NEWS *Power*: An EFMC Monthly News Bulletin
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Delinking social vices from Poverty: Causes of Poverty

Recently I was in a meeting where child poverty was the key issue for discussion. I listened as an erudite scholar spoke passionately over several minutes on the ills of child (and mother's) poverty and ended by making several recommendations which all bordered on advocacy for policy changes. I listened with rapt attention the entire time to see if I will hear what I wanted to hear, but I heard what I have always heard from people – poverty is caused by poor or inadequate policies and it is the cause of social vices.

In as much as this may be true, it is not the complete truth. In Nigeria, laziness is the commonest cause of poverty. Nigerians are "LAZY" (with capital letters). What is the origin of Nigerian or African time? – Laziness. I have lived in Nigeria long enough to know that majority of Nigerians are lazy, particularly when they are in Nigeria. People even find it difficult to roast the food that somebody else killed. It is not uncommon to see people looking for a jobs-come late for interview and give excuses why they came late. It is not uncommon to see somebody who says he/she gives attention to details write a letter in a computer with several errors and not noticing it. I have even seen somebody who told how time conscious he was in an interview come late on his first day at work. Nigerians are lazy. Reports are submitted late, assignments are never done, work is postponed – sometimes indefinitely, career upgrade is put off to next year, food is not cooked early or finished very late when kids are already asleep, the list is endless. As an entrepreneur, I have seen lazy staff who yesterday were begging for jobs and willing to do anything, now giving excuses why they cannot deliver simple job packages. It amazes me to see the same Nigerians who are unwilling to work from 8 – 5 pm effectively doing three different jobs in US. This has made me to conclude that their laziness is not genetic, but environmentally-induced.

The next commonest cause of poverty in Nigeria is lack of planning. Nigerians have little or no skills in planning. The inability of the government to guarantee constant power supply and employers to guarantee timely payment of salaries and wages has institutionalized this planlessness of most Nigerians. Just take a look at NEXT, Shoprite or any of the major shopping malls in the first week of a new month, and you will understand what I mean. Purchases without plans, wrong purchases on the road, multiple purchases of the same good and several wasteful expenditures are the hallmark of most Nigerians. Have you not seen a 40k earner buying shoes of 7k just to impress, or withdrawing the entire funds with ATM just to go out with friends? People do not plan their expenditures, their travels, their investments and their debts. This is why people find it difficult to pay bills that are well scheduled like school fees of their children, house rent, hospital bills of their just delivered wives and other similar recurrent but scheduled bills.

The third most common cause of poverty in Nigeria is assumptions. We as Nigerians assume a lot. We assume that someone will give us money when we ask, that an angel will save us from landlords and pay our bills, someone will take over the payment of our children's school fees, someone will bring bags of food to our homes when we are hungry. To ensure that this happens, some people spend their productive hours praying and fasting and forgetting the spiritual injunction that "whatever a man sows, that is also what he will reap". So if we sow prayers, we reap answers. And a heavenly answer may be (as it is in most cases), Go and Work. People assume that landlords will forget or let go, that hospitals will be merciful and reduce their bills that schools will look the other way and allow the students to continue schooling and that even transporters will carry them free to their destinations. These assumptions have severally led to diverse forms of frustrations and sometime depressions. This is the third reason why Nigerians are poor.

Am I saying that policies are not needed? No. They are needed, but they are not the primary reason why people are poor.

I am told that the laziness of Nigerians can be linked to the abundant natural resources in Nigeria – including the black gold. This is why Nigeria still export raw materials and import finished products. This is why the economy is still 95% crude oil dependent. This is why despite 24/7 summer, power problems are still a major challenge in Nigeria. This is why Nigerians are still sending sick people to India and other countries where people are less lazy for medical care.

Friends, understand that the Government cannot and should not do everything. Take a look at countries where things work. The people play a major role. They take responsibility and choose to make a difference. We must change our mindset if the entire nation must move forward. We must destroy laziness, procrastination, 'planlessness' and assumption to build a nation we all can be proud of.

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Monthly Report: May 30th 2014 – June 29th 2014 (Q3M3)

1.0 Executive Summary

The month of June witnessed renewed activity across all thematic areas of the project. The month was spent essentially to review the gaps in the targets achieved for the project year so far and strategize on how to cover the gaps and end the project year on a strong note. In view of the new funding realities and strategic shifts, new approaches to do more with much less were put in place. Also EFMC worked at strengthening relationship between PHC and feeder sites, as well as reached out to more feeder sites to ensure wider reach. Also essential consumables were provided to all sites.

