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United States

Agency for International Development

**Nigeria Combatting Childhood Communicable Diseases
(NCCCD)**

**Project Paper
620-0004**

July 1993

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ACTION MEMORANDUM FOR THE DEPUTY ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: Don Clark, Director, AFR/CCWA 

SUBJECT: Nigeria Combatting Childhood Communicable Diseases
(NCCCD) Project

I. PROPOSED ACTION:

Your approval is requested for a \$40 million grant from the Development Fund for Africa (DFA) appropriation to the Federal Government of Nigeria (FGN) for the Nigeria Combatting Childhood Communicable Diseases (NCCCD) Project. Project assistance over a seven year period would include technical assistance, advisory services, training and program support. It is planned that a total of \$7,100,000 will be obligated in FY 1993.

II. DISCUSSION:

A. Background: The proposed project is to be financed through a grant from the Development Fund for Africa (DFA). Its goal is to assist the Federal Government of Nigeria in its efforts to promote a healthier and more productive society and a decrease of morbidity and mortality. The project purpose is improved maternal and child health practices. Support of the Nigerian health sector has been a central focus of AAO/Nigeria's program for nearly ten years, in accordance with A.I.D. policies and Congressional direction. Since 1986, when the initial Combatting Childhood Communicable Diseases (CCCD) Project was launched with financial support from the Africa Bureau Regional Africa Child Survival Initiative (ACSI), AAO/Nigeria has encouraged and financed the introduction of child survival interventions as a means for building a comprehensive health care system. At the local level, this project is an important effort in addressing rapid population growth and infant, child, and maternal morbidity and mortality. Over the past six years the ACSI/CCCD Project has played a central role in strengthening the capacity of staff from selected states and Local Government Areas (LGAs) to plan, implement, and monitor the impact of focused child survival interventions, particularly the Expanded Program for Immunization (EPI) and malaria, and such infrastructure development as continuing education and health information systems.

By continuing to provide assistance which remedies high mortality and high fertility conditions in the context of the ongoing democratic reform and decentralization, AAO/Nigeria is afforded new opportunities: (a) to influence policies regarding the provision of public and private health care; (b) to engage in meaningful dialogue on the practical application of democratic governance principles in Nigeria; and, most significantly, (c) to lighten the burden of ill health and excessive fertility on the population of Nigeria and, thus, improve the lives of many Nigerians. The project will thus continue to support the FGN's commitment to its overall health sector program.

B. Project Description: The NCCCD project will provide support through two project elements: (a) strategies to strengthen infrastructure in support of technical interventions; and (b) major child survival interventions.

NCCCD will be implemented through Nigeria's three tier administrative structure which includes: the Ministry of Health and Social Services (MHSS) and the Primary Health Care Agency of Nigeria (PHCDAN) at the federal level, the State Ministries of Health (SMOH), and the Local Government Areas, where the principal assistance for the strengthening of Primary Health Care (PHC) service delivery will take place. NCCCD will focus on nine states and initially on the twelve LGAs involved in the forerunner ACSI/CCCD project. Project resources and host government absorptive capacity will permit the expansion of LGA participation at the rate of approximately twelve LGAs per year for four years. It is, generally, understood among all parties that each LGA will have differing requirements, interests, and capabilities. NCCCD will recognize and be responsive to those differences. It is expected that the level of effort will vary from one LGA to the next, and that they will be "graduating" at different times.

The success of the project is largely dependent on improved infrastructure, especially at the local level. Selection and "graduation" of local government areas participating in the project are key elements and markers of NCCCD implementation. The development and adoption of selection and operational criteria for the participation of focus LGAs as well as the monitoring of inputs to those entities and the results derived therefrom are critical concerns to be addressed on a continuing basis throughout the life of the project (LOP) by representatives of federal, state, and LGA government's tasked with that job in direct collaboration with AAO/Nigeria and NCCCD Project Managers.

The first project element for strengthening infrastructure, focuses on interventions to: (a) improve management of health resources at the local level; (b) foster continuing education and strengthen in-service training systems; (c) establish standards of quality assurance for child survival interventions throughout the national primary health care system; (d) strengthen health education and communications; (e) improve the health information system at all levels; (f) support operations research to

strengthen implementation of child survival interventions; and (g) stimulate private sector delivery of primary health care.

Child survival interventions will focus on: (a) prevention (i.e., immunization; maternal, infant and child nutrition; safe motherhood; and child spacing); and (b) case management of the sick child, including integrated strategies for treating the child suffering from a combination of fever, diarrhea, acute respiratory infections (ARI), and malnutrition.

LGA selection, needs assessment in terms of technical assistance and resources, work plan preparation, establishment of operational standards of performance, nature and magnitude of self-help contribution, and means of measurement towards achievement of "graduation" status are topics of critical concern. There is general agreement among project participants that these matters are priority implementation issues requiring a concerted effort. The establishment of criteria is a crucial prerequisite to the provision of assistance to newly participating LGAs. To formulate an effective modus operandi for this aspect of the project, including the development of necessary selection and operational criteria, AAO/Nigeria will participate on a committee of federal, state and LGA representatives tasked with that job. Such matters will be addressed by NCCCD on a continuing basis.

LGA capacities to use technical assistance vary considerably and need to be considered in LGA selection, span of program activities, and speed of implementation. Such criteria include: (a) understanding of, commitment to, and support for PHC programs on the part of LGA officials; (b) capability, commitment, and motivation of the LGA PHC Coordinator; (c) LGA topography, facilities, and means of communications (roadways, rivers, etc.); (d) type and distribution of health-care providers (public, private, commercial, traditional); (e) public sector staffing levels, qualifications, and motivation; (f) adherence to gender concerns and the rights and involvement of women; (g) presence of or commitment to a system of village health committees and voluntary village health workers; and (h) access to, and patterns of use of, public health facilities.

The NCCCD vision is that "graduated" LGAs will:

- routinely prepare annual work plans with defined targets for access, quality, and coverage, and will utilize such work plans to implement an effective PHC program throughout their respective areas of jurisdiction.
- possess and operate a functional revolving drug fund ensuring availability of ten essential drugs at all health facilities within their respective jurisdictions.

- be providing basic preventive (EPI and family planning), maternal health (prenatal and postpartum), and integrated case management (ARI, control of diarrheal diseases, malaria, and pneumonia) services to their respective populations.
- implementing throughout their respective areas of jurisdiction ongoing programs of training and supervision aimed at ensuring defined levels of quality.
- At least twenty percent of the communities within such LGAs will have functioning village health committees charged with planning and monitoring their own PHC programs.
- Each functional entity within such LGAs (i.e., communities, health facilities, districts) and the LGAs, themselves, will be utilizing at least five indicators to monitor program implementation.

During the design process, various factors were identified that require a continuing dialogue with host country counterparts during project implementation. These include the following topics: (a) sustainability; (b) cost-recovery; (c) host country contribution of resources; (d) standards of care and quality assurance; (e) donor coordination; (f) policy environment; (g) decentralization of public sector service delivery; (h) private sector participation; (i) ethnosocial considerations, (j) equity in allocation of resources for health services and beneficiary access to health facilities; and (k) public opinion with respect to health and population considerations.

C. Beneficiaries: The primary beneficiaries of the proposed project are women and children who will have improved health through maternal and child health services in the selected states and Local Government Areas of Nigeria.

D. Conditions and Covenants: The Project Grant Agreement will incorporate specific Conditions Precedent to Disbursement of Grant Funds and Covenants; these are set forth in the attached Project Authorization.

E. Financial Summary of Project: The following table represents illustrative financial plans for the project:

TABLE 1 SUMMARY COST ESTIMATE AND FINANCIAL PLAN (US \$ Millions)					
ELEMENT	A.I.D.		HCC		TOTAL
DESCRIPTION	FX	LC	FX	LC	(US \$)
TECH ASSISTANCE	<u>19.8</u>	<u>(2.2)</u>			<u>19.8</u>
1. CDC PASA	7.1)			7.1
2. R&D + AFR Buy-ins	7.3				7.3
3. AAO Direct	2.0				2.0
4. Admin Support (PAF)	3.4	(2.2)			3.4
5. PARTICIPANTS	<u>0.3</u>				<u>0.3</u>
6. COMMODITIES	<u>4.3</u>				<u>4.3</u>
LOCAL COSTS		<u>14.6</u>		<u>28.6</u>	<u>43.2</u>
7. MHSS/PHCDAN		2.5		6.6	9.1
8. SMOHs		3.2		14.5	17.7
9. LGAs		6.0		7.5	13.5
10. Private Sector		0.4			0.4
11. Local TA		2.5			2.5
12. AUDIT	<u>1.0</u>				<u>1.0</u>
PROJECT TOTAL	25.4	14.6		28.6	68.6

F. Environmental Examination: The Africa Bureau Environmental Officer found that categorical exclusions and a negative determination exempt this grant from further environmental examination, according to 22 CFR 216.2 (c)(2) and 216.3 (b).

G. Waivers: Your waiver of competition is requested, pursuant to your authority under Handbook 1B, Chapter 12C4(a)(2)(c) to authorize the procurement from UNICEF of \$2,500,000 in cold chain, clinical and laboratory and training equipment, as described and justified in the waiver set forth in Annex P. This waiver is justified on the basis that the adherence to competitive procedures would not be in the best interest of the United States. The requirement for any waiver for the transportation of those items (at an approximate shipping cost of \$375,000) will be made by FA/OP/TRANS.

H. Justification to the Congress: The Congress was given official notification of this project through a Congressional Notification dated May 28, 1993. The CN expired on June 11, 1993 without objection.

I. Statutory Checklists: The Statutory Checklists have been satisfactorily completed and are included in Annex B of the Project Paper.

J. Project Paper Development: The development of the project is as follows: a) 92 STATE 191928 reported on the Project Identification Document (PID) ECPR review and authorized AAO/Nigeria to proceed with development of the Project Paper (PP) drawing on guidance provided by that message; and b) STATE 097268 reported on the ECPR review of the PP and approved the PP, subject to further guidance provided in STATE 128251. Annex A of the Project Paper identifies specific elements of that guidance as responded to by the Project Paper. The final version of the PP, including the joint development with REDSO/WCA of a Procurement Plan, responds to that guidance.

III. COMMITTEE ACTION AND FINDINGS: The Africa Bureau ECPR met on March 30, 1993 and recommended that the DAA/AFR approve the Nigeria Combatting Childhood Communicable Diseases Project. Below are primary issues based on ECPR discussions. A more detailed response to the ECPR issues from AAO/Nigeria is attached.

- Project Management. The first, and main issue concerned the level of the mission's USDH staff resources for project management and oversight given the size and scope of the program. The issue extended to the ability of REDSO/WCA to provide adequate support for project implementation. The ECPR decided that, working with REDSO/WCA, the mission should identify options for streamlining administrative, financial and contracting actions in an effort to reduce the management load for implementing this project. In accordance with

Abidjan 07934, which is attached, the AAO/Nigeria and REDSO have jointly concurred on a procurement plan for the Project. The content of the procurement plan is presented in Tab 1. The plan discusses both the magnitude (volume of actions) and sequence and timing of assistance required by AAO/Nigeria, i.e. it will cover procurement actions and REDSO/WCA support - including audits of grantee entities receiving U.S. Government resources.

The plan delineates the specific actions required from both AAO/Nigeria, REDSO/WCA and AID/W to ensure timely implementation of the project. The plan, is now the basis of a management agreement between REDSO/WCA, AAO/Nigeria and AID/W as to when specific actions are initiated and which support services are required for the successful implementation of this important project.

Concerning the accounting certifications that are required, the ECPR, including the Africa Bureau Controller, concluded that the method which will be used by AAO/Nigeria is acceptable (the A-133 certification is prepared by a contractor and the USDH controller utilizes this information as the basis for formal A.I.D. Certification). However, the responsibility for the correctness and completeness of the information upon which the certification is based ultimately rests with the mission.

- Sustainability. The ECPR raised concerns on the sustainability of project interventions, especially with budget allocations at the LGA level and in establishing criteria for LGA selection and graduation.

The Project Paper has been modified to incorporate these concerns. The Project now incorporates a comprehensive discussion regarding efforts achieved under the NPA Primary Health Care Support Program and how these efforts will assist in achieving sustainability under the follow-on project (see Tab 2). The AAO/Nigeria and Nigerian counterparts have established criteria for selection and graduation of LGAs which will ensure proper budgetary support at the LGA level (See Tab 3). These criteria will ensure that A.I.D. funding to LGAs will be limited to those entities which show the desired policy and financial commitment, and potential technical and managing capacity.

- OYB Transfers. The discussion centered around the proposed use of OYB transfers and their consistency with DFA requirements for measuring and reporting on project impact. It was concluded by the ECPR that the proposed vehicle for accessing centrally-funded contracts will be through buy-ins utilizing funds obligated under the Grant Agreement. When OYB transfers are utilized to meet special requirements, specific measurable impact indicators will be linked to contractor performance at the purpose and/or output levels.

• Covenants. The ECPR noted that the financial requirements for ensuring project success were presented in terms of covenants which generally would otherwise be included as conditionality under a non-project assistance modality. The covenants have been revised (see Tab 4) and the content of a number of the previously proposed covenants are included in Annex Q which will serve as an agenda for bilateral dialogue during project implementation. As an initial step in that dialogue, the substance of Annex Q will be issued in a Project Implementation Letter.

The project design and emphasis is in conformance with A.I.D.'s and AAO/Lagos' policies and strategies for child survival. Addressing the Government's strategies and priorities, the Project supports Nigeria's primary health care program. The feasibility analyses, including economic, financial, institutional and social soundness indicate that the project is an appropriate mechanism for achieving the objectives of the Project.

IV. RECOMMENDATIONS: That you sign the attached Project Paper Facesheet/Project Data Sheet, and the attached Project Authorization.

Approved: _____



Disapproved: _____

Date: _____

7/21/92

Attachments:

Abidjan 07934 -- REDSO/WCA Concurrence/Procurement Plan
Project Authorization
Nigeria CCCD Project Paper
AAO/Nigeria's Response to STATE 128251

Clearances:

AFR/CCWA/PDEA, PTuebner: PT Date: 6/11/93
AFR/CCWA/NIG, CDoggett: (draft) Date: 6/11/93
GC/AFR, JScales: JM Date: 6/16/93
AFR/ARTS/HHR, MWarren: MS Date: 6/11/93
AFR/MRP/RC, LGrizzard: LG Date: 6/22/93
AFR/DP, MBonner: MB Date: 6/18/93

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ACTION AID-00

ACTION OFFICE AFCW-04
INFO GC-01 GCAF-02 GCCM-01 SEOP-01 SERP-01 AMAD-01 PODI-01
FABP-02 POCE-01 LAV-01 /016 A0 28/2200Z

INFO LOG-00 AF-00 CIAE-00 DODE-00 EB-00 /003W
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P 281643Z MAY 93
FM AMEMBASSY ABIDJAN
TO AMEMBASSY LAGOS PRIORITY
SECSTATE WASHDC PRIORITY 8522

UNCLAS ABIDJAN 007934

AFR/CCWA FOR PAUL TUEBNER

AIDAC

E. O. 12356: N/A
SUBJECT: NIGERIA NCCCD PROJECT (620-0004)

REF: STATE 128251

1. AID AFFAIRS OFFICER GENE CHIVAROLI AND PSC JOHN LUNDGREN MET WITH REDSO/WCA DIRECTOR FRITZ GILBERT AND REDSO/WCA PROJECT COMMITTEE (RLA, RCO, HPN, PDE AND D/D) ON MAY 18 AND 19 TO CONFER ON THE IMPLEMENTATION AND PROCUREMENT PLAN FOR THE SUBJECT PROJECT AS REQUIRED IN PARAGRAPH 4C OF REFERENCED CABLE. BASED ON THESE DISCUSSIONS REDSO/WCA CONCURS IN THE PROCUREMENT PLAN WHICH IS BEING SUBMITTED BY AAO/NIGERIA FOR INCLUSION IN THE FINAL PRINTING OF THE PROJECT PAPER.
2. ONE OF THE ADMINISTRATIVE STREAMLINING PROCEDURES WHICH WAS AGREED TO DURING THESE DISCUSSIONS WAS THAT THE REDSO/WCA DIRECTOR WOULD GRANT BLANKET DOA 551 CONCURRENCE (AS CONTEMPLATED BY DELEGATION OF AUTHORITY 551 SECTION 6. C.) ON ALL BUY-INS TO CENTRALLY FUNDED CONTRACTS BECAUSE THESE ACTIONS ARE PROGRAMMATICALLY REVIEWED BY AN AID/W PROJECT OFFICER AND THE CONTRACTING ACTION IS HANDLED BY FA/OP.
3. IN CLEARING THE SUBSTANCE OF THIS CABLE, AAO/NIGERIA CHIAVAROLI INDICATED THAT, ON OR ABOUT MAY 24, HIS OFFICE WILL DHL TO AFR/CCWA A COMPLETE PROJECT PAPER (INCLUDING THE DRAFT ACTION MEMORANDUM AND AUTHORIZATION) AS REVISED BY AAO/NIGERIA SUBSEQUENT TO ECPR AND REDSO/WCA CONSULTATIONS. REDSO/WCA JOINS AAO/NIGERIA IN REQUESTING THAT THE BUREAU AUTHORIZE THE SUBJECT PROJECT AS SOON AS POSSIBLE. CECIL

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SECTION ON METHODS OF IMPLEMENTATION AND FINANCING
(PAGES 59-60) CONTAINED IN THE FINANCIAL PLAN, INCLUDING
THE REVISED TABLE 3 ON PAGE 60.

ACTION OFFICE AFCV-04
INFO AFDP-06 AFPE-02 AFAR-05 OL-01 FAPB-01 PDID-01 GC-01
GCAF-02 GCM-01 SEOP-01 SERP-01 AFON-06
/032 A4 KL 04/1442Z

INFO LOG-00 AF-00 CIAE-00 DODE-00 EB-00 /003W
-----C75705 041420Z /48 38

P 041325Z JUN 93
FM AMEMBASSY LAGOS
TO SECSTATE WASHDC PRIORITY 3229
INFO AMEMBASSY ABIDJAN

UNCLAS LAGOS 08404

AIDAC

AID/W FOR AFR/CCWA/PTUEBNER
ABIDJAN FOR REDSO

E.O. 12356: N/A
SUBJECT: NIGERIA CCCD PROJECT PAPER AND AUTHORIZATION

REF: (A) STATE 128251; (B) STATE 097266; (C) STATE
164718; (D) ABIDJAN 087934

1. INTRODUCTION: AAO/NIGERIA HAS COMPLIED WITH INSTRUCTIONS REFTELS (A) AND (C) RE MODIFICATIONS TO PROJECT PAPER, INCLUDING JOINT PREPARATION OF PROCUREMENT PLAN IN COLLABORATION WITH REDSO/WCA. AAO CHIAROLI AND PSC LUNDGREN CONFERRED IN ABIDJAN WITH REDSO DIRECTOR AND HIS STAFF DURING THE WEEK OF 5/17, AS REPORTED REFTEL (D). COMPLETE REVISED PROJECT PAPER PACKAGE ADDRESSED TO

AFR/CCWA PTUEBNER, WILL BE HAND CARRIED BY RUDOLPH THOMAS FOR DELIVERY ON MONDAY, WITH REQUEST THAT AFR/CCWA:

- (A) RECUPERATE FROM THE ORIGINAL PP VERSION REMAINING IN CCWA THE IEE SIGNATURE PAGE SIGNED BY AFR ENVIRONMENTAL OFFICER AND GC/AFR FOR SUBSTITUTION OF UNSIGNED PAGE TRANSMITTED WITH PACKET IDENTIFIED ABOVE;
- (B) PRINT AND DISTRIBUTE COMPLETE PP (INCLUDING THE FORWARDING OF 100 COPIES TO LAGOS AND 20 COPIES TO REDSO/WCA); AND
- (C) PROCESS ASAP PROJECT AUTHORIZATION.

POINTS RAISED REFTELS (A) AND (C) AND OTHER MATTERS REFLECTED IN THE FINAL REVISED PP ARE ADDRESSED AS FOLLOWS (WITH ALL PAGES CITED REFERRING TO THE REVISED PP):

2. REDSO/WCA'S SUPPORT TO NCCCD IMPLEMENTATION AND THE PROCUREMENT PLAN: A REWRITTEN PROCUREMENT PLAN IS CONTAINED ON PAGES 39-46 OF THE REVISED PP. THIS REVISED PROCUREMENT PLAN AND A RELEVANT STATEMENT CONTAINED IN THE SECTION ON MANAGEMENT AND ADMINISTRATION (PAGE 54) ADDRESS THE LEVEL AND KIND OF REDSO/WCA SUPPORT AND SERVICES TO BE PROVIDED NCCCD. THE PROCUREMENT PLAN DETAILS THE PROCUREMENT ACTIONS TO BE TAKEN AND THE ROLES TO BE PLAYED BY PARTICIPATING PARTIES. THE PROCUREMENT PLAN INDICATES THAT REDSO/WCA WILL NEGOTIATE THE PASA WITH CDC AS WELL AS THE CONTRACT

FOR THE PAF FUNCTION. COMMODITY PROCUREMENT THROUGH UNICEF WILL BE PROCESSED BY FA/OP FOLLOWING HB15 PROCEDURES. THE PROCUREMENT PLAN IS SUPPLEMENTED BY THE

3. THE NPA EXPERIENCE AND LOCAL CURRENCY CONTRIBUTION: THE REVISED PP PROVIDES ON PAGES 4-5 A COMPREHENSIVE DISCUSSION REGARDING THE NPA PRIMARY HEALTH CARE SUPPORT PROGRAM (PHCSP). THE PHCSP HAS SUPPORTED ATTAINMENT OF NCCCD OBJECTIVES THROUGH THE STRENGTHENING OF HEALTH POLICY DEVELOPMENT AND HEALTH SECTOR ADMINISTRATION AND FINANCING. THE PHCSP HAS SUBSTANTIALLY INCREASED MHSS CAPACITY TO SUPPORT STATE AND LGA HEALTH SECTOR ACTIVITIES, INCLUDING INCREASED EMPHASIS ON PRIMARY HEALTH CARE AND DECENTRALIZATION OF AUTHORITY TO PROVIDE IT.

4. NCCCD LOCAL COSTS ELEMENT: DURING THE ECPR REVIEW, AAO/CHIAROLI STRESSED THE IMPORTANT CONTRIBUTION OF THE PHCSP TO THE OVERALL AAO/NIGERIA PROGRAM, IN GENERAL, AND NCCCD, SPECIFICALLY. HE OUTLINED NEGOTIATIONS NOW UNDERWAY TO ATTRIBUTE A PORTION OF THE LOCAL CURRENCY GENERATED FROM THE NPA TO SUPPORT THE NCCCD PROJECT AND REPEAT AND THE FHS II AND AIDS PREVENTION AND CONTROL PROJECTS. HE AGREED THAT ANY OF THE NPA FUNDS NEGOTIATED IN SUPPORT OF THE NCCCD PROJECT COULD RESULT ULTIMATELY IN REDUCING THE DOLLAR REQUIREMENT OF THE PROJECT. NEGOTIATIONS ON THE USE OF THE NPA LOCAL CURRENCIES ARE NOT COMPLETE AND NOT LIKELY

TO BE COMPLETED UNTIL A NEW GOVERNMENT AND A NEW MINISTER OF HEALTH ASSUMES OFFICE, PROBABLY IN OCTOBER. THE NCCCD AUTHORIZATION SHOULD GO FORWARD IN ACCORDANCE WITH FUNDING LEVEL SHOWN ON PROJECT DATA SHEET. INTERNAL ADJUSTMENTS TO THE PROJECT BUDGET CAN BE MADE SUBSEQUENT TO COMPLETION OF NEGOTIATIONS ON THE USE OF NPA LOCAL CURRENCY WHEN, AND IF, SUCH ADJUSTMENTS ARE EVENTUALLY DEEMED NECESSARY.

5. CRITERIA FOR LGA SELECTION AND GRADUATION: DISCUSSION OF NCCCD IMPLEMENTATION AT THE LGA LEVEL (PAGES 31-34) ADDRESSES CRITERIA FOR LGA SELECTION AND GRADUATION, INCLUDING PRESENTATION OF A QUOTE UNQUOTE OF THE TYPICAL GRADUATED LGA. CRITERIA FOR SELECTION INCLUDES INTER ALIA COMMITMENT, FINANCIAL AND OTHERWISE, ON THE PART OF INDIVIDUAL LGAS. FORMULATION OF AN EFFECTIVE MODUS OPERANDI FOR SELECTING LGAS AND MONITORING THEIR PROGRESS TO GRADUATION IS AN ELEMENTARY ASPECT OF THE ENVISIONED PROJECT IMPLEMENTATION PROCESS. AS STIPULATED IN THE DRAFT PROJECT AUTHORIZATION MEMO, SELECTION AND QUOTE GRADUATION UNQUOTE OF LOCAL GOVERNMENT AREAS (LGAS) PARTICIPATING IN THE PROJECT ARE KEY ELEMENTS AND MARKERS OF NCCCD IMPLEMENTATION. THE DEVELOPMENT AND ADOPTION OF SELECTION AND OPERATIONAL CRITERIA FOR THE PARTICIPATION OF FOCUS LGAS AS WELL AS THE MONITORING OF INPUTS TO THOSE ENTITIES AND THE RESULTS DERIVED THEREFROM ARE CRITICAL CONCERNS TO BE ADDRESSED ON A CONTINUING BASIS THROUGHOUT LOP BY REPRESENTATIVES OF FEDERAL, STATE, AND LGA GOVERNMENT TASKED WITH THAT JOB IN DIRECT COLLABORATION WITH AAO/NIGERIA AND NCCCD PROJECT MANAGERS. MUCH OF THE

THRUST OF THE DIALOGUE AGENDA DETAILED IN ANNEX Q IS DIRECTED TO THAT END.

6. ACCESSING CENTRAL CONTRACTS: AS INDICATED ON PAGE 37, R&D CENTRAL PROJECTS WILL BE ACCESSED THROUGH BUY-INS AND/OR OYB TRANSFER ARRANGEMENTS. THE PRINCIPAL VEHICLE FOR ACCESSING CENTRALLY-FUNDED CONTRACTS (CAS) WILL BE THROUGH BUY-INS UTILIZING FUNDS OBLIGATED UNDER THE GRANT AGREEMENT (GA). WHEN OYB TRANSFERS ARE UTILIZED

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WITH FUNDS OUTSIDE THE GA TO MEET SPECIAL REQUIREMENTS, RECOURSE TO THAT MECHANISM WILL BE SUPPORTED BY USE OF MEMORANDA OF UNDERSTANDING (MOU) LINKING CA PERFORMANCE TO SPECIFIC MEASURABLE IMPACT INDICATORS AT THE PURPOSE AND/OR OUTPUT LEVELS. SCOPES OF WORK (SOWS) WILL BE DRAFTED TO RESPOND TO THE TECHNICAL ASSISTANCE NEEDS OF NCCCD; THE WORK PERFORMED BY THE CAS WILL BE SUPERVISED BY AAO/NIGERIA.

THE PROCUREMENT PLAN (PP PAGES 42-43) STIPULATES THAT WHETHER OR NOT THE BUY-IN OR THE OYB TRANSFER MECHANISM IS UTILIZED, APPROPRIATE PROCEDURES, INCLUDING THE ELABORATION OF DETAILED SCOPES OF WORK (SOWS), WILL BE ESTABLISHED TO ASSURE THAT: (A) QUALITY DELIVERABLES ARE RECEIVED PROMPTLY; (B) SOW PERFORMANCE INDICATORS ARE LINKED TO PROJECT IMPACT INDICATORS; AND (3) CAS ARE HELD ACCOUNTABLE FOR PERFORMANCE AGAINST THOSE INDICATORS. INITIAL PIO/TS AND/OR PROJECT DESCRIPTIONS WILL DETAIL THE REQUIREMENT AND THE TECHNICAL ASSISTANCE TO BE PROVIDED; SUBSEQUENT, PROBABLY YEARLY, PROCUREMENT ACTIONS WILL BE NEEDED FOR INCREMENTAL FUNDING OF THE CONTRACTS. AAO WILL WORK WITH THE APPROPRIATE AFR

AND/OR RD OFFICE TO ASSURE THE TIMELY SUBMISSION OF QUALITY PIO/TS, ETC. AFR AND RD OFFICES WILL BE RESPONSIBLE FOR ASSURING THAT THE PROCUREMENT DOCUMENTATION IS FORWARDED TO OP AND ACTED UPON. AAO DOES NOT FORESEE ANY PROBLEM WITH PERFORMANCE MONITORING OF CA INPUTS TO THE DEGREE NECESSARY FOR MEASURING PROJECT IMPACT IN COMPLIANCE WITH DFA REPORTING REQUIREMENTS.

7. PRECEPTS FOR PROJECT SUCCESS: INITIAL VERSIONS OF THE PP INCLUDED CONCEPTS IN THE FORM OF COVENANTS TO BE CONSIDERED AS ITEMS ON A NON-BINDING CHECKLIST INTENDED TO CONVEY PHILOSOPHIC AND INTELLECTUAL AGREEMENT AMONG AAO AND HOST COUNTRY REPRESENTATIVES REGARDING VARIOUS FACTORS OF A NATURE SUSCEPTIBLE TO INFLUENCING PROJECT SUCCESS. WITH THE EXCEPTION OF MATTERS PERTAINING TO DONOR COORDINATION, THESE CONCEPTS, ARE NO LONGER RETAINED AS COVENANTS, BUT HAVE BEEN COMPILED IN ANNEX Q, WHICH WILL SERVE AS AN AGENDA FOR BILATERAL DIALOGUE CONTINUING OVER LOP. AS AN INITIAL STEP IN THAT DIALOGUE, THE SUBSTANCE OF ANNEX Q WILL BE ISSUED AS A PIL.

8. METHODS OF FINANCING: AS INDICATED ON PAGES 59-60, EVERY EFFORT WILL BE MADE TO EMPLOY COST-REIMBURSEMENT MECHANISMS. ONLY IN THE EVENT THAT THIS IS NOT POSSIBLE WILL FUNDS BE ADVANCED TO RECIPIENT AGENCIES. IN THAT CASE, THE PAF WILL PREPARE THE NECESSARY CERTIFICATIONS AND DOCUMENTATION FOR THE ADVANCE OF FUNDS. AS INDICATED IN THE SECTION STARTING PAGE 65, WHEN AND IF THE ADVANCE MECHANISM IS UTILIZED, AAO WILL INSTITUTE

APPROPRIATE CONTROLS APPLICABLE TO FUNDING ADVANCES TO HOST COUNTRY INSTITUTIONS.

9. CDC PASA: AS INDICATED ON PAGES 41 AND 44, THE PASA WITH CDC WILL SPECIFY, PRIMARILY, TECHNICAL ASSISTANCE INPUTS. HOWEVER, A LIMITED AMOUNT OF OFFSHORE TRAINING AND COMMODITY PROCUREMENT WILL BE INCLUDED IN THE SCOPE OF WORK. COMMODITY PROCUREMENT WILL BE LIMITED TO SPECIALIZED ITEMS (DISEASE SURVEILLANCE SOFTWARE, FOR EXAMPLE) FOR WHICH CDC HAS EXPERT KNOWLEDGE AND ACCESS. THE SAME PRINCIPLE WILL APPLY TO TRAINING BEING PROVIDED BY CDC; I.E. EPIDEMIOLOGICAL TRAINING COURSES AT CDC. A-76 DETERMINATION OF UNIQUE SUITABILITY WILL ACCOMPANY THE INITIAL PIO/T ORDERING THE PASA.

10. PHC RECURRENT COSTS AND COST RECOVERY: THE PP PUTS THE SUBJECT OF PHC RECURRENT COSTS AND COST RECOVERY INTO PROPER PERSPECTIVE IN A SECTION (PP PAGES 7-9) BEARING THAT TITLE. ADDITIONAL TREATMENT OF THE NCCCD COST RECOVERY STRATEGY IS FOUND ON PAGE 13 IN THE DISCUSSION REGARDING STRATEGIES TO STRENGTHEN INFRASTRUCTURE IN SUPPORT OF TECHNICAL INTERVENTIONS AS WELL AS ON PAGE 14 IN THE DISCUSSION RELATING TO THE STRENGTHENING OF FINANCIAL MANAGEMENT AND INFORMATION SYSTEMS AT THE LOCAL LEVEL. COST RECOVERY AND FINANCIAL SUSTAINABILITY ARE SUBJECTS TREATED IN THE FINANCIAL ANALYSIS CONTAINED IN ANNEX H. THESE SAME SUBJECTS ARE MAJOR ELEMENTS OF THE BILATERAL DIALOGUE AGENDA DETAILED IN ANNEX Q. DISCUSSION OF THOSE SUBJECTS AS A PART OF THAT BILATERAL DIALOGUE AND SIMILAR CONSULTATION

ENVISIONED WITH OTHER DONORS, PARTICULARLY THE WORLD BANK, IS A KEY ELEMENT OF THE NCCCD COST RECOVERY STRATEGY.

11. NCCCD EVALUATIONS: AS INDICATED ON PAGE 76, MANAGEMENT REVIEWS WILL INCLUDE EXTERNAL CONSULTANTS, WHO WILL PROVIDE AN INDEPENDENT, OUTSIDE PERSPECTIVE. AAO/NIGERIA WILL ENFORCE THE SAME STANDARDS IN THE COMPOSITION OF NCCCD MANAGEMENT REVIEW TEAMS AS WAS THE CASE WITH THE EVALUATION OF THE ACSI/CDCD EFFORT IN NIGERIA.

12. DATA SHEET: INCORRECT ENTRIES ON THE DATA SHEET HAVE BEEN RECTIFIED.

13. NEW COVENANTS: THE PP ADOPTS THE NEW COVENANTS AS TRANSMITTED REFTEL (A).

14. AAO APPRECIATES GUIDANCE CONTAINED REFTEL (C) AND WILL KEEP PERTINENT SUGGESTIONS IN MIND AS PROJECT IMPLEMENTATION PROGRESSES. IN THE MEANTIME, PP REVISION REFLECTS RELEVANT OBSERVATIONS MADE IN REFTEL (C).

15. THE CONDITION PRECEDENT TO FIRST DISBURSEMENT HAVING TO DO WITH OPINION OF COUNSEL REGARDING VALIDITY OF AGREEMENT EXECUTED WITH GRANTEE WAS SUBJECT OF RECENT AAO CONSULTATION WITH REDSO/RLA. THE CONCLUSION OF THAT CONSULTATION WAS THAT SAID CP WAS NOT NECESSARY, NOR WAS IT A MEANINGFUL REQUIREMENT IN THE NIGERIAN CONTEXT. THEREFORE, THAT CP HAS BEEN ELIMINATED FROM THE PP AND THE DRAFT PROJECT AUTHORIZATION.

16. CONSULTATION WITH REDSO ESTABLISHED A REQUIREMENT FOR INCLUDING IN THE PP NECESSARY SOURCE/ORIGIN, COMPETITION, AND TRANSPORTATION WAIVERS FROM CODES 000 AND 935 TO CODE 899 TO PERMIT COMMODITY PROCUREMENT THROUGH UNICEF. THEREFORE, PP NOW INCLUDES SUCH WAIVERS AS ANNEX P TO THE PP. THESE WAIVERS AND APPLICABLE CERTIFICATIONS ARE INCLUDED IN THE DRAFT PROJECT AUTHORIZATION.

17. RAPID, STEEP DEPRECIATION OF THE NAIRA HAS TAKEN PLACE IN RECENT MONTHS. WHILE THE ANTICIPATED HOST COUNTRY CONTRIBUTION (HCC) IN NAIRA AS SHOWN IN THE ORIGINAL VERSION OF THE PP REMAINS CONSTANT, THE DOLLAR VALUE HAS BEEN DRAMATICALLY REDUCED BY THE DEPRECIATION OF THE NAIRA. OVERALL PROJECT COST AND THE VARIOUS FINANCIAL TABLES HAVE BEEN REVISED, ACCORDINGLY, TO REFLECT THE CONTEMPORARY DOLLAR VALUE OF THE ANTICIPATED HCC.

18. THE ACTION MEMO INDICATES THAT CONGRESS WAS GIVEN OFFICIAL NOTIFICATION OF NCCCD THROUGH A CONGRESSIONAL

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RDAA-01 OFDA-02 HEAL-04 PGP-04 FHAD-02 CDC-06 AFON-06
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DRAFTED BY: AID/AFR/CCWA/PSEA: JPPADDACK: JPP
APPROVED BY: AID/AA/AFR:RCOBB
GC/AFR: JSCALES (DRAFT) R&D/H/AP: JHEIBY (DRAFT)
AFR/ART/HHR: HWARREN (DRAFT) AFR/MRP/CONT: LGRIZZARD (DRAFT)
AFR/CCWA: MGDOLDEN AFR/CCWA: CROZELL
AFR/CCWA/PDEA: PTUEBNER AFR/DP/PPD: PRAOER (DRAFT)

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SUBJECT: ECPR GUIDANCE -- NIGERIA CCCD PROJECT PAPER

1. SUMMARY. ON MARCH 30, 1993, THE EXECUTIVE COMMITTEE FOR PROJECT REVIEW (ECPR), CHAIRED BY DAA/AFR RICHARD A. COBB, MET TO REVIEW THE SUBJECT PROJECT PAPER FOR A PROPOSED SEVEN-YEAR, DOLS 48.0 MILLION EFFORT. THE

GOVERNMENT OF NIGERIA WILL CONTRIBUTE THE NAIRA EQUIVALENT OF DOLS 26.6 MILLION THROUGH LOCAL OPERATING COSTS AND IN-KIND CONTRIBUTIONS. THE GOAL TO WHICH NCCCD CONTRIBUTES IS TO PROMOTE A HEALTHIER AND MORE PRODUCTIVE SOCIETY. THE PROJECT'S PURPOSE IS TO IMPROVE MATERNAL AND CHILD HEALTH PRACTICES.

FIVE ISSUES AND FOUR CONCERNS WERE DISCUSSED. ISSUES/CONCERNS PREVIOUSLY RESOLVED BY THE PROJECT COMMITTEE WERE PRESENTED IN A SEPARATE PAPER AS AN ANNE TO THE ECPR ISSUES PAPER; THESE RECOMMENDATIONS FOR AAO/NIGERIA WILL BE SENT SEPTEL. DAA/AFR COBB APPROVED THE NCCCD PP, AT THE PROPOSED FUNDING LEVEL OF DOLS 48 MILLION, SUBJECT TO GUIDANCE CONVEYED IN THIS CABLE WITH MODIFICATIONS DESCRIBED, DAA/AFR WILL AUTHORIZE THE PROJECT IN AID/W.

2. ATTENDANCE. PRESENT AT THE DELIBERATIONS WERE THE FOLLOWING OFFICES' REPRESENTATIVES: AAO/NIGERIA'S REPRESENTATIVES WERE GENE CHIAVAROLI AND PSC JOHN LUNDGREN; AFR/CCWA (MGOLDEN, CROZELL, PTUEBNER, GHERRITT, WILLIAMS AND J-PPADDACK); R AND D/H (JHEIBY, J TOMARO, MAANDERSON AND DGIBB); GC/AFR (JOHN SCALES); R AND D/POP (KRISTA STEWART); AFR/ARTS (RHALADAY); AND AFR/MRP/CONT (LARRY GRIZZARD).

3. OPENING REMARKS.

A. AFR/CCWA DIRECTOR, MYRON GOLDEN, OPENED THE SESSION

WITH A DISCUSSION OF THE PROPOSED PROJECT IN THE CONTEXT OF THE APPROVED NIGERIA COUNTRY PROGRAM STRATEGY PAPER (CPSP). THE AAO/NIGERIA STRATEGY REQUIRES A MINIMUM USDH

PRESENCE IN LAGOS; AND, THOUGH NIGERIA HAD BEEN IDENTIFIED AS A QUOTE FOCUS UNQUOTE COUNTRY BY AFR IN APRIL 1992, THE PORTFOLIO WAS TO BE LIMITED TO THE HEALTH, POPULATION, AND NUTRITION (NPN) SECTOR. THE ECPR WAS REMINDED THAT AFR GUIDANCE IN APPROVING THE CPSP HAD INCLUDED THE REQUEST THAT A MANAGEMENT ASSESSMENT OF THE OVERALL AAO/NIGERIA PORTFOLIO BE COMPLETED AND FEASIBLE MANAGEMENT PLANS IDENTIFIED; AND THAT THIS ASSESSMENT WAS PERFORMED AND FEASIBLE STRUCTURES WERE IDENTIFIED. AAO AND AFRIS SUCCESSFUL PARTNERSHIP WITH THE RESEARCH AND DEVELOPMENT BUREAU, ACHIEVED OVER THE PAST SEVERAL YEARS, WAS NOTED AS A CRITICAL FEATURE OF THE NIGERIA STRATEGY.

B.1. AAO/NIGERIA, GENE CHIAVAROLI, PROVIDED FURTHER BACKGROUND. HE NOTED SEVERAL STUDIES RECENTLY COMPLETED FOR THE PROJECT BY THE CENTERS FOR DISEASE CONTROL (CDC) AND R&D BUREAU. THE CULMINATION OF THIS PREPARATORY WORK WAS A WEEK-LONG WORKSHOP, HELD IN LAGOS WITH 50 TO 60 NIGERIANS, TO DISCUSS THE NCCCD PROGRAM CONCEPT, GAIN MORE IDEAS, AND BUILD CONSENSUS AMONG PROJECT PARTICIPANTS. STRONG HOST COUNTRY AGREEMENT WITH THE NCCCD WAS EVIDENT, AND AS A RESULT OF THIS WORKSHOP CHANGES WERE AGREED UPON AND ARE REFLECTED IN THE PROJECT PAPER.

B.2. POLICY ENVIRONMENT. CHIAVAROLI NOTED THAT AFR/DNI'S RECENT STUDY CONCERNING SUSTAINABILITY HIGHLIGHTED KEY

LESSONS LEARNED DURING THE NCCCD'S PREDECESSOR PROJECT, THE ACSI/CCCD, AND MADE SPECIFIC RECOMMENDATIONS FOR THE FUTURE. THE AAO AND CDC/WHO LARGELY AGREED WITH THE OHI REPORT, AND AAO HAS UNDERTAKEN TO INCORPORATE THESE RECOMMENDATIONS INTO THE NCCCD. HE NOTED FURTHER, THAT THE PRIMARY HEALTH CARE SUPPORT GRANT (AEPRP, NON-PROJECT ASSISTANCE, NO. 620-0003) HAD ACHIEVED ITS PURPOSES IN THE AREAS OF DECENTRALIZATION OF THE NATIONAL PRIMARY HEALTH CARE SYSTEM AND ENHANCED BUDGETS FOR LGAS. THESE ARE ESPECIALLY RELEVANT IN THAT THE MAJORITY OF INTERVENTIONS IN THE FOLLOW-ON PROJECT WILL BE DIRECTED AT THE LOCAL GOVERNMENT AREA (LGA).

B.3. GOVERNANCE AND QUALITY ASSURANCE. ONE OF THE RECOMMENDATIONS MADE IN THE PRE-REVIEW WORKSHOP HELD IN NIGERIA, WAS TO INCLUDE A GOVERNANCE COMPONENT SO AS TO IMPROVE THE LOCAL MANAGEMENT OF HEALTH RESOURCES. OTHER NEW ELEMENTS IN THE PROJECT INCLUDE THE ADDITION OF A QUOTE QUALITY ASSURANCE UNQUOTE ADVISER, WHICH WILL BE PROJECT FUNDED.

B.4. MANAGEMENT. AN ASSESSMENT RECENTLY HAS BEEN COMPLETED OF AAO/NIGERIA AND ITS COUNTERPARTS. THE RECOMMENDATIONS OF THIS STUDY ARE ELABORATED BELOW UNDER ISSUE ONE. CHIAVAROLI ALSO NOTED HIS APPRECIATION FOR THE EXTENSIVE NUMBER OF TDYS BY REDSO, AID/W AND CDC STAFF.

4. ISSUE ONE: MANAGEMENT OF THE PROJECT.

4.A. THE FIRST, AND MAIN ISSUE CONCERNED THE LEVEL OF THE MISSION'S USDH STAFF RESOURCES FOR PROJECT MANAGEMENT AND OVERSIGHT GIVEN THE SIZE AND SCOPE OF THE PROGRAM. THE ISSUE EXTENDED TO THE ABILITY OF REDSO/WCA TO PROVIDE ADEQUATE SUPPORT FOR EXAMPLE, ARE THERE WAYS TO CONSOLIDATE AND STREAMLINE CONTRACTING, CONTROLLER, AND LEGAL ACTIONS NECESSARY FOR IMPLEMENTATION?

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4.B. DISCUSSION. THE MISSION WILL BE ACTIVELY INVOLVED IN GUIDING, MANAGING, AND ENSURING INSTITUTIONAL DEVELOPMENT OR RESTRUCTURING OF NUMEROUS INSTITUTIONS AT THE FEDERAL, STATE AND LOCAL LEVELS OVER THE LIFE-OF-THE-PROJECT (LOP). THE PROJECT'S NUMEROUS IMPLEMENTATION ACTIONS, ESPECIALLY DURING THE FIRST YEAR, WILL ENTAIL MANAGEMENT BURDENS FOR A USOH STAFF OF FOUR, AND A HIGH DEMAND FOR SERVICES PROVIDED BY REDSO/WCA (CONTRACTING, LEGAL AND TECHNICAL). ALL IN ATTENDANCE AGREED THAT THE ORGANIZATION OF THE LARGE ARRAY OF QUOTE TECHNICAL UNQUOTE SUPPORT WAS NOT IN QUESTION; THE ISSUE RELATES TO FINANCIAL AND OPERATIONAL MANAGEMENT.

FINANCING IS PROBABLY DIRECT ADVANCE/REIMBURSEMENT.

USING TABLE 3 ON PAGE 49 AS THE FORMAT, THE PLAN SHOULD LIST EACH ELEMENT DESCRIPTION AS A DISCRETE PROCUREMENT ACTION. THE APPROPRIATE A.I.D. PARTICIPANTS REQUIRED TO PREPARE THE PROCUREMENT ACTION SHOULD THEN BE IDENTIFIED WITH A CORRESPONDING TIME FRAME TO BEGIN AND COMPLETE THE EVENT AND THE ACTION AGENT RESPONSIBLE FOR ENSURING THAT EACH ACTION IS COMPLETED TO AVOID UNNECESSARY DELAYS IN PROJECT IMPLEMENTATION. ONCE AGREEMENT IS REACHED ON ITS CONTENTS, THE PLAN WILL FORM THE BASIS OF A MANAGEMENT AGREEMENT BETWEEN REDSO/WCA, AAO/NIGERIA AND A.I.D./W AS TO WHEN SPECIFIC ACTIONS ARE INITIATED AND SUPPORT SERVICES ARE REQUIRED FOR THE SUCCESSFUL IMPLEMENTATION OF THIS IMPORTANT PROJECT.

THE PROJECT PAPER DID NOT SPELL OUT THE LEVEL AND KIND OF SUPPORT AND SERVICES THAT WILL BE REQUIRED OF REDSO/WCA. THROUGHOUT THE PROJECT LOP, REDSO/WCA WILL HAVE CONCURRENCE RESPONSIBILITY UNDER DOA 551, IMPLEMENTATION ACTIONS AND A HEAVY DEMAND WILL BE PLACED ON THE CONTRACTING OFFICE.

CONCERNING THE ACCOUNTING CERTIFICATIONS THAT MAY NEED TO BE DONE, THE ECPR, INCLUDING THE AFRICA BUREAU CONTROLLER, CONCLUDED THAT THE METHOD WHICH WILL BE USED BY AAO/NIGERIA IS ACCEPTABLE (THE QUOTE A-133 UNQUOTE CERTIFICATION IS PREPARED BY CONTRACTOR AND THE USDH CONTROLLER UTILIZES THIS INFORMATION AS THE BASIS FOR FORMAL A.I.D. CERTIFICATION). MISSION IS REMINDED HOWEVER THAT THE RESPONSIBILITY FOR THE CORRECTNESS AND COMPLETENESS OF THE INFORMATION UPON WHICH THE CERTIFICATION IS BASED ULTIMATELY RESTS WITH THE MISSION.

AAO REPRESENTATIVES POINTED OUT THAT THE ONGOING ACS1-CCCD REGIONAL PROJECT ALREADY PROVIDES A GOOD BASELINE OF EXPERIENCE; AND NCCCD, LIKE ACS1-CCCD, WILL HAVE STRONG PASA SUPPORT FROM CDC/IMPO. THE AAO EXPRESSED CONCERN ABOUT THE HEAVY WORKLOAD IN CONTRACTING AND LEGAL SUPPORT REQUIRED OF REDSO. IT WAS NOTED THAT MOST REQUIREMENTS FOR REDSO SUPPORT LIKELY WILL COME DURING THE FIRST YEAR OF THE PROJECT.

5. ISSUE TWO: SUSTAINABILITY.

4.C. ECPR DECISION. WORKING WITH REDSO/WCA, THE MISSION SHOULD IDENTIFY OPTIONS FOR STREAMLINING ADMINISTRATIVE, FINANCIAL AND CONTRACTING ACTIONS IN AN EFFORT TO REDUCE THE MANAGEMENT LOAD OF IMPLEMENTING THIS PROJECT. AS A STARTING POINT, THE AAO/NIGERIA AND REDSO/WCA WILL JOINTLY PREPARE A PROCUREMENT PLAN WHICH WILL BE SUBMITTED TO AID/W FOR INCLUSION IN THE AUTHORIZATION PACKAGE. THE PLAN WILL DISCUSS BOTH THE MAGNITUDE (VOLUME OF ACTIONS) AND SEQUENCE AND TIMING OF ASSISTANCE REQUIRED BY AAO/NIGERIA, I.E. IT WILL COVER PROCUREMENT ACTIONS AND REDSO/WCA SUPPORT -- INCLUDING AUDITS OF GRANTEE ENTITIES RECEIVING U.S. GOVERNMENT RESOURCES.

5.A. ISSUE: HOW HAS THE PROJECT DESIGN BUILT-IN SUSTAINABILITY?

5.B. DISCUSSION. DURING THE REVIEW OF NIGERIA'S CPSP, IT WAS AGREED THAT HEALTH INTERVENTIONS WERE LONG-TERM IN NATURE AND THAT CONTINUED, LONG-TERM ACTIVITIES IN THIS SECTOR WERE JUSTIFIED. HOWEVER, THE NCCCD PROJECT PAPER STATES THAT PROJECT ACTIVITIES UNDER THE CURRENT ACS1/CCCD PROJECT WILL BE CONTINUED UNDER THE NEW PROJECT. WHILE THE PROJECT PAPER DOES INCORPORATE ELEMENTS OF EXPERIENCE GAINED TO DATE IN THE HEALTH SECTOR, IT DOES NOT GIVE A SENSE OF WHY THIS ASSISTANCE MUST BE CONTINUED NOR HOW NIGERIANS WILL HAVE DEVELOPED THE CAPACITY TO REPLICATE OR MAINTAIN THE SERVICES ENVISAGED UNDER THE PROJECT ONCE A.I.D. FINANCING IS WITHDRAWN.

SPECIFICALLY, THE PLAN SUBMITTED WILL BE DESIGNED IN SUCH A MANNER AS TO DELINEATE THE SPECIFIC ACTIONS REQUIRED FROM BOTH AAO/NIGERIA, REDSO/WCA AND AID/W TO ENSURE TIMELY IMPLEMENTATION OF THE PROJECT. WE SUGGEST THAT A TABULAR FORMAT WITH SOME DESCRIPTIVE NARRATIVE SHOULD BE SUFFICIENT. TABLE 3 ON PAGE 49 OF THE PROJECT PAPER MAY BE A GOOD FORMAT WITH SOME REVISIONS. THE METHOD OF

ON THE RECURRENT COST FRONT, THE PAPER DOES NOT DISCUSS RECENT MISSION EXPERIENCE WITH NON-PROJECT ASSISTANCE USED TO ENHANCE PUBLIC HEALTH POLICIES AND ENCOURAGE GREATER BUDGETARY ALLOCATIONS PROVIDED TO BOTH STATE AND LOCAL GOVERNMENT AUTHORITIES (LGAS). THIS IS ESPECIALLY RELEVANT SINCE IT APPEARS THAT THE PROJECT, AS DESIGNED, IS HIGHLY DEPENDENT ON USAID VERSUS NIGERIAN ADMINISTRATION AND FINANCING.

IMPLEMENTATION LINE SHOULD SPECIFICALLY REFER TO THE MANNER IN WHICH FUNDS ARE COMMITTED, NOT OBLIGATED. THE METHOD OF FINANCING COLUMN SHOULD REFER TO THE MANNER IN WHICH A.I.D. PAYS, I.E., DIRECT PAY, ADVANCE, REIMBURSEMENT, LETTER OF CREDIT, ETC. THERE APPEARS TO BE SOME ASYMMETRY THAT EXISTS IN THE TABLE AS CURRENTLY PRESENTED WHICH CONFUSES THE LEVEL AND NATURE OF PROCUREMENT ACTIONS REQUIRED FOR PROJECT IMPLEMENTATION. THIS CONFUSION MAY RESULT IN THE PROJECT'S IMPLEMENTATION ARRANGEMENTS APPEARING MORE OR LESS COMPLICATED THAN THEY REALLY ARE. FOR EXAMPLE, IF THE LOCAL COST ACTIONS LISTED ARE ACTIONS WHICH WILL BE COMMITTED AND PAID THROUGH THE PAF CONTRACT, THEN THE METHOD OF IMPLEMENTATION IS ONE DIRECT A.I.D. CONTRACT RATHER THAN FOUR BILATERAL AGREEMENTS AS CURRENTLY PRESENTED, AND THE METHOD OF

FINALLY, THERE WAS CONCERN THAT CRITERIA FOR SELECTING LGAS, AND CRITERIA FOR QUOTE GRADUATING UNQUOTE THEM WAS NOT SPECIFIED, EXCEPT AS INDICATED IN THE PROPOSED CONDITIONS PRECEDENT AND COVENANTS APPEARING IN THE DRAFT

AUTHORIZATION AND ACTION MEMORANDUM.

5.B. ECPR DECISION. THE PROJECT PAPER WILL BE MODIFIED TO INCORPORATE THESE CONCERNS. THE AAO NIGERIA AND NIGERIAN COUNTERPARTS WILL ESTABLISH CRITERIA FOR SELECTION AND GRADUATION OF LGAS TO BE INCLUDED IN THE NCCCD. WHILE A COMPLETE DETAILED PROCESS FOR SELECTION

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WILL BE DEVELOPED LATER, THE ECPR CONCLUDED THAT A DESCRIPTION OF THE QUOTE VISION OF THE LGA SELECTION CRITERIA UNQUOTE MUST BE INCLUDED IN THE PROJECT PAPER FOR AUTHORIZATION. THESE CRITERIA WILL ENSURE THAT A.T.D. FUNDING TO LGAS WILL BE LIMITED TO THOSE ENTITIES WHICH SHOW THE DESIRED POLICY AND FINANCIAL COMMITMENT, AND POTENTIAL TECHNICAL AND MANAGING CAPACITY. THE PROJECT PAPER AND AUTHORIZATION WILL INDICATE THAT THE CRITERIA WILL SUBSEQUENTLY BE NEGOTIATED IN DETAIL WITH THE

NIGERIANS.

6. ISSUE THREE: LOCAL COST FINANCING.

6.A. ISSUE: DUE TO THE APPARENT LACK OF OPERATING FUNDS AT THE LGA LEVEL, THE PC QUESTIONED HOW REASONABLE IT IS TO ASSUME THAT THE REQUIRED PROJECT INPUTS ON THE PART OF THE FEDERAL GOVERNMENT OF NIGERIA (FGN) WILL BE AVAILABLE TO SUSTAIN PROJECT ACTIVITIES SINCE THE MAJOR HOST COUNTRY CONTRIBUTIONS AT BOTH THE STATE AND LGA LEVELS ARE PRIMARILY FOR SALARIES AND HEALTH FACILITIES. THIS IS ESPECIALLY RELEVANT SINCE A.I.D. FUNDS ARE REQUESTED TO FINANCE DOLS 14.6 MILLION IN LOCAL COSTS.

6.B. DISCUSSION. ONE OF THE MAJOR ACCOMPLISHMENTS OF THE MISSION'S NPA INTERVENTION (PHC, NO. 620-0003) HAS BEEN TO FORMALLY INCREASE FGN FUNDING TO BOTH THE STATE AND LGAS FOR HEALTH SECTOR ACTIVITIES. WHILE THESE RESOURCES HAVE ACTUALLY REACHED THESE LEVELS OF GOVERNMENT, THEY HAVE PRIMARILY BEEN SUFFICIENT TO COVER ONLY RECURRENT COST REQUIREMENTS AND NOT THE OPERATIONAL REQUIREMENTS FOR CARRYING OUT PROJECT ACTIVITIES. THE PC WAS CONCERNED THAT ADEQUATE RESOURCES BE ALLOCATED IN A TIMELY MANNER FROM THE CENTRAL GOVERNMENT TO COVER THE OPERATIONAL BUDGET OF LGAS FOR SUSTAINING PROJECT ACTIVITIES.

6.C. ECPR DECISION. (1) THAT BUDGETARY ALLOCATION TO THE HEALTH SECTOR, AND PRIMARY HEALTH CARE IN PARTICULAR, AT THE LGA LEVEL BE PART OF THE CRITERIA FOR SELECTION OF LGAS. (2) AAO/NIGERIA INDICATED THAT IT HAD INITIATED

DISCUSSIONS WITH THE FGN TO NEGOTIATE A REDUCTION IN THE U.S. DOLLAR COSTS AUTHORIZED FOR THIS PROGRAM BY THE AMOUNT OF LOCAL CURRENCY GENERATED BUT NOT PROGRAMMED UNDER THE SECOND AND THIRD TRANCHES OF THE PHC-NPA

PROGRAM. THE ECPR ENCOURAGED THE AAO/NIGERIA TO PURSUE THIS DIALOGUE WITH INTENT TO MINIMIZE DOLLAR COSTS AUTHORIZED UNDER THIS PROJECT FOR LOCAL COST EXPENDITURES. WE EXPECT THIS AMOUNT COULD BE REDUCED FROM U.S. DOLS 14.6 MILLION TO LESS THAN U.S. DOLS 4 MILLION AT A MINIMUM. MISSION WILL ADVISE A.I.D./W OF THE AMOUNT TO BE REDUCED PRIOR TO AUTHORIZATION.

7. ISSUE FOUR: OYB TRANSFERS.

7.A. ISSUE. IS THE PROPOSED USE OF OYB TRANSFERS CONSISTENT WITH DFA REQUIREMENTS FOR MEASURING AND REPORTING ON PROJECT IMPACT? WILL OYB TRANSFERS ASSURE SUFFICIENT ACCOUNTABILITY TO AAO/NIGERIA FOR CONTRACTOR PERFORMANCE; AND, WHETHER OR NOT THE OYB TRANSFER IS THE MOST APPROPRIATE MECHANISM TO ASSURE RELIABLE, QUALITY TECHNICAL ASSISTANCE RESPONSIVE TO AAO/NIGERIA, AND WITH THE LEAST MANAGEMENT BURDEN TO THE MISSION AND REDSO.

7.B. DISCUSSION. THE PROJECT ANTICIPATES APPROXIMATELY DOLS 7.3 MILLION IN OYB TRANSFERS FOR PROJECT ACTIVITIES.

