



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

The Rivers 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 Rivers State Government to conduct this assessment. Financial assistance was provided by USAID under the terms of the Cooperative Agreement AID-620-A-00002, of the Strengthening Integrated Delivery of HIV/AIDS Services Project. This report does not necessarily reflect the views of FHI 360, USAID or the United States Government.

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Foreword

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.

Thank You



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
Rivers 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 Rivers 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 Rivers 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

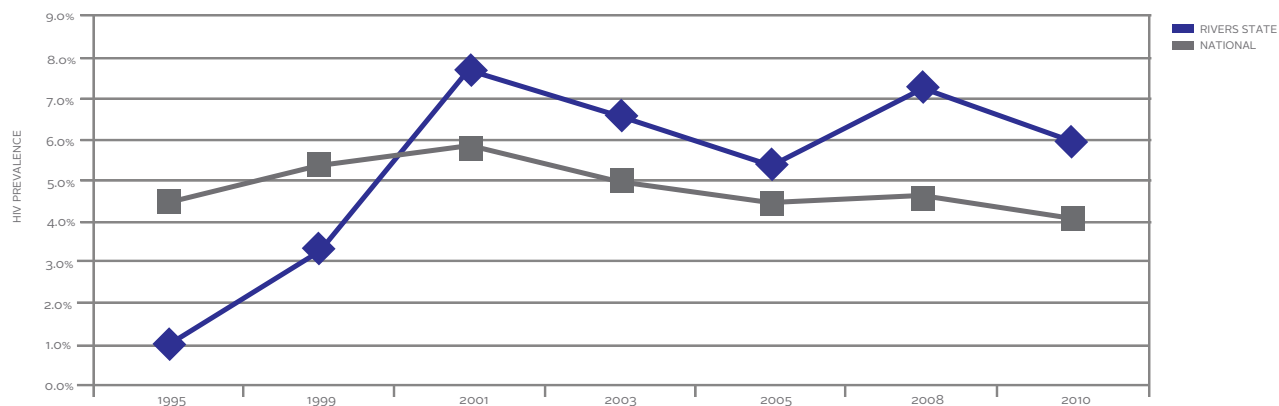
2 Rivers State HIV Profile

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 (1995-2010)



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

The law establishing the Rivers State Agency for the Control of HIV/AIDS (RIVSACA) was enacted in 2009. The agency which is supervised by the Governor's office has the function of planning and coordinating the activities of the various sectors in the HIV response. RIVSACA also facilitates the engagement of all LGAs and sectors on issues of HIV prevention, care and support, advocacy, policy and guidelines development, promotion of research and mobilization of resources (local and foreign).

The State HIV/AIDS Control Programme housed in the State Ministry of Health is responsible for the health sector response. This department implements HIV control activities in health facilities. Also, the State Council on HIV/AIDS comprises delegates from all LGAs, line ministries and other stakeholders as deemed necessary.

The present focus of programming in PMTCT in the country is to ensure that 1) at least 90% of all pregnant women have access to quality testing and counselling; 2) at least 90% of all HIV positive pregnant women have access to antiretroviral drugs; and 3) 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 (WRA), 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.

In the light of this global and national commitment toward elimination of mother-to-child transmission of HIV, we therefore set out to assess the readiness of the state to meet the elimination targets.

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

SECTION

5

Assessment Design

This cross-sectional survey utilised mixed (quantitative and qualitative) methods.

5.1 SAMPLING/SITE SELECTION

A complete list of all health facilities in the state was provided by the Department of Planning, Research and Statistics (DPRS) of the Rivers SMOH. All public and private health facilities which met defined criteria were assessed. All facilities with ANC services were included while facilities with current implementing partner (IP) support providing ARV drugs for PMTCT or with

Box 1: Site selection

Site Inclusion Criterion

- Providing ANC

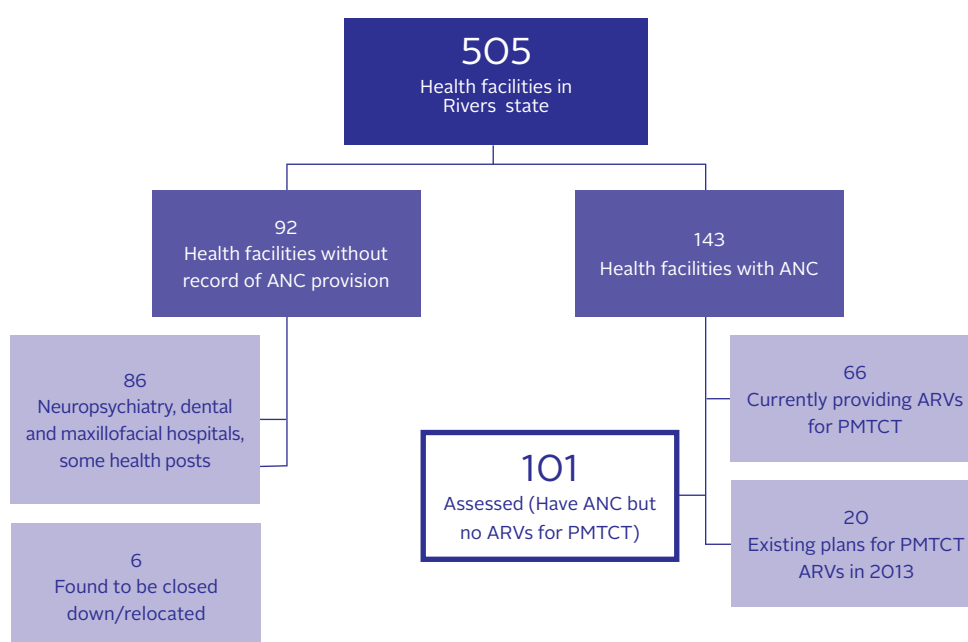
Site Exclusion Criteria

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

plans for PMTCT services in 2013 (Global Fund or PEPFAR) were excluded. A total of 327 health facilities provided ANC but had no support to

provide ARVs for PMTCT as at the time of the survey (please see Figure 2 below). These were fully assessed.

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



5.2 STUDY TOOL

The Rivers State rapid-health facility assessment (R-HFA) tool included both quantitative and qualitative elements. The quantitative aspect used a semi-structured instrument to collect information from the facility head or other officers about facility and service characteristics. The tool collected information on facility ownership and the current scope of PMTCT related services. In addition, it 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. Geospatial location of the facilities was ascertained using GPS devices.

The qualitative section was a key informant interview (KII) with the same officers 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 and funding from USAID. A planning meeting was convened by the Ministry of Health with the State Agency for the Control of HIV/AIDS (SACA), LGA health department and FHI 360 to discuss logistics and mobilize stakeholders.

A total number of 15 teams comprised of three members each were deployed between June and August 2013 to cover the entire state. GPS devices were used to obtain location coordinates for facilities. Key informant interviews were conducted with the

heads of facilities and where available, heads of laboratory and pharmacy units.

5.4 CHALLENGES

Some facilities were not visited during the initial assessment due to incomplete facility lists. Other facilities in Abual/Odual and Gokana LGAs could not be visited due to security concerns, which necessitated a supplemental assessment in August 2013.

SECTION

6 Findings

The assessment included a total of 327 facilities that provided ANC but not ARVs for PMTCT. The sections below present the findings on the characteristics and readiness of these facilities for PMTCT scale-up in Rivers State.

6.1 FACILITY OWNERSHIP AND HEALTH CARE LEVEL

Table 2 shows characteristics of assessed facilities based on ownership (public/private) and level of service delivery (primary/secondary). About one-third of facilities were privately owned while the remaining were public. There were no faith-based

facilities among those assessed. Both primary and secondary level facilities in the state were run by the state government rather than having the LGA authority being responsible for primary level as is the case in other states. About two-thirds of the facilities operated at the primary level and six of these facilities were health posts (please see appendix for details). The majority of the publicly-owned facilities were at the primary level while most of the privately-owned facilities were secondary. There were no tertiary health facilities among those assessed.

Table 2: Characteristics of facilities providing ANC with no PMTCT ARV support

OWNERSHIP	FACILITY TYPE		TOTAL
	PRIMARY LEVEL	SECONDARY LEVEL	
Private			
Private for profit	32	86	118
Public			
State government	183	20	203
Federal government	5	1	6
Overall total	220	107	327

6.2 HUMAN RESOURCES AND SERVICE UTILIZATION

Human resources and service utilization disaggregation according to facility level is presented in Table 3. Human resource capacity was measured by the average number of each cadre per facility and the proportion of facilities without any worker in the assessed cadre. Cadres assessed were doctors, nurses/midwives, trained community workers, laboratory, medical records and pharmacy staff. The data showed fewer staff and wider coverage gaps in primary compared to secondary health facilities. Almost all secondary facilities were covered by doctors (95.3%) and nurses (97.2 %), whereas only 71.6% of primary level facilities were covered by at least one doctor and 64.9% had at least one nurse. The average health worker per facility was much higher in secondary facilities for doctors, nurse/midwife, lab scientist, pharmacists/pharmacy technician

compared with primary facilities. However, the average number of community nurses, community health officers (CHOs) and community health extension workers (CHEWs) in primary facilities are about twice of what is available at the secondary facilities. Among the primary facilities, doctors and pharmacists/pharmacy technicians had the lowest average per facility whereas at the secondary level, records officers had the lowest average per facility.

Utilization statistics in Table 3 were similar between primary and secondary facilities in terms of having at least one OPD attendance, one ANC attendance and one delivery in the last 12 months. However, the frequency of utilization among the secondary facilities was more despite the fact that there were more primary level facilities. The assessment found a substantial gap between the average number of attendees for a first ANC visit compared with the average number of

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

DOMAIN	Item	220 PRIMARY FACILITIES			107 SECONDARY FACILITIES			TOTAL 327 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	1.1	28.4%	71.6%	4.4	4.7%	95.3%	2.2	20.7%	79.3%
	Registered nurse/midwife	2.1	35.1%	64.9%	8.3	2.8%	97.2%	4.1	24.6%	75.4%
	Other trained health workers (Community Nurses, CHOs, CHEWs)	6.3	9.0%	91.0%	3.5	30.8%	69.2%	5.4	16.1%	83.9%
	Record officers	1.6	19.8%	80.2%	1.9	18.7%	81.3%	1.7	19.5%	80.5%
	Laboratory technician/scientists	1.8	14.9%	85.1%	2.3	3.7%	96.3%	2.0	11.2%	88.8%
	Pharmacy technician/pharmacists	1.0	26.1%	73.9%	1.7	25.2%	74.8%	1.2	25.8%	74.2%
SERVICE UTILIZATION	OPD attendance in the last 12 months	1242.7	5.4%	94.6%	5323.1	5.6%	94.4%	2569.8	5.5%	94.5%
	ANC first attendees recorded in the last 12 months	167.0	4.1%	95.9%	280.1	6.5%	93.5%	203.8	4.9%	95.1%
	Deliveries taken in the last 12 months	39.7	17.6%	82.4%	123.6	7.5%	92.5%	67.0	14.3%	85.7%

*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	209 PUBLIC FACILITIES			118 PRIVATE FACILITIES			TOTAL 327 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	1.1	30.8%	69.2%	4.1	2.5%	97.5%	2.2	20.7%	79.3%
	Number of registered nurse/midwife	2.7	35.5%	64.5%	6.7	5.1%	94.9%	4.1	24.6%	75.4%
	Number of other trained health workers (community nurses, CHOs, CHEWs)	6.7	7.1%	92.9%	3.3	32.2%	67.8%	5.4	16.1%	83.9%
	Number of records officers	1.8	15.6%	84.4%	1.6	26.3%	73.7%	1.7	19.5%	80.5%
	Number of lab technician/scientists	1.9	12.8%	87.2%	2.1	8.5%	91.5%	2.0	11.2%	88.8%
	Number of pharmacy technician/pharmacists	1.1	22.3%	77.7%	1.5	32.2%	67.8%	1.2	25.8%	74.2%
SERVICE UTILIZATION	Number attended OPD in the last 12 months	2301.2	2.8%	97.2%	3069.5	10.2%	89.8%	2569.8	5.5%	94.5%
	ANC first attendees recorded in the last 12 months	185.0	3.3%	96.7%	239.0	7.6%	92.4%	203.8	4.9%	95.1%
	Deliveries taken in the last 12 months	40.8	18.5%	81.5%	114.1	6.8%	93.2%	67.0	14.3%	85.7%

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

deliveries at both primary and secondary facilities; this suggests a large dropout between ANC attendance and facility delivery.

Table 4 presents human resources and service utilization data disaggregated by facility ownership. The private facilities had higher averages of almost all health worker cadres except CHO and CHEW, which were higher among public facilities. Moreover, unlike public facilities, almost all private health facilities had a doctor and at least a nurse (97.5% and 94.9% respectively).

6.3 SUMMARIES OF OTHER DOMAINS

Findings related to the scope of service available in facilities, facility infrastructure, environmental enablement for maternal and child health (MCH) services and community support/participation is presented in Table 5, disaggregated by facility level. Almost all sites assessed had facilities for physical examination, laboratory services and dispensing. However, only one-third provided TB services. Similarly, about a third of assessed facilities had spaces for directly observed therapy short course (DOTS) clinic and about half had DOTS waiting area with the proportions lower among secondary facilities.

Table 5: Summary of domain responses disaggregated by facility level (1)

		FACILITY TYPE		
		Primary level n = 220	Secondary level n = 107	Total n = 327
SERVICE AVAILABILITY	Physical exam (including weight, assessing GA, blood pressure)	214 (97.3%)	107 (100.0%)	321 (98.2%)
	Laboratory services (onsite or by referral): Hb, urinalysis	198 (90.0%)	105 (98.1%)	303 (92.7%)
	Dispensing of haematinics and IPTp	214 (97.3%)	107 (100.0%)	321 (98.2%)
	Labour and delivery services (with 24 hour shifts)	190 (86.4%)	105 (98.1%)	295 (90.2%)
	Referrals for emergency obstetric and newborn care	210 (95.5%)	94 (87.9%)	304 (93.0%)
	Family planning services (condoms, hormonal contraceptives)	190 (86.4%)	82 (76.6%)	272 (83.2%)
	Immunization services	147 (90.7%)	47 (57.3%)	194 (79.5%)
	Child follow up clinics	196 (89.1%)	83 (77.6%)	279 (85.3%)
	TB services (specify which - e.g. DOTS, microscopy)	82 (37.3%)	34 (31.8%)	116 (35.5%)
	HIV testing and counselling	175 (75.9%)	86 (80.4%)	261 (79.8%)

Table 5: Summary of domain responses disaggregated by facility level (1) *(Continued)*

IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	OPD consulting room	170 (77.3%)	67 (62.6%)	237 (72.5%)
	Lab Room	152 (69.1%)	62 (57.9%)	214 (65.4%)
	Phlebotomy	142 (64.5%)	72 (67.3%)	214 (65.4%)
	ANC space	207 (94.1%)	96 (89.7%)	302 (92.4%)
	ANC room	169 (76.8%)	75 (70.1%)	244 (74.6%)
	Space that can be used for confidential counselling	172 (78.2%)	85 (80.3%)	258 (78.9%)
	Maternity delivery room	214 (97.3%)	102 (95.3%)	316 (96.6%)
	Pharmacy store	181 (82.3%)	86 (80.3%)	267 (81.7%)
	Pharmacy dispensary	183 (83.2%)	84 (78.5%)	267 (81.7%)
	Space for adherence counselling	133 (60.5%)	61 (57.0%)	194 (59.3%)
	DOTS clinic	74 (33.6%)	41 (38.3%)	115 (35.2%)
	DOTS waiting area	94 (42.7%)	58 (54.2%)	152 (46.5%)
	Medical records/M&E	163 (74.1%)	75 (70.1%)	238 (72.8%)

Enabling environment for MCH considers if facilities have support to provide maternal health services, conduct outreach or subsidise ANC (Table 6). The assessment found that the enabling environment was similar between primary and secondary level facilities. The majority of respondents reported other preferred birth options in the community

outside health facilities. This supports the earlier finding of low delivery numbers compared to ANC attendance. The most popular birthing places – other than health facilities - included churches (83.5%), TBAs (51.7%) and maternity homes (24.5%).

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

		FACILITY TYPE		Total n = 327
		Primary level n = 220	Secondary level n = 107	
ENABLING ENVIRONMENT	MDG Support for MCH services	27 (12.3%)	2 (1.9%)	29 (8.9%)
	Free ANC services	118 (53.6%)	16 (15.0%)	129 (39.4%)
	Regular monthly community outreach	159 (72.3%)	16 (15.0%)	175 (53.5%)
	Midwives Service Scheme (MSS) midwives	21 (9.6%)	8 (7.5%)	29 (8.9%)
	SURE-P midwives	14 (6.4%)	5 (4.7%)	19 (5.8%)
COMMUNITY BIRTHING PLACES	Places other than health facilities where women deliver in this community	202 (91.8%)	77 (72.0%)	279 (85.3%)
	Other Places – churches	198 (90.0%)	75 (70.1%)	273 (83.5%)
	Other Places – mosque	10 (4.5%)	3 (2.8%)	13 (4.0%)
	Other Places – TBA	127 (57.7%)	42 (39.3%)	169 (51.7%)
	Other Places – maternity home of trained midwife	52 (23.6%)	28 (26.2%)	80 (24.5%)
	Others	8 (3.6%)	4 (3.7%)	12 (3.7%)
COMMUNITY SYSTEMS (ARE THE FOLLOWING AVAILABLE?)	Ward development committee	75 (34.1%)	13 (12.1%)	88 (26.9%)
	Village development committee	14 (6.4%)	7 (6.5%)	21 (6.4%)
	Community development association	112 (50.9%)	14 (13.1%)	126 (38.5%)
	Community-based organization	112 (50.9%)	12 (11.2%)	124 (37.9%)
	Community support group for people living with HIV (PLHIV)	107 (48.6%)	17 (15.9%)	124 (37.9%)

Table 7 has domain responses disaggregated by facility ownership. The patterns for availability of various service components were similar to those shown previously in Tables 5 and 6. Findings in public facilities mirrored those of primary health centres (for which these form a

majority) and similarly private sites were similar to those of secondary level facilities. TB services, immunization and HTC services were available in the fewest facilities.

Table 7: Summary of domain responses disaggregated by facility ownership

		FACILITY OWNERSHIP		
		Public n = 209	Private n = 118	Total n = 327
SERVICE AVAILABILITY	Physical exam (including weight, assessing GA, blood pressure)	203 (97.1%)	118 (100%)	321 (98.2%)
	Laboratory services (onsite or by referral): Hb, urinalysis	190 (90.9%)	113 (95.8%)	303 (92.7%)
	Dispensing of haematinics and IPTp	204 (97.6%)	117 (99.2%)	321 (98.2%)
	Labor and delivery services (with 24 hour shifts)	178 (85.2%)	117 (99.2%)	295 (90.2%)
	Referrals for emergency obstetric and newborn care	197 (94.3%)	107 (90.7%)	304 (93.0%)
	Family planning services (condoms, hormonal contraceptives)	182 (87.1%)	90 (76.3%)	272 (83.2%)
	Immunization services	200 (95.7%)	65 (55.1%)	265 (81.0%)
	Child follow up clinics	186 (89.0%)	93 (78.8%)	279 (85.3%)
	TB services (p e.g. DOTS, microscopy)	77 (36.8%)	39 (33.1%)	116 (35.5%)
	HTC	166 (79.4%)	95 (80.5%)	261 (79.8%)
IDENTIFIED STRUCTURE (CAN SPACE BE IDENTIFIED FOR THE FOLLOWING?)	OPD consulting room	197 (94.3%)	118 (100.0%)	315 (96.3%)
	Lab room	176 (84.2%)	108 (91.5%)	284 (86.9%)
	Phlebotomy	112 (53.6%)	81 (68.6%)	193 (59.0%)
	ANC space	199 (95.2%)	111 (94.1%)	310 (94.8%)
	ANC room	174 (83.3%)	104 (88.1%)	278 (85.0%)
	Space that can be used for confidential counseling	161 (77.0%)	90 (76.3%)	251 (76.8%)
	Maternity delivery room	199 (95.2%)	117 (99.2%)	316 (96.6%)
	Pharmacy store	164 (78.5%)	100 (84.7%)	264 (80.7%)
	Pharmacy dispensary	171 (81.8%)	108 (91.5%)	279 (85.3%)
	Space for HTC/adherence counseling	153 (73.2%)	85 (72.0%)	238 (72.8%)
	DOTS clinic	81 (38.8%)	20 (16.9%)	101 (30.9%)
	DOTS waiting area	76 (36.4%)	20 (16.9%)	96 (29.4%)
	Medical records/M&E	168 (80.4%)	100 (84.7%)	268 (82.0%)

Table 8 shows the enabling environment for facilities included in the assessment. Less than 10% of the facilities had Millennium Development

Goal (MDG) support for MCH services and SURE-P midwives. Similarly, very few facilities reported having functional community systems.

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

		FACILITY OWNERSHIP		
		Public n = 209	Private n = 118	Total n = 327
ENABLING ENVIRONMENT	MDG Support for MCH services	125 (59.8%)	2 (1.7)	29 (8.9%)
	Free ANC Services	164 (78.5%)	4 (3.4%)	129 (39.4%)
	Regular Monthly Community Outreaches	18 (8.6%)	11 (9.3%)	175 (53.5%)
	MSS midwives	9 (4.3%)	11 (9.3%)	29 (8.9%)
	SURE-P midwives	23 (27.4%)	10 (8.5%)	19 (5.8%)
COMMUNITY BIRTHING PLACES	Places other than health facilities where women deliver in this community	192 (91.9%)	87 (73.7%)	279 (85.3%)
	Other Places - churches	119 (56.9%)	50 (42.4%)	169 (51.7%)
	Other Places - mosque	7 (3.3%)	5 (4.2%)	12 (3.7%)
	Other Places - TBA	190 (90.9%)	83 (70.3%)	273 (83.5%)
	Other Places – maternity home of trained midwife	44 (21.1%)	36 (30.5%)	80 (24.5%)
COMMUNITY SYSTEMS	Ward development committee	79 (37.8%)	9 (7.6%)	88 (26.9%)
	Village development committee	15 (7.2%)	6 (5.1%)	21 (6.4%)
	Community development association	114 (54.5%)	10 (8.5%)	124 (37.9%)
	Community-based organization	85 (54.1%)	6 (5.1%)	91 (37.1%)
	Community support group for PLHIV	110 (52.6%)	14 (11.9%)	124 (37.9%)

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 Community preference for delivery outside health facilities

In the KIs conducted with health workers in Rivers State, respondents believed that many women

prefer the services of TBAs, private clinics and churches to deliver their babies even though they usually attend ANC at a health facility. Reasons for this practice included a firm traditional belief in the abilities of the TBA, perceived high cost of services at health facilities, security concerns, poor comprehension of health information due to low literacy levels and superstitious beliefs surrounding hospital based deliveries. Table 9 below captures these themes as well as some verbatim quotes from respondents supporting these themes.

Table 9: Some women prefer to patronize traditional birth attendants (TBAs), private clinics and churches

THEMES	QUOTES
Some women prefer to patronize traditional birth attendants (TBAs), private clinics and churches	<p>“We don’t know (why women prefer the TBAs), we have done awareness, town crier but to no avail; when it is time to deliver, they go outside (to the TBAs).”</p> <p>“They are told in churches [that] there are ghosts in their houses [so] for six months they stay in churches.”</p> <p>“They go where they feel comfortable with.”</p>
Why women prefer to deliver with TBAs	<p>“They believe that churches and TBAs are the best.”</p> <p>“...Due to the cost; they feel the TBAs’ cost are cheaper.”</p> <p>“Because they are very educated...”</p> <p>“[Because of] poverty, cultural belief, they don’t want to go through surgery.”</p>
Reasons for poor patronage of the health facilities	<p>“Due to the cultural beliefs, people go to the TBAs and churches.”</p> <p>“The people that are not aware of the benefits of hospital based deliveries do not patronize the hospital.”</p> <p>“The location, [the facility] is not centrally located [with] bad roads.”</p> <p>“[There are] bad boys around including thieves, no electricity supply most times so patients don’t like to deliver in the facility.”</p> <p>“Self-medication by the community people.”</p>

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

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

building for staff as well as provision of better structures and social amenities will go a long way to improve service quality in the state (please see Table 10).

Table 10: Reasons why some health facilities are well patronized

THEMES	QUOTES
Reasons for good patronage of health facility	<p>"...The free medical service and the good staff at the facility."</p> <p>"Mainly because the PHC offer free services."</p>
Role of village/ward development committee	<p>"They [the VDC] provide security in the night and come around. The village development committee help to create awareness about the services available in the facility."</p> <p>"They help people with financial difficulty to obtain free medical service by giving recommendation letter..."</p> <p>"They help with disciplinary actions of the community ...and also with providing accommodation for some health workers like youth corps members."</p> <p>"They support to provide electricity to the facility."</p>

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

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

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

Table 11: Respondents' suggestions on improving service quality

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

6.5 SCENARIOS FOR ELIGIBILITY FOR PMTCT SERVICES

The number of facilities that meet the different HR cut-offs by type of ownership is presented in Table 12. Percentages are derived based on the total number of facilities assessed. About 80% of all assessed facilities were covered by at least one

part-time of full-time doctor – 44.6% and 35.2% in the public and private sectors respectively. Apart from the availability of nurses/midwives, more public facilities met the cut-off criteria compared to private facilities. The criterion that gives the highest number of facilities is the “clinical care staff (nurses or community health workers)”.

Table 12: Scenarios for scale-up using different cut-offs

CRITERIA	CUT-OFF	OWNERSHIP	NUMBER OF FACILITIES MEETING CRITERIA	% OF TOTAL (N=327) FACILITIES
Have ANC but no IP		Public	209	63.9
		Private	118	36.1
Facility covered by doctors	At least 1	Public	146	44.6
		Private	115	35.2
Availability of nurses/midwives	At least 4	Public	49	15.0
		Private	68	20.8
Community health workers	At least 4	Public	148	45.3
		Private	47	14.4
Clinical care staff (nurses or community workers)	At least 4	Public	179	54.7
		Private	97	29.7
ANC attendance in the last 12 months	Equal or above state mean (203.8)	Public	59	18.0
		Private	34	10.4
Deliveries in the last 12 months	At least 1	Public	172	52.6
		Private	110	33.6
Minimum HR complement 1	At least 4 clinical care staff, 1 pharmacy, 1 lab, 1 records officer	Public	123	37.6
		Private	61	18.7
Minimum HR complement 2	At least 1 doctor, 4 clinical care, 1 pharmacy, 1 lab, 1 records officer	Public	98	30.0
		Private	61	18.7
Minimum HR complement 3 (National standard for PMTCT service)	1 doctor, 1 nurse, 2 other health workers, 1 pharmacy, 1 lab, 1 records officer	Public	80	24.5
		Private	39	11.9
Composite criterion	At least 4 clinical care staff, 1 pharmacy, 1 lab, 1 records, above average ANC attendance, at least 1 delivery	Public	43	13.1
			19	5.8

SECTION

7 Geospatial representation of facilities

The maps below show the location of sites that provided PMTCT services at the time of the assessment, 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 existing PMTCT services as at period of assessment

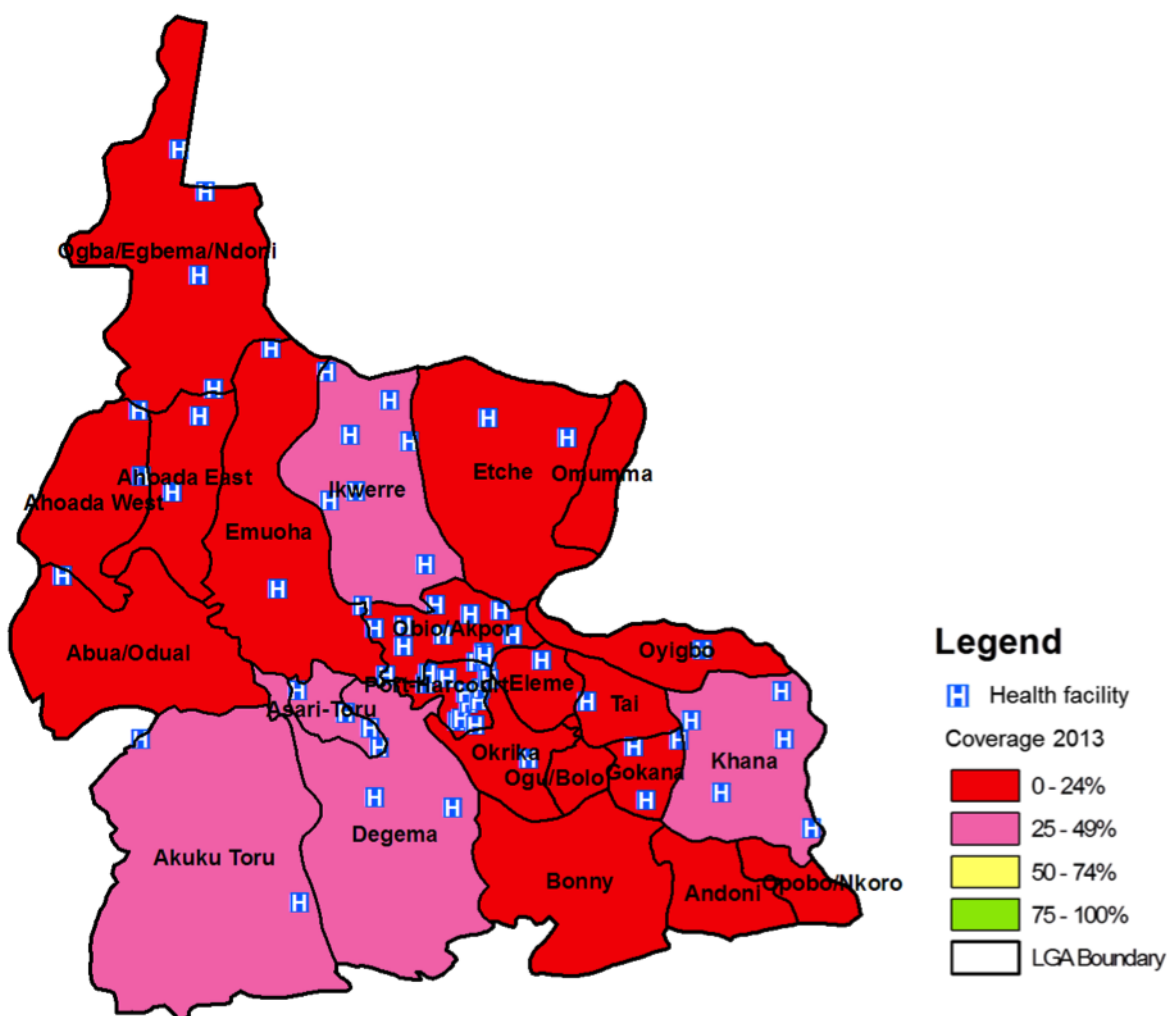


Figure 4: Map showing spread of assessed facilities (with ANC but no PMTCT)

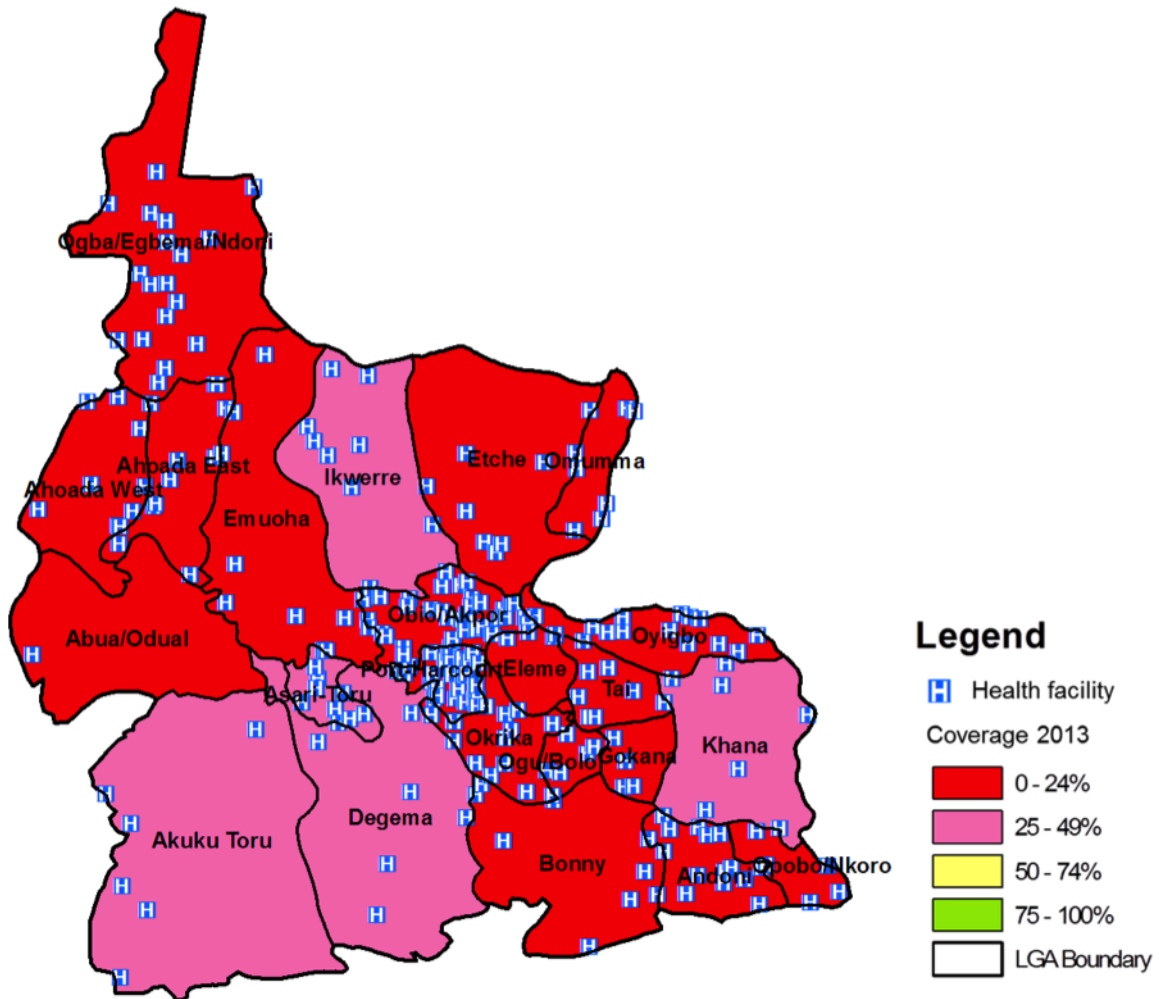


Figure 5: Map showing spread of facilities meeting national HR criteria for PMTCT services

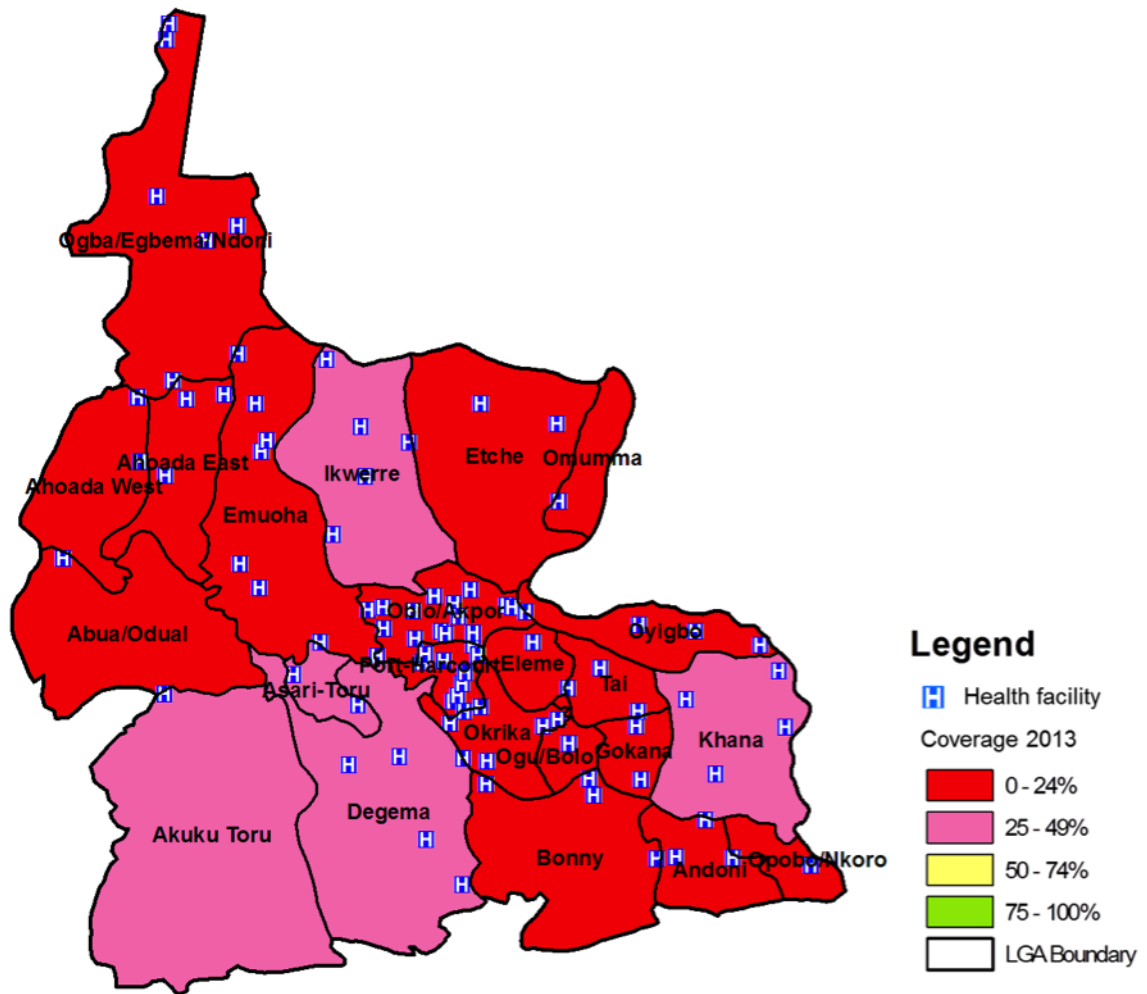


Figure 6: Map showing facilities meeting state-defined HR criteria for PMTCT services

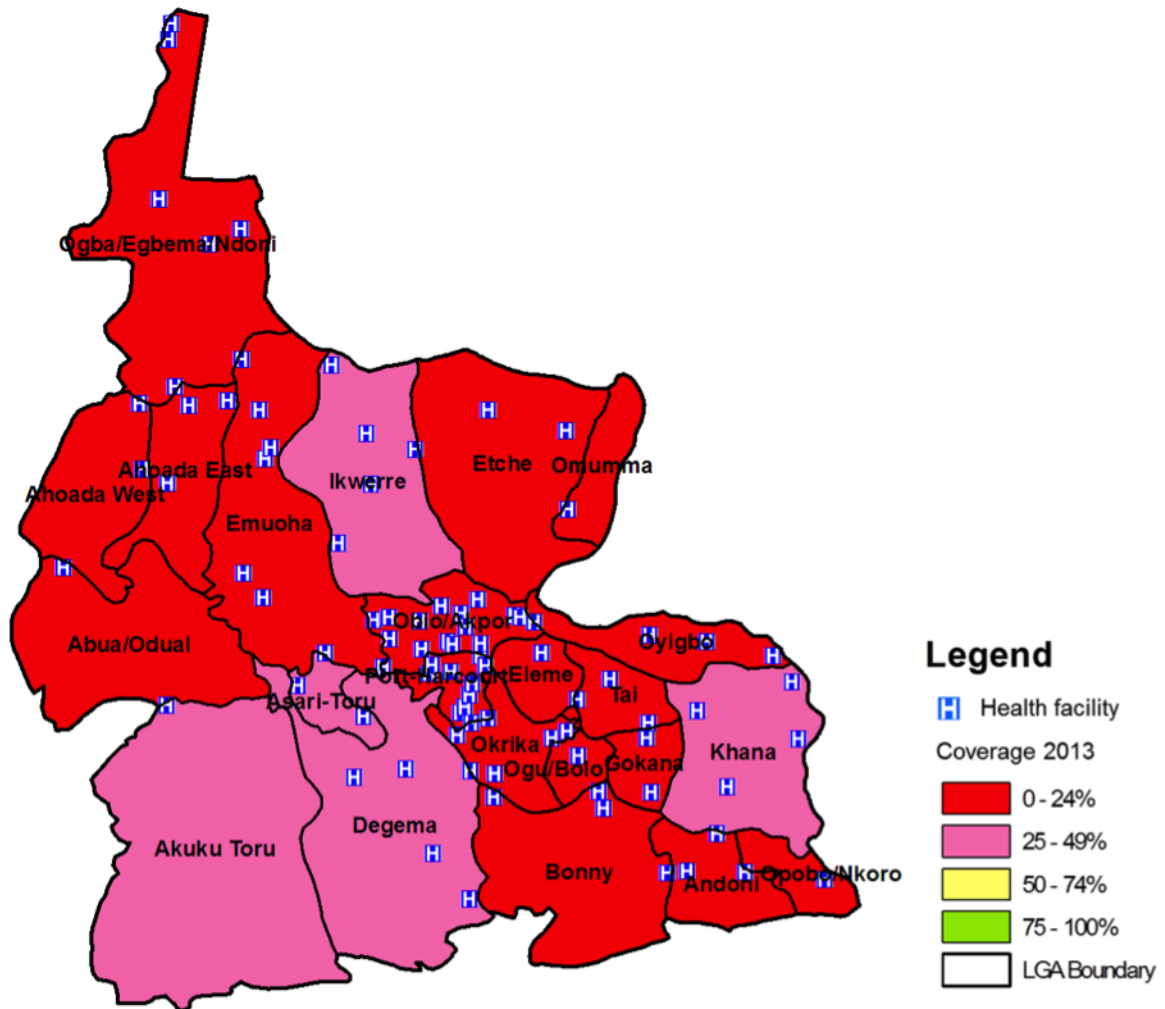


Figure 7: Map showing 2014 coverage scenario (current PMTCT sites + those meeting national HR criteria)

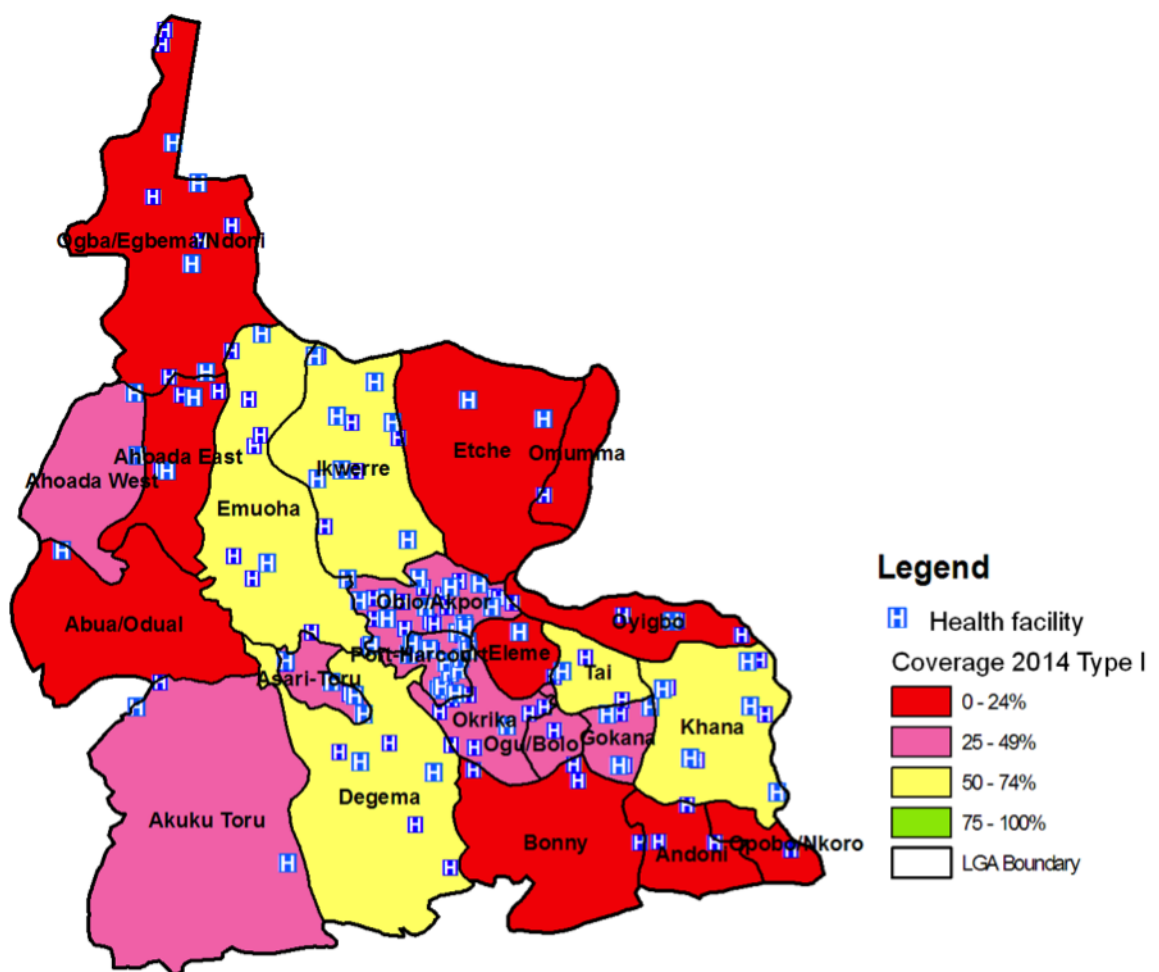


Figure 8: Map showing 2014 coverage scenario (current PMTCT sites + sites meeting state-defined HR criteria)

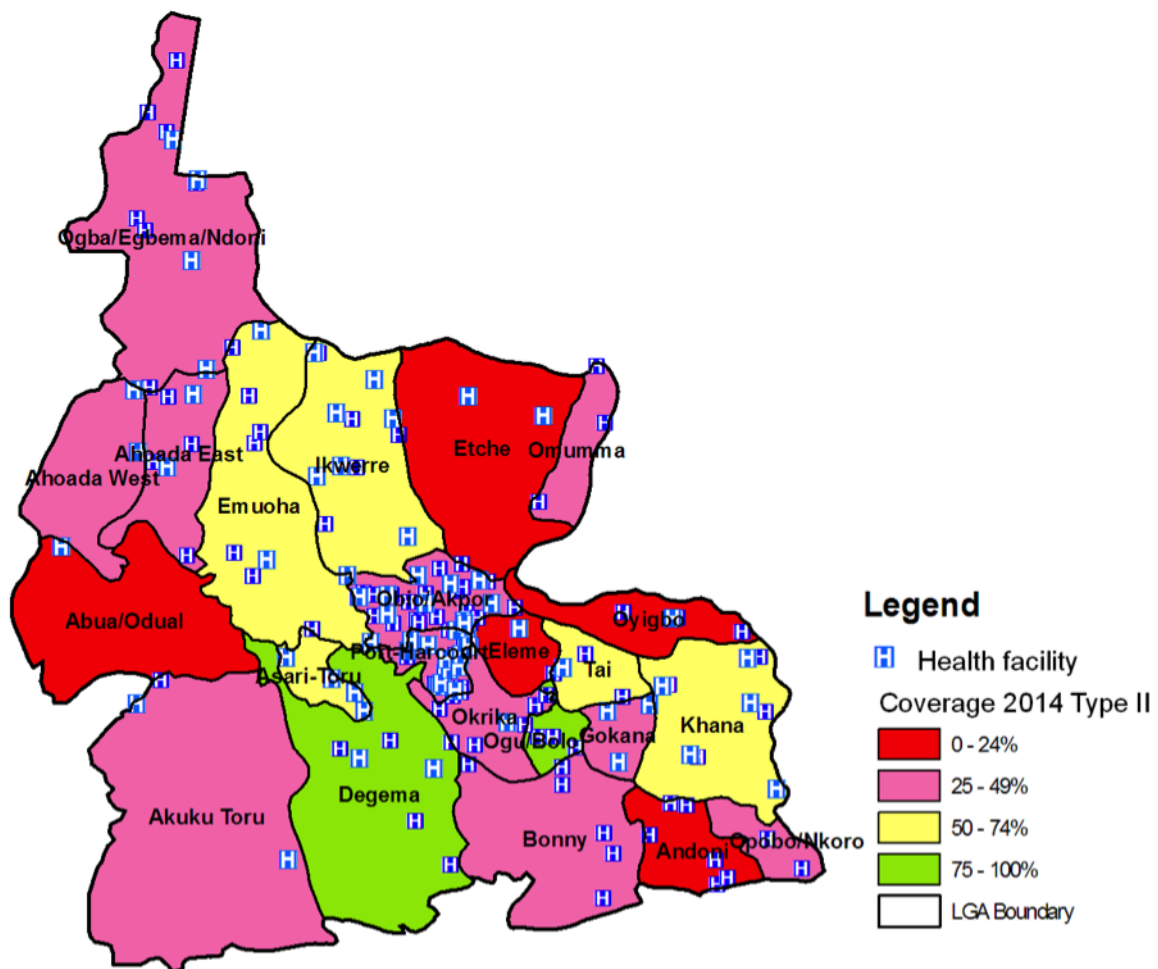
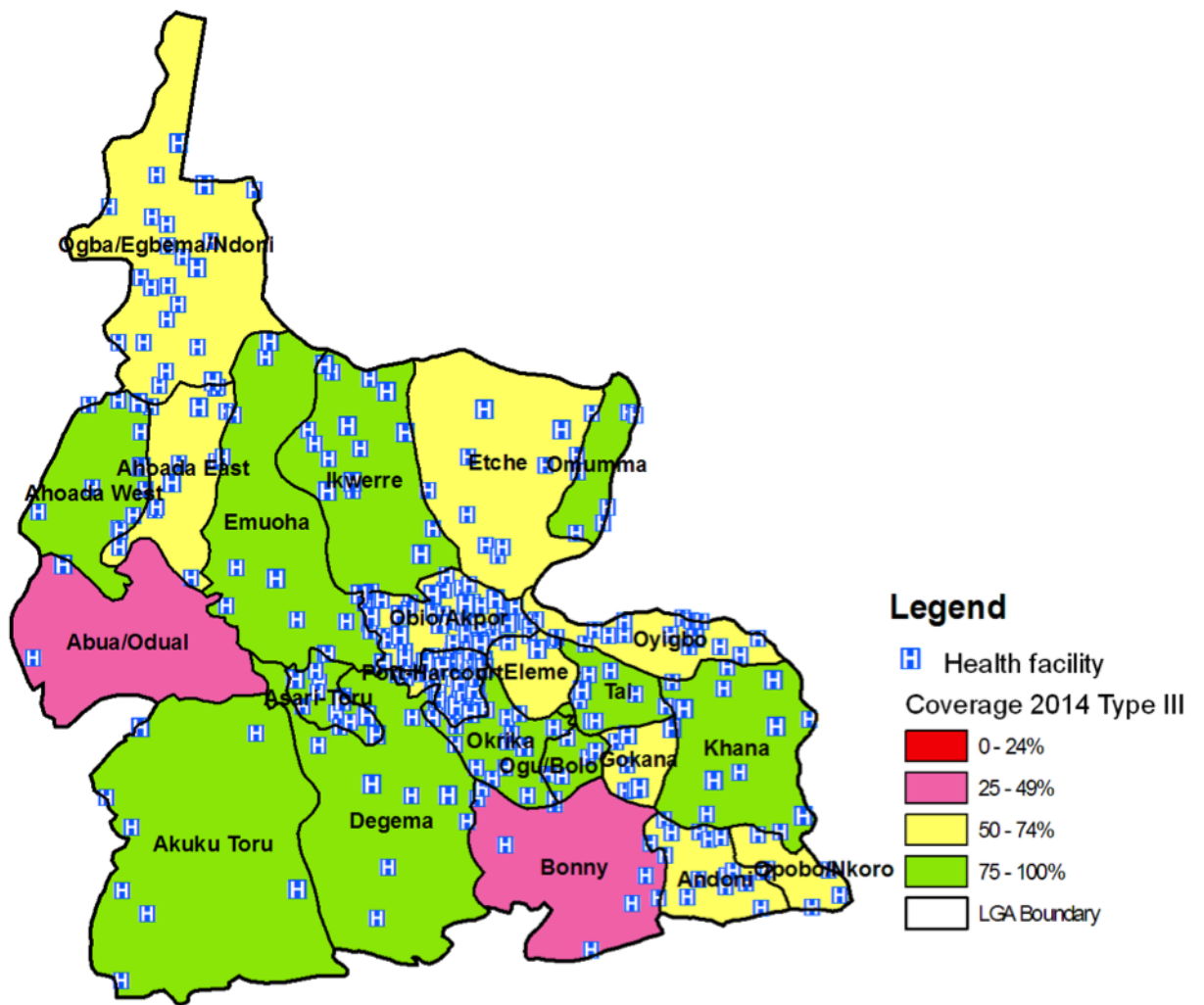


Figure 9: Map showing 2014 coverage scenario (current PMTCT sites + sites earmarked for initial phase of eMTCT scale-up)



SECTION

8

Conclusion

Overall, Rivers State demonstrated a relatively strong capacity to sustain scaling up of PMTCT services. Of the 327 facilities assessed, 157 (48%) met the national minimum human resource standard for PMTCT service delivery. The relatively strong findings related to human resource and infrastructure present a favorable platform for the planned scale-up towards eMTCT in the state. However, poor utilization of health

facilities for delivery and the high patronage of TBAs will require targeted interventions during scale up.

SECTION

9

Recommendations

The gap in human resource and infrastructure between the facilities meeting the national minimum criteria and those which did not should be closed in order to ensure that all facilities with ANC are able to provide PMTCT services. Demand creation for facility delivery needs to feature prominently in the design of interventions for eMTCT. Implementing partners and other stakeholders need to work with the state government to improve coverage of PMTCT services in Rivers State.

There is also the need to improve the community involvement and ownership by establishing and strengthening existing ward and village development committees as well as community-based organizations. These community based interventions once linked to facility based interventions will ensure availability of comprehensive care and support services for all clients.

Appendix

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

DOMAIN	ITEM	220 PRIMARY FACILITIES					107 SECONDARY FACILITIES				
		Median	Mean	Min	Max	Total	Median	Mean	Min	Max.	Total
HUMAN RESOURCES	Number of doctors	1	1.2	0	13	254	3	4.4	0	24	474
	Number of registered nurse/ midwife	1	2.2	0	45	475	6	8.3	0	56	887
	Number of other trained health workers (community nurses, CHOs, CHEWs)	5.5	6.4	0	30	1404	2	3.5	0	27	379
	Number of records officers	1	1.6	0	22	354	1	1.9	0	8	200
	Number of lab technician/ scientists	1	1.8	0	10	404	2	2.3	0	7	248
	Number of pharmacy technician/ pharmacists	1	1.0	0	9	223	1	1.7	0	9	186
SERVICE UTILIZATION	Number attended OPD in the last 12 months	522	1254.0	0	21393	275872	1520	5323.1	0	124588	569574
	ANC first attendees recorded in the last 12 months	94	168.6	0	2881	37081	127	280.1	0	3589	29975
	Deliveries recorded in the last 12 months	21	40.0	0	319	8805	55	123.6	0	873	13221

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

DOMAIN	ITEM	209 PUBLIC					118 PRIVATE				
		Median	Mean	Min	Max	Total	Median	Mean	Min	Max.	Total
HUMAN RESOURCES	Number of doctors	1	1.1	0	20	237	3	4.2	0	24	491
	Number of registered nurse/midwife	1	2.7	0	42	570	4	6.7	0	56	792
	Number of other trained health workers (community nurses, CHOs, CHEWs)	6	6.7	0	30	1399	2	3.3	0	20	384
	Number of records officers	1	1.8	0	22	367	1	1.6	0	8	187
	Number of lab technician/scientists	2	1.9	0	9	399	2	2.1	0	10	253
	Number of pharmacy technician/pharmacists	1	1.1	0	9	230	1	1.5	0	9	179
SERVICE UTILIZATION	Number attended OPD in the last 12 months	600	2312.2	0	124588	483243	1000	3069.5	0	41175	362203
	ANC first attendees recorded in the last 12 months	92	185.9	0	2881	38856	120	239.0	0	3589	28200
	Deliveries taken in the last 12 months	20	41.0	0	435	8563	57.5	114.1	0	873	13463

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

S/N	LGAS	PUBLIC (N=209)		PRIVATE (N=118)	
		Facilities with at least one doctor	Number of doctors needed to meet national standard	Facilities with at least one doctor	Number of doctors needed to meet national standard
1	Abual/Odual	3	1	N/A	N/A
2	Ahoada East	5	7	3	0
3	Ahoada West	5	3	2	0
4	Akuku Toru	1	5	N/A	N/A
5	Andoni	9	10	N/A	N/A
6	Asari-Toru	6	4	0	1
7	Bonny	2	1	5	0
8	Degema	4	2	N/A	N/A
9	Eleme	7	0	1	0
10	Emuoha	9	1	1	0
11	Etche	5	6	N/A	N/A
12	Gokana	8	1	1	0
13	Ikwerre	8	1	N/A	N/A
14	Khana	4	4	2	0
15	Obio/Akpor	14	0	51	0
16	Ogba-Egbema-Ndoni	7	8	6	0
17	Ogu/Bolo	3	2	N/A	N/A
18	Okrika	10	2	2	0
19	Omuma	4	2	N/A	N/A
20	Opobo/Nkoro	5	2	N/A	N/A
21	Oyigbo	6	0	9	1
22	Port Harcourt	15	0	32	1
23	Tai	6	1	N/A	N/A
Total		146	63	115	3

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

S/N	LGAS	PUBLIC (N=209)		PRIVATE (N=118)	
		Facilities with at least one doctor	Number of doctors needed to meet national standard	Facilities with at least one doctor	Number of doctors needed to meet national standard
1	Abual/Odual	3	1	N/A	N/A
2	Ahoada East	4	8	3	0
3	Ahoada West	5	3	2	0
4	Akuku Toru	3	3	N/A	N/A
5	Andoni	6	13	N/A	N/A
6	Asari-Toru	4	6	1	0
7	Bonny	1	2	5	0
8	Degema	6	0	N/A	N/A
9	Eleme	5	2	0	1
10	Emuoha	9	1	0	1
11	Etche	7	4	N/A	N/A
12	Gokana	7	2	N/A	N/A
13	Ikwerre	7	2	N/A	N/A
14	Khana	6	2	1	0
15	Obio/Akpor	13	1	33	1
16	Ogba-Egbema-Ndoni	8	7	4	1
17	Ogu/Bolo	2	3	N/A	N/A
18	Okrika	8	4	1	1
19	Omuma	2	4	N/A	N/A
20	Opobo/Nkoro	4	3	N/A	N/A
21	Oyigbo	5	1	8	1
22	Port Harcourt	15	0	28	0
23	Tai	6	1	N/A	N/A
Total		136	73	112	6

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

S/N	LGAS	PUBLIC (N=209)		PRIVATE (N=118)	
		Facilities with at least one doctor	Number of doctors needed to meet national standard	Facilities with at least one doctor	Number of doctors needed to meet national standard
1	Abual/Odual	3	2	N/A	N/A
2	Ahoada East	10	4	2	2
3	Ahoada West	7	2	0	4
4	Akuku Toru	6	0	N/A	N/A
5	Andoni	16	6	N/A	N/A
6	Asari-Toru	8	4	0	2
7	Bonny	3	0	3	4
8	Degema	5	2	N/A	N/A
9	Eleme	7	0	0	2
10	Emuoha	9	2	1	0
11	Etche	10	2	N/A	N/A
12	Gokana	8	2	N/A	N/A
13	Ikwerre	9	0	N/A	N/A
14	Khana	7	2	2	0
15	Obio/Akpor	10	8	29	44
16	Ogba-Egbema-Ndoni	13	4	5	2
17	Ogu/Bolo	4	2	N/A	N/A
18	Okrika	11	2	0	4
19	Omuma	6	0	N/A	N/A
20	Opobo/Nkoro	5	4	N/A	N/A
21	Oyigbo	6	0	7	6
22	Port Harcourt	13	4	18	30
23	Tai	5	4	N/A	N/A
Total		181	56	68	100

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

S/N	LGAS	PUBLIC (N=210)		PRIVATE (N=118)	
		Facilities with at least one doctor	Number of doctors needed to meet national standard	Facilities with at least one doctor	Number of doctors needed to meet national standard
1	3	4	0	N/A	N/A
2	11	8	4	3	0
3	7	4	4	1	1
4	6	6	0	N/A	N/A
5	17	11	8	N/A	N/A
6	10	10	0	0	1
7	3	3	0	5	0
8	6	6	0	N/A	N/A
9	5	5	2	0	1
10	10	9	1	0	1
11	4	10	1	N/A	N/A
12	9	8	1	1	0
13	8	8	1	N/A	N/A
14	7	5	3	1	1
15	14	13	1	38	13
16	15	10	5	4	2
17	4	4	1	N/A	N/A
18	11	8	4	1	1
19	6	5	1	N/A	N/A
20	5	2	5	N/A	N/A
21	6	5	1	5	5
22	13	14	1	21	12
23	4	6	1	N/A	N/A
Total		164	45	80	38

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

S/N	LGAS	PUBLIC (N=210)		PRIVATE (N=118)	
		Facilities with at least one doctor	Number of doctors needed to meet national standard	Facilities with at least one doctor	Number of doctors needed to meet national standard
1	3	4	1	N/A	N/A
2	11	8	1	3	0
3	7	4	1	2	0
4	6	6	0	N/A	N/A
5	17	11	2	N/A	N/A
6	10	10	0	0	1
7	3	3	0	5	0
8	6	6	0	N/A	N/A
9	5	5	2	1	0
10	10	9	0	0	1
11	4	10	7	N/A	N/A
12	9	8	0	1	0
13	8	8	1	N/A	N/A
14	7	5	1	2	0
15	14	13	0	51	0
16	15	10	0	6	0
17	4	4	1	N/A	N/A
18	11	8	1	1	1
19	6	5	0	N/A	N/A
20	5	2	2	N/A	N/A
21	6	5	0	7	3
22	13	14	2	29	4
23	4	6	3	N/A	N/A
Total		184	25	108	10

Appendix 8: 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	63	3
2	Nurses	73	6
3	Trained health workers – CHOs, CHEWs etc.	56	100
4	Pharmacist/pharmacy technicians	45	38
5	Lab scientist/ technicians	25	10
6	Records officer	31	31

Appendix 9: List of Contributors

RIVERS STATE GOVERNMENT

Dr Golden Ow'honda	Ikurayeke Janny	Dr Sibor Leeleebari
Nathaniel Okonta	Yoko Ikekita K.	Igbanibo Doris
Fyneface I. David	Aliawite M. Golden	Vivian O. Martyns
Speiribo Charles	Essein B. Sylvester	Romeo Ine Rose
Nyeche Isabella	Augusta Pepple	Okereuku C. Henry
Kashirim Linus	Tamuno O. D. Walson	Jack T. Karibi
Abolo Sandra	Igoni S. Keupheh	Eddy E. Eidenehi
Jack T. Karibi	Helen W. Elechi	

TECHNICAL ASSISTANCE

Phyllis Jones-Changa	Irene Osaigbovo	Mahmud Khaled
Dr Kwasi Torpey	Enyindah, Nwabueze D.	Oguine M.Uzoma
Dr Hadiza Khamofu	Kadiku O. Salimat	Henry A Daniel
Dr Maurice Ekanem	Nwajide Julie C	Dr Edward 'Kola Oladele
Bright Anoemuah	Walong Garba	Dr Seun Asala
Dr Ig'basi Ngozi	Dr Robert Chiegil	Olufunso Adebayo
James Ogbobe	Dr Uche Ralph-Opara	Okache Adama
Nseabasi U. Enyenihi	Simpson Tumwikirize	Christsian Obominuru
Ugoh Emmanuel I.	Joseph Okoegwale	Okonkwo Eze Angela
Dr Ojo John Olujide	Ajayi Olufunmilola	Raymond Yoila Samari
Adelaja Olatunbosun	James Gba	Sulaiman Gbadamosi
Dr Mariya Saleh	Kunle Lawal	Ezenwaankwo Stanley
Williams Ojo	Rebecca Dirks	
Elizabeth Akor	Jill Vitick	

CONSULTANTS

Dr Oluwafemi Popoola
Dr Oluwaseun Akinyemi

Glossary

Acquired Immune Deficiency Syndrome (AIDS)

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

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

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

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

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

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

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

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

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

Printing supported by

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