EFMC successfully facilitated a step down training on Continuous Quality Improvement (CQI) to staff and Seven (7) EFMC-supported comprehensive sites; paid comprehensive and PMTCT sites monthly obligated funds for the month of April; facilitated the retirement of Q2 funds from some supported sites and ensured proper handling of resources at site levels. Following the IHVN sub-partner meeting on June 18th, 2014, the HSS unit further facilitated a Partners/Stakeholders forum that brought together Medical directors, Government officials (from FCT Agency for the Control of AIDS [FACA], Health and Human Services Secretariat [HHSS]) and some PLHIV for the purpose of updating them on the new strategic shift which will take effect from October 2014 and discuss way forward

The Clinical care unit focused on sanitizing the pediatric figures as well as improving the current reach in the month of June by sensitizing healthcare workers at the immunization clinics of supported sites to refer all unscreened women for HIV screening and refer children of HIV-infected women for appropriate tests. The unit also participated in a CQI step down meeting for staff of EFMC and representatives of comprehensive sites. There will be follow-up to ensure CQI teams are set up and functional at the comprehensive sites. The team paid visits to supported sites to mentor staff on various aspects of HIV program to ensure quality service delivery.

The PMTCT team focused on new weekly target for Project Assistants and Volunteers, building the capacity of Staff of the team especially the SURE–P interns, Supported sites and Feeder sites as well as developed new strategies towards meeting and surpassing the unit's target by end of the project year. The unit received a new Project Manager and had a successful handing over of the unit's activities early in the month.

Supportive visits were made to both the PMTCT and Comprehensive sites with emphasis on sites which had been activated in Rubochi axis in March this year. To make the mentoring/supportive visits more effective, new mentoring reporting form was introduced and used by team members for all sites visited during the month. A copy of the report given to the site and other copy filed for reference purpose. The PMTCT team built capacity of staff at some newly identified feeder sites especially in regards to Post-test Counseling and result disclosure and initiating pregnant women on ARVs. Linkages for referrals for reactive pregnant women were strengthened at newly acquired feeder sites. The CMD and staff of the General Hospital Bwari were engaged in establishing linkages of all units providing PMTCT service and follow up for exposed babies in line with National guidelines.

In a bid to effectively utilize the PHC staff, especially those whose monthly output were below 30 HTC, EFMC developed a strategy of supporting these PHC staff to search, identify and work with TBA/maternity homes within their proximity to increase their HTC output. Unit members participated in Staff Meetings where issues concerning on-going changes in the program were communicated to everyone. The team also participated in CDC ANC survey assessment in Bwari General Hospital.

The Laboratory team actively supported the facilities in provision of services to clients through TA/ Mentoring visits. The facilities were mentored on CD4 analysis, Documentation and Record keeping and other Quality issues. In areas where gaps were identified, corrective actions were instituted. Facilities were also supplied with reagents and commodities based on the report of their usage and quantification. A refill request was made from EFMC central store to IHVN.

IHVN biotech Engineers were notified of Equipment that were due for maintenance (both corrective and preventive). Also, the Beckman Hematology analyzer belonging to MDH that was taken out for repairs have been traced to be with Darlez Nig. Ltd. IHVN and EFMC are both working towards getting the machine back to the facility. More so, MDH has now been enrolled in the National Proficiency Testing Scheme (NPTS) to enable them receive EQA Panels from One world Accuracy.

The community services team supported three facilities with high client inflow with PITC while other facilities were able to carry out the PITC services on their own with periodic technical assistance by the unit. The unit also supported an orphanage home and a church with HTC activities.

Household Economic Strengthening (HES) training and mentoring was conducted at two different venues (Modern Health Hospital and Abaji General Hospital) for the caregivers of Orphans and Vulnerable Children (OVC) in FCT. The care givers were drawn from all supported comprehensive sites in FCT except Kuje and Keffi General Hospitals. Support group meetings were also held at four comprehensive sites in the month of June.

2.0 Performance @ a GLANCE (ACTION PLUS UP)

Variable	Monthly Achievement	Cumulative Achievement	Annual Target	% Achievement (cumulative/annual target)
Patients in Care (clinical care - Adult)	169	5490	4,767	115%
TB/HIV	2	77	150	51%
Adults on ART	135	4397	4,145	106%
Children in care (clinical care)	11	316	443	71%
Children on ART	8	217	386	56%
HTC	6015	84931	138,544	61%
Number of pregnant women with known HIV status (includes women who tested for HIV and received their results)	4083	28708	40,299	71%
Vulnerable Children	57	3216	4,000	80.4%

3.0 June Facts Sheet

Clinical Care	• Sensitized healthcare workers at the Immunization clinics of supported sites to refer all unscreened women for HIV screening and refer children of infected women for appropriate tests. • Compiled TB/HIV data from DOTS clinics of supported facilities. • Requested for and received the Protocol for viral load testing from IHVN. • Provided mentoring for the new doctor posted to Clinical Care unit/MHH on activities of the ART program. • Facilitated sessions on Continuous Quality Improvement (CQI) during step down for EFMC staff. • Facilitated comprehensive sites' CQI meeting. • Attended first quarter EID Coordination Meeting for Abuja Municipal and Bwari Area Councils organized by FASCP/UNICEF. • Mentored staff across all supported facilities on various aspects of qualitative HIV care and treatment.
Community Services	• PITC was carried out in all ARISE supported sites. • Follow-up of clients at ARISE facilities. Clients who either missed their appointments or refill dates were reached through phone calls at 6 ARISE comprehensive sites.

	• Rachael Orphanage home and Redeemed church Kubwa were supported with HTC activities. • 87 (M-36, F-51) clients who missed appointments were followed up. 7 Loss to Follow-Up (LTFU) returned back for treatment. • Eligible individuals received a minimum of one clinical service at all ARISE Comprehensive sites. • Coordination of Support Group meetings at AGH, MHH, GGH and BGH. 69 (M-20, F-49) clients were in attendance. • The unit provided Technical Assistance to GGH on HTC. • 147 care-givers were trained on Household Economic Strengthening skills.
Commodity, Procurement & Medical Logistics	• Exchange and redistribution of ARVs to reduce expiries. • Acquisition and redistribution of RTKs between facilities. • Provided hands-on training to Kuje General Hospital ARV Pharmacists. • Supplied consumables to facilities
Health Systems Strengthening	• Capacity of EFMC technical staff and twelve (12) participants from seven (7) comprehensive sites built on CQI. • Paid PMTCT sites monthly obligated funds for the month of April. • Pre-CDC Sites Monitoring Strategy (SMS) visit to 6 EFMC's PMTCT sites.
Laboratory Services	• Facilitated referral linkages for all our supported facilities. • Facilitated the supply of Laboratory reagents and commodities to sites for provision of services. • Supported the provision of ART services at 8 comprehensive sites by ensuring that CD4 and other monitoring tests are done. • Laboratory reagents and commodities were received from IHVN and distributed to facilities for quality service provision. • Followed up with IHVN on the enrolment of MDH in the National Proficiency Test Scheme (NPTS). • Capacities of Laboratory personnel at KJGH, BGH, MHH, built on CD4 analysis, good documentation and Record keeping and on making proper quantification and forecasting of commodities. • Facilitated the servicing and maintenance of CD4 Cyflow analyzer at MHH and ERMA Hematology analyzer at AGH.
Prevention of Mother to Child Transmission	• Structured TA visits to 12 sites to address peculiar situations. • Capacity building for staff at 3feeder sites. • Selected PHCs informed and prepared for CDC visit. • Participated in CDC ANC survey assessment in Bwari General Hospital. • Support PHC staff to identify and work with at least 3

	feeder sites within their proximity. • More than 6 new feeder sites identified. Greater buy-in of the PHCs in handling feeder sites. • Strengthen EID and sample Batching.

4.0 Next Steps

1. Participate in PMTCT/Paediatric TWG Meeting organized by FASCP.
2. Plan towards conducting a refresher course on the ART program for clinicians at Maitama District Hospital.
3. Develop proposal on Adult vaccination.
4. Improve site capacity on reporting stock utilization and resupply to reduce incidence of stock out.
5. Strengthen EID and sample batching across PMTCT sites.
6. Continuous capacity building of staffs especially new SURE-P Interns.
7. Requisition and supply of DTS Controls to facilities.
8. Acquisition of RTKs for redistribution to facilities.
9. Follow up on trained caregivers on way forward for HES.
10. Facilitate CDC SMS visit to our sites.

5.0 Conclusion

The month of June witnessed renewed activities across all thematic areas of the project as it was spent essentially to review the gaps in the targets achieved for the project year. It is hoped that more successes will be achieved as more efforts will be made to improve participation, facilitation, strengthening and follow-up.

Courtesy: **Communication Team**