UNDER THE OYB TRANSFER MECHANISM, FUNDS ARE INCORPORATED INTO THE QUOTE CORE UNQUOTE ELEMENT OF A CONTRACT WHICH WILL REMAIN AVAILABLE FOR ANY OTHER QUOTE CORE UNQUOTE

TYPE OF ACTIVITY CHOSEN BY THE CONTRACTOR. IN THIS SITUATION, FUNDS LOSE THEIR MISSION IDENTITY, MAKING IT DIFFICULT TO TRACK SINCE NO UNIQUE SCOPE OF WORK IS PRODUCED. ALSO, UNDER THIS MECHANISM, SPECIFIC COUNTRY PERFORMANCE INDICATORS ARE NOT DEVELOPED, MAKING IT DIFFICULT TO REPORT ON THE IMPACT OF TECHNICAL ASSISTANCE INTERVENTIONS. IN ACCORDANCE WITH DFA REPORTING, THIS MECHANISM MAY HINDER THE PERFORMANCE MONITORING REQUIRED FOR MEASURING PROJECT IMPACT AND REPORTING TO CONGRESS.

CCWA AND AAO REMINDED THAT, PRESENTLY, UNDER PROCEDURES ESTABLISHED BY AFR/DP AND THE R AND D BUREAU, EACH OYB TRANSFER IS PERFORMED UNDER A SIGNED MEMORANDUM OF UNDERSTANDING BETWEEN THE BUREAUS SPECIFYING SCOPES OF WORK FOR THE R AND D CONTRACTORS.

R AND D BUREAU REPRESENTATIVES ALSO EXPLAINED A RELATIVELY NEW MECHANISM, WHICH THE R AND D BUREAU HAS USED SUCCESSFULLY, KNOWN AS A QUOTE DESIGNATED CORE UNQUOTE MECHANISM, WHICH PROVIDES THE ACCOUNTABILITY OF THE BUY-IN SCOPE OF WORK WITH A DETAILED BUDGET, ALLOWING THE MISSION TO RECEIVE SPECIFIC DELIVERABLES. THIS MECHANISM COULD PRESERVE THE EASE OF USE OF THE OYB TRANSFER.

7.C. ECPR DECISION. BECAUSE OF THE SPECIAL NATURE OF THE DFA REPORTING ARRANGEMENTS, THE PRINCIPLE VEHICLE FOR ACCESSING CENTRALLY FUNDED CONTRACTS UNDER THIS PROJECT SHOULD BE THE BUY-IN. UNDER SPECIAL CIRCUMSTANCES, THE MISSION MAY USE A TRANSFER MECHANISM SUPPORTED BY A

MEMORANDUM OF UNDERSTANDING PROVIDED THAT THE INSTRUMENT LINKS THE CONTRACTORS' PERFORMANCE TO THE SPECIFIC MEASURABLE IMPACT INDICATORS TO BE ACHIEVED UNDER THE PROJECT AT EITHER THE PURPOSE OR OUTPUT LEVEL, DEPENDING ON THE NATURE OF THE ACTIVITY. DAA/AFR COBB NOTED THAT THE CHOICE OF THE MECHANISM SHOULD BE GUIDED BY THE FOLLOWING PRINCIPLES: (1) THE MISSION'S ABILITY TO GET A QUALITY DELIVERABLE PROMPTLY, (2) THE EXISTENCE OF A SCOPE OF WORK WITH ESTABLISHED PERFORMANCE INDICATORS LINKED TO PROJECT IMPACT INDICATORS, AND (3) ACCOUNTABILITY OF THE CONTRACTOR TO ACHIEVING THOSE INDICATORS. THIS REVISION SHOULD BE INCORPORATED INTO THE PROCUREMENT PLAN TO BE COMPLETED AS PART OF ISSUE NO.1 AND MAY REQUIRE SPLITTING OUT THE DIFFERENT PROCUREMENTS.

6. ISSUE FIVE: COVENANTS.

6.A. ISSUE: IS THE PROJECT ADEQUATELY DESIGNED WITH RESPECT TO CONDITIONS PRECEDENT AND COVENANTS?

6.B. DISCUSSION. SOME PC MEMBERS NOTED THAT THE FINANCIAL REQUIREMENTS FOR ENSURING PROJECT SUCCESS ARE PRESENTED IN TERMS OF COVENANTS WHICH GENERALLY WOULD OTHERWISE BE INCLUDED AS CONDITIONALITY UNDER A NON-PROJECT ASSISTANCE MODALITY. IT WAS FELT, THEREFORE, THAT THE ULTIMATE SUCCESS OF THE PROJECT WOULD DEPEND ON NON-BINDING ACTIONS OF THE FGN SINCE COVENANTS ARE, BY THEIR NATURE, NON-BINDING. AAO/NIGERIA NOTED THAT ITS INTENTION

IN THE COVENANTS WAS TO ESTABLISH A NON-BINDING CHECKLIST WITH ELEMENTS WHICH WERE ALREADY INCLUDED IN THE PP,

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WHICH, EVEN IF THEY WERE SUSCEPTIBLE TO BEING BARGAINED AWAY, WOULD OFFER AN OPPORTUNITY TO THE AAO/NIGERIA TO HIGHLIGHT THEIR IMPORTANCE AND BE THE BASIS FOR DIALOGUE WITH NIGERIAN COUNTERPARTS THROUGHOUT THE LOP. THE COVENANTS WOULD INDICATE THAT THE GRANTEE WOULD AGREE PHILOSOPHICALLY AND INTELLECTUALLY ON VARIOUS ELEMENTS OF THE PROJECT; SOME WERE INTENDED AS BASES FOR NEGOTIATING CRITERIA FOR SELECTION (AND GRADUATION) OF LGAS WITHIN THE PROJECT.

6.C. THE PC ALSO EXPRESSED ITS CONCERN WITH THE CONDITIONS PRECEDENT WHICH IMPLY THAT THE MISSION WILL BE ADVANCING FUNDS TO GOVERNMENTAL INSTITUTIONS RATHER THAN UTILIZING THE PREFERRED METHOD OF COST REIMBURSEMENT, PER A.I.D. HANDBOOK 19.

6.D. ECPR DECISION. OAA/AFR COBB REQUESTED THAT GC/AFR, AAO/NIGERIA AND AFR/CCWA REVIEW THE COVENANTS TO ADDRESS THE ABOVE CONCERNS. THE COVENANTS HAVE BEEN REVISED AND ARE INCLUDED AT THE END OF THIS CABLE, AND THE CONTENT OF A NUMBER OF THE PREVIOUSLY PROPOSED COVENANTS WILL BE INCLUDED IN THE PROJECT PAPER ELSEWHERE OR IN IMPLEMENTATION LETTERS AS AGREED BY THE GROUP THAT REVIEWED THE COVENANTS. FURTHERMORE, CONCERNING THE USES OF ADVANCES INSTEAD OF REIMBURSEMENT, THE AAO/NIGERIA NOTED THAT EVERY EFFORT WILL BE MADE TO EMPLOY COST-REIMBURSEMENT MECHANISMS IN THE PROJECT AND THAT ONLY IN

THE EVENT THAT IT WAS NOT POSSIBLE, WOULD FUNDS BE ADVANCED TO THE GRANTEE. IN THE LATTER CASE, THE CONTRACTOR WILL PREPARE THE NECESSARY CERTIFICATION AND ADVANCE OF FUNDS. THIS DECISION, TOO, WILL HAVE AN IMPACT ON THE CONTENTS OF THE PROCUREMENT/FINANCING PLAN TO BE SUBMITTED PURSUANT TO ISSUE NO.1.

9. CONCERNS. FOUR CONCERNS HAD BEEN VOICED IN THE ISSUES PAPER. THE ECPR ADOPTED THE SUGGESTED RECOMMENDATIONS FOR EACH OF THE FOUR CONCERNS. THE CONCERNS ARE LISTED BELOW AS THEY WERE PRESENTED TO THE ECPR.

10. CONCERN ONE: RECOMMENDATIONS ON PROCUREMENT.

10.A. CDC PASA. BEFORE USAID CAN ENTER INTO AN AGREEMENT WITH A PARTICIPATING GOVERNMENT AGENCY FOR ANY PARTICULAR SERVICE, THE AGREEMENT MUST BE JUSTIFIED ON GROUNDS OF QUOTE PREDOMINANT CAPABILITY UNQUOTE OR BEING QUOTE UNIQUELY QUALIFIED UNQUOTE TO PERFORM THOSE TECHNICAL SERVICES.

IF CDC IS TO PROVIDE PARTICIPANT TRAINING OR PROCURE A SUBSTANTIAL AMOUNT OF DATA PROCESSING EQUIPMENT, THEN THERE MUST BE A CLEARLY DEMONSTRATED QUOTE PREDOMINANT CAPABILITY UNQUOTE ON THE PART OF CDC. FA/OP WAS NOT CLEAR ON CDC'S PARTICIPATION IN THESE TWO AREAS. THE PROJECT PAPER SHOULD BE REVISED TO REFLECT THIS.

11. CONCERN TWO: INCREASED RELIANCE ON COST RECOVERY.

11.A. IN AN ERA OF DECLINING ECONOMIC CONDITIONS, THE PROJECT SEEKS TO SUPPORT INCREASED RELIANCE ON COST RECOVERY IN THE HEALTH SECTOR. WHILE THE IMPLEMENTATION OF THE BAHAKO INITIATIVE AND COST RECOVERY MAY ADDRESS THE PC'S CONCERN ON THIS ASPECT OF SUSTAINABILITY, LITTLE INFORMATION BEYOND STATING THAT COST RECOVERY WILL BE AN AREA FOR OPERATIONS RESEARCH IS INCLUDED IN THE PROJECT PAPER. IMPROVED QUALITY OF CARE MAY FACILITATE INCREASED

COST RECOVERY, BUT DOES NOT HIGHER QUALITY ALSO IMPLY HIGHER COSTS? REGARDLESS OF THE PAYMENT MECHANISM, THERE ARE LIMITS ON HOW MUCH HEALTH CARE NIGERIANS CAN AFFORD. HOW WILL THE PROJECT ADDRESS THE NEED TO INCREASE THE OVERALL EFFICIENCY OF HEALTH SERVICES, PARTICULARLY IN THE PUBLIC SECTOR? THE PP IS VAGUE ON THE SUBJECT, AND SHOULD BE REVISED TO INCORPORATE A SPECIFIC STRATEGY.

11.B. ECPR DECISION. THE PC NOTED THAT COST RECOVERY IN THE PUBLIC SECTOR WILL NEED MORE EMPHASIS IN THE FUTURE. THE COST-RECOVERY COVENANT HAS BEEN RE-DRAFTED TO ADDRESS THIS CONCERN. MISSION WILL INCORPORATE THE STRATEGY INTO THE PP.

12. CONCERN THREE: MANAGEMENT REVIEWS.

12.A. THE PC SUPPORTED THE USE OF MANAGEMENT REVIEWS FOR EVALUATION. HOWEVER, THE PC BELIEVES IT IS IMPORTANT THAT EXTERNAL EVALUATORS ARE UTILIZED IN FUTURE REVIEWS, AS HAS BEEN THE CASE IN THE RECENT ACS1/CCCD EVALUATION.

12.B. ECPR DECISION. THE ECPR HAS REQUESTED THAT THE

MISSION ENFORCE THE SAME STANDARDS IN THE COMPOSITION OF MANAGEMENT REVIEW TEAMS FOR THE PLANNED NCCCO EVALUATIONS AS FOR THE EVALUATION OF THE ACS1/CCCD-NIGERIA.

13. CONCERN FOUR: RECOMMENDED MINOR EDITS ON THE PROJECT PAPER FACESHEET.

13.A. CHANGES TO THE PP FACESHEET SHOULD BE MADE:

(1) THE ESTIMATED FINAL DATE OF OBLIGATION IN BOX 7 SHOULD BE CHANGED TO QUOTE FY 99 UNQUOTE.

(2) THE AMOUNT APPROVED THIS ACTION, IN BOX 9.E., SHOULD BE CHANGED FROM DOLS 40 MILLION TO DOLS 7.4 MILLION TO REFLECT THE FIGURES IN TABLE 4.A. ON PAGE 50 OF THE PROJECT PAPER.

(3) THE GEOGRAPHIC CODE FOR THE SOURCE/ORIGIN OF GOODS AND SERVICES IN BOX 15 OF THE PP SHOULD BE CHANGED TO QUOTE 935 UNQUOTE PER HANDBOOK 13, APPENDIX 4.C.6. (B).

(4) THE PROPER AUTHORIZED AGENT RESPONSIBLE FOR NEGOTIATING THE PASA AND THE PERSONNEL ADMINISTRATION AND FINANCE (PAF) CONTRACT FOR AAO/NIGERIA IS REDSO/WCA/OP, NOT USAID/W NOR AAO/NIGERIA. PROCUREMENT FROM UNICEF IS DONE THROUGH AID/W, FOLLOWING HANDBOOK 15 GUIDELINES. THE TABLE ON PAGE 31 WAS REVISED ACCORDINGLY.

(5) THE METHODS OF FINANCING NEED TO BE REVISED AND CERTIFIED BY THE AAO/NIGERIA CONTROLLER.

(6) THE FACESHEET AND PD WILL REDUCE AUTHORIZED LOP WHEN AFR/CCWA IS ADVISED BY AAO/NIGERIA OF OUTCOME OF LOCAL CURRENCY DISCUSSIONS.

14. NEW COVENANTS. FOLLOWING ARE THE RE-DRAFTED COVENANTS WHICH HAVE GC/AFR'S APPROVAL SUBJECT TO ANY NECESSARY CHANGES ARISING FROM THE IMPLEMENTATION PLAN

A VACCINE COORDINATION PANEL: THE GRANTEE COVENANTS TO SUPPORT AND PARTICIPATE IN INITIATIVES, WHICH MAY BE UNDERTAKEN BY A.I.D., TO ESTABLISH A COORDINATION PANEL OF GOVERNMENT, DONOR, AND PRIVATE SECTOR SUPPLIER AND USERS,

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BEGINNING IN THE FIRST YEAR AND CONTINUING THROUGHOUT THE PROJECT, FOR THE PERIODIC REVIEW AND RESOLUTION OF ISSUES PERTAINING TO POLICIES, PROCEDURES, AND FUNDING SOURCES REQUIRED TO SUPPORT SUSTAINABLE PROCUREMENT OF VACCINES THAT MEET INTERNATIONAL STANDARDS AND, WHERE APPLICABLE, USAID POLICIES.

B. DONOR COORDINATION: THE GRANTEE COVENANTS TO PROMOTE, THROUGHOUT THE LIFE OF THE PROJECT, COORDINATION OF DONOR INPUTS INTO THE HEALTH SECTOR GENERALLY, AND THE ESTABLISHMENT OF A MULTIAGENCY COORDINATING COMMITTEE OR SIMILAR BODY, WHICH MAY BE INITIATED BY A.I.D.

C. UTILIZATION OF INSECTICIDES: THE GRANTEE COVENANTS THAT NO FUNDS DISBURSED UNDER THIS PROJECT SHALL BE USED

FOR INSECTICIDES OTHER THAN PERMETHREN, FOR THE FIELD IMPREGNATION OF BED NETS WITHOUT WRITTEN APPROVAL FROM A.I.D.

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DRAFTED BY: AID/AFR/CCWA/PDEA: JPPADDACK: JPP
APPROVED BY: AID/AFR/CCWA: MGOLDEN
AFR/CCWA: CROZELL AFR/CCWA/PDEA: PTUEBNER
AFR/CCWA: GMERRITT (DRAFT) R&D/H/AP: JHEIBY (DRAFT)
AFR/ARTS/HHR: MWARREN (DRAFT) GC/AFR: JSKALES (DRAFT)
AFR/MRP/CONT: LGRIZZARD (DRAFT)

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AIDAC ABIDJAN FOR REDSO/WCA, ATTENTION KIM FINAN
E.D. 12356: N/A

TAGS:

SUBJECT: ADDITIONAL GUIDANCE FOR THE NIGERIA CCCD PROJECT PAPER

REF: STATE 128251

1. REF CABLE SUBMITS THE ECPR GUIDANCE CONCERNING

DISCUSSIONS AND AGREEMENTS REACHED DURING THE ECPR WHICH WAS HELD MARCH 30, 1993. AN ANNEXED PAPER TO THE ISSUES PAPER WAS PROVIDED AT THE ECPR MEETING COVERING ALL RESOLVED ISSUES BY THE PROJECT COMMITTEE. BECAUSE THE ISSUES PAPER WAS LENGTHY, IT WAS DECIDED THAT THESE RESOLVED ISSUES WOULD BE PRESENTED IN A SEPARATE PAPER. THIS CABLE INCLUDES THE CONTENTS OF THIS PAPER, AND REPRESENTS SUGGESTIONS TO CONSIDER DURING PROJECT IMPLEMENTATION.

2. ISSUE NO. 1. DOES THE TRAINING COMPONENT OF THE PP SUFFICIENTLY ADDRESS THE NEED FOR STRUCTURED LONG-TERM LOCAL MANAGEMENT TRAINING OF SENIOR LEVEL NIGERIANS AT ALL LEVELS OF THE GOVERNMENT?

2.A. DISCUSSION. TRAINING, A MAJOR RESPONSIBILITY OF THE STATES AND THE LGAS, APPEARS TO BE UNDER-SUPPORTED BY THE

GOVERNMENT. THE PC EXPRESSED SOME CONCERN REGARDING PROVISION OF LIMITED FUNDS FOR LONG-TERM TRAINING. HEALTH LEADERSHIP AT THE LGA LEVEL REQUIRES THE EQUIVALENT OF A MASTERS OF PUBLIC HEALTH DEGREE, AS SOME ARGUE UNCLEAR HOW THE LGAS WILL CONTINUE PROJECT ACTIVITIES AFTER THE END OF USAID ASSISTANCE. DO THE CONTINUING EDUCATION UNITS PROVIDE THE KIND OF TRAINING NEEDED AT SENIOR LEVELS? SHOULD THE PROJECT INVEST MORE IN

FOR LGA STAFF? THE PC DISCUSSED THE LIMITED VALUE OF U.S. TRAINING WHEN COMPARED TO NEEDS

IN A COUNTRY AS LARGE AS NIGERIA. SHOULD OUR INVESTMENT NOT BE FOCUSED ON STRUCTURED TRAINING IN NIGERIA?

2.B. RESOLUTION. THAT THE AID/NIGERIA CONSIDER

SUPPORTING THE FOLLOWING TRAINING INTERVENTIONS. THIS IS AN ISSUE WHICH AID/NIGERIA WILL CONFRONT IN THE IMPLEMENTATION PHASE. FIRST, MANAGEMENT LEADERSHIP TRAINING MUST TAKE PLACE FOR EACH OF THE LGAS. THIS IS DIFFICULT AS ON-THE-JOB TRAINING, AS DESCRIBED IN THE PROJECT PAPER. THE DIFFICULT CIRCUMSTANCES OF NIGERIA CALL FOR MORE IN-DEPTH EDUCATIONAL EXPERIENCE THAN CURRENTLY DESCRIBED. THERE ARE LONG TERM MANAGEMENT

AVAILABLE IN NIGERIA WHICH COULD BE SUPPORTED BY TUITION PAYMENTS OF SUFFICIENT SIZE AS TO GIVE THE LGA HEALTH MANAGERS REAL CLOUT IN GETTING THE QUALITY NECESSARY AND THE NUMBERS NEEDED. CDC COULD BE REQUESTED TO ESTABLISH A FIELD EPIDEMIOLOGY TRAINING PROGRAM (FETP) FOR NIGERIA. LEADERSHIP TRAINING MIGHT BE GIVEN EARLY IN THE LIFE OF THE PROJECT -- AS OPPOSED TO SCATTERED THROUGH-OUT THE LOP -- SO THAT NIGERIANS MAY WORK WITH THE EXPATRIATES WITH THE OBJECTIVE OF REPLACING MOST OF THEM BY THE YEAR 2000. SECOND, THE CAPACITY TO CONDUCT MANAGEMENT TRAINING SHOULD BE INSTITUTIONALIZED.

3. ISSUE NO. 2: LIMITED INFORMATION WAS PROVIDED ON THE DEVELOPMENT OF ADEQUATE MECHANISMS TO ENSURE THE PURCHASE OF QUALITY AND LOW-COST VACCINES BY APPROPRIATE LEVELS OF GOVERNMENT. SHOULD THE NIGERIANS NOT BE ENCOURAGED TO DEVELOP A LOCAL CAPACITY TO PRODUCE VACCINES?

3.A. DISCUSSION. LIMITED INFORMATION WAS ALSO PROVIDED ON THE DEVELOPMENT OF ADEQUATE MECHANISMS TO ENSURE THE PURCHASE OF QUALITY AND LOW-COST VACCINES BY ANY LEVEL OF GOVERNMENT, ESPECIALLY WHEN IT APPEARS THAT THE LGAS HAVE BEEN CHARGED WITH THIS RESPONSIBILITY. LABORATORY CAPACITY AND VACCINE PRODUCTION CAPACITY ARE TWO AREAS NOT TARGETED FOR ASSISTANCE. CAN THE QUALITY OF SERVICES BE ASSURED WITHOUT ADDRESSING CLINICAL LABORATORY SERVICES? IS A NATIONAL VACCINE PRODUCTION CAPACITY ESSENTIAL TO THE

LONG-TERM EFFECTIVENESS OF IMMUNIZATION ACTIVITIES? OBJECTIVE OF USAID SUPPORT WOULD BE TO BRING NIGERIAN VACCINE PRODUCTION CAPACITY UP TO W.H.O. STANDARDS. THE GLCVI PROGRAM CAN HELP IMPROVE QUALITY AND VOLUME AS WELL AS THE VARIETY OF VACCINES. NIGERIA NOW PRODUCES YELLOW FEVER VACCINE. PRODUCING VACCINES WILL HELP SUSTAIN VACCINE AVAILABILITY AND CREATE JOBS.

3.B. RESOLUTION. VACCINE PRODUCTION POSSIBILITIES DURING PROJECT IMPLEMENTATION AS AN OPTION.

4. ISSUE NO. 3. DOES THE LOGFRAME ADEQUATELY REFLECT WHAT THE MISSION IS TAKING ON WITH A U.S. DOLS 40 MILLION EFFORT?

4.A. DISCUSSION. THE PC FEELS THAT, AS STATED, THE PROJECT PURPOSE OF QUOTE IMPROVING PRACTICES UNQUOTE UNDERSELLS WHAT THE MISSION IS REALLY TAKING ON VIA A U.S. DOLS 40 MILLION GRANT, ESPECIALLY WHEN THE OBJECTIVELY VERIFIABLE INDICATORS ARE CAST TO MEASURE IMPACT ON

PEOPLE. FURTHERMORE, THE PURPOSE LEVEL ASSUMPTIONS DO NOT APPEAR TO ADEQUATELY ARTICULATE SPECIFIC CONDITIONS NECESSARY FOR ACHIEVEMENT OF THE PROJECT PURPOSE, SOME OF WHICH MAY FALL OUTSIDE THE MANAGEABLE INTEREST OF THE MISSION. THIRD, OUTPUTS ARE WELL STATED AND DEFINED, BUT HOW DO YOU MEASURE QUOTE IMPROVED CASE MANAGEMENT OF ARI,

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4.B. RESOLUTION. (1) PROJECT COVENANTS WERE RE-DRAFTED BY THE PC TO SIGNAL A.I.D. CONCERNS ABOUT ADMINISTRATIVE PRACTICES THAT IMPINGE ON PROJECT SUCCESS TOWARD QUOTE IMPROVING PRACTICES UNQUOTE. PC DISCUSSION HIGHLIGHTED THE POSITIVE TRENDS TOWARD GREATER ADMINISTRATIVE DECENTRALIZATION AND GREATER ALLOCATION OF FEDERAL BUDGETARY RESOURCES TO LOCAL GOVERNMENTS (AND NEW REGULATIONS HAVE BEEN AIMED TO ENHANCE LGA CAPACITIES TO COLLECT LOCAL TAXES FOR REVENUES).

4.B. (2) THE PP SHOULD MAKE THE FOLLOWING CORRECTIONS IN THE LOGFRAME. ON PAGE 68 OF THE PROJECT PAPER UNDER THE INDICATORS FOR OUTPUT NUMBER 1, IT STATES THAT 80 PERCENT OF CHILDREN, HAVE RECEIVED SCHEDULED DPT 1, POLIO AND MEASLES BY THE YEAR 2000. THIS SHOULD READ DPT 3, POLIO 4 AND MEASLES. W.H.O. RECOMMENDS 4 DOSES OF POLIO. THE LOGFRAME ALSO STATES THAT 75 PERCENT OF WOMEN DELIVERING

HAVE RECEIVED PROTECTIVE LEVEL OF TETANUS ANTITOXIN IN THE LAST 12 MONTHS, WHICH IS INCORRECT.

4.B. (3) CONCERNING THE OUTPUTS STATEMENT, THAT AAO/NIGERIA CONSIDER EMPLOYMENT OF NIGERIAN AND AFRICAN SOCIAL SCIENTISTS (E.G., ANTHROPOLOGISTS), AS PARTIAL OBSERVERS AT TIMES THROUGHOUT THE LIFE-OF-PROJECT. ADEQUATE MEASUREMENT OF THIS REQUIRES MONITORING BY PARTICIPANT OBSERVERS WHO ACTUALLY STUDY SAMPLES OF CHILD CARETAKERS UNQUOTE. THIS SOURCE OF DATA WOULD SUPPLEMENT, NOT SUBSTITUTE, FOR SURVEY RESEARCH, AND

SOME QUOTE GROUND TRUTH UNQUOTE.

5. ISSUE NO. 4. IS SUFFICIENT ATTENTION ATTACHED TO THE NEED TO IMPROVING COMMUNITY PARTICIPATION AND THE PARTICIPATION OF NIGERIAN NGOS?

5.A. DISCUSSION. LIMITED ATTENTION SEEMS TO BE PAID TO ASSESSING AND IMPROVING COMMUNITY PARTICIPATION. FOCUS GROUPS SHOULD BE CONSIDERED SINCE INVOLVEMENT OF THE COMMUNITY IS AN IMPORTANT ELEMENT FOR SUSTAINABILITY. FINALLY, ON THE QUESTION OF SUPPORT TO THE NIGERIAN ASSOCIATION OF NON-GOVERNMENTAL ORGANIZATIONS (NANGO), DISCUSSIONS FOCUSED ON THE DISCONNECT BETWEEN THE CLEAR

STRATEGY AND PREDISPOSITION TO ASSIST THE NGOS, AND THE LACK OF AN ADEQUATE COUNTERPART ON THE NIGERIAN SIDE (BOTH

GEOGRAPHICAL AND TECHNICAL LIMITATIONS), INCLUDING NANGO. PRIVATE VOLUNTARY ORGANIZATIONS PLAY AN IMPORTANT ROLE IN THE DELIVERY AND SUPPORT OF CHILD SURVIVAL ACTIVITIES, AND THIS PROJECT SHOULD CONSIDER/DISCUSS THEIR SUPPORT TO THESE GROUPS.

5.B. RESOLUTION. THE PC HOPES AAO/NIGERIA WILL BE ABLE TO TAKE THESE INTO CONSIDERATION.

6. ISSUE NO. 5. DOES THE PROJECT NEED A FORMAL MECHANISM FOR REVIEWING PROGRESS AND DEVELOPING AN ANNUAL WORKPLAN, ALONG THE LINES OF THE RECENT PRE-IMPLEMENTATION WORKSHOP?

6.A. DISCUSSION. A NUMBER OF REVIEWERS COMMENTED ON THE IMPRESSIVE SCOPE OF THE PP, WHICH REVIEWS THE COMPLEX DYNAMICS OF CHILD SURVIVAL INITIATIVES IN NIGERIA. THE EVOLVING POLITICAL BACKGROUND PLACES ANY PLAN AT A CERTAIN AMOUNT OF RISK. AT THE SAME TIME, REVIEWERS THOUGHT THAT THIS IS A CRITICAL TIME FOR DEVELOPMENT ASSISTANCE TO SUPPORT CHILD SURVIVAL IN NIGERIA. ON BALANCE, THE RISKS SEEM FULLY JUSTIFIED. THE PC APPLAUDED THE MISSION'S EFFORTS TO CARRY-OUT THE RECENT PRE-IMPLEMENTATION WORKSHOP, AND QUESTIONED WHETHER SUCH A JOINT NIGERIAN-USAID MEETING MIGHT NOT ALSO BE ABLE TO ADDRESS THE ISSUE OF QUOTE GRADUATING UNQUOTE LGAs AND SELECTING

NEW ONES.

6.B. RESOLUTION. THE PC HOPES THAT AAO/NIGERIA WILL CONTINUE THE WORKPLAN DEVELOPMENT PROCESS ON AN ANNUAL BASIS, THEREBY CONTINUING THE DIALOGUE WITH THE FGN AND NIGERIAN NGOS.

7. ISSUE NO. 6. IS THERE SUFFICIENT EMPHASIS ON THE QUALITY OF HEALTH CARE -- AS OPPOSED TO INCREASED LEVELS OF FUNDING FOR HEALTH CARE -- IN THE PROJECT?

7.A. THE PP IS PERSUASIVE IN MAKING THE CASE THAT THE HEALTH SECTOR SUFFERS FROM INADEQUATE INPUTS, AND THAT MEASURES OF HEALTH SYSTEM OUTCOMES NEED IMPROVEMENT. IT IS LESS CLEAR WHAT ADDITIONAL ANALYSIS IS IMPLIED BY PP REFERENCES TO QUOTE QUALITY UNQUOTE AND SPECIFIC EFFORTS IN QUALITY ASSURANCE. WHAT IS THE EVIDENCE THAT THERE IS A QUOTE QUALITY UNQUOTE PROBLEM IN NIGERIA, BEYOND STRAIGHTFORWARD RESOURCE LIMITATIONS? WHAT DISTINGUISHES THE PROPOSED EFFORTS IN QUOTE QUALITY ASSURANCE UNQUOTE FROM TRADITIONAL TECHNICAL ASSISTANCE?

7.B. NUMEROUS RECENT ANALYSES DEMONSTRATE THAT NIGERIANS CAN GREATLY IMPROVE HEALTH SYSTEMS BY ACHIEVING GREATER COST EFFECTIVENESS (E.G., USING SINGLE VISITS TO BOTH IMMUNIZE CHILDREN AGAINST SEVERAL DISEASES AT THE SAME TIME AND TO PROVIDE MATERNAL MEASURES). MORE EFFECTIVE

SERVICE INTEGRATION SHOULD IMPROVE IMPACT EVEN AT THE SAME BUDGETARY LEVELS.

7.C. RESOLUTION. THE PC HOPES THAT AAO/NIGERIA WILL BE ABLE TO PURSUE THIS MATTER AGGRESSIVELY, AS SUGGESTED BY THE HIRING OF THE QUOTE QUALITY ADVISOR UNQUOTE. THE PC COMPLIMENTS AAO/NIGERIA'S RENEWED EMPHASIS ON QUALITY, AND HOPES THAT QUALITY OF HEALTH CARE IN NIGERIA, CONSIDERED AS A SEPARATE ISSUE FROM BUDGETARY RESOURCES, WILL BE A MAIN FEATURE OF PROJECT IMPLEMENTATION.
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U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

PROJECT AUTHORIZATION

NAME OF COUNTRY: Nigeria
NAME OF PROJECT: Nigeria Combatting Childhood
Communicable Diseases (NCCCD)
PROJECT NUMBER: 620-0004

1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize under the Development Fund for Africa (DFA) the Nigeria Combatting Childhood Communicable Diseases Project for Nigeria, involving planned obligations of not to exceed forty million United States Dollars (US\$40,000,000) in grant funds over seven years from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the project is through December 31, 2000.
2. The Project's goal is a healthier and more productive society, with a subgoal of reduced fertility and decreased morbidity and mortality. In fulfilling the project's purpose, of improved maternal and child health practices, activities will focus on strengthening infrastructure, with emphasis on the state and local level, and on major child survival interventions. Particular attention shall be given to the selection, monitoring, and "graduation" of local government areas (LGAs) participating in the project.
3. The Project Agreement which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

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a. Source and Origin of Commodities, Nationality of Services:

Commodities financed by A.I.D. under the Project shall have their source and origin in countries included in A.I.D. Geographic Code 935, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, suppliers of commodities or services shall have countries included in A.I.D. Geographic Code 935 as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

b. Conditions Precedent to Disbursement:

(1) Conditions Precedent to First Disbursement:

Prior to the first disbursement of funds, or the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D. a statement of the name(s) of the person(s) holding or acting in the office of the Grantee specified in Section 8.2 of the Grant Agreement, and the names of any additional representatives, together with a specimen signature of each person specified in such statement.

(2) Conditions Precedent to Disbursement of Funds to the Grantee:

Prior to disbursement of Grant funds to the Grantee, or to the issuance by A.I.D. of documentation pursuant to which such disbursement may be made, the Grantee shall:

- (a) Demonstrate to A.I.D.'s satisfaction the adequacy of its financial accounting and internal control systems; and
- (b) Furnish the name of the bank and account number of the separate account into which Grant funds disbursed to the Grantee will be maintained for Project purposes.

(3) Conditions Precedent to Disbursement of Funds to any State Institution:

Prior to disbursement of Grant funds to any particular institution at the state level of government, or to the issuance by A.I.D. of documentation pursuant to which such disbursement may be made, that institution shall:

- (a) Demonstrate to A.I.D.'s satisfaction the adequacy of its financial accounting and internal control systems; and
 - (b) Furnish the name of the bank and account number of the separate account into which Grant funds disbursed to the Grantee will be maintained for Project purposes.
- (4) Conditions Precedent to Disbursement of Funds to Any Local Government Institution:

Prior to disbursement of Grant funds to any particular institution at the local level of government, or to the issuance by A.I.D. of documentation pursuant to which such disbursement may be made, that institution shall:

- (a) Demonstrate to A.I.D.'s satisfaction the adequacy of its financial accounting and internal control systems; and
 - (b) Furnish the name of the bank and account number of the separate account into which Grant funds disbursed to the Grantee will be maintained for Project purposes.
- (5) Covenants:

(a) Vaccine Coordination Panel:

The Grantee covenants to support and participate in initiatives, which may be undertaken by A.I.D., to establish a coordination panel of government, donor, and private sector suppliers and users, beginning in the first year and continuing throughout the Project, for the periodic review and resolution of issues pertaining to policies, procedures, and funding sources required to support sustainable procurement of vaccines that meet international standards and, where applicable, A.I.D. policies.

(b) Donor Coordination:

The Grantee covenants to promote, throughout the life of the Project, coordination of donor inputs into the health sector generally, and the establishment of a multiagency coordinating committee or similar body, which may be initiated by A.I.D.

(c) Utilization of Insecticides:

The Grantee covenants that no funds disbursed under this Project

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shall be used for insecticides other than permethren, for the field impregnation of bed nets without written approval from A.I.D.

4. Competition requirements are waived to permit single-source procurement from UNICEF of cold chain, clinical, and laboratory and training equipment, as described and justified in Annex P.

Approved: 

Disapproved: _____

Date: 7/21/95

Clearances:

AFR/CCWA/PDEA, PTuebner: PT
AFR/CCWA/NIGERIA, TDoggett: TD
GC/AFR, JScates: JS
AFR/ARTS/HHR, MWarren: MW
AFR/MRP/RC, LGrizzard: LG
AFR/DP, MBonner: MB

Date: 6-11-93
Date: 6-11-93
Date: 6/11/93
Date: 6/11/93
Date: 6/18

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PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number

DOCUMENT CODE

3

COUNTRY/ENTITY

NIGERIA

3. PROJECT NUMBER

620-0004

4. BUREAU/OFFICE

AFRICA

06

5. PROJECT TITLE (maximum 40 characters)

NIGERIA CCCD (NCCCD)

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
 1 2 3 1 00

7. ESTIMATED DATE OF OBLIGATION
 (Under "B:" below, enter 1, 2, 3, or 4)

A. Initial FY 93

B. Quarter 4

C. Final FY 99

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(5,000)	(2,100)	(7,100)	(25,400)	(14,600)	(40,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country		2,700	2,700		18,800	18,800
Other Donor(s)						
TOTALS	5,000	4,800	9,800	25,400	33,400	58,800

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	530	510				7,100		40,000	
(2)									
(3)									
(4)									
TOTALS									

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

560 570 350 450

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code CS NUTR FPLAN

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

The project purpose is to improve maternal and child health practices.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
 0 9 9 6 0 9 9 8 0 9 0 0

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of 6 page PP Amendment.)

USAID Controller approval of methods of implementation/financing:

Henry J. Hollander

17. APPROVED BY

Signature

Richard Cobb

Title

Richard Cobb
 Deputy Assistant
 Administrator,
 Bureau for Africa

Date Signed

MM DD YY
 0 7 2 1 9 3

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY
 | | | | | |

EXECUTIVE SUMMARY

I. INTRODUCTION

The Nigeria Combatting Childhood Communicable Diseases (NCCCD) project, the second phase of A.I.D.'s child survival program in Nigeria, continues initiatives begun under the Africa Child Survival Initiative/Combatting Childhood Communicable Diseases (ACSI/CCCD) project. These child survival efforts will continue to focus on the principal childhood diseases; i.e., malaria, acute respiratory infections, diarrheal diseases, and those preventable by immunization. The new project will expand its scope to include improved case management of the sick child, maternal/child nutrition practices, and maternal care including child spacing. Human resource development (education and communication programs), a health information system, and institutional capacity building at the primary health care delivery level are the means by which quality health care will be assured. NCCCD is a key element of the AAO/Nigeria program strategy enunciated in the Nigeria Country Program Strategic Plan (CPSP) 1993-2000, approved in September 1992. (92 State 370236).

The Project Identification Document (PID) approved in May 1992 (92 State 191928) originally proposed a five-year project funded at \$20 million. Subsequently, technical analysis supported an expansion of program efforts to encompass a seven-year project funded at \$40 million. The rationale and authorization for this increase was included in the approved CPSP. The CPSP provided a detailed overview of Nigeria's economy, the current political climate, and relevant demographic and societal characteristics of the country's population. The CPSP also examined in-depth: (a) the role of health in Nigeria's economic development; (b) major preventive health problems in Nigeria; (c) constraints of the national health system; and (d) interventions undertaken by various elements of the country's public and private sectors and the donor community.

Infant and maternal mortality rates are high, reflecting the substandard quality of life typical of sub-Saharan Africa. A combination of measles, pneumonia, diarrhea, malaria and malnutrition is commonly associated with under-five deaths in Nigeria. Perinatal mortality, a significant problem in Nigeria, reflects the magnitude of high risk births common to all regions of the country, where maternal health and prenatal care are neglected. Childhood malnutrition continues to impose adverse effects on the physical and mental capacities of the Nigerian population.

Nigeria has multiple overlapping health systems bridging from traditional medicine to public sector service delivery. All are characterized by constraints relating to management, resource availability, quality of care, and health education of the targeted beneficiaries.

A.I.D. policy guidelines incorporated into NCCCD design will help Nigeria: (a) reduce infant and early child mortality and morbidity; (b) reduce maternal mortality and morbidity; (c) use child survival interventions as the basis for building a more comprehensive, high quality health care system over time; (d) ensure that gains made in improving child survival and health are sustained; and (e) develop effective technologies and improved systems for delivery of quality child survival services.

The Project Paper addresses all the issues and concerns raised in the ECPR PID review cable (92 State 191928); particularly, matters pertaining to: (a) project management; (b) technical assistance requirements with balanced inputs from CDC and non-CDC sources; (c) NCCCD interaction with other program elements; (d) the participation of local institutions in project implementation; (e) health sector policy environment; (f) quality of care; (g) sustainability, cost-recovery and host country contribution; (h) private sector delivery; and (i) other donor activity. The project espouses a strong WID orientation.

II. PROJECT DESCRIPTION

The goal and subgoal of the project are identical to their counterparts in the Nigeria CPSP. The project purpose and outputs reflect the CPSP's strategic objective and corresponding targets related to the improvement of maternal and child health practices in Nigeria.

- GOAL** - Healthier and More Productive Society
- SUBGOAL** - Reduced Fertility and Decreased Morbidity and Mortality
- PURPOSE** - Improved Maternal and Child Health Practices

PROJECT OUTPUTS

- Improved Planning and Management of Public and Private Health Systems
- Improved Immunization Practices and Coverage
- Improved Case Management of ARI, Fever (Malaria) and Diarrhea
- Improved Child Nutrition Practices
- Improved Maternal Care

A. Implementation Strategy

NCCCD strategy is oriented toward: (a) increased availability and utilization of improved health services; (b) institutional development of counterpart agencies, including expanded counterpart participation in program implementation; (c) development of program management capabilities among counterparts; (d) strengthening of functional support mechanisms; (e) support of program objectives by public opinion leaders; (f) development of cost-recovery mechanisms; (g) sustainable health care service delivery; (h) increased participation of private sector providers; and (i) the development and operation of effective commodity logistics systems.

NCCCD will be implemented through Nigeria's three-tier administrative structure, which in health includes: the Ministry of Health and Social Services (MHSS); the new Primary Health Care Agency of Nigeria (PHCDAN); State Ministries of Health (SMOHs), and Local Government Areas (LGAs). Although NCCCD will emphasize service delivery at the LGA level (including individual communities and health care facilities), activities of its various components will be implemented at all levels of the public health system. Activities initiated at the federal and state level will be those directly related to operations at the LGA level. Additionally, a series of private sector activities in service delivery and product promotion and distribution will be developed and implemented. These will be coordinated with the public sector to improve primary health care delivery.

Implementation of NCCCD will be largely channeled through and coordinated with the PHCDAN. The project will support PHCDAN in the development of its operational capacity and execution of its responsibilities, a relationship that is expected to be evolutionary as the PHCDAN increases in responsibility and capacity.

Due to the magnitude of the situation in terms of geography, population, and managerial implications, NCCCD will continue the ongoing ACSI/CCCD pattern of concentrating resources in focus states and LGAs. Assistance to the states will target broad responsibilities at that level in such areas as health information and education, training, surveillance, and operational support for technical programs. In each focus state, intensified activities will be implemented at the LGA level. Specific

interventions in child spacing, safe childbirth, nutrition, and the control and prevention of diarrhea, malaria, acute respiratory infections, and childhood communicable diseases will be undertaken at the LGA level within communities and individual health care facilities.

NCCCD will start with the nine states and twelve LGAs in which CCCD is now working. Project resources and host government absorptive capacity will permit the expansion of LGA participation at the rate of approximately twelve LGAs per year for four years. This will allow the addition of, at least, one LGA per state per year for each of four years beginning in 1993/94. Thus, it is estimated that by the second year of project implementation, NCCCD will be directly involved with a total of approximately 24 LGAs; the third year will see approximately 36 LGAs, at which time, original LGAs will begin to "graduate", ceding their places to new LGAs.

NCCCD will give particular emphasis to monitoring and evaluation activities. The monitoring and evaluation (M/E) strategy of NCCCD is designed to: (a) build capacity for M/E at the LGA, state, and federal levels of the Nigerian health system; (b) allow NCCCD staff to monitor and evaluate project implementation with a view toward identifying and addressing operational difficulties and revising program plans, accordingly; and (c) meet A.I.D. reporting requirements.

Throughout life of the project, AAO/Nigeria will remain in continual dialogue with host country counterparts at all levels of government, and those within the private sector, on key policy issues and areas of concern confronting NCCCD. A joint report will be issued, annually, relative to the degree to which precepts reflecting various areas of concern have been respected; i.e., Nigerian perception of project ownership and the planning process; financial management and accountability; counterpart contributions; cost-recovery initiatives; personnel and technical expertise for sustainability; intervention replication; equity and sociocultural considerations; beneficiary education; and donor coordination.

B. Project Interventions

The NCCCD project will provide support through two project elements; i.e., strategies to strengthen infrastructure in support of technical interventions; and major child survival interventions. The success of the project is largely dependent on improved management and infrastructure, especially at the local level. Selection and "graduation" of local government areas (LGAs) participating in the Project are key elements and markers of NCCCD implementation. The development and adoption of selection and operational criteria for the participation of focus LGAs as well as the monitoring of inputs to those entities and the results derived therefrom are critical concerns to be addressed on a continuing basis throughout LOP by a committee of federal, state, and LGA representatives tasked with that job in direct collaboration with AAO/Nigeria and NCCCD project managers.

The first project element focuses on interventions to: (a) train local government officials and develop capability for planning and financial management; (b) foster continuing education and strengthen the in-service training system; (c) establish standards of quality assurance for child survival interventions throughout the national primary health care system; (d) strengthen health education and communications; (e) improve the health information system at all levels; (f) support operations research to strengthen implementation of child survival interventions; and (g) stimulate private sector delivery of primary health care.

Child survival interventions will focus on: (a) prevention [i.e., child spacing; safe motherhood; maternal, infant and child nutrition; and immunization]; and (b) case management of the sick child, including integrated strategies for treating the child suffering from a combination of fever, diarrhea, acute respiratory infections (ARI), and malnutrition.

NCCCD will remain alert to the evolution of pertinent cost reimbursable and sustainability issues, while stimulating institutional and managerial sustainability, a principal requisite, susceptible to NCCCD intervention, for improving the Nigeria health sector's long-term cost recovery capability.

Strategies to Strengthen Infrastructure in Support of Technical Interventions

Management of Health Resources at the Local Level: Health care delivery at the local level is the ideal place for demonstrating improved governance in Nigeria, given the emphasis of both the MHSS and A.I.D. in that sector. NCCCD will provide support to strengthen: (a) organization and managerial effectiveness in health at the LGA level; (b) transparency in decision-making and information; (c) empowerment of grass roots organizations; and (d) strengthened accountability. This intervention will involve wide scale in-country training of local government leaders and staff at universities with institutions of local government or public administration. Technical assistance will be provided to LGAs to improve financial management and information systems as well as to engage in operations research on management problems at the LGA level.

Continuing Education (CE): This intervention will enhance the capability of the Continuing Education System Network designed to reach all health care workers, public and private, at regular intervals in a systematic manner with updated training. Support will be provided to strengthen the technical knowledge and training skills of Schools of Health Technology and affiliated Continuing Education Units, and to develop a national field epidemiology training program to strengthen national surveillance systems and epidemic response capability.

Quality Assurance (QA): The Quality Assurance initiative will institutionalize an ongoing process of examination and improvement of health care services. NCCCD will support the implementation of QA initiatives designed to effect measurable improvements in all phases and aspects of the program. To that end, a coordinated technical assistance effort will be included in the project to assist in integrating QA methods such as client-focused quality assessments, the establishment of high standards of performance and total quality management techniques into each of the technical and support programs of the project as well as the entire AAO HPN portfolio.

Health Education and Communications (HE/C): The HE/C component is a key element of an integrated IEC strategy applicable to the entire AAO HPN portfolio. Emphasizing behavioral change as a key element of primary health care, NCCCD will strengthen the institutional capacity of the HE/C infrastructure at federal and state levels to support PHC at the LGA level. NCCCD will specifically address the need for: (a) improved program planning; (b) a clearer understanding of the role of HE/C in primary health care; and (c) strengthened HE/C coordination at all levels. NCCCD will continue support to the African Regional Health Education Centre (ARHEC) for training state and LGA HE/C officers, with particular emphasis on techniques stressing community involvement.

Health Information Systems (HIS): The HIS component will strengthen the capacity of the MHSS at all levels for monitoring and evaluation, and responding to information needs for program and health status at all levels. NCCCD will provide: HIS training to LGA PHC personnel at all levels; and technical assistance to strengthen the national HIS, with particular attention to the development of HIS capacities in focus states. NCCCD will support implementation of the national 150-site Target Disease Sentinel Surveillance System, the eight-site Inpatient Hospital Reporting system, and HIV/STD surveillance.

Operations Research (OR): NCCCD will support the development of protocols and procedures for commissioning, disseminating and utilizing the results of OR. Specific studies will be directed to the use of implementation data for the identification and solution of operational problems in

primary health care delivery. Major OR topics will focus on constraints to implementation of child survival program strategies; i.e., problems related to availability, access, quality, coverage and impact of service delivery, training and supervision requirements, behavioral change objectives, and cost-effectiveness.

Private Sector Initiatives: The conceptual framework of A.I.D.'s program strategy for private sector initiatives in Nigeria envisions the development of a wide range of activities supported by the entire portfolio, including: (a) strengthening of service delivery; (b) improvement of managerial capacity of selected organizations involved in the delivery of health services; (c) introduction of primary health care information, products and services into urban-based, pre-dominantly curative services; (d) upgrading of the overall quality of services provided in the private sector; and (e) development and testing of approaches to financing health and family planning services in Nigeria.

Major Child Survival Interventions

Preventive Health Care: NCCCD will emphasize the development and implementation of interventions designed to prevent maternal/child morbidity and mortality.

Expanded Programme on Immunization (EPI): The EPI component includes immunization of reproductive age women against tetanus and infants/children against tuberculosis, measles, tetanus, diphtheria, pertussis, polio, and yellow fever. EPI objectives are to achieve and sustain national coverage of eighty percent for childhood antigens and to reduce vaccine-preventable disease incidence. To accomplish this, EPI delivery capability will be strengthened in both rural and urban areas. NCCCD will initiate an urban EPI targeting measles, starting with a pilot activity to be tested in Lagos State. This initiative will focus on improving immunization-related activities, including better use of data for programmatic purposes and innovative use of strategies to improve immunization coverage.

Maternal and Child Nutrition: NCCCD will focus on improvement in the nutritional status of children under thirty-six months of age; and lactating and pregnant women, with special emphasis on the reduction of protein energy malnutrition and micronutrient deficiencies. Specific objectives relate to: improvement of maternal and child nutritional practices, including the promotion of breastfeeding and use of proper weaning foods. Improved nutrition practices will be integrated into ongoing primary health care activities and case management protocols, particularly those involved with diarrheal disease, ARI, measles, maternal health, and birth spacing.

Safe Motherhood and Child Spacing: These initiatives will: (a) promote safe motherhood, with emphasis on policy change and operations research required for solving problems related to high maternal and neonatal morbidity and mortality; (b) strengthen the quality of, and access to, maternal health services focusing on antenatal, safe delivery, and postpartum care; (c) promote the dissemination of child spacing service, information and counseling to pregnant women presenting for prenatal care and to mothers on every occasion that they present their babies at clinics; (d) upgrade health provider skills at the community and secondary levels to recognize and respond to obstetrical emergencies; (e) increase community knowledge concerning problems arising during pregnancy; and (f) improve the ability of health care workers for the provision of client education and counseling. Maternal health initiatives under NCCCD will be coordinated with the Family Health Services project (FHS-II).

Case Management of the Sick Child: NCCCD recognizes the need for a holistic approach to the treatment of infant and child illness.

Malaria: NCCCD will support MHSS malaria control strategy emphasizing: (a) early recognition and adequate treatment of cases to reduce deaths and duration of illness; (b) prophylactic use of effective antimalarial drugs during pregnancy to prevent severe malaria and anaemia in the mother, particularly, during first and second pregnancies; and (c) support of operations research leading to the improvement of malaria control.

Control of Diarrheal Diseases (CDD): While supporting the development of diarrheal disease training units (DTUs), NCCCD will: (a) improve case management of infants and children presenting with diarrheal disease; (b) reinforce the promotion of ORS and use of home fluids; and (c) promote the use of breastfeeding and weaning foods.

Acute Respiratory Infections (ARI): The improvement of pneumonia case management in government and private health institutions will be the focus of the ARI program. The process will include: (a) the development of ARI policy, control strategies, and tools for monitoring and evaluating ARI activities; (b) the strengthening of service delivery capabilities and ARI training; and (c) the refinement of management procedures (supervision, monitoring and referral systems). ARI training units (ATUs) will be developed in conjunction with DTUs.

C. Implementation Modalities

Issues pertaining to the organization, structure, and function of the AAO/Nigeria program management capability, in general, and NCCCD project management, specifically, were key elements of concern during project design. Various scenarios and configurations were considered. The design effort included research and deliberations on the part of a special management review team. The anticipated assignment of a direct-hire HPN Officer as NCCCD Project Manager and the creation of a Health Sector Program Coordinating Committee supported by a long-term contract Quality Assurance (QA) Advisor responds to ECPR concerns with respect to overall AAO/Nigeria program management capability and functioning methodology.

Issues pertaining specifically to NCCCD project management concerns and the role of CDC were resolved through adoption of several key design considerations; i.e., (a) a CDC Public Health Specialist will serve as Project Coordinator under the direct responsibility of the HPN Officer/Project Manager; (b) the CDC Project Coordinator, serving as a technical assistance advisor to the host country, will be located in close physical proximity to his/her Nigerian counterparts; (c) the QA Advisor (responsible for the identification and acquisition of technical resources required for NCCCD implementation as well as the coordination of NCCCD initiatives with overall program management concerns) will facilitate project management on the part of the HPN Officer; and (d) significant utilization of non-CDC technical resources will assure fulfillment of project requirements beyond the predominant capabilities of CDC.

CDC will provide three long-term expatriate technical assistance positions on the implementation team. The QA Advisor will be obtained through an OYB transfer to R&D/H. CDC will provide approximately one-third of the short-term consultants, with the other two-thirds coming from central contracts and/or AFR regional projects through buy-ins and/or OYB transfers. The PASA with CDC will provide for modest procurement of offshore participant training and commodities related to strengthening MHSS health information systems.

UNICEF has been CCCD's foremost donor collaborator in Nigeria, playing an important operational role in project implementation, especially with respect to EPI and CDD. Under NCCCD, this collaborative relationship will continue in areas of mutual interest and benefit.

The local procurement of goods and services will be handled by an administrative support unit (servicing the entire AAC portfolio), which will also provide: (a) personnel management services for all local-hire individuals; (b) comprehensive accounting and vouchering services for most, if not all, local operations; and (c) general services such as space management and motor pool operations. NCCCD will fund its proportionate share of the overall contract providing said services.

III. ESTIMATED COSTS AND FINANCIAL PLAN

NCCCD will be implemented over approximately seven years. Obligations will take place over seven fiscal years. The first obligation in the amount of \$7.1 million will occur late FY93. Project Activity Completion Date (PACD) is December 31, 2000. A.I.D. will provide one hundred percent of the foreign exchange and approximately forty-four percent of local currency funding.

The total project cost is estimated at U.S.\$58.8 million, as presented in the table on the following page. Of this amount, A.I.D. will contribute \$40 million, or approximately 68%. The various levels of the Nigerian governmental structure (i.e., federal, state, and local) will contribute \$18.8 million (calculated based on recent exchange rate trends and contemporary projections of 35 naira to the dollar) for local operating costs through cash and in kind contributions. HCC estimates are based upon actual contributions made over the last four years to A.I.D.-sponsored projects. HCC requirements will be met by the end of Year 2000.

A.I.D.'s contribution includes \$25.4 million in U.S. dollar funding for technical assistance, offshore training, commodities, and the audit function; and a \$14.6 million local currency contribution. \$7.1 million is budgeted for a PASA with CDC. The PASA will fund both long-term and short-term technical assistance (\$6.4m), offshore participant training (\$0.4m) and offshore commodities (\$0.3m). Additional offshore procurement of participant training (\$.03m) and commodities (\$4.3m) will take place outside of the CDC PASA.

Included within the \$4.3 million budget for commodities: \$1.0 million for the procurement of U.S. source and origin vehicles; and \$3.0 million for the procurement of cold chain, clinical, and laboratory, and training equipment with UNICEF acting as the procurement agent. The utilization of UNICEF for such procurement and the approval of the necessary waivers to permit that action is consistent with DFA authorization and guidance. A.I.D. will procure \$300 thousand of training and information materials to support private sector participation in project implementation.

The local currency amount is budgeted for: (a) support of public sector activities at the various levels of operational responsibility; (b) support of private sector involvement in project implementation; (c) payroll of local professional staff augmenting the expatriate element of the project management team; and (d) the local cost element of the project's administrative support function.

Approximately thirty-six percent of the A.I.D. contribution (\$14.4m) is programmed for child survival technical interventions, while sixty-four percent (\$25.6m) is oriented to institution-building initiatives grouped together as strategies to strengthen infrastructure in support of the technical interventions. 5.5 percent (\$2.2m) is dedicated, specifically, to the private sector, which will, in reality, receive a larger amount of benefits, indirectly, through public sector initiatives fostering health care delivery in the private sector.

TABLE 1 SUMMARY COST ESTIMATE AND FINANCIAL PLAN (US \$ Millions)					
ELEMENT DESCRIPTION	A.I.D.		HCC		TOTAL (US \$)
	FX	LC	FX	LC	
1. TECH ASSISTANCE	<u>19.8</u>	<u>(2.2)</u>			<u>19.8</u>
CDC PASA	7.1				7.1
R&D + AFR Buy-ins	7.3				7.3
AAO Direct	2.0				2.0
Admin Support (PAF)	3.4	(2.2)			3.4
2. PARTICIPANTS	<u>0.3</u>				<u>0.3</u>
3. COMMODITIES	<u>4.3</u>				<u>4.3</u>
4. LOCAL COSTS		<u>14.6</u>		<u>18.8</u>	<u>33.4</u>
MHSS/PHCDAN		2.5		4.3	6.8
SMOHs		3.2		9.5	12.7
LGAs		6.0		5.0	11.0
Private Sector		0.4			0.4
Local TA		2.5			2.5
5. AUDIT	<u>1.0</u>				<u>1.0</u>
PROJECT TOTAL	25.4	14.6		18.8	58.8

IV. COUNTERPART PARTICIPATION AND PROJECT NEGOTIATION

The Project design has benefitted from close collaboration on the part of visiting consultants with counterpart officials and local ACSI/CCCD project staff. All components reflect Nigerian inputs to the design process. Since NCCCD builds upon the ongoing ACSI/CCCD project and continues the essential elements thereof, NCCCD will benefit from the continuity of personal involvement and effort in Nigeria that characterizes the work of a number of ACSI/CCCD associates.

During the design process, various factors were identified that require continuing dialogue with host country counterparts during project implementation. These include the following topics: (a) sustainability; (b) cost-recovery; (c) host country contribution of resources; (d) standards of care and quality assurance; (e) donor coordination; (f) policy environment; (g) decentralization of public sector service delivery; (h) private sector participation; (i) ethnosocial considerations, (j) equity in allocation of resources for health services and beneficiary access to health facilities; and (k) public opinion with respect to health and population considerations.

These topics were addressed at the NCCCD pre-project workshop held in Enugu, Feb. 1-3, 1993, with more than thirty representatives from all levels of government, the PHCDAN, and the private sector in attendance. For the new project to succeed, that group stressed the need for: (a) management training at the local level, especially to assure development of adequate and transparent management and financial systems; (b) community ownership and involvement in project planning and implementation at the local level; (c) strengthened health education to improve health practices and increase individual and community responsibility for health care; and (d) a more strongly integrated approach to the delivery of quality primary health care services at the local level. General agreement was reached on project design and the roles of the project partners.

The final Project Paper reflects the deliberations and concurrence of government counterpart officials and nongovernmental representatives, ACSI/CCCD project staff, and others concerned with child survival in Nigeria who participated in the pre-project workshop.

V. CONTRIBUTORS

This Project Paper was developed with the creative input of numerous individuals and several major institutional contributors. It is beyond the scope of this document to specify the various contributions, but a partial list of those participating in the effort follows below. AAO/Nigeria wishes to acknowledge that their substantial input shaped this document and contributed to its substance.

Nigerian and U.S. collaborators worked together in a true spirit of partnership, grappling with many difficult issues related to project design, the formulation of implementation strategies, ownership, and the delineation of roles and responsibilities. The project design benefitted greatly from the dynamic and frank exchange of views among Nigerian and American collaborators that characterized the project development process. The project will endeavor to promote the continuation of this dialogue throughout project implementation.

Among the key contributors:

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**NIGERIA
COMBATING
CHILDHOOD
COMMUNICABLE
DISEASES
(NCCCD)
620-0004
PROJECT PAPER**

**AAO/NIGERIA
JUNE 1993**

**NIGERIA
COMBATTING
CHILDHOOD
COMMUNICABLE
DISEASES
(NCCCD)
620-0004
PROJECT PAPER**

**Volume I
Basic Project Paper
Selected Annexes
(A thru D, J thru Q)**

**AAO/NIGERIA
JUNE 1993**

**NIGERIA COMBATting CHILDHOOD
COMMUNICABLE DISEASES
(NCCCD)
620-0004
PROJECT PAPER**

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NOTE: Annexes E through J are located in Volume II.

I. PROJECT RATIONALE AND DESCRIPTION

A. Project Rationale

1. Introduction: The Nigeria Combatting Childhood Communicable Diseases (NCCCD) project, the second phase of A.I.D.'s child survival program in Nigeria, continues initiatives begun under the Africa Child Survival Initiative/Combatting Childhood Communicable Diseases (ACSI/CCCD) project. These child survival efforts will continue to focus on the principal childhood diseases. Human resource development (education and communication programs), a health information system, and institutional capacity building at the primary health care delivery level are the means by which quality health care will be assured. NCCCD will provide technical assistance to Nigeria for child survival program activities and will focus on the principal childhood diseases; i.e., malaria, acute respiratory infections, diarrheal diseases, and those preventable by immunization. NCCCD will build on the accomplishments of ACSI/CCCD which began support to Nigeria in 1986. The new project will expand its scope to include improved case management for the sick child, child nutrition practices and maternal care including child spacing.

Program efforts will concentrate in nine of Nigeria's thirty states, focusing extensively in up to sixty of the approximately 300 LGAs in those nine states. The states addressed by NCCCD are home to 29.5 million people, one-third of Nigeria's population. An estimated 5.1 million children under age five and 5.9 million women of reproductive age are involved, making the target population in the nine focus states larger than the combined populations of Central African Republic, Lesotho, Liberia, Swaziland and Togo.

Table 1: Targeted Interventions for Child Survival	
Prevention	<p><u>Prenatal</u></p> <ul style="list-style-type: none"> ● Family spacing to ensure interval > 24 months ● Malaria chemoprophylaxis 1st and 2nd pregnancies ● Tetanus toxoid ● Nutrition education and supplementation <p><u>Delivery</u></p> <ul style="list-style-type: none"> ● Identification and referral of high risk mothers ● Childbirth attended by trained person ● Neonate care <p><u>Child</u></p> <ul style="list-style-type: none"> ● Exclusive breast-feeding for four months ● Optimal infant feeding ● Immunization (BCG, DPTX3, PolioX4, Measles, YF) ● Vitamin A supplementation
Case Management	<p><u>Clinical assessment and treatment of the sick child</u></p> <ul style="list-style-type: none"> ● Fever/Malaria ● Diarrhea/Dysentery ● Cough/Pneumonia

The major risk factors affecting child survival in this large and heterogeneous population require a balanced agenda of preventive and case management services as indicated in Table 1. The proposed

NCCCD program interventions are based on a recognition that the most serious health problems afflicting the children of Nigeria can be addressed, wholly or partially, by relatively inexpensive and simple technologies; e.g., measles and neonatal tetanus by immunizations, diarrheal diseases by correct use of rehydration fluids, and ARI and malaria by other appropriate case management therapies, etc. Other emerging health-related problems of critical importance to child survival and maternal health, such as untimely pregnancy and HIV/AIDS, can be addressed, in part, through the same delivery infrastructure created for the aforementioned technologies.

Nigeria has a large, ethnically diverse and dynamic population (90 million). While the health status of the population has generally improved since 1960, the country continues to have some of the highest rates of mortality among non-refugee, non-war populations in Africa. Rates of infant and child mortality remain unacceptably high (infant mortality = 90/1000; child mortality = 115/1000) and the plight of infants and children is further complicated by high maternal mortality (15/1000). This continued burden of death and disease among mothers and children undermines the integrity of the Nigerian family. Vast areas of Nigeria remain without well-established and efficiently operating Primary Health Care (PHC) systems, and mortality rates in the northern states are much higher than the southern states. In the face of declining or nonexistent public services and increasingly unaffordable private care, a large segment of the population remains subject to the burdens of excessive fertility and high morbidity and mortality. And, now, AIDS, the latest scourge of child survival and maternal health, has entered the scene. Clearly assistance in tackling these significant health problems will go a long way toward helping Nigerian development.

2. Policy Environment and Dialogue: The cornerstone of the Nigeria PHC effort is a comprehensive national health policy, based on a bottom-up strategy that places responsibility for management at the Local Government Area (LGA) level. This policy endorses and promotes community participation in planning, management, monitoring and evaluation of the health system at the LGA level.

Currently, each of Nigeria's 593 LGAs is responsible for establishing, managing and monitoring all ten components of the PHC system identified in Table 2. Historically, the development of the PHC program has been facilitated by the establishment of focus areas with model programs which can then be replicated throughout the nation. In 1986, fifty-two LGAs were selected as models for the PHC approach and were given federal financing to begin the development of their programs. By June 1990, all PHC facilities and programs responsibilities has been shifted to the LGAs. This PHC approach promotes sustainability by assisting local communities to muster available local resources, public and private, for addressing urgent health needs through the use of low cost, technically sound, culturally acceptable but effective interventions.

However, in spite of measurable progress to date in the amelioration of debilitating health conditions and the enhancement of institutional capacity, particularly in the ACSI/CCCD *focus* states and LGAs,¹ Table 2 shows, also, that the National PHC objectives have been only partially achieved.

¹ Subsequent to a ministerial request that ACSI/CCCD concentrate its efforts in certain "focus" states, A.I.D. (in consultation with the MHSS, WHO, and UNICEF) agreed to specific geographic areas of concentration. Thus, midway in its effort, ACSI/CCCD began to focus assistance on PHC implementation at the LGA level in nine focus states, with one focus LGA in each state. The focus states designated were: Lagos, Osun, Oyo, Enugu, Anambra, Niger, Kebbi, Sokoto, and Plateau. Through reorganization of jurisdictions, the original number of LGAs within the focus states expanded to twelve.

Table 2: Nigerian Primary Health Care Objectives/Targets (1992-2000) and Current Status			
Component	National Objective	National Indicator	Current Level and Source
EPI Coverage	80% immunization by age 1	% fully immunized	43.6% 1991 EPI Surveys
Antenatal Care	50% immunized w/ 5 doses-TT	% fully immunized	59.2% rec'd prenatal care (NDHS) 40.9% rptd => 2 TT (NDHS)
Nutritional Status of Pregnant Women	90% newborns with minimum birth weight of 2500 grams	% newborns with birth weight >2500 grams	31% of pregnant women undernourished by UCH survey
Nutritional Status of Children	90% of children with weight for age over 3rd percentile	% of children with weight for age above 3rd percentile	35.7% (NDHS)
Attendance at Delivery	70% of deliveries by trained attendants, including TBAs	% deliveries by trained attendant	36.6% (NDHS)
Contraceptive Prevalence	10% of at risk women using modern family planning method	% women in reproductive age using modern family planning	3.8% (NDHS)
Access to Health Services	80% of population w/i 5 kms or 30 mins of VHW/health facility	% of population living within 5 kms or 30 minutes	26% within 1 mile, 34.6% <30 minutes (NDHS)
Access to Potable Water	40% of pop. w/i 200 Ms of potable water	% of pop. living w/i 200 Ms	Data not available
Access to latrine	60% of pop. w/i 50 Ms of latrine or toilet	% living within 50 Ms	Data not available
Availability of Essential Drugs	80% of VHWs and Health Facilities with drugs continuously available	% of VHWs/HFs with drugs available	CCCD study to be finalized

NCCCD capitalizes on the favorable general policy environment characterized by current Ministry of Health and Social Services (MHSS) orientation to preventive health and ongoing efforts to decentralize responsibility for PHC to the LGA level.

NCCCD will work with the MHSS, the new Primary Health Care Development Agency of Nigeria (PHCDAN) and other technical assistance partners to address areas of policy; e.g., (a) establishment of standard treatment protocols for target diseases, (b) addition of ORS to the essential drug list; and (c) establishment of protocols to address disease control requirements, including response standards for outbreaks and epidemics. NCCCD will address key policy issues and constraints — such as financial and institutional sustainability of PHC programs, including the desirability of institutionalizing cost-recovery mechanisms — facing the various components of child survival at all levels of implementation. Many of these issues were discussed in a Pre-Project Workshop held in February, 1993, attended by representatives of all levels of government, the PHCDAN, and the private and nongovernmental sectors. For the project to succeed, the group stressed the need for:

(a) management training at the local level, especially to assure development of adequate and transparent management and financial systems; (b) community ownership and involvement in project planning and implementation at the local level; (c) strengthened health education to improve health practices and increase individual and community responsibility for health care; and (d) a more strongly integrated approach to the delivery of quality primary health care services at the local level.

PHC implementation in Nigeria is being undertaken through the collaborative efforts of communities, LGAs, States, the MHSS, with the assistance of NGOs, bilateral and multilateral partners. The planning of this project, which began early in 1992, culminated at the Pre-Project Workshop where a consensus was reached on program objectives, inputs and activities, the roles and responsibilities of the partners, Nigerian ownership of the program, and the importance of a community focus of sustainability. NCCCD project design synthesizes the inputs and expresses the collective wisdom of the collaborating partners.

Throughout life of the project, AAO/Nigeria will remain in continual dialogue with host country counterparts at all levels of government, and those within the private sector, on key policy issues and areas of concern confronting NCCCD. Annex Q — Precepts for Project Success — provides a basic agenda for this dialogue, which will be formalized in periodic meetings among host country representatives from the public and private sectors, NCCCD project management and AAO/Nigeria. A joint report will be issued, periodically, relative to the degree to which the precepts listed Annex Q have been respected. These precepts reflect various areas of concern, as follows:

- Nigerian Perception of Project Ownership and the Planning Process
- Financial Management and Accountability
- Counterpart Contributions
- Cost-Recovery Initiatives
- Personnel and Technical Expertise for Sustainability
- Intervention Replication
- Equity and Sociocultural Considerations
- Beneficiary Education
- Donor Coordination

3. Relationship to Other USAID Projects: In addition to the NCCCD project, USAID provides support and technical assistance to Nigeria through: (a) the Nonproject (NPA) Primary Health Care Support Program (PHCSP); (b) the Nigeria Family Health Services (FHS) Project; (c) AIDSCAP and; (d) the University Development Linkage (UDLP) Project.

PHCSP: NCCCD benefits from past and ongoing interventions under the nonproject (NPA) Primary Health Care Support Program (PHCSP), which provides strong support at the federal level for the strengthening of PHC service provision at the state and LGA levels, in such areas as: (a) PHC systems development; (b) local governance and health financing; (c) monitoring and evaluation through the PHC information systems; (d) integration of MCH/FP and nutrition into PHC service delivery; (e) development of AIDS/HIV surveillance capability within the PHC system; and (f) support for PHC training at universities and schools of health technology. These initiatives are of significant importance to NCCCD, particularly with regard to the application of local currency generated by the PHCSP in support of NCCCD operations.

Under the PHCSP, A.I.D. agreed to make available a total of \$36 million, in three tranches, when certain conditions relating to health policy were met. The Ministry of Finance receives the dollars for general revenue purposes and, in turn, transfers an equivalent amount of Naira into a special

MHSS account to be used for priority programs agreed upon between the MHSS and AAO/Nigeria. The conditions for the first tranche were met in April, 1990, and a total of \$15 million was transferred to the Ministry of Finance; the equivalent amount of 118,743,000 Naira was programmed according to an agreement reached between AAO/Nigeria and the MHSS. When the CPs for the second tranche were met in November, 1992, \$10 million were transferred to the Ministry of Finance and 192,730,000 Naira were deposited in the MHSS Special Account. Planning and negotiations for disbursement under the second tranche were completed in March 1993; these actions represent an important outcome within the context of collaborative efforts between AAO/Nigeria and the MHSS for the improvement of PHC service delivery throughout Nigeria. The CPs for the third tranche disbursement were met shortly before the December 31, 1992, expiration date; the last tranche of \$11 million will be transferred according to procedures articulated in the applicable PIL issued in February, 1993. To protect the purchasing power of these funds from the depreciation of the Naira, disbursements will be made at various intervals with the final disbursement to be made in January 1994 at the latest.

Agreement with the MHSS stipulates that Naira generated by the third tranche will be used in direct support of A.I.D.-financed technical assistance projects oriented specifically to child survival, child spacing, and AIDS prevention and control. The use of these funds will be restricted to furthering the goals of those projects. The funds will be used only upon agreement by the MHSS and AAO/Nigeria, pursuant to joint approval of annual work plans and/or joint approval of ad hoc requirements. These funds will constitute an additional element of host country counterpart contribution to the A.I.D. program in Nigeria. As previously agreed with the FGN, the use of the local currency generated by the PHCSP in no way implies a reduction in overall funding from A.I.D. for its program in Nigeria; specifically, application of PHCSP funds in support of PHC initiatives, while constituting an important contribution to the defrayment of operational costs, will not obviate the need for a substantial local costs element under the NCCCD, whose local cost budget requirements, as identified in the project Financial Plan, were established taking into full account anticipated application of local currency generated through the PHCSP.

FHS is a comprehensive family planning assistance activity with initiatives in the public and private sectors, IEC and the policy arena. There is a logical interface between the NCCCD project and FHS in child spacing and maternal health which both projects intend to develop fully. FHS supports programs in family life education, community IEC and mobilization, stimulation of private sector enterprises, training and support for public sector facilities as well as an extensive commodities distribution effort. FHS also supported the introduction of a maternal health initiative to reduce deaths from obstetric emergencies in a two state demonstration activity in Bauchi and Oyo States. The FHS project which began in 1988 has expended approximately \$67 million in bilateral funding. A.I.D. is currently engaged in the design of a follow-on family health services project running concurrent with the NCCCD.

AIDSCAP is a recent addition to the AAO/Nigeria portfolio. This project will provide technical assistance in the development of AIDS education and disease prevention programs. NCCCD will relate to this project in a collaborative effort to reduce the incidence of HIV/AIDS in the pediatric population by programs to educate the grass roots of the community and primary health care personnel about the risks of perinatal transmission.

UDLP in Nigeria is supported under a co-operative agreement with the Johns Hopkins University. This activity links three Nigerian Universities at Ilorin, Maiduguri and Benin with the MHSS in a training program for state and LGA health planners and program managers. The UDLP works to stimulate and involve the University community in applied research on community based

health systems. NCCCD will build on the UDLP base within the university community to expand the involvement of Nigerian academics in developing solutions to factors which mitigate against child survival.

4. Relationship to Other Donor Programs: The AAO/Nigeria encourages other donor investment in infrastructure at the primary care level, and other projects which complement AID financed support. The AAO/Nigeria will initiate an Inter-Agency Coordinating Committee with the MHSS. It is expected that the MHSS will assume the lead in this committee. This will permit the technical assistance and training provided under this project to take into account materials prepared under complementary projects and avoid duplication of effort. Additionally, AAO/Nigeria will support MHSS efforts to work with the donor community to examine and resolve issues relevant to the long-term procurement of vaccines meeting international standards.

The World Bank's investment in the health and population sectors in Nigeria is wide. The \$34 million Sokoto Health Project begun in January 1986, and the \$32 million Health and Population Project strengthen the MHSS's capacity to assist the state and LGA health programs and to prepare new health and population policies and projects. The Essential Drugs project, launched in 1990 for \$68 million, focuses on five states (Edo and Delta; Cross River; Gongola; and Kwara) and all major urban areas served by the eighteen Federal hospitals. The project supports technical assistance and management training for the MHSS to assure an affordable and sustainable supply of safe drugs, especially for primary health care through drug revolving funds and cost recovery policies and procedures. The Bank's Health Systems Fund, a \$70 million loan signed in 1990, provides a line of credit to the states for strengthening health delivery systems at the local level, and core funds for developing cost systems and financial management at the state level. The Bank also supports a project, Choices for Health, to develop a practical guide for efficient health sector resource allocation.

The World Health Organization (WHO) serves principally as a technical advisor, with little financial input, to health and primary health care projects implemented by the public sector, supported by various donors. It has provided critical technical assistance to various child survival initiatives, as well as being involved in essential drugs and water supply. Through its Global Programme on AIDS (GPA), WHO has played a major role in support of AIDS prevention and control in Nigeria, the focus of which has been the development of policies and planning to combat AIDS.

UNICEF supports interventions at the national level, focussing on policy promotion and management support to the health sector, specifically for primary health care, and especially for immunization and diarrheal disease control. At state, LGA and community levels, UNICEF is providing management support for PHC in LGAs of ten focus states. Other programs in the \$125 million Country Program include: (a) mass media capacity building; (b) community participation and mobilization of nongovernmental organizations; (c) support for the development and communication of a national policy on AIDS; (d) development of sustainable information systems; (e) integrated water supply, sanitation and health education projects, including Guinea worm eradication; and (f) household food security and nutrition. By providing technical support, vaccines, ORS, training materials, and cold chain equipment, UNICEF has been an operational partner in the implementation of the ASCI/CCCD project, particularly the EPI and CDD components.

Rotary International has provided the oral polio vaccine requirement, over \$6 million, for the Polio-Plus project in Nigeria, and provided \$1.7 million for cold chain equipment. Polio-Plus project activities in Nigeria are funded through contributions of individual Rotarians, local Rotary Clubs, and a social mobilization grant of over one million dollars from USAID. Nigerian Rotarians are active in 300 LGAs with an estimated population of sixty million, with 20,000 community

volunteers, 7,000 of whom have been trained to mobilize the population for immunization. Rotarian volunteers contribute to EPI implementation by providing transport for staff and cold chain, social mobilization, and recording immunizations.

The African Development Bank supports a health facility construction project in Bauchi State, as well as a state-wide health information systems project. Several other multilateral and bilateral organizations, including the United Nations Development Programme, the European Economic Commission, the Government of Japan are providing assistance to Nigeria's health sector, with particular attention to the area of water and sanitation. The Ford Foundation is also active in Nigeria with program oriented to reproductive health, AIDS prevention, and women's issues.

5. PHC Recurrent Costs and Cost Recovery

The ways and means to meet recurrent costs within the overall Primary Health Care (PHC) system is a major issue that transcends the national PHC program and Nigeria CCCD. The World Bank addressed the issue intensively in its financial analysis of health care costs in Nigeria, published in October, 1991.² That report offers recommendations and guidelines for improving cost recovery procedures, based on model simulations in one state (i.e., Ogun State).

At the micro level, the [public health] sector faces a woefully inadequate system of cost recovery. Lacking resources, especially drugs, the sector provides a poor level of service, despite the availability of trained staff.³

The report concludes that price increases accompanied by higher quality care could increase revenues at public health care facilities.

Better service means that health care facilities must have more medical supplies, more drugs, and a well-trained and committed work force. Another important conclusion is that management capability needs to be significantly strengthened before an extensive cost-recovery program is attempted.⁴

Although the World Bank report concludes "that more intensified cost recovery in the public health care sector is an objective both desirable and achievable",⁵ the overall presentation of data is not conclusive with respect to any significant degree of financial sustainability achievable within the near future. In fact, the simulations demonstrate that a favorable balance between costs and revenues depends much on the assumptions applied to key variables.

² Document of the World Bank, Report No. 8382-UNI, Federal Republic of Nigeria - Health Care Cost, Financing and Utilization (in two Volumes). Western Africa Department, Population and Human Resources Operations Division, the World Bank, October 18, 1991.

³ (I:108-09)

⁴ (I:84)

⁵ (I:116)

This highlights the need for carefully identifying the key variables and their relative costs and targeting improvements selectively.⁶

This last statement provides a balanced, insightful summary of the present situation regarding cost recovery in the Nigerian health and family planning sector; i.e., desirable, somewhat possible, but clearly not predictable. The Bamako Initiative (i.e., cost recovery with regard to essential drugs) offers the best approach and most likely potential for substantive revenue generation within Nigeria's PHC system.

The National Health Policy for Nigeria calls for universal entitlement to essential health care as a national goal. Such a goal implies an immense financial burden that surpasses the current capacity of the public treasury. Effective implementation of the national PHC program will require competent resource management to identify and adopt financially sustainable, effective, and equitable options for program development. The task will entail a macro approach to government health budgets, revenues, and expenditures, with particular regard to the State and LGA levels. It will, also, require detailed cost analysis of service delivery on a continuing basis.

The World Bank will take the lead within the donor community with regard to (a) ascertaining the feasibility of new approaches to the solution of health financing issues and (b) elaborating the mechanisms by which to institute those approaches. One of the first, major steps in this regard might involve the conditionality associated with the disbursement of funds under the new World Bank Population Loan. Experience to be gained under that program will likely provide pertinent guidance for NCCCD implementation.

In tandem with World Bank efforts, NCCCD will explore the potential for various approaches to cost recovery, particularly, with respect to revenue generation capacity associated with the distribution of ORS packets, bed nets, and health cards, etc., as well as specific service delivery interventions such as vaccinations. NCCCD will apply, as appropriate, World Bank guidelines regarding cost recovery strategy; i.e., (a) improvement of cost recovery through higher fees consistently applied; (b) protection of the poor from excessive financial burden; (c) encouragement of fee collection through revenue retention at site; (d) assurance of an adequate supply of drugs; (e) enhancement of the referral system through clear price signaling; (f) reduction of the share of recurrent costs spent on personnel; (g) coordination of public and private health sector supply; and (h) establishment of effective management information systems.⁷ The "Outline of Principles for a Cost Recovery Program" issued by the World Bank⁸ will be an important tool in that effort.

Nevertheless, the scenario for self-financing sustainability does not suggest a likely denouement in the foreseeable future. NCCCD faces a situation characterized by: (a) a large segment of the target population comprised of individuals with exceedingly low purchasing power; (b) a large segment of the target population located in rural areas deprived of services from either the public or private sector; (c) a social setting where the status and education of women is so low that essentially women have no cash income nor freedom of choice; (d) a private sector health care system sustained by a thin strata of clientele with purchase power at parity with the cost of private health care of quality;

⁶ (I:116)

⁷ (I:117-19)

⁸ (II:119, Annex R)

and (e) a governmental financial situation capable of providing only limited social services to a large and growing population. With respect to item (e), the World Bank report states:

One underlying reality that exacerbates Nigeria's health care problems is the decreasing availability of public funds at the federal, state and local levels. State and local spending in Nigeria is highly dependent on federal aid, but the Federal Government itself is highly dependent on oil revenue. The downturn in the oil market in the 1980s seriously reduced the resources available for public spending to the more modest levels of the 1970s. Allocation of funds to the public sector has fallen sharply: the federal health budget (recurrent and capital) in 1990 was only 40 percent in real value that of 1981. This squeeze is felt down through the system, so that states and local governments will likely have experienced a similar reduction in real resources for health care....

Examination of the state and local data for the early 1980s shows that expenditure on nonrecurrent costs (such as maintenance, medical supplies and drugs) has been cut back to the barest minimum, while personnel costs have increasingly dominated recurrent outlays.⁹

Although implementation efforts under NCCCD will direct appropriate attention to pertinent cost reimbursable and sustainability issues, it is unlikely that NCCCD, or any other contemporary general health service delivery project in Nigeria, will be able to achieve self-financing host country PHC programs within the present decade. Alternatively, NCCCD can be expected to stimulate institutional and managerial sustainability, a principal requisite for improving the sector's long-term cost recovery capability. NCCCD will integrate cost recovery mechanisms into its activities to the extent feasible.

Vaccines and the maintenance of an effective cold chain represent the major new recurrent costs associated with NCCCD. For the most part, NCCCD will rely upon infrastructure (i.e., PHC facilities and personnel) already existent. The training, research, MIS, and IEC functions will generate a demand for continuing initiatives to maintain program quality in those areas beyond LOP. NCCCD will develop the institutional and managerial capacities within the PHC services to do so. Those functional support activities will not engender financial sustainability requirements beyond the overall PHC service delivery program as a whole.

6. Appropriateness of Project Approach: Support of the health sector has been a central focus of the USAID program in Nigeria for nearly ten years; NCCCD will build on previous experiences. Since 1986, USAID technical assistance efforts through ACSI/CCCD have encouraged and financed the introduction of child survival interventions as a means for developing a comprehensive health care system at the local level and as a mechanism for addressing infant, child and maternal morbidity and mortality, as well as rapid population growth.

NCCCD design benefits, not only from the trials of ACSI/CCCD implementation, but from a formal evaluation undertaken in March 1991 by an independent team of seven consultants responding to an AFR/TR/HPN initiative. The evaluation used the following parameters to assess the merits and long-term sustainability of ACSI/CCCD initiatives in Nigeria: (a) effectiveness of technical interventions; (b) institutional capacity of the host government to implement the project; (c) constituency of project activities; (d) appropriateness and effectiveness of training; (e) health care financing; and (f) national leadership and strength of the host country to negotiate with donors.

⁹ (I:108)

In all areas, the evaluation found the program to be performing well. The technical interventions of EPI, CDD, and malaria control were found sound and progressive. Institutional capacity of the host government to implement the project at all levels (federal, state, and LGA) was deemed adequate. The effort was characterized as the "wave and direction of the future for Nigeria". The Ministry of Health was evaluated as doing a good job marketing the complex policy and organizational changes necessary to decentralize the responsibility for PHC to the LGAs, where leadership was found to have the vision necessary for building PHC capacity at the local level.

In summary, the ACSI/CCCD program in Nigeria has performed an important trailblazing function for NCCCD, and, in so doing, points its offspring in the right direction with regard to program focus and content. The ACSI/CCCD project has played a central role in strengthening the capacity of staff from selected states and LGAs to plan, implement, and monitor the impact of focused child survival interventions, particularly EPI and malaria, and such infrastructure development as Continuing Education and data collection and surveillance through HIS.

Along the way, a number of broad-based lessons have been learned, such as: (a) political leadership is key to program implementation; (b) valid, appropriate, and realistic policies are the basis for sound program implementation; (c) effective implementation requires systematic planning; (d) quality of services and quality assurance are critical to achieving targets; (e) community partnerships are essential to effective child survival program implementation; (f) effective delivery of vaccines is critical to EPI; (g) essential information is necessary for the formulation and implementation of effective malaria policies; (h) applied research is needed to solve problems encountered in program implementation; (i) management and disease surveillance data (HIS) are essential to program management; (j) to be effective, technical assistance must be integrated into counterpart agencies; (k) administrative support is critical to program success; and (l) EPI and CDD strategies are effective, notwithstanding practical complications encountered in service delivery. NCCCD gives emphasis to all these items.

ACSI/CCCD experience has suggested the wisdom of orienting NCCCD interventions as follows: (a) assistance to the focus states to target broad responsibilities for strengthening infrastructure at the state level in support of technical interventions at the LGA level; and (b) in each focus state, intensified activities implemented at the LGA level. The NCCCD project will continue to work to strengthen primary health care (PHC) capacities at the local government (LGA), state and federal levels with respect to the management of health sector resources, health information, health education and communication, applied research, and in-service training. Specific CDD, EPI, malaria, ARI, maternal health, family planning, and nutrition interventions will be undertaken at the LGA level and, more specifically, within communities and health care facilities. Due to the magnitude of the situation in terms of geography, population, and managerial implications, and in the absence of reason to do otherwise, NCCCD will continue to concentrate resources in the original focus states.

The ACSI/CCCD experience has been positive; significant advances have been made in the augmentation of national, and limited state, capability to field child survival programs. The effort in individual states has only recently (within the last two years) gotten underway. LGA experience is also limited, both in terms of longevity and the number of LGAs addressed. Notwithstanding the successes of ACSI/CCCD, A.I.D.'s child survival efforts in Nigeria, to date, have only begun to scratch the surface of a large field to cultivate over the coming decade(s).

ACSI/CCCD experience has proven the effectiveness of the PHC effort in Nigeria. PHC has saved the lives of thousands of Nigerian children through strong political will and affordable and simple technologies. The political support of former minister of health, Professor Ransome-Kuti, has made

PHC the foundation of the Nigerian health care system. Such support has shown that PHC policy change and operational implementation is possible, notwithstanding shortcomings among certain participants; e.g., (a) commitment within the ranks of state and peripheral health workers has been modest; and (b) supervision throughout the PHC system is weak, due primarily to limited mobility resulting from lack of transport and the poor organizational skills of managers.

Infrastructure for training facilities and service delivery is in place, but needs substantial strengthening for quality outputs. Schools of health technology require equipping and staff training. Continuing education units (CEUs) are being established, although financial support is moderate. Long-term financial sustainability of PHC service delivery at the LGA level will require innovative mechanisms, such as drug revolving funds, fee for services, shifting of tax revenues in favor of PHC, and other possible means. Although each LGA is responsible for the management and delivery of primary health care services to its constituents, resources for the procurement of supplies, training of personnel, and evaluation of progress within individual LGAs are limited. Creative and innovative strategies will be needed to assist each LGA to mobilize accessible, affordable, and acceptable primary health care services necessary to meet the MHSS policy challenge of "Health for All by the Year 2000".

7. **Adherence to A.I.D. Policy:** The AAO/Nigeria program represents a comprehensive, cost-effective and balanced approach to child survival objectives and broader health goals in accordance with USAID health policy guidelines advocating that *"USAID will focus on reduction of infant and child mortality and morbidity as the main intermediate objective toward the ultimate health goal"*. NCCCD will address A.I.D.'s primary specific health sector objectives; i.e., (a) reduce infant and early child mortality and morbidity; (b) reduce maternal mortality and morbidity; (c) use of child survival interventions as the basis for building a more comprehensive health care system over time; (d) ensure that gains made in improving child survival and health are sustained; and (e) develop new, basic, effective technologies and improved systems for delivery of child survival services.

B. Project Description

1. **Goal and Purpose:** The Project goal is the same as the Mission Program Goal as stated in the Country Program Strategic Plan: a **"Healthier and More Productive Society."** The Program Subgoal is **"Reduced Fertility and Decreased Morbidity and Mortality."** The purpose of this project is to contribute to the achievement of the subgoal by **improving maternal and child health practices** in nine states and strategic LGAs. This project purpose reflects the recommendations of the Pre-Project Workshop. The focus will be on developing model programs for the sustainable implementation of maternal and child health care at the operational levels, supported by decentralized health systems. The end-of-project status (EOPS) indicators of achievement of the purpose will be reductions in infant and child mortality and risk factors in the target areas.

Achievement of the project purpose requires: (a) continued political and financial support for maternal and child health care at the federal, state and LGA levels, by both the public and private sectors; (b) continued support by other donors for projects which contribute to the overall objectives; and (c) use of the health care facilities by the target population, at a sufficient level to attain the EOPS.

2. Outputs: The Project Outputs directly support the targets under Strategic Objective 2 of the Mission Strategy:

- **Improved Immunization Practices and Coverage**

The objectively verifiable indicators also equate with the CPSP Benchmark Indicators: Quality of immunization standards, immunization coverage, measles and polio incidence, and immunization of women against tetanus.

- **Improved Case Management of ARI, Fever (Malaria) and Diarrhea**

Indicators include correct home management of fever, and diarrhea, correct clinical assessment, treatment and counseling for ARI, fever, and diarrhea.

- **Improved Child Nutrition Practices**

Indicators include measurement of exclusive breastfeeding, supplementary feeding, and levels of micronutrient deficiency.

- **Improved Maternal Care**

Indicators include measures of prenatal care, births assisted by trained attendants, birth spacing counseling and services for the reduction of high risk births.

- **Improved Planning and Management of Public and Private Health Services**

This project output contributes to the CPSP's Cross-cutting Target. Indicators for this output will measure improved capacity at the Federal, State and LGA levels to: (a) develop work plans and budgets; (b) monitor data collection and analysis; (c) design, implement and assess IEC programs and strategies; (d) use effectively operations research; (e) implement and monitor effective logistics systems; (f) ensure adequate staff training and availability; and (g) collect, analyze, and disseminate epidemiological and program data related to MCH interventions. Indicators to measure improvements in private health services will include their capacity to offer clients MCH services that comply with MHHS practice standards.

3. Project Elements: A.I.D. will provide support through two project elements; i.e., Strategies to Strengthen Infrastructure in Support of Technical Interventions; and Major Child Survival Interventions.

**3.1. Strategies to Strengthen Infrastructure
in Support of Technical Interventions**

The success of the project's child survival interventions is largely dependent on improved management and strengthened infrastructure, especially at the local level. To that end, the project will carry out a series of interventions to: (a) train local government officials and develop sound systems of planning and financial management; (b) establish standards of quality assurance for broad-based child survival interventions; (c) strengthen continuing education, health education and communication, and health information systems; and (d) support operations research specifically designed to improve PHC delivery.

NCCCD will integrate cost-recovery mechanisms into its activities to the extent feasible. Recognizing the interrelationship among PHC recurrent costs generated through operational initiatives, the long-term goal of sustainability, and the desirability of adopting cost-recovery mechanisms within PHC programs, NCCCD will explore and develop the potential for cost recovery within the realm of its activities, particularly, with respect to the revenue-generation capacity associated, for example, with the distribution of ORS packets, bed nets, and health cards, as well as specific service delivery interventions such as vaccinations. NCCCD will adopt World Bank guidelines as an underpinning of its cost-recovery strategy; i.e., (a) improvement of cost recovery through higher fees consistently applied; (b) protection of the poor from excessive financial burden; (c) encouragement of fee collection through revenue retention at site; (d) assurance of an adequate supply of drugs; (e) enhancement of the referral system through clear price signaling; (f) reduction of the share of recurrent costs spent on personnel; (g) coordination of public and private health sector supply; and (h) establishment of effective management information systems.

NCCCD will remain alert to the evolution of pertinent cost reimbursable and sustainability issues, while stimulating institutional and managerial sustainability, a principal requisite, susceptible to NCCCD intervention, for improving the Nigeria health sector's long-term cost recovery capability. Cost recovery and related issues of host government financing and long-term sustainability of PHC services are key topics within the continuing dialogue scenario depicted in Annex Q.

Management of Health Resources at the Local Level: With the emphasis being placed on primary health care delivery at the local level by the MHSS and the strong support given to that sector by A.I.D. as well as other donors, it is the ideal sector in which to demonstrate improved governance. With that goal as well as the need to improve planning and implementation of programs to achieve the project's child survival targets, NCCCD will provide support to strengthen three priority areas:

- Organizational and managerial effectiveness in the health sector at the LGA level;
- Empowerment of grass roots organizations; and
- Transparency in decision-making and accountability, both to superior organizations and to grass roots beneficiaries of the programs.

Applied Training for LGA and PHC Personnel: Key factors contributing to management limitations in public sector health programs at the LGA level include: (a) lack of training of LGA personnel in planning, programming and budgeting, supervision, monitoring and evaluation, and management information systems; and (b) absence of supportive systems for the management of resources and personnel.

Project efforts to improve management at local level will emphasize inter-active, participative training and follow-up for local government leaders and staff, to take place at four centers. The centers will be located at universities with institutions of local government or public administration that are willing to make a commitment to support high quality, intensive training. The program will emphasize: (a) real-world problem case studies generated by the trainees; (b) group-team activities to work through those problems; and (c) the development of tangible outputs (analytical studies, plans, budgets, supervision protocols, management information systems, etc.) reflecting conditions in which trainees actually work and through which trainees would field-test on their return to LGAs.

Training in these areas will be followed up by site visits on the part of program faculty to assess and support trainees' progress in the development and utilization of planning, budgeting, supervision, and management information systems. Faculty will serve three functions in these follow-ups: (a) personal support for alumni; (b) problem-solving; and (c) applied research in the utilization and development

of model routines to guide planning and program development, budgeting, supervision, monitoring and evaluation and effective managerial use of information. The proposed training will be offered to LGA secretariat members, particularly the LGA secretary, LGA planners, and PHC coordinators, with briefer PHC sensitization programs are envisioned for LGA Chairpersons and Department Supervisors. Priority attention will be given to the involvement of women in this training.

Additionally, under a small grants program, the project proposes to provide incentive grants to LGAs to demonstrate the implementation of applicable new and progressive procedures. Recipients could form a new group of "model LGAs."

Financial Management and Information Systems: Improvement in the management of health resources at the local level will require the provision of support to PHC managers in focus states and LGAs to institutionalize financial information systems and strengthen financial management skills. Such assistance will concentrate on mechanisms to ensure that adequate amounts are being allocated in (a) state budgets to fund state responsibilities for PHC, including supervision, support and training at the LGA level; and (b) LGA budgets to fund LGA implementation of PHC; and the development of sound, transparent financial planning and accounting systems. Analysis of recurrent costs demands generated by PHC operations, the relationship of such trends to host country financial capabilities, and the ways and means to institutionalize cost-recovery mechanisms will be prime areas of concern in the NCCCD strategy to strengthen health sector financial management at the state and local levels of government.

Operations Research: A program of operations research to gather additional information on conditions, problems, and options for strengthening management at the local level will be carried out under the project. Research undertaken will be explicitly linked to operational problems identified during the implementation of USAID's health program. An initial agenda of operations research and follow-up initiatives could include: (a) strategic assessment of local government; (b) the elements of civic participation; (c) the role of local government structures; (d) LGA budgetary, accounting and auditing systems; (e) health policy analysis; (f) local revenue generation; (g) monitoring, supervision, and evaluation systems; and (h) accountability structures and practices.

Continuing Education (CE): The continuing education (CE) strategy will enhance the capability of PHC workers to provide quality health care to the community. This strategy calls for:

- Strengthening institutional capacity at the Federal, State, LGA and facility level to manage a systematic approach for assessing, planning, implementing, and evaluating CE.
- Correlation of community mobilization activities with health worker technical training.
- Development of a logistics system capable of supporting the increased utilization of services.
- Interaction with non-training elements to assure adequate responses when operational problems, such as lack of drugs, equipment, and supplies, threaten to negate the effective utilization of skills learned through CE.

To implement its CE strategy, NCCCD will use a comprehensive approach, addressing issues and decisions from various sources using the expertise and other resources (political, technical, educational, financial, and managerial) within the different institutions. In so doing, NCCCD will provide a coherent program of relevant educational activities leading to progressive learning.

To date, much of the in-service training has been remedial (teaching skills that should have been learned in pre-service training). Pre-service training needs to be strengthened to provide the health care worker with the basic knowledge, attitudes, and skills needed to perform his/her job. NCCCD CE initiatives will continue to build on the pre-service education base, providing new skills and enabling health workers to adapt to changing conditions and priorities on the job. The CE program for health workers will:

- Develop and institutionalize a decentralized CE system for PHC workers and those working with PHC-related problems.
- Develop the capacity of staff within Continuing Education Units (CEUs) to assess needs, plan, implement and evaluate training programs on an ongoing basis.
- Strengthen the capacity and capability of Schools of Health Technology (SHT) staff through: (a) provision of training materials; and (b) upgrading technical knowledge, teaching and administrative skills.

To achieve those objectives, NCCCD will support the development of a Continuing Education System Network (CESN) designed to reach all health care workers, public and private, at regular intervals in a systematic manner. The CE component of NCCCD will facilitate: (a) editing and production of appropriate training materials; (b) dissemination of those training materials and revised policies to the SHTs; and (c) the institution of a systematic approach that assures maintenance of pre-service learned skills and utilization of the new skills learned.

The program will utilize and strengthen existent infrastructure and staff at MHSS, State Ministries of Health (SMOH), LGA, and facility levels. It will also coordinate with, and provide assistance to, the private sector, other educational institutions, and national professional organizations to facilitate the participation of those entities as important members of the CE network. National expertise will be identified to provide technical assistance for the improvement of PHC provider technical skills and CEU administrative, training and curricula development capabilities.

MHSS and SMOH epidemiologists will receive training as part of a national field epidemiology training program (FETP) sponsored jointly by one or more universities, the MHSS, and NCCCD. The objectives of the FETP will be to: (a) train a professional Nigerian cadre in applied epidemiology; (b) develop an institutionalized CE program made up of short-term training courses in epidemiology (including HIV/STD surveillance); (c) strengthen national surveillance systems; (d) develop capacity for responding to public health emergencies, such as outbreaks of endemic diseases and disasters, both natural and man-made; and (e) strengthen academic and operational linkages.

Quality Assurance: Because Quality Assurance (QA) is central to the successful implementation of all USAID projects, including NCCCD, a coordinated technical assistance effort will be developed in the office of the AAO. This will be supported by a resident technical advisor who will facilitate the integration and institutionalization of efficient, sustainable quality assurance methods into each of the technical and support programs. Ultimately, this activity will foster an enabling environment in which client focused quality assessments, total quality management techniques and the maintenance of high quality standard of performance are fully accepted and integrated into all aspects of Nigeria's health system. QA activities will involve the collaboration of Nigerian university counterparts who will participate in (a) the identification and selection of case materials; (b) curriculum development and (c) methodology refinement.

In the NCCCD project, QA activities will concentrate on processes for the continuous examination and improvement of health care services. Specific areas to be addressed include: (a) the uniform application of quality of care standards; (b) effective supervision supported by objectively measurable competency based performance standards for service providers; (c) identification and analysis of quality problems utilizing appropriate tools, such as cause-effect diagrams, pareto charts, process flow-charting, and systems models; (d) problem prioritization utilizing appropriate techniques; (e) methodology refinement through evaluation of alternative techniques for assessing and improving quality; (f) clarification of the relationship among cost, system efficiency, quality of care, and the client's willingness to pay; (g) dissemination of Nigeria-specific case materials demonstrating QA effectiveness; and (h) stimulation of initiative and teamwork through the application of appropriate incentives. The following categories of activities will be included in the development and institutionalization of a QA initiative that supports and is coordinated with other USAID activities.

Quality Awareness Workshops: Awareness workshops will provide a general orientation to the QA field for policy-makers and health system managers. Officials at the federal, state, and LGA levels will be candidates for these workshops. Nigeria specific case examples and relevant materials will be developed to focus on the technical interests of the participants.

Skills Training: Training will cover the entire range of mainstream QA techniques, organization of a QA program, and quality management skills. These workshops will be for project staff, QA coordinators for participating programs, and representatives of Nigerian universities.

Planning Activities: Plans for the development and implementation of QA activities will be written for every level of a health system. When necessary, a workshop approach will be used to achieve a consensus among the key elements that must cooperate to make QA effective. The actual implementation of quality assurance activities will take place at the facility and community level and this will involve the integration of a QA component into each subproject work plan.

Case Material Development: Program resources will be provided for: (a) the systematic documentation of QA experience in Nigeria; and (b) the subsequent development of case materials for incorporation into training materials.

Methodology Refinement Studies: Studies comparing alternative techniques for quality assessment and improvement, including both cost-effectiveness and efficiency criteria, will be integrated into management activities at the Federal, State and LGA level.

Quality of Care Monitoring: External assessments of quality variables (utilizing baseline measurements and follow-up assessments) in representative samples of facilities and clients will be integrated into project impact analyses.

Health Education and Communications (HE/C): The Health Education and Communications (HE/C) component of NCCCD is an essential part of a program-wide IEC strategy. The NCCCD HE/C activities will be planned and coordinated with other USAID projects. The integrated IEC strategy emphasizes behavioral change as the key objective of the HE/C program. There are two components to this strategy:

- Use of comprehensive, systematically planned educational programs to achieve individual and collective behavioral change at the LGA level, with special attention given to community programs involving community members, health workers, schools, and other relevant individuals and organizations; and

- **Strengthening of infrastructure at the LGA, State and Federal levels (in both the public and private sectors) to facilitate the provision of adequate support to the LGAs.**

The institutional capacity of the HE/C infrastructure at all levels needs to be strengthened to address weak HE/C program planning, lack of clarity about the meaning and role of HE/C in PHC, shortages of trained HE/C personnel, and the lack of basic resources.

HE/C at the LGA Level: At the LGA level, NCCCD will support assistance in HE/C to districts, communities, health facilities, schools, and other groups and institutions. The focal point for this input will be the LGA HE/C Officer. Each LGA will be encouraged, through an incentive program, to ensure professional training for its HE/C Officer at the African Regional Health Education Centre (ARHEC), associated with the University of Ibadan.

Getting Started in the Community: HE/C can only be effective at the LGA level if it is planned and implemented with family and community participation. Working through and with Village Health Committees (VHCs) and community groups, HE/C programs for women will be organized to enhance their status and role as participants in, not merely as beneficiaries of, improved family health care practices.

LGA Relationship to the SMOH: In the HE/C context, the LGA HE/C Officer and staff as well as health workers in clinics will relate to their respective focus states through:

- Training of trainers (TOT) involving SMOH Health Education Units, CEUs, and MHSS staff to develop the skills among the members of the LGA PHC teams required to carry out community HE/C programs.
- Specialized in-service training in relevant HE/C areas; e.g., formative research, focus groups, materials development, and counseling.
- Participation in the initial CEU supervisory skills training cycle and other CEU training opportunities, including follow-up supervision.
- Access to print and other educational materials produced at the state level for mass distribution.
- Participation in large, statewide educational campaigns, special events, and media programs.
- Participation in state-convened meetings on topics of interest to the patient, the community, and school health education.

HE/C Inputs at the State Level: NCCCD HE/C activities will be undertaken in collaboration with SMOH Health Education Units, CEUs, and SHTs. NCCCD will enhance counterpart capacity at the state level to: (a) support HE/C in the LGAs; (b) provide HE/C training to LGA staff and facility-level health workers; (c) improve technical competence of HE/C staff; and (d) advocate for HE/C program resources.

SMOH Relationship to the Federal Level: SMOH CEUs will relate to the Federal Health Education Bureau (FHEB) in several ways:

- MHSS will provide TOT to SMOH CEU staff to enable them to train teams from focus LGAs in community HE/C.
- Focus state staff will participate in periodic technical meetings and conferences organized by MHSS.
- Standards of practice for HE/C practitioners developed by MHSS will be circulated, reviewed and discussed with the states prior to adoption.
- States will participate in specialized in-service HE/C training organized by MHSS.
- MHSS will produce and circulate to SMOH print materials designed for mass audiences and/or adaptation by the states.
- MHSS and SMOHs will collaborate on the development and implementation of national campaigns, important media events of a national or regional nature, and other large-scale communication activities.
- MHSS will provide other technical and training assistance as needed.

HE/C Inputs at the Federal Level: NCCCD assistance at the Federal level will focus on institutional development of the Federal Health Education Bureau (FHEB) and, through it, on the development of effective HE/C practice and research in Nigeria. Assistance to the FHEB will enable that entity to assume a national leadership role in HE/C. Major FHEB responsibilities for NCCCD implementation will include:

- Development and dissemination of standards and guidelines for HE/C practice in PHC programs.
- Collaboration with ARHEC for staff training to strengthen the capacity of SMOH HE/C staff.
- Training of SMOH HE/C staff in focus states.
- Organization and facilitation of national conferences for the exchange of HE/C information and experiences addressing PHC needs.
- Organization and sponsorship of special technical working groups to prepare guidelines and technical documents for assuring the accuracy and consistency of messages diffused nationally.
- Staff development through participation in scientific meetings and workshops within and outside Nigeria.
- Information/education/communication dissemination through print materials, electronic media, newsletters, and literature reviews.
- Privatization of media development activities.

Health Information Systems (HIS): The HIS component of the project will be implemented in the NCCCD focus States and LGAs, and at the federal level, particularly in disease surveillance, including HIV/STDs.

Local Government Area Level: HIS training will be provided to LGA PHC Coordinators and Assistant Coordinators to strengthen their skills in the collection and use of data for management, planning, monitoring, evaluation, supervision, and communication. Indicators will be selected by which LGA officials will be able to monitor their implementation of child survival within PHC. Training will be provided in interpreting and using this data. Annually, in preparation for work plan development, an LGA self-evaluation will be carried out (workshop recommendation).

State Level: SMOHs in focus states will have enhanced HIS capacities. Objectives include:

- Establishment of an HIS Office in each focus SMOH, with the provision of necessary hardware, software, and training to managers and implementors involved in the operation of the HIS and its related reporting systems; e.g., NiCare (PHC M/E and commodities systems), EPID (Forty Disease Surveillance notification), and 150-Site Sentinel Surveillance.
- Training for faculty at the Schools of Health Technology (SHT), based on the continued development and refinement of modules for the development of PHC management and supervisory skills.
- Training and continuing education for appropriate personnel, focused on: (a) M/E (Monitoring & Evaluation) analysis including the development and use of indicators; (b) cost-effectiveness; (c) communication; (d) advocacy; (e) supervision; (f) program planning and management (including management of commodities); and (g) design and production of a feedback bulletin.¹⁰
- Development and implementation of protocols for epidemic preparedness and response; and impact evaluation of decision and health outcomes.

Federal Level: NCCCD will strengthen the capacity for monitoring and evaluation at the national level. Assistance will be provided to:

- Increase the capacity of the PHC M/E Unit to collect, analyze, disseminate, and develop guidelines for data use at Local Government and State levels.
- Develop materials on advocacy and case studies demonstrating uses of data at LGA and State Levels for program policies and management, priority setting, and the allocation of resources.

¹⁰ This training will strengthen the capacity of SMOHs to provide supervision, feedback, and (in collaboration with Zonal PHC Officers) the provision of technical assistance to LGAs for the: (a) completion and forwarding of HIS forms; (b) use of data for program planning and management at local levels; (c) priority setting; (d) allocation of resources; and (e) training of health care facility employees.

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- **Train key officials (e.g., zonal M/E officers and state PHC directors and their staff) for M/E analysis; monitoring and evaluation, including the development and use of indicators at Stat and LGA levels; communication; supervision; program planning and management; and computer use.**
- **Organize and conduct a systems analysis of the PHC M/E and disease reporting systems including: (a) the mapping of data flow and use; (b) reduction of inconsistencies in the systems; (c) development of a manual outlining the parameters of the two systems; and (d) analytic description of staff responsibilities within, and between, different tiers of the health system. An evaluation would be carried out in February 1994 as recommended by the pre project workshop.**
- **Organize a Medical Records Office for data storage and verification in the M/E Unit.**

Sentinel and Inpatient Hospital Surveillance System: The project will support and strengthen the implementation of the 150-site Target Disease Sentinel Surveillance System and the eight-site Inpatient Hospital Reporting System. Assistance will include validation studies to evaluate and improve reporting of the eight-site Inpatient Hospital Surveillance System and training of appropriate personnel in data collection and use.

HIV/STD Surveillance: The basic strategy of the HIV/STD surveillance initiative will be to develop and operate a comprehensive reporting system combining HIV/STD epidemiologic input from the National AIDS Control Program (NACP) with the MHSS HIS sentinel system. The HIV/STD surveillance initiative will be linked to other NCCCD activities oriented to the improvement of health information and surveillance in Nigeria.

The initiative will: (a) provide adequate information to the MHSS National AIDS Control Program (NACP) for monitoring and evaluation purposes; (b) enable adequate tracking of the HIV/AIDS epidemic; (c) facilitate targeting of interventions (geographically and by high risk behavior groups); (d) provide sufficient surveillance data to the AIDSCAP project for its evaluation component; (e) build epidemiologic capacities within the MHSS; and (f) support the broader AIDSCAP project with bilateral inputs, as required, to maximize the overall efforts of AAO/Nigeria's HIV/AIDS prevention and control program.

HIV/STD serosurveillance activities will include: (a) support and supervision for field operations; (b) data analysis; (c) laboratory consultation with the CDC field station laboratory in Abidjan; (d) development and fielding of training courses in HIV/AIDS and STD surveillance, including adaptation of course materials to the Nigerian context; (e) training workshops supporting specific HIV/STD surveillance exercises; (f) integration of HIV/STD surveillance into the overall NCCCD HIS initiative and supporting data systems, the 150-site target disease sentinel surveillance system, and the eight-site inpatient hospital reporting system; and (g) limited-scope applied research activities relevant to HIV/AIDS/STD surveillance and evaluation administered through the NCCCD operations research mechanism.¹¹

¹¹ Potential research topics include: (a) evaluation of the quality of mortality data available from public morgues in Lagos; (b) evaluation of alternative, more cost-effective strategies for confirmation of HIV antibody test results; (c) evaluation of the impact of the HIV/AIDS epidemic on tuberculosis prevalence and treatment demand in Nigeria; and (d) assessment of HIV seroprevalence in new and potentially important population groupings in Nigeria.

Support to Epidemiologic Initiatives: The project will also support the systematic monitoring and evaluation efficacy (clinical, hematologic, and parasitologic) and cost-effectiveness of treatments at the PHC level of the health system and will strengthen MHSS and SMOH capacities for responding to epidemics through a successful emergency disease notification system involving four zonal public health laboratory centers of excellence and thirteen teaching hospital laboratories. The project will continue to work with the MHSS Department of Disease Control and PHC to produce the *Nigerian Bulletin of Epidemiology* on a quarterly basis and will also support MHSS acquisition of selective medical library publications on microfiche at the Central Medical Library.

Private Sector PHC Data: PHC Data from Christian Health Association of Nigeria (CHAN), whose affiliates provide approximately forty percent of the health services delivered in rural areas, are not currently utilized in national health planning and monitoring. Based upon a analysis of data management needs, NCCCD will assist, as appropriate, with technical assistance, hardware, software, forms, and training to facilitate reporting of PHC and reportable disease information in accordance with MHSS format. AID supported PVOs, e.g., Africare, will also be provided assistance to monitor child survival implementation using the national format.

Operations Research (OR): Beyond the specialized requirements of the various project components, research priorities will focus on broader issues related to: (a) the constraints to the implementation of program strategies directed at major causes of childhood morbidity and mortality; (b) the problems related to availability, access, quality, coverage, and impact of service delivery; (c) training and supervision requirements; (d) behavior change objectives; (e) cost-recovery and cost-effectiveness considerations; and (f) rationalization of health budgets currently weighted disproportionately to payroll requirements to the detriment of program operations. In line with the pre-project workshop recommendations, NCCCD OR will be increasingly directed at the use of implementation data to identify and solve operational problems. OR will address specific technical requirements, such as:

- **Urban Immunization:** Cost-effective strategy for urban immunization targeting the delivery of services to a high density, under-served, mobile populations.
- **Treatment of the Sick Child:** Development and testing of simplified integrated strategies for clinical management of the sick child.
- **Malaria:** Continued surveillance for drug sensitivity and field testing of the effectiveness of insecticide-impregnated bed nets and curtains in the reduction of malaria transmission. Within the framework of the treatment of the sick child, strategies to reduce impact of malaria parasitemia, fever, and anemia.
- **ARI:** Development of community and health facility ARI implementation strategies.
- **Nutrition:** Micronutrients (Vitamin A, I, and Fe) critical to health, mental development, and productivity. Assessment of iodine status utilizing filter paper collections of blood.
- **Infectious Disease:** Tetanus and HIV prevalence.

The Operations Research component will support, strengthen, and institutionalize within the MHSS, the development of protocols and procedures for commissioning, disseminating, and utilizing the results of operations research (OR). Specific assistance will include: (a) the sponsorship of seminars focused on research results; (b) production of a compilation of research results; and (c) publication of case studies on the use and impact of data.

Private Sector Initiatives: The private sector in Nigeria is a major source of health care, especially in the southern sections of the country. Primary health care, especially disease prevention, is much less of a focus of this sector than curative care, nevertheless there is a substantial role for this sector under the project. NCCCD will encourage private sector initiatives which support primary health care, in coordination with the Family Health Services Project (FHS II). Proposed private sector activities have been identified that will be further assessed in the early phases of the project to determine both feasibility and potential impact on the project purpose. Some ideas include use of private sector advertising capabilities to support interventions, social marketing of weaning foods as well as ORS, and training of private sector practitioners at all levels in certain project areas. To be explored on the policy front are licensing questions and the quality of services and medications as a means of improving health care at all levels.

3.2. Major Child Survival Interventions

Improving the health of Nigerian children requires the implementation of key Maternal and Child Health (MCH) interventions to address the major factors associated with infant and child morbidity, disability, and mortality. In addition to MHSS child survival strategies assisted by the ongoing CCCD project, attention will also be given to issues of ARI, child spacing, delivery, and nutrition. CCCD experience in Nigeria and elsewhere has identified a need to move beyond individual symptomatic responses (e.g., ORS for diarrhea, antimalarial for fever, etc.) to a more holistic approach of assessment and treatment with a balanced emphasis on prevention and case management.

Preventive Health Care: Priority attention will be given to five preventive issues: immunization, infant and child nutrition, safe motherhood, maternal nutrition, and child spacing.

Expanded Program on Immunization (EPI): The EPI component includes immunization of infants/children against tuberculosis, measles, tetanus, diphtheria, pertussis, polio, and yellow fever and women of reproductive age against tetanus. NCCCD will expand and/or modify the EPI spectrum of coverage in response to additional disease control requirements, as may arise during life-of-project, in accordance with operations research identifying needs and appropriate response procedures. National EPI objectives are to achieve and sustain national coverage of eighty percent, or higher, for childhood antigens and to reduce vaccine-preventable disease incidence. NCCCD will focus on strengthening EPI capacity in the nine focus status through a problem-oriented implementation strategy in focus LGAs and intensified efforts in selected urban areas. Collaboration with WHO and UNICEF is an important element of the EPI implementation strategy.

A major challenge of the EPI is the continued availability of adequate quantities of potent vaccine. While vaccine procurement is a MHSS responsibility, donors need to work with the Government to assure that an effective strategy for vaccine procurement, storage, and distribution is available. Special challenges to be met include: (a) maintaining the momentum of the EPI in view of ongoing political change and increasing program costs; (b) demonstrating disease impact on morbidity and mortality; (c) stimulating greater involvement of the private sector; and (d) maintaining adequate supplies of international standard vaccines and an effective cold chain. NCCCD will provide support for MHSS donor coordination initiatives to resolve these issues.

In addition to playing a major role in donor coordination initiatives to assure adequate supply of vaccines for the national EPI, NCCCD will support specialized vaccine-related initiatives, such as: (a) in-country vaccine production in line with W.H.O. standards; (b) augmentation of clinic laboratory service capability; (c) provision of seed funds for the procurement and stockage of required vaccines for PHC delivery at the local level; and (d) operations research on epidemiologic, economic,

and technical factors related to EPI and/or the possible introduction of new vaccines appropriate for inclusion in EPI; e.g., Hepatitis-B, Intramuscular Polio Vaccine (IPV)/Measles combination, DPT/Hepatitis-B combination, etc. Appropriate epidemiologic studies, assessment of local vaccine production capabilities and quality control needs, field testing of different vaccines and dosage regimens, and related training are envisioned as activities related to the expansion of EPI initiatives. NCCCD will assist in the effort to improve the quality and volume of vaccines in Nigeria.

Urban EPI: WHO, UNICEF and USAID have identified the need to improve EPI in Nigeria's urban areas. An AID-financed urban EPI project (REACH) targeting measles started in mid-1992 in Lagos State. This initiative focuses on improving immunization-related activities in the pilot area, including better use of data for programming and innovative strategies to improve immunization coverage (e.g., reducing dropouts, vaccination of sick children, better training for health workers).

Measles control in a rapidly urbanizing population will require a special focus within the existing EPI to reach infants as soon as they lose maternal antibodies and become susceptible. Due to earlier age of infection, intensity of exposure, and higher prevalence of malnutrition, earlier immunization coverage will be needed in urban areas than in rural areas to reduce, more effectively, childhood mortality due to measles.

To complement the broader national EPI, urban-specific strategies responsive to some of the specific challenges peculiar to Nigerian cities will be implemented in focal areas. This effort will incorporate broader EPI operational concerns into an urban focus with emphasis on site selection, planning, assessment, social mobilization, increased private sector participation, etc.

Infant and Child Nutrition: As a part of the overall objective advocating the reduction of infant, child and maternal morbidity and mortality, the project will focus on the improvement of the nutritional status of children under thirty-six months of age with special emphasis on the reduction of protein energy malnutrition and micronutrient deficiencies. Nutrition initiatives will include education and communications, training and research and studies. The program will be carried out with counterparts in selected States and LGAs.

Breastfeeding Promotion: Promotion of exclusive breastfeeding and elimination of bottle feeding will have significant impact on infant mortality below six months of age by reducing early diarrhea episodes and giving the child the best nutritional start possible. This activity will include emphasis on: (a) initiation of breastfeeding within a half hour of birth; (b) utilization of colostrum; (c) exclusive breastfeeding between four and six months of age; and (d) continuation of breastfeeding along with complementary food for twenty-four months. These actions will also have a positive effect on postpartum infertility and increased birth spacing.

NCCCD will carry out the following actions related to the promotion of breastfeeding:

- Continued support to the MHSS for the development and implementation of a national breastfeeding policy and strategy.
- Development and testing of IEC approaches including: (a) social marketing and individual counseling; (b) development of health worker and TBA training materials; (c) outreach to community groups; and (d) development of related educational materials.
- Research and ethnographic studies at the community level to better understand mothers' real constraints to proper breastfeeding practices.

- **Integration of training and educational materials into primary health care training courses at all levels.**

Child Feeding (Weaning): The nutrition component will work to improve the availability and accessibility of nutritious weaning foods. One initiative will support the development and promotion of homemade recipes; another will provide support to the private sector for product development, testing, marketing and distribution of appropriate weaning foods.

Specific actions related to child feeding and weaning will include research on constraints to optimal child feeding practices and development and testing of child feeding protocols, including home-based and commercially produced weaning products.

Nutrition and the Reduction of Diarrheal, ARI, and Measles Mortality: Good nutritional status reduces the severity of diseases, such as diarrhea, pneumonia and measles, and decreases the child's risk of death. Good nutritional status also strengthens a child's immune system and its ability to prevent/control infection. Exclusive breastfeeding and the reduction of bottle feeding will have a significant impact on reducing diarrhea for the young child as well as giving the child the best nutritional start possible. Although the current national CDD Program includes feeding as part of case management, implementation of this component will receive additional attention under the NCCCD project.

Because of the high prevalence of micronutrient deficiencies in Nigeria and the linkages of these deficiencies to child morbidity (particularly with respect to diarrhea and ARI) and mortality, the nutrition intervention will (a) focus on assessing the geographical distribution of these problems and (b) design follow-up pilot projects to test the cost-effectiveness of Vitamin A, iodine (I) and iron interventions in focus LGAs.

Case Management Protocols: CDD, ARI, and measles case management strategies will be modified to include nutritional components based on results and lessons learned from infant and child feeding initiatives. CDD training and educational materials will be revised to include infant and child feeding information appropriate to the reduction and treatment of diarrheal diseases. Clinical and operations research will be supported to test the impact of Vitamin A on morbidity and mortality, with specific focus on the treatment of measles and reducing the prevalence and severity of diarrhea and ARI.

Growth Monitoring and Promotion (GMP): Infant/child growth monitoring and promotion emphasizing mother counseling at the health clinic and community level has been an effective approach for educating mothers about the linkage of proper feeding practices to good nutrition. The MHSS has undertaken an extensive operations research project on health worker capacity to monitor infant/child growth. The project will support the strengthening and expansion of this initiative, with particular attention given to the development and testing of counseling materials and the evaluation of GMP strategies at select LGA and community levels.

Safe Motherhood: Maternal health will focus on antenatal, safe delivery, and postpartum care to address the major causes of maternal and infant mortality. Key initiatives will focus on policy change, information systems, community health education, and operations research. A major cause of infant mortality, perhaps as high as twenty-five percent, relates to events associated with delivery. Risks associated with maternal and infant mortality can be minimized through: (a) the identification and referral of high risk mothers (recognizing that referral facilities are not uniformly available); (b) delivery by a attendant trained in hand washing and umbilical cord care; (c) attention to newborn's

airway and temperature. Specific problems include obstructed delivery and asphyxia, hemorrhage, and infection. For LGAs providing quality under-five preventive and curative services and willing to invest in improved delivery care, NCCCD will develop and implement safe motherhood interventions focusing on policy change, information and training in safe delivery, community health education, and operations research.

Maternal Nutrition: The importance of maternal nutrition as a critical element of the child survival program cannot be overstated. Improvement in maternal nutrition will decrease maternal mortality, increase birth weights and neonate survival rates, and improve the mother's capacity to lactate and take better care of her child. Better maternal nutrition, coupled with improved obstetrical care and a reduced reproductive burden, will contribute to an overall improvement in the health and well-being of Nigerian women of reproductive age. NCCCD will address the problems of maternal nutrition through the following actions:

- Clinical and operations research on the prevalence of maternal nutrition and linkages to low birth weight and early childhood malnutrition and on cost effectiveness of maternal nutrition strategies.
- Ethnographic research on constraints to improved maternal nutrition.
- Development and implementation of health education and communications approaches focused on maternal nutrition and educational and training materials which emphasize the importance of improving the diet of the pregnant woman as an essential element of maternal health.

Child Spacing: A high percentage of infant mortality risk relates to untimely pregnancies; i.e., "too early, too close, too many, and too late". For births occurring within 24 months of the previous birth infant mortality is double (118.4) that of births occurring at intervals of 24-47 months (68.9) (NDHS). Local communities need to be made aware of these risks, gain knowledge of family spacing options to limit such risks, and have access to quality services providing spacing methods. NCCCD will work with the Family Health Services (FHS) project (the family planning project financed by AAO/Nigeria) to promote child spacing at the LGA and health facility level.¹² NCCCD and FHS will coordinate training, commodity supply, and monitoring initiatives as appropriate to overall AAO/Nigeria program requirements and objectives. Workshop participants endorsed the importance of child spacing as an integral component of child survival strategies.

Case Management of the Sick Child: Throughout most of the life of the CCCD project, sick children were generally treated on the basis of the mother's complaint: fever, diarrhea, cough. Research supported by CCCD has shown that overlap between symptom complexes is common (e.g., 90% of children with pneumonia also met the case definition for malaria). WHO has identified a more holistic approach to clinical assessment and treatment as a high priority. Specific CCCD research in this area is in process. During the first year of NCCCD, improved assessment and treatment strategies are expected to emerge to cover the three major causes of childhood morbidity and mortality; i.e., malaria, ARI, and diarrhea. Associated aspects of prevention are included in the individual disease descriptions.

¹² Whether program objectives involve disease prevention, treatment of the sick child, maternal health, or family planning, the PHC service delivery mechanism in the public sector implies, for the most part, the same health care facilities and service personnel.

A high percentage of episodes of child illness receive treatment from private sector providers (physicians, chemists, medicine sellers). An ACSI/CCCD-financed study is currently evaluating public and private sector treatment of fever and malaria describing pharmaceutical source, prescribed dose, quality, and cost. With that information, NCCCD will test alternative strategies to upgrade drug treatment practices of all providers.

Malaria: The NCCCD malaria initiative will collaborate with the MHSS, participating SMOHs and LGA Health Departments to utilize a multidisciplinary approach to reduce: (a) mortality in young children by proper management of malaria illness and by reduction of the frequency of low birth weight; and (b) morbidity in young children as measured by the duration of acute illness, frequency of recurrent illness, and the prevalence and degree of malaria-associated anemia.

Specific objectives of the LGA malaria initiative include: (a) recognition of malaria as a febrile illness or severe disease at the home and at all levels of health facilities; (b) proper management of the disease at all levels as recommended by appropriate guidelines; (c) prompt referral of appropriate cases to recommended levels of health care; (d) improvement in target population knowledge and practice of self-protection from mosquito contact, including environmental sanitation and prompt utilization of appropriate health facilities and the referral system; and (e) prevention of severe anemia and low birth weight infants through the use of recommended prophylaxis during high risk first and second pregnancies.

The malaria control strategy will emphasize: (a) integration of the management of pediatric malaria, along with diarrhea and ARI, into a comprehensive program for the treatment of the sick child; (b) early recognition and adequate treatment of cases to reduce deaths and duration of illness; (c) prophylactic use of effective antimalarial drugs during pregnancy to prevent severe malaria and anaemia in the mother, particularly, during first and second pregnancies; (d) periodic training of health workers to implement recommended malaria control activities; (e) provision of adequate quantities of recommended antimalarial drugs; (f) community mobilization and health education; (g) maintenance of trained Malaria Control Staff at the MHSS and State Ministries of Health (SMOHs) for planning and monitoring guidance; and (h) support of operations research leading to improved malaria control.

A surveillance component will: (a) continue to monitor drug sensitivity and (b) support specific disease surveillance studies throughout the country such as the epidemiology of urban malaria and the acceptability, effectiveness, and utilization of impregnated bed nets and curtains.

Control of Diarrheal Diseases (CDD): The diarrheal disease component will focus on:

- Establishment of needs based on population distribution, the epidemiology of diarrhea, and existing supplies in health centers.
- Assessment of health personnel knowledge of the correct case management of each type of diarrhea, awareness of the importance of the nutritional management of diarrhea cases, and skills pertaining to the education of mothers about case management at home.
- Identification of interventions to improve the prescribing practices of pharmacists and drug sellers for different types of diarrheal diseases.

The program will: (a) integrate case management strategies and interventions for diarrhea along with fever (malaria) and ARI into a comprehensive program for the treatment of the sick child; (b) improve case management of infants and children presenting with diarrheal disease; (c) reinforce the promotion of ORS and use of home fluids; (d) promote the use of breastfeeding and weaning foods; (e) integrate nutrition and child feeding into the Nigeria CDD program, including comprehensive promotion of breastfeeding and child feeding; (f) involve the private sector in weaning food production and marketing; and (g) undertake other CDD activities linked to nutritional concerns, such as growth monitoring.

CDD interventions will include: (a) development of a Diarrhea Treatment Unit (DTU) in each focus state; (b) distribution of ORS to health facilities in focus states; (c) establishment of an ORT corner in each hospital or clinic in all focus LGAs and ORT corners in at least fifteen non-focus LGAs in focus states; and (d) institutionalization of CDD training through CEU programs.

Support will also be provided to Nigerian scientists to improve the quality of scientific information needed for the control of cholera and other diarrheal diseases and to assure that research findings are fed back to CDD policy-makers for continual revision and improvement of program content.

Acute Respiratory Infections (ARI): The objectives of the ARI program are a reduction of: (a) mortality attributable to pneumonia in children under five years of age; (b) inappropriate use of antibiotics and other drugs for the treatment of ARI in children; and (c) the incidence of acute lower respiratory tract infections. As ARI cases are often accompanied by malnutrition, NCCCD will prepare and institutionalize protocols for treating malnourished children with ARI.

ARI program strategy will emphasize case management - the early detection and treatment of pneumonia cases in children under five years of age, while stressing the importance of high coverage rates for immunization against measles and whooping cough. Efforts will be directed to the development of appropriate preventive strategies and interventions subject to appraisal of effectiveness, cost, and feasibility. In view of data demonstrating that Vitamin A supplementation reduces pneumonia mortality, pilot studies to document Vitamin A effectiveness in Nigeria will be considered. NCCCD will work with the MHSS, participating SMOHs and LGAs, and other donors, particularly UNICEF, to assure the availability of ARI drugs in both the public and private sectors.

ARI training units (ATU) will be developed using the same sites as those established for the diarrheal disease training units (DTU). The ATUs will be used for the training of trainers for smaller training units established in model LGAs. The ATUs will demonstrate the application of ARI treatment protocol in inpatient and outpatient settings and serve as venue for the practicum during clinical management training courses on ARI.

A phased Information, Education, and Communications (IEC) program will play an important role in the ARI program to educate health workers on the standard case management protocol and create an awareness among mothers on home care for children with simple coughs and colds and early signs of pneumonia. For the initial phase (as ARI training on new standard case management protocols is still underway), one-on-one and group health education will be conducted using IEC materials designed for the different cadres of Nigerian health workers, such as leaflets, posters, and job aids. IEC activities will be expanded to reach larger audiences through mass media, including radio and television, when a sufficient percentage of health facilities have already adopted the new standard case management plan. A comprehensive training program for health providers at all levels will be an important consideration.

II. IMPLEMENTATION PLAN

Project Geographic Focus

NCCCD will focus on nine states and initially on the twelve LGAs inherited from the forerunner ACSI/CCCD project. Project resources and host government absorptive capacity will permit the expansion of LGA participation at the rate of approximately twelve new LGAs per year for four years. This will allow the addition of at least one LGA per state per year for each of four years beginning in 1993/94. Thus, it is estimated that by the second year of project implementation, NCCCD will be directly involved with a total of approximately 24 LGAs; the third year will see approximately 36 LGAs, at which time, original LGAs will begin to "graduate", ceding their places to new LGAs. LGA expansion and graduation is projected in the following table.

NCCCD PROPOSED LGA EXPANSION 1993-2000				
YEAR	CURRENT	NEW (+)	COMPLETE (-)	TOTAL
1992-Year 0	12	0	0	12
1993-Year 1	12	12	0	24
1994-Year 2	24	12	0	36
1995-Year 3	36	12	12	36
1996-Year 4	36	12	12	36
1997-Year 5	36	0	12	24
1998-Year 6	24	0	12	12
1999-Year 7	12	0	12	0

Final determination on NCCCD geographic coverage will involve continued discussions with appropriate authorities at all three levels of government. The process and criteria for selecting and determining the magnitude and timing of LGA expansion within a given state will be described later in this section.

A. Implementation in the Public Sector

NCCCD will be implemented through Nigeria's three tier administrative structure which includes: the Ministry of Health and Social Services (MHSS) and the Primary Health Care Agency of Nigeria (PHCDAN) at the federal level, the State Ministries of Health (SMOH), and the Local Government Areas (LGAs). As PHCDAN shoulders major responsibilities for assisting the states and LGAs implement PHC initiatives within their respective jurisdictions, NCCCD will support PHCDAN in the execution of that mandate. NCCCD implementation will be largely, but not exclusively, channeled through and/or coordinated with the PHCDAN.

Although the principal service delivery initiatives will be undertaken at the state and LGA levels, major implementation objectives involve MHSS initiatives at the federal level; e.g., (a) strengthening of PHCDAN and zonal office capacity in support of PHC delivery at the state and LGA levels; (b) development and modification of program policies, strategies, and standards of practice; (c) curriculum and training materials development, and the modification and revision of existing materials; (d) establishment of health information systems (HIS) for national reporting of specific

diseases, sentinel reporting of specific diseases, and PHC monitoring; and (e) coordination of PHC with AIDS/STD control programs in surveillance-related activities.

1. Federal Level: Ministry of Health and Social Services (MHSS), including the PHCDAN and the four Zonal Offices

Implementation of NCCCD at the federal level will focus on:

- Collection, analysis, and utilization of HIS data for planning and evaluation.
- Development of policies and standards as the basis for enhanced quality of care.
- Monitoring of implementation strategies regarding appropriateness, effectiveness, and efficiency.
- Identification of constraints to effective program implementation and the use of applied research to resolve such constraints.
- Support for MHSS initiatives in donor coordination with immediate attention to the resolution of issues relevant to the long term procurement of international standard vaccines.
- Monitoring demand, supply availability, condition, distribution, and use of essential commodities.

NCCCD will task the MHSS to undertake specific actions at the federal level in collaboration with individual components of the project, as follows:

Policy Assessment - The MHSS will: (a) conduct annual reviews of technical strategies for EPI, CDD, malaria, ARI, STDs, and TB; and (b) update and distribute technical guidelines to state and local governments, PVOs, and private institutions in a federal effort to upgrade PHC service delivery throughout Nigeria.

Continuing Education (CE) - The MHSS will: (a) manage the continuing education system for manpower planning, development, and training; (b) undertake training materials development and the technical review and updating of training materials; and (c) oversee the provision of continuing education to state trainers.

Health Education/Communications (HE/C) - The MHSS will: (a) develop technical guidelines (standards of practice) for health education in PHC programs; (b) conduct and disseminate the results of operations research on the efficacy of health education interventions; (c) undertake organizational development and support the operation of state health education units; and (d) plan for health education manpower needs and provide appropriate training.

Health Information Systems (HIS) - Through its PHC monitoring and evaluation unit, the MHSS will participate in, and augment, its institutional capacity for the collation, analysis, and feedback of PHC data. The MHSS will also: (a) support the strengthening of state epidemiology units for the collection, analysis, and feedback of notifiable disease and sentinel surveillance data; (b) institutionalize the computerized recording, analysis and reporting of inpatient admissions and deaths by age and cause at twelve tertiary care institutions; (c) support the preparation and distribution of the quarterly technical publication *Nigeria Bulletin of Epidemiology*; (d) improve the national HIS

capacity for integrating data derived from the primary, secondary, and tertiary health care levels, combining that data with economic and political inputs; and (e) strengthen the ability of health officers to define data needs and use information for decision-making.

Program Evaluation - The MHSS will conduct annual national strategy reviews and participate in periodic reviews of NCCCD technical cooperation.

Operations Research (OR) - The MHSS will develop an operations research system designed to strengthen the capabilities of Nigerian investigators, while addressing programmatic questions related to the implementation of NCCCD initiatives. Representative actions will involve; e.g., (a) identification of constraint factors appropriate for research, the results of which would likely improve program implementation; (b) solicit and process proposals for national and/or collaborative research; and (c) organize and support research based on appropriate national and international review.

Epidemiologic Capacity Building - The MHSS will: (a) participate with other Nigerian institutions in the development of a national training program in applied epidemiology; (b) organize and conduct research to measure the effectiveness and efficiency of child survival interventions; and (c) develop a national surveillance program for the investigation and control of outbreaks; e.g., yellow fever, cerebro-spinal meningitis (CSM), cholera, and lassa fever.

Commodity Monitoring - The MHSS will institutionalize in collaboration with UNICEF a computerized monitoring system for key child survival commodities.

2. State Ministries of Health (SMOHs)

At the State level, project initiatives are primarily concerned with capacity development and technical support for implementation and monitoring of: (a) health activities at the LGA level, (b) the Health Information System (HIS), (c) continuing education (CE), and (d) health education and communication (HE/C). Certain initiatives of the project will involve the University Teaching Hospitals (UTHs) and the Schools of Health Technology (SHTs). The SHTs fall under the direct administrative control of the State Ministries of Health; the UTHs are under federal administrative control.

Implementation of NCCCD at the state level will focus on:

- Collection, analysis, and utilization of HIS data for planning, implementation, and evaluation of Primary Health Care.
- Strengthening of continuing education through the establishment of a CE system that will plan and coordinate training activities.
- Development of Continuing Education Units (CEUs) within Schools of Health Technology to: (a) provide in-service training; (b) adapt materials, as needed; (c) monitor the quality of training through follow-up activities; and (d) liaise with program managers and other sectors.
- Strengthening of inventory control systems to ensure the availability of adequate quantities of currently potent commodities at the LGA level.

- Development of capacity and provision of technical support in Health Education/Communications to LGAs in behavior risk assessment, program planning, professional development, training, continuing education, sustained community participation, evaluation, and materials development and advocacy.
- Development of capacity and provision of technical support for monitoring the implementation and of activities at the LGA level.
- The adoption of quality assurance methods throughout the health system.

3. Local Government Areas (LGAs)

The LGAs are somewhat akin to counties in the United States. Within each LGA, there are several administrative layers. All LGAs are not created equal. It is, generally, understood among all parties that each LGA will have differing requirements, interests, and capabilities. NCCCD will recognize and be responsive to those differences. It is expected that the level of effort will vary from one LGA to the next, and that each will be "graduating" at different times from the others. There is no reason to wish or anticipate otherwise. Implementation of NCCCD at the LGA level will extend to individual communities and health care facilities, focusing on the following:

- Planning, implementation, and monitoring of integrated primary health care interventions.
- Stimulation and support of community involvement and community organizations to identify health-related problems, set priorities, and plan solutions.
- Improvement in the management of health care material, fiscal and personnel resources to promote sustainability
- Education and monitoring of preventive and curative care provided by the private sector (e.g., health facilities, pharmacists, and patent medicine sellers) to assure acceptable quality of goods and services.
- Strengthening the delivery of health education through primary schools.
- Upgrade the quality of services

NCCCD Assistance at the LGA Level

Selection of LGAs: LGA selection, needs assessment in terms of technical assistance and resources, work plan preparation, establishment of operational standards of performance, nature and magnitude of self-help contribution, and means of measurement towards achievement of "graduation" status were all topics of intense discussion at the recent pre-project workshop held in Enugu.

There is general agreement among all project participants that these matters are priority implementation issues requiring a concerted effort, in due course, among all actors. The establishment of criteria is a crucial prerequisite to the provision of assistance to newly participating LGAs. Formulation of an effective modus operandi for selecting LGAs and monitoring their progress to graduation is an elementary aspect of the envisioned project implementation process. Selection and "graduation" of LGAs participating in the project are key markers of NCCCD implementation. The development and adoption of selection and operational criteria for the participation of focus LGAs

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as well as the monitoring of inputs to those entities and the results derived therefrom are critical concerns to be addressed on a continuing basis throughout LOP by representatives of federal, state, and LGA government tasked with that job in direct collaboration with AAO/Nigeria and NCCCD project managers. Much of the thrust of the dialogue agenda detailed in ANNEX Q is directed to that end.

LGA capacities to use technical assistance vary considerably and need to be considered in LGA selection, span of program activities, and speed of implementation. Such criteria include: (a) understanding of, commitment to, and support for, PHC programs on the part of LGA officials; (b) capability, commitment, and motivation of the LGA PHC Coordinator; (c) LGA topography, facilities, and means of communications [roadways, rivers, etc.]; (d) type and distribution of health-care providers [public, private, commercial, traditional]; (e) public sector staffing levels, qualifications, and motivation; (f) adherence to gender concerns and the rights and involvement of women; (g) presence of, or commitment to, a system of village health committees and voluntary village health workers; and (h) access to, and patterns of use of, public health facilities.

The specific criteria to be used for selection of additional LGAs to receive NCCCD assistance were discussed at the Pre-project Workshop. At a minimum the selected LGAs should be: (a) those with committed officials and PHC staff, (b) those in which 50% or more of health services are provided by public sector health centers and clinics, and (c) those willing to establish a line item budget for PHC [with annual incremental allocations].

Once selected, LGA participation involves three initial steps: a situational analysis to be carried out by LGA staff with NCCCD assistance (described below); participation in CEU training, including skill-building in plan development and management; and development of a coordinated work plan, including all partner inputs.

The LGA Program: Based on the situational analysis, to include a self assessment of need, program capacity, commitment, and local cost-sharing, the LGA will then develop a work plan, including: (a) basic *CORE* components; (b) selected *OPTIONAL* components based on need and local willingness to support such interventions; and (c) jointly agreed upon research and *DEVELOPMENTAL* components. The following are illustrative components in each category.

CORE

1. Participation in CE and HE/C training.
2. Situational analysis including facility survey and development of work plan.
3. Management and financial training.
4. Development and maintenance of revolving drug fund.
5. Basic PHC Monitoring.
6. Health Education Training through CEU.
7. Quarterly district level support for training and problem-solving.
8. Development and support of village health committees.
9. Expanded Program on Immunization at fixed facilities.
10. Use of disease specific treatment guidelines in treatment of fever, cough, and diarrhea.

OPTIONAL

1. Accelerated EPI strategies (annual or biannual campaigns).
2. ARHEC training for Health Educator and follow-on as described in project description.
3. Access to family planning training, supplies, IEC, and supervision.
4. Assess to safe motherhood, training, IEC, supplies, and supervision.

DEVELOPMENTAL

1. Development and testing of integrated clinical assessment and treatment of the sick child.
2. Outreach on treatment guidelines to other providers - private and commercial.

Characteristics of a "Graduated LGA": The NCCCD vision of a "graduated" LGA foresees that:

- Such LGAs will routinely prepare annual work plans with defined targets for access, quality, and coverage; and will utilize such work plans to implement an effective PHC program throughout their respective areas of jurisdiction.
- Such LGAs will possess and operate a functional revolving drug fund ensuring availability of ten essential drugs at all health facilities within their respective jurisdictions.
- All health facilities within such LGAs will be providing basic preventive (EPI and family planning), maternal health (prenatal and postpartum), and integrated case management (ARI, CDD, malaria, and pneumonia) services to their respective populations.
- Such LGAs will be implementing throughout their respective areas of jurisdiction ongoing programs of training and supervision aimed at ensuring defined levels of quality.
- At least twenty percent of the communities within such LGAs will have functioning village health committees charged with planning and monitoring their own PHC programs.
- Each functional entity within such LGAs (i.e., communities, health facilities, districts) and the LGAs, themselves, will be utilizing at least five indicators to monitor program implementation.

Specific Action at the LGA Level:

Planning

The situational analysis of each LGA will examine two separate areas. The first is an analysis of existing human resources and training needs relative to the establishment of a PHC network (including the range of management training needs). The second will scrutinize health services and address such factors as population, access, coverage, and quality, to establish base line data for targets. Indicators of health education quality (at both the facility and community level) will be included as a part of base line quality assessment.

Analysis will include an assessment of all health providers and facilities in each LGA regardless of individual status; i.e., whether: (a) under the jurisdiction of the LGA; or (b) a private provider of health care; e.g., NGO clinics, physicians, and TBAs; or (c) a provider of drugs; e.g., pharmacies and medicine sellers.

NCCCD will assist the staff of each LGA in the development of an implementation plan based on the results of the situation analysis. The plan will treat factors related to: (a) the establishment of the PHC network; (b) the span of service delivery coverage; (c) magnitude and quality of the health services proposed; and (d) budgetary and financial assistance requirements.

LGA implementation plans will be based on the national PHC strategy with choices given to the LGA, in consultation with NCCCD, as to core, optional and demonstration components. The mix of interventions will vary considerably depending upon such factors as population density (urban:rural) and geographic location (North:South). Emphasis will be placed on addressing the five PHC child survival priorities (i.e., prenatal care, attended birth delivery, nutrition education, immunization, treatment of acute illness) and family planning through both government and private service providers. NCCCD will also focus on the adequate representation of women at all levels of project implementation and commitment on the part of local leadership to overcome gender imbalance in the promotion and administration of health care delivery.

Implementation

The size of the grants to be made by NCCCD to an LGA under the project will be based on: (a) the technical elements contained in the implementation plan; (b) the size of the target population; (c) the magnitude of the coverage proposed; (d) per capita cost of the services proposed; (e) the status of the principal service providers in the area and those included in the plan; i.e., profit or nonprofit; and (f) the capacity of the LGA (and State) to meet financial requirements. The establishment of an appropriate matching grant formula for project assistance (based on per capita and socioeconomic factors) is under discussion. NCCCD will encourage LGA participation in the Bamako Initiative (drug revolving fund scheme, etc.) in collaboration with UNICEF.

All service providers will be encouraged: (a) to follow technical guidelines established at the national level and promulgated by the CEU at the state level; and (b) to use standard operating procedures; e.g., immunization schedule, ORT and appropriate feeding for diarrheal disease, antimalarial drugs for fever, and antibiotics for rapid and labored respiration.

Implementation will be phased in accordance with the development of LGA management and technical capabilities strengthened through appropriate training, including participation in CEU training programs.

Monitoring

Criteria to be used to assess the progress of project implementation within each LGA include: i.e., (a) the extent to which a PHC network has been established; (b) client access to services; (c) quality of services provided including provision of education to clients; (d) utilization rates and coverage; (e) impact, and (f) progress towards sustainability. Evaluation of LGA performance will utilize appropriate indicators measuring progress made towards attainment of targets set for the individual Focus LGAs and their States.

B. Implementation in the Private Sector

The CPSP mandates a sectorwide approach to stimulating private sector involvement in pursuit of AAO/Nigeria's overall Program Goal and the CPSP's two Strategic Objectives: (1) Improved Voluntary Use of Family Planning and (2) Improved Maternal and Child Health Practices. While the overall AAO/Nigeria private sector program will be managed as a whole, certain initiatives in

the private sector will be funded through NCCCD, others through the Family Health Services - II Population Project (FHS-II), as appropriate to the programmatic content of the specific activities.

A range of private sector development activities has been identified for possible interventions to be implemented under NCCCD. Further assessment during the early implementation phase of the project will permit a prioritization of private sector activities in terms not only of their feasibility and sustainability but also of their potential impact. The Private Sector Strategy in Annex I presents the conceptual framework within which private sector activities will be implemented under NCCCD.

The private sector program of NCCCD will:

- improve the managerial capacity of selected private sector organizations involved in the delivery of PHC services, e.g., state affiliations (Lagos, Enugu, Cross Rivers, Kaduna) of the Association of General and Private Medical Practitioners, Guild of Medical Directors, CHAN, etc.;
- introduce primary health care information, products and services into urban-based, predominantly curative services;
- upgrade through training, information-sharing, and common treatment protocol, the overall quality of services provided in the private sector; and
- develop and test new approaches to financing PHC services in Nigeria.

Activities supporting service delivery and product promotion and distribution will focus on increasing access to, and use of, basic PHC goods and services through the private sector, with specific attention given to exploiting the potential of NGOs and a wide variety of community-level structures and organizations, including focus groups and voluntary health workers. Some private nonprofit organizations are relatively accessible and responsive; e.g., the members of CHAN, a group of church-related NGOs providing 30-40% of health care in Nigeria. Most Nigerian profit-making private sector providers own and operate small clinics that are not affiliated with larger "umbrella-type" associations.

NCCCD will provide technical assistance and conduct in-country training programs in priority technical and management fields for NGO/PVO staffs. Short courses and workshops will be held as needed. Research activities will consist of: (a) surveys that define the characteristics of Nigerian private sector services and the context in which private sector health care providers are currently delivering health and family planning services; (b) evaluations of the private sector activities supported under NCCCD; and (c) operations research and special studies on incentives and approaches to increase the coverage and quality of private sector primary health care.

C. The NCCCD Partnership with UNICEF

UNICEF has been an operational partner in the implementation of ACSI/CCCD in Nigeria, especially with respect to EPI and CDD. Under NCCCD, this collaborative relationship will continue and be expanded. The relationship between UNICEF and NCCCD will be twofold: (a) NCCCD and UNICEF will collaborate closely on programs of mutual interest, including specific activities which complement NCCCD; (b) UNICEF will be utilized as the procurement source for cold chain, clinical, and laboratory equipment required under NCCCD.

Collaboration and Coordination

At the national level, UNICEF and NCCCD will continue to work together in their support of Nigeria's EPI and CDD programs, both in terms of policy development and implementation. UNICEF will continue to take the lead in procurement of vaccines and cold chain materials while NCCCD will continue to spearhead the effort to establish an inventory control system. UNICEF and NCCCD will collaborate closely in initiatives such as ARI, safe motherhood, and PHC systems development. The collaboration will be supported by continual dialogue, regular meetings, attendance at each other's major national and zonal seminars, sharing of key reports and documents, and information generated through local operations research and pilot projects for effective strategies and interventions, and through joint evaluation efforts.

Program collaboration at the State and LGA level will be facilitated by some of the same strategies used at the national level, including document sharing, regular meetings in the mutual Focus States and LGAs, and attendance at major meetings both in shared and other focus states.

NCCCD will complement ongoing UNICEF activities in three areas: nutrition, immunization and the Bamako Initiative, with a special emphasis on health education and communications (HE/C) support activities. UNICEF has extensive experience with a variety of health-related HE/C approaches in Nigeria. UNICEF's mass communications experience will complement NCCCD's more locally targeted HE/C activities.

The Bamako Initiative

Emphasizing community participation, the Bamako Initiative (BI) promotes self-reliance in the supply of essential drugs to the population through the use of drug revolving funds and encourages the use of funds realized for the purchase of additional drugs and for PHC development in general.

By 1992, BI was operative in seventeen LGAs with plans for expansion to another twenty LGAs in 1993. Of the seventeen current LGAs, three are ACSI/CCCD Focus LGAs. In these mutual LGAs, the experience has been positive. In cooperation with UNICEF, NCCCD will support community mobilization initiatives, including: (a) establishment of development committees, HE/C and training activities; (b) improvement of administrative and financial management and financial information systems; and (c) strengthening the BI monitoring role of the States.

D. Technical Assistance Inputs

1. Role of the Centers for Disease Control and Prevention (CDC)

CDC has a unique capability to provide technical assistance inputs to NCCCD. Since the mid-1980s, CDC has provided technical leadership to the ACSI/CCCD program in thirteen countries, including Nigeria. CDC capability relates to the strengthening of local and state health departments. With its mandate in the US as the nation's Prevention Agency, CDC has as its prime responsibility the planning, implementation, and monitoring of prevention programs. CDC has a strong scientific base in tropical medicine and public health. Over thirty units of CDC serve as WHO Collaborating Centers. CDC is the world's center of excellence in epidemiology; its Field Epidemiology Training Program (FETP) has been effective in establishing sustainable national programs in various countries.

CDC's International Health Program Office has a core of multidisciplinary personnel

(epidemiologists, social scientists, public health advisors) with a career commitment to health development. Provision of continuity in outlook and access to technical expertise is a major advantage of CDC collaboration. With more than 4,000 employees, CDC has access to expertise in most of the technical disciplines involved in NCCCD.

Nigeria's collaboration with CDC dates back to 1966 under the A.I.D.-funded Smallpox Eradication and Measles Control Program. Over the intervening years prior to ACSI/CCCD, CDC continued to collaborate with Nigeria in several technical areas including: (a) assistance in outbreak investigation and epidemic control; (b) regional support in epidemiologic surveillance and EPI; (c) assistance in policy formulation and training for the reinstatement of EPI; and (d) training of Nigerian professionals at CDC in a wide range of areas. Through twenty-five years of collaboration, Nigerians and CDC staff have developed a mutual sense of respect and collaboration.

Through the implementation of its country-specific ACSI/CCCD program in Nigeria, CDC has been cooperating with the MHSS since 1986, providing support to three technical areas (EPI, CDD, Malaria Control) and four support areas (HIS, Continuing Education, Health Education, Operations Research). Major ACSI/CCCD interventions have included development of: (a) disease notification and sentinel surveillance capabilities at federal and state levels; (b) data processing capabilities in federal and state units and tertiary hospitals; (c) continuing education and health education strategies; (d) collaborative training program with the African Regional Health Education Center (ARHEC); (e) operations research review procedures; (f) PHC delivery mechanisms focusing on support to LGAs; and (g) policy, quality of care, and monitoring and evaluation standards for EPI and malaria.

CDC will continue to build on these past efforts in areas of CDC's predominate capabilities; namely, (a) HIS development at LGA, State, and Federal Levels; (b) execution of continuing education (CE) initiatives, including CEU development in schools of health technology; (c) HE/C support in collaboration with ARHEC; (d) organization and management of PHC initiatives at the LGA level; (e) OR systems development and operation; (f) technical support for programs dealing with EPI, malaria, endemic disease control, and case management techniques; and (g) HIV/STD surveillance.

2. Role of R&D Cooperating Agencies

R&D Bureau central projects, for the most part housed in the Office of Health and the Office of Nutrition, will provide technical assistance in those disciplines outside of CDC's range of expertise. Such areas will include; for example, safe motherhood practices, family planning, mass media communications, micronutrients, nonprofit private sector initiatives, and local-level health system management and financing.

R&D central projects will be accessed through buy-ins and/or OYB transfer arrangements. The principal vehicle for accessing centrally-funded contracts (CAs) will be through buy-ins utilizing funds obligated under the Grant Agreement (GA). When OYB transfers are utilized with funds outside the GA to meet special requirements, recourse to that mechanism will be supported by use of memoranda of understanding (MOUs) linking CA performance to specific measurable impact indicators at the purpose and/or output levels. Scopes of Work (SOWs) will be drafted to respond to the technical assistance needs of NCCCD; the work performed by the CAs will be supervised by AAO/Nigeria.

Listed below by program components are the R&D central projects that may be called upon to offer technical assistance needed to achieve NCCCD objectives.

NCCCD Project Program Component and R&D Central Projects	
Program Component	R&D Central Projects
1. Child Survival	Applied Diarrheal Disease Research-ADDR (R&D/H/AR) HealthCom (R&D/H/HSD) Children's Vaccine Initiative (R&D/H/AR) BASICS (R&D/H/HSD)
2. Maternal and Infant Nutrition	VitAI (R&D/Nutrition) WELLSTART (R&D/H/HSD) NUTRICOM (R&D/Nutrition)
3. Maternal Health	WELLSTART (R&D/H/HSD) MotherCare (R&D/H/HSD) BASICS ((R&D/H/HSD)
4. Cross-Cutting Functional Support	Health Financing and Sustainability (R&D/H/HSD) Data for Decision-making (R&D/H/AR) Applied Research in Child Survival Services (R&D/H/HSD) Demographic and Health Surveys (R&D/H and R&D/P)

E. Training Plan

NCCCD training strategy stresses: (a) improvement of management and supervision skills; and (b) the more effective delivery of services by health workers at the peripheral level. TOT and skills training in supervision and management will be directed to supervisory personnel at all management levels. PHC training for peripheral health workers will include, not only health facility employees, but community health workers (VHWs), community extension workers, traditional birth attendants (TBAs), NGO volunteers, and other participating members from the private sector. NCCCD training initiatives will stress the participation of women as health care trainees and administrators.

Training will be a key element of the project. The principal modes will be in-country seminars, workshops, on-the-job training with supervisory visits, and publication and distribution of newsletters and circulating training materials. Management training will be institutionalized. Organization of specific courses in the formal sense will be a relatively limited, but important, part of NCCCD's training strategy. The organization and conduct of in-country courses will be facilitated by one, or more, American institutions of higher learning known to A.I.D.'s Office of International Training (OIT) through past provision of health sector training. In terms of numbers of individuals trained, offshore participant training will be negligible in comparison with in-country training.

Training will take the form of continuing education (CE) benefitting service personnel with the objective of increasing individual technical capacities and improving job performance. On-the-job training will be supplemented with longer-term advanced leadership training where appropriate. Additional information on specific types of training to be covered by NCCCD is contained in the narratives describing each of the other project components. Specific skills training are prominent in project components dealing, for example, with: (a) data collection and processing; (b) epidemiology surveillance; (c) health education/communications methodology; (d) PHC monitoring and evaluation; (e) nutritional practices; (f) case management in the treatment of the sick child; (g) malaria prevention and control techniques; (h) maintenance of the EPI cold chain; and (i) training-of-trainers (TOT).

To a large extent, the technical content, magnitude, and timing of actual training programs will be the prerogative of individual state training committees, which will devise state-specific training plans from year to year in accordance with national and state priorities and LGA demand. Training will be organized and conducted based on annual work plans promulgated by individual states and LGAs. In addition to providing training through the three administrative levels of the public sector, NCCCD CE initiatives will be undertaken in collaboration with: (a) National Association of Nigerian Nurse-Midwives (NANNM); (b) University Teaching Hospitals (UTHs); (c) various professional associations for physicians; and (d) Christian Health Association of Nigeria (CHAN).

Annex L contains tables providing an illustrative breakdown of: (a) in-country training by subject matter of training, category of health worker trained, and order of magnitude in approximate numbers of individuals likely to receive training in each of the subject matter areas over the life of project; and (b) offshore participant training by location of training, subject matter of training, category of health worker trained, approximate numbers of individuals likely to receive training over the life of project, and length of training in person/months (P/M).

In addition: (a) approximately 100,000 copies of newsletters and circulated training materials will be distributed to more than thirteen thousand peripheral level health workers during the course of the project; (b) PHC officials at the LGA level will make periodic supervisory visits to health facilities for the express purpose of conducting on-the-job training with specific objectives for facility personnel; and (c) CEU officials will conduct supervisory visits to LGAs for the express purpose of conducting on-the-job training with specific objectives for LGA managers.

F. Procurement Plan

1. Overview

The project is financed from the Development Fund for Africa (DFA) appropriations account, except for Centrally-funded activities of the Offices of Health, Nutrition and Population, Bureau of Research & Development. All procurement will be conducted following the procurement guidelines for activities financed under the DFA. Accordingly, the project will maximize the procurement of goods and services of U.S. origin and from U.S. sources. Long-term technical assistance, except for local-hire expertise, will be of U.S. origin. Vehicles will be procured from Code 000 (U.S.) source and origin to the extent possible. Computer equipment purchases may be from other free world country sources and will be of U.S. origin. Cold chain, clinical, and laboratory equipment purchased through UNICEF in accordance with AID/W guidelines will be from Code 899 sources. Commodities procured through UNICEF may be shipped on other than U.S. flag carriers. Source/origin, competition, and transportation waivers from Codes 000 and 935 to Code 899 for commodities (\$2.5 million) and approximately \$375,000 in transportation costs for those commodities are included in Annex P to the Project Paper. Participant training will be conducted in the U.S., in Nigeria and in other developing countries.

Services and commodities procured by nongovernmental organizations under their respective cooperative agreements will be of U.S. source and origin with the possible exception of special training material which may need to be purchased from other free world country source and origin (Code 935). Commodities procured directly by A.I.D. or through A.I.D. contractors will be shipped on U.S. flag carriers in compliance with the U.S. Cargo Preference Act. The AAO/Nigeria project manager will maintain records of all project procurement by A.I.D. Geographic Code and will report, as required, to AID/W.

Procurement methods and estimated costs for each category of procurement to be undertaken is detailed in the following table.

TABLE OF PROCUREMENT METHODS AND ESTIMATED COSTS									
Items	\$ Amt 10'	Est Vol of Act- ion	Procurement Agent			Imple- ment- ing Agent	Source		
			A A O - N	R E D S O	W A S H		000	935	941
TECH ASSIST	<u>19.8</u>								
PASA	7.1	7		x		CDC	x		
ST/LT TA	(6.4)								
Participants	(0.4)								
Commodities	(0.3)								
Buy-ins	7.3	31			x	CAs	x		
Other TA	2.0	14	x	x		Cntr	x		
Admin Sup (PAF)	3.4	7		x		PAF	x		
FX	(1.2)								
LC	(2.2)								
PARTICIPANTS	<u>0.3</u>								
AAO Program	0.2	30	x			PAF		x	
OIT Program	0.1	4			x	Cntr	x		
CDC Program	(0.4)	25		x		CDC	x		
COMMODITIES	<u>4.3</u>								
Vehicles	1.0	5	x			PAF	x		
Equip/Supplies	0.3	12	x			PAF	x		
Data Proc Equip	(0.3)	4		x		CDC	x		
Clinic/Lab Eqp	3.0	6			x	UNICE	x	x	
LOCAL COSTS	<u>14.6</u>								
Program Opns									
MHSS/PHCDAN	2.5	14	x			PAF		x	
Goods	(1.7)								
Services	(0.8)								
SMOHs	3.2	63	x			PAF		x	
Goods	(1.9)								
Services	(1.3)								
LGAs	6.0	180	x			PAF		x	
Goods	(3.2)								
Services	(2.8)								
Pvt Sector	0.4	21	x			PAF		x	
Goods	(0.1)								
Services	(0.3)								
Local Tech Asst	2.5	140	x			PAF		x	
Admin Sup (PAF)	(2.2)	7	x			PAF		x	
AUDIT	<u>1.0</u>	7	x	x		Cntr	x	x	
TOTAL	40.0								

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Procurement actions will be undertaken with assistance from REDSO/WCA and/or AID/W offices, as appropriate. For the most part, project contractors will be responsible for subsequent implementation actions. For example, the PASA agreement with CDC, negotiated with REDSO/WCA/OP assistance, will require that CDC: (a) provide long-term and short-term technical assistance; (b) arranging train selected categories of participants (approximately 25 individuals, but probably grouped into five or so actions); and (c) procure data-processing equipment (approximately four actions) as an integral part of the Health Information System component implementation. There will be one contract (with periodic amendments for incremental funding) negotiated by REDSO/WCA/OP for the Personnel, Administrative, Financial (PAF) administrative support unit.

The PAF will be assigned broad administrative support functions, including: participant training (approximately 30 actions grouped into about five actions); vehicle, supplies and equipment procurement; vouchering, disbursement, financial management and auditing of local costs; and monitoring of host country contributions. Other major procurement tasks for AAO/Nigeria will be to process buy-ins from centrally-funded projects.

2. Procurement Responsibilities

Major procurement actions, and the responsible offices, are further described as follows:

Participating Agency Service Agreement with Centers For Disease Control and Prevention

AAO:	PIO/T drafted by mid-June '93 with input of REDSO/WCA/HPN (will include A-76 Determination of unique suitability)
REDSO/WCA:	DOA 551 Concurrence of PIO/T (7/93)
REDSO/WCA/OP:	Negotiate PASA (7-9/93)
AAO/REDSO:	Annual documentation and negotiation of incremental funding amendments

Based on a determination of unique suitability, the project will procure technical and professional services through PASA arrangements with the U.S. Centers for Disease Control and Prevention (CDC). Although the PASA will specify, primarily, technical assistance inputs, a limited amount of off-shore training and commodity procurement will be included in the scope of work. Training and commodity procurement will be limited to circumstances directly related to CDC technical assistance inputs; i.e., only in those cases when CDC has predominant capability due to the direct linkage of such procurement with the technical assistance provided by CDC. A-76 determination of unique suitability will accompany the initial PIO/T ordering the PASA. Specific requirements for long and short-term technical assistance, participant training, and commodities will be identified in periodic work plans to be elaborated by each participating counterpart agency, as approved by NCCCD project management and authorized by AAO/Nigeria. Procurement of local technical and professional services will be addressed under the discussion on Local Costs.

AAO will engage expertise to prepare appropriate procurement orders requesting REDSO/WCA to negotiate a PASA agreement with CDC. Annual amendments to the PASA are envisioned, as required, for incremental funding and necessary modification and/or clarification of the scope of work. The PASA with CDC will provide for: (a) technical assistance in the form of three technical officers on long-term assignments for a total of fourteen person/years;¹ (b) short-term technical

¹ The services of the senior Public Health Officer will be required throughout the life of project; the Epidemiologist for three years; the third officer for four years.

expertise in areas of CDC predominant capability (e.g., endemic disease control, health information systems, public health management, continuing education, health education, immunization operations, etc.), averaging approximately twelve person/months per annum throughout life of project; (c) arrangement and administrative management of specialized CDC training for Nigerians in the U.S. in accordance with the overall procurement plan for participant training described later in this section; and (d) procurement of specialized offshore commodities in accordance with the overall project commodity procurement plan described in this section.

Project Financial and Administrative (PAF) Support

A project financial and administrative support arrangement is in place until June 30, 1994. A new PAF will be contracted to be in place by June 30, 1994, to support NCCCD and FHS2.

AAO: Prepare PIO/T to add incremental funding to present PAF (AAI) contract (7/93) for first year of NCCCD
Develop and issue PIO/T to REDSO/WCA for competition and negotiation of follow-on PAF (9/93)

REDSO/WCA: DOA 551 Concurrence of PIO/Ts (7/93, 9/93)

REDSO/WCA/OP: Amend present PAF (AAI) contract, adding funding (8/93).
Implement PIO/T for follow-on PAF contract (9/93 - 6/94).

NCCCD will profit from contracting arrangements through which AAO/Nigeria will secure project administrative service from an appropriate firm under competitive contracting procedures. This administrative support will be provided through a Personnel, Administration and Financial Unit (PAF) organized to provide: (a) local personnel management services; (b) procurement of goods and services; (c) infrastructure maintenance/transportation/logistics support; and (d) comprehensive financial and accounting services.

The cost of establishing and operating the PAF will be shared proportionally by projects within the AAO portfolio. Program costs for goods and services procured by the PAF on behalf of NCCCD will be met by NCCCD funds provided through arrangements currently in existence at the mission utilizing a work order mechanism modeled after AID's PIO documentation.

Consideration will be given to the feasibility of obtaining the services of a Gray Amendment firm for the administrative support contract.

Buy-ins and OYB Transfers to Centrally-funded Projects

AAO: Prepare and forward to AID/W., descriptions for buy-ins and OYB transfers. (7/93, cont.)
Prepare PIO/Ts for buy-ins (CY 94, cont.)

AID/W: Appropriate AFR and RD Offices review mission submissions, approve and forward to OP (7/93 cont).

OP: Necessary contracting actions (7/93 cont).

AAO/Nigeria will prepare documentation requesting buy-ins and/or OYB transfers for the procurement of approximately sixty person months of long and short-term technical assistance, Nigerian and American, per annum, from central contracts (CAs) administered by the Bureau for Research and Development and the Africa Bureau. The project anticipates using about six centrally-funded projects. The buy-in mechanism will be utilized exclusively for accessing CAs with funds obligated under the Grant Agreement. Whether or not the buy-in or the OYB transfer mechanism

is utilized, appropriate procedures, including the elaboration of detailed scopes of work (SOWs), will be established to assure that: (a) quality deliverables are received promptly; (b) SOW performance indicators are linked to project impact indicators; and (3) CAs are held accountable for performance against those indicators. Initial PIO/Ts and/or project descriptions will detail the requirement and the technical assistance to be provided; subsequent, probably yearly, procurement actions will be needed for incremental funding of the contracts. AAO will work with the appropriate AFR and/or RD Office to assure the timely submission of quality PIO/Ts, etc. AFR and RD Offices will be responsible to assure that the procurement documentation is forwarded to OP and acted upon. PIO/Ts for buy-ins to centrally funded contracts have blanket DOA 551 Concurrence from the REDSO/WCA Director and therefore will not have to transit REDSO/WCA on their way to AID/W.

Direct AAO contracts

AAO: Prepare PIO/Ts. Compete/negotiate contracts (as needed).
REDSO/WCA: Review and concur, as required under DOA 551, in PIO/T.

AAO/Nigeria will contract directly with individuals and/or firms for approximately 18 months of long- and short-term technical assistance, Nigerian and American, per year, to assist AAO/Nigeria in such areas as monitoring and evaluation, work plan development, redesign, operational support, budget analysis, planning and audit, and coordination of NCCCD with other elements of the AAO program.

UNICEF Procurement

NCCCD: Develop specs for procurement (continuous from 6/93)
AAO: Prepare/issue PIO/C worksheets (continuous from 6/93)
REDSO/WCA: DOA 551 concurrence of PIO/C worksheets
AID/W: FA/OP scrutinizes worksheet and issues PIO/C to UNICEF for procurement

AAO will issue worksheet PIO/Cs to AID/W to procure through UNICEF approximately \$2.5 million (exclusive of procurement and transportation costs) of cold chain, clinical, laboratory, and training equipment and materials to support health service delivery at the state and LGA levels as well as institutional development at all levels. The utilization of UNICEF for this purpose capitalizes on that agency's preeminent capability for such procurement and is consistent with DFA authorization and guidance. Justification for source/origin, competition, and transportation waivers from Codes 000 and 935 to Code 899 are contained in Annex P to permit utilization of the UNICEF procurement system (UNIPAC). The bulk of the procurement will be in direct support of the focus LGAs, which will come on stream and graduate in approximate three-year cycles throughout life of project. Thus, the procurement of these commodities will continue over life of project. It is anticipated that procurement will take place annually, except for the last year; thus, this category of procurement will involve approximately six major procurement orders.

PAF Procurement

NCCCD: Develop commodity lists and specs (8/93 cont). Develop IO for PAF.
AAO: Review/concur.
PAF: Execute commodity procurement orders.

The PAF will procure approximately sixty-five vehicles at an estimated cost of \$1.0 million. These vehicles will support NCCCD operations at all levels of the health management structure. The

majority of the vehicles will be utilized at the LGA and state levels. In the case of the former, new LGAs will be absorbed, from year to year, into the project. A substantial number of the vehicles will be replacements for key counterpart entities in the second half of the project; therefore, procurement will take place over much of the life of project. It is anticipated that procurement will take place in approximately five major lots. The PAF will be given responsibility for assuring an adequate maintenance capability including in-country supply of spare parts.

The PAF will also procure approximately \$300,000 of offshore commodities to support the integration of private sector initiatives into the overall NCCCD program. The commodities will, primarily, support NGO training and IEC interventions, in accordance with work plans to be developed by individual organizations. It is anticipated that procurement of this category of commodities will take place, biannually, except for the last year; thus, this procurement will involve approximately twelve major lots.

CDC Procurement

NCCCD: Develop commodity lists and specs.
AAO: Review/concur.
CDC: Implement procurement request.

As an adjunct to its technical assistance efforts, CDC will procure under the PASA approximately \$300,000 of data-processing equipment and materials to support the institutional development of the national HIS and to strengthen counterpart continuing education, and monitoring and evaluation capacities. Such procurement on the part of CDC is appropriate and justified as a direct adjunct to that agency's technical assistance and operational responsibilities; i.e., the commodities support the technical assistance function and vice versa. It is anticipated that this category of procurement will involve approximately four major lots over the life of the project.

Participant Training

AAO: Prepare PIO/Ps for OIT action (continuing)
OIT: Implement participant placement/support (continuing).
NCCCD: Prepare IO for training to be managed under the CDC PASA and the PAF contract (continuing).
PAF & CDC: Implement training (continuing).

The procurement of offshore training will adhere to the following guidelines: (a) CDC will assume responsibility for making participant training arrangements under its PASA in those cases where CDC has predominant capability for identifying specific training needs and the sources for meeting those needs; (b) AAO will issue PIO/P's to the Office of International Training (OIT) in AID/W in those cases where OIT has predominant capability for arranging specific training opportunities; and (c) NCCCD staff will request PAF to make and administer training arrangements in those cases where neither CDC nor OIT offer appropriate training opportunities.

In accordance with the present training plan, AAO/Nigeria will: (a) request the PAF to administer approximately sixty person/months of short-term offshore training arrangements for approximately thirty individuals; and (b) issue PIO/P's to OIT for approximately four individuals to undertake approximately thirty-six person/months of training in the U.S. Under the terms of PASA, CDC will make arrangements for and manage short-term technical training in the U.S. for approximately twenty-one individuals.

Notwithstanding the estimated offshore training requirements indicated above, all training will be undertaken in accordance with the NCCCD training plan, as modified by specific work plans to be elaborated, periodically, by participating counterpart agencies, as approved by NCCCD project management and authorized by AAO/Nigeria.

Audit Services

The US Government places the management responsibility for Federal financial assistance programs on the recipient. A.I.D., the Federal funding agency, will retain authority to evaluate, review, and monitor the recipient and to review the recipient's audit to assure compliance with Federal requirements. Therefore, the PAF will procure from off-shore and local sources periodic financial audit of NCCCD functions and those sub-recipients, i.e., MHSS, SMOHs, LGAs receiving more than \$25,000, in accordance with the Office of Management Budget (OMB) Circular A-133. These audits must meet the requirements of GAO Government Auditing Standards known as the "Yellow Book".

AAO/Nigeria will procure from offshore and local sources, on periodic and ad hoc bases, financial management expertise to perform external audits of NCCCD functions in their various configurations and loci of operations.

Local Costs

The PAF will be responsible for virtually all local procurement of goods and services, using the work order mechanism which is now in place at the mission. Local cost procurement will include (a) program operations, (b) local technical assistance, and (c) local administration and operation.

Program operations will absorb much of the PAF's energies and attention. The PAF will not be responsible for decision-making concerning the specific goods and services required to support NCCCD program operations; this will be the responsibility of NCCCD project management. Requirements will be transmitted to the PAF by NCCCD project management through work orders containing precise specifications concerning the goods and services required; the work order will contain relevant funding citations and commitment authorization.

Program operations are divided into four categories corresponding to counterpart agency designation; i.e., (a) MHSS/PHCDAN; (b) SMOHs, nine in number; (c) LGAs, varying over time from twelve to approximately sixty in number; and (d) the private sector made up of a wide variety of organizations and diverse NGO representation. Procurement activity in each category will coincide with periodic work plans approved by NCCCD project management and authorized by AAO/Nigeria. Project funds channeled to individual state entities and the LGAs will be provided through the PAF vouchering and accounting system.

Procurement at the MHSS/PHCDAN level will: (a) include health zone representation; (b) involve separate work plans for the MHSS and the PHCDAN; and (c) involve a total of approximately fourteen work plans against which PAF procurement action will take place.

Procurement at the SMOH level will: (a) include other state-level entities, such as Continuing Education Units (CEUs), Schools of Health Technology (SHTs), and University Teaching Hospitals (UTHs), and other secondary institutions; (b) involve work plans covering those various institutions; and (c) involve a total of approximately sixty-three work plans against which PAF procurement action will take place.

Procurement at the LGA level will: (a) service individual health care facilities, districts, and communities within each LGA; and (b) involve work plans that take into account the initiatives and needs of the various participating entities within a given LGA. The types of goods and services for which PAF will take procurement action include: (a) arrangements for in-country training seminars and courses; (b) contracting of local institutions and individuals for the conduct of studies, research, and general data collection; (c) procurement of local commodities, such as bicycles, training materials, and general supplies; (d) acquisition of temporary facilities and means of in-country transportation; and (e) printing, publication, and other media mechanisms.

The PAF will be responsible for contracting, personnel management, and payroll functions in support of approximately twenty local-hire professionals (field epidemiologists, technical advisors, program officers, and support personnel) working on behalf of NCCCD project management. The organization and operation of PAF, itself, will require a substantial amount of local procurement of goods and services; e.g., the hiring of administrative personnel, acquisition and maintenance of facilities, conduct of motor pool operations, maintenance of accounts for utility services, and procurement of supplies. These activities will be conducted in accordance with an annual work plan.

3. Procurement Action

The following table depicts the various types of procurement actions (illustrated by specific implementation agent) to be taken by AAO with REDSO/WCA and R&D Bureau support. AAO/Nigeria will prepare SOWs and PIOs, with assistance and/or concurrence from REDSO/WCA in accordance with DOA 551 guidelines. REDSO/WCA will negotiate the PASA with CDC, as well as those contracts exceeding AAO/Nigeria contracting authority, the principal example being the PAF contract for administrative support services. Procurement action for OYB Transfers and Buy-ins, including the development of SOWs, will be undertaken in collaboration with R&D/Health, and R&D/Population, with FA/OP taking contracting actions, as appropriate.

ACTIONS	INITIAL ACTION (FY)	SUPPLEMENTAL AND/OR INCREMENTAL ACTIONS (#)
<u>Contracts</u>		
Admin Support (PAF)	FY94	6
AAO Project Mgt	FY93	13
Audit	FY95	6
<u>OYB Transfers</u>		
ARCCS	FY93	5
DHS	FY94	2
Wellstart	FY94	3
<u>Buy-ins</u>		
Demo/Governance (AFR)	FY94	3
Health Fin/Mgt	FY94	3
Healthcom	FY94	2
Mothercare	FY94	3
VITAL	FY94	2
<u>Other</u>		
CDC PASA	FY93	6
Clinic/lab Commodities	FY94	6
Direct Participants	FY94	4

G. Implementation Schedule

The Implementation Schedule addresses principal project components, describes critical tasks and activities to be accomplished, and notes certain significant milestones. For some components, especially those carried over from ACSI/CCCD, the Implementation Schedule lists numerous activities, reflecting the detailed planning made possible by the experience gained and the lessons learned in ACSI/CCCD.

This is particularly true of the Continuing Education (CE), Health Education & Communications (HE/C), and Health Information System (HIS) components. For other components, especially those not included in ACSI/CCCD, the major initial focus will be to complete in-depth needs assessments and develop very specific and targeted strategies and work plans. This would be true, for example, for portions of the nutrition component; i.e., specific interventions will depend on the results of baseline data to be gathered during the first year of the project, with work plans then being developed in a collaborative fashion on the basis of that information. Similarly, the particulars of the Private Sector efforts will derive, in part, from analysis of the institutional capacity of the private sector, to be completed early in the project.

For the CE component, significant activities in the early years of implementation include: (a) development and testing of teaching materials on the integrated care of the "sick child"; (b) establishment of adequate "clinical practice sites" for pre-service and in-service training; (c) dissemination of child survival training materials (developed by ACSI/CCCD) to all training institutions in Nigeria; and (d) development and use of appropriate training materials for HIV/AIDS/STDs, maternal health, nutrition, and interpersonal communications skills. In the latter years of the project, CE will focus, also, on capacity-building and CE institutionalization at the federal, state and LGA levels.

The HIS component will have several major subcomponents. Because of the urgency of the now exponential rate of increase in HIV/AIDS in Nigeria, one of these subcomponents (i.e., an effective system for HIV/STD surveillance) will receive special emphasis in the early years of the project. The strengthening of HIS capacity (including the use of data for decision-making at federal, state and LGA levels) at all levels will be undertaken after completion of initial studies concerning data utilization and assessment of the contemporary status of HIS. The refinement and institutionalization of Nigeria-specific software for child survival/family planning commodities and the institutionalization of the *Nigeria Bulletin of Epidemiology* as a crucial feedback and policy dissemination mechanism will be significant implementation milestones.

The development of epidemiologic and outbreak control capacity (including emergency preparedness) will be addressed by a series of short-courses in the first years of the project and by the development of an FETP (Field Epidemiology Training Program) by the end of the project.

In the first year, HE/C activities concentrate on the analysis of village-level health education baseline studies and the development of targeted strategies and work plans with PHC Village Development Committees. Two HE/C specialists will be hired. A pilot study will be done of the Modifiable Risk Factor System in one state, and if successful and useful, it will be expanded to other areas during the course of the project. Intensive LGA level health education interventions will occur in the second and following years. The strengthening of local capacity will be accomplished through the establishment of a cooperative program with the African Regional Health Education Centre (ARHEC)

in Ibadan. HE/C materials will be developed and disseminated. The HE/C knowledge of federal, state and LGA health workers involved in health education will be updated through conferences and collaboration with the Continuing Education Units (CEUs) at Schools of Health Technology (SHT).

Private Sector and Quality Assurance efforts will begin with needs/capacity/KAP assessments and the definition of an agenda and work plans. Early on, an institution will be identified as the site for the development of a Center for Research on Health Care/Private Sector. This center will be the focal point for significant operations research.

Activities in the areas of EPI, treatment of the sick child (CDD, ARI, malaria), maternal health and nutrition will focus on the dissemination of technical guidelines and their implementation down to the village-level (where clear guidelines exist) and the development/refinement of guidelines and strategies (where clear guidelines do not yet exist).

In the first years of the project, micronutrient assessments will be completed, and intervention strategies initiated. ARI training materials development for VHWs will be a priority, as will the widespread dissemination of guidelines on the prevention of HIV/Hepatitis B in the health care setting. In addition to the Urban EPI Initiative in Lagos State, other important EPI focuses will be: (a) improvement of the cold chain; (b) software development for tracking EPI commodities; and (c) support for the incorporation of Yellow Fever Vaccine into routine EPI. Continued support for the National Malaria Network will be augmented through the dissemination and evaluation of treatment guidelines. By the end of the first two years of the project, the results of a study of bed nets for the prevention of malaria will provide the basis for determining future courses of action in that regard.

Presentation of the Implementation Schedule

A detailed Implementation Schedule is found in Annex K. It is presented in two formats. The first lists the key NCCCD activities by component, duration, and date by which a particular activity will begin. Major project components are recognized by an asterisk (*) in front of the name of the component, and each component's essential activities are indented under the name of the component.

The second format displays the name of the activity and a time-line for the life of the project for each of the activities. In this presentation, the hatched bars represent "summary activities", filled bars represent discrete tasks or activities, and "pyramids" represent milestones.

H. Management and Administration

The administrative organization for the management of NCCCD reflects the following guiding principles:

- That NCCCD be institutionalized in Nigerian counterpart institutions as soon as feasible. Relevant considerations include: technical program focus, functional support activities, and locus of operations. Special attention will be addressed to the role of the new PHCDAN.
- That the NCCCD implementation structure: (a) maintain and/or accelerate present project momentum; (b) place minimal administrative demands on AAO/Nigeria; and (c) access technical assistance, as efficiently and effectively as possible, from a variety of sources (e.g., CDC, R&D CAs, and other central/regional projects).

NCCCD Project Management²

The AAO/Nigeria HPN Officer will function as the project manager of NCCCD. He/she will be responsible for overall program coordination and will be supported by local-hire professional support staff, as well as a long-term technical advisor. This long-term advisor will be responsible for managing QA program activities, coordinating other USAID and donor programs, and assisting in the identification of NCCCD technical assistance requirements.

CDC long-term personnel will play key roles on the project management team. The Project Coordinator, a senior CDC public health specialist, will report to the HPN Officer. CDC will fill two additional long-term expatriate positions.³ Other members of the project management team will include approximately twenty, or more, Nigerian professionals serving as: (a) technical staff responsible for the planning and monitoring of technical/functional interventions focused on such areas as: HIS, HE/C, CE, private sector, nutrition); (b) field epidemiologists⁴ at the State and LGA levels; and (c) local support staff.

The project management team will be organized for the execution of two broad functions; i.e., program planning and field operations. The program planning function will include preparation, interpretation and/or transmission of: (a) AAO program guidance to field operations units; (b) technical assistance requirements to CDC and non-CDC sources; (c) administrative support requirements to the central administrative support unit;⁵ and (d) project progress reporting to the AAO and, on behalf of the AAO, to AID/W and CDC/Atlanta. Field operations will be directed out of offices located in Lagos and Kaduna (or Abuja).

The Lagos office, to be physically located in close proximity with PHCDAN headquarters in Yaba, will be the principal seat of NCCCD project management. Based in Yaba, the NCCCD Project Director (the senior CDC public health specialist) — assisted by a senior Nigerian epidemiologist, serving as deputy director, and appropriate technical and support staff — will collaborate on a daily, routine basis and share project implementation responsibilities with the Executive Director and technical staff of the PHCDAN.

² NCCCD project management structure was formulated taking into consideration the PID review issue in that regard as indicated in the ECPR guidance cable. See Annex A for a discussion of that consideration.

³ It is anticipated that the individuals filling the three CDC positions will represent the following professional categories: (a) Project Director/PHC Specialist; (b) HIS Specialist/Epidemiologist; and (c) Technical Officer. NOTE: The Epidemiologist will be responsible for coordinating related NCCCD activities with the operational aspects of the Nigeria HIV/AIDS prevention and control project implemented by AIDSCAP.

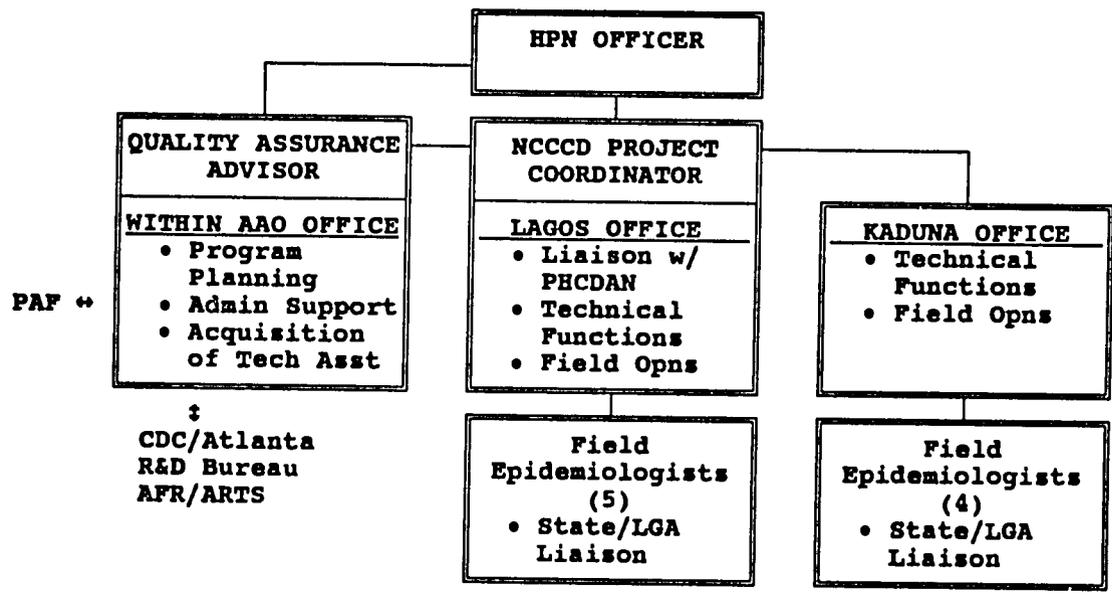
⁴ Field epidemiologists are already functioning under ACSI/CCCD. Their primary responsibilities: to serve as project liaison officers to State and LGA personnel affiliated with NCCCD activities, with a view to the facilitation of project implementation in their respective states. Under NCCCD, the field epidemiologists will continue that basic function, while assuming, eventually, an appropriate relationship with: (a) PHCDAN representatives, including zonal PHC officers; and (b) FHS-II (and other A.I.D.-funded) project personnel in their respective states.

⁵ I.e. the PAF (Personnel, Administration and Finance) unit to be described in the following section.

The Lagos office will house major technical support functions working closely with, and/or integrated into, counterpart units; e.g., the central HIS structure. A second CDC officer, the Epidemiologist, will also be located in Lagos. That office will be responsible for supervising the operations of field epidemiologists assigned to each of the five southern-most NCCCD Focus States.⁶ The Kaduna (or Abuja) office, under the supervision of the third CDC technical officer assisted by a senior local-hire epidemiologist serving as deputy director, together, with appropriate technical and support staff, will be responsible for supervising the operations of field epidemiologists assigned to each of the four northern-most NCCCD Focus States.⁷

The figure below depicts NCCCD management and organizational structure.

NCCCD PROJECT MANAGEMENT ORGANIZATION CHART



⁶ I.e., Anambra, Enugu, Lagos, Osun, and Oyo.

⁷ I.e., Kebbi, Niger, Plateau, and Sokoto. If, and when, appropriate government apparatus and/or American regional representation moves to the new federal capital in Abuja, consideration will be given to moving the Kaduna field office to Abuja.

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Administrative Support

NCCCD administrative support requirements will be satisfied by a Personnel, Administration and Finance (PAF) unit contracted, specifically, to undertake such responsibilities on behalf of the entire AAO/Nigeria program. AAO/Nigeria will contract for the establishment of the PAF to provide administrative support services for all projects and program-funded personnel in the AAO/Nigeria project portfolio.⁸ Thus, NCCCD will receive the bulk of its administrative support from the PAF.⁹

The PAF will be managed by a senior expatriate business manager, assisted by an expatriate deputy, at least one of whom will have professional senior financial management credentials. The PAF will respond directly to requests for administrative support services issued by the directors of the individual projects in accordance with policy guidance and oversight provided by the AAO HPN Officer and, in matters of financial management, the AAO Controller. PAF responsibilities will focus on the effective and efficient response to all requests for administrative support emanating from the various components of the AAO/Nigeria program.

Installation and operational costs of the PAF will be met by funds made available directly through the contract establishing the PAF. The cost of establishing and operating the PAF will be shared by the individual projects, in proportion to the number of units of measurement and/or the dollar amount of services rendered. Program costs (i.e., specific goods and services procured by the PAF on behalf of an individual project) will be met by funds available to the respective project receiving the goods and services. Funding availability to PAF for meeting project-specific program requirements will be mobilized through an appropriate work order mechanism.

Administrative support services to be performed by the PAF:

Personnel Management (Employee Payroll and Benefits)

Pursuant to requirements identified by, and in agreement with, the management authority of individual projects and implementing agencies, as applicable; PAF will screen, recruit, and administer the payroll and salary benefits of Nigerian professional personnel and support staff (e.g., secretarial, clerical, transport, maintenance and housekeeping personnel) at project sites in Lagos and up-country.¹⁰

Professional personnel will be contracted as employees of the respective project and/or implementing agency, as appropriate. Support staff will be contracted as employees of the PAF.

⁸ To establish the PAF, consideration will be given to the execution of a contract with a Gray Amendment firm selected from among such firms for its predominant capability in the administrative and financial management area under circumstances similar to those encountered in Nigeria.

⁹ By virtue of CDC being a U.S. Government agency, transactions pertaining to a number of financial and support services on behalf of CDC will be handled through the American Embassy in Lagos; e.g., disbursements for direct local payments made by CDC, housing for expatriate personnel, security, etc.

¹⁰ Personnel policies for local staff will be established in accordance with those in practice at the American Embassy, Lagos.

Procurement of Commodities and Direct Services

Pursuant to requirements identified by, and in agreement with, management authority of individual projects and implementing agencies, as applicable; PAF will serve as the procurement and/or contracting agent, as appropriate, for the procurement of offshore commodities and local goods and services at project sites in Lagos and up-country.

The PAF will undertake procurement activities in compliance with the applicable provisions of A.I.D. Handbook 15.

Infrastructure Maintenance/Transport/Logistics Support

The PAF will provide a wide range of general support services at project sites in Lagos and up-country, including:

- Leasing and space management for project management office facilities independent of counterpart infrastructure; including housekeeping and maintenance.¹¹
- Identification and leasing of suitable rental housing for project-affiliated expatriate personnel, as necessary;¹² provision of maintenance and security services for said housing.¹³
- Establishment and implementation of standard procedures for motor pool operations; maintenance and servicing of project vehicles.
- Telecommunications management (telephones, FAX, E-mail).
- Organization of project-related conferences, large meetings and/or training sessions; provision of logistical support for same.
- Travel and transportation arrangements for project staff (including in-country shipment and port clearance of household effects of expatriate personnel).
- Satisfaction of necessary Government of Nigeria documentation and administrative arrangements pertaining to A.I.D.-sponsored project activity and expatriate personnel performing services in Nigeria.

¹¹ Leasing, space management and maintenance activities involving premises occupied by AAO/Nigeria will be undertaken, on an exceptional basis, pursuant to special guidance and appropriate funding arrangements as directed by the AAO.

¹² The leasing of living quarters will be coordinated with AAO/Nigeria to assess availability and/or suitability of appropriate living quarters already under U.S. government control.

¹³ All security matters will be coordinated with the Security Section of the American Embassy, Lagos; security services will be obtained from sources utilized/recommended by the Security Section.

Comprehensive Financial Services

A substantial amount of project funds will be disbursed to finance local cost (LC) activities, either directly or through subproject agreements, at the national, state and LGA levels, including the involvement of private sector client groups.

Structuring financial management policies and procedures to meet applicable provisions of A.I.D. Handbook 19, the PAF will perform professional accounting services, including internal audit controls and compliance with standards of practice for A.I.D. contractors.

Representative actions will include: (a) develop standardized formats and procedures for management control of expenditures and disbursements; (b) activate disbursements and control expenditures in accordance with A.I.D. principles and standards of accounting; (c) review and consolidate accounting documentation for the preparation and submission of expenditure vouchers to AAO; (d) conduct field audits of grantee procedures for receiving, recording, and liquidating grant funds; (e) monitor the management of imprest funds under the control of a variety of public and private entities; (f) develop subagreements between project units and public and private entities and individuals, including subcontracts, short-term consultant contracts, and other agreement/grant forms; and (g) monitor and record counterpart contributions.

The PAF will consider engaging through a subcontract the services of a local professional accounting firm to perform, under the guidance of the PAF Manager and/or his/her deputy, the accounting and audit functions indicated above.

Program Management Structure: AAO/Nigeria¹⁴

The AAO/Nigeria HPN Officer will be the project manager for all HPN projects in the AAO portfolio.¹⁵ He/she will: (a) interpret and communicate AAO program policy and guidance; (b) coordinate and monitor program implementation; (c) report on the performance, progress and impact of individual projects; (d) review and modify program and project work plans; (e) review and take appropriate action on project requests for CA consultancies and other short-term technical assistance; (f) coordinate and manage certain interproject interests and activities;¹⁶ and (g) facilitate the provision of effective and efficient PAF support to the individual projects.

¹⁴ The AAO/Nigeria program management structure was formulated taking into consideration the PID review issue in that regard as indicated in the ECPR guidance cable. See Annex A for a discussion of that consideration.

¹⁵ Other USDH positions in AAO/Nigeria include the AID Affairs Officer, Program Officer, and Controller. These individuals will provide policy, program, and financial management guidance to the HPN Officer.

¹⁶ A number of AAO/Nigeria program interventions will be of common interest to NCCCD, FHS-II, and/or AIDSCAP; e.g., private sector initiatives, media communications, health information data collection and processing, commodity logistics, and family planning service delivery at PHC facilities. To varying degree, each of these initiatives will require a common point of operational management to maximize implementation effectiveness and to minimize duplication of effort as well as confusion on the part of counterparts. In some cases (private sector initiatives, presently, being the most likely example), a joint operational unit will probably be formed with program personnel representing two or more of the individual projects.

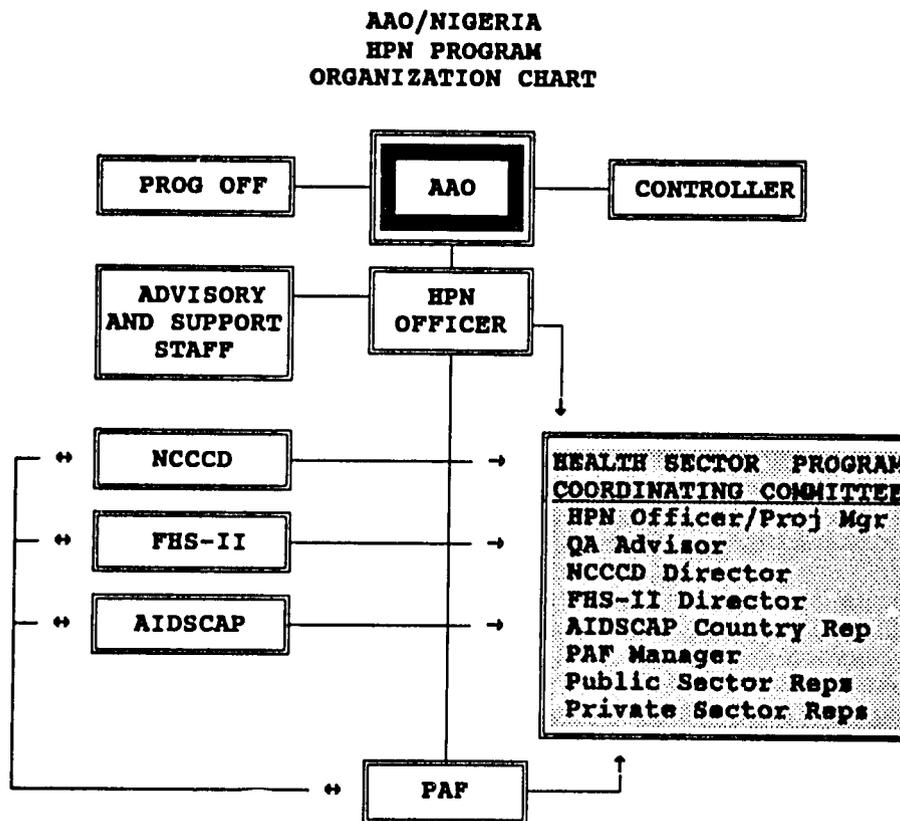
The HPN Officer assisted by the QA Advisor will chair the AAO/Nigeria health sector program coordinating committee. This committee will coordinate individual project operations, address and resolve issues, and plan activities. The committee membership, in addition to the HPN Officer and the QA advisor, will include as standing members the project coordinators representing each of the individual projects in the AAO portfolio and the PAF Manager. Appropriate public and private sector counterparts will also be represented on the committee.

As the principal technical advisor to the HPN Officer, the QA advisor will: (a) ensure the integration of appropriate QA practices by all program elements of the AAO/Nigeria portfolio; (b) facilitate AAO collaboration with other donors; and (c) analyze and facilitate satisfaction of all program technical assistance requirements.

In addition, the HPN Officer will supervise a program support staff charged with: (a) collecting and maintaining information relevant to AAO health sector program operations; and (b) preparing and processing program and project-specific documentation on behalf of AAO/Nigeria.

REDSO/WCA staff will provide additional support to strengthen AAO project management capabilities, particularly in such areas as: health sector development (HHR); program development and analysis (PDE); legal advice (RLA); and contracting (OP). OP will carry substantial responsibility for execution of project procurement actions. OP and HHR will provide technical inputs on a regular, recurring basis as an integral part of project implementation. In addition to circuit-riding coverage, PDE and RLA will provide professional advice on a case-by-case basis.

The figure below depicts the organizational structure for management of the AAO/Nigeria HPN program.



III. COST ESTIMATE AND FINANCIAL PLAN

A. Introduction

NCCCD will be implemented over approximately seven years. Obligations will take place over seven fiscal years. Project Activity Completion Date (PACD) is December 31, 2000. Estimated project costs are based on data obtained, for the most part, through experiences derived from the ongoing ACSI/CCCD/Nigeria project, including a series of intensive technical analyses oriented to prolongation of project activities into the second phase; i.e., NCCCD. Table 1 presents the Summary Cost Estimates and Financial Plan for the entire NCCCD project. As indicated in Table 1, A.I.D. will provide one hundred percent of the foreign exchange and approximately forty-four percent of local cost funding.

B. Cost Summary

The total project cost is estimated at U.S.\$58.8 million, as presented in Table 1. Of this amount, A.I.D. will contribute \$40 million, or approximately sixty-eight percent. The various levels of the Nigerian governmental structure (i.e., federal, state, and local) will contribute \$18.8 million (calculated based on recent exchange rate trends and contemporary projections of 35 naira to the dollar) for local operating costs through cash and in kind contributions. Various state and local governments may contribute cash through their respective budget processes; however, cash in support of NCCCD will, for the most part, be channeled into local procurement and operational activities at the overall level of their respective jurisdictions, rather than directly through a special NCCCD project account.

For further details on the host country contribution (HCC), see the narrative discussion on that subject in Section G of this chapter. The projection of HCC to the project is presented in Table 5. It is anticipated that HCC requirements will be met by the end of Year 2000. Detailed discussion on the sustainability of host country health delivery services is contained in Annexes E (Technical Analysis) and H (Economic and Financial Analyses), as summarized in Chapter VI. Discussion pertaining to private sector sustainability is contained in Annex I (Private Sector Strategy).

A.I.D.'s contribution includes \$25.4 million in U.S. dollar funding for technical assistance, offshore training, commodities, and the audit function; and a \$14.6 million local cost element. The local cost amount is budgeted for: (a) support of public sector operational activities; (b) support of private sector involvement in project implementation; and (c) payroll of Nigerian professional staff serving on the A.I.D. side of the project management team. Approximately \$2.2 million of the foreign exchange required for the administrative support (PAF) contract will be converted into local currency to meet the local cost requirements of that function.

TABLE 1 SUMMARY COST ESTIMATE AND FINANCIAL PLAN (US \$ Millions)					
ELEMENT DESCRIPTION	A.I.D.		HCC		TOTAL (US \$)
	FX	LC	FX	LC	
1. TECH ASSISTANCE	<u>19.8</u>	<u>(2.2)</u>			<u>19.8</u>
CDC PASA	7.1				7.1
R&D + AFR Buy-ins	7.3				7.3
AAO Direct	2.0				2.0
Admin Support (PAF)	3.4	(2.2)			3.4
2. PARTICIPANTS	<u>0.3</u>				<u>0.3</u>
3. COMMODITIES	<u>4.3</u>				<u>4.3</u>
4. LOCAL COSTS		<u>14.6</u>		<u>18.8</u>	<u>33.4</u>
MHSS/PHCDAN		2.5		4.3	6.8
SMOHs		3.2		9.5	12.7
LGAs		6.0		5.0	11.0
Private Sector		0.4			0.4
Local TA		2.5			2.5
5. AUDIT	<u>1.0</u>				<u>1.0</u>
PROJECT TOTAL	25.4	14.6		18.8	58.8

C. Project Inputs and Outputs

The costing of project inputs/outputs is presented in Table 2. Project outputs are defined as the various health sector components receiving benefits under NCCCD. These components are divided into two major groupings; i.e., Strategies to Strengthen Infrastructure in Support of Technical Interventions¹ and Major Child Survival Interventions.² Approximately thirty-six percent of the A.I.D. contribution (\$14.4 million) is programmed for child survival technical interventions, while sixty-four percent (\$25.6 million) is oriented to the institution-building initiatives grouped together as the strategies to strengthen the infrastructure supporting the technical interventions. 5.5 percent (\$2.2 million) is dedicated, specifically, to the private sector, which will, in reality, receive a larger amount of benefits, indirectly, through public sector initiatives fostering health care delivery in the private sector. Project inputs are defined as the various categories under which the procurement of goods and services will take place to produce the benefits accruing to the project. Project inputs equate with the project elements for financial reporting purposes.

¹ These include: (a) Management of Health Resources at the Local Level [MHR/LGA]; (b) Continuing Education [CE]; (c) Quality Assurance [QA]; (d) Health Education/Communications [HE/C]; (e) Health Information Systems [HIS]; (f) Operations Research [OR]; and (g) Private Sector Initiatives.

² These are grouped under two categories; i.e., Prevention and Case Management of the Sick Child. Prevention includes Child Spacing [CH/SP], Safe Motherhood [S/M], Maternal/Child Nutrition [NUTR], and the Expanded Program on Immunization [EPI]. Case Management of the Sick Child includes Malaria [MAL], Control of Diarrheal Diseases [CDD], and Acute Respiratory Infections [ARI].

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TABLE 2 COSTING OF PROJECT OUTPUTS/INPUTS (US \$ Millions)															
PROJECT INPUTS	PROJECT OUTPUTS														
	MAJOR CHILD SURVIVAL INTERVENTIONS							STRATEGIES TO STRENGTHEN INFRASTRUCTURE							TTL
	PREVENTION				CASE MGT			MHR/LGA	CE	QA	HE/C	HIS	OR	PVT	
	CH/SP	S/M	NUTR	EPI	MAL	CDD	ARI								
TECH ASSISTANCE	0.8	0.8	1.2	1.6	0.8	0.7	0.7	3.1	2.2	3.2	1.2	1.8	0.8	0.9	19.8
1. CDC PASA	0.1	0.1	0.1	1.4	0.5	0.2	0.2	0.2	1.4	0.4	0.6	1.4	0.5	0.0	7.1
2. R&D + AFR B'ins	0.6	0.6	1.0	0.0	0.0	0.4	0.4	1.6	0.0	2.0	0.2	0.0	0.1	0.4	7.3
3. AAO Direct TA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.0	0.7	0.1	0.0	0.0	0.3	2.0
4. Admin Spt (PAF)	0.1	0.1	0.1	0.2	0.3	0.1	0.1	0.4	0.8	0.1	0.3	0.4	0.2	0.2	3.4
5. PARTICIPANTS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.2	0.3
6. COMMODITIES	*	*	0.9	1.2	0.1	*	*	0.8	0.2	0.1	0.4	0.2	0.1	0.3	4.3
LOCAL COSTS	0.6	0.5	0.8	0.8	1.2	0.7	0.5	2.0	1.9	1.1	1.3	1.6	0.9	0.7	14.6
7. MHSS/PHCDAM	0.1	0.1	0.2	0.2	0.6	0.1	0.1	0.1	0.3	0.2	0.1	0.2	0.2	0.0	2.5
8. SMOHs	0.2	0.1	0.1	0.2	0.2	0.1	0.1	0.3	0.8	0.2	0.2	0.5	0.2	0.0	3.2
9. LGAs	0.2	0.2	0.3	0.3	0.3	0.4	0.2	1.3	0.6	0.4	0.7	0.7	0.4	0.0	6.0
10. Private Sector	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.4
11. Local TA	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.3	0.2	0.3	0.3	0.2	0.1	0.3	2.5
12. AUDIT	*	*	0.1	0.1	0.1	*	*	0.3	0.1	*	0.1	0.1	*	0.1	1.0
TOTAL	1.4	1.3	3.0	3.7	2.2	1.4	1.2	6.3	4.4	4.4	3.0	3.7	1.8	2.2	40.0

Technical Assistance

Approximately \$19.8 million in foreign exchange (FX) (thirty-four percent of total project cost) fall into the technical assistance category. This assistance includes the following:

- CDC PASA: \$7.1 million - CDC will provide major project inputs, including: (a) the Project Director and two additional long-term expatriate members of the project management team; (b) short-term expertise in areas equating with CDC predominant capabilities; e.g., EPI, endemic disease control, HIS, continuing education, and health education; (c) offshore training; and (d) procurement of specialized data processing equipment supporting the HIS component.
- R&D Bureau and AFR Bureau Buy-ins: \$7.3 million - NCCCD will rely on central contractors for technical assistance beyond CDC predominant capabilities; e.g., quality assurance, nutrition, micronutrients, child spacing and safe delivery, health finances, private sector initiatives, mass communications, etc.

- **AAO Direct Contracts: \$2.0 million** - To facilitate project implementation, AAO will procure, directly, long-term and short-term technical assistance in such areas as monitoring and evaluation, work plan development, redesign, operational support, budget management, planning and audit, and coordination of NCCCD with other elements of the overall AAO program.
- **Administrative Support (PAF): \$3.4 million** - NCCCD will contribute with its proportionate share to the funding of the Personnel, Administration and Financial unit (PAF) responsible for providing administrative support to the overall AAO/Nigeria program.

Participant Training

AAO/Nigeria will directly finance approximately \$300 thousand of short-term offshore training both in the U.S. and Africa. An additional \$400 thousand of short-term offshore training appropriate to CDC serving as the training coordinator will take place in the U.S. under the CDC PASA. In its totality, offshore training represents approximately one percent of total project funding.

Commodities

AAO/Nigeria will directly finance approximately \$4.3 million of commodities procured offshore. An additional \$300 thousand of commodities appropriate to CDC serving as the procurement agent will be financed under the CDC PASA. The offshore procurement of commodities, in its totality, represents approximately eight percent of total project funding.

Local Costs

A.I.D. will fund \$14.6 million (25% of total project cost) for the procurement of goods and services under the local costs (LC) element. This compares with an HCC of \$18.8 million (32% of total project cost). The A.I.D. LC contribution will support project operations at the federal (\$2.5m), state (\$3.2m), and local (\$6.0m) levels; and within the private sector (\$0.4m). An additional \$2.5 million is programmed for local technical assistance supporting project implementation.

Audit

\$1.0 million is budgeted for special audit functions beyond those integral to routine financial management procedures incorporating internal audit mechanisms.

D. Financial Management

The financial management of NCCCD will be under the overall responsibility of the AAO/Nigeria Project Manager (i.e., the AAO HPN Officer) assisted by: (a) the AAO Controller for accounting and audit functions and the monitoring of HCC; (b) the AAO Program Officer for the issuance of project implementation documentation, periodic reporting, and overall program budget guidance; (c) the NCCCD project management team for the identification of specific funding needs and the monitoring and tracking of operational outlays; and (d) the PAF unit responsible for administrative support, including procurement, receiving, payment, and accounting functions related to locally-procured goods and services.

With appropriate assistance, as indicated above, the AAO HPN Officer will ensure that appropriate actions are taken with regard to the following:

- Monitoring of all uses of A.I.D. funds under the project.
- Maintenance of project budgets.
- Assurance that proper accounting systems and internal controls are in place at implementing organizations prior to the disbursement of funds to such entities.
- Preparation of quarterly project accruals.
- Preparation of Project Implementation Orders.
- Coordination of project audits, including those directed to implementing agencies.
- Identification and tracking of HCC.
- Review and administrative approval of project invoices, vouchers, and support documentation before processing to WAAC.
- Identification of funds for de-earmarking and de-commitment.
- Preparation of project implementation letters to outline financial procedures and the re-programming of funds for uses under different project elements.
- Monitoring of project advances to ensure timely liquidation.

The audit of NCCCD will be undertaken in accordance with the Audit Management Plan (AMP) developed and managed by the AAO/Nigeria Controller.

E. Methods of Implementation and Financing

Table 3 presents the implementation and financing plan for each input, each of which equates with the project elements, five in number, to be utilized for financial reporting purposes. Direct payment is the preferred method of financing and generally provides suitable controls over disbursement. Direct payment/reimbursement will be utilized for all foreign exchange financing under the project, except where the use of Letters of Credit is appropriate and will facilitate implementation efficiency.

Specific arrangements are indicated with respect to each category of funding recipient; i.e., (a) direct reimbursement will be made to CDC through PASA arrangements; (b) AID/W central contracts will be accessed for direct payment through OYB transfers and/or buy-in mechanisms; and (c) direct AAO contracts will be handled through direct invoicing.

The procurement of goods and services (core requirements) for the establishment and operation of the PAF will be financed through Letter of Credit (L/C) arrangements issued under the contract for the provision of administrative support services to the AAO/Nigeria program as a whole. The procurement of goods and services in direct program support of NCCCD will be handled under the administrative support contract through separate budget control and L/C arrangements. The administrative support of other programs in the AAO/Nigeria portfolio (e.g., FHS-II and AIDSCAP) will, likewise, be segregated into separate budget control and L/C arrangements. There will be no commingling of core PAF contract financing with the operational funds of the various projects serviced by the PAF. (See the discussion on the administrative support functions of the PAF, particularly, that pertaining to comprehensive financial services in Section H of Chapter II.)

All activities involving Local Costs will be financed through PAF administrative support arrangements under budget control and L/C arrangements specific to NCCCD. Funds made available to, or for the benefit of, public sector entities and/or operations at the federal, state, and LGA levels will be subject to provisions contained in Project Implementation Letters (PILs) issued specifically for that purpose. Every effort will be made to employ cost-reimbursement mechanisms. Only in the event

that this is not possible will funds be advanced to recipient agencies. In that case, the PAF will prepare the necessary certifications and documentation for the advance of funds. See Section H, below, for discussion of controls applicable to funding advances to host country institutions. Funds made available to, or for the benefit of, private sector entities and/or operations will be subject to provisions contained in Memoranda of Understanding issued specifically for that purpose. Disbursement to individual, local technical assistance contractors will be made pursuant to contracts entered into with each of the individuals concerned.

AAO/Nigeria will continue its ongoing inquiry with the Debt-For-Development Coalition to ascertain when, and if, conditions are propitious for the application of Debt-For-Development interventions as a mechanism for leveraging the exchange of dollars for naira to meet the local costs of NCCCD implementation. If circumstances become appropriate, consideration will be given to the application of such means to meet the project's naira requirements.

**TABLE 3
NIGERIA NCCCD PROJECT
METHODS OF IMPLEMENTATION AND FINANCING**

ELEMENT DESCRIPTION	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	AMOUNT U.S.\$ (millions)
1. TECHNICAL ASSISTANCE			<u>19.8</u>
CDC PASA	PASA	Direct Reimbursement	7.1
R&D + AFR Buy-ins	AID/W Central Contracts	OYB Trans + Buy-ins	7.3
AAO Direct	AAO Contracts	Direct Payment	2.0
ADMIN SUPPORT (PAF)	AAO Contract	L/C	3.4
2. PARTICIPANT TRNG	Direct Placement	Direct Payment	<u>0.3</u>
3. COMMODITIES	Implementation Orders	Direct Payment PAF Payment	<u>4.3</u>
4. LOCAL COSTS			<u>14.6</u>
MHSS/PHCDAN	PAF Implementation	PAF Payment	2.5
SMOHs	PAF Implementation	PAF Payment	3.2
LGA _s	PAF Implementation	PAF Payment	6.0
Private Sector	PAF Implementation	PAF Payment	0.4
Local TA	PAF Implementation	PAF Payment	2.5
5. AUDIT	Direct Contract	Direct Payment	<u>1.0</u>
PROJECT TOTAL			40.0

F. Obligations and Expenditures

Table 4a presents the plan to obligate A.I.D. funds over the life of the project. The first obligation in the amount of \$7.1 million will occur late FY93. NCCCD will commence expenditure of funds after the appropriate conditions precedent under the Project Agreement have been satisfied, and earmarking and commitment procedures have been completed. It is anticipated that the total A.I.D. contribution under the project will be fully obligated by the end of FY1999. The Project Assistance Completion Date (PACD) is December 31, 2000.

TABLE 4a PROJECTION OF OBLIGATIONS BY FISCAL YEAR (U.S. \$ Millions)								
ELEMENT DESCRIPTION	O B L I G A T I O N S							TOTAL
	FY93	FY94	FY95	FY96	FY97	FY98	FY99	
1. TECH ASSISTANCE	<u>4.0</u>	<u>2.5</u>	<u>3.2</u>	<u>3.6</u>	<u>2.5</u>	<u>2.4</u>	<u>1.6</u>	<u>19.8</u>
CDC PASA	2.5	1.0	1.0	1.0	0.6	0.6	0.4	7.1
R&D + AFR BUY-INS	0.9	0.9	1.3	1.7	1.0	1.0	0.5	7.3
AAO DIRECT	0.3	0.3	0.3	0.3	0.3	0.3	0.2	2.0
ADMIN SUPPORT (PAF)	0.3	0.3	0.6	0.6	0.6	0.5	0.5	3.4
2. PARTICIPANTS	<u>0.1</u>	<u>0.0</u>	<u>0.1</u>	<u>0.0</u>	<u>0.1</u>	<u>0.0</u>	<u>0.0</u>	<u>0.3</u>
3. COMMODITIES	<u>0.9</u>	<u>0.0</u>	<u>0.9</u>	<u>0.9</u>	<u>0.9</u>	<u>0.7</u>	<u>0.0</u>	<u>4.3</u>
4. LOCAL COSTS	<u>2.1</u>	<u>2.5</u>	<u>1.9</u>	<u>2.3</u>	<u>1.9</u>	<u>2.1</u>	<u>1.8</u>	<u>14.6</u>
MHSS/PHCDAN	0.5	0.4	0.3	0.4	0.3	0.3	0.3	2.5
SMOHs	0.5	0.5	0.3	0.5	0.5	0.5	0.4	3.2
LGAs	0.7	1.0	0.9	0.9	0.8	0.9	0.8	6.0
PRIVATE SECTOR	0.1	0.1	0.0	0.1	0.0	0.1	0.0	0.4
LOCAL TA	0.3	0.5	0.4	0.4	0.3	0.3	0.3	2.5
5. AUDIT	<u>0.0</u>	<u>0.0</u>	<u>0.3</u>	<u>0.0</u>	<u>0.3</u>	<u>0.0</u>	<u>0.4</u>	<u>1.0</u>
ANNUAL TOTAL	7.1	5.0	6.4	6.8	5.7	5.2	3.8	40.0
CUM TOTAL	7.1	12.1	18.5	25.3	31.0	36.2	40.0	

The projection of A.I.D. expenditures over the life of the project is presented in Table 4b. Planned expenditures are based on expectations that circumstances favoring uninterrupted project implementation will prevail. Cumulative expenditures for each year of the project fall within cumulative obligation goals outlined in Table 4a.

TABLE 4b PROJECTION OF EXPENDITURES BY FISCAL YEAR (U.S. \$ Millions)									
ELEMENT DESCRIPTION	EXPENDITURES								TOTAL
	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FY00	
1. TECH ASSISTANCE	0.6	2.4	3.4	3.6	2.9	2.5	2.2	2.2	19.8
CDC PASA	0.4	1.3	1.3	1.3	1.0	0.6	0.6	0.6	7.1
R&D + AFR BUY-INS	0.0	0.5	1.3	1.5	1.0	1.0	1.0	1.0	7.3
AAO DIRECT	0.1	0.3	0.3	0.2	0.3	0.3	0.2	0.3	2.0
ADMIN SUPPORT (PAF)	0.1	0.3	0.5	0.6	0.6	0.6	0.4	0.3	3.4
2. PARTICIPANTS	0.0	0.1	0.0	0.1	0.0	0.0	0.1	0.0	0.3
3. COMMODITIES	0.1	0.6	0.4	0.7	0.8	0.7	0.6	0.4	4.3
4. LOCAL COSTS	0.5	2.2	2.2	2.1	2.1	1.9	1.8	1.8	14.6
MHSS/PHCDAN	0.1	0.4	0.4	0.4	0.3	0.3	0.3	0.3	2.5
SMOHs	0.1	0.5	0.6	0.6	0.6	0.4	0.2	0.2	3.2
LGAs	0.2	0.9	0.8	0.8	0.8	0.8	0.8	0.9	6.0
PRIVATE SECTOR	0.0	0.1	0.1	0.0	0.1	0.0	0.1	0.0	0.4
LOCAL TA	0.1	0.3	0.3	0.3	0.3	0.4	0.4	0.4	2.5
5. AUDIT	0.0	0.0	0.0	0.3	0.0	0.3	0.0	0.4	1.0
ANNUAL TOTAL	1.2	5.3	6.0	6.8	5.8	5.4	4.7	4.8	40.0
CUM TOTAL	1.2	6.5	12.5	19.3	25.1	30.5	35.2	40.0	

G. Host Country Contribution (HCC)

National health care policy has designated the LGAs as the primary implementors of PHC. Consequently, PHC facilities and personnel that hitherto were the responsibilities of State Governments have been transferred to the LGAs in compliance with the new policy. The Departments of Health Care Services in LGAs run a somewhat parallel organizational structure with the SMOHs. The SMOHs now play a liaison role between the MHSS and Departments of Health Care Services of LGAs. The cost of health care services is partitioned among the three levels of government. As a consequence, HCC involves contributions at the federal, state and LGA levels. The projection of HCC to NCCCD is presented in Table 5, below.

TABLE 5 PROJECTION OF HOST COUNTRY CONTRIBUTIONS (Cash and In Kind)									
CONTRIBUTION DESCRIPTION	1993/ 94	1995	1996	1997	1998	1999	2000	TOTAL	
								NAIRA	US\$
(millions)									
TOTAL ALL LEVELS	94.0	92.6	92.8	93.7	94.5	94.9	95.0	657.5	18.78
Health Facilities	8.9	8.7	8.7	8.7	8.7	8.7	8.6	61.0	
Other Real Estate	9.9	9.3	9.3	9.3	9.3	9.2	9.2	65.5	
Vehicles & Equip	6.6	6.6	6.6	6.7	7.0	7.1	7.3	47.9	
Pharmaceuticals	21.0	21.0	21.0	21.4	22.0	22.0	22.0	150.4	
Salaries & Wages	40.2	39.8	39.8	39.7	39.6	39.6	39.6	278.3	
Training	0.7	0.7	0.7	0.7	0.7	0.8	0.8	5.1	
Opns & M'tenance	6.7	6.5	6.7	7.2	7.2	7.5	7.5	49.3	
FEDERAL GOVT	21.7	21.1	21.1	21.5	22.1	22.1	22.1	151.7	4.33
Health Facilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Real Estate	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7	
Vehicles & Equip	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Pharmaceuticals	21.0	21.0	21.0	21.4	22.0	22.0	22.0	150.4	
Salaries & Wages	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.4	
Training	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Opns & M'tenance	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.2	
STATE GOVT	47.2	47.2	47.4	47.7	47.9	47.9	47.9	333.2	9.52
Health Facilities	1.9	1.9	1.9	1.9	1.9	1.9	1.8	13.2	
Other Real Estate	6.8	6.8	6.8	6.8	6.8	6.7	6.7	47.4	
Vehicles & Equip	2.3	2.3	2.3	2.3	2.6	2.7	2.8	17.3	
Pharmaceuticals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Salaries & Wages	30.9	30.9	30.9	30.9	30.8	30.8	30.8	216.0	
Training	0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.1	
Opns & M'tenance	5.0	5.0	5.2	5.5	5.5	5.5	5.5	37.2	
LOCAL GOVT (LGAs)	25.1	24.3	24.3	24.5	24.5	24.9	25.0	172.6	4.93
Health Facilities	7.0	6.8	6.8	6.8	6.8	6.8	6.8	47.8	
Other Real Estate	3.0	2.4	2.4	2.4	2.4	2.4	2.4	17.4	
Vehicles & Equip	4.3	4.3	4.3	4.4	4.4	4.4	4.5	30.6	
Pharmaceuticals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Salaries & Wages	8.9	8.9	8.9	8.8	8.8	8.8	8.8	61.9	
Training	0.4	0.4	0.4	0.4	0.4	0.5	0.5	3.0	
Opns & M'tenance	1.5	1.5	1.5	1.7	1.7	2.0	2.0	11.9	

Based on N35:US\$1

An in-depth study designed to ascertain the accountable magnitude of host country contribution (HCC) to the major ongoing projects in the AAO/Nigeria portfolio (i.e., ACSI/CCCD/Nigeria and Family Health Services) was completed in September, 1992. Focused on actual HCC support to those projects during the period 1989 through mid-1992, the study determined that HCC to the projects in question would meet mandatory requirements.³

³ In addition to inquiry at the federal level, the study collected data in four states and nine LGAs representative of FHS and CCD activity. For the period investigated, HCC at the federal level plus that of the four sample states and nine sample LGAs totaled \$30.3 million (FHS:\$11.4 and CCD:\$18.9). Breakdown of HCC source was attributed as follows: MHSS - 33%; SMOHs - 54%; and LGAs - 13%. Were the contributions of all the participating states and LGAs included in the calculations, the percentages attributable to the states and LGAs would have been greater.

Conduct of the study required the development of ad hoc data collection and cost-accounting procedures to establish HCC magnitudes, for the investigators found that MHSS, SMOH, and LGA officials have yet to recognize the need for identifying, quantifying, recording, and reporting HCC on a regular basis. Existing MHSS, SMOH, and LGA accounting systems offered no reliable procedures for reporting required HCC data.

Although HCC magnitudes were adequate, the study demonstrated the need for establishing standards and procedures to quantify with auditable evidence the various assets contributed by the host country.

On behalf of NCCCD (and FHS-II), AAO/Nigeria will establish: (a) appropriate standards and procedures for collecting and reporting HCC data; and (b) a system for monitoring HCC at the federal, state and LGA levels. The system will include a set of four tools (see the table below) to guide project officials in the identification, calculation, recording and reporting of HCC. Project staff and counterpart officials will be trained in the use of the methods adopted, including appropriate mechanisms for determining standard values to be used for the assessment of assets contributed.

Tools for Calculating, Recording and Reporting HCC	
Activity/Item Identification Checklist	● To identify project activities and items of accounting for HCC.
Guidelines for Quantification	● To facilitate the calculation of project activity costs attributable to HCC simultaneously with implementation.
Cost Accounting Procedures	● To record costs incurred by the MHSS, SMOHs, and LGAs for project activities.
Quarterly Cost Summary of Government Contribution	● To submit quarterly reports on HCC at the federal, state, and LGA levels.

Items of Contribution

HCC will be classified under seven categories, as defined below, to facilitate identification and verification; i.e., (a) health facilities; (b) other real estate; (c) vehicles and other equipment; (d) pharmaceuticals; (e) salaries and allowances; (f) training; and (g) operations and maintenance.

Sources of cost data will include; for example, (a) books of accounts for salaries and other treasury payment vouchers; (b) imprest receipts and invoices; (c) budget proposals; (d) estimated costs based on recorded project activities; and (e) ministerial records of works and surveys which provide cost valuation for land and building accommodation. Monetary contributions will be tracked, when and where appropriate. Cash accounting, when possible, will simplify quantification of HCC magnitude.

Definition and Calculation of Costs

Health Facilities: Health facilities (clinics, health centers, etc.) including structures, clinical equipment, tools, furniture, and administrative support items. The cost of clinical equipment and furniture will be obtained from the books of accounts in most facilities. Budgetary proposals will be utilized in the absence of books of accounts, when officials can confirm receipt and utilization of relevant monies.

Other Real Estate: Land Costs will cover undeveloped plots allocated to project activities. Building costs will cover office accommodation, stores and other nonclinical space utilized by project staff. Estimated cost of the buildings or annual rents, where applicable, will be obtained from the Land and Survey Division of the Ministry of Works. Where facilities are commonly shared, building costs will be allotted according to space allocation.

Vehicles and Equipment: Vehicle costs will include original price of vehicles purchased new or used. Equipment costs cover purchase, handling, transportation and installation of nonclinical equipment; e.g., cold room equipment for EPI vaccines. Cost figures will be retrieved from project accounts, receipts, and invoices applicable to activities for which items are supplied.

Pharmaceuticals: Pharmaceuticals include; for example, the purchase of EPI vaccines and contributions to the Revolving Drug Fund (RDF) and the Bamako Initiative (BI). Purchase vouchers will be used to verify contributions.

Salaries & Allowances: Salaries and allowances cover the basic salaries, plus rent and housing allowances of all categories of staff contributing to project activities. Percentages varying from 100% to 5% will be used to estimate the contributions of varying categories of officials and workers; for example, Commissioners of Health, directors and coordinators of PHC, community health extension workers (CHEWs), clinic employees, and traditional birth attendants (TBAs). The cost of salaries and allowances will be obtained, for the most part, from salary vouchers.

Training: Training Costs cover expenditures for conference and seminar halls, honoraria for facilitators, training materials, accommodation for trainers and participants, food and transportation allowances, vehicle operation, stationery, refreshments and meals, publicity, certificates of attendance, and other costs associated with organizing courses, seminars and conferences related to project activity. Cost data will be obtained from budgets, funding receipts, and records of expenditures.

Operations and Maintenance: Operations and maintenance costs cover expenditures for the operation and repair of vehicles, clinical and nonclinical equipment, and buildings. Specific cost items include fuel, lubricants, spares, other materials and labor costs, utility expenses such as telephone, electricity, water, Fax and postage. Cost data will be obtained from project accounts of actual expenditures, payment receipts, invoices and budget proposals. Cost-sharing with off-project activity will be based on the level of use of facilities, vehicles, and equipment.

H. Funding Advances to Host Country Institutions

Funds made available to host country institutions, whether agencies of federal, state or local government or entities of the private sector, will be subject to control in accordance with A.I.D. regulations and generally accepted accounting procedures.

Each institution receiving A.I.D. funds will be required to maintain an accounting system and implement financial procedures meeting the following minimum standards:

- The accounting system adequately identifies the receipt and disbursement of A.I.D. funds.
- Accounting entries are supported by appropriate documentation which are properly classified and filed. Documentation can readily be traced to books of original entry and vice versa.

- The accounting system generates timely and accurate financial reports. Bank reconciliations are done timely and accurately.
- The system has appropriate internal controls to ensure the integrity and accuracy of the financial data.
- Proper budgetary procedures exist to preclude the overspending of budget line items.

The advance of funds to public and/or private entities will be subject to AAO/Nigeria Controller determination concerning the adequacy of the accounting and procurement systems in place with respect to the particular recipient entity concerned.⁴

⁴ In August 1991, at the request of the AAO/Nigeria Controller, the Lagos Office of Price Waterhouse conducted a review of the implementation and maintenance of accounting and procurement procedures of the Federal Ministry of Health, selected State Ministries of Health, and selected LGAs, active in A.I.D.-supported programs. The review focused on: (a) general characteristics of the accounting and procurement systems in place; (b) degree of standardization of the accounting and procurement systems; (c) appraisal of the appropriateness, coverage and usage of the procurement systems in place; (d) system maintenance with reference to recording and files, facilities for file and record maintenance, and the degree to which changes in administration affect the continuity of such maintenance; (e) existence and utilization of internal controls and procedure manuals; (f) adequacy of accounting personnel training and experience; and (g) assessment of institutional ability to handle, record and maintain roll over funding advances.

The Price Waterhouse study found that "All the ministries of state governments and local government authorities operate a standardized accounting and internal control system as set out in the Federal Government approved Financial Memorandum."

According to the study, the major features of the systems include the following: (a) receipts and payments system, hence no accruals accounting; (b) adequate segregation of duties; (c) limits of authority and proper approval procedures for all expenditure; (d) expenditure incurred on the basis of annual budgets; (e) pre-disbursement audits; (f) monthly financial reporting for budgetary control purposes; (g) a procurement system based on predetermined requirements and on a competitive tendering; (h) inventory system that is supported by approvals for requisitions/issues and user-generated requests for purchases; and (i) systematic archiving, unaffected by changes in personnel or administration.

Areas of weakness noted included: (a) general lack of professional accounting qualification among personnel, mitigated by the fact that the majority take part in on-the-job and in-service training and have substantial practical experience; (b) occasional pooling of donor funds into a general account, a practice to be precluded through appropriate terms in a funding agreement; and (c) separation of original invoices and invoice listings from disbursement records, a practice to be precluded through appropriate terms in funding agreements.

The Price Waterhouse study concluded "that despite the lapses noted, the systems in operation have adequate controls and are able to handle, record and maintain rollover type advances of funds."

IV. MONITORING AND EVALUATION PLAN

The monitoring and evaluation (M/E) strategy of NCCCD is designed to: (a) build capacity for M/E at the LGA, State, and Federal levels of the Nigerian health system; (b) allow NCCCD staff to monitor and evaluate project implementation with a view toward identifying and addressing operational difficulties and revising program plans; and (c) meeting A.I.D. reporting requirements.

The indicators and sampling frames (as well as the program planning cycles for which evaluation results are needed) are, necessarily, different in various respects when it comes to meeting the three objectives of this strategy. M/E activities serving the threefold strategy will be implemented based on the following principles:

- As few project resources as possible will be spent on data collection activities that fulfill solely the monitoring and reporting needs of NCCCD or A.I.D.
- As many project resources as possible will be spent in helping LGA and State-level managers build monitoring systems that they, themselves, can maintain for providing information of sufficient quality to support sound program decisions.
- Evaluation designs will be based on a limited and realistic set of objectives at the LGA level; and, then, in support of those objectives at the State and Federal levels.

A. Evaluation Context for NCCCD

The NCCCD evaluation strategy will allow A.I.D. to monitor and report on the extent to which the program is achieving its goals, targets and objectives. Equally important are NCCCD activities that will strengthen Nigerian capacity at the LGA, State, and Federal levels to design and implement M/E activities that will lead to strong, sustainable PHC programs. Planned activities to build strong PHC programs have been designed to meet the CPSP Cross-cutting Target of "Improved Planning and Management of Public and Private Health Systems" and include collaboration in the design of work plans, objectives, and targets at the LGA and State levels.

Specifically, LGAs will be assisted in the (a) review of available data; (b) definition of program priorities and objectives; and (c) selection of a limited number of indicators for measuring progress toward those objectives. Whenever feasible, data required will be derived from institutionalized sources designed for use by LGA, State, and Federal program managers.

At all levels of M/E, NCCCD will support MHSS efforts to measure progress toward the Global Summit Goals for Child Survival. There is, by intent, significant overlap between the targets specified in the CPSP Program Logframe and the Summit Goals; and between elements of the MHSS program for monitoring and evaluating PHC development and the Summit Goals.

Special efforts will be made to coordinate M/E activities of NCCCD with those of the MHSS and other major partners in child survival programs. Planned and ongoing activities by these institutions and agencies are briefly described below.

Ministry of Health and Social Services (MHSS)

In 1990, the MHSS developed detailed guidelines for the development of PHC at the LGA level, including baseline surveys and situation analyses to provide data for: (a) planning; (b) establishment

of PHC committees at the village, district and LGA levels; (c) development of a monitoring system that includes house numbering and home-based records; (d) in-service training of health personnel, including village health workers (VHWs) and traditional birth attendants (TBAs); and (e) the expansion of mechanisms to increase community participation in health.¹

The MHSS PHC M/E system is not yet fully operational and is expected to undergo further modifications during the coming year. Forms were designed, and personnel from each LGA were trained in their use in 1991 and 1992. The registry for incoming report forms is currently being expanded and relocated; the next step will be to hire and train additional staff skilled in data entry, analysis and interpretation. The results of a recent (November 1992) field assessment of the current status of the M/E system at the LGA level will be used to determine additional needs for training and support. ACSI/CCCD has provided technical assistance in implementing this system, and NCCCD will continue to do so, with a view toward eventual utilization of the MHSS system as a source of data for program monitoring.

The Primary Health Care Development Agency of Nigeria (PHCDAN) is currently conducting a survey of the status of PHC implementation at the LGA level. State-level personnel are using a standardized checklist to interview the PHC coordinator in each LGA concerning: (a) PHC infrastructure at the LGA and district levels; (b) PHC service coverage and quality; (c) the status of the PHC information system; and (d) activities in PHC supervision and continuing education. Responses for individual checklist items are weighted and summed to construct an overall PHC development score for each LGA. This effort will be supported by NCCCD. Repeated administrations by the PHCDAN in the future will allow documentation of trends for specific aspects of PHC development in focus LGAs.

A complementary monitoring exercise is also underway by the EPI, CDD and ARI programs of the MHSS PHC Department. Staff have been trained to administer a standardized program assessment instrument at the State and LGA levels. The assessment addresses the current status of program activities and needs. The assessment has been completed in ten states; plans are underway to revise the instrument and conduct assessments in the remaining States in 1993. NCCCD will provide technical and financial support to the MHSS in this activity. The MHSS M/E Unit has accepted responsibility for data entry and analysis. These assessments will contribute to NCCCD M/E activities.

World Health Organization (WHO)

Although WHO, like CCCD, is providing technical assistance to the MHSS M/E Unit, no additional M/E activities will be carried out by WHO/Nigeria at the State or LGA levels.

UNICEF

UNICEF assistance in PHC over the next five years will be targeted to sixty-nine LGAs in ten focus

¹ Federal Ministry of Health, Nigeria. Guidelines and Training Manual for the Development of Primary Health Care System in Nigeria. Lagos, Nigeria: Federal Ministry of Health, 1990.

states. UNICEF has recently completed baseline surveys in twenty-nine of these focal LGAs.² The survey methodology included household interviews with mothers of children under five years of age, in-depth interviews with key informants at the LGA and facility levels, and focus group discussions with mothers. A multistage sample design based on random sampling of enumeration areas within the target LGAs and random sampling of households within enumeration areas resulted in a final sample of approximately 400 mothers in each of the twenty-nine LGAs. Survey content (and evaluation indicators) are derived from the Global Summit Goals for Child Survival. Many of these indicators overlap with those in the NCCCD logframe and the MHSS PHC M/E plan. While there is no overlap in focal LGAs between UNICEF and NCCCD, there is overlap in focal States. MHSS has asked both projects to work in Niger, Osun and Oyo states. Baseline data collected in collaboration with UNICEF will provide a basis for comparison with NCCCD focal LGAs.

Family Health Services

Current and projected indicators and data sources have been defined for the Family Health Services project.³ A broad array of methods have been recommended, including use of: (a) NDHS data collected in 1990, 1994 and 1998; (b) the Nigerian 1991 census and five percent post-enumeration survey; (c) the Federal Office of Statistics (FOS) 1992 survey of contraceptive use, sources and knowledge; (d) audience research studies; (e) facility-based studies of service delivery and the availability of commodities; (f) sentinel surveys; and (g) a project management information system. NCCCD and FHS-II data sources will be coordinated particularly promising is the combined use of NDHS and health facility surveys of service quality.

National Urban EPI Metropolitan Lagos Project

In 1992, a major A.I.D.-funded project designed to develop and test strategies for improving immunization quality and coverage was initiated in Lagos State in collaboration with the REACH Project. Three methods are being used to collect baseline information: (a) EPI coverage surveys in all fifteen Lagos LGAs using the traditional thirty-cluster sampling design; (b) facility-based assessments of the quality of PHC services in samples of six facilities in each of the twelve urban Lagos LGAs, including both public and private facilities; and (c) a series of focus groups with mothers to identify attitudes toward immunization and potential barriers to the utilization of services. These baseline data will be used to plan LGA-specific interventions to improve the quality of immunization services and their use by mothers and children. Each LGA will select programmatic objectives and indicators for monitoring program implementation. These data may be useful both to complement baseline data collected in the CCCD focal LGA in Lagos State (Ojo), and as a basis for comparison with other focal LGAs.

Nigeria Demographic and Health Surveys (NDHS)

An important source of baseline information will be the 1990 Nigeria Demographic and Health Survey (NDHS). The NDHS is a nationally representative survey conducted by the Federal Office

² Department of Sociology & Anthropology, Obafemi Awolowo University. Goals for children and development in the 1990s. Baseline analysis for 31 focal local government areas in Nigeria. Lagos, Nigeria: Federal Government of Nigeria in collaboration with The United Nations Children's Fund. (DRAFT). June 1992.

³ Lacey, Linda. Evaluation strategy for the Nigerian Family Health Services projects. The Evaluation Project, University of North Carolina, Draft, August 20, 1992.

of Statistics (FOS). Results are available on breastfeeding and nutrition practices, home case management of common childhood diseases, and maternal care. The sample was designed to produce results that are representative of health zones. Use of the NDHS to monitor trends at the population level in NCCCD focal LGAs will require modifications in the sample design.

ACSI/CCCD Evaluation Strategy and Lessons Learned

The ACSI/CCCD evaluation plan presents indicators and data management tools to measure the process and outcomes of CCCD assistance to primary health care at the LGA and State levels.⁴ There are various sources of indicator data.

Project records and reports monitor project inputs and the outputs resulting from application of inputs. These outputs include: (a) training; (b) the development of work plans and other management procedures; (c) the establishment of policies; and (d) the activation of specific operations.

Anticipated project outcomes at the facility level include improved service coverage, quality and management. Facility-level outcomes are monitored through observation-based assessments of the quality of care and facility management in stratified samples of facilities within each LGA.

Anticipated community- and household-level outcomes include increased immunization coverage, improved home case management of common childhood diseases and increases in knowledge and positive attitudes toward PHC among child caretakers. Baseline levels of key outcome indicators at the household level have been established through community-based sample surveys in selected LGAs.

Suleja and Barkin-Ladi LGAs have served as models for the development and implementation of monitoring and evaluation strategies. Additional baseline data in these two LGAs include studies of drug quality and logistics reviews designed to assess the supply and distribution systems for PHC essential drugs, including antimalarials, antibiotics, and paracetamol.

The table below summarizes the types of baseline data expected to be available in CCCD focal LGAs by September 1993.

⁴ CCCD-Nigeria. Monitoring and Evaluation Plan for CCCD Interventions in Six Nigerian States. Lagos, Nigeria: January 1991.

BASELINE DATA AVAILABLE BY SEPTEMBER 1993 CCCD FOCUS STATES AND LGAs							
STATE	LGA	PROJECT INPUTS	PROJECT OUTPUTS	FACILITY OUTCOMES	COMMUNITY OUTCOMES	DRUG QUALITY	LOGISTIC REVIEW
Anambra	Oyi	x	x	x			
Enugu	Nsukka	x	x	x			
Kebbi	Zuru	x	x	x			
Lagos	Ojo	x	x	x	x*		
Niger	Gurara ^b	x	x	x	x	x	x
	Lapai	x	x	x			
	Suleja ^b	x	x	x	x	x	x
Osun	Ife Central	x	x	x			
Oyo	Egbeda	x	x	x			
Plateau	Barkin-Ladi	x	x	x	x	x	x
	Pankshin	x	x	x			
Sokoto	Kaura Namoda	x	x	x	x		

* Collected as baseline data for the National Urban EPI Metropolitan Lagos Project.

^b Gurara and Suleja were one LGA (Suleja) at the time the community survey, drug quality study, and logistics review were conducted.

Lessons Learned and Implications for NCCCD

On the basis of their experience to date CCCD staff have arrived at the following conclusions relevant to the projected activities of NCCCD.

1. *The CCCD project serves as an important model and training ground for building Nigerian capacity in monitoring and evaluating health programs.* CCCD project management serves as a model for local counterparts. Participation in project planning and evaluation builds the skills of Nigerian epidemiologists and other public health professionals working for the project.

Implications for NCCCD:

● NCCCD will include mechanisms that allow project staff to review and revise, periodically, the specific objectives of project activities, and the indicators used to monitor progress.

● NCCCD will support a staff person whose responsibilities include tracking project achievements and coordinating the implementation of the evaluation strategy.

2. *Locally-defined objectives and indicators are critically important in building capacity and fostering ownership of PHC programs.* Future activities should include a systematic series of working sessions with LGA- and State-level program managers to review available data, establish

PHC priorities, develop short- and long-term program objectives, and develop indicators and supporting methodologies to track progress toward these objectives. Planning sessions should be used as opportunities to transfer skills in program M/E to LGA and State managers, who will be encouraged to review available indicators and select those that will provide timely, valid data on program progress at a reasonable cost in time, human, and material resources.

Implications for NCCCD:

- Promotion of PHC program ownership at the community, facility, and LGA levels is critically important if program targets are to be achieved and sustained.
- Indicators at the operational level will reflect local priorities and program objectives.
- NCCCD will support a staff person responsible for building the technical capacity of project staff.

3. *LGA and State Level PHC Managers Need Feasible Strategies for Monitoring the Quality of PHC Services.* The community survey and facility assessment methods currently used for project planning and evaluation are resource intensive, and divert program personnel and resources from other (more routine) health system responsibilities. CCCD program personnel report that further effort is needed, in collaboration with LGA and State managers, to develop more sustainable and routine methods for PHC program M/E. The establishment of a Modifiable Risk Factor Tracking System (MRFTS) at the State level and the institution of quality assurance standards will also contribute to the monitoring and evaluation strategy.

Implications for NCCCD:

- Project support will include systematic development and testing of routine methods for program monitoring and evaluation.
- Sufficient flexibility in project design will allow rapid response to LGA and State level proposals for innovative monitoring strategies.
- Activities will be designed to strengthen data utilization methodology for local program managers with a view to program improvement.

4. *Indicators, alone, cannot provide adequate data for evaluating the outcomes of CCCD interventions.* Monitoring trends through the use of indicators provides pre- and post-intervention measures or time trends, but often does not allow more careful analysis of the contribution of specific program activities. Changes in trends may be due to: (a) broader societal or programmatic changes; (b) general availability of increased resources, rather than the specific strategy used; or (c) additional motivation associated with implementation of new activities. Other evaluation research designs, including the use of "control" groups or staggered intervention designs that allow comparisons of areas with and without targeted PHC intervention activities, often provide stronger results more amenable to interpretation.

Implications for NCCCD:

- The limitations of an indicators-only approach to M/E calls for the development of strategies to buttress that approach with smaller-scale studies designed to answer specific operational and evaluation research questions.

B. CPSP Program Logframe Indicators and Data Sources

Indicators and Target Levels for Improved Maternal and Child Health Practices

Utilization of a system to measure project outcomes (more operationally detailed than the output indicators in the project logframe) will facilitate the tracking of progress towards targets meaningful to the measurement of project impact. Such a supplementary M/E system will take two forms; i.e., measurement of operational outcomes applicable to: (a) specific maternal/child health targets; and (b) each level of the health system. The table below reflects sample MCH outcomes.

SAMPLE MCH OUTCOMES AND MEASUREMENT INDICATORS	
OUTCOMES	MEASUREMENT INDICATORS
1. Improved immunization practice and coverage	<ul style="list-style-type: none"> • All health facilities have functioning cold chain equipment, EPI-related supplies (needles, syringes, etc.) and unexpired vaccines. • State mechanism providing quarterly feedback on EPI service statistics. • CE programs established that provide ongoing refresher training in EPI service delivery.
2. Improved quality of ARI case management at home and in health facilities	<ul style="list-style-type: none"> • Development and testing service protocols for integrated case management of sick child at facility level. • All facilities have essential drugs for ARI case management. • Curricular materials in ARI developed and introduced into CE system. • Effective strategies for educating caretakers in recognition and response to ARI are developed, tested and implemented.
3. Improved quality of fever (malaria) case management at home and in health facilities	<ul style="list-style-type: none"> • Federal policy on malaria recognized and implemented by health workers. • Systematic malaria control program established in all Focus States. • Capacity for drug efficacy and quality studies established in all Focus States. • All facilities have effective antimalarials in stock. • Development and testing service protocols for integrated case management of sick child at facility level. • Consistent patient education messages provided to child caretakers and facilities.
4. Improved quality of CDD case management at home and in health facilities	<ul style="list-style-type: none"> • System for review and (if needed) revision of federal CDD treatment protocol. • All facilities have ORS in stock. • Development and testing service protocols for integrated case management of sick child at facility level.
5. Improved nutritional status of young children and lactating and pregnant women, including a reduction in protein energy malnutrition and micronutrient deficiencies	<ul style="list-style-type: none"> • National nutrition policy, strategy, and program developed to improve maternal and child feeding practices. • Strategy and supporting materials developed and tested for IEC and HE/C to promote improved maternal and child nutrition practices, including outreach to community groups. • Adequate MHSS staff trained in maternal and child nutrition. • Curricular materials on nutrition developed, tested, and incorporated into CE systems. • Report of survey for assessment of Vitamin A, iron deficiency and IDD conducted. • Interventions designed and field tested to address immediate problems of Vitamin A and iron deficiencies through the PHC system. • Improved pre-service training on nutrition. • Counseling strategies and materials developed for growth monitoring program.
6. Improved maternal health and family planning practices	<ul style="list-style-type: none"> • Curricular materials on maternal health for use by CE system developed, tested and implemented. • Basic equipment needed for maternal health services (e.g., sphygmomanometer, scales) available. • TBA training and supervision system functioning.

The CPSP targets are appropriate, but quite broad and ambitious. Although NCCCD targets are related to the goals of the World Summit for children and the Ministry's own Primary Health Care goals, the project's impact will be primarily limited to its Focus States and LGAs. Several of the project's components have a national scope, but the main thrust of its PHC interventions will be limited to the Focus States and LGAs within which NCCCD will directly operate. NCCCD efforts in its Focus States and LGAs will have an impact, hopefully significant, on national indicators; however, measurable achievement of NCCCD target attainment will, necessarily, be limited to the specific areas in which NCCCD operates.

Even then, the focus areas are geographically dispersed, planned program activities are diverse, and available resources are distributed across wide LGA, State and Federal levels. Achievement of program objectives and targets will be possible only through changes at the community level. Programmatic activities developed in collaboration with communities, LGAs and States will need to be robust and focused for the program to meet its targets.

Specific NCCCD Indicators for the Cross-cutting Target

Indicators specified in the CPSP Program Logframe for the Cross-cutting Target (i.e., "Improved Planning and Management of Public and Private Health Systems") have been supplemented as shown in the table below utilizing, where possible, variables drawn from a recent (late 1992) PHCDAN PHC implementation survey.

Further Specification of Program Logframe Indicators for Cross-cutting Target	
CPSP LOGFRAME INDICATOR	CCCD PROJECT-SPECIFIC INDICATOR
Personnel develop work plans & budgets.	<ul style="list-style-type: none"> ● Facilities/LGAs with current work plans and budgets. ● LGAs where PHC Department has drawn up a plan for staff development (training) of trained staff.*
Personnel monitor the collection and analysis of project-specific data.	<ul style="list-style-type: none"> ● Facilities that returned M&E forms to LGA headquarters last month.* ● LGAs that returned M&E forms last month.*
Personnel use operations research to address relevant program and policy issues.	<ul style="list-style-type: none"> ● LGAs/States from which ≥ 1 operations research project is carried out annually.
Personnel implement and monitor effective system to ensure facilities are stocked with adequate supplies.	<ul style="list-style-type: none"> ● Days per month when stocks of vaccines, ORS, condoms, antibiotics (etc.) are sufficient to meet three-day demand.
Personnel ensure that sufficient numbers of staff receive proper training and that properly training staff are available.	<ul style="list-style-type: none"> ● Health districts in LGA with at least one person with midwifery training* ● Health districts in LGA providing antenatal care weekly.* ● Health districts in LGA where at least one facility provides immunization daily.* ● LGA health workers trained to use Standing Orders.*
Personnel collect, analyze and disseminate epidemiological and program data related to A.I.D.-supported interventions in MCH/FP.	<ul style="list-style-type: none"> ● Feedback bulletins produced and distributed annually at Federal and State levels.

*Indicator drawn from 1992 PHCDAN PHC Implementation Survey.

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Data Sources/Methods

NDHS (1990/1994/1998) as Outcome Data Source

The CPSP Program Logframe recommends use of NDHS as the data source for numerous key indicators of project outcomes. NDHS 1990 data will be used to establish baseline levels, with 1994 and 1998 data providing intermediate measures of progress toward objectives.

The use of the NDHS is appropriate insofar as it efficiently provides valid data on progress toward objectives in focal LGAs without overburdening local, state or project staff. The items needed to support logframe indicators are available in the current NDHS instrument. The sample design for the 1990 NDHS provides data representative only at the zonal level, and therefore should be considered only as a very rough indication of baseline levels.

The CPSP recommends oversampling in focal LGAs for the 1994 and 1998 NDHS to provide data representative of the CCCD intervention areas. This strategy will provide two measurement points from comparable samples with a four-year interval. Program hypotheses are that indicator levels will move, significantly, in the desired direction during this interval. In the absence of a control group, however, it will be difficult to attribute changes in indicator levels to NCCCD interventions or to make causal statements about intervention effectiveness. Comparison with national or zonal results will be difficult given wide variations in PHC development among LGAs.

Therefore, NCCCD will attempt to construct a comparison group using the overall data set. For example, it may be possible to "match" each CCCD focal LGA with an artificially constructed LGA (or group of clusters) within the larger NDHS file that has not been the recipient of targeted PHC development activities. Matching could be based on: (a) urban/rural characteristics; (b) level of PHC development in 1989; or (c) other key parameters. If the construction of an artificial "control" group is not feasible given the survey sample, the plan for oversampling in the 1994 and 1998 NDHS might be expanded to include a comparison group of LGAs that have not received targeted assistance.

Considerations of sample size and costs for oversampling will need to be discussed directly with NDHS staff; it will not be possible to arrive at even a rough estimate without relevant consultation.

Periodic Facility Surveys

Periodic facility surveys of a sample of health facilities drawn from all focus LGAs are recommended in the CPSP Program Logframe as a source of data on the quality of PHC services. Facility-based assessments at the LGA level are also an important programmatic element of the current CCCD program, providing data that program managers need to plan programs and monitor progress.

Such data, collected by State and LGA program personnel, will be summarized periodically and used to monitor trends in focus LGAs. LGA-specific results are more meaningful than those drawn from a sample of facilities across all focus LGAs, because they are directly related to LGA program interventions. Use of existing results collected as part of programmatic activities will also preclude the need for "special" data collection efforts to meet NCCCD and A.I.D. needs.

Data Sources for Cross-cutting Target

In addition to the data sources specified in the CPSP, NCCCD will attempt to identify or develop others to assess "improved planning and management of public and private health systems", such as:

(a) results of PHCDAN PHC surveys in 1992 and annually/biennially thereafter; (b) registry recordings of M/E units at LGA, Zonal and Federal levels where receipt of reports is recorded; and (c) data from the NCCCD MIS.

C. Considerations for Internal and External Management Evaluations

Management reviews can be useful to program and project personnel, if conducted in a collaborative manner and viewed as opportunities to identify and discuss program improvement. NCCCD will schedule management reviews to include the participation of all personnel directly involved in project implementation, as well as external consultants, who will be utilized to provide an independent, outside perspective. AAO/Nigeria will enforce the same standards in the composition of management review teams as was the case with the evaluation of the ACSI/CCCD effort in Nigeria. Two-stage management reviews will be employed. In the first stage, project personnel will conduct an internal review of project accomplishments and operational difficulties. This action will be conducted in conjunction with the preparation of annual reports. The results of this internal evaluation will then be used as the starting point for an external project review. The external review will be conducted no more frequently than every two years.⁵ The results being discussed with project personnel before finalization will serve as the basis for constructive, joint problem-solving. This is consistent with the CPSP plan for smaller-scale, more frequent external reviews rather than formal midterm and final evaluations.

D. Implementation Issues

Transition to Routine (Sustained) PHC M/E

A portion of the Cross-cutting Target of "Improved Planning and Management of Public and Private Health Systems" is to assist health personnel at all levels develop routine systems for monitoring public health programs and outcomes. While the data sources specified in the CPSP initially rely heavily on surveys; over time, the routine data and supervisory systems within Focus States and LGAs will be strengthened, and monitoring data will be available through routine sources maintained and used at the community, facility, and district levels. NDHS surveys, supplemented by special surveys, will be used as a means for evaluating progress toward program level targets. The table below depicts the planned transition from special surveys to routine data sources.

⁵ External evaluations are scheduled for 9/96, 9/98, and 9/00.

Data Sources and Methods, Initially and After Program Development		
TYPE OF M/E DATA	INITIAL METHOD	METHOD UNDER DEVELOPMENT
Quality of Service Delivery	Facility Survey	Routine Supervision
Availability of Drugs, Equip & Supplies	Facility Survey	Routine Supervision
Community and Individual Behavior	30-Cluster Survey	100 Household Survey; Modified Risk Factor Tracking System (MRFTS)
Morbidity	30-Cluster Survey	Health Info System
Vaccination Coverage	30-Cluster Survey	Administrative Method

Special Monitoring and Evaluation Studies

To supplement the use of indicators in program M/E, Nigerian counterparts at all levels will be encouraged to design and carry out specific evaluation research studies to address operational questions and/or investigate the effectiveness of their intervention strategies. Special studies topics will be identified by community, facility, and LGA personnel through the development and monitoring of their PHC activities. The research will be carried out by MHSS/SMOH personnel, collaborating universities, and/or SHTs. Possible study topics include:

- Investigation of 100 household surveys rather than community-based sample surveys, as a method for collecting program M/E data at the facility and LGA level.
- Diary methodology as a strategy for monitoring community outreach by village health workers.
- Efficacy of self-monitoring as a strategy for improving links between facilities and communities.
- Comparative analysis of facility-based and community-based interviews with caretakers as a source of data on community PHC needs.

E. Project Design Summary: Logical Framework (Logframe)

The Project Logframe follows closely the CPSP Logframe: the Project Goal, Subgoal, Purpose and Outputs each has a counterpart in the CPSP logical framework; i.e., the CPSP Goal, Subgoal, Strategic Objective 2 (Improved Maternal and Child Health Practices), the Targets of that Strategic Objective, and the CPSP Cross-cutting target.

NCCCD and CPSP indicators are comparable, if not identical. This situation lends itself to efficient, simultaneous monitoring and evaluation of NCCCD performance and CPSP implementation. The Project Logframe follows, beginning on the next page.

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
GOAL Healthier Society	<u>Measurements of Goal Achievement</u> <ul style="list-style-type: none"> ● GDP/capita ● Median Annual Income ● Annual Average Rural Wages 	Federal Office of Statistics and World Bank and IMF Reports. DHS Surveys, 1990/94/98; World Bank and UN Surveys and Reports.	Factors beyond project control will support EOPS in the attainment of the Project Goal. Means of measuring goal attainment will be available prior to project end. Achievements of other projects, funded by A.I.D. and other donors, particularly those addressing family planning and maternal/child health materialize as anticipated.
SUBGOAL Reduced Fertility and Decreased Morbidity and Mortality	<ul style="list-style-type: none"> ● Reduced Total Fertility Rate from 6.0 (1990) to 5.5 by YR 2000. ● Increased life expectancy at birth for males from 49.5 to 51 by YR 2000, and for females from 48.5 to 51 by YR 2000. 		

NOTE: The Project Goal and Subgoal equates with the Program Goal and Subgoal of the Nigeria Country Program Strategic Plan (CPSP) for 1993-2000.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
PURPOSE Improved Maternal and Child Health Practices in the public and private sectors	<u>Conditions that will indicate purpose has been achieved: End of Project status.</u> <ul style="list-style-type: none"> ● Decreased infant mortality from 90/1000 in 1990 to 75/1000 by YR 2000. ● Decreased child (1-4) mortality from 115/1000 in 1990 to 90/1000 by YR 2000. ● Decreased rate of severe malnutrition (wt/ht) from 9.1% in 1990 to 5% by YR 2000. ● Decreased rate of high risk births (women < 18, interbirth interval < 24 mos, parity > 3, age > 35) from 79% in 1990 to 60% by YR 2000. ● Decreased rate of maternal mortality from 15/1000 live births in 1990 to 10/1000 by YR 2000. 	<ul style="list-style-type: none"> ● DHS Surveys, 1990/94/98. ● DHS Surveys, 1990/94/98. ● DHS Surveys, 1990/94/98; Community Surveys. ● DHS Surveys, 1990/94/98. ● Sisterhood surveys as part of DHS. 	There will be continued political and financial support at federal, state, and LGA levels and in the private sector for maternal and child health care. Factors beyond project control will support the attainment of EOPS. Other donor contributions continue to complement project as a means to reach overall objectives. Means of measuring the attainment of EOPS will be available prior to project end. Clientele access health care facilities in sufficient numbers and frequency to attain EOPS.

NOTE: The Project Purpose equates with Strategic Objective 2 of the CPSP.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>OUTPUTS ⁶</p> <p>1. Improved Immunization Practices and Coverage</p>	<p><u>Magnitude of Outputs</u></p> <ul style="list-style-type: none"> ● 8 of 10 critical EPI elements performed correctly by YR 2000. ● 80% of children <1 have received scheduled DPT3, Polio X4 doses and measles vaccines by YR 2000. ● Measles morbidity reduced 65% from pre-immunization levels by YR 2000. ● Polio incidence reduced to 1/1000 by YR 2000. ● 75% of parturient women surveyed in past 12 months have received protective levels of tetanus antitoxin. 	<ul style="list-style-type: none"> ● Biennial facility surveys on sample of health facilities. ● Annual coverage est. based on <1 reported vaccinations; DHS Surveys, 19/90/94/98. ● Coverage x vaccine efficacy. ● Annual sentinel surveillance. ● Serologic surveys 1993/98. 	<p>There will be continued political and financial support at federal, state, and LGA levels and in the private sector for maternal and child health care.</p> <p>Factors beyond project control will support the attainment of EOPS.</p>
<p>2. Improved Case Management of ARI, Fever (Malaria) and Diarrhea</p>	<ul style="list-style-type: none"> ● Increased correct home case management of fever by child caretakers from 60% in 1990 to 80% by YR 2000. ● Increased correct home case management of diarrhea by child caretakers from 30% in 1990 to 60% by YR 2000. ● 80% of children <5 seen at health facilities with ARI, fever (malaria) and diarrhea received care meeting standards re clinical assessment, treatment and counseling by YR 2000. 	<ul style="list-style-type: none"> ● DHS surveys, 1990/94/98; Community Surveys. ● DHS surveys, 1990/94/98; Community Surveys. ● Biennial facility surveys on sample of health facilities. 	<p>Other donor contributions continue to complement project as a means to reach overall objectives.</p> <p>Means of measuring the attainment of EOPS will be available prior to project end.</p>
<p>3. Improved Child Nutrition Practices</p>	<ul style="list-style-type: none"> ● Infants 0-4 mos exclusively breastfed. increased from 1% in 1990 to 10% by YR 2000. ● Mothers feeding nutritious food to infants 6-9 months increased from 70% in 1990 to 90% by YR 2000. ● Vitamin A and Iodine deficiency in <5s decreased (to be determined). 	<ul style="list-style-type: none"> ● DHS surveys, 1990/94/98. ● DHS surveys, 1990/94/98. ● DHS surveys, 1990/94/98. 	<p>Clientele access health care facilities in sufficient numbers and with sufficient frequency to attain EOPS.</p>
<p>4. Improved Maternal Care</p>	<ul style="list-style-type: none"> ● Pregnant women with 2 prenatal visits from trained health provider increased from 52% in 1990 to 75% by YR 2000. ● Births attended by trained attendant increased from 30% in 1990 to 50% by YR 2000. ● Postpartum women informed and offered birth spacing information and services increased from <10% in 1990 to 25% by YR 2000. ● Postpartum women using modern methods of contraception increased from <5% in 1990 to 20% by YR 2000. 	<ul style="list-style-type: none"> ● DHS surveys, 1990/94/98. ● DHS surveys, 1990/94/98. ● DHS surveys, 1990/94/98; Biennial facility surveys on sample of health facilities. ● DHS surveys, 1990/94/98. 	

⁶ The objectively verifiable indicators for the Project Outputs are applicable to Focus States and LGAs specifically addressed by A.I.D. program interventions.

<p>5. Improved Planning and Management of Public and Private Health Systems</p>	<ul style="list-style-type: none"> ● Annual work plans and budgets developed ● Project specific data collected and analyzed ● IEC programs and strategies designed, implemented and analyzed. ● Program and policy decisions supported by Operations Research ● Health facilities stocked with adequate supplies ● Health facilities are staffed with trained personnel 	<ul style="list-style-type: none"> ● Copies of plans and budgets ● Project reports ● IEC materials and reports ● Studies ● Health facility surveys 	
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NOTE: Project Outputs 1 thru 4 equate with the Targets of Strategic Objective 2 of the CPSP; Project Output 5 is an extension of the CPSP Cross-cutting Target.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>INPUTS</p> <p><u>A.I.D.</u></p> <p>Tech Assist</p> <ul style="list-style-type: none"> ● CDC PASA 7.1 ● CA Buy-ins 7.3 ● Other TA 2.0 ● Admin Sup 3.4 <p>Participants 0.3</p> <p>Commodities 4.3</p> <p>Local Costs</p> <ul style="list-style-type: none"> ● Prg Opns 12.1 ● Local TA 2.5 <p>Audit 1.0</p> <p>Total \$40.0</p> <p><u>HCC</u></p> <p>Federal Govt 4.3</p> <p>State Govt 9.5</p> <p>LGA's 5.0</p> <p>=====</p> <p>TOTAL \$58.8</p>	<p><u>Implementation Target</u></p> <p><u>Strategies to Strengthen Infrastructure in Support of Technical Interventions</u></p> <ul style="list-style-type: none"> ● Management of Health Resources at the Local Level ● Continuing Education (CE) ● Quality Assurance (QA) Standards ● Health Education/Communications (HE/C) ● Health Information Systems (HIS) ● Operations Research (OR) ● Private Sector Initiatives <p><u>Major Child Survival Interventions</u></p> <ul style="list-style-type: none"> ● Prevention <ul style="list-style-type: none"> ● Timing of Births ● Safe Motherhood ● Maternal/Child Nutrition ● Expanded Program on Immunization (EPI) ● Case Management of the Sick Child <ul style="list-style-type: none"> ● Malaria ● Control of Diarrheal Diseases (CDD) ● Acute Respiratory Infections (ARI) 	<ul style="list-style-type: none"> ● AAO internal program documentation ● Project progress reports ● Interim and final evaluations ● Financial reports ● Site visits and facility inspection reports 	<ul style="list-style-type: none"> ● A.I.D. funding availability and obligations made in timely fashion ● Counterpart in kind and budgetary contributions are forthcoming as anticipated

V. CONDITIONS PRECEDENT AND COVENANTS

Introduction

The conditions precedent and covenants specified in this document are drawn from several fundamental and mutually avowed principals. First among these is the principal that Nigerian participation and ownership of NCCCD is essential to project success. In order to benefit the people of Nigeria, the project and its components must be equitable and sustainable when donor support ends. Responsibility for assuring sustainability is shared by USAID, representatives of the Nigerian government at the federal, state and local levels, and NCCCD project management.

A second fundamental consideration is that project success is dependent upon modification of perceptions and behaviors that influence efficient management of the health system and beneficiary willingness to adopt and maintain effective public health practices.

In addition to the technical aspects of project implementation, continual dialogue among the various partners will be necessary to assure the sustainability of socially acceptable, equitable, and effective health programs that provide high quality services and improve the health and well-being of the Nigerian people. This must be accomplished in an environment which simultaneously facilitates a phased reduction of U.S. inputs (both technical and financial) over the life of project and increases participation of the private sector.

A. Conditions Precedent

1. Conditions Precedent to First Disbursement

Prior to the first disbursement of funds, or the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D. the following:

A statement of the name(s) of the person(s) holding or acting in the office of the Grantee specified in Section 8.2. of the Grant Agreement, and the names of any additional representatives, together with a specimen signature of each person specified in such statement.

2. Conditions Precedent to Disbursement of Funds to the Grantee

Prior to disbursement of Grant funds to the Grantee, or to the issuance by A.I.D. of documentation pursuant to which such disbursement may be made, the Grantee shall:

(a) Demonstrate to A.I.D.'s satisfaction the adequacy of its financial accounting and internal control systems; and

(b) Furnish the name of the bank and account number of the separate account into which Grant funds disbursed to the Grantee will be maintained for Project purposes.

3. Conditions Precedent to Disbursement of Funds to any State Institution

Prior to disbursement of Grant funds to any particular institution at the state level of government, or to the issuance by A.I.D. of documentation pursuant to which such disbursement may be made, that institution shall:

(a) Demonstrate to A.I.D.'s satisfaction the adequacy of its financial accounting and internal control systems; and

(b) Furnish the name of the bank and account number of the separate account into which Grant funds disbursed to the Grantee will be maintained for Project purposes.

4. Conditions Precedent to Disbursement of Funds to any Local Government Institution

Prior to disbursement of Grant funds to any particular institution at the local level of government, or to the issuance by A.I.D. of documentation pursuant to which such disbursement may be made, that institution shall:

(a) Demonstrate to A.I.D.'s satisfaction the adequacy of its financial accounting and internal control systems; and

(b) Furnish the name of the bank and account number of the separate account into which Grant funds disbursed to the Grantee will be maintained for Project purposes.

B. Covenants

1. Vaccine Coordination Panel:

The Grantee covenants to support and participate in initiatives, which may be undertaken by A.I.D., to establish a coordination panel of government, donor, and private sector suppliers and users, beginning in the first year and continuing throughout the Project, for the periodic review and resolution of issues pertaining to policies, procedures, and funding sources required to support sustainable procurement of vaccines that meet international standards and, where applicable, USAID policies.

2. Donor Coordination:

The Grantee covenants to promote, throughout the life of the Project, coordination of donor inputs into the health sector generally, and the establishment of a multiagency coordinating committee or similar body, which may be initiated by A.I.D.

3. Utilization of Insecticides:

The Grantee covenants that no funds disbursed under this Project shall be used for insecticides other than permethren, for the field impregnation of bed nets without written approval from A.I.D.

VI. SUMMARY OF ANALYSES

A. Technical Analysis

With an estimated population of ninety million people, Nigeria has roughly four million births annually, approximately twenty percent of those occurring in sub-Saharan Africa. Using the <5 mortality rate of 191 deaths per 1000 live births (NDHS), 760,000 children under five years old die annually in Nigeria.

Based on World Fertility Survey and DHS data, five-year mid-point infant mortality has fallen gradually from approximately 120 deaths per 1000 live births in 1967 to 87 in 1987. Child mortality has leveled off and is starting to increase: 113.5 (1977), 103.3 (1982) and 115.2 (1987). This upward trend is expected to continue due to three factors: (a) increasing poverty; (b) increasing malaria resistance to affordable drugs; and (c) HIV infection. As evidenced by DHS data from Zambia, continuation of the downward trends in mortality seen over the last twenty years is no longer assured; without action, under five mortality rates are expected to rise in sub-Saharan Africa over the next decade.

Two parameters describe the health status of a population, nutritional status and mortality. As shown in the following table, data from the 1990 NDHS document serious health problems in Nigeria; problems are more severe in the northern zones.

Zone	Wasting % > -2SD	Stunting % > -2SD	Under Weight % > -2SD	Infant Mortality	1-4 Mortality	<5 Mortality
NE	11.3	51.9	44.6	87.7	139.2	214.6
NW	12.1	50.4	43.8	109.8	151.2	244.4
SE	7.6	36.6	29.6	82.7	66.5	143.7
SW	5.5	43.1	35.7	84.6	90.3	167.2
TOTAL	9.1	43.1	35.7	91.4	109.6	191.0

High rates of malnutrition and mortality represent the cumulative impact of poverty, lack of education, underdevelopment, high risk behavior, and disease. However, there are currently available, low cost, feasible, and effective primary health care strategies to combat many of these factors of malnutrition and mortality. These factors have been incorporated into the Nigerian Primary Health Care Strategy. The following table indicates estimates of age-specific mortality rates, the intervention strategies proposed for NCCCD,¹ the risk factors which the interventions address, and the magnitude of the risk factor by age.

¹ As discussed in Chapter II, NCCCD interventions within the individual LGAs may be Core (C), Optional (O), or Developmental (D).

NCCCD INTERVENTION STRATEGIES TO REDUCE RISKS as related to NIGERIAN UNDER-FIVE MORTALITY BY AGE (Risk Factor Intensity by Age * = LOW, ** = MODERATE, *** = HIGH)											
Age			Pre-Preg	Preg	0-1 Mo	2-5 Mos	6-11 Mos	1 Yr	2 Yr	3 Yr	4 Yr
Deaths per 1000 Live Births					50	30	20	50	30	20	10
Intervention	LGA	Risk Factor	Intensity of Risk								
Child Spacing	O	Birth Interval <24 Months, Maternal Malnutr Low Birth Weight	**	***	***	**	*				
Nutrition Ed Iron Supple Malaria Chemo	O O O	Anemia Undernutrition Malaria	**	***	***	**	*				
Safe Delivery	O	Asphyxia Hemorrhage Infection			***	*					
TT in Pregnancy	C	Neonatal Tetanus			***						
Breastfeeding Ed & Advocacy	C	Undernutrition Diarrhea			***	***	**	**	*		
Optimal Feeding Ed & Micronutr	C	Undernutrition Diarrhea					***	***	***	***	***
EPI	C	Pertussis Measles Poliomyelitis Tetanus				***	**	**	**	*	*
CASE MANAGEMENT Policy & Strategy Rev Drug Fund Trng	C	Malaria Pneumonia Diarrhea		**	**	**	***	***	***	**	*
					***	***	***	**	**	*	*
					*	***	***	***	**	**	*

Nigeria, under the dynamic leadership of the former Minister of Health Okoye Ransome-Kuti, has decentralized, over the last seven years, its primary health care services to the community level. The system is based in the community with village health workers supported by health posts, health centers, secondary hospitals at the LGA level, tertiary hospitals at the state level, and specialist hospitals at the Federal level.

In accordance with the Year 2000 objectives set at the 1989 World Summit on the Child, Nigeria has set ten PHC Targets for the 1992-2000 period. Progress has been most marked in EPI where coverage in the first year of life exceeded fifty percent of the target population in 1990. Nigerian Year 2000 PHC objectives and their current status are detailed in Annex E, pages E-9,10. NCCCD incorporates for its focus states and LGAs eight of the ten objectives, excluding water and sanitation. In the twenty percent of the 593 LGAs currently implementing PHC effectively (MHSS estimate), significant progress is being made toward the ten targets. The NCCCD will expand quality service delivery initially in the focus LGAs and less intensively in all LGAs of the nine focus states (roughly 30% of the Nigerian population).

With the limitations of resources available for health in Nigeria (public and private), improvements in child health, child survival, and maternal health will require a bottom-up approach with communities increasingly involved in their own preventive and curative care. This will require an increased understanding and commitment on the part of health staff to community communication and mobilization, and a community-directed strategy of education and empowerment.

The proposed strategies are technically sound and are in line with local and technical assistance resources. Issues will be addressed in the following areas during project implementation:

Management:

- Planning, budgeting, and monitoring at LGA
- Establishment of drug revolving funds

Fiscal:

- Line item budgets
- Fiscal accounting systems at State and LGA Levels

Commodities:

- Adequate supplies of potent vaccine
- Cold chain equipment
- Transport

Quality:

- Systems to ensure potent drugs
- Continuing education and supervision at each level
- Monitoring of quality at each level

Community:

- Access to quality services
- Education on risk reduction behavior
- Empowerment that families can improve child health

Monitoring of program implementation will be carried out at each level: community, facility, LGA, State, federal. As part of program planning, each level will develop its own set of indicators. A list of possible indicators is provided on pages E-17 and 18. At the project level, supplemental sampling in implementation LGAs is proposed for the NDHS in 1995 and 1999.

Feasibility

Child Spacing: The importance of family spacing and maternal issues to individual, family, and national health, and the basic program decision to merge major initiatives at the delivery level require that substantial efforts be made to increase family planning information and services availability.

As indicated by the 1990 NDHS, knowledge, demand, first-time use and continued use of modern family planning methods are low. IEC efforts, however, are expected to increase demand over the life of the project, as will steps to incorporate family planning objectives and interventions into PHC. Specifically, NCCCD priorities in training, continuing education, health education and communication and community mobilization will support child spacing initiatives as a part of PHC. With regard to logistic feasibility, FHS, the MHSS and the private sector are working to increase the availability of trained personnel and supplies.

Maternal Care: There are two priorities in maternal care: (a) to assess and upgrade the quality of ante-natal care (ANC); and (b) to expand coverage. In Nigeria, the demand for ante-natal care is relatively high with good acceptability. The elements of ANC - nutrition counseling, TT, malaria chemoprophylaxis (two-dose schedule in 6-12 months), and identification and referral of high risk mothers — are not always well practiced.

Safe-delivery methods are well-known, technically feasible, and of low cost. The major obstacle, however, is the lack of access to, and the quality of, referral services for high risk mothers. Inadequacies in LGA and private hospital obstetric services, although beyond the scope of this project, limit potential achievement of safe motherhood objectives.

Nutrition and Breastfeeding: While there are limitations with respect to the availability of food, adequacy of stocks, and affordability to the consumer, most cases of malnutrition in Nigeria result from poor feeding practices and inadequate treatment of illness, especially in the area of supplemental feeding. Lack of exclusive breastfeeding during the first three months of life and improper weaning were identified by the NDHS and other studies as major constraints. The interventions are technically and logistically feasible. The cost is low, probably less expensive than current practices. Major constraints relate to acceptability of improved practices subject to knowledge, tradition, and motivation on the part of both health workers and mothers. Although micro-nutrient deficiency is increasingly recognized as important to child health, feasibility of micro-nutrient interventions is low because of the lack of knowledge in this problem area.

Inclusion of feeding messages in the treatment of the sick child is an important and frequently overlooked nutritional intervention. As in the area of infant feeding, the strategies are technically and logistically feasible and affordable. Major constraints include: (a) client reluctance, lack of knowledge, and predilection for traditional practices; and, primarily, (b) the failure of health care providers to emphasize the importance of feeding in the care of the sick child.

Immunization: The sustainability of increased immunization coverage will require considerable effort. As to technical feasibility, the EPI strategy works and is targeting potent vaccine to the population at risk; i.e., infants in their first year of life. From the logistics perspective, the current EPI infrastructure is capable of maintaining coverage only in the sixty percent range and then only if vaccine in adequate amounts is supplied from the Federal level, and cold chain equipment is assured by international partners. Achievement of overall EPI targets will require new and improved strategies. In areas where vaccine is available, demand and acceptability are high.

"The Sick Child": Three diseases — fever (presumptive malaria), ARI, and diarrhea — account for a large percentage of post neonatal childhood morbidity and mortality. Over the last five years, vertical treatment strategies have been developed, which provide low-cost, effective strategies of case management (clinical assessment, treatment, and counseling). Increasingly, WHO and its partners are recognizing the overlap in clinical symptomatology and the need for a more holistic approach to the sick child; e.g., ninety percent of pneumonia cases meet the clinical criteria for malaria.

From a technical perspective, current standing orders — chloroquine for fever, ampicillin or cotrimoxazole for pneumonia, and ORT for acute dehydrating diarrheas — will be effective in over eighty percent of cases. Effective use of these therapies, however, requires: (a) recognition of illness on the part of the child caretaker; (b) desire and permission on the part of the decision-maker to seek care; and (c) physical, economic, and cultural access to health care services.

In general, there is a desire for, and a high acceptability of care. The major constraints relate to access and the quality of care, as provided by the various health systems, private and public.

Sustainability

Within the economic, political, and infrastructure realities of Nigeria, a variety of factors are likely to support or undermine the continuity of donor-supported activities and benefits. By definition, contextual factors (contrary to program factors) are generally beyond the control of project administration. In Nigeria, however, these factors are of great significance and are key elements in determining the probability of sustainability. Those found to be the most important in Nigeria are of a political and/or economic nature. Other contextual factors include resource, sociocultural, environmental, and economic issues.

Political Factors: Nigeria is an emerging democracy. The transition from military to civilian government has had an extended period of gestation and has been accompanied by significant geopolitical redefinition. In two years, Nigeria has gone from nineteen to thirty-one states (including the federal capital) and from 360 to 593 LGAs; the latter have been given an unprecedented degree of autonomy and fiscal authority over the federal monetary subventions to their communities. The transition process has been characterized by political instability with frequent changes in local leadership and priorities, which has negatively affected the sustainability of donor programs.

Economic Factors: Health has not done well in the competition for funds. Since 1980, the proportion of the total federal budget allocated to health has shown a downward trend. In the face of increasingly severe financial constraints, the prospects for a near term reversal of this trend are remote. For these reasons, Nigeria's ability to finance health programs is a contextual consideration that weights heavily against the ultimate sustainability of many donor-supported programs.

Program Factors: Program factors are heavily influenced by, or are under, the direct control of the project. Perceived effectiveness and counterpart perception of ownership are the most important program factors; others include: (a) integration and institution-strengthening; (b) local financing, community participation, and private sector provision of services; (c) relative strength of training interventions; and (d) constituency-building through a process of mutually respectful negotiations.

One of the greatest challenges facing the Nigerian health sector is the need to enhance community perceptions of the effectiveness of primary, prevention-oriented health care programs. The PHC program is beginning to gain widespread recognition and support, in part because the CCCD project activities are seen as effective by key policy makers, health administrators, and recipients. This is positively affecting the potential for sustainability.

Perceived Nigerian ownership of ongoing ACSI/CCCD/Nigeria components is clear. Nigerians at the federal, state and local government levels strongly agree that interventions such as EPI, CDD, malaria control, HIS and training are Nigerian-owned. It is locally perceived that ongoing interventions address the established needs of Nigerians, demonstrating a positive affect on the future of NCCCD sustainability. EPI, continuing education, HIS are rated most likely to be sustainable.

The Pre-Project Workshop, held February 1-3, 1993 and attended by Nigerian public and private sector officials from the federal, state, zonal and LGA levels, endorsed the overall project approach and the specific technical interventions as described in the Project Paper. A series of considerations to enhance the sustainability of NCCCD and its activities have been included in the Technical Analysis (Annex E).

B. Administrative Analysis

Public Sector

Three levels of government (federal, state, LGA) provide health care. The federal level is responsible for policy formulation, technical assistance and provision of services in tertiary institutions. States are responsible for secondary care, technical assistance, training for health workers and supervision. The responsibility for PHC implementation has recently been transferred to the LGAs, but LGA effectiveness in this is compromised by frequent rotation of LGA chairmen, insufficient experience of PHC staff and lack of management expertise.

The creation of new states and LGAs has thinned out managerial staff. Both the federal and state levels are responsible for provision of technical assistance, logistics support and supervision to LGA level PHC. The country has been divided into four PHC zones, created to improve coordination between the federal, state and LGAs efforts.

The Primary Health Care Development Agency of Nigeria (PHCDAN) was created as part of a deliberate effort to ensure sustainability of PHC. The PHCDAN will be expected to work through structures similar to those of the PHC department of the MHSS, but it is not yet clear how the Agency will function, and precisely how it will coordinate with the MHSS.

Other "special agencies" within the presidency which are involved in health related matters are DFRRRI (Directorate of Food, Roads & Rural Infrastructures), MAMSER (The Political Education and Mobilization Agency) and Better Life for Rural Dwellers. Collaboration with these agencies and with other sectors such as agriculture, information and the Office of Statistics is provided for in PHC but it is not clear to what extent it has been achieved.

Health has consistently been allocated less than five percent of the total federal budget, however, *extrabudgetary* government funding for PHC has been significant. While this demonstrates the political commitment of the present government to PHC, there are doubts as to its sustainability as a system of PHC funding. About ten percent of state budgets are allocated to health, though most is spent on curative care and secondary health facilities. LGAs allocate an average of ten percent of their budgets to health. Data on government health expenditures on health are often not up-to-date and are aggregated, making analysis difficult. Additional efforts to mobilize resources have included user fees, drug cost recovery schemes (including the Bamako Initiative), planning for national health insurance and community responsibility for disadvantaged families. Data is not available to determine the expenditures by NGOs, private health institutions and households.

While all the three levels of government may generate revenue, the federal government has the bulk of resources. Revenue allocation formulae are used for sharing federally monies. Very roughly, federal funds are allocated in this way: federal (48.5%), states (24%), Local Governments (20%). At all levels a disproportionate amount of funds allocated to health are used for salaries and allowances.

Federal allocations account for sixty to ninety percent of state revenues. States augment this by internally with taxes, licenses, fees, etc. About ten percent of state revenue is allocated to the health sector, shared between the State Ministry of Health (SMOH) and the State Hospitals Management Boards (SHMB). There is some evidence that funding for the state ministries of health is declining. The SMOHs do not appear to have clear criteria for fund allocation to PHC and no costing has been done of the technical and logistic support the SMOHs provide to LGAs.

The federal government may contribute as much as eighty to ninety percent of LGA income, and LGAs spend an average of ten percent of their total budget on health. In any given LGA, the amount may vary depending on commitment of the LGA chairman and of the PHC department head, and on donor presence in the LGAs.

The MHSS has attempted to optimize the utilization of scarce resources; efforts include (a) use of an essential drug list, (b) use of standard treatment protocols, (c) improvement in management procedures, including accountability to the community, (d) use of volunteer village health workers. Government facilities (teaching/specialist hospitals, general hospitals and Local Government PHC Centers) are supposed to use a cost recovery mechanism for drugs called the Revolving Drug Fund (RDF) which aims to ensure the availability of essential drugs. Despite a 100,000 naira start-up grant from the MHSS to every LGA, the success of this fund has varied.

Because of reorganization, there is some uncertainty as to the "organogram" and "chain of command". The federal health management structure was reorganized recently, including the creation of the PHCDAN to handle PHC implementation. The exact roles of the PHCDAN *vis-à-vis* the MHSS is not yet clear, although it is anticipated that the PHCDAN will work more through the four PHC Zones, than from Lagos.

Each state is to have created a unified Primary Health Care Department, but the assumption of PHC responsibility by LGAs and the zonal focus of the PHCDAN have created uncertainty in the states as to their role in PHC. The LGAs are now the implementing level for PHC; guidelines developed by the MHSS for the reorganization of LGA health departments have been distributed. In addition, the creation of new states and LGAs has left some of them relatively resource poor in terms of personnel, material and finances.

An AIDS program has been established, the head of which reports directly to the Minister of Health. The program is understaffed and the capability of the staff varies; few personnel at federal and state levels have managerial training and technical training may not be sufficient. Other constraints are a lack of commitment by LGA chairpersons and lack of transportation. The WHO Global Program on AIDS has three technical staff attached to the program.

Inadequate numbers and quality of managerial personnel hamper supervision and the monitoring and evaluation of the health care system at all levels. At the federal departmental and zonal levels, turnover of staff has been minimal, allowing continuity. Most senior officials have had specialized training and many work in their areas of specialty; most top management staff have had management training. Many departments, however, are understaffed and zones are probably understaffed compared to their expected responsibilities. The MHSS has deployed Federal Technical Facilitators to the zonal headquarters, but their impact has not to be ascertained.

SMOH departments have maintained their senior professional staff over the years, but changes in approach dictated by changing state administrations has affected performance. Lower cadre staff appear to be frequently rotated between departments and rarely stay in positions where they have received specialized training. Departments are often understaffed, and there is a maldistribution of available professional staff between the various departments. LGAs recruit junior staff, but senior staff are recruited for LGAs by the state.

Few PHC Coordinators have had management training. The distribution of staff — in number, qualification and experience — is uneven between LGAs. A general shortage of all categories of staff exists at all levels. Even where there are staff, logistics and transportation constraints make

implementation difficult. Instability in the political administration of LGAs occasioned by frequent splitting of LGAs has resulted in frequent transfer of staff and the spreading of limited staff among more LGAs.

The federal PHC Department coordinates and regulates the training of special cadre of primary health care workers. The Department of Disease Control and International Health oversees training for environmental/occupational health and disease control. The Department of Planning, Research and Statistics plans training for planners, statisticians and researchers. The Department of Hospitals Services and Training oversees training of doctors, nurses/midwives and medical technicians. All training institutions in the country follow national curricula and are regulated by national professional councils/boards.

Though PHC training programs have been carried out, problems exist with respect to: (a) coordination of training programs; (b) quality and appropriateness of training; and (c) utilization of training. Work force needs are not well-defined. While basic training for various categories of manpower is stipulated, career development and working conditions are not clear. State Ministries of Health control and support training in State Schools of Nursing and Midwifery as well as Schools of Health Technology. There does not appear to be any needs assessment guiding the production of professionals from these institutions. Some states over-produce pre-service trained personnel, and graduates cannot find jobs.

LGAs have no training institutions, but some have organized staff re-orientation. Federal Technical Facilitators and consultants from the federal level and donor agencies have provided support for LGA level training programs.

The MHSS is the focal point for donor assistance in the health sector. Some donors have been allocated specific states and LGAs to carry out their activities, reducing duplication of activities. Major constraints to supervision are too few supervisors and lack of transportation. Much reliance has been placed on donor agencies such as CCCD and UNICEF for the provision of vehicles; even then, transportation remains a problem in some LGAs due to inefficient maintenance and vehicle use procedures. Another method of monitoring PHC activities involves receipt of reports from LGA committee meetings.

The PHC Monitoring and Evaluation system (PHC Department) and the National Health Information Center (Department of Planning, Research and Statistics) are involved in monitoring PHC. The 1991 National Census results have been published and will improve the accuracy of certain health status indicators. At all levels the system has been constrained by shortage of forms, inadequate training of staff who need to fill the forms, transportation, and lack of motivation on the part of the health workers. ACSI/CCCD has played a significant role in the development of the National Health Information System by providing training and materials, and developing appropriate software.

Coordination of donor agencies by both federal, state and LGAs has not been effective. Government and donor consultation at project identification, planning and implementation phases has been weak. In 1988, the MHSS started to hold meetings with all donors in the health sector to improve coordination, meetings which are to be revived now under AAO stimulation. The government has not been able to completely utilize the funds made available by the donors for project implementation. MHSS is now encouraging direct LGA contact to minimize bottle-necks. Decision-making at the federal and state levels is highly centralized. Few people are involved; they are generally overworked and not available for donor consultations.

Private Sector

The number of physicians, nurses, midwives, and pharmacists practicing in the private sector is not available, and estimates vary considerably. One estimate is 6,000 physicians, 3,500 pharmacists, and 10,000 nurses. Still, it appears that the private health sector in Nigeria is large, growing, diverse, energetic and urban-based.

For this discussion, the private sector includes: (a) profit-making providers of health and family planning goods and services (groups and individuals, modern and traditional); (b) profit-making manufacturers, distributors, and vendors of health and family planning products; and (c) nonprofit providers of health and family planning goods and services (NGOs and PVOs).

These care-givers in Nigeria provide, primarily, curative services in return for fees. Primary and preventive services are offered in significant magnitude by nonprofit providers, especially in rural areas. Although the private sector provides some amount of family planning and primary health care services in Nigeria, the activities are not orchestrated nor are they monitored or documented by or for public sector health officials.

AAO/Nigeria Experience with the Private Sector

The FHS Project has worked with Sterling Winthrop Limited of Nigeria, a private sector pharmaceutical firm, to market the "Right Time" condom. Members of the National Association of Nigerian Nurses and Midwives (NANNM) have received the family planning training and supplies. The Planned Parenthood Federation of Nigeria (PPFN), the Christian Health Association of Nigeria (CHAN) and Africare, three nonprofit organizations, have promoted and/or provided family planning products and services.

The private sector has been minimally involved in AAO/Nigeria's activities in child survival.

Both public sector officials and private sector providers hope that the private sector play a more active role in the provision of primary and preventive health care. Private providers are now more willing to explore prospects for cooperation with each other and the government, and are interested in predominantly urban areas.

The private sector has an important role to play in the AAO/Nigeria projects, but, unlike the public sector, the private sector is difficult to access and involve in public health activities. In general, the private sector, especially profit-making providers, are suspicious of public sector officials and reluctant to provide services that do not generate profits. In addition, nonprofit providers, especially groups with religious affiliations, are reluctant to cooperate with each other.

Managers of the FHS-II and NCCCD Projects will need to give focused attention to the private sector to: (a) overcome suspicions of the government and each other; (b) secure their effective participation in primary and preventive health care services; and (c) measure the impact of their programs on the health of the communities served.

The new projects supported by AAO/Nigeria need to develop and implement strategies for: (a) encouraging sustained participation of the private sector; and (b) documenting the impact of services provided by the private sector.

C. Social Soundness Analysis

The largest country in sub-Sahel Africa, Nigeria has over ninety million people whose expectations rose during the oil boom years and who are now suffering a recession exacerbated by severe monetary devaluation and overpopulation. With an estimated 2.7 percent population growth rate, the population is expected to double in about twenty-six years.

Project benefits will reach the target population, women of childbearing age and their children, largely through the newly created Primary Health Care Development Agency of Nigeria (PHCDAN), supplemented by the secondary and tertiary levels of public sector delivery, by private sector profit-making and missionary services as well as by other NGO activities.

The perspective of the direct beneficiary population is reflected in the project design. Implementation and evaluation plans are oriented to beneficiary participation in the implementation process. Operations research, KAP studies and a variety of IEC activities will emphasize the role of local institutions and individuals as project participators and moderators of sociocultural considerations.

The population is heterogeneous with respect to the degree of modernization as well as ethnicity and religion. Seventy-five percent of the people live in rural communities with less than 20,000 people. The southern states have had a longer and more intensive exposure to education and modern economic forces. Twenty-eight tertiary educational institutions produce a substantial educated elite. The school systems educate three million secondary school and twelve million primary school students. The 250 ethnic groups include three major and seven additional, large groups with distinct value systems and concepts of appropriate behavior for men and women.

The traditional worldview continues to influence values and behaviors, even though about half the population (including virtually all in the Far North) is Muslim and the other half, Christian. Individuals operate according to overlapping and ostensibly conflicting ethnic, religious and modern beliefs and value systems. Traditional healers provide a significant proportion of the health care. Education increases understanding and faith in the Western scientific-based worldview and increases knowledge of specific illnesses and treatment, thereby augmenting the proportion of diseases considered to be physically-based.

To a great extent, NCCCD strategy demands: (a) personal and societal reevaluation of core values and self-image, including changes in private behaviors; (b) faith in the microbe theory of illness; (c) deviation from existing moral authority; (d) belief in the ability to control nature with scientific rather than occult powers; and (e) rejection of a pro-natalist and fatalist worldview.

Significant ethnic variations in terms of beliefs and practices are evident from the few health education needs assessments undertaken. While many problems arising from partial absorption of messages, conflicting traditional beliefs, and non-recognition of symptoms cut across ethnic groups; common problems need confirmation, and problems unique to ethnic groups need identification through focused ethnographic surveys, including focus group discussions and in-depth interviews.

Consensus decision-making facilitates compliance with the new behaviors. Consensus legitimizes behavioral change and absolves individuals of culturally discomfiting, personal responsibility for innovation. Trusted influentials are empowered by their reference groups to foster consensus. However, their support must first be enlisted through time consuming preliminaries which include the assistance of intermediaries and representational gifts as well as the provision of relevant health

information. Imposition of communally determined sanctions to ensure compliance is another traditional practice adapted to modern health practices in some communities. In such cases, mothers are fined for noncompliance with the immunization schedule or with other communally approved, health practices.

The administrative environment at all levels inhibits dissemination of health education and service delivery. Elected officials are often more responsive to the federal government offices which supply their recurrent and capital funds than to their constituents, who only pay minimal taxes. Changes in the structure of government (new states and LGAs; new appointments and/or elected officials) and in health care personnel assignments disrupt health care delivery. Undersupply of essential drugs, diversion of supervision and commodity vehicles, de facto reduction of hours of service coupled with impolite treatment of clients undermine client compliance. Reluctance to achieve goals at the expense of interpersonal relations contributes to delays in achieving specific targets.

The status of women affects their capacity to care for their children and themselves. Although a small group of educated women have risen to positions of power and influence and many are benefiting from educational opportunities, especially in the South, women are second-class citizens discriminated against by customary rulings with respect to divorce, inheritance and child custody, and by the failure to protect girls against child marriage and pregnancy, a traditional condition which continues to prevail in the Muslim Far North. The husband has the prerogative to make health care decisions regarding his family even though the woman carries them out. Poor women have become responsible for increasing proportions of subsistence income as husbands' incomes lose purchasing power. Parents are forced to weigh the perceived efficacy of a new health behavior and its economic and opportunity costs against competing priorities.

Maternal health is complicated by poor obstetrical care, insufficient access to trained traditional birth attendants and a variety of sociocultural constraints. More than half of the northern women and 16% of the southern women deliver without assistance and are, therefore, at greater risk of dying due to pregnancy and delivery complications. Harmful traditional practices integral to the socialization process for young girls continue to undermine prospects for maternal/child health. Three types of genital mutilation are practiced with at least one type being practiced in virtually all the states. In addition, a deep episiotomy (*gishiri*), postpartum boiling bath and uvulectomy for infants of both sexes are practiced in the Muslim North.

The media have contributed to social mobilization and have the potential for promoting specific behavioral changes through well-researched health communication campaigns. More effective health education directed at captive audiences in schools and in adult literacy programs is essential for intervention sustainability. School children are caretakers for their siblings and, by the end of the project, will be the adult beneficiaries.

Project impact will equate with the degree to which the project stimulates behavioral change among beneficiaries and participants at present inhibited by varying degrees of beneficiary ignorance and conflicting beliefs and priorities as well as by service provision inadequacies. The project will not, however, assure equitable distribution of benefits across the entire country. Instead the project will focus on Enugu and Anambra States in the Southeast; Oyo and Osun States in the Southwest; Plateau State in the Middle Belt; and, Sokoto, Kebbi and Niger States in the Northwest. Replication will be: (a) dependant upon institutionalization of in-country technical assistance coupled with the sensitive use of findings from focused ethnographic studies; and (b) significantly enhanced by an effective in-school health education curriculum.

Concentration of project resources on the development of service delivery without appropriate regard to the sociocultural factors impinging upon target population willingness to adopt new behaviors will severely limit project impact in the long run. The initiation of appropriate sociocultural and operations research studies is needed at project commencement. The results of these studies need to be transformed into specific plans oriented to the sociocultural realities of Nigeria.

D. Economic and Financial Analyses

Economic Analysis

The three components of the AAO/Nigeria HPN Program mandated by the Nigeria CPSP, including NCCCD, FHS-II, and AIDS Prevention and Control, have sound economic justification, both in the short-term (expansion of service delivery) and in long-term (institution and capacity building). The AAO program supports health interventions generally accepted as being cost-effective and worthwhile investments for both Nigeria and A.I.D. The outputs from the program are sufficiently valuable to warrant the expenditure of scarce resources.

Over the CPSP period (1993-2000), four key factors will likely affect the cost-effectiveness of the AAO/Nigeria HPN program and should be monitored regularly.

First, the value of the naira has fallen, substantially, since 1986. It is expected that the naira will continue to devalue; however, exact trends are difficult to predict. This will reduce the cost-effectiveness of those program components that are heavily dependent on foreign inputs.

Second, Nigeria's economy in 1991 was marked by rising inflation stemming from a large government deficit financed by the Central Bank. Consumer prices rose 23% for the year, compared with 3.6% in 1990. It is difficult to predict future trends in inflation, especially with the transition in government. In the presence of inflation, the real costs of inputs with fixed nominal incomes fall. Economic incentives will tend to increase use of these lower cost inputs; however, safeguards must be taken to ensure that technically efficient (e.g., managerially and medically appropriate) combinations of inputs are used to preserve the quality of health services.

Third, if the SAP is maintained, efforts to reduce government budget deficits will continue. This heightens the need to use cost-effective interventions at a scale of activity affordable to the nation. Ensuring adequate public budget allocations for those aspects of PHC characterized by public and/or merit goods with substantial externalities is a justifiable objective. The financial analysis examines those concerns in further detail.

Fourth, without appropriate attention to quality of care, the assumed cost-effectiveness of the interventions promoted by the AAO HPN program may be threatened.

According to the 1990 Nigeria Demographic Health Survey (NDHS), large regional differences in health status, total fertility rates, and contraceptive prevalence exist across the country. The benefits of AAO/Nigeria programs have yet to reach important segments of the population. For distributional reasons, future NCCCD and FHS-II interventions should attempt to target a broader swath of population subgroups. This may tend to decrease the cost-effectiveness of some of the interventions, because these populations are typically harder to reach; but on equity grounds, effort in that regard is merited to the extent project resources allow.

Financial Analysis

Programs that are cost-effective are not necessarily affordable. In choosing the appropriateness of health interventions, cost-effectiveness information must be used in combination with public and private budget targets to determine a financially viable scale of activity. Because multiple components of the AAO program reach across federal, state and local governments, and the private sector; assessment of financial viability against a straightforward budget target is not feasible. However, it is possible to: (a) identify critical factors, which may threaten the financial sustainability of the program; and (b) establish project implementation guidelines to alleviate related concerns.

Factors Affecting Financial Sustainability

The following issues are factors, which may inhibit financial sustainability of the program.

Federal Level

Federal budget allocations to the health sector are small, both as a proportion (<3%) and in absolute terms (44% of 1981 expenditures in real terms).

Federal budget allocations to personnel are high, threatening efficient combinations with non-personnel recurrent costs, which represented only 13% of the 1991 recurrent budget.

Increased percentages of the regular MHSS budget need to focus on PHC-related activities (1991:20%) and AIDS Prevention and Control.

State Level

Real resources devoted to health services have declined rapidly on a per capita basis since 1985.

Personnel costs account for 80% of state recurrent spending.

Although the states remain responsible for supervision, support and training of PHC activities in LGAs, evidence suggests that states are not allocating, at present, sufficient amounts to handle their PHC responsibilities.

States also appear deficient in their capacity for monitoring levels and patterns of state spending.

LGA Level

An increasing proportion of LGA revenues is coming from federal and state funding support (increasing from 71% in 1980 to 88% in 1991) and federal statutory allocations (5% before 1987; 10% during 1987/89; 20% in 1992).

LGA health budgets are heavily skewed to personnel costs (72%-79%).

Although, on average, health-related activities account for 20%-25% of total LGA recurrent budgets and the proportions dedicated to health appear to be increasing, there is no clear delineation of resources required for PHC.

Financial information and management systems for LGA health sector activities are grossly lacking.

Counterpart Contributions

With the exception of MHSS purchases of vaccines (99%), a majority of counterpart contributions at the state and LGA level for ACSI/CCCD have been made in terms of existing personnel, land and buildings and facilities (state: 82%, LGA: 73%). Lack of counterpart contributions to support non-personnel recurrent expenditures (for such items as operations, maintenance, vehicles, and equipment) may threaten the sustainability of program benefits.

The Primary Health Care Support Program has provided useful learning experience for obtaining substantive counterpart funding. First, the timing of counterpart contributions should be carefully integrated with realistic estimates of the time frames for completion of corresponding program activities or conditionalities. Second, there is a critical need to establish mutually agreeable detailed procedures for monitoring counterpart funds, in terms of planned allocations, actual disbursements, and actual spending. Third, management of donor coordination within the MHSS should take high priority, be fundamentally strengthened, and aggressively implemented to avoid missed opportunities.

The Private Sector

The current ACSI/CCCD project has given limited attention to the potential involvement of the private sector. In light of limited public budgets for health, without increased reliance on private service provision and the financing of CCCD-related activities, financial sustainability may be threatened.

In light of limited MHSS support for population activities and in the absence of effective involvement on the part of the private sector, the financial sustainability of family planning interventions is unlikely.

NGOs have already been active in AIDS Prevention and Control. However, they require substantial support in terms of: (a) technical and management training; and (b) development of strategies and work plans. Advocacy for AIDS programs is required at all levels of government.

Cost-Recovery Initiatives

Although full cost-recovery (of total recurrent costs) is, generally, not a feasible goal for PHC-related activities over the next seven years for many communities, the potential of cost-recovery for sustaining critical elements of PHC has yet to be adequately explored. Most initiatives are still unable to cover even non-personnel recurrent costs.

Cost-recovery mechanisms tend to be weak in financial information systems, financial management, transparent accounting tools, and strategies for the allocation of revenues.

Guidelines for Addressing Factors Affecting Financial Sustainability

The guidelines for addressing the factors affecting financial sustainability focus on: (a) increasing the role of national resources in PHC-related activities; and (b) adjusting the public-private sector mix of resources with respect to provision and financing of health services as a means for promoting efficiency and equity.

Federal Level

Within the context of the AAO/Nigeria HPN program, increased allocations of the MHSS budget for primary health care, population activities, and AIDS Prevention and Control might be increased, primarily, through the imposition of additional counterpart funding requirements. Throughout program implementation, AAO will continually reassess the feasibility of increased counterpart funding in direct support of each component of the program.

State Level

All components of the program need to work with the SMOHs in Focus States with a view to the institutionalization of financial information systems and the strengthening of financial management skills to ensure that adequate amounts are allocated in state budgets to fund state responsibilities for PHC including supervision, support and training at the LGA level. Not only should this financial management system identify the flow of funds to PHC over time, but it should link outputs/outcomes with resource costs as a means for monitoring efficiency and appropriateness of quality health services.

LGA Level

All components of the program need to work with the LGA Health Departments of Focus LGAs with a view to the institutionalization of financial information systems and the strengthening of financial management skills to ensure that adequate amounts are being allocated in LGA budgets to fund LGA implementation of PHC. Not only should this financial management system identify the flow of funds to PHC over time, but it should link outputs/outcomes with resource costs as a means for monitoring efficiency and appropriateness of quality health services.

Counterpart Contributions at all Levels

Federal, state and LGA governments need to support increasing, but feasible, proportions of total project costs with counterpart contributions (cash and in kind) to support all components of the AAO HPN program. Policy dialogue with counterpart entities should consider the solicitation of letters of commitment for counterpart contributions from each level of government.

Although personnel and facilities will continue to be important contributions from all three levels of government, increased commitment on the part of counterpart jurisdictions to meet non-personnel recurrent costs is a critical concern, especially at state and LGA levels. HCC in this regard will be a subject of discussion and negotiation at all stages of preimplementation and implementation planning. Non-personnel counterpart contributions will include allocations for the purchase of expendable commodities and supplies; and direct support for operations and maintenance of vehicles and equipment. Careful consideration of changing foreign exchange rates is required to ensure that minimal real levels of these items are funded within the financial means of governments.

The timing of counterpart contributions will be integrated with realistic estimates of funding availability and reasonable time frames for completion of program activities. HCC will be integrated as much as possible into rolling plans and periodic budget planning exercises.

Detailed and mutually agreeable procedures for monitoring counterpart funds, in terms of planned allocations, actual disbursements, and actual spending must be established. The maintenance of separate accounts for A.I.D. and counterpart funds is indicated.

The management processes of the federal, state and LGA governments related to obtaining and documenting counterpart funds, including legal and administrative requirements, need to be strengthened.

Implementation of donor coordination procedures is crucial to the maximization of program impact.

The Public and Private Sector Mix

Orientation of NCCCD to the encouragement of private sector involvement in both the provision and financing of health care, including the development of an effective mix of public and private sector participation, is a priority concern. Guidelines in this regard focus on the following considerations.

Public Sector Concentration: Public Resources and Public Provision

The focus of public resources concentrated on those services and activities characterized by the presence of major externalities, merit goods, public goods, and the presence of substantial impediments to market functioning. Broader public support may be required for targeted populations at high risk and/or unable to pay for services.

Privatization of Service Provision: Public Sector Resources and Private Provision

Emphasis placed on: (a) engaging selected private providers and organizations committed to the delivery of PHC services related to NCCCD activities, with a view to strengthening their capability to deliver said services; and (b) contracting for private sector support services. Encouragement of public support to nonprofit organizations that focus on high risk populations and the very poor.

Privatization of Financing (The Bamako Initiative): Private Sector Resources and Public Provision

Strongly endorsed by the MHSS, the Bamako Initiative (BI) is intended to provide overall financial support for PHC/MCH. BI provides an appropriate environment for NCCCD contribution to cost-recovery efforts, particularly with respect to the provision of technical assistance to LGAs for BI start-up activities emphasizing the development of financial information systems and financial management skills for LGAs and communities.

Full Privatization: Private Sector Resources and Private Provision

In general, this group will concentrate, necessarily, on curative care for that segment of society willing to pay for such services; this will reduce the burden of curative care on the public sector. The commercial element of the private sector can not be expected to make substantial profits on preventive care; nevertheless, dialogue with private provider organizations to encourage the delivery of EPI, ARI, CDD, malaria treatment, and family planning at adequate levels of quality is indicated.

E. Environmental Analysis

An Initial Environmental Examination (IEE), prepared for the submission of the Project Identification Document (PID), was approved by the Africa Bureau Environmental Officer on May 7, 1992, and cleared by GC/Africa on June 12, 1992.

The IEE recommended categorical exclusion for technical assistance; training; document and information transfer; studies and research; policy reform; and commodities and equipment, including procurement of office equipment and furniture, passenger vehicles, audiovisuals, pharmaceuticals, medical supplies, and clinical equipment and supplies.

A negative determination was recommended for commodities and equipment, including procurement of refrigerators/freezers and pesticides. The refrigerators/freezers are potential requirements in support of cold chain operations for immunization interventions. The pesticides are integral to an experimental bednet program for the prevention of malaria. Depending upon the outcome of said research, consideration will be given to the broader use of pesticide-impregnated bednets, particularly, as part of a private sector distribution initiative.

The approved IEE included an annex, which discussed in detail the identification and evaluation of environmental impact pertaining to the bed net program.

Project Paper (PP) design has not engendered any further considerations with respect to environmental impact. An updated IEE is amended to the PP for the approval of the Africa Bureau Environmental Officer and CG/Africa for the sole reason that the PP proposes increased funding over the level suggested in the PID (i.e., \$40 million in lieu of \$20 million) and a longer project duration (i.e., seven years instead of five).

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United States

Agency for International Development

**Nigeria Combatting Childhood Communicable Diseases
(NCCCD)**

**Project Paper
620-0004**

ANNEXES

July 1993

UNCLASSIFIED

RESPONSE TO PID REVIEW ISSUES AND ECPR GUIDANCE CABLE¹

Issues pertaining to the organization, structure, and function of the AAO/Nigeria program management capability, in general, and NCCCD project management, specifically, were key elements of concern during project design. Various scenarios and configurations were considered. The design effort included research and deliberations on the part of a special management review team made up of a professional management consultant, a retired A.I.D. Mission Director, and a R&D/Health representative, working in close collaboration with the A.I.D. Affairs Officer, the Program Officer, and the Project Development Officer (consultant).

The anticipated assignment of a direct-hire HPN Officer as NCCCD Project Manager and the creation of a Health Sector Program Coordinating Committee² supported by a Quality Assurance Advisor (contract) responds to ECPR concerns with respect to overall AAO/Nigeria program management capability and functioning methodology.

Issues pertaining specifically to NCCCD project management concerns and the role of CDC were resolved through adoption of several key design considerations; i.e.,

- A CDC Public Health Specialist will serve as Project Coordinator under the direct responsibility of the HPN Officer/Project Manager, supported by Quality Assurance Advisor assisting the HPN Officer coordinate actions of all elements of the AAO/Nigeria HPN program.
- The CDC Project Coordinator, serving as a technical assistance advisor to the host country, will be located in close physical proximity to his/her Nigerian counterparts.
- The Quality Assurance Advisor, responsible for the identification and acquisition of non-CDC technical resources required for NCCCD implementation, will facilitate project management on the part of the HPN Officer, including coordination of NCCCD initiatives with overall program management concerns.
- Significant utilization of non-CDC technical resources will assure fulfillment of project requirements beyond the predominant capabilities of CDC.

¹ STATE 191928, dated 17 June, 1992, copy attached hereto.

² Chairperson, HPN Officer; Executive Secretary, Quality Assurance Advisor; general members: NCCCD Coordinator, FHS-II Coordinator, AIDSCAP Country Representative, and Administrative Support Unit (PAF) Manager; counterpart members: appropriate representatives from the public and private sectors.

The organizational structure for project management and the functions of the various team members are described in Section II.H. (Management and Administration).

Technical assistance requirements and inputs are described in Section II.D. (Technical Assistance Inputs). The rationale for CDC involvement is addressed in the subsection pertaining to the role of CDC. The field control of technical assistance inputs is discussed in Section II.H. (Management and Administration), Subsection "NCCCD Project Management".

Project management and implementation relationships with public sector institutions are described in: (a) Section II.A. (Implementation in the Public Sector); (b) Section I.B.3. (Project Elements); and (c) Section II.H. (Management and Administration).

The interaction of NCCCD with other AAO/Nigeria program elements is addressed in Section I.A.3. "Relationship to Other USAID Projects".

Issues pertaining to the current policy environment are discussed in Section I.A.2. "Policy Environment and Dialogue".

Issues pertaining to the decentralization of public sector service delivery are discussed in Section I.B.3.1. (Strategies to Strengthen Infrastructure in Support of Technical Interventions), Subsection "Management of Health Resources at the Local Level"; and Section II.A. (Implementation in the Public Sector).

Quality of care issues are discussed in Section I.B.3.1. (Strategies to Strengthen Infrastructure in Support of Technical Interventions), Subsection "Quality Assurance (QA) Standards".

Discussion of other donor activity is found in Section II.C. (NCCCD Relationship with UNICEF) and Section I.A.4. "Relationship to Other Donor Programs". Detailed discussion of contemporary other donor activities in Nigeria related to the health and population field can, also, be found in Section III.C. and Annex C of the Nigeria CPSP. Coordination of donor activity is the subject of specific covenants to that effect as indicated in Chapter V (Conditions Precedent and Covenants). Coordination of donor activity is an item on the bilateral dialogue agenda detailed in Annex Q, "Precepts for Project Success."

The surmounting of health information constraints is the subject of Section I.B.3.1. (Strategies to Strengthen Infrastructure in Support of Technical Interventions), Subsection "Health Information Systems" and Chapter IV (Monitoring and Evaluation

Plan).

The fostering of private sector involvement in health service delivery is the subject of Section II.B. (Implementation in the Private Sector) and Annex I (Private Sector Strategy).

The quantification and monitoring of host country contributions (HCC) is addressed in Section III.G. (Host Country Contribution) and Section III.D. (Financial Management).

Discussion of sustainability and cost-recovery issues is the subject of: (a) Section IA5, "PHC Recurrent Costs and Cost Recovery"; (b) Section IV of Annex E (Technical Analysis); and (c) Sections IV, V, and VI of Annex H (Economic and Financial Analyses). Discussion pertaining to private sector sustainability is contained in Annex I (Private Sector Strategy). Sustainability and cost-recovery are the subjects for continuing bilateral dialogue as indicated in Annex Q, "Precepts for Project Success."

Chapter IV (Monitoring & Evaluation Plan) presents a detailed discussion on the subject of outcome and output measurements and the indicators therefor.

Section II.F. (Procurement Plan) provides details pertaining to anticipated offshore procurement of technical assistance, participant training, and commodities; and local procurement of goods and services under Local Costs.

REDSO/WCA monitored the progress of Project Paper development and participated in the review process of the final version.

The following table summarizes location of response to each point of interest raised in the ECPR review cable (92 State 191928).

RESPONSE TO ECPR PID REVIEW CABLE	
ISSUES	RESPONSE REFERENCE
Project Management/Team Functions	PP Sec. II.H.
Technical Assistance Requirements/Inputs	PP Sec. II.D.
Project Management Relationships w/Public Sector Institutions	PP Sec.'s II.A., I.B.3., II.H.
NCCCD Interaction w/Other AAO/N Program Elements	PP Sec. I.A.3.
Policy Environment	PP Sec. I.A.2.

Decentralization of Public Sector Service Delivery	PP Sec's I.B.3.1., II.A.
Quality of Care	PP Sec.I.B.3.1.
Other Donor Activity	PP Sec. II.C., Sec. I.A.4., and PP Chpt. V. Also, Nigeria CPSP, Sec. III.C., Annexes C and Q.
Health Information Constraints	PP Sec. I.B.3.1. & PP Chpt. IV.
Private Sector Delivery	PP Sec. II.B. & Annex I
Host Country Contribution	PP Sec.'s III.G. & III.D.
Sustainability and Cost-Recovery	PP Sec. I.A.5.; Sec. IV, Annex E; Sec.'s IV, V, VI, Annex H; Annex Q; and Annex I.
Outcome/Output Measurements & Indicators	PP Chpt IV.
Procurement Plan	PP Sec. II.F.

ACTION: AID-3 INFO: AMB DCM/ECON (5)

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SUBJECT: NIGERIA COMBATting COMMUNICABLE CHILDHOOD
 DISEASES (628-0004) PID - ECPR GUIDANCE CABLE

1. SUMMARY. THE EXECUTIVE COMMITTEE FOR PROJECT REVIEW (ECPR), CHAIPED BY DIRECTOR, AFR/CCWA, MYRON GOLDEN, MET ON MAY 1, 1992. REPRESENTATIVES FROM AFR/CCWA, USAID/NIGERIA, AFR/DP, RD/H, RD/POP, AFR/ARTS/EHR, AFR/ONI/TPPI, AND GC/APR PARTICIPATED. THE ECPR ADDRESSED THREE ISSUES THAT HAD NOT BEEN RESOLVED AT THE PROJECT COMMITTEE (PC) ISSUES MEETING, HELD ON APRIL 24, 1992. USAID IS AUTHORIZED TO PROCEED WITH DEVELOPMENT OF THE PROJECT PAPER (PP) DRAWING ON GUIDANCE PROVIDED BELOW. APPROVAL AND AUTHORIZATION OF THE PP WILL TAKE PLACE IN AID/W. END SUMMARY.

2. ISSUE ONE CONCERNED THE ORGANIZATION, STRUCTURE AND FUNCTION OF THE PROJECT MANAGEMENT UNIT (PMU) AND WHETHER IT WOULD BE ADEQUATE FOR SUPERVISING AND COORDINATING THE VARIOUS COMPONENTS OF THE CCCD PROJECT WITH THOSE OF THE FAMILY HEALTH SERVICES II/POPULATION AND HIV/AIDS PROJECTS. MOST IMPORTANTLY, IT WAS ASKED, WHY DOESN'T THE MISSION HAVE ONE PMU MANAGE THE ENTIRE PORTFOLIO? A RELATED ISSUE QUESTIONED THE CAPACITY OF THE U.S. CENTERS

FOR DISEASE CONTROL (CDC) TO ADMINISTER THE PMU.

ISSUE ONE DISCUSSION: THE PROJECT PROPOSES TO INTERVENE IN THE NIGERIA HEALTH CARE SYSTEM WITH THE AIM TO STRENGTHEN THE CAPACITY OF PUBLIC AND PRIVATE SECTORS TO PROVIDE QUALITY MATERNAL AND CHILD HEALTH CARE SERVICES AT THE FEDERAL, STATE AND LOCAL LEVELS. THE PROJECT IS TO BE MANAGED BY A PMU. IT WAS UNCLEAR TO THE FC, FROM A MANAGEMENT PERSPECTIVE, WHY THERE SHOULD BE SEPARATE PMUS FOR THIS PROJECT AND FOR THE LARGER FAMILY HEALTH SERVICES II, BOTH OF WHICH ADDRESS HEALTH CARE ISSUES. THE PC WAS CONCERNED THAT THIS ARRANGEMENT WOULD PLACE AN EXCESSIVE BURDEN ON THE MISSION'S LIMITED USDS STAFF AS WELL AS DUPLICATE COSTS.

MISSION REPRESENTATIVES POINTED OUT THAT THE IDEA OF USING ONE PMU WAS RECOMMENDED BY THE RECENT HEALTH SECTOR

ASSESSMENT. HOWEVER, AFTER EXTENSIVE DELIBERATION, BOTH THE MISSION AND THE COM AGREED IT WOULD BE MORE DIFFICULT TO MANAGE THESE TWO RELATED BUT DIVERSE ACTIVITIES WITH ONE PMU BECAUSE THERE ARE DISTINCT UNITS AND DIVISIONS DEALING WITH FAMILY PLANNING AND CHILD SURVIVAL ACTIVITIES WITHIN THE COM HEALTH INSTITUTIONS, ESTABLISHING TWO SEPARATE PMU'S WOULD BE CONSISTENT AND REASONABLE. WITH THE MISSION SERVING AS THE FOCAL POINT FOR BOTH PROJECTS THE TWO PMU'S WOULD COMPLEMENT/SUPPLEMENT EACH OTHER WHERE NECESSARY AND AS APPROPRIATE.

THE PC ALSO RAISED CONCERNS AT THE ECFR ABOUT THE PROJECT BEING PRIMARILY IMPLEMENTED THROUGH A PARTICIPATING AGENCY SERVICES AGREEMENT (PASA) WITH THE CDC. THE CCCD-PROJECT FOCUSES ON SYSTEMS-STRENGTHENING DIRECTED TOWARD IMPROVING THE MANAGEMENT CAPABILITIES OF THE FEDERAL, STATE AND LOCAL HEALTH INSTITUTIONS. THE PROJECT REQUIRES SOME TECHNICAL SKILLS THAT MAY BE BEYOND CDC'S CAPACITY IN TERMS OF OVERALL PROJECT MANAGEMENT. IN ADDITION, CONCERN WAS EXPRESSED ABOUT CDC HAVING DUAL ROLES AS AN IMPLEMENTING AND ADMINISTRATIVE BODY.

ISSUE ONE RECOMMENDATION:

(A) THE ECFR RECOMMENDED THAT THE ISSUE OF ONE VERSUS TWO PMU'S SHOULD BE RECONSIDERED PRIOR TO FINALIZING THE PROJECT DESIGN. MISSION MAY WISH TO INCLUDE AN ORGANIZATION MANAGEMENT SPECIALIST WHO COULD EXAMINE ALTERNATIVE PROJECT MANAGEMENT OPTIONS INCLUDING JOINT AS WELL AS SEPARATE PMU'S FOR THE FHS II AND CCCD PROJECTS AND SUBCONTRACTING OPTIONS. THE RATIONALE FOR USING ONE SCENARIO OR THE OTHER SHOULD INCLUDE CONTRACTOR ACCOUNTABILITY AND MANAGEABILITY CONCERNS, GIVEN THE

MISSION'S LIMITED DIRECT HIRE STAFF. COST DUPLICATION SHOULD BE AVOIDED.

(B) IF THE MISSION BELIEVES THAT CDC HAS UNIQUE CAPABILITIES TO IMPLEMENT MAJOR PORTIONS OF NIGERIA CCCD, THE PP MUST MAKE A STRONG CASE. THE PP MUST LAY OUT THE TECHNICAL AND ADMINISTRATIVE REQUIREMENTS OF THE PROJECT. THE CAPABILITIES OF THE CDC MUST THEY BE MATCHED UP WITH THESE REQUIREMENTS. THE MISSION IS ENCOURAGED TO EXPLORE ADDITIONAL AVENUES FOR PROJECT MANAGEMENT AND TECHNICAL ASSISTANCE, AS WELL.

3. ISSUE TWO: THE PC QUESTIONED HOW WELL USAID COULD MANAGE ITS PORTFOLIO OF LARGE HEALTH, POPULATION, AND NUTRITION (HPN) PROJECTS WITHOUT THE PRESENCE OF A U.S. DIRECT-HIRE (DH) HPN OFFICER ON STAFF AT THE MISSION. IT

WAS FURTHER DEBATED WHETHER OR NOT THE ADDITION OF A DR HPN OFFICER SHOULD BE MADE A CONDITION FOR APPROVAL AND AUTHORIZATION OF THE CCCD PROJECT.

ISSUE TWO DISCUSSION: THE A.I.D. AFFAIRS OFFICE IN NIGERIA IS PRESENTLY STAFFED BY THREE U.S. DIRECT HIRES: THE AAO, A PROGRAM OFFICER AND A CONTROLLER. THE MISSION HAS SEVERAL MAJOR PROJECT AND NONPROJECT (NPA) ACTIVITIES INCLUDING NIGERIA CCCD, FAMILY HEALTH SERVICES II, AIDS AWARENESS AND PREVENTION, AND ITS ONGOING PRIMARY HEALTH CARE SUPPORT PROGRAM. GIVEN THE SINGLE SECTOR FOCUS OF USAID'S PORTFOLIO, THE PC WAS TROUBLED BY THE LACK OF A DIRECT HIRE HPN OFFICER AT THE MISSION TO PROVIDE TECHNICAL SUPERVISION AND OVERSIGHT OF PROJECT IMPLEMENTATION. THE PC WAS FURTHER CONCERNED THAT WITHOUT AN HPN OFFICER, ROUTINE REQUIREMENTS OF PROJECT MANAGEMENT WILL DISPLACE BROADER ANALYTICAL AND REPRESENTATIONAL TASKS BY THE AAO AND PROGRAM OFFICER.

THE MISSION REPRESENTATIVE TOOK STRONG ISSUE WITH THE ADDITION OF A DR HPN OFFICER BEING MADE A CONDITION OF PROJECT APPROVAL AND AUTHORIZATION. HE MADE IT CLEAR THAT IT HAS LONG BEEN THE MISSION'S DESIRE TO HAVE A DIRECT-HIRE HPN OFFICER, THAT THIS POSITION HAS BEEN APPROVED BY AFR, BUT THAT COMPETING PRIORITIES FOR OFFICIAL USDE PRESENCE AT THE POST HAVE SO FAR PRECLUDED APPROVAL OF ADDITIONAL STAFF. UNTIL THOSE PRIORITIES ARE MODIFIED, THE AAO FELT THAT ADEQUATE PROJECT OVERSIGHT COULD BE OBTAINED THROUGH A PERSONAL SERVICES CONTRACT.

ISSUE TWO RECOMMENDATION: THE PC RECOMMENDED THAT, IN LIGHT OF CURRENT STATE DEPARTMENT RESTRICTIONS ON INCREASING STAFF, ARRANGEMENTS FOR SUPERVISION AND

OVERSIGHT OF THE CCCD PROJECT BE LEFT TO THE DISCRETION OF THE MISSION. THE BUREAU WILL INCREASE ITS EFFORTS AT THE HIGHEST LEVELS OF THE AGENCY AND STATE DEPARTMENT TO SECURE APPROVAL FOR THE DR RESOURCES NEEDED BY THE MISSION. AID/W DOES FEEL STRONGLY, HOWEVER, THAT THE PRINCIPAL PROJECT COORDINATOR FOR THIS PROJECT SHOULD BE A DIRECT HIRE EMPLOYEE OF THE USG (EVEN IF A PSC) AND NOT AN EMPLOYEE OF AN OUTSIDE INSTITUTIONAL CONTRACTOR.

4. ISSUE THREE CONCERNED THE CHOICE OF VENUE FOR APPROVAL AND AUTHORIZATION OF THE PP.

ISSUE THREE DISCUSSION: THE ECPR DISCUSSED THE AUTHORIZATION VENUE. IF DELEGATED TO THE FIELD, REDSO/WCA WOULD BE THE LOCUS OF CONCURRENCE AND, GIVEN THE LACK OF USDH HEALTH STAFF IN NIGERIA, THE LOCUS OF ANY/ALL HEALTH EXPERTISE INVOLVED IN THE PROJECT REVIEW. HOWEVER, REDSO ITSELF HAS ONLY A SMALL CORE OF HEALTH PROFESSIONALS, AND THEY HAVE NOT BEEN INTIMATELY INVOLVED WITH NIGERIAN HEALTH SECTOR ISSUES. THE FACT THAT AID/W HAS MANY HEALTH EXPERTS WHO HAVE WORKED CLOSELY WITH THE MISSION AND ARE FAMILIAR WITH NIGERIA'S HEALTH SECTOR ISSUES MAKES A STRONG CASE FOR BRINGING THE PP BACK TO WASHINGTON FOR BOTH APPROVAL AND AUTHORIZATION. THE MISSION REQUESTED

AID/W APPROVAL AND AUTHORIZATION.

ISSUE THREE RECOMMENDATION: THE ECPR CONCLUDED THAT THE PP WOULD BE APPROVED AND AUTHORIZED IN AID/W. HOWEVER, FDSO/WCA INPUTS INTO THE REVIEW WILL BE NECESSARY TO ENSURE AGREEMENT ON THE FINAL DESIGN AMONG ALL PARTIES INVOLVED IN IMPLEMENTING THE PROGRAM (PER DELEGATION OF AUTHORITY 551).

5. IN DEVELOPING THE PP, THE MISSION SHOULD TAKE NOTE OF THE FOLLOWING CONCERNS AND GUIDANCE:

(A) RELATED TO ISSUE ONE ABOVE, THE ECPR ADVISES THAT THE PP BE CLEAR IN DEFINING AND DESCRIBING: THE ORGANIZATIONAL STRUCTURE AND FUNCTIONS OF THE PMU; THE INDIVIDUAL RESPONSIBILITIES OF EACH TECHNICAL ASSISTANCE ENTITY; THE FUNCTIONAL AREAS, INCLUDING SYSTEM-STRENGTHENING, WHICH WILL BE COVERED BY EACH ORGANIZATION, AND TECHNICAL CAPABILITIES AND BUDGETARY REQUIREMENTS FOR EACH; THE PMU'S INSTITUTIONAL RELATIONSHIP WITH FEDERAL AND STATE MOCS AND THE LOCAL GOVERNMENTS; AND HOW NIGERIA CCCD WILL INTERACT WITH OTHER HEALTH SECTOR ACTIVITIES.

(B) GIVEN THE DYNAMIC CHANGES UNDERWAY IN NIGERIA DUE TO FAR-REACHING ADMINISTRATIVE DECENTRALIZATION AND

TRANSITION TO CIVILIAN, DEMOCRATIC RULE, THE PP SHOULD UPDATE DESCRIPTIONS OF THE CURRENT POLICY ENVIRONMENT. THE PP SHOULD SHOW HOW U.S. PROJECT/NONPROJECT ACTIVITIES AND/OR THOSE OF OTHER DONORS ARE ADDRESSING THE MAJOR POLICY AND SYSTEMIC CONSTRAINTS OF HEALTH CARE DELIVERY, E.G., POLICIES SURROUNDING DECENTRALIZATION OF PUBLIC SECTOR SERVICES, INAPPROPRIATE REGULATIONS, AND QUALITY OF CARE CONCERNS. THE PP SHOULD INCLUDE A MATRIX SHOWING HOW

THE VARIOUS USAID AND OTHER DONOR ACTIVITIES IN HEALTH, POPULATION AND NUTRITION FIT TOGETHER.

(C) THE PP SHOULD CLEARLY SHOW HOW INFORMATION CONSTRAINTS, AS OUTLINED IN THE PID, WILL BE ADDRESSED AT THE FEDERAL, STATE AND LOCAL LEVELS.

(D) THE PID SUGGESTED THERE WERE POLICY CONSTRAINTS TO INCREASED PRIVATE SECTOR INVOLVEMENT IN THE HEALTH CARE SYSTEM, BUT DID NOT SPECIFY WHAT INCENTIVES THE PROJECT AND THE GOV MIGHT PROVIDE FOR INCREASED PRIVATE SECTOR INVOLVEMENT. RESULTS OF THE R&D EXERCISE ON PRIVATE SECTOR STRATEGY SHOULD BE INCORPORATED INTO THE FINAL DESIGN TO ADDRESS THIS CONCERN.

(E) THE MISSION WILL NEED TO QUANTIFY THE HOST COUNTRY CONTRIBUTION. THE PID MENTIONS THAT THE HOST COUNTRY CONTRIBUTION WILL BE DOLLARS 8 MILLION AND STATES WHAT THE IN-KIND CONTRIBUTION WILL COVER BUT FAILS TO SET FORTH THE VALUE OF EACH ITEM. THE PP SHOULD CLEARLY ARTICULATE THE VALUE OF EACH COMPONENT OF THE HOST COUNTRY CONTRIBUTION AND INCLUDE IN ITS DISCUSSION HOW IT WILL MONITOR HOST COUNTRY CONTRIBUTIONS.

(F) COST-RECOVERY ISSUES RELATIVE TO FINANCIAL AND INSTITUTIONAL SUSTAINABILITY, INCLUDING QUALITY ASSURANCE, NEED TO BE ADDRESSED IN THE PP. THIS IS PARTICULARLY CRITICAL AT THE LGA LEVEL WHERE AUTHORITY FOR IMPLEMENTING PRIMARY HEALTH CARE (PHC) RESTS, BUT ALSO, WHERE SEVERE FUNDING LIMITATIONS THREATEN TO UNDERMINE LGA CAPABILITY TO IMPLEMENT SIGNIFICANT PHC INTERVENTIONS.

(G) THE BENCHMARKS AND INDICATORS IN THE PP SHOULD BE REFINED. THE MISSION SHOULD UPDATE PROJECT INDICATORS BASED ON THE 1991 DHS SURVEY.

(H) THE PP MUST INCLUDE A DETAILED DFA PROCUREMENT PLAN.

(I) REDSO/WCA, UNDER DELEGATION OF AUTHORITY 551, WILL PARTICIPATE IN THE PP REVIEW PROCESS BEFORE SUBMISSION OF PP TO AID/W.

G. AID/W COMMENDS USAID FOR AN UNUSUALLY THOROUGH PROJECT IDENTIFICATION DOCUMENT AND EXTENSIVE BACKGROUND PREPARATIONS. FAKER

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STATUTORY CHECKLISTS

5(C1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. Narcotics Certification

(FAA Sec. 490): (This provision applies to assistance provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance relating to international narcotics control, disaster and refugee relief assistance, narcotics related assistance, or the provision of food (including the monetization of food) or medicine, and the provision of non-agricultural commodities under P.L. 480. This provision also does not apply to assistance for child survival and AIDS programs which can, under section 542 of the FY 1993 Appropriations Act, be made available notwithstanding any provision of law that restricts assistance to foreign countries.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) has the President in the April 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 calendar

days, of a resolution disapproving such a certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals and objectives established by the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, or that (b) the vital national interests of the United States require the provision of such assistance?

(a) Yes.
Certified for
1992.
Determination for
1993 not yet made.

(2) with regard to a major illicit drug producing or drug-transit country for which the President has not certified on April 1, has the President determined and certified to Congress on any other date (with enactment by Congress of a resolution approving such certification) that the vital national interests of the United States require the provision of assistance, and has also certified that (a) the country has undergone a fundamental change in government, or (b) there has been a fundamental change in the conditions that were the reason why the President had not made a "fully cooperating" certification.

N/A

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No.

3. **Seizure of U.S. Property** (FAA Sec. 620(e)(1)): If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

No.

4. **Communist countries** (FAA Secs. 620(a), 620(f), 620D; FY 1993 Appropriations Act Secs. 512, 543): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the

No.

recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

No.

5. **Mob Action** (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?

No.

6. **OPIC Investment Guaranty** (FAA Sec. 620(l)): Has the country failed to enter into an investment guaranty agreement with OPIC?

7. **Seizure of U.S. Fishing Vessels** (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?

No.

8. **Loan Default** (FAA Sec. 620(q); FY 1993 Appropriations Act Sec. 518 (Brooke Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?

No.

No.

9. **Military Equipment** (FAA Sec. 620(s)): If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other

Yes. Taken into account by the Administrator at

resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

time of approval of Agency OYB.

No.

10. **Diplomatic Relations with U.S.** (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

Nigeria is in arrears by about US\$2.8 million as of January 1992. Nigeria's payment status was taken into account in the taking into consideration memo.

11. **U.N. Obligations** (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

12. **International Terrorism**

a. **Sanctuary and support** (FY 1993 Appropriations Act Sec. 554; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

No.

No.

b. **Airport Security** (ISDCA of 1985 Sec. 552(b)). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No.

13. **Discrimination** (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No.

14. **Nuclear Technology** (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

No.

No.

No.

15. **Algiers Meeting** (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)

16. **Military Coup** (FY 1993 Appropriations Act Sec. 513): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?

No.

17. **Refugee Cooperation** (FY 1993 Appropriations Act Sec. 538): Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?

Yes.

18. **Exploitation of Children** (FAA Sec. 116(b)): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse

No.

or forced conscription into military or paramilitary services?

B. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")

No.

1. **Human Rights Violations (FAA Sec. 116):** Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

2. **Abortions (FY 1993 Appropriations Act Sec. 534):** Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No.

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

Yes. Revised by GC/LP as of January 1993.

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. **Host Country Development Efforts** (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

(a) N/A
(b) An important aspect of the project is its fostering of private sector involvement in primary health care.
(c) N/A
(d) N/A
(e) N/A
(f) N/A

2. **U.S. Private Trade and Investment** (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

3. **Congressional Notification**

a. **General requirement** (FY

1993 Appropriations Act Sec. 522; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of substantial risk to human health or welfare)?

Yes.
A Congressional Notification was submitted on , 1993.

b. **Notice of new account obligation** (FY 1993 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

c. **Cash transfers and nonproject sector assistance** (FY 1993 Appropriations Act Sec. 571(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes.

(b) Yes.

5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A

6. **Water Resources** (FAA Sec. 611(b); FY 1993 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures

N/A

established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

7. **Cash Transfer and Sector Assistance** (FY 1993 Appropriations Act Sec. 571(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? N/A

8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A

9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. (b) See A.1, above.

10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). N/A

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. A.I.D. study indicates contribution by host country more than matches 25% required contribution. Monitoring of H/C local currency contribution is fully described in project paper.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess No.

foreign currency of the country and, if so, what arrangements have been made for its release? Yes.

c. **Separate Account** (FY 1993 Appropriations Act Sec. 571). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies: (a) Yes.

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account? (b) Yes. (c) Yes. Annual work plans and sub-agreements will establish necessary agreements.

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government? Yes.

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes? Yes.

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? Yes.

12. Trade Restrictions

a. **Surplus Commodities** (FY 1993 Appropriations Act Sec. 520(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

b. **Textiles (Lautenberg Amendment)** (FY 1993 Appropriations Act Sec. 520(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

N/A

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3) (as referenced in section 532(d) of the FY 1993 Appropriations Act): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

(a) No.

(b) No.

14. **PVO Assistance**

a. **Auditing and registration** (FY 1993 Appropriations Act Sec. 536): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A

b. **Funding sources** (FY 1993 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A

15. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect

The AAO has made provisions for such reporting to take place within sixty days of the signing of the project agreement.

to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

16. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes.

Yes.

Yes.

Special efforts have been made to involve women in the design of the project. American and Nigerian women will continue to play important roles in its implementation.

17. **Women in Development** (FY 1993 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

18. **Regional and Multilateral Assistance** (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

No.

19. **Abortions** (FY 1993 Appropriations Act, Title II, under heading "Population, DA," and Sec. 524):

No.

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No.

b. Will any funds be used to

lobby for abortion? N/A

20. **Cooperatives** (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

21. **U.S.-Owned Foreign Currencies** N/A

a. **Use of currencies** (FAA Secs. 612(b), 636(h); FY 1993 Appropriations Act Secs. 507, 509): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. N/A

b. **Release of currencies** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? N/A

22. **Procurement**

a. **Small business** (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes.

b. **U.S. procurement** (FAA Sec. 604(a) as amended by section 597 of the FY 1993 Appropriations Act): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section? Yes.

c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? N/A

d. **Non-U.S. agricultural procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) No.

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) No.

f. Cargo preference shipping (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? Yes.

g. Technical assistance (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes.

h. U.S. air carriers (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? Yes.

i. Termination for convenience of U.S. Government (FY 1993 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes.

j. Consulting services (FY 1993 Appropriations Act Sec. 523): If assistance is for consulting service Yes.

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through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

k. Metric conversion
(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes.
Yes.
Yes.

l. Competitive Selection Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

23. Construction

a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A

b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N/A

c. Large projects, Congressional approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in

N/A

the Congressional Presentation), or does assistance have the express approval of Congress?

Yes.

24. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

Yes.

25. **Communist Assistance** (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

26. **Narcotics**

No.

a. **Cash reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?

Yes.

No.

27. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?

Yes.

28. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?

Yes.

29. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities?

Yes.

30. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes.

31. **Military Personnel** (FY 1993 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes.

32. **Payment of U.N. Assessments** (FY 1993 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? Yes.

33. **Multilateral Organization Lending** (FY 1993 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes.

34. **Export of Nuclear Resources** (FY 1993 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? Yes.

35. **Repression of Population** (FY 1993 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? No.

36. **Publicity or Propaganda** (FY 1993 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? Yes.

37. **Marine Insurance** (FY 1993 Appropriations Act Sec. 560): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or

appropriate?

No.

38. **Exchange for Prohibited Act** (FY 1993 Appropriations Act Sec. 565): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

Yes. The project will be authorized for seven years.

39. **Commitment of Funds** (FAA Sec. 635(h)): Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement?

40. **Impact on U.S. Jobs** (FY 1993 Appropriations Act, Sec. 599):

No.

(a) Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business?

No.

(b) Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.?

No.

(c) Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country?

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

N/A

1. **Agricultural Exports (Bumpers Amendment)** (FY 1993 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or

introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

N/A

2. **Tied Aid Credits** (FY 1993 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

Yes.

3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Nigerian university resources, including personnel, have been used to undertake preliminary studies for the project.

4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

The broad objective of the project is a healthier and more productive society.

5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

(a) A successful project will assist in reducing health care costs and increasing health care capacity.

6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained

(b) The project supports efforts towards decentralization of health care services at the local level.

(c) The project will promote the

basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

health status of women.
(e) N/A

Yes.

7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes. The ultimate beneficiaries of improved health care services will be the poor majority.

8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

No.

9. Abortions (FAA Sec. 104(f); FY 1993 Appropriations Act, Title II, under heading "Population, DA," and Sec. 534):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No.

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

Yes.

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning

No.

methods and services?

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?

No.

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No.

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?

Yes.

10. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

The major contract required for the provision of administrative support services will be awarded to a disadvantaged enterprise, based on its predominant capability.

11. **Disadvantaged Enterprises** (FY 1993 Appropriations Act Sec. 563): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

N/A

12. **Biological Diversity** (FAA Sec. 119(g)): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals

into such areas?

13. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act): Yes.

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: N/A

- (1) stress the importance of conserving and sustainably managing forest resources;
- (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas;
- (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management;
- (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices;
- (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded;
- (6) conserve forested watersheds and rehabilitate those which have been deforested;
- (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing;
- (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation;
- (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas;
- (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate

and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

N/A

N/A

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

Yes.

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

N/A

14. **Energy** (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

15. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

16. **Deobligation/Reobligation** (FY 1993 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

17. **Loans**

N/A

a. **Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. **Long-range plans** (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

N/A

c. **Interest rate** (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

N/A

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d. **Exports to United States** (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

See 6, above.

18. **Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

19. **Agriculture, Rural Development and Nutrition, and Agricultural Research** (FAA Secs. 103 and 103A):

N/A

a. **Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. **Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve

N/A

nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

N/A

c. **Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

Assistance will strengthen PHC capacities with respect to health information and training for health and family planning, and nutrition, while promoting integrated delivery systems.

20. **Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

21. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

N/A

22. **Energy, Private Voluntary Organizations, and Selected Development**

Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

N/A

23. Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?

STATUTORY CHECKLISTS

5(C1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. Narcotics Certification

(FAA Sec. 490): (This provision applies to assistance provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance relating to international narcotics control, disaster and refugee relief assistance, narcotics related assistance, or the provision of food (including the monetization of food) or medicine, and the provision of non-agricultural commodities under P.L. 480. This provision also does not apply to assistance for child survival and AIDS programs which can, under section 542 of the FY 1993 Appropriations Act, be made available notwithstanding any provision of law that restricts assistance to foreign countries.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) has the President in the April 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 calendar days, of a resolution disapproving such a certification), that (a) during the previous year the country has cooperated fully with the United States or taken

adequate steps on its own to satisfy the goals and objectives established by the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, or that (b) the vital national interests of the United States require the provision of such assistance?

(a) Yes.
Certified for
1992.
Determination for
1993 not yet made.

(2) with regard to a major illicit drug producing or drug-transit country for which the President has not certified on April 1, has the President determined and certified to Congress on any other date (with enactment by Congress of a resolution approving such certification) that the vital national interests of the United States require the provision of assistance, and has also certified that (a) the country has undergone a fundamental change in government, or (b) there has been a fundamental change in the conditions that were the reason why the President had not made a "fully cooperating" certification.

N/A

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No.

3. **Seizure of U.S. Property** (FAA Sec. 620(e)(1)): If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

No.

4. **Communist countries** (FAA Secs. 620(a), 620(f), 620D; FY 1993 Appropriations Act Secs. 512, 543): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country

No.

from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

5. **Mob Action (FAA Sec. 620(j)):** Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No.

6. **OPIC Investment Guaranty (FAA Sec. 620(l)):** Has the country failed to enter into an investment guaranty agreement with OPIC? No.

7. **Seizure of U.S. Fishing Vessels (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5):** (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? No.

8. **Loan Default (FAA Sec. 620(q); FY 1993 Appropriations Act Sec. 518 (Brooke Amendment)):** (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds? No. No.

9. **Military Equipment (FAA Sec. 620(s)):** If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at Yes. Taken into account by the Administrator at

time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

time of approval of Agency OYB.

10. **Diplomatic Relations with U.S.** (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

11. **U.N. Obligations** (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

Nigeria is in arrears by about US\$2.8 million as of January 1992. Nigeria's payment status was taken into account in the taking into consideration memo.

12. **International Terrorism**

a. **Sanctuary and support** (FY 1993 Appropriations Act Sec. 554; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

No.

No.

b. **Airport Security** (ISDCA of 1985 Sec. 552(b)). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No.

13. **Discrimination** (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No.

14. **Nuclear Technology** (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or

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received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

No.

No.

No.

15. **Algiers Meeting (ISDCA of 1981, Sec. 720):** Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)

16. **Military Coup (FY 1993 Appropriations Act Sec. 513):** Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?

No.

17. **Refugee Cooperation (FY 1993 Appropriations Act Sec. 538):** Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?

Yes.

18. **Exploitation of Children (FAA Sec. 116(b)):** Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services?

No.

B. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")

1. **Human Rights Violations** (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

No.

2. **Abortions** (FY 1993 Appropriations Act Sec. 534): Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No.

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5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

- A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS
- Yes. Revised by GC/LP as of January 1993.
1. **Host Country Development Efforts** (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to:
- (a) increase the flow of international trade;
 - (b) foster private initiative and competition;
 - (c) encourage development and use of cooperatives, credit unions, and savings and loan associations;
 - (d) discourage monopolistic practices;
 - (e) improve technical efficiency of industry, agriculture, and commerce; and
 - (f) strengthen free labor unions.
- (a) N/A
(b) An important aspect of the project is its fostering of private sector involvement in primary health care.
(c) N/A
(d) N/A
(e) N/A
(f) N/A
2. **U.S. Private Trade and Investment** (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).
- N/A
3. **Congressional Notification**
- a. **General requirement** (FY 1993 Appropriations Act Sec. 522; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress,

has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of substantial risk to human health or welfare)?

b. **Notice of new account obligation** (FY 1993 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

Yes.
A Congressional Notification was submitted on , 1993.

c. **Cash transfers and nonproject sector assistance** (FY 1993 Appropriations Act Sec. 571(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes.

(b) Yes.

5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A

6. **Water Resources** (FAA Sec. 611(b); FY 1993 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A

7. **Cash Transfer and Sector**

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Assistance (FY 1993 Appropriations Act Sec. 571(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

N/A

8. Capital Assistance (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

N/A

9. Multiple Country Objectives (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

(b) See A.1, above.

10. U.S. Private Trade (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

11. Local Currencies

a. Recipient Contributions (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

A.I.D. study indicates contribution by host country more than matches 25% required contribution. Monitoring of H/C local currency contribution is fully described in project paper.

b. U.S.-Owned Currency (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

c. Separate Account (FY 1993

Appropriations Act Sec. 571). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

Yes.

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(a) Yes.

(b) Yes.

(c) Yes. Annual work plans and sub-agreements will establish necessary agreements.

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

Yes.

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

Yes.

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

Yes.

12. Trade Restrictions

a. **Surplus Commodities** (FY 1993 Appropriations Act Sec. 520(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

b. **Textiles (Lautenberg Amendment)** (FY 1993 Appropriations Act Sec. 520(c)): Will the assistance (except for programs in Caribbean Basin Initiative

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countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

N/A

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3) (as referenced in section 532(d) of the FY 1993 Appropriations Act): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

(a) No.

(b) No.

14. PVO Assistance

a. Auditing and registration (FY 1993 Appropriations Act Sec. 536): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A

b. Funding sources (FY 1993 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A

15. Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

The AAO has made provisions for such reporting to take place within sixty days of the signing of the project agreement.

16. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes.

Yes.

Yes.

Special efforts have been made to involve women in the design of the project. American and Nigerian women will continue to play important roles in its implementation.

17. **Women in Development** (FY 1993 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

18. **Regional and Multilateral Assistance** (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

No.

19. **Abortions** (FY 1993 Appropriations Act, Title II, under heading "Population, DA," and Sec. 524):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No.

b. Will any funds be used to lobby for abortion?

No.

20. **Cooperatives** (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to

assist rural and urban poor to help themselves toward a better life? N/A

21. U.S.-Owned Foreign Currencies

a. **Use of currencies** (FAA Secs. 612(b), 636(h); FY 1993 Appropriations Act Secs. 507, 509): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. N/A

b. **Release of currencies** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? N/A

22. Procurement

a. **Small business** (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? N/A

b. **U.S. procurement** (FAA Sec. 604(a) as amended by section 597 of the FY 1993 Appropriations Act): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section? Yes.

c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? Yes.

d. **Non-U.S. agricultural procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A

e. **Construction or engineering services** (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible? No.

under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

f. **Cargo preference shipping** (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No.

g. **Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes.
Yes.

h. **U.S. air carriers** (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? Yes.

i. **Termination for convenience of U.S. Government** (FY 1993 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes.

j. **Consulting services** (FY 1993 Appropriations Act Sec. 523): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? Yes.

k. Metric conversion
(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? **Yes.**

Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? **Yes.**

1. Competitive Selection Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? **Yes.**

23. Construction

a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?

b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? **N/A**

c. Large projects, Congressional approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? **N/A**

24. U.S. Audit Rights (FAA Sec. 301(d)): If fund is established solely by

U.S. contributions and administered by an international organization, does Comptroller General have audit rights? Yes.

25. **Communist Assistance** (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.

26. **Narcotics**

a. **Cash reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? No.

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes.

27. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? No.

28. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.

29. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? Yes.

30. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes.

31. **Military Personnel** (FY 1993 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes.
32. **Payment of U.N. Assessments** (FY 1993 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? Yes.
33. **Multilateral Organization Lending** (FY 1993 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes.
34. **Export of Nuclear Resources** (FY 1993 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? Yes.
35. **Repression of Population** (FY 1993 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes.
36. **Publicity or Propaganda** (FY 1993 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? No.
37. **Marine Insurance** (FY 1993 Appropriations Act Sec. 560): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? Yes.
38. **Exchange for Prohibited Act** (FY 1993 Appropriations Act Sec. 565): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or

United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? No.

39. **Commitment of Funds** (FAA Sec. 635(h)): Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement? Yes. The project will be authorized for seven years.

40. **Impact on U.S. Jobs** (FY 1993 Appropriations Act, Sec. 599):

(a) Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business? No.

(b) Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.? No.

(c) Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country? No.

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1993 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct N/A

competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

2. **Tied Aid Credits** (FY 1993 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

N/A

3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Yes.

4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

Nigerian university resources, including personnel, have been used to undertake preliminary studies for the project.

5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

The broad objective of the project is a healthier and more productive society.

6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's

(a) A successful project will assist in reducing health care costs and increasing health care capacity.
(b) The project supports efforts towards decentralization of health care services at the local level.
(c) The project will promote the

status; and (e) utilize and encourage regional cooperation by developing countries.

health status of women.
(e) N/A

7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes.

8. **Benefit to Poor Majority** (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes. The ultimate beneficiaries of improved health care services will be the poor majority.

9. **Abortions** (FAA Sec. 104(f); FY 1993 Appropriations Act, Title II, under heading "Population, DA," and Sec. 534):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No.

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No.

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?

Yes.

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family

No.

planning?

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? No.

10. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes.

11. Disadvantaged Enterprises (FY 1993 Appropriations Act Sec. 563): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? The major contract required for the provision of administrative support services will be awarded to a disadvantaged enterprise, based on its predominant capability.

12. Biological Diversity (FAA Sec. 119(g)): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? N/A

13. Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Yes.

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts

N/A

of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

N/A

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

Yes.

14. **Energy** (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key

N/A

countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

15. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management. N/A

16. **Deobligation/Reobligation** (FY 1993 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? N/A

17. **Loans**

a. **Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A

b. **Long-range plans** (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? N/A

c. **Interest rate** (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A

d. **Exports to United States** (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual N/A

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production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

18. **Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

See 6, above.

19. **Agriculture, Rural Development and Nutrition, and Agricultural Research** (FAA Secs. 103 and 103A):

a. **Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A

b. **Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement

N/A

and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. **Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

20. **Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

Assistance will strengthen PHC capacities with respect to health information and training for health and family planning, and nutrition, while promoting integrated delivery systems.

21. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

22. **Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

a. concerned with data

collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

23. Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?

N/A

INITIAL ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION
(PID level IEE)

PROJECT COUNTRY: Nigeria

PROJECT TITLE: Combatting Childhood Communicable Diseases (CCCD) Project (620-0004)

FUNDING: FY93-97: LOP US\$ 20 Million

IEE PREPARED BY: Eugene R. Chiavaroli, AAO
USAID/Lagos

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination	_____
Negative Determination	XXX
Categorical Exclusion	XXX
Deferral	_____

SUMMARY OF FINDINGS:

The project includes activities that have no significant adverse impact on the environment or on natural resources:

(a) technical assistance is recommended for categorical exclusion under 22 CFR 216.2(c)(2)(i);

(b) training is recommended for categorical exclusion under 22 CFR 216.2(c)(2)(i);

(c) document and information transfer is recommended for categorical exclusion under 22 CFR 216.2(c)(2)(v);

(d) studies and research are recommended for categorical exclusion under 22 CFR 216.2(c)(2)(iii);

(e) policy reform is recommended for categorical exclusion under 22 CFR 216.2(c)(2)(xiv); and

(f) commodities and equipment, including procurement of office equipment and furniture, passenger vehicles, audiovisuals, pharmaceuticals, medical supplies, and clinical equipment and supplies, are recommended for categorical exclusion under 22 CFR 216.2(c)(1)(i).

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(g) commodities and equipment, including procurement of refrigerators/freezers and pesticides, are recommended for a negative determination.

(1) cold chain operations will likely require procurement of approximately 900 refrigeration units with individual unit average capacity of 500 liters, utilizing standard commercial refrigerant such as Freon-12 (Dichloro-difluoro-methane, chemical formula CCl_2F_2 , boiling point -21.6 degrees fahrenheit) covered by and conforming to OSHA Hazard Communication Standard and Material Safety Data Sheet specifications. The possibility of escaped freon with ensuing endangerment to the ozone layer of the atmosphere is slight. Risk of an occurrence resulting in indirect project impact on the environment is negligible. A negative determination is appropriate with regard to the procurement of refrigeration units for cold chain operations.

(2) malaria prevention operations will likely require, during the LOP, procurement and distribution of several million bednets impregnated with permethin, deltamethrin, and/or pyrethroids. Specific interventions involving impregnated bednets have yet to be determined; procedures will, however, generally reflect considerations addressed in Annex A to this IEE. Procurement and use of impregnated bednets and/or one or more of the aforementioned pesticides will adhere to the provisions of 22 CFR 216.3(b). Risk of an occurrence resulting in direct or indirect project impact on the environment and/or participating beneficiaries and project personnel is negligible. Endangerment to the environment and/or population is slight. A negative determination is appropriate with regard to the procurement of impregnated bednets and/or related pesticides for the malaria prevention program.

A monitoring and evaluation element will be integral to the bednet usage program.

CLEARANCE:

USAID/Lagos, AAO: Eugene R. Chiavaroli DATE: May 7, 1992
Eugene R. Chiavaroli

CONCURRENCE:

Bureau Environmental Officer:

John J. Gullet

APPROVED: ✓
DISAPPROVED: _____
DATE: 4/5/92

CLEARANCE:

GC/Africa:

John J. Gullet DATE: 12 Jun 92

ANNEX A

The impregnated bednet initiative under Nigeria CCCD will profit from other project activities designed to test the efficacy of insecticide impregnated bednets in controlling transmission of malaria in rural and urban population in Africa; e.g., the Regional Project 698-0482 involving a four-year study (FY 1990-94) undertaken in the Bagamoyo district of Tanzania to assess public health efficacy, acceptability of bednets among the study population, the prevalence of malaria in the population, and the impact of the intervention on mosquito vectors: Regulation 216.3(b)(1)(l).

Project 698-0482 was designed to provide bednets and insecticide to 10,000 individuals in the study district, along with instructions in their use, to achieve the highest possible rate of use of the bednets. Initially, a behavioral science study of the local population was conducted to determine how to explain the advantages of the nets to the study groups. Nigeria CCCD will undertake a pilot bednet activity similar to that of Project 698-0482, including the conduct of appropriate behavioral studies.

Under Project 698-0482, bednets will be impregnated with insecticide by their recipients under the supervision of the project staff and local village health workers: Regulation 216.3(b)(1)(d). This methodology embodies an IPM approach: Regulation 216.3(b)(1)(c). Project 698-0482 was designed to train health care staff in the use of the bednets and in survey methods which they will use collect data for the study: Regulation 216.3(b)(1)(k). During the study, impacts will be monitored to ensure that no adverse effects occur re the study population: Regulation 216.3(b)(1)(l). Nigeria CCCD will undertake similar training and monitoring activities.

Under the supervision of village health workers, bednets will be re-impregnated with insecticide, as necessary, throughout the life of Project 698-0482. Each applicant for nets will be given the requested number (based on family size), together with sachets of insecticide sufficient to treat a single net, a plastic bag for impregnation and a pair of disposable gloves. All plastic containers, bags and gloves used as part of the project will be collected by village health workers and discarded in pit latrines treated with alkali: Regulation 216.3(b)(1)(j). Nigeria CCCD will adopt similar practices for the impregnation of nets in the field in accordance with the provisions of Regulation 216 applicable to the specific insecticide utilized.

Details of the Nigeria CCCD bednet program have yet to be determined re: (a) the extent to which the impregnation of bednets will be accomplished in the field under circumstances

similar to those described above; and (b) the degree to which nets will be procured already treated with insecticide. In any case, Nigeria CCCD will adhere to the provisions of Regulation 216 applicable to the specific insecticide utilized.

As with Project 698-0482, it is likely that either permethrin or deltamethrin will be selected for Nigeria CCCD as the insecticide of choice. The final choice of insecticide will be deferred pending determination of detailed implementation procedures.

Regulation 16 pesticide procedures for permethrin are satisfied. However, pursuant to Regulation 16, Section 216.3(b)(1)(iii), deltamethrin must be EPA-registered for the intended purpose at the time of use, or an environmental assessment must be performed.

The grant agreement will contain a covenant stipulating that utilization of insecticides other than permethrin for the field impregnation of nets requires the approval of the Africa Bureau Environmental Officer.

IDENTIFICATION AND EVALUATION OF ENVIRONMENTAL IMPACT

A. Selection of Insecticide:

Currently, the World Health Organization recommends the use of synthetic pyrethroids, such as permethrin and deltamethrin, to treat mosquito nets. Permethrin is registered by the US EPA for use in impregnating mosquito nets. Deltamethrin is registered by Canada and by a number of other countries, but registration of deltramethrin has yet to be sought in the U.S. because of a restrictive marketing agreement which recently expired. Currently, an application for a food use tolerance has been submitted and a full application for registration is expected shortly. Registration is likely because of the close chemical similarity among the synthetic pyrethroids, including permethrin and others already registered by US EPA. The only data requirements probably will be for acute toxicity and residue analysis. Studies to generate these data can be performed quickly, if data are not already available to the company: Regulation 216.3(b)(1)(a).

Since Regulation 16, Section 216.3(b)(1)(iii) requires that an unregistered pesticide may be financed only after an environmental assessment is performed, such an assessment will be performed and approved by the Bureau Environmental Officer (BEO), if deltamethrin is chosen and EPA registration for such use has yet to be completed by the time of use. If any other insecticide not registered by EPA is selected an environmental assessment and approval by the BEO will, likewise, be necessary.

B. Use of Insecticide

Initial work in the Gambia used permethrin at 200 mg/m²; this requires approximately 100ml of insecticide per net: Regulation 216.3(b)(1)(i). Deltamethrin has been used more widely and is currently the insecticide of choice in a large intervention in China, where some 2 million people are using impregnated bednets. No ill effects were reported. Thus, deltamethrin has had an excellent record level of safety and has a wider usage than the other pyrethroid. Furthermore, the compound is used at 25 mg/m². This is the level shown to be effective in other studies; the purpose of this study is to determine effectiveness under these conditions: Regulation 216.3(b)(1)(f). This would amount to 10 mls of the commercial formulation, and would be easier to work with, as well as being safer: Regulation 216.3(b)(1)(b).

Environmental impact of these compounds would be minimal as they are used indoors in small quantities: Regulation 216.3(b)(1)(g). Pyrethroids are safe to mammals, including humans and birds: Regulation 216.3(b)(1)(e). Disposal of used sachets, bags and other materials will satisfy Regulation 216.3(b)(1)(j) requirements.

C. Impact Considerations

Impact on Land Use:

There will be negligible environmental impact on land use as a result of the project.

Impact on Water Quality:

Water quality might be a concern, if residual insecticide and insecticide-coated plastic bags, gloves, and other materials are discarded in pit latrines with potential for affecting ground water. In any case, Deltamethrin is not expected to have significant impact.

Impact on Atmospheric Quality:

The project will have no impact on air pollution.

Impact on Natural Resources:

This project is expected by definition to alter the behavior and survival rates of mosquitoes in the study area. This will have minimum impact on ecology of the area, except for improving human health. This application method is especially compatible with natural resources because it minimizes exposure of ecosystems to pesticides: Regulation 216.3(b)(1)(g).

Cultural and Socioeconomic Impacts:

This project will have a cultural impact on the study population, since it will impart new information about malaria and its control, and will possibly alter behavior. However, there exists in the study area in infrastructure of primary health care workers, so the type of education and information activities to be conducted under the project will be familiar to the populace.

Impact on Human Health:

The fact that the study population will be sleeping in close proximity to an insecticide poses the question of whether human health will be adversely affected. The insecticide selected has low mammalian toxicity and has been widely used in close proximity to humans without significant impact. Therefore, it is not expected to have an adverse impact.

General and Other Possible Impacts:

There are no other impacts expected from this project.

CONCLUSION

The areas most likely to have impacts have been evaluated per Regulation 16, Section 216.3(b)(1)(i)(a-1). No significant adverse impact is expected.

INITIAL ENVIRONMENTAL EXAMINATION
or
CATEGORICAL EXCLUSION
(Amendment)

PROJECT COUNTRY: Nigeria

PROJECT TITLE: Combatting Childhood Communicable Diseases (CCCD) Project (620-0004)

FUNDING: FY93-99: LOP US\$ 40 Million

IEE PREPARED BY: Eugene R. Chiavaroli, AAO
USAID/Lagos

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination	_____
Negative Determination	<u>xxx</u>
Categorical Exclusion	<u>xxx</u>
Deferral	_____

SUMMARY OF FINDINGS:

The project includes activities that have no significant adverse impact on the environment or on natural resources:

(a) technical assistance is recommended for categorical exclusion under 22 CFR 216.2(c)(2)(i);

(b) training is recommended for categorical exclusion under 22 CFR 216.2(c)(2)(i);

(c) document and information transfer is recommended for categorical exclusion under 22 CFR 216.2(c)(2)(v);

(d) studies and research are recommended for categorical exclusion under 22 CFR 216.2(c)(2)(iii);

(e) policy reform is recommended for categorical exclusion under 22 CFR 216.2(c)(2)(xiv); and

(f) commodities and equipment, including procurement of office equipment and furniture, passenger vehicles, audiovisuals, pharmaceuticals, medical supplies, and clinical equipment and supplies, are recommended for categorical exclusion under 22 CFR 216.2(c)(1)(i).

(g) commodities and equipment, including procurement of refrigerators/freezers and pesticides, are recommended for a negative determination.

(1) cold chain operations will likely require procurement of approximately 900 refrigeration units with individual unit average capacity of 500 liters, utilizing standard commercial refrigerant such as Freon-12 (Dichloro-difluoro-methane, chemical formula CC12F2, boiling point -21.6 degrees fahrenheit) covered by and conforming to OSHA Hazard Communication Standard and Material Safety Data Sheet specifications. The possibility of escaped freon with ensuing endangerment to the ozone layer of the atmosphere is slight. Risk of an occurrence resulting in indirect project impact on the environment is negligible. A negative determination is appropriate with regard to the procurement of refrigeration units for cold chain operations.

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(3) see below

A monitoring and evaluation element will be integral to the bed net usage program.

CLEARANCE:

USAID/Lagos, AAO: Eugene R. Chiavaroli DATE: June 3, 1993
Eugene R. Chiavaroli

CONCURRENCE:

Bureau Environmental Officer: [Signature]

APPROVED: ✓
DISAPPROVED: _____

DATE: June 10, 1993

CLEARANCE:

GC/Africa: [Signature] DATE: June 11, 1993

(3) Regarding the particular pesticides to be used in the project: (a) there is a Covenant in the Project Authorization that provides for the use of permethrin, and (b) Annex A below provides the Risk/Benefit Analysis as required by Reg 16, Section 216.3(b)(i).

ANNEX A

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C. Impact Considerations

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Impact on Natural Resources:

This project is expected by definition to alter the behavior and survival rates of mosquitoes in the study area. This will have minimum impact on ecology of the area, except for improving human health. This application method is especially compatible with natural resources because it minimizes exposure of ecosystems to pesticides: Regulation 216.3(b)(1)(g).

Cultural and Socioeconomic Impacts:

This project will have a cultural impact on the study population, since it will impart new information about malaria and its control, and will possibly alter behavior. However, there exists in the study area in infrastructure of primary health care workers, so the type of education and information activities to be conducted under the project will be familiar to the populace.

Impact on Human Health:

The fact that the study population will be sleeping in close proximity to an insecticide poses the question of whether human health will be adversely affected. The insecticide selected has low mammalian toxicity and has been widely used in close proximity to humans without significant impact. Therefore, it is not expected to have an adverse impact.

General and Other Possible Impacts:

There are no other impacts expected from this project.

CONCLUSION

The areas most likely to have impacts have been evaluated per Regulation 16, Section 216.3(b)(1)(i)(a-l). No significant adverse impact is expected.

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I. Health Status of Nigerian Mothers and Children

Although vital statistics data in Nigeria are incomplete and occasionally contradictory; available data, supplemented by surveys and special studies, provide sufficient quality information to facilitate assessment of needs, assignment of priorities, and identification of opportunities for technical collaboration.

A. Health Status

Health status is traditionally assessed by three parameters: mortality, nutritional status, and life expectancy. As routine vital statistics data are limited, health status estimates are based on surveys such as the 1991 Nigerian Census and the 1990 Nigerian Demographic and Health Survey (NDHS).

Nigerian infants and children have some of the highest rates of mortality among non-refugee non-war populations in Africa. As shown by the following table depicting infant, child, and under-five mortality in Nigeria, mortality rates are especially high in the northern areas of the country.

INFANT, CHILD, AND UNDER-FIVE MORTALITY IN NIGERIA BY REGIONAL AREA (1990 NDHS) DEATHS PER 1000			
REGION	INFANT MORTALITY	CHILD (1-4) MORTALITY	UNDER-FIVE MORTALITY
Northeast	87.7	139.2	214.6
Northwest	109.8	151.2	244.4
Southeast	82.7	66.5	143.7
Southwest	84.6	90.3	167.2
Total	91.4	109.6	191.0

Based on these rates, an estimated 670,000 Nigerian infants and children die each year, 1836 per day. (Population of 90 Million x CBR 39/1000 x <5 Mortality 191/1000).

The rate of maternal mortality in Nigeria is not well documented. Limited data suggest a rate as high as ten to fifteen maternal deaths per 1000 live births, a figure that seems excessive. Additional studies to define the magnitude of the problem of maternal mortality are needed.

Nutritional status provides an objective measurement of health status and an indication of the risk of mortality. As shown in the following table depicting the nutritional status of under-five children, undernutrition, as with mortality, is greater in the northern regions of Nigeria.

NUTRITIONAL STATUS OF UNDER-FIVE NIGERIAN CHILDREN NIGERIAN REGIONAL AREAS (NDHS 1990) PERCENTAGE OF WASTING, STUNTED, AND UNDERWEIGHT (5565 CASES)			
REGION	WASTING % >-2SD	STUNTING % >-2SD	UNDERWEIGHT % >-2SD
Northeast	11.3	51.9	44.6
Northwest	12.1	50.4	43.8
Southeast	7.6	36.6	29.6
Southwest	5.5	35.6	26.9
Total	9.1	43.1	35.7

In normal populations, three percent of the population fall is less than two standard deviations (-2SD) below the mean. Wasting (weight for height) reflects acute malnutrition and carries an increased risk of mortality. Stunting (height for age) reflects chronic undernutrition. Underweight (weight for age) reflects thinness. As assessed by weight for height, undernutrition (i.e., >-2SD below the NCHS/CDC/WHO international reference), is, primarily, a problem for children under the age of three years.

Data on maternal nutrition is limited. A 1990 study at the University of Ibadan in the Southwest, a better nourished area, indicated that thirty-one percent of pregnant women were malnourished based on weight for height assessment.

Life expectancy for Nigerians is low: 49 years for males and 53 years for females. This is significantly below the 70+ expectancy in developed countries.

The data are clear, — rates of mortality and malnutrition are high, and far above the Year 2000 targets set at the World Summit for the Child in September 1989: infant mortality < 50 deaths per 1000 live births and under-five mortality of < 70 deaths per 1000 live births.

B. Major Causes of Infant and Child Morbidity and Mortality

Two sources of routine data provide information on under-five morbidity and mortality. The national Notifiable Disease Reporting (NDR) system provides monthly data on forty diseases. This system provides, primarily, outpatient data based on clinical diagnoses. The computerized inpatient reporting system, currently being installed in eight hospitals, collects data on inpatient admissions and deaths. With the availability of diagnostic studies, inpatient data is of better quality. While neither system provides community based data, they are useful in identifying the major causes of childhood morbidity and mortality, as shown in the following table.

MAJOR CAUSES OF MORBIDITY AND MORTALITY IN CHILDREN UNDER FIVE						
NOTIFIABLE DISEASE REPORTING 1990/1991			INPATIENT AT 3 HOSPITALS		INPATIENT DEATHS AT 3 HOSPITALS	
DISEASE	CASES NR = Not Reportable	PERCENT DISTRIBU- TION	ADMISSION	PERCENT DISTRIBU- TION	DEATHS AND CASE FATALITY RATE	PERCENT DISTRIBU- TION
Perinatal	NR		1116	17.35	285 (25.54)	17.49
Malnutrition	NR		656	10.20	312 (47.55)	19.15
Anemia	NR		292	4.54	76 (26.03)	4.67
Sickle Cell	NR		136	2.11	16 (11.76)	0.98
Asphyxia at Birth	NR		132	2.05	63 (47.73)	3.87
Malaria	799,262	48.63	743	11.55	67 (9.02)	4.11
Diarrhea	518,766	31.58	472	7.34	163 (34.53)	10.01
Pneumonia	143,613	8.74	808	12.56	176 (21.78)	10.80
Measles	81,670	4.97	253	3.93	73 (28.85)	4.48
Pertussis	31,737	1.93				
Ophthalmia	6,764	0.41				
Schisto'm'sis	4,871	0.30				
STDs	4,111	0.26				
Tuberculosis	3,880	0.24	73	1.13	17 (23.29)	1.04
CSM	3,524	0.21	92	1.43	25 (27.17)	1.53
Cholera	3,192	0.19				
Yellow Fever	2,905	0.18				
Neonatal Tetanus	2,520	0.15	285	4.43	135 (47.37)	8.29
Polio	1,224	0.07	16	0.25	4 (25.0)	0.25
TOTAL	1,643,930	100.00	6,433	1629	100.00	0.25

Notifiable Disease Reporting (NDR) only measures the "tip of the iceberg". Sensitivity of the system can be estimated by comparing the number of guineaworm cases reported in 1990, (i.e., 9,050) with that found through active village to village surveillance (i.e., 641,000 cases). Only 1.4 percent of cases were reported through the NDR system.

Prospective studies, surveys, and outbreak investigations provide a more valid assessment of disease-specific morbidity and mortality. From these studies, it is evident that nearly all unprotected children will be infected with measles and from two to five percent will die. Neonatal tetanus is estimated to effect approximately one percent of infants born to mothers unprotected with tetanus toxoid. Although less well documented, most nonimmunized children will suffer from pertussis and from one to two percent will die. One in 200 nonimmunized children will be paralyzed with polio.

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Analysis of the above data and extensive reports in the medical literature indicates that five groupings of health risks account for much of the under-five mortality in Nigerian. The following table lists these five groups and corresponding ailments.

MAJOR CAUSES OF UNDER-FIVE MORTALITY	
GROUPING	AILMENT
Conditions associated with birth.	Asphyxia, neonatal tetanus, birth injury, pneumonia, sepsis.
Diseases preventable by immunization.	Measles, pertussis, diphtheria, polio, and childhood TB.
Acute infectious diseases.	Malaria, pneumonia, and diarrhea.
Malnutrition.	Protein, calorie, and micronutrient deficiencies.
Acute epidemic diseases.	Cerebrospinal meningitis, cholera, and yellow fever.

C. Risk Factors (Why do Nigerian Children Die?)

Under-five morbidity and mortality result from a range of behavioral and disease insults (risk factors) acting on populations vulnerable from poverty, lack of education, and poor environmental sanitation in a setting where health services are unavailable, inaccessible, or of poor quality. Mortality seldom results from a single event but, usually, represents the cumulative impact of sequential or simultaneous risks; e.g., repeated inadequately treated infections in an undernourished child.

While economic development is a long-term solution, significant improvements in health status can be achieved through use of low cost, technically sound, culturally acceptable, effective health interventions. Such interventions (e.g., family spacing) are often important steps on the road to development and improved quality of life.

The following table depicts the risk factors for maternal and child mortality in terms of impact on health, intervention strategies, and AAO/Nigeria program intervention.

**RISK FACTORS FOR MATERNAL AND CHILD MORTALITY
IMPACT ON HEALTH, INTERVENTION STRATEGY, AND A.I.D. ASSISTANCE**

AGE GROUP	RISK FACTOR	IMPACT	INTERVENTION STRATEGY	A.I.D.
Proximate Determinants	Poverty	High	Economic Development Increase Status of Women	
	Illiteracy	Mod	Education and Adult Literacy	
	Lack of Potable Water	Mod	Safe Water	
Prepubertal Female	Undernutrition	Mod	Improved Nutrition	
	Low Age 1st Pregnancy < 18 years	High	Education Law (Age of Marriage)	
Fertile Age Women	Short Inter-birth Interval < 24 months	High	Breastfeeding Family Planning	FHS
	Parity > 4	Mod	Family Planning	FHS
Pregnant Women	Undernutrition Anemia Malaria HIV/STDs Abortion Ectopic Eclampsia	High	Family Planning Prenatal Care including TT and malaria chemoprophylaxis Identification and Referral of High Risk Pregnancies	FHS CCCD
Women at Delivery	Delayed Attendance Obstructed Labor Hemorrhage Infection	High	Delivery by Trained Attendant Availability and Use of Referral Services For Emergencies	FHS
Newborn	Asphyxia Hypothermia Pneumonia Sepsis	Mod	Delivery by Trained Attendant	FHS
	Neonatal Tetanus	High	Tetanus Toxoid Safe Delivery	CCCD FHS
	Low Birth Wt	Mod	Family Planning Prenatal Care Malaria Chemoprophylaxis	FHS CCCD
Infant	Undernutrition Infection Pneumonia Malaria Diarrhea Measles	High	Breastfeeding and Proper Weaning Immunization Recognition and Treatment of Illness	FHS CCCD
Infant Child	Undernutrition Infections Pneumonia Malaria Diarrhea Measles	High	Immunization Recognition and Treatment of Illness Family Community Health Facility Hospital	CCCD

D. Risk Reduction Opportunities

The following table lists five categories of risk reduction opportunities for addressing maternal/child health problems in Nigeria.

RISK REDUCTION OPPORTUNITY	INTERVENTIONS
Family Planning	Child spacing techniques, contraception.
Maternal Care	Antenatal care, safe delivery practices, postpartum care and family planning.
Nutrition	Breastfeeding (exclusive 0-3 months), breastfeeding for 24 months, nutritious weaning from 6 months, micronutrient deficiency identification and supplementation.
Immunization	Tetanus toxoid to women (antenatal care plus), BCG, DPT, Polio, Measles, and Yellow Fever to infants under one, Yellow Fever and CSM, where indicated.
Case Management of the Sick Child (fever/malaria, ARI, diarrhea)	<ul style="list-style-type: none">• <u>Home/Community</u>: recognition of illness, treatment of mild illness, recognition/referral of moderately & severely ill child, compliance with recommended therapy.• <u>Health Systems</u>: clinical assessment, treatment, counseling.

II. Nigerian Health Structure

A. Policy

Health policy in Nigeria is based on Primary Health Care (PHC) as defined at Alma Ata in 1978; i.e.

IT IS ESSENTIAL CARE BASED ON PRACTICAL, SCIENTIFICALLY SOUND, SOCIALLY ACCEPTABLE METHODS AND TECHNOLOGY. IT IS UNIVERSALLY ACCESSIBLE TO INDIVIDUAL FAMILIES IN THEIR COMMUNITY, THROUGH THEIR FULL PARTICIPATION AND AT A COST THAT THE COMMUNITY AND COUNTRY CAN AFFORD AND MAINTAIN AT EVERY STATE OF DEVELOPMENT, IN THE SPIRIT OF SELF RELIANCE AND SELF DETERMINATION. IT IS THE FIRST LEVEL OF CONTACT OF INDIVIDUALS, THE FAMILY AND THE COMMUNITY WITH THE NATIONAL HEALTH SYSTEM, BRINGING HEALTH CARE AS CLOSE AS POSSIBLE TO WHERE PEOPLE LIVE AND WORK.

Ministry of Health and Social Services (MHSS) PHC policy and responsibilities are defined in the National Health Policy and Strategy to Achieve Health for All Nigerians (1988) and in various MHSS publications on PHC. Nigeria's health strategy has a bottom up orientation emphasizing the principles of Alma Ata. The following table indicates PHC responsibilities by the various levels of health care.

PRIMARY HEALTH CARE RESPONSIBILITIES BY LEVEL	
LEVELS	RESPONSIBILITIES
Family	Practice of prevention; e.g., nutrition, hygiene, immunization Recognition of illness Treatment of mild illness Referral of moderate & severe illness Compliance with therapy
Community	Formation of Village Development (Health) Committee Assessment of needs and assignment of priorities Water and sanitation Selection and support of VHVs Access to and use of essential drugs Monitoring and use of information
Health Facility	Support to community PHC Supervision of VHVs Prevention (EPI, Nutrition, ANC) Maternity Services Revolving Drug Fund Diagnosis and treatment of illness Referral to hospital Monitoring and use of information
Local Government Area	PHC Management Revolving Drug Fund Training and supervision Preventive and curative services as per facility Notifiable Disease Surveillance Monitoring and Evaluation; Use of information
State	PHC support to LGAs (training, logistics, supervision) Secondary Hospitals at LGA Tertiary Hospital Monitoring and Evaluation, Use of information Research
Federal	Policy Financial Support to States and LGAs through Zonal offices PHC Support to States and LGAs Health Information System policy, training, and feedback Teaching and specialized hospitals Training strategies and materials Health Education strategies and materials Disease Control International health Liaison with international partners Monitoring and Evaluation, Use of information Research

B. Health Systems

Nigeria has multiple overlapping health systems as summarized in the following table.

HEALTH CARE SYSTEMS UTILIZED IN NIGERIA						
SYSTEM	ACCESS	QUALITY	COV'R AGE	AFFORD-ABILITY	EFFEC-TIVENESS	EFFI-CIENCY
Traditional: Spiritualists, Herbalists, TBAs (w/o trng)	High	Low/High*	High	High	Low/High*	Low/Mod
Pharmacies, Markets, Chemists	High	Low/Mod	High	Mod	Low/High	Low/Mod
Private, nonprofit	Mod	Mod/High	Mod	Mod	Mod/High	Mod/High
Private for Profit	Low/Mod	Low/High	Low	Low	Low/High	Mod/High
Public	Mod	Low/High	Mod	Mod/High	Low/High	Low/High

* Documented effective in mental illness - Ref. Brieger-ARHEC

C. PHC Targets and Current Status

Nigeria has adopted ten PHC Targets; most have not yet been achieved, are consistent with the Year 2000 global targets and remain relevant. See the table below.

NIGERIAN PRIMARY HEALTH CARE OBJECTIVES/TARGETS (1992-2000) AND CURRENT STATUS			
COMPONENT	NATIONAL OBJECTIVE	NATIONAL INDICATOR	CURRENT LEVEL/SOURCE
EPI Coverage	80% full immunization by age 1	% fully immunized	43.6% '91 EPI Cov'rge Surveys
Antenatal Care	50% fully immunized w/ 5 doses TT.	% fully immunized	59.2% rec'd PNC (NDHS) 40.9% = >2 TT (NDHS)
Nutri Status: Pregnant Women	90% of newborns will have a minimum birth weight of 2500 grams	% of newborn with birth weight >2500 grams	31% of pregnant women undernourished by UCH survey
Nutritional Status: Children	90% of children will have weight for age over 3rd percentile	% of children with weight for age above 3rd percentile	35.7% (NDHS)
Attendance at Delivery	70% of deliveries will be by trained attendant including trained TBAs	% deliveries by trained attendant	36.6% (NDHS)
Contraceptive Prevalence	10% of at risk women using modern family planning method	% reproductive age ♀ using modern family planning	3.8% (NDHS)
Access to Health Services	80% of population live within 5 kms 30 minutes of VHW or health facility	% of population living within 5 kms or 30 minutes	26% within 1 mile 34.6% under 30 minutes (NDHS)
Access to potable Water	40% of the population will live within 200 Ms of a source of potable water	% of population living with 200 Ms	Data not available
Access to latrine	60% of the population will live within 50 Ms of a latrine or toilet	% living with 50 Ms	Data not available
Availability of Essential Drugs	80% of VHWs and Health Facilities with drugs continuously available	% of VHWs/HFs with drugs available	CCCD study being finalized

D. Major Constraints

Nigeria has a health policy and strategy which potentially could achieve the ten PHC targets listed above. As exemplified in certain LGAs, e.g., Barkin Ladi in Plateau State, quality services are, and can be, implemented in Nigeria. Characteristics of this and other LGAs with effective PHC delivery include:

- Continuous committed leadership on the part of the LGA PHC Coordinator.
- Effective working relationship with LGA and traditional authorities including participation in planning, financing, and community mobilization.
- Commitment to PHC with full participation of Village Development Committees and Village Health Workers.
- Autonomous well-managed revolving drug fund (RDF) ensuring the availability of adequate quantities of potent drugs.
- Functioning transport available and used by PHC.
- Commitment to quality assurance in terms of continuing education and enlightened supervision.
- Commitment to monitoring, problem identification, and problem-solving.

However, as indicated above, the PHC targets have not been achieved nationwide due to deficiencies in a number of areas, including:

Vision - PHC, as eloquently articulated by the Minister of Health, has not been fully accepted or implemented by the health establishment, especially, those in secondary and tertiary care.

Continuity of Leadership - Frequent shifts in leadership at all levels have been a major obstacle to the development and sustainability of programs.

Management - The single greatest obstacle to PHC implementation relates to management deficiencies at all levels: LGA, State, and Federal. Basic skills in planning; personnel, fiscal, and logistics management; and monitoring and evaluation are not always available to those that need them. This is, especially, a problem in the newly created LGAs.

Dissemination and Use of Technical Guidelines - Nigeria has adapted and adopted technical guidelines for priority health issues. Major guidelines have been approved by the National Council of Health and are available in published manuals. Needs assessments have, however, documented major discrepancies between policy and practice in both the public and private sectors. Current guidelines have not been fully incorporated into pre-service and in-service education.

Community Participation and Health Education/Communications - PHC requires a full partnership on the part of the community. Without it, the behavioral changes required to achieve health will not occur. Fundamental to this process is the need for a dynamic mind-set and assumption of responsibility on the part of health workers concerning the potential and need for informing and empowering communities. Health education is critical to the process of empowerment and communication with communities.

Trained Personnel - Nigeria lacks trained personnel, especially, in remote rural areas. Conditions of service and personnel deployment are key issues. Experience in Niger State has demonstrated the need for and the effectiveness of in-service education.

Availability of Resources - The structural adjustment program (SAP) and inflation have severely limited the ability of health budgets to fund basic essentials for health services. Currently, at most levels of government, ninety percent, or more, of appropriated resources are utilized for personnel costs. Future projections are for limited economic growth and for continued limitation of funds.

Pharmaceuticals - Availability of quality essential drugs and vaccines is a challenge for Nigeria. Fake and adulterated drugs are a major problem of the market place. In one study, thirty percent of antimalarial drugs did not meet minimum standards. 120 deaths from adulterated paracetamol syrup (acetaminophen) emphasizes the potential for harm within the drug sector. Of equal concern is the polypharmacy (use of multiple often ineffective or dangerous drugs) in both the public and private health sectors.

E. Addressing the Constraints¹

In years past, international assistance to PHC has focused on specific vertical initiatives. Recent experience has pointed to the need for a modified approach. While vertical programs are frequently required at the central level, service delivery is integrated at the level of delivery.

Four major factors have been identified as critically important to the implementation of technical strategies; i.e., (a) efficient management; (b) collection and use of data (HIS); (c) training and quality assurance; and (d) health education/communications directed at mobilizing community participation and advocacy to achieve the changes in behavior needed for addressing issues of nutrition, prevention, care of the sick child, family planning, and HIV/AIDS.

Clinical studies have shown a significant overlap between the three major causes of severe illness in children (malaria, ARI, and diarrhea). The multiplicity of this threat to child health necessitates a more generic approach to treatment of the sick child.

Effective PHC implementation requires a bottom up approach starting at the grassroots level, with priority given to those activities needed to support the more peripheral levels. The following table, identifying needs within the health care system and appropriate responses in terms of inputs and outputs, suggests an implementation approach for addressing constraints within Nigeria's PHC system.

¹ The Nigeria CPSP (1992-2000) mandates a country program exclusively in the HPN sector, and within that sector, concentrating on PHC delivered by the public and private sectors as appropriate to the respective roles of each. Alternative approaches within the health sector — for example, (a) the provision of program assistance to curative versus preventive initiatives or (b) the placement of emphasis on secondary and tertiary care — have been rejected, out of hand, as being alien to the pursuit of socioeconomic development objectives, too capital-intensive, and too much oriented to medical treatment for elective purposes or the terminally ill as opposed to improvement in the health and productivity of the emerging generation. Concentration of program assistance, exclusively in the private sector, whether nonprofit or profit-oriented, would ignore the substantial, sine qua non role of the public sector in the delivery of health care services to major segments of the Nigerian population beyond the interests of the private sector.

IMPLEMENTATION APPROACH FOR ADDRESSING CONSTRAINTS WITHIN NIGERIA'S PHC SYSTEM			
LEVEL	IDENTIFIED NEED	INPUT	OUTPUT
Family	Lack of knowledge of basic health care issues: breastfeeding, weaning, EPI, recognition of illness, treatment of mild illness, and referral of moderately and severely ill child.	Formative research studies of key determinants of family behavior re breastfeeding, weaning, EPI, recognition of illness.	Identification of five basic health behavior messages needed at family level.
	Lack of appropriate health behavior.	Community health education through VDCs and VHWs.	Improved health behaviors as evidenced by community surveys/NDHS.
Community	Lack of understanding of community decision-makers of key maternal and child health issues.	Development and testing of a pictorial story board to be used with community leaders in discussing key health issues.	Story board developed and used.
	Lack of active involvement in health and nutrition.	Develop strategies in community education.	Strategies developed, tested, and implemented.
	Lack of active involvement in addressing and monitoring health problems.	Develop strategies to involve communities in assessing and prioritizing needs, changing behavior, monitoring impact.	Strategies developed, tested, and implemented.
	Lack of functioning Village Development Committee.	Adaptation of module "Know and involve the community" for use with health facility staff on identification of key local leaders and VDC development.	Module adapted and new material developed.
	Absence of basic essential drugs - antipyretics, antimalarials, condoms, at oral contraceptives.	Development of strategy options to ensure availability of essential drugs; e.g., chemists or RDF.	Strategic options to ensure essential drugs at village level developed, tested, and implemented. Adequate quantities of essential drugs available at village level.

Health Facility	Inadequate involvement of health facility staff in community.	Development of strategy for improving outreach, education, and monitoring of mother/community KAP.	Facility staff effectively supporting village-based PHC activities.
	Inadequate supervision of VDCs and VHWs.	OR study on cost effectiveness of bicycles/motorcycles for district supervision. Transport for district supervision.	OR report issued. Facilities have operational PHC transport for community PHC supervision.
	Poor quality of service due to lack of quality in training, CE, and supervision.	Development and testing of 12 simplified lesson plans for CE use at HF in focus and nonfocus LGAs.	Lesson plans developed and used by LGA/facility staff trained at CEU.
	Inadequate attention given to maternal and child nutrition.	Develop strategies to increase use of Road to Health, age/weight data.	Improved nutrition.
	Inadequate supply of essential drugs.	Revolving drug fund (RDF) training. Increase LGAs with functioning Bamako Initiative.	HF staff trained in RDF. Health facilities have essential drugs.
LGA	Lack of LGA political commitment to PHC.	LGA pre-selection negotiation and orientation. Management training for LGA officials.	Criteria for LGA screening, selection and negotiation developed and utilized. LGA officials participating in PHC planning, implementation, and monitoring.
	Lack of essential drugs.	Development of LGA Revolving Drug Funds (RDF).	Training in management, including RDF at Barkin Ladi. Initial supply of drugs provided to LGAs (Bamako initiative).
	Poor quality of PHC services. Lack of transport for PHC and supervision.	Provision of PHC vehicles.	LGAs have functioning vehicle for use in PHC training/supervision.
	Lack of effective HE/C at LGA, facility, and community levels.	Upgrade LGA capacity through advocacy for HE/C training and grant.	LGAs providing support for staff training in HE/C, including support for operational activities.
		Development of tracking system for supporting visits to Hfs.	Hfs provided CE through visit or training exercise on monthly basis.
	Inadequate collection and use of HIS data.	Training in data collection, analysis, and utilization.	Improved decision-making.

State	Poor quality of PHC services.	Development/strengthening of CE Unit in SHT. Strengthen clinical practice sites. Training of LGA trainers. Field supervision of LGAs by CEU: minimum of 3 days per quarter per focus LGA.	Focus states have functioning CEUs and CECs. SHT clinical practice sites providing technically correct training. Planned training sessions completed. Focus LGAs provided support and supervision thru quarterly visits.
	Inadequate epidemiologic capacity at the state level.	Train epidemiologist in each state.	Epidemiologic capacity - response mechanism improved.
	Lack of timely, quality data for decision-making.	Notifiable, sentinel, M&E, hospital reporting developed. Quarterly feedback bulletin developed. Vaccine inventory and EPI coverage reports available on monthly basis.	80% of expected reports received within 30 days. Quarterly feedback provided to LGAs. Feedback mechanism on service statistic data providing feedback on quarterly basis.
	Lack of HE/C work plan and program.	Train MPH health educator in each state at ARHEC. Strengthen health education training at CEU. Strengthen capacity in monitoring and evaluating HE/C programs. HE/C visit to focus LGAs on quarterly basis.	All focus states have MPH trained health educator. CEU HE/C capacity strengthened. 2 states have functioning system to monitor behavioral risk factors. Focus LGAs provided support/supervision visit once per quarter.
	Lack of CCCD coordination support to State implementation of PHC.	Assignment of one doctor (MD or PhD) and vehicle to each focus state.	Focus states have in residence CCCD public health advisor or epidemiologist.
Federal	Slowness in reviewing, acting upon, and implementing policy change.	Strengthen access to medical literature and review process.	PHC policies technically current, disseminated, and used.
	Inadequate epidemiologic capacity.	Develop epidemiology training program for training six epidemiologists per year.	6 Nigerians per year receiving training in field epidemiology.
	Lack of current scientific information.	Continue to support Medline at Central Medical Library. Support microfiche ref service.	Up-to-date scientific information available.
	Lack of effective public health response to epidemics.	Field training in applied epidemiology.	Epidemiologic response to outbreaks/adverse events functioning.
	Lack of data for decision-making and its effective use.	Strengthen notifiable disease, HIV/STD, sentinel, and hospital reporting. Produce, annually, 4 issues of <i>Nigerian Epidemiology Bulletin</i> . M&E providing useable data on quarterly basis.	Surveillance reports received and analyzed within 90 days of end of reporting period. Four issues <i>Nigerian Epid Bulletin</i> issued within 60 days of target date. M&E providing feedback of analyzed data each quarter.
	M&E system may be collecting more data than can be justified by use.	Support national/international review of M&E reporting.	Review and report by July 1994.

Federal (continued)	Lack of meaningful feedback of PHC M&E data and lessons learned to PHC providers.	Develop quarterly feedback of interpreted M&E data through PHC inputs into the <i>Nig Epid Bulletin</i> , <i>The Road</i> , or a PHC Feedback.	Health Facilities receiving quarterly feedback of interpreted PHC M&E data with guidance on implications for program implementation.
	Lack of effective collaboration with PVOs in HIS, Training (CE), and Health Education/Communications.	Develop with the Christian Health Association of Nigeria (CHAN) strategies to share expertise, training materials, and training courses.	PHC and CHAN meeting on quarterly basis: to review progress in coordination; and to identify opportunities for linkages.
	Technical and operational constraints without obvious solution impeding progress.	Research topics identified, reviewed, and approved by OR committee. Major research topics identified for collaborative research.	At least 10 Nigerian investigator research projects completed annually.
	Malaria incidence rising.	Test efficacy of impregnated bed nets and curtains.	Report by January 1995.
Project Management	Lack of coordination between MHSS, AAO, other donors and partners.	Quarterly meetings of partners convened by MHSS.	Partners knowledgeable about inputs and coordination mechanisms strengthened.
	Lack of sharing of lessons learned.	Annual report prepared and circulated to all States and LGAs and partners.	Report judged by peers as contributing to development of PHC.
	Suboptimal supervision and coordination of state CCCD epidemiologists/coordinators.	Quarterly meeting of epidemiologists on technical issues. Supervisor identified for each epidemiologist; each visited on a quarterly basis.	CCCD state epidemiologists sharing progress, problems, solutions on quarterly basis; and supported through quarterly field visits.
	Suboptimal coordination between AAO, CCCD, and FHS.	Quarterly coordination meetings held. Task forces organized on overlapping issues.	All AAO projects cooperating and implementation coordinated. Task forces functioning in timely contributory manner. ²

F. Measuring the Response to Health Care Constraints

Monitoring will be carried out at each level of health care responsibility (i.e., community, facility, LGA, state, federal), with indicators developed jointly among collaborating participants from each level. While the indicators will be generic, each unit; e.g., facility, LGA, state, will have responsibility for setting and monitoring its own targets. Transmission of data on target monitoring will be limited to the level supervising the monitored level. Listed below, as examples, are indicators suggested by current project implementors for their own operational use under NCCCD.

² Principal opportunities for interproject collaboration include: (a) family planning; (b) safe motherhood (training of TBAs); (c) breastfeeding and infant nutrition; and (d) AIDS/HIV/STDs.

The potential scope of interproject collaboration includes: (a) training and interproject involvement of state coordinators and CCCD epidemiologists; (b) development of health education/communications materials for CEU training; (c) operations research; e.g., EPI & FP integration; (d) training of staff at the LGA level; (e) assistance in developing M/E criteria; and (f) training of SMOH HE/C staff in formative research, planning, and methods.

INDICATORS FOR MONITORING PHC IMPLEMENTATION AT VARIOUS LEVELS

VILLAGE LEVEL:

1. VHWs (total/trained/active).
2. TBAs (total/trained/active).
3. Access to potable water (> 1 safe source).
4. Village Health Committee active.
5. Percent under ones with measles vaccine.
6. Percent of 2 and 3 year olds undernourished by arm circumference (color coded arm band).
7. Essential drugs available in village: antimalarials, paracetamol, family planning devices etc.
8. Standing orders on treatment available to those providing drugs.
9. Percent of pregnant women delivered by a trained health worker.

HEALTH FACILITY LEVEL:

1. % villages with active VHCs.
2. Number & % of villages/wards visited during month.
3. Availability of in-date properly stored vaccines at the facility.
4. Percent of children under one receiving immunization: DPT1, OPV3, and Measles.
5. Percent of pregnant women receiving first prenatal visit.
6. Percent of children = > 3rd percentile weight for age.
7. RDF functioning and providing 10 essential drugs including ORS.
8. % children with diarrhea receiving appropriate home treatment.
9. % sick children provided appropriate case management.
10. M&E and Notifiable Disease forms submitted on timely basis.

LGA LEVEL:

1. % health facilities having in-date properly stored vaccines and ORS packets.
2. % health facilities successfully operating the RDF.
3. % health facilities with at least one staff trained in CDD/ARI/MALARIA standard case management.
4. % health facilities making regular, complete and prompt M/E and DSN returns.
5. % health facilities providing daily integrated PHC services.
6. % of under ones receiving DPT1, OPV3, and Measles vaccinations.
7. % health facilities visited by the District health leader/LGA.
8. % pregnant women receiving first prenatal visit.
9. Unusual health events; e.g., outbreaks, unexplained deaths identified and reviewed.
10. Days/month LGA PHC vehicles on the road and used for the desired purposes.

STATE LEVEL:

1. % LGAs with regular supply of vaccines.
2. % LGAs with functional cold chain system.
3. % under ones receiving DPT1, OPV3, and Measles vaccinations.
4. % LGAs participating in the state CEU activities in the month.
5. % LGAs visited/supervised in the month/quarter.
6. % LGAs with functioning RDF.
7. % LGAs making regular, prompt and complete M&E, DSN, sentinel returns.
8. Unusual health events; e.g., outbreaks, unexplained deaths.
9. Data feedback provided on quarterly basis.

III. Feasibility

A variety of factors can be analyzed to assess the relative importance and feasibility of key maternal and child health interventions. The following table presents five such factors — i.e., impact on health, effectiveness, logistic feasibility, acceptability, and cost-effectiveness — relative to specific maternal/child risks and relevant response strategies.

SELECTION OF INTERVENTION STRATEGIES IMPACT ON HEALTH, EFFECTIVENESS, LOGISTIC FEASIBILITY, CULTURAL ACCEPTABILITY AND COST EFFECTIVENESS + Very Low, ++ Low, +++ Medium, +++++ High						
RISK	STRATEGY	IMPACT ON HEALTH	EFFECTIVENESS	LOGISTIC FEASIBILITY	ACCEPTABILITY	COST-EFFECTIVENESS
Interval: <24 months Parity >4	Family Planning	++++	+++	++	+	++
Failure to Identify/Refer High Risk	Antenatal Care	++++	+++	++	++	++
Neonatal Tetanus	Tetanus Toxoid	++++	++++	+++	++	++++
Malaria in Pregnancy	Chemoprophylaxis	+++	++	++	+++	++
Delivery Complication, Sepsis	Attended Delivery	++++	++	+	++	+
Malnutrition	Exclusive Breastfeeding 0-3 months	+++	+++	+++	++	++
	Food Supplementation >6 months	+++	+++	+++	++	+++
Measles	Measles Vaccine	++++	+++	+++	++++	++++
Malaria	Case Management	++++	+++	+++	++++	+++
Diarrhea	Case Management	++++	++	++	++	++
Pneumonia	Case Management	++++	+++	++	+++	+++

A. Family Planning

ACSI/CCCD focused on specific disease control activities and a limited scope of support strategies. The shift of program implementation to LGA PHC delivery; the importance of family spacing and maternal issues to individual, family, and national health; and the basic program decision to merge major initiatives at the delivery level: all require that substantial efforts be made to increase family planning information and services availability.

With respect to effectiveness, family spacing methods vary from moderate (rhythm, condoms), to high (oral contraceptives) to very high (Norplant and surgical methods). As to logistic feasibility, FHS, the MHSS, and the private sector are working to increase the availability of trained personnel and supplies.

As indicated by the 1990 NDHS: knowledge, demand, first-time use, and continued use of modern family planning methods are low. IEC efforts are expected to increase demand over the life of project. Given the current subsidization of family planning efforts, cost, although moderate, is not an obstacle to the inclusion of family planning in the overall maternal/child health strategy. Program emphasis should be on the reduction of high risk births (births < 18 years, intervals < 24 months, parity > 4, age > 35).

With its priorities in training, continuing education, health education/communications, and community mobilization, NCCCD has an excellent opportunity to support child spacing initiatives as part of PHC.

Because of local factors limiting demand, overall feasibility is low. Nevertheless, from development and health perspectives, steps need to be initiated for the incorporation of family planning objectives and interventions into PHC. Actions to be taken include:

- Strengthen in focus states an understanding of the child spacing issue and develop a commitment to include family planning in CEU training.
- With assistance from FHS, assess current knowledge and practice of family planning in focus LGAs.
- With assistance from FHS, adapt and develop a training module for use in CEU training.
- Identify and upgrade skills of focus LGA facility personnel in knowledge of, and advocacy for, contraceptive services and counseling in family planning.
- Include contraceptives in RDF development to ensure availability of condoms, pills, injectables at facility level and condoms and orals at community level.
- Monitor progress through M/E system, identify problems, and find solutions.

With these steps, modest targets re postpartum advocacy of contraceptives, contraceptive usage, and reduction of high risk births are approachable.

B. Maternal Care

Lack of effective maternal health care is a major, perhaps the most important, health problem in Nigeria. Data from the 1990 NDHS document low use of basic essential maternal health services; e.g., (a) lack of antenatal care (ANC) - 34.8%; (b) no tetanus toxoid - 46.4%; (c) delivery at home - 61.9%; and (d) lack of attendance of trained attendant at delivery - 57.8%.

There are two priorities in maternal care: (a) to assess and upgrade the quality of ANC; and (b) to expand coverage. In Nigeria, the demand for antenatal care is relative high with good acceptability. The elements of ANC — nutrition counseling, TT, malaria chemoprophylaxis (two-dose schedule in 6-12 months), and identification and referral of high risk mothers — are not always well practiced.

Methods are well-known, technically feasible, and of low cost. The major obstacle, however, is lack of access to, and the quality of, referral services for high risk mothers. Inadequacies in LGA and private hospital obstetric services, although beyond the scope of this project, limit potential achievement of safe motherhood objectives.

Increased attendance at delivery by trained personnel could significantly decrease perinatal mortality, which accounts for twenty to forty percent of infant mortality. The basic procedures of hand washing, cord cutting and care, warming, and air way care are technically and logistically feasible. Referral of delivery complications (C-sections) is a major problem in many areas both in terms of transport and availability of quality services.

Postpartum care is almost nonexistent in Nigeria; it is estimated at <5%. This, however, is not a problem of access, as over fifty percent of infants are receiving immunization usually at the appropriate time of six weeks. Integration of maternal and child services, rather than using the separate day (ANC, Well Child, Sick Child clinics on separate days) approach, could significantly increase the opportunities for postpartum counseling on breastfeeding, childhood nutrition, and family planning.

Critical interventions required for the strengthening of maternal health services in focus LGAs include:

- Through use of M/E forms and contact with private sector providers, assessment of maternal health coverage in focus LGAs.
- With assistance from MotherCare and/or the Nigeria Nurse Midwives Association, assessment of quality re current maternal health services.
- Based on results of needs assessment, development of a training strategy for upgrading the quality of maternal health services.
- Assured availability of basic equipment; e.g., sphygmomanometer, scales.
- With the assistance of VDCs, identification of trained and untrained TBAs in at least one district in each LGA.
- Provision of TBA training and equipment to those TBAs attending a significant number of deliveries per month.
- Monitoring of results through the M/E evaluation system, as a means for assessing the utility of the system for the provision of data that are meaningful, useful, and actually used.

Overall, feasibility of improving antenatal care is high, delivery care is low to moderate, and postnatal care is moderate.

C. Nutrition

As evidenced by the 1990 NDHS data, malnutrition is a major problem for Nigerian children. In a recent arm circumference study in Barkin Ladi LGA, four percent were severely malnourished (<12.5 cm) and twelve percent were moderately malnourished (12.5-13.5 cm).

While there are limitations with respect to the availability of food, adequacy of stocks, and affordability to the consumer, most malnutrition in Nigeria results from poor feeding practices and inadequate treatment of illness, especially in the area of supplemental feeding.

Lack of exclusive breastfeeding during the first three months of life and improper weaning were identified by the NDHS and other studies as major constraints. The interventions are technically and logistically feasible. The cost is low, probably less expensive than current practices. Major constraints relate to acceptability of improved practices subject to knowledge, tradition, and motivation on the part of both health workers and mothers. Nutrition is a prime area for HE/C directed at improving community understanding of, and advocacy for, appropriate infant feeding practices, including the adequate supply of micronutrients.

Micronutrient deficiency is increasingly recognized as important to child health. In deficient areas, Vitamin A supplementation has been associated with increased survival; iodine supplementation, with improved mental development. Micronutrient status is not well known in Nigeria, although it is an evident, major problem in some areas; e.g., goiter is not uncommon throughout Nigeria. Feasibility of micronutrient interventions is low because of lack of knowledge of the problem.³

Inclusion of feeding messages in the treatment of the sick child is an important and frequently overlooked nutritional intervention. As in the area of infant feeding, the strategies are technically and logistically feasible and affordable. Major constraints include: (a) client reluctance, lack of knowledge, and predilection for traditional practices; and, primarily, (b) the failure of health care providers to emphasize the importance of feeding in the care of the sick child.

Relatively modest inputs into nutrition are expected to have significant impact through utilization of: (a) ethnographic studies (in focus states) focused on maternal and health worker KAP, leading to the development and testing of intervention strategies; (b) information gained in CEU training and in national IEC efforts; and (c) CE and supervision oriented to strengthening feeding as a key component in the treatment of the sick child.

Communities need to be empowered to monitor the nutritional status of their children through use of the "Road to Health" Cards and/or annual monitoring of arm circumference using color-coded arm bands. Applied research in this area is needed.

Opportunities for improvement in nutrition are mixed. Minimal inputs into micronutrients are expected to have major results. As in other areas involving behavior patterns, improvement of feeding habits is a slow, but important process.

D. Immunization

Over the last decade, the Government of Nigeria, with assistance from UNICEF, WHO, A.I.D., and Rotary, has reestablished an effective immunization program meeting international quality standards. National Immunization Days (NIDs), State Immunization Days (SIDs) and Local Immunization Days (LIDs) were used to boost coverage in 1990 to the 70-80% range. Morbidity and mortality were within expected parameters, indicating that the program was moving toward both its coverage and disease reduction targets. Then, in 1991, in the absence of special international support, coverage

³ The Program Against Micronutrient Malnutrition (PAMM) at Emory University has developed an effective training strategy in which nationals are trained in survey techniques, blood spot collection and analysis, data analysis, policy formulation, and strategy development. Essential data for policy change can be developed within twenty-four months. Such a program is pertinent to Nigeria's situation and needs.

fell to the 50-60% range. This gives an indication of the coverage levels achievable through the current infrastructure in the absence of the extraordinary externally-funded efforts used in 1990.

Sustainability and increased coverage will require considerable effort. As to technical feasibility, the EPI strategy works and is targeting potent vaccine to the population at risk; i.e., infants in their first year of life.

From the logistics perspective: the current EPI infrastructure is capable of maintaining coverage only in the sixty percent range and, then, only if vaccine in adequate amounts is supplied from the Federal level and cold chain equipment is assured by international partners. Achievement of global targets⁴ will require new and improved strategies. In areas where vaccine is available, demand and acceptability are high. Measles and tetanus vaccines have been identified in the World Bank Monograph on Health Priorities (Mosley and Jamison in press) as the most cost-effective of potential health intervention strategies in the developing world.

Building on successes to date, NCCCD will continue to provide important inputs oriented to the further strengthening of EPI in Nigeria. Priority requirements critical to the attainment of that objective include:

- Computerization of vaccine inventory, including cold chain monitoring at two federal and focus state stores.
- Maintenance of an effective vaccine inventory distribution system in the focus states.
- Assistance to focal LGAs to ensure a functioning cold chain at each fixed facility.
- Work with LGA staff to assess and strengthen EPI advocacy, logistics, implementation and monitoring.
- Work toward full compliance with the national immunization schedule, including polio at birth, yellow fever with measles, and TT for fertile-age women.
- Work with LGA staff to set targets and to implement strategies to achieve those targets.
- Continuation of efforts to strengthen HIS in focus states and LGAs and at the Federal Level through: (a) monitoring of coverage, sentinel surveillance, and special studies; and (b) development of user capacity to utilize data for program improvement.

Provided political will and partner participation continues strong, achievement of coverage targets is feasible and highly probable. The disease reduction goals are not technically feasible and need to be adjusted to address the issues of strategy, vaccine efficacy, and resource availability.

E. Treatment of the Sick Child

Three diseases — fever (presumptive malaria), ARI, and diarrhea — account for a large percentage of post neonatal childhood morbidity and mortality. Over the last five years, vertical treatment strategies have been developed, which provide low-cost, effective strategies of case management (clinical assessment, treatment, and counseling). Increasingly, WHO and its partners are recognizing

⁴ I.e., 90% coverage; 90% reduction in measles morbidity; 95% reduction in measles mortality; NNT elimination; and polio eradication.

the overlap in clinical symptomatologies and the need for a more holistic approach to the sick child; e.g., ninety percent of pneumonia cases meet the clinical criteria for malaria.

From a technical perspective, current standing orders — chloroquine for fever, ampicillin or cotrimoxazole for pneumonia, and ORT for acute dehydrating diarrheas — will be effective in over eighty percent of cases. Effective use of these therapies, however, requires: (a) recognition of illness on the part of the child caretaker; (b) desire and permission on the part of the decision-maker to seek care; and (c) physical, economic, and cultural access to health care services.

In general, there is a desire for care and a high acceptability of care. The major constraints relate to access and the quality of care, as provided by the various health systems, private and public. Significant decreases in illness-related morbidity and mortality can be achieved through:

- Development of a more holistic approach to treatment of the sick child.
- Dissemination of technical guidelines in user-friendly formats and job aids to both public and private providers.
- Development of Revolving Drug Funds (RDFs) in focus LGAs, including appropriate management training.
- Support of quality care as developed in Niger State through the monitoring of quality (facility needs assessments) and continuing (in-service) education.
- Shifting clinical services from unipurpose clinics to integrated comprehensive (preventive and curative) services.
- Incorporation of technical guidelines into pre-service education.
- Utilization of linkages with manufacturers and professional association to encourage more appropriate usage of drugs in the treatment of childhood illnesses in both the public and private sectors.

IV Sustainability

The present discussion on sustainability benefits from a recent, intensive assessment⁵ focused on: (a) documenting lessons learned in the implementation of ACSI/CCCD/Nigeria; (b) assessing the potential for host country sustainability in the future; and (c) enhancing the prospect in that regard with respect to the design of NCCCD.

A. Key Factors Affecting Sustainability

1. Contextual Factors Affecting Sustainability

By definition, contextual (i.e., external nonproject) factors are beyond the control of the project. In Nigeria, however, such factors are significant in the assessment of sustainability, indeed, of sustainability itself. The table below presents five groupings of such factors; i.e., economic, resource, political, sociocultural, and environmental.

⁵ Atlantic Resources Corporation, October 1992.

Contextual (External, Non-Project) Factors Influencing Project Sustainability
<p>I. Economic Factors</p> <ul style="list-style-type: none"> ● Structural adjustment, decline in GNP and earning power ● Policies and activities of other donors, such as UNICEF and World Bank ● Changes in the A.I.D. foreign assistance agenda ● Increasing level of urbanization ● Progress towards industrialization and economic development ● Declining infrastructure (condition of facilities, roads, vehicles, etc.) ● Trends toward privatization ● Changing health priorities within Nigeria and emerging health issues (also an environmental factor)
<p>II. Resource Factors</p> <ul style="list-style-type: none"> ● Administrative capacity of MHSS, including level of training of staff and structure ● Generally large base of highly trained, capable health professionals ● Personnel turn-over and movement to private sector ● Brain drain among the most qualified health professionals ● Patterns of health resource allocation ● Availability of health-related data
<p>III. Political Factors</p> <ul style="list-style-type: none"> ● Political system may change in near future, bringing a change in the overall political agenda ● Level of civil stability ● Extent to which decision-making and autonomy are decentralized ● Heterogeneity of population, population size and size of the country (also an environmental factor)
<p>IV. Sociocultural Factors</p> <ul style="list-style-type: none"> ● Cultural Issues (e.g., corruption, ethnosocial animosities) ● Fundamentalist religious movements, Islamic and Christian (also a political issue) ● Consumer preferences
<p>V. Environmental Factors</p> <ul style="list-style-type: none"> ● Natural disasters and disease outbreaks ● Emerging health problems (also an economic factor) ● Population size and heterogeneity and size of country (also a political factor)

1.1. Economic Factors⁶

Nigeria faces an uncertain economic future. Oil revenues have been on a decline and other major exports have suffered in world markets. Although the economic policy environment has improved and its economy has grown since 1987, Nigeria's external debt has also grown and is now rising faster than the GDP. Much borrowing has taken place (under World Bank guidance) to finance expenditures in the social sector, including support to population and health systems development. Projects such as DFRRI, MAMSER and BETTER LIFE have enjoyed very liberal lines of credit. Nigeria is caught in a downward debt spiral.

Nigeria's revenues are shared among the three levels of government through a complex sharing formula. Some funds are retained outright by the federal government, and the rest are deposited into the Federation Account. The allocation is 50% federal, 32% to the states, 15% for local governments and 3% for special programs. States and LGAs generate their own revenues by charging user fees, income taxes, property taxes, licensing fees and vehicle fees. States are expected to share these revenues with LGAs, but the sharing of funds has been sporadic.

⁶ See Annex H (Economic and Financial Analyses) for an in-depth discussion of Nigeria's economic and financial situation.

Health has not done well in the competition for funds. Since 1980, the resources allocated to health have shown a downward trend. The proportion of the federal budget allocated to health has ranged from approximately 1.3 to 3.5%. In real terms, however, the 1992 value is only a fraction of the allocation for 1981. The prospect for a near term reversal of this trend are remote. At the state and LGA level the picture is a bit brighter with an increased percentage of local budgets being allocated to health.

The process of decentralized fiscal control is resulting in an overall increased expenditure on health. The proportion of the total federal budget being passed directly to the states and local governments is considerably less than fifty percent and much of the value (purchasing power) is lost with the deflation of the Naira.

For these reasons, Nigeria's ability to finance health programs is a contextual consideration that weights heavily against the ultimate sustainability of much of the NCCCD agenda of interventions.

1.2. Resource Factors

The role of donors in providing and subsidizing health sector resources in Nigeria is significant and has influenced their programs, thus blurring the distinction between purely contextual and project-related factors.

Nigeria has taken positive steps to enhance the administrative capacity of the MHSS and the SMOHs. The Civil Service Reform Act of 1988 established the size and configuration of Federal and State Ministries and reduces the numbers of trained personnel who can be transferred from departments where they have acquired technical skills. Low salaries and limited career development/training opportunities for public sector workers severely limit the ability of key ministry departments to attract and retain skilled workers.

Nigeria's 14 medical schools, 54 nursing schools, 46 specialty nursing schools, 63 schools of midwifery and 31 schools of health technology produce an abundance of trained manpower. During the period 1978-1987 the number of professional personnel increased as follows: (a) doctors from 17,904 to 56,120; (b) nurses from 17,904 to 56,120; and (c) midwives increased from 13,101 to 45,852.⁷

Despite this abundance, the health sector has been handicapped by an inability to distribute health personnel to rural areas, difficulties in retaining trained health personnel ("Brain Drain"), and variable quality in health education.

Despite significant donor inputs, Nigeria continues to have limited health infrastructure to support its PHC programs. Health facilities and equipment are generally in poor repair or are nonfunctional. Supplies, disposables and drugs are dependent on imports and are in chronic shortage. The devaluation of the Naira has had a profoundly negative impact on Nigeria's pharmaceutical industry and on its ability to maintain the supply of essential vaccines and drugs.

1.3. Political Factors

Nigeria is in the process of geopolitical formation. The past two years have brought a reform of the national civil service, the election of civilian governments at state and LGA level, and the initiation

⁷ The World Bank, Health Systems Fund Project report 4/3/91.

of a democratic transition to civilian leadership in the Presidency. These changes have been in the context of a realignment of the states and local governments. Nine new states and 593 local governments have been constituted, each with a civilian government and local fiscal and political autonomy.

The impact of these reforms on the organizational, administrative, and service delivery capacity of the public health sector can not be overstated. The already limited numbers of trained, state-based administrative, managerial and service delivery staff have been split to accommodate the needs of new state and LGA administrations. Transfers have disrupted working relationships. Scarce resources have been shared (often grudgingly) between old and new states, leaving all poorly equipped. This is complicated by the fact that in many cases, the new state and LGA leaders have not viewed health as an immediate priority.

Ultimately, however, the move toward decentralized local government may be expected to result in an increased governmental responsiveness to local need (including the provision of health services) and increased accountability by local authorities.

1.4. Sociocultural Factors

Nigeria is a land of more than 400 distinct ethnolinguistic groups, a consideration which enhances, substantially the complexity of health education and service delivery programs. Tribal and religious affiliations play an important role in government at every level. In the northern and eastern parts of the country these tensions often erupt into armed conflict.

Much of the chronic under-utilization of health facilities which handicaps the delivery of PHC services is a consequence of these same conflicts. PHC clients are often uneasy about seeking services from facilities outside of their immediate community or from providers who speak a different language or practice a different religion. While Nigerians often observe that the Nation's strength is in its diversity, the health sector is struggling to meet competing demands of many interest groups.

1.5. Environmental Factors

In the 1990s, Nigeria will need to address several environmental issues. The emergence of new diseases such as AIDS and diseases of the elderly coupled with the resurgence of continuing disease problems such as malaria and tuberculosis will present serious challenges. The population is rapidly becoming more urban and older. While data is not readily available to facilitate for an in-depth assessment of the impact of environmental changes on the sustainability of CCCD project activities, it seems obvious that these new challenges will add to the already substantial demand for health services and further stretch scarce resources.

2. Project-Related Factors Affecting Sustainability

As recapitulated in the table below, the following project-related factors affecting sustainability will be discussed within the context of their various indicators; i.e., (a) perceived effectiveness; (b) integration and institution-strengthening; (c) local financing, community participation, and private sector provision of services; (d) relative strength of training interventions; (e) constituency-building through a process of mutually respectful negotiation; and (f) counterpart perception of ownership.

Project-Related Factors Affecting Sustainability and Applicable Indicators
<p>I. Perceived Effectiveness</p> <ul style="list-style-type: none"> ● Development of work plans and national policy statements ● Implementation of HIS/MIS or special surveys to measure project impact ● Completion of operations research and special studies to assess program quality and develop solutions ● Use of data for making decisions, identifying problems, developing solutions and confirming project's importance at health sector council meetings
<p>II. Integration and Institution-Strengthening</p> <ul style="list-style-type: none"> ● Effective supervisory system (using checklists) decentralizing technical and managerial responsibility to the peripheral level ● Integration of service delivery at delivery sites ● Integration at national level into existing MHSS structures ● Support activities operational and integrated at the national level ● Competency as basis for assessing worker performance
<p>III. Local Financing, Community Participation, and Private Sector Provision of Services</p> <ul style="list-style-type: none"> ● Assumption of project costs by government ● Implementation of fee-for-service/cost recovery ● Private provision of project-related services ● Donor complementarity and coordination
<p>IV. Relative Strength of Training Interventions</p> <ul style="list-style-type: none"> ● Development and implementation of training strategy ● Development and implementation of continuing health education policy ● Development and implementation of supervisory system ● Completion of facility training needs assessments ● Training of trainers ● Project training activities integrated into existing MHSS training structures
<p>V. Constituency-Building Through a Process of Mutually Respectful Negotiation</p> <ul style="list-style-type: none"> ● National counterparts participate in country assessments, project development and modification, and clearly view the project as a priority ● Relevant agencies participate in project workshops ● MHSS procedures facilitate the inclusion of local concerns and decisions within national-level plans
<p>VI. Counterpart Perception of Ownership</p> <ul style="list-style-type: none"> ● Degree of ownership perception on part of counterparts ● Degree to which project-related decisions are being made by organizations/bodies representing local constituencies ● Project development and modifications originating with counterpart representatives ● Progressive assumption of project costs and management responsibilities on the part of community beneficiaