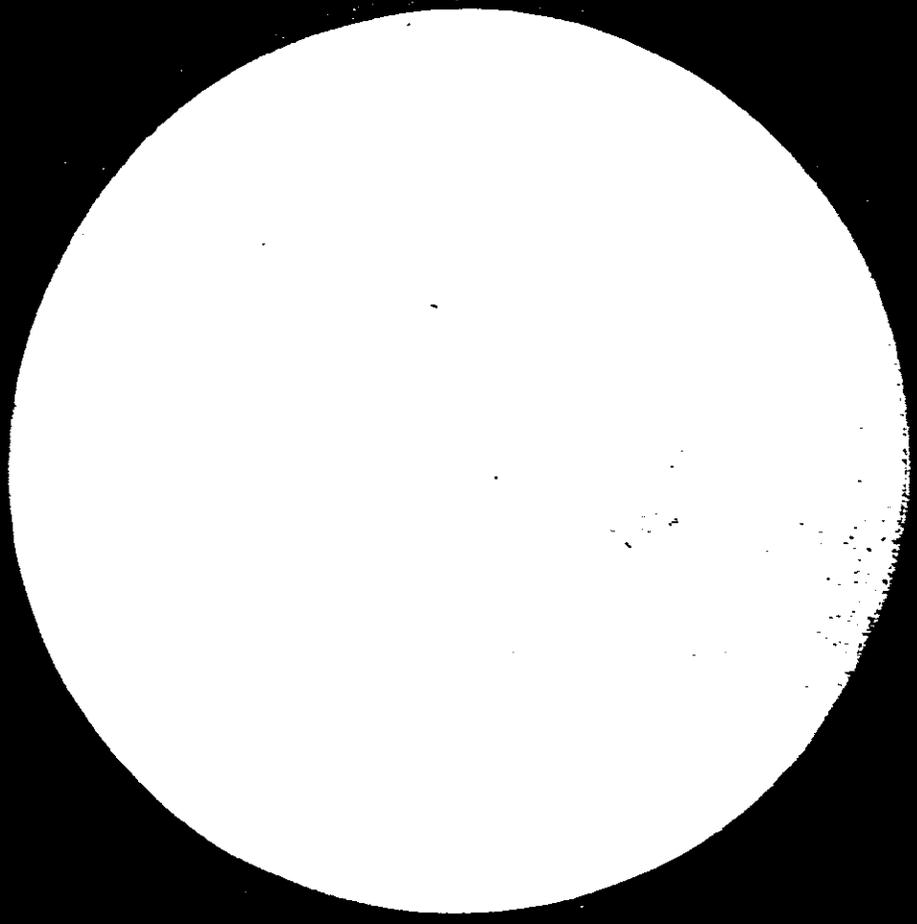


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FAMILY HEALTH INTERNATIONAL
NIGERIA



Family Health International (FHI) and the USAID IMPACT Project in partnership with the Institute of Tropical Medicine, Management Sciences for Health, Population Services International, Program for Appropriate Technology in Health and the University of North Carolina at Chapel Hill

**REPORT OF RAPID ASSESSMENT
IN
SELECTED LGAs
IN
TARABA STATE,
NIGERIA.
DECEMBER 2000.**

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Acronyms

AIDSCAP	AIDS Control & Prevention Project
AIDSTECH	AIDS Technology Project
CBO	Community based Organization
CCH	Chief Community Health
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CNO	Chief Nursing Officer
DFID	Department for International Development
DOTS	Direct Observation Therapy Shortcourse
FCS	Federal Christian Students
FSW	Female Sex Worker
FHI	Family Health International
HBC	Home Based Care
IDC	Infectious Disease Control
IIRO	International Islamic Religious Organization
IMPACT	Implementing AIDS Prevention & Care Project
JAYDA	Jalingo Youth Development Association
JUTH	Jos University Teaching Hospital
LGA	Local Government Authority
MTCT	Mother-to-child transmission
MWASD	Ministry of Women Affairs and Social Development
NACA	National Action Committee on AIDS
NASCP	National AIDS and STD Control Program
NCWS	National Council of Women Societies
NGO	Non governmental organization
NISER	Nigerian Institute of Social and Economic Research
NLC	Nigeria Labour Congress
NMA	Nigerian Medical Association
NPI	National Program on Immunization
NURTW	National Union of Road Transport Workers
OVC	Orphan and Vulnerable Children
PE	Primary Education
PMO	Principal Medical Officer
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
PS	Permanent Secretary
PTF	Presidential Trust Fund
SAPC	State AIDS Program Coordinator
SCHEW	Senior Community Health Extension Worker
STD	Sexually transmitted diseases
STI	Sexually transmitted Infections
TB	Tuberculosis
UBE	Universal Basic Education
UMTH	University of Maiduguri Teaching Hospital
UNDP	United Nations Development Program

Summary

Family Health International (FHI), Nigeria, conducted a rapid assessment in Taraba State as part of the process of redesigning its ongoing IMPACT (Implementing AIDS Prevention and Care) project being funded by the United States Agency for International Development (USAID). The overall goal of the redesign is the development of comprehensive programs in key priority communities for both prevention and care. This will entail working with pilot Local Government Authorities (LGAs) to develop strategic plans of action to work with high risk and vulnerable populations through local organizations and structures.

The assessment was conducted by a six person team in four local governments of Jalingo, Gassol, Lau and Zing in Taraba state and Kaltungo LGA in neighboring Gombe state from December 8 – 12, 2000. The objectives of the assessment were to identify risk groups, risk settings and behaviors, health and social welfare systems and structures. It was also to identify potential partners and assess the political environment for HIV/AIDS/STI programming.

The team interviewed key informants from the state public service and the local government authorities. Key State government officials from the Ministries of Health, Education, Local Government, Information, and Women Affairs and Social Development were interviewed. Local government officials, religious leaders and representatives of civil society organizations were interviewed in the three local governments.

Major Findings

The following are major findings from the assessment:

- There is a general consensus that HIV/AIDS is a problem and genuine demand exist for HIV/AIDS intervention program.
- Traditional institutions are willing to support HIV/AIDS programs.
- Sexual activities are heightened on market days.
- Widespread transfusion of unscreened blood in Gassol LGA.
- Only few NGOs/CBOs are involved in HIV/AIDS programming.
- Youths, transport workers, FSWs and women are at high risk of HIV infection

8. Recommendations

- Comprehensive programming should be focussed in the three LGAs of Gassol, Zing and Jalingo.
- Develop and strengthen STI clinical services.
- Develop and strengthen care and support structures.
- Integrate HIV/AIDS program into the activities of statewide unions and associations.
- Explore the possibility of working with the state Ministry of Women Affairs and Social Development in the area of OVC.

1. IMPACT PROJECT

Family Health International (FHI) is a private voluntary organization based in the United States. FHI has over 25 years experience in reproductive health, particularly in the areas of family planning and HIV/AIDS. With funding from USAID, FHI has, for over a decade, been working in HIV/AIDS programming in Nigeria – AIDSTECH 1988 – 1991; AIDSCAP 1992 – 1997; a Bilateral Grant Agreement – 1997 – 1998 and now the IMPACT Project that began in 1998. FHI has developed excellent collaborative relationships with public and private sector organizations in Nigeria including non-governmental organizations and community based organizations.

In the initial phase of the IMPACT Project, FHI has been working with a variety of NGOs and national organizations to develop pilot initiatives in working with high risk groups. Under the next phase of the project, FHI, working closely with National Action Committee on AIDS, state and local government, plans to concentrate lessons learned in key high-risk areas in Nigeria. The goal of the second phase of the project is to develop comprehensive prevention and care programming in key risk areas. This will entail working with pilot Local Government Authorities to develop strategic plans of action and working with high risk and vulnerable populations through local organizations and structures in selected key risk areas. In each selected risk area, FHI will work with a variety of partners to reach the identified high risk and vulnerable groups with prevention and care programming. Where possible, this work will be linked to work with national organizations and structures, such as the FHI collaboration with the Military, Police, Unions and Schools.

To initiate the second phase, FHI conducted a desk review of HIV/AIDS data in Nigeria. Based on the prevalence rates and existence of high-risk settings, FHI identified a number of key states. Among these states, FHI identified five for initial rapid assessments. They are Anambra, Nassarawa, Taraba, Kano and Lagos states. The rapid assessment in these states are to enable FHI determine whether or not to proceed with comprehensive HIV/AIDS/STI programs in them.

FHI proposed a participatory process as follows:

- Rapid Assessment in selected states and LGAs
- Selection and orientation of partners
- In-depth Assessments in selected states/LGAs
- Project Design
- Project implementation and evaluation.

This overall comprehensive approach is aimed towards establishing a synergy of effort for a greater impact to ensure the link between prevention and care and the link between related high risk and vulnerable populations.

This report presents the findings of the rapid assessment team for Taraba state.

2. Methodology and objectives

A key component of the methodology was the development of a Key Informant Interview guide that may be adapted for use by other planners. The methodology also comprised of key informant interviews with government officials at state and local government level; non-governmental organizations, key institutions, and key health care workers in major health facilities.

The assessment was conducted in four Local Government Authorities of Jalingo, Gassol, Lau and Zing in Taraba state and Kaltungo Local Government Authority in neighboring Gombe state from December 8 – 12, 2000. The objectives of the assessment were:

- To identify risk settings and behaviors
- To identify of risk groups
- To identify potential implementing partners, networks and structures for prevention and care for People Living With HIV/AIDS (PLWHA)
- To identify health and social welfare systems and structures
- To assess the political environment for programming

The Rapid Assessment Team consisted of two senior staff from FHI/Nigeria in Lagos, one representative from the Federal Ministry of Health (NASCP), Nigerian Institute of Social and Economic Research and two consultants.

3. Taraba State

Taraba State, with 60,000 square kilometres land area and a population of about 2 million was carved out of the old Gongola State in 1991. The state has 16 Local Government Authorities (LGAs). It is bounded on the North-East by Adamawa State and on the West and South-West by Plateau and Benue States. On its eastern border lies the Republic of Cameroun. The people of the State are predominantly farmers and petty traders.

The Rapid Assessment team met with government officials in the ministries of Health, information, Education, Women Affairs and Social development and Bureau of Local Government Affairs. These ministries provided varied information on their perception and efforts in HIV/AIDS control and the opportunities for effective action in Taraba State.

Ministry of Health:

Taraba State Government's HIV/AIDS program is anchored by the Ministry of Health. Due to poor funding, the Ministry has conducts only a few awareness and public enlightenment programs. Key informants in the Ministry could only recollect one instance in 1987 when a separate budget was made for HIV/AIDS. There are no collaborations with donors or multilateral agencies. Ministry officials are open to collaborations with donor agencies. They are optimistic that recent visits to the state by international organizations such as the

World Health Organization (WHO) and the World Bank, for assessment, could have provided the much needed donor support in the fight against AIDS.

The State AIDS Committee was established in 1992 with a State AIDS Program Coordinator appointed at the time. During the same period, desk officers were appointed to oversee HIV/AIDS in the local governments. Although some of the key informants interviewed were aware of the existence of NACA, not many were aware of either the National Policy on HIV/AIDS or plans to establish SACA (State Action Committee on AIDS) and LACA (Local Action Committee on AIDS) in states.

HIV testing is done in eight general hospitals and four cottage hospitals in the state. The government provides reagents for the tests. Few NGOs are involved in HIV/AIDS work in the state. They include; Taraba State branch of the Society for Women and AIDS in Nigeria (SWAAN) and the Fellowship of Christian Students (FCS).

Ministry of Education

The Ministry of Education has no specific programme on HIV/AIDS but there has been collaboration with the FCS for awareness raising in schools. Primary and Secondary school curricula include health education but Family Life Education is yet to be integrated. The officials of the ministry however expressed eagerness to integrate HIV/AIDS education once approval is given at the federal level. There is willingness by the ministry to collaborate with other agencies working in HIV/AIDS to reach in-school youth. There are 1,260 government owned primary schools and 152 government owned secondary schools in the state.

Bureau of Local Government Affairs

The Bureau supervises all Local Government Authorities and all matters related to the traditional leadership institution in the state. The department has not been involved in HIV/AIDS activities and had no knowledge of any on-going programs. However, the Bureau's relative strength in the control of the traditional rulers and committee of LGA Chairmen, can be utilized for effective mobilization and education. The bureau has regular meetings with traditional rulers who can be utilized to reach the grass root.

Ministry of Information

The Ministry is charged with supervision and control of all the state government owned media agencies. In collaboration with UNICEF, there is an on-going communication Programme on HIV/AIDS. They also carry out advocacy meetings with traditional and religious leaders in the State. The ministry officials have benefited from specific training on HIV/AIDS Programme in Nigeria through workshops organized by various agencies. The ministry, however, expressed a willingness to be part of the HIV/AIDS programming in the state using its media outlets for information dissemination

The responsibilities of the Ministry include welfare programs, women affairs and rehabilitation. Although there is awareness about HIV/AIDS, the Ministry has not held any specific program in respect of the disease.

At present, there is no program targeting orphans and vulnerable children in the state. The ministry registers and liaises with women NGOs. Some of these women NGOs are the National Council of Women's Societies (NCWS) and the Womens' Rights and Action Protection Alternative (WRAPA).

Observations

All the key informants agreed that the state has LGAs with high risk settings. They include; Zing, {Sabon Layi area}, Gassol, (Mutum Biyu, Tella, Dan-anicha area), Jalingo (Sabon Layi, Gidan-Dorowa and the city center), Wukari and Sardauna (Gembu area). The Rapid Assessment team focused on four of these LGAs – Jalingo, Lau, Zing and Gassol.

Common risk factors for HIV infection found in the state include high sexual networking, polygyny; early marriage, divorce and frequent re-marriages, wife inheritance, transfusion of unscreened blood, and quack medical practice especially in Gassol LGA. The risk settings include market places, truck stops and schools. High-risk groups identified were FSWs, truck drivers, and migrant traders while youth constitute the vulnerable population.

Community's perception of HIV/AIDS is that of fear. All diseases with weight loss are erroneously regarded as AIDS. There is also a high degree of social stigma leading to denial.

Availability of risk behaviours, risk settings, and the willingness of the political leaders, traditional leaders and other stakeholders to collaborate with foreign donor agencies to implement HIV/AIDS programs make Taraba State conducive for interventions that address HIV/AIDS prevention and care.

4.0 JALINGO LOCAL GOVERNMENT

4.1 Political Environment

Jalingo Local Government is the seat of government in Taraba State. It has an estimated population of about 425,957 persons and inhabited by nine different ethnic groups. The people are pre-dominantly farmers and petty traders.

Not much has been done about the problem at the LGA level, though there is an awareness of the reality of the disease among the officials. There is no AIDS Committee but there is an AIDS Action Manager in the LGA, who, over the years, had no budget to implement HIV/AIDS activities. There is however the optimism that this situation might change in the new year as there is a plan to allocate N2.5million for HIV/AIDS programming for the 2001-2003 rolling plan. In the health sector, many of the health workers in the LGA have not received any specific training on HIV/AIDS. Key informants

in the LGA have heard of the national campaign on HIV/AIDS but have not seen it. Although not very active in the area of HIV/AIDS, there is an ongoing collaboration with UNICEF in respect of other health-related issues.

4.2 Risk Environment

Jalingo harbours the biggest market – Central Market - in Taraba state where a large number of migrant traders buy and sell. Specific geographic areas that can be regarded as high-risk settings include Sabo layi, Gidan Mangoro , Jarka dafiri and Gidan Dorowa.

Major risk factors include early marriages, pre-marital and extra-marital sex, hawking, and such socio-cultural practices as wife inheritance and skin scarifications or tattooing (Tribal Marks). High-risk groups include FSWs, transport workers and migrant traders who could spend up to 2-3 weeks outside their homes. The vulnerable population include both in-school and out-of-school youth.

4.3 PRIVATE/CIVIL SOCIETY ENVIRONMENT

There are active civil society organizations in the LGA, which are basically, community development and social mobilization oriented but none of the groups was found to be involved in any systematic HIV/AIDS programming in the LGA.

Society for Women and AIDS in Nigeria (SWAAN)

SWAAN, Taraba State branch, is a newly formed organization with a focus on HIV/AIDS. Although yet to commence the implementation of project activities, the organization is already in touch with key district and traditional rulers in the state to secure the support of key gatekeepers for HIV/AIDS campaign in the state. The organization has been publicized through the mass media and plans to raise awareness on HIV/AIDS, identify PLWHA, liaise with health facilities and work with CSWs. It also plans to support PLWHA

Apart from government agencies, SWAAN also collaborates with students' organizations such as the Fellowship of Student Nurses (FSN) and the Liberty Club in the College of Education, Jalingo. SWAAN expressed a willingness to work with other groups in the campaign against HIV/AIDS.

International Islamic Relief Organization

International Islamic Relief Organization (IIRO) is an NGO with support from Saudi Arabia. The Nigerian regional office is located in Kaduna. Jalingo Clinic, which is an aspect of the organization's humanitarian effort, was established in 1998. The group has organized series of public enlightenment program amongst youths on HIV prevention. In the clinic, about 90% of the HIV positive cases seen, come from Gassol LGA. This development led the IIRO to initiate discussions with the Gassol LGA on the ways and means of preventing further spread of HIV infection in the area.

The activities of the group include care of orphans (including AIDS orphans). IIRO clinicians and caregivers/relatives are finding it increasingly difficult to cope the problems of AIDS orphans.

In the last quarter of 1999, the organisation had an upsurge in the number of HIV-positive patients it had to deal with in the clinic. These were mainly truck-drivers and those operating in the motor parks. An average of 13 patients presently on TB therapy in the clinic were HIV-positive. In the absence of a community home-based care services for PLWHA, the physician in charge of the clinic manages to undertake some home visits. The HIV-positive patients usually present with TB. At present, there is no plan to establish a network of PLWHA because of the fear of stigmatization.

The NGO enjoys community support. The Emir (traditional leader) of Jalingo, for example, is an ardent financier, supporter and chairman of the advisory board of the IIRO. He is also interested in HIV/AIDS prevention in the community. Key informants agreed that there were no socio-cultural hindrances to the use of condoms among Muslim youths in the area.

Jalingo Youths Development Association (JAYDA)

JAYDA, a registered organization established in 1999 evolved to forge unity and peace amongst youths of Jalingo origin. The organization has 357 registered members with ages ranging from 18-45 years. The organization conducts extra-mural classes to coach students preparing for SSCE and JAMB and has established six mass literacy classes. The group conducts public enlightenment and education campaign on the prevention of HIV/AIDS and encourages orthodox medical care rather than alternative for care for patients.

The Shiites' (an Islamic group) belief that God who creates and also destroys rather than HIV and AIDS constitutes a limitation to JAYDA's program. The strength of the organization is their commitment to their goals and objectives. There has been no sponsorship by any organization so far.

National Union of Road Transport Workers

The National Union of Road Transport Workers (NURTW), Taraba State Chapter, derives its policies from the national body. The group met by the team had no previous experience of work in HIV/AIDS but is willing to get actively involved in the campaign against HIV/AIDS with credible and willing partners. The organization has a structure capable of enhancing its participation in the HIV/AIDS Programming. In the past, NURTW had assisted the Federal Ministry of Health to distribute vaccines to the rural areas for immunization.

Nigeria Labour Congress

The Nigeria Labour Congress, Taraba State, is a branch of the national umbrella body. Presently, it does not manage or implement any specific HIV/AIDS Programme. The

organization of strength based on registered trade unions under the congress in Taraba State. The organization has had unfettered access to the mass media because the union of journalists is part of the congress and some Journalists actually serve on the executive committee of the congress at the state level. The congress is willing to work with the government and other NGOs.

4.4 CARE AND SUPPORT NETWORKS AND STRUCTURES.

The State Specialist Hospital, Jalingo is a 300-bed capacity facility with eight full-time and one NYSC doctors. There are 193 nurses but no Community Health Officers. It is a referral hospital that receives cases from all other general hospitals, PHC clinics, cottage hospitals and private health facilities in the State. The entire state and part of Adamawa State are the catchment areas of the hospital. The hospital, on its part, refers cases to Jos University Teaching Hospital (JUTH) and University of Maiduguri Teaching Hospital (UMTH).

The hospital does not have a policy on HIV/AIDS care and management. Opportunistic infections treatment for AIDS patients is free in the hospital but most patients are not ready to declare their status and benefit from the free drugs Programme. This is attributed to fear of stigmatization.

HIV testing is done in the hospital and reasons for testing include screening of blood from donors, routine test for patients admitted for TB and pre-surgery. The latter has been discontinued due to ethical reasons. Individuals who present symptoms are subjected to the HIV antibody test when they fail to respond to treatment.

About 3-4 cases are seen every week. There is no mentioned case of pediatric HIV/AIDS in the hospital. Majority of the cases are also TB patients. The State Ministry of Health currently supplies testing kits. While there is no specialized HIV/AIDS counselor in the hospital, the PMO provides some counseling services for persons who test positive. There is a proposal to do an in-house training of counselors between December 2000 and January 2001 to cope with the increasing problem of HIV/AIDS. There is no home-based care services provided by the hospital. There is no HIV/AIDS intervention for pregnant women in the hospital, an indication that MTCT has not yet taken off there. Key informants in the hospital have not seen the national policy on AIDS.

Tuberculosis patients are seen regularly in the hospital and although the hospital manages TB using the DOTS, the drugs are not always available free. The hospital also undertakes STI management, though it has no separate STI clinic. STI diagnosis is based on history, clinical observations and at times, laboratory investigations. The hospital does not use the syndromic approach and it does not refer STD cases to other facilities. STD cases seen in the hospital are however, on the increase. The hospital does not provide condom but it does educate STD patients on the use of condom. Major constraints in handling STDs include the habit of coming late to the hospital with infection and the difficulties experienced in tracing contacts. There is a School of nursing and Midwifery attached to the hospital and a state Committee on AIDS.

The following priority areas of possible assistance were identified:

- Provision of drugs for opportunistic infections
- Provision of anti-retroviral drugs
- Implementation of MTCT interventions
- Establishment of a counseling unit in the hospital

5.0 LAU LOCAL GOVERNMENT

5.1 Political Environment

Lau Local Government has a population of about 224,000 majority of whom are farmers. Other economic activities undertaken in the area include petty trading, fishing, and working on rice mills. A sugar factory is proposed for the LGA and may take off in the near future.

The council has no on-going programme on HIV/AIDS and has not had any collaboration with any agency in this regard.

There is no AIDS committee or AIDS action manager in the LGA. No specific provision for HIV/AIDS has been made in the LGA's budget so far. However, an unspecified amount has been included in the 2000-2003 rolling plan for HIV/AIDS.

The Council officials were unaware of any significant HIV/AIDS problem in the area. An offer to assist HIV/AIDS campaign efforts by providing transportation and an information officer for a community-wide impact was made by officials of the LGA. They however envisaged no major problems in prevention and care efforts in HIV/AIDS in Lau LGA as the people were said to be peaceful.

There are four secondary schools in the LGA but the official could not easily provide the number of primary schools.

5.2 Risk settings

Markets, particularly on market days, present risk settings in the LGA. This is because on such occasions, there is a lot of sex trading and networking. Other risk settings include the presence of beer drinking joints (beer parlors) patronized by migrant traders.

5.3 Private/Civil Society Structures and organizations

No NGOs/CBOs were found during the visit.

5.4 Care and Support Structures and Networks

Health officials in the LGA revealed that the absence of testing facilities and data on the prevalence of HIV/AIDS in the LGA made it difficult to draw definite conclusions about the magnitude of the problem. There has not been an increasing incidence of suspected AIDS cases in the LGA according to the officials. There are Traditional Birth Attendants (TBAs),

Age Health Workers (VHWs), Community Health Officers (CHOs) and Community Health Extension Workers (CHEWs) within the LGA.

A cottage hospital managed by a CHO meets the health needs of the LGA in conjunction with about 34 Primary Health Care centers scattered in various communities. The cottage hospital rarely sees AIDS cases.

6.0 Zing Local Government

6.1 POLITICAL ENVIRONMENT

The Zing LGA has a population of about 219,272 and HIV prevalence of 7 per cent. It was created out of the former Zing Native Authority in 1976. There are 38 villages in the LGA. The high HIV prevalence in the area, which is above the national average, is of tremendous concern to officials of the LGA.

The inhabitants are mostly Christians though Muslims and traditional worshippers are also present. The main ethnic group is the Mumuye. Others include the Yandang, Fulani and Hausas. Majority of the people in Zing LGA are farmers and petty traders.

The HIV/AIDS Programme in the LGA is said to have 0.5million Naira budget for 1999 during which only N10, 000 (Ten thousand Naira) was disbursed for HIV/AIDS-related activities while the rest of the budget was diverted to other activities unrelated to HIV/AIDS.

6.6 RISK ENVIRONMENT

Key factors identified as being responsible for the rapid spread of HIV infection include multiple sexual partners and the frequency of partner change. Factors that could contribute to the frequent partner change include concurrent sex partnerships commonly practiced in the area. Sexual networking is high among adolescents and young adults especially when most leave their homes to attend school elsewhere.

Amongst the population, poverty is implicated for the vulnerability of most women to HIV infection through sex. "If a man has money, he can just snatch any woman from her husband", a key informant intoned.

Sabon Layi area of Zing was identified as hot spot for sexual activities. There are three brothels that house commercial sex workers. There is also a very big market held every Wednesday, which attracts a lot of migrant traders from neighboring communities.

There are 4 secondary schools, 47 primary schools, one (1) general hospital, 2 private clinics and 29 health posts in this LGA.

6.3 COMMUNITY SOCIETY ENVIRONMENT

Two religious, non-governmental organizations working in Zing LGA include the United Methodist and Catholic Church Organizations. The major activity they conduct are awareness raising through sensitization seminars, drama and health education programs.

6.4 CARE AND SUPPORT NETWORKS AND STRUCTURES

General Hospital Zing has 100 bed capacity and 3 medical doctors (2 full-time and one NYSC doctors). There are 75 nurses/midwives and one CHO. People come from a distance of over 100-km to seek care in the hospital and its major catchment areas include Zing, Lau, Yoro Local Government Areas in Taraba state and Mayo Belwa in Adamawa State. The hospital receives referrals from United Methodist Church of Nigeria Hospital (UMCN), St. Monica's Hospital Yakoko and Local Government health posts. However, referral cases from St Monica are for laboratory investigations. Zing General Hospital refers patients to Jalingo Specialist Hospital.

As at the time of the team's visit, only four cases had been seen during the year and all the four had died. The hospital sees an average of 7-8 TB patients per month. The hospital does not have HIV/AIDS policy of its own and its staff have not seen the national policy on AIDS.

Testing is done for both HIV and TB in the hospital. However, there is neither pre- or post-test counseling for the clients. Oftentimes, once diagnosis is made, relatives request for discharge. HIV screening started in 1997 using reagents supplied by the state. HIV testing is also done in the hospital for donated blood. In addition, HIV testing are also done for referred clients. About 5-7 tests are done every week and 20% positive blood has been recorded among blood donors. HIV tests costs N300 in Zing GH. With respect to TB, AFB sputum staining is performed. In July 1999, 2 out of 5 tested were AFB-positive (40%) and in July 2000, 1 out of 4 (25%) were positive. There is no Home-based Care, PLWA support group or MTCT intervention in the hospital. There is also no orphanage in Zing LGA.

The General Hospital handles STD cases and on the average sees about 5-6 cases a week. Usually the STDs are treated first but only sent to the laboratory for investigation after initial treatment failure. The laboratory has 3 functional microscope using mirror because of frequent power outages. Condoms are not provided by the hospital but people can access condom in the market within Zing.

St Monica Hospital Yakoko, a major TB referral hospital, was established in 1968 and managed by 2 reverend nursing sisters for the Catholic diocese of Jalingo. It is a 42-bedded facility with 16 bed spaces dedicated to TB cases. The hospital has 10 nurses and no medical doctor. The hospital collaborates with CHAN but has not received assistance from any donor agency. The management attributed the high utilization of the hospital to the quality of care and love shown to patients including PLWHAs. The philosophy of the hospital is that HIV/AIDS is a disease of "love" and not "fear". It runs 5 outstation health

posts and 2 outstation clinics. Patients come from UMCN, outstation centers of the hospital and other hospitals within the state and other parts of the country. Community members who live outside Yakoko usually return to the village when they become sick.

The first clinically suspected AIDS patient was seen in the hospital in 1989 but HIV screening started in 1993. Currently, the hospital sees about 10 new AIDS cases per month. Test kits used in the hospital are ordered directly from Germany and the cost of HIV test is ₦150.00 compared to ₦ 300/₦ 400 in other public health facilities. This price advantage encourages people to visit the facility for testing.

The facility also cares for TB patients and carries out AFB test. Currently, there are about 16-18 sputum-positive new cases every month. Twenty percent (5 out of 25) of TB patients presently on admission in the hospital are also HIV⁺. Most cases are migrant men and unmarried females whom the hospital felt were probably sex workers. From the hospital records the age group mostly affected is 20-35 years.

Reasons for performing HIV tests include screening blood from donors and suspected AIDS cases. There are five trained counselors who conduct pre and post test counseling. CHAN and Catholic Resource Center Kaduna trained these counselors. In the management of HIV/AIDS, the hospital lays emphasis on diet (nutrition). Very few patients living around Yakoko are followed up through home visits. There is no established home-based care team in St. Monica because most of the HIV/AIDS patients come from afar. Hospital staff interviewed believe it is easier for health facilities in Jalingo to embark on home-based care. There is no MTCT intervention in the hospital. The extended families in the community support AIDS orphans. Reportedly, this family support system is overburdened and breaking down as HIV/AIDS has a negative impact on the culture and tradition of the people. This presents opportunity for OVC programing, which currently does not exist formally in the area.

Treatment of STI cases is based on clinical and laboratory (microscopy and VDRL) diagnosis, however, outstation clinics treat STDs symptomatically. From hospital records, the number of STD cases reduced from 1997 to 1999. In 1997, a total of 1873 (1036 males and 837 females) cases were recorded. In 1998, 1420 was recorded while 1408 were recorded in 1999. STD patients are informed of their result and counseling done on the meaning of the results. Counseling is focused on self-discipline/control and abstinence from sex until one is rechecked. Condoms are not provided in the hospital but IEC materials on HIV/AIDS including condoms are strategically displayed in the hospital. The Rev. Sisters managing the hospital have a positive disposition to the use of condoms only in marriage relationship. This according to them is the position of the Bishop of the Catholic Archdiocese of Jalingo.

Lack of funds, and inadequate support from government and donor agencies limit and overburden the system. The presence of the facility is seen as a factor that contributes significantly to the increase of Zing's population especially because of the large number of patients seeking care. The management of the hospital would want improved nursing care and support in government hospitals to reduce the burden on them. They also requested financial assistance from the government as they claimed to bear the burden of HIV/AIDS in the state and beyond.

There were no visible HIV/AIDS programs at the local level. NGOs in the LGA, however, believed it was time programmed HIV/AIDS initiatives commenced in the area. The LGA officials in the local government were not aware of any HIV/AIDS policies at the national and state levels.

7.0 Gassol Local Government Authority

7.1 Political Environment

Gassol Local Government created in 1996 has an estimated population of 229,439 and is one of the most densely populated LGAs in the state. The indigenes of Gassol are mostly farmers and they engage in petty trading. The land is very fertile and produces large quantities of yam, which has led to the influx of yam merchants from different parts of the country into the area. Two to three days of the week are set aside as market days, hence businessmen and women move from one market to the other spending at least 2 nights in one site.

There is a high level of awareness and acknowledgement of the problem of HIV/AIDS in the community and among members of the legislative council. The LGA in its project document for 2001-2003 identified AIDS as a priority disease targeted for intervention. There is commitment and interest to implement HIV/AIDS prevention activities but the limiting factor remains resources. There is no budgetary allocation for the disease and the health facilities do not have reagents for HIV testing.

Key informants in the LGA neither knew about the National Action Committee on AIDS (NACA) nor plans to establish a State Action Committee on AIDS (SACA). They are also unaware of the existence of a State AIDS Control Program. There is no collaboration with any international organization or donor agency on HIV/AIDS. Also there are no NGOs working on HIV/AIDS. The LGA has 7 public and 3 private secondary schools and 102 public and 34 private primary schools.

7.2 Risk Environment

This LGA has a high rate of population migration (in and out of the towns). There is a strong presence of Female Sex Workers (FSW) in and around some locations such as Mutum Biyu, Tella, Sabon Gida Tarki and Dan-anicha. These locations have heavy truck stops, brothels and markets. They are focal points for truck drivers who usually sleep overnight on their way to Cameroun and other parts of Nigeria who mainly patronize the FSWs. The market areas are the major meeting points for sex trade. These markets last between one to four days in the respective towns and villages. The duration of these markets causes migrant traders to seek places to stay for the entire period before returning to their bases.

Highly concentrated among FSWs, truck drivers, migrant traders, local farmers and the youth. Major drug outlets abound in markets, truck stops, brothels and bars. The people of Gassol are at high risk of HIV infection because of their unsafe sexual practices and questionable medical practice which includes; transfusion of unscreened blood and use of unsterilized sharp instruments such as needles and blades. One of the LGA officials concluded, "in fact we need HIV/AIDS intervention projects".

The team made an on-the-spot visit to the areas notably identified as high-risk settings. The visit coincided with the market day at Mutum-Biyu. FSWs could be seen negotiating with their clients who were mostly transport workers and traders. The Chairlady of the FSWs was highly appreciative of our concerns and expressed her willingness to cooperate.

At Tella, FSWs were mostly in their rooms, and their mobilization was very easy. The health workers at the dispensary mobilized the FSWs at the various hotels visited. A brief meeting was held with about 35 FSWs in attendance. They were eager to submit themselves for a medical check-up thinking that was the reason for the team's visit. The health workers from the dispensary send letters to the FSW, inviting them for medical check up biannually which stopped in 1995 due to lack of reagent. Their main complaint was lack of facilities for regular medical check-up. Condom usage was not popular amongst clients because "they take a longer time which is not good for business". So they believe a medical check up is better than advising their clients to use the condom. Efforts were made to disabuse this perception. The town's traditional leader is in support of any program to help the FSWs.

Health workers worried about the increasing numbers of the FSWs decided to evict them by obtaining a court warrant from the area magistrate court. Following the warrant, 150 FSWs were taken to the court premises. However the men in the village rose up to the defence of the FSWs saying they should not be evicted.

7.2 Private/Civil Society Environment

In Gassol, there are no known NGOs working on HIV/AIDS prevention and care. There may be an opportunity to tap existing unions in the area with national structure, NUT and NURTW are present. Due to the traditional leaning of the area, mobilizing the communities through their leaders and religious organizations will be necessary. The social organization of the communities and the risk groups (e.g. FSWs) are structurally suitable to accommodate projects.

7.3 Care and Support

There is a state-owned 15-bed cottage hospital with a resident doctor who was unavoidably absent during the visit. Patients who utilize the clinics are mainly from within the LGA with the hospital receiving referrals from the 10 primary health care facilities. The hospital is equipped for HIV testing. There are 12 nurses but no trained counselors. TB patients are treated on outpatient basis with streptomycin and other drugs prescribed by the PMO. Information on TB and HIV prevalence could not be obtained from the hospital.

due to the absence of the laboratory scientist. Patients with Sexually Transmitted Diseases are usually sent to the laboratory for microscopic examination

The health dispensary at Tella, a new facility awaiting commissioning, provides skeletal services. The community health extension worker is only about 2 months old in that office. He was only aware of 2 AIDS cases, which he referred to Wukari for treatment but later died. His assistant is aware of 5 AIDS related deaths in the community within the last year. The dispensary does not have facilities for HIV screening but the HIV prevalence is presumably very high. Sexually transmitted diseases are treated symptomatically with gentamycin injections. The health workers are not aware of the syndromic management of STIs.

8.0 Kaltungo LGA, Gombe State.

Following recommendation from the desk review, an exploratory visit to Kaltungo was made. Through out the trip to Kaltungo no major truck stop was found, though a handful of trailers plied the route during the trip. Only a trailer was packed in a village in Kaltungo LGA. On enquiring, if this was the truck stop the villagers reported that it was not a truck stop because the place is dangerous due to incessant armed robber attack at night. This made the truck to do all they want to do and move on as soon as possible.

Kaltungo and Biliri town, were not overnight truck stops, however, very close to Yola in Adamawa State there was a major truck stop.

The proposed programing with long distance truck drivers will be difficult because there are no overnight truck stops along the Yola – Kaltungo –Gombe axis.

7. General Observations

- ⊗ General consensus that HIV/AIDS is a problem and a real demand exists for HIV/AIDS intervention Programs.
- ⊗ The state's policy statement exempts patients with opportunistic infections from paying fees. HIV testing facilities and a confirmatory centre are available in the state
- ⊗ Traditional institutions are willing to support HIV/AIDS programming.
- ⊗ Sexual activities are heightened on special market days. A large population of FSWs the state especially within Gassol LGA. They are organised, along tribal lines with a highly respected leadership structure.
- ⊗ Though not a major truck stop, trailer, luxurious buses and 911 lorry drivers bring traders to various markets in Tella/Mutum Biu/Dan Anicha/Sabongida Tarki. The clients of FSWs are migrant traders from different parts of Nigeria.
- ⊗ Transfusion of unscreened blood by some private health facilities in Gassol LGA.
- ⊗ Very few NGOs are currently involved in HIV/AIDS prevention activities though needs assessments have being conducted by World Bank and MERLIN both international organisations.
- ⊗ The youths, long distance truck drivers, FSWs and widows/widowers are at high risk of contracting and transmitting HIV.
- ⊗ Faith-based organizations in the forefront of care and support activities are overwhelmed by the demand for services.
- ⊗ There are no on-going program on OVC and home-based care while St. Monica's Hospital offers pre- and post-test counseling for HIV⁺ patients.

Recommendations

The team wishes to recommend that FHI works with Taraba State Government for HIV Prevention, Care and Support with program focus in Gassol, Zing, and Jalingo LGAs. Consideration should be given to programming in Wukari LGA. Though not visited during the assessment, Wukari LGA was identified by most informants as an important area for intervention. Develop and strengthen STI clinical services and care/support structures. Integrate HIV/AIDS programs into the activities of statewide unions and associations and assist LGAs to develop strategic plans..

Facilitate the identification of PLWHA, OVC and the establishment of networks, whilst the possibility of OVC programming with Ministry of Women Affairs & Social Development through the office of the wife of the Executive Governor should be explored

Recommended Potential Partners

Target Group	Jalingo	Zing	Gassol
Sex Workers	SWAAN	SWAAN	SWAAN
Transport Workers	NURTW	NURTW	NURTW
PLWHA	International Islamic Relief Org.	St. Monica Hospital, Yakoko	Islamic Relief Org.
Youth in School	NUT?? FCS??		
Youth out of School	JAYDA		
VC	MWASD	MWASD	MWASD

Appendix A: Persons Met

Organization Visited	Persons Contacted	Designations
State Government		
Ministry of Health, Jalingo	Dr. Hamidu B. Mohammed	Permanent Secretary
	Dr. Saley AJI	Director, PHC
	Mr. John Solomon PAI	State AIDS Program Coordinator
Ministry of Information, Youth and Sports	Mr. Andrew H. Ambinkanme	Director of Information
Ministry of Education	Alhaji Tafida Sulaiman	Permanent Secretary
	William D. Lamu	Asst. Director
	Manasseh Y. Garba	Asst. Director (PE)
	Sambo Keyehgu	Asst. Director Planning
	Emmanuel Lambajo	Coordinator (UBE)
	Ezra M. Audu	Director Inspectorate Services
Ministry of Women's Affairs & Social Development		
	Mr. David .E. Polycarp	Secretary
	Mrs. Fatima A Sani	Director, Women Affairs
	Mr. Daniel D. Danjuma	Director, Social Welfare
	Levi Kangla	Asst. Director Child Development
	Com. Cyprian A. James	Director, Rehabilitation
Office of the Secretary to the State Government	Mr. Cletus WUI	Permanent Secretary, General Administration
Bureau of Local Government Affairs	Evangelist Jonah Bala Zhema	Director LGA
State Specialist Hospital, Jalingo	Dr. MADAKI	Principal Medical Officer
Jalingo LGA	Mr. John Solomon PAI	SAPC/Chief Laboratory technologist
	Hajia Ramatu Isamahuru	Focal Person Women Affairs
	Mr. Bello N. Kalau	Director Primary Health Care
	Kefas Nyasore	Asst. Director Infectious Disease Control
	Paul N. Audu Kungana (J.P)	Secretary to Jalingo LGA
	Mrs. Hauwa Usman	Chief Nursing Sister
	Paul Marafa	Asst. Director Infectious Disease Control
International Islamic Relief Organization, Jalingo	Dr. A.U Umar	Medical Director
Nigeria Medical Association	Dr. Phillip Duwe	Chairman
Jalingo LGA		
	James R. Aji	Assit. Director IDC
	Alh. Inuwa Abdallah	D/PHC
	Joel Danladi Adamah	Ag. Sec
	Justina Simon	"Childcare trust" Coordinator

	Umaru Nadabba	Women Development Officer
General Hospital, Zing	Esther Lackson	Chief Nursing Officer
	Paul Rambe Yanana	Lab Scientist
Gassol LGA	Mr Jackson Aselema Abada	Director, PHC
	Andrew D. Samaila	Public Health Officer
	Aliyu Jai Barde	NPI Cold Chain Officer
	Hon Umar S. Ahmed	Councillor Tella ward
Cottage hospital, Mutum Biyu	Maliki P. Atsinde	CNO
	Galadima Fupsil	Assist. CNO
Health Dispensary; Tella	Nuhu Yakubu	CHO Supervisor
	Haruna Ibrahim	SCHEW
	El-Hamman Abubakar	CCH Assist.
Site Visits	Mr. Adams	Hotelier and Chairman of Edo tribe Tella
	"Madam Ba Hausa"	Chairlady, Mutum Biyu
	"Auntie" Hausawa	Chairlady, Hausa Community
Lau LGA, Lau	Alhaji B.A Madugu	Executive Chairman
	Mr. Dominic AZiba	Secretary to the LGA
	Mr. Lulah peter Dabale	Leader of council
	Mr. Yunana Kinka	Vice Chairman
	Malam Ibrahim Mohammed	Dep. Director, PHC.
IGOs		
Society for Women and AIDS in Nigeria (Tarabate Chapter)	Mrs. Jemima Mairabo	Chairperson
	Mrs. Mary Hassan	
	Mrs. Dimah Audu	
Jalingo Youth Development Association (JAYDA)	Mr. Missa Jida	Chairman
	Mr. Suleiman Ali Dada	Secretary
	Ms. Binta Magaji	Clerk
Nigeria Labor Congress	Com. Jibrin Saidu	Secretary
	Com. Joshua Sambo Kwanchi	Asst. Secretary
National Union of Road Transport Workers, State Council, Jalingo	Com Abdulahi Ade	Asst. State Secretary
	Com. Muazu Garuba	State Trustee I

NIGERIA
 RAPID ASSESSMENT TOOLS
 Key Informant Interview Guide

Government Response

- Ongoing efforts
- Ongoing collaboration-
 - With donors/international agencies
 - With NGOs/CBOs
 - Acceptability of donor support*
- Ongoing Program with women, youth, poverty alleviation, microenterprise and child welfare
- Presence of structures
 - Are there any community health workers here – TBA, CHOs etc.
 - AIDS Committee at state level
 - State AIDS Coordinator
 - AIDS Action Manager
 - Integration of AIDS into PHC
 - Number of schools – secondary, tertiary etc.
 - Economic activities (any major employers)
- Awareness of NACA and other state multi-sectoral structures (is there a state HIV/AIDS policy or do they have access to policy papers)
- Perceived effectiveness of existing structures (regular meetings, activities etc)
- Budgetary allocations, released and actual expenditure related to HIV/AIDS
- Felt need for HIV/AIDS programs
 - Other areas of priority
- Socio-cultural/religious issues and concerns

HIV/AIDS/STI RISK SETTINGS

- Risk behavior – what kind of behaviors/activities that you have seen that make people vulnerable/susceptible to HIV?
- What in your own opinion constitute the greatest risk behavior that facilitates HIV/STI transmission in this state/LGA/community?
- What do you feel is the risk for HIV in this community OR what is the perception to be the risk in this state/LGA/community?
- What are the geographic areas where risk behaviors take place?
- Community mobilization around the issue of HIV/AIDS

- What are the opportunities for HIV/AIDS prevention and care programming in this community?
- What do you think is an effective way to handle the HIV/AIDS situation in this community?

ASSESSMENT OF CIVIL SOCIETY ORGANIZATIONS' POTENTIAL FOR BEHAVIOR CHANGE INTERVENTIONS.

1. Experience in community development and HIV/AIDS activities
2. HIV related programming experience
3. Relevant local/state/regional experience
4. Collaboration
 - Are there other organizations working in HIV prevention & care
 - Is there any networks of local NGOs in community development & HIV
 - Any linkages/referral systems with other service providers in the area (health service, spiritual service, micro-enterprise, education etc)
 - Perception of work with other NGOs
 - Perception of work with government
5. Do you use any communications materials
 - What materials are you using
 - What is the most effective channel of communications of communicating to your target group
6. Where are you currently getting your funding for programs
7. Where do you refer people for services
8. Relevant administrative/managerial resources and expertise
 - What is the organizational structure – is there an org. chart?
 - Do you have a bank account
9. Access to personnel and other resources
 - What is your membership – how many voluntary and how many full-time paid staff
 - Access to communications – telephone, fax, email

SUPPORT

Overarching Impression Discussion Points

To be discussed by each site team before deployment and at debriefing meeting

State HIV prevalence rates MC name OMC name
.....

1. High risk groups Locations and size: FSW, Truckers, Migrant men, At risk youth, Informal settlements
2. Who are partners in HIV broad comprehensive Care and Support. public, voluntary and private and what are they doing?
3. Patient load/demand for Care and Support? Change over time? In each level of care from state to primary.
4. Potential for learning site to be established. E.g., nursing training college, care partners, etc. within a site (LGA).
5. Home based care (professional support for illnesses) demand for terminally/chronically ill.
6. Get a sense of what the burden of HIV/AIDS epidemic is (through mortality estimates in general and TB patients).

Health Care Structure

How many of the following are in the LGA?

- Government Hospitals.....
- Teaching Hospitals (qualify Gov.)....
- Mission Hospitals.....
- Private Hospitals.....
- Public Health Centres.....
- Public Health Clinics.....
- Church and religious clinics.....
- Private Sector providers
- NGO clinics.....
- CBO clinics.....
- Traditional medicine practitioners.....

- Are there community health workers in the area?

Health Facility

What is your position designation.....
What are your primary duties.....
What kind of Health facility is this
How many in-patient beds are there

What is the geographical catchment area of this facility.....
What is the catchment area of this facility in population.....
How many doctors in this facility
How many nurses in this facility
How many CHO/CHEWs in this facility.....

Who refers patients to you:

Who do you refer patients to (name if possible):

Teaching hospital.....
Federal Medical Centre.....
Specialist Hospital.....
General Hospitals
Primary health care Centres.....
Primary health care Clinics.....
Village health workers
Church and religious clinics.....
Private Sector providers
NGO/CBO clinics.....
Traditional medicine practitioners.....

Are there community health care workers attached to health facilities

When did you start seeing suspected AIDS cases.....
Has there been a gradual increase of suspected AIDS cases.....
Have there been periods of rapid change (more or less).....
How many suspected AIDS cases do you see each week

Do you have a copy of the National HIV policy guidelines?.....
Can we see which version you are using.....
Do you have your own HIV policy
Can we see it?.....

Specific technical areas

VCT

Do you do HIV testing in this facility – where do you get your supplies

Do you send patients for testing – where.....

What happens to those who test positive.....

Are they told their results.....

Do you have HIV counseling services.....

Who trained your HIV counselors - what curriculum was used, when.....

- not active but planned – where , when will they open, who will be in charge.....
- Do you have linkages with other Care and Support activities and services.....

Home based care (professional support for illnesses)

- Describe HBC activities
- Describe the structure of home based care staff/teams....
- demand for terminally/chronically ill care
- Describe composition and types of services provided and length of time have been active (e.g. terminally ill vs. HIV only, TB incorporated, linkages to clinical care.)
- Linkages with other Care and Support activities and services.....
- Linkages with prevention activities.....

PLWA groups/networks

- Are there any PLWA groups - name, location, who is in charge.....
- not active but planned.....
- Describe composition and types of services provided and length of time have been active (e.g., advocacy, support, peer education etc.)

MTCT

- Any MTCT interventions – what?

OVC

- When children do not have their immediate parents who takes care of them?
- Do you suspect any changes in extended families ability to take care of their relatives children? Briefly describe.
- What type of impact has HIV/AIDS had on children.....

- Are there any child survival project in the area.....
If yes, brief description
- Are there any motherless child homes?
- # and brief description

TB

- Are TB patients cared for at this facility
If no, where are they referred
- Has there been a gradual increase of TB cases.....
- Method of TX
- Availability of drugs, type and consistency

STI

Name and address of HCF

.....
.....
.....

Teaching Hospital |__|
 Federal medical centre |__|
 General hospital |__| person interviewed
 Health Centre |__| (name and position)
 Private clinic |__|
 NGO clinic |__|
 Other |__|
 Specify

How many STD patients were seen in this
 Health care facility last week? |__| |__|

How many cases of STD do you see at this clinic
 during an average month? M |__| |__| F
 |__| |__|

Are the numbers of male patients with STDs
 increasing compared to last year Y|__| N|__|

Are the numbers of female patients with STDs
 increasing compared to last year Y|__| N|__|

From your records:			
	1997	1998	1999

How many STDs in adult males			
Male urethral discharge			
Male genital ulcer			
How many STDs in adult females			
Female urethral discharge			
Female genital ulcer			

Who refers patients to you:

- Teaching Hospital |__|
 Federal medical centre |__|
 General hospital |__|
 Health Centre |__|
 Private clinic |__|
 NGO clinic |__|
 Self-referral |__|
 Other |__|

Specify

Where do you refer difficult STD cases to

What type of diagnosis do you base your treatment on?

- An etiologic diagnosis such as gonorrhoea or syphilis?
- A syndromic diagnosis such as urethral discharge or genital ulcer disease?

Etiologic =1
 Syndromic =2 |__|
 Both =3

Do you have a microscope in this clinic? Y |__| N
 |__|

Do you perform HIV testing in this clinic? Y |__| N
 |__|

What is the name of the test
 Do you tell the patients the results Y |__| N
 |__|

Do you counsel patients on the meaning of the results Y
 |__| N |__|

Do you send your STD patients (or specimens) to another facility for laboratory investigations? Y
 |__| N |__|

Where

DO you keep a supply of condoms in this clinic? Y |__| N
|__|

ASK TO HAVE ONE Y |__|

Do you provide condoms to your STD patients? Always

Sometime ___
Never ___

Do you provide instructions to your patients on how to use condoms?

Always

|__|

Sometimes |__|
Never |__|

Do you follow any specific treatment guidelines in your management of STD patients?

Y |__| N

|__|

IF YES, which?

Have you received a copy of the STD treatment schedules recommended by the National AIDS and STD Control Programme?

Y |__| N |__|

Verified Y |__| N |__|

What are the main constraints on your work with STD?

.....
.....
.....

Health Care Facility Data

We would be very grateful for the following information, if it is available:

Hospital admissions and clinic attendance			
	1997	1998	1999
Medical admissions			
Surgical admissions			
Paediatric admissions			
Adult male outpatient attendance			
Adult female outpatient attendance			
Paediatric outpatient attendance (under 5)			
How many TB cases (all forms) were recorded			
How many smear positive pulmonary TB cases were recorded			
How many smear negative pulmonary TB cases were recorded			
How many extra pulmonary TB cases were recorded			
How many smear positive pulmonary TB cases completed their TB treatment			
How many smear positive pulmonary TB cases died before completing their TB Rx			
How many smear positive pulmonary TB cases were lost to follow up			

If this intervention is not available until later, please leave a copy of this form with the Health Care Facility. It should be returned to:

Family Health International
 18a Temple Road
 Ikoyi
 Lagos.