7%)
	Community-based organization	194 (43.1%)	2 (5.3%)	196 (40.2%)

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 determine demand for health facility-based PMTCT services.

6.4.1 MANY WOMEN PREFER TO DELIVER WITH TBAS, PRIVATE CLINICS AND CHURCHES

In the KIIs conducted with health workers in Cross River State, respondents were of the opinion that many women prefer the services of Traditional Birth Attendants (TBAs), private clinics and churches during deliveries even though these women may attend ANC at the health facilities. Some of the reasons proffered for this observation include a firm traditional belief in the abilities of the TBA, spiritual powers from church deliveries, perceived cost of services at the health facilities, illiteracy and superstitious beliefs. Table 9 below captures all of these themes as well as some verbatim quotes from respondents supporting these themes.

Table 9: 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	"They prefer to deliver with TBAs or at home. Only when there are complications, they will come to the clinic"
	"In this place, there is no night nurse and no security"
	"They say that labour did not last long so they could not reach here"
Why women prefer to deliver with TBAs	"Because it is the culture and tradition of people here to use TBAs""
	"The facilities here are dilapidated and have only few nurses""
	"TBAs will not charge them plenty money like hospital"
Reasons for poor patronage of the health facilities	"Because of cultural beliefs, people will prefer to go to the TBAs and churches"
	"The people here believe that they can be saved when they deliver in churches because of spiritual powers"
	"There are no medical equipments and resources in most hospitals"
	"The people here are poor so they go to where they will pay small money"

6.5 Scenarios for Eligibility for PMTCT Services

Human resource complements are disaggregated by facility ownership and presented in Table 6. Human resources were more abundant in private than public facilities. The criterion most frequently met was staff qualified to give nursing care which comprised nurses and community health professionals. Few facilities met minimum criteria as described relevant for PMTCT services. Shortages of laboratory and pharmacy staff restricted the proportion of facilities meeting minimum requirements. These findings suggest only marginal numbers of facilities have the required complement of workers and current client patronage to suggest effective implementation of PMTCT services; as seen with the composite criterion which is satisfied by only 15 health facilities.

Table 10: Different HR related cut-offs

Criteria	Cut-off	Ownership	Number of facilities meeting criteria	% of total (N=488) facilities
Have ANC but no implementing partner support for ARVs in PMTCT		Public	450	92.2
		Private	38	7.8
Facility covered by doctors		Public	98	20.0
		Private	38	7.4
Availability of Nurses/ Midwives	At least 4	Public	13	2.7
		Private	9	1.8
Community health workers	At least 4	Public	136	27.9
		Private	15	3.1
Clinical care staff (nurses or community workers)	At least 4	Public	152	31.1
		Private	27	5.5
ANC attendance in the last 12 months	Equal or above state mean (84)	Public	121	24.8
		Private	12	2.5
Deliveries in the last 12 months	At least 1	Public	345	70.7
		Private	30	6.1
National PMTCT HR requirement	At least 1 doctor, I nurse/ midwife, 2 CH/CHEWs, I Pharmacist/technician, 1 Lab/ technician, 1 records staff	Public	6	1.2
		Private	10	2.0
Minimum HR complement 1	At least 4 clinical care staff, 1 pharmacy, 1 lab, 1 records	Public	11	2.3
		Private	11	2.3
Minimum HR complement 2	At least 1 doctor, 4 nursing care, 1 pharmacy, 1 lab, 1 records	Public	8	1.6
		Private	11	2.3
Composite criterion	At least 4 clinical care staff, 1 pharmacy, 1 lab, 1 records, above average ANC attendance, at least 1 delivery	Public	8	1.6
		Private	5	1.0

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 for different scenarios by the end of 2014.

Figure 3: Map showing currently existing PMTCT services

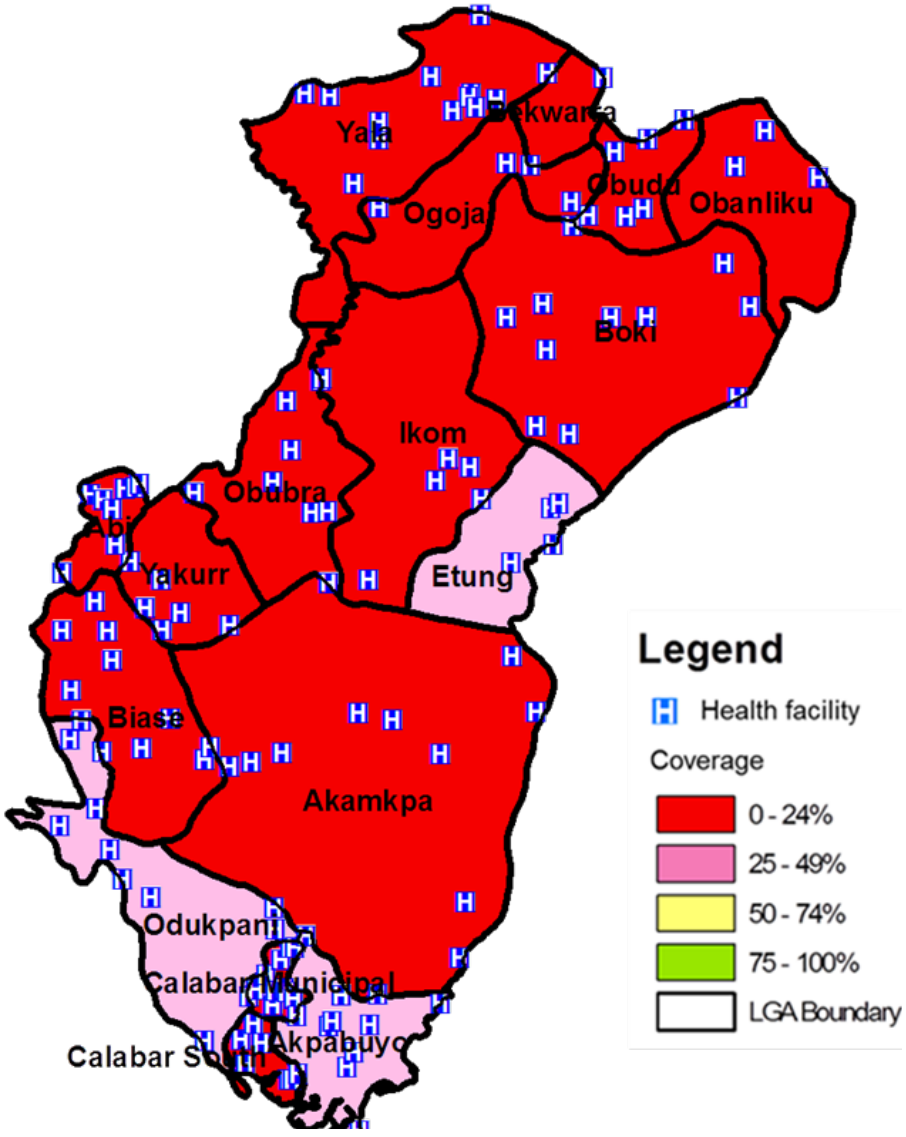


Figure 4: Map showing spread of assessed facilities (with ANC but no PMTCT)

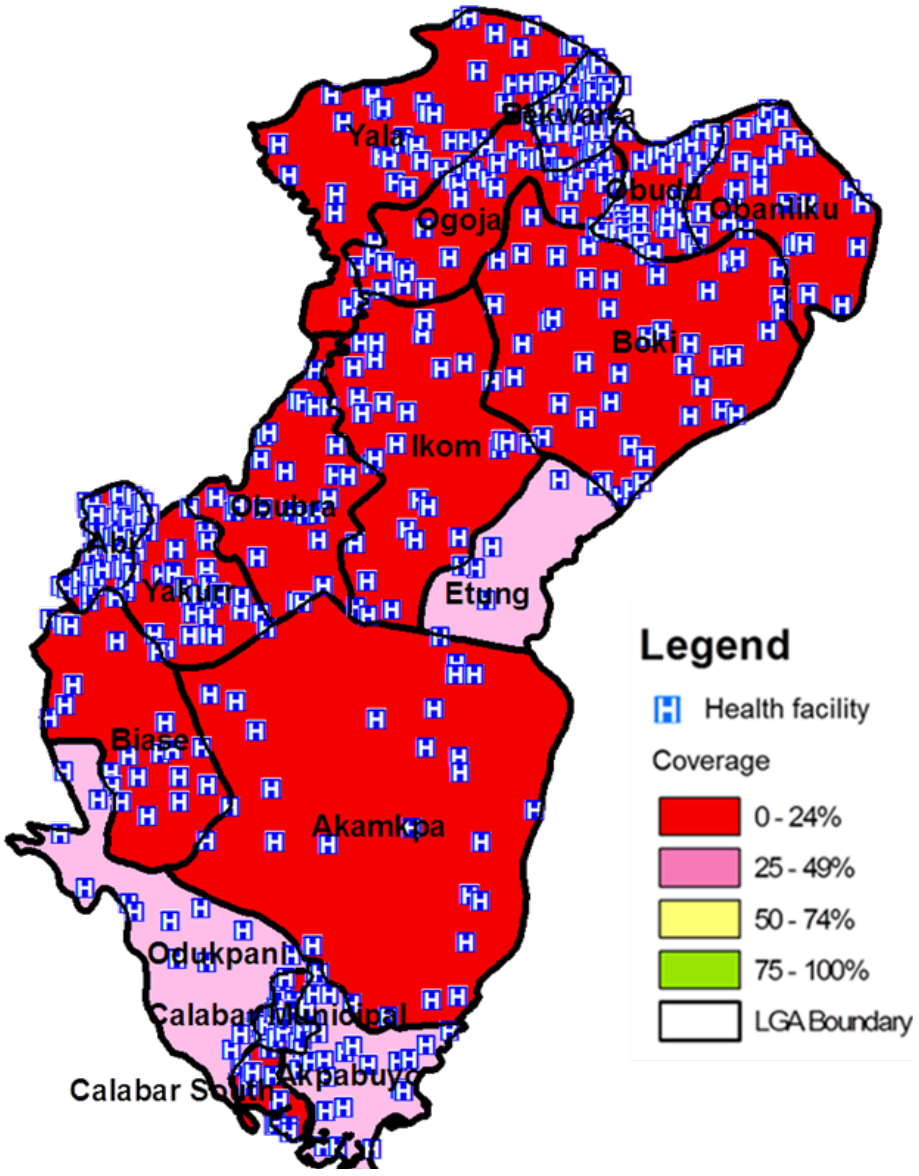


Figure 5: Map showing spread of facilities meeting national HR criteria for PMTCT services

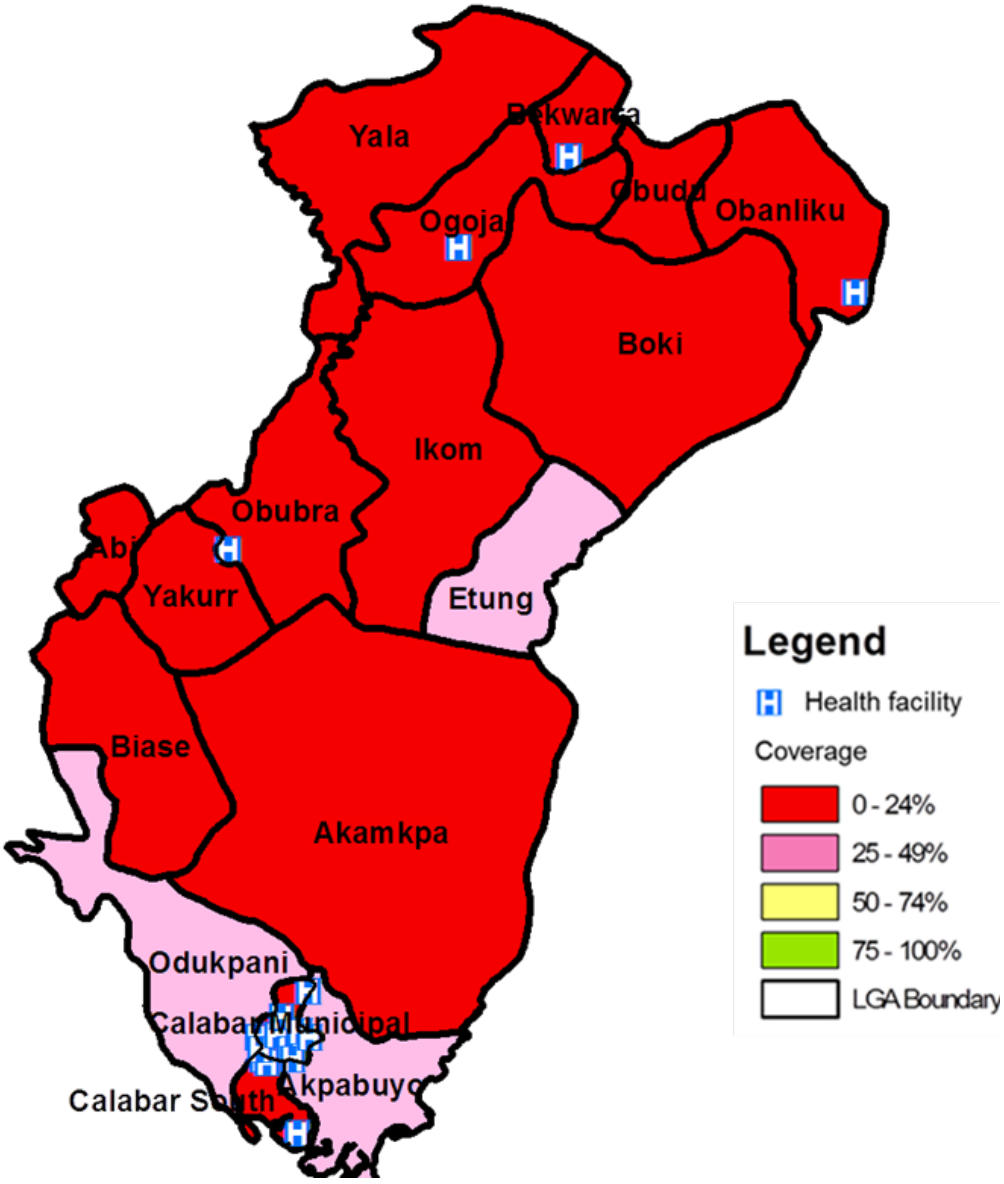


Figure 6: Map showing spread of facilities meeting state-defined HR criteria for PMTCT services

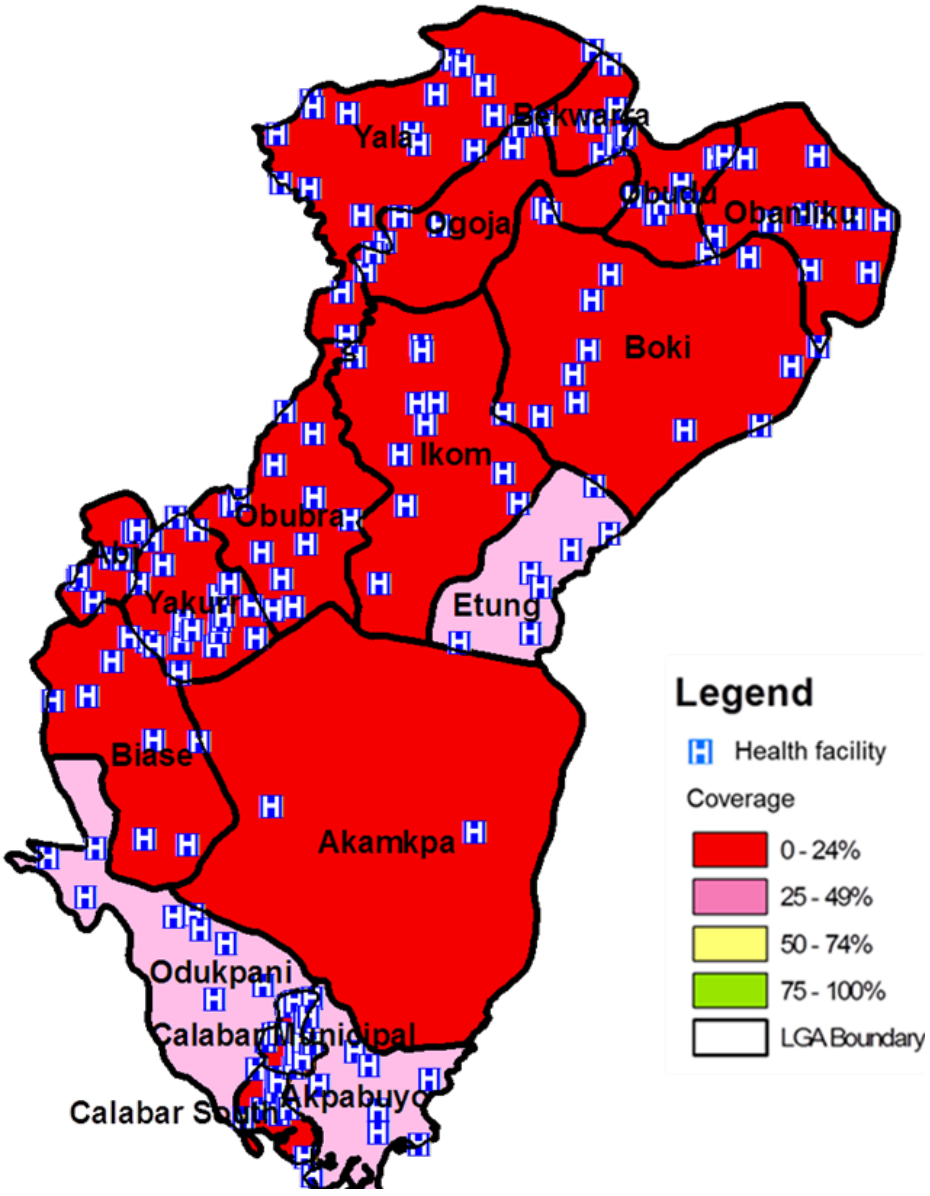


Figure 7: Map showing scenario for 2014 (current PMTCT sites + facilities national HR criteria for PMTCT services)

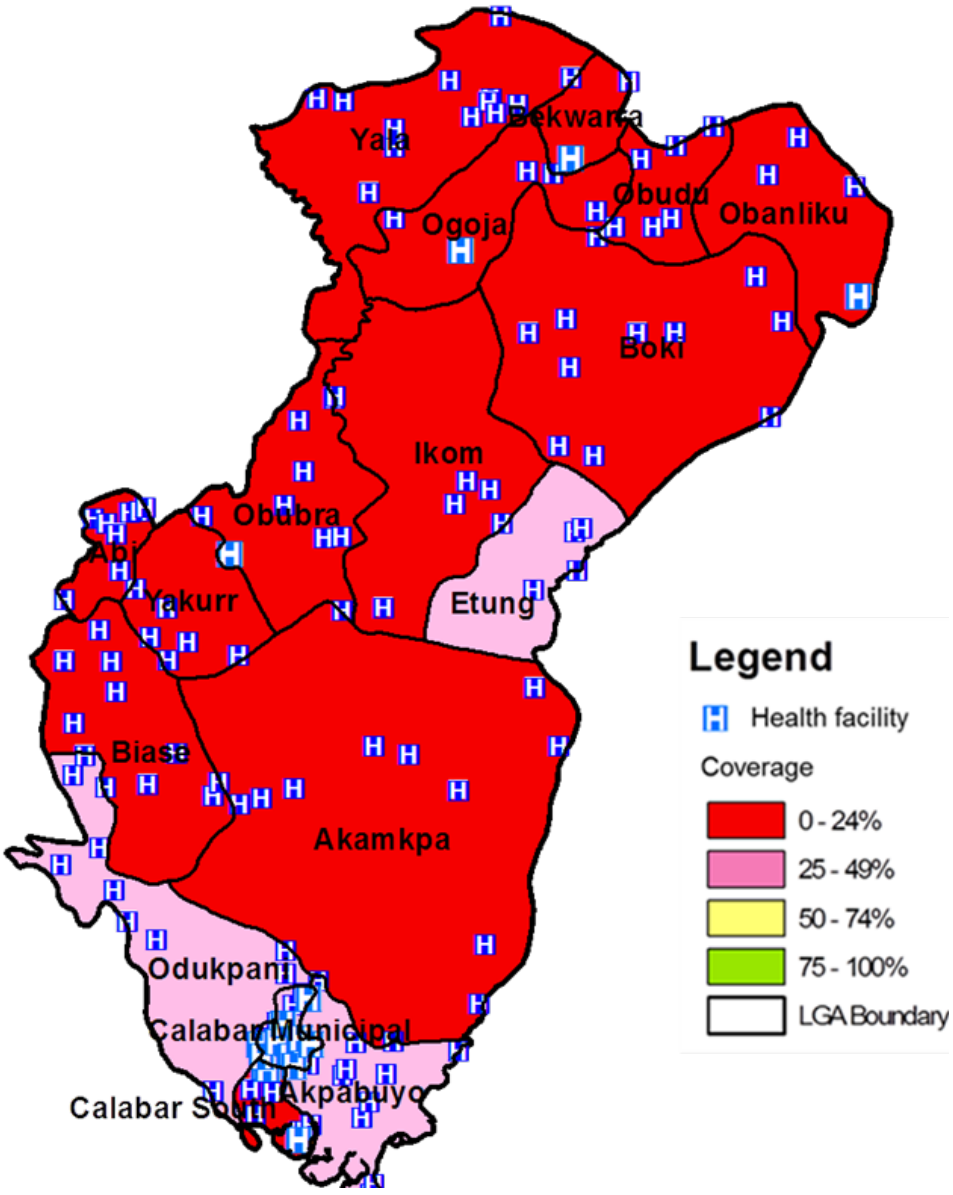


Figure 8: Map showing scenario for 2014 (current PMTCT sites + facilities which met state-defined HR criteria for PMTCT services)

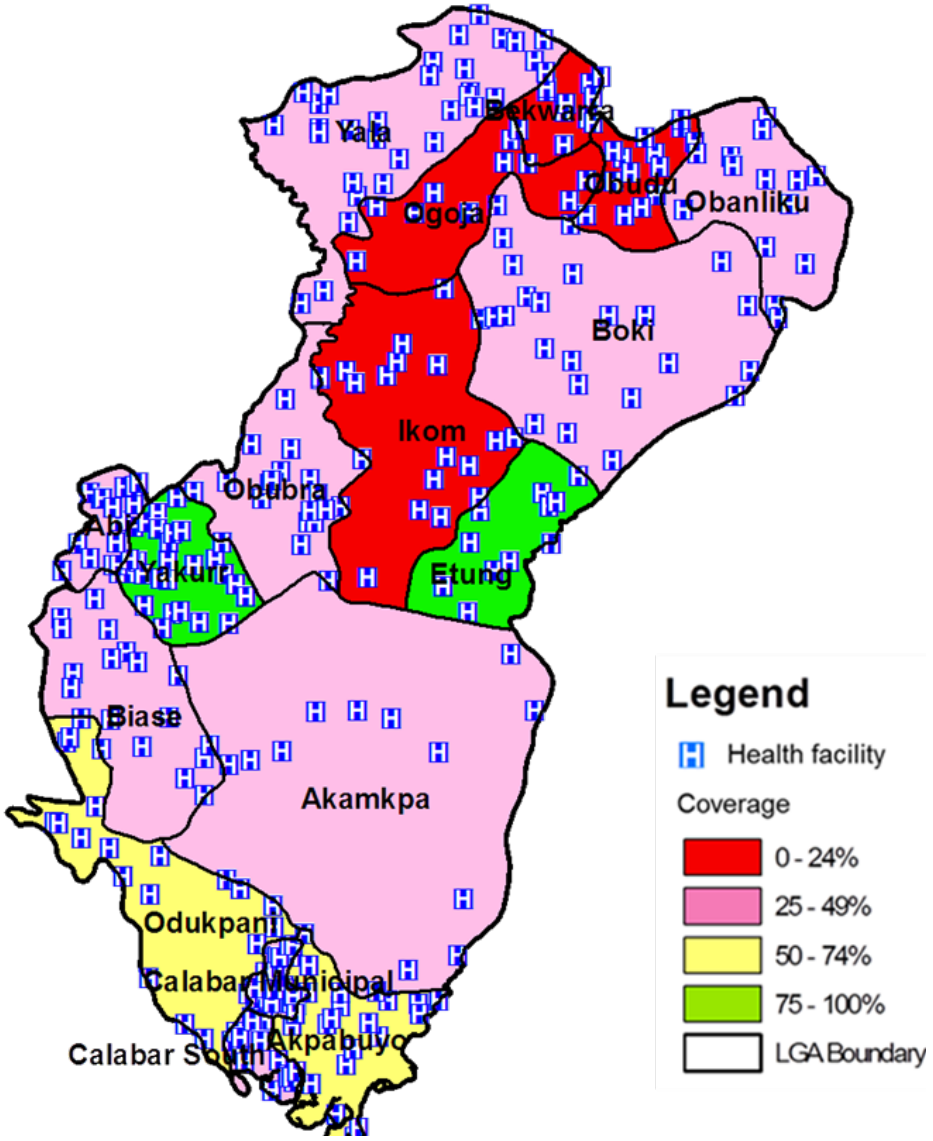
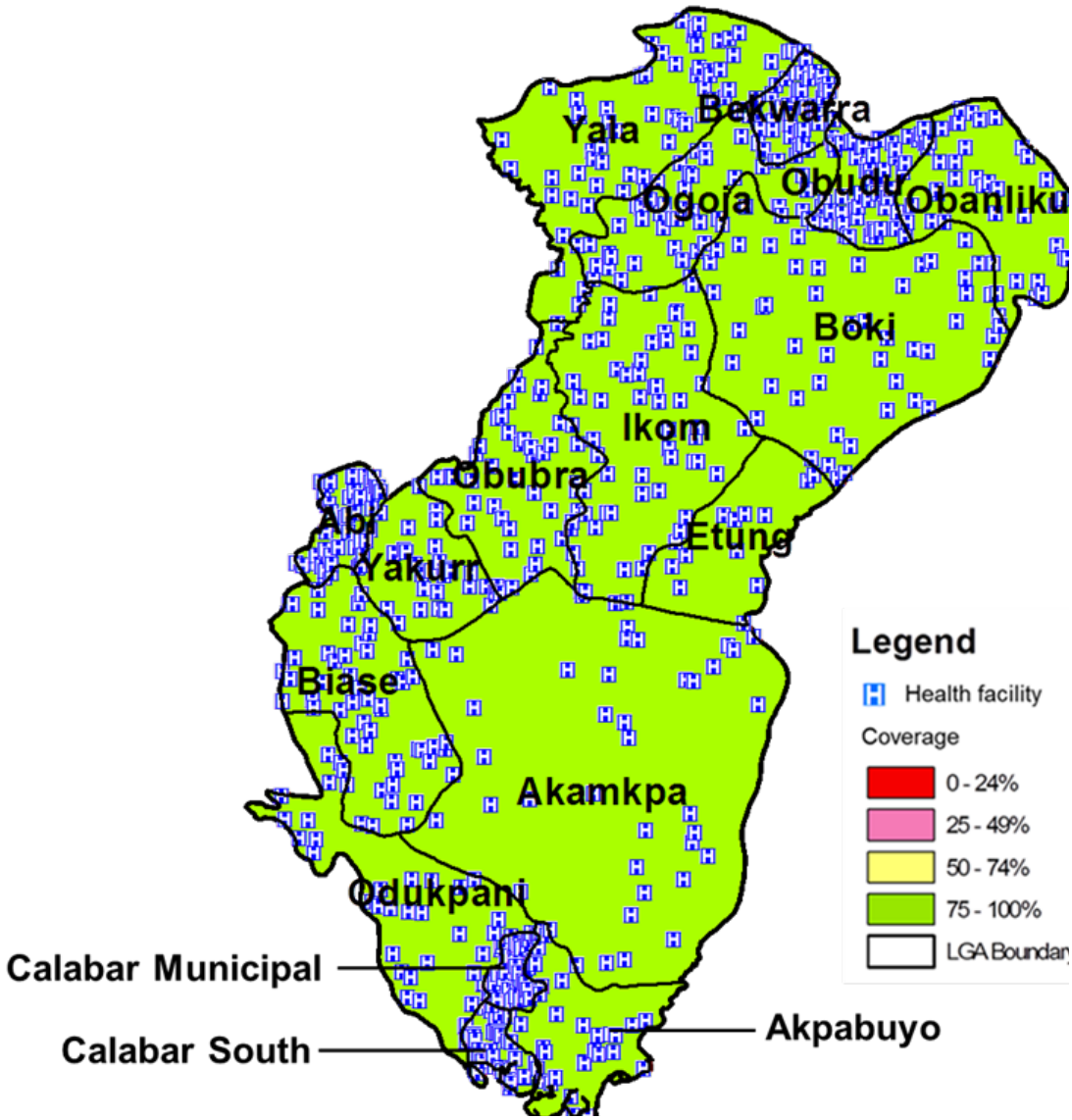


Figure 9: Map showing coverage scenario for 2014 (current PMTCT sites + scale-up to 80% of ANC health facilities currently without PMTCT services)



SECTION

8 Conclusion

Findings from the Cross River State rapid state-wide health facility assessments clearly show gaps in human resources in majority of the facilities assessed. In general, infrastructure available for PMTCT service provision is inadequate in the state. It was also observed that private facilities had better HR, infrastructure and services utilisation when compared to public owned facilities. Community involvement will be a critical component of PMTCT scale up in the state especially demand creation for improved uptake of ANC and delivery services at the facilities.

SECTION

9 Recommendations

Data from this assessment should be disseminated widely and used in developing a comprehensive state PMTCT scale-up plan. All stakeholders (partners, donor agencies) need to work with the state government to improve infrastructure, HR availability and ensure capacity-building for health care workers in all facilities identified for PMTCT scale up.

A comprehensive scale-up plan should also include private health facilities as findings from the assessment reveal that the private health sector has the potential for PMTCT scale up and will cater for some population in the state.

Appendix

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

Domain	Item	452 PRIMARY FACILITIES					36 SECONDARY FACILITIES					488 FACILITIES				
		Min	Median	Average	Max	Total	Min	Median	Average	Max	Total	Min	Median	Average	Max	Total
Human resources	Number of doctors*	0			3		1			8		0			8	
	Number of registered nurse/midwife	0	0	0.4	7	177	0	2	3.4	27	121	0	0	0.6	27	298
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	0	2	3.1	45	1397	0	3	4.3	23	149	0	3.0	3.2	45	1546
	Number of records officers	0	0	0.2	4	105	0	1	1.3	10	46	0	0	0.3	10	151
	Number of lab technician/ scientists	0	0	0.1	4	61	0	1	1.6	10	59	0	0	0.3	10	120
	Number of pharmacy technician/ pharmacists	0	0	.06	6	27	0	0	1.1	12	39	0	0	0.1	12	66
Service utilization	Number attended OPD in the last 12 months	0	190	406	9128	182678	0	912	3272	17911	117825	0	200	619	17911	300503
	ANC first attendees recorded in the last 12 months	0	45	83	1278	37065	0	26	137	1489	4855	0	44	87	1489	41920
	Deliveries taken in the last 12 months	0	12	23	154	10263	0	18	62	600	2180	0	12	26	600	12443

*** The practice of having a physician provide support to multiple facilities in the state makes it impossible to avoid double counts. Measures of central location and totals are therefore not calculated**

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

Domain	Item	452 PRIMARY FACILITIES					36 SECONDARY FACILITIES					488 FACILITIES				
		Min	Median	Average	Max	Total	Min	Median	Average	Max	Total	Min	Median	Average	Max	Total
Human resources	Number of doctors*	0			8		0			7		0			8	
	Number of registered nurse/ midwife	0	0	0.5	27	207	0	2	2.4	14	91	0	0	0.6	27	298
	Number of other trained health workers (Community Nurses, CHOs, CHEWs)	0	2	3.2	45	1399	0	3	4.0	23	147	0	3.0	3.2	45	1546
	Number of records officers	0	0	0.3	10	117	0	1	0.9	7	34	0	0	0.3	10	151
	Number of lab technician/ scientists	0	0	0.2	10	70	0	1	1.3	5	50	0	0	0.3	10	120
	Number of pharmacy technician/ pharmacists	0	0	0.1	12	41	0	0	0.7	5	25	0	0	0.1	12	66
Service utilization	Number attended OPD in the last 12 months	0	191	463	12859	207165	0	702	2456	17911	93338	0	200	619	17911	300503
	ANC first attendees recorded in the last 12 months	0	45	83	1278	36899	0	26	132	1489	5021	0	44	87	1489	41920
	Deliveries taken in the last 12 months	0	12	23	154	10121	0	21	61	600	2322	0	12	26	600	12443

***The practice of having a physician provide support to multiple facilities in the state makes it impossible to avoid double counts. Measures of central location and totals are therefore not calculated**

Appendix 3: Coverage gap for doctors 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	Abi	41	1	40	N/A	N/A	N/A
2	Akampa	26	1	25	1	1	0
3	Akpabuyo	24	4	20	N/A	N/A	N/A
4	Bakassi	16	0	16	1	0	1
5	Bekwarra	40	26	14	1	1	0
6	Biase	22	0	22	1	1	0
7	Boki	41	2	39	3	2	1
8	Calabar Municipal	16	6	10	7	7	0
9	Calabar South	4	0	4	6	6	0
10	Etung	5	0	5	N/A	N/A	N/A
11	Ikom	24	13	11	6	6	0
12	Obanliku	27	2	25	N/A	N/A	N/A
13	Obubra	23	20	3	3	3	0
14	Obudu	37	4	33	N/A	N/A	N/A
15	Odukpani	13	1	12	1	1	0
16	Ogoja	30	2	28	1	1	0
17	Yakurr	22	0	22	7	7	0
18	Yala	39	0	39	N/A	N/A	N/A
	Total	**450**	**82**	**368**	**38**	**36**	**2**

Appendix 4: Coverage gap for nurse/midwives 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	Abi	41	11	30	N/A	N/A	N/A
2	Akampa	26	10	16	1	1	0
3	Akpabuyo	24	3	21	N/A	N/A	N/A
4	Bakassi	16	1	15	1	0	1
5	Bekwarra	40	8	32	1	1	0
6	Biase	22	1	21	1	1	0
7	Boki	41	7	34	3	2	1
8	Calabar Municipal	16	12	4	7	7	0
9	Calabar South	4	2	2	6	5	1
10	Etung	5	1	4	N/A	N/A	N/A
11	Ikom	24	6	18	6	3	3
12	Obanliku	27	4	23	N/A	N/A	N/A
13	Obubra	23	7	16	3	2	1
14	Obudu	37	7	30	N/A	N/A	N/A
15	Odukpani	13	2	11	1	0	1
16	Ogoja	30	5	25	1	1	0
17	Yakurr	22	2	20	7	6	1
18	Yala	39	7	32	N/A	N/A	N/A
	Total	**450**	**96**	**354**	**38**	**29**	**9**

Appendix 5: Coverage gap for community workers 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	Abi	41	14	30	N/A	N/A	N/A
2	Akampa	26	19	9	1	0	1
3	Akpabuyo	24	16	9	N/A	N/A	N/A
4	Bakassi	16	15	1	1	1	0
5	Bekwarra	40	34	7	1	0	1
6	Biase	22	14	14	1	1	0
7	Boki	41	32	9	3	2	1
8	Calabar Municipal	16	15	2	7	6	2
9	Calabar South	4	4	0	6	6	0
10	Etung	5	5	0	N/A	N/A	N/A
11	Ikom	24	13	9	6	4	3
12	Obanliku	27	24	3	N/A	N/A	N/A
13	Obubra	23	22	1	3	3	0
14	Obudu	37	18	21	N/A	N/A	N/A
15	Odukpani	13	10	4	1	0	1
16	Ogoja	30	25	7	1	1	0
17	Yakurr	22	22	0	7	7	0
18	Yala	39	32	9	N/A	N/A	N/A
	Total	**450**	**334**	**135**	**38**	**31**	**9**

Appendix 6: Coverage gap for records officer (RO) 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	Abi	41	3	38	N/A	N/A	N/A
2	Akampa	26	4	22	1	0	1
3	Akpabuyo	24	0	24	N/A	N/A	N/A
4	Bakassi	16	0	16	1	0	1
5	Bekwarra	40	9	31	1	0	1
6	Biase	22	1	21	1	1	0
7	Boki	41	1	40	3	0	3
8	Calabar Municipal	16	5	11	7	7	0
9	Calabar South	4	0	4	6	3	3
10	Etung	5	5	0	N/A	N/A	N/A
11	Ikom	24	1	23	6	3	3
12	Obanliku	27	1	26	N/A	N/A	N/A
13	Obubra	23	20	3	3	3	0
14	Obudu	37	6	31	N/A	N/A	N/A
15	Odukpani	13	1	12	1	0	1
16	Ogoja	30	4	26	1	0	1
17	Yakurr	22	22	0	7	7	0
18	Yala	39	18	21	N/A	N/A	N/A
	Total	**450**	**101**	**349**	**38**	**24**	**14**

Appendix 7: Coverage gap for laboratory staff 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	Abi	41	8	33	N/A	N/A	N/A
2	Akampa	26	1	25	1	1	0
3	Akpabuyo	24	0	24	N/A	N/A	N/A
4	Bakassi	16	0	16	1	0	1
5	Bekwarra	40	3	37	1	0	1
6	Biase	22	0	22	1	1	0
7	Boki	41	7	34	3	1	2
8	Calabar Municipal	16	4	12	7	7	0
9	Calabar South	4	1	3	6	4	2
10	Etung	5	2	3	N/A	N/A	N/A
11	Ikom	24	3	21	6	6	0
12	Obanliku	27	2	25	N/A	N/A	N/A
13	Obubra	23	3	20	3	3	0
14	Obudu	37	6	31	N/A	N/A	N/A
15	Odukpani	13	2	11	1	0	1
16	Ogoja	30	3	27	1	1	0
17	Yakurr	22	0	22	7	5	2
18	Yala	39	2	37	N/A	N/A	N/A
	Total	**450**	**47**	**403**	**38**	**29**	**9**

Appendix 8: Coverage gap for pharmacy staff 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	Abi	41	5	36	N/A	N/A	N/A
2	Akampa	26	1	25	1	0	1
3	Akpabuyo	24	0	24	N/A	N/A	N/A
4	Bakassi	16	0	16	1	0	1
5	Bekwarra	40	2	38	1	0	1
6	Biase	22	0	22	1	0	1
7	Boki	41	0	41	3	1	2
8	Calabar Municipal	16	4	12	7	6	1
9	Calabar South	4	0	4	6	4	2
10	Etung	5	0	5	N/A	N/A	N/A
11	Ikom	24	1	23	6	2	4
12	Obanliku	27	1	26	N/A	N/A	N/A
13	Obubra	23	0	23	3	1	2
14	Obudu	37	1	36	N/A	N/A	N/A
15	Odukpani	13	1	12	1	0	1
16	Ogoja	30	1	29	1	0	1
17	Yakurr	22	0	22	7	0	7
18	Yala	39	1	38	N/A	N/A	N/A
	Total	**450**	**18**	**432**	**38**	**14**	**24**

Appendix 9: Summary of Human Resource Gaps in Cross River 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	368	2
2	Nurses	354	9
3	Trained Health Workers – CHOs, CHEWs etc.	135	9
4	Record Officers	349	14
5	Lab. Scientist/ technicians	403	9
6	Pharmacist/pharmacy technicians	432	24

Appendix 10: Summary of Human Resource Gaps in 179 facilities selected for PMTCT scale up in Cross River State

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	113	0
2	Nurses	80	3
3	Trained Health Workers – CHOs, CHEWs etc.	8	1
4	Record Officers	105	6
5	Lab. Scientist/ technicians	112	3
6	Pharmacist/pharmacy technicians	137	15

Appendix 9: List of Contributors

CROSS RIVER STATE GOVERNMENT

Dr. Sonny Omini
Agnes J. Orim
Angela Bebia
Atim Bassey
Bassey Effanaga
Bassey Effiong
Bassey Etim Bassey
Camel Ngu
Catherine J. Obeteng
Chris Ita
Dorothy Ushie
Dr. Atana Ewa
Dr. Emmanuel Adams
Edward Enyia
Ekpenyong Theresa
Eld. Mrs. Nkoyo Oka
Emilia Ugbe
Franca Oba
Gloria
Grace Kekong
Helen Izato
Iquo Okpebri
John Odok
Julius Emuru
Justina Uyana
Kuwo Edet
Maria Ukpe
Mary Amah
Mary Igwu
Mary Omaji
Mercy Egbe
Monica Agbor
Mr. Egbe
Mrs. Bassey
Mrs. Ejue
Mrs. Ekpenyoung
Mrs. Emeh
Mrs. Ewa
Mrs. Mfam
Mrs. Nelly
Mrs. Philomina Omang
Mrs. Theresa Okon
Nneka Alobi
Patience Uke
Patricia Asuquo
Patricia Ikpai
Patricia Uke
Patrick Mgbe
Philomena R. Effa
Rebecca Obi
Regina Odey
Victoria Adie

TECHNICAL ASSISTANCE

Phyllis Jones-Changa
Dr Edward 'Kola Oladele
Dr Maurice Ekanem
Williams Ojo
Ajayi Olufunmilola
Chritsian Obominuru
Dr Igbasi Ngozi
Enyindah, Nwabueze D.
Dr Kwasi Torpey
Dr Mariya Saleh
Dr Henry Ayuk
Dr Frank Eyam
James Gba
James Ogbobe
Kadiku Olabisi Salimat
Mahmud Khaled
Dr Robert Chiegil
Dr Uche Ralph-Opara
Simpson Tumwikirize
Joseph Okoegwale
Nseabasi Ukoh Enyenihi
Nwajide Julie C
Oguine M.Uzoma
Okonkwo-Eze Angela U
Dr Hadiza Khamofu
Dr Seun Asala
Olufunso Adebayo
Mrs Okache Adama
Raymond Yoila Samari
Sulaiman Gbadamosi
Ugoh Emmanuel I.
Walong Garba
Kunle Lawal
Rebecca Dirks
Jill Vitick

CONSULTANTS

Dr Oluwafemi Popoola
Dr Oluwaseun Akinyemi

Glossary

Acquired Immune Deficiency Syndrome (AIDS) – This is a disease of the human immune system caused by HIV infection.

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

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

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

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

Primary Health Care (PHC) – This is defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".

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

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

Printing supported by

Strengthening Intergrated Delivery Of HIV/AIDS Services

USAID FROM THE AMERICAN PEOPLE

fhi360 THE SCIENCE OF IMPROVING LIVES

NIGERIANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

Funded by the President's Emergency Plan for AIDS Relief through U.S. Agency for International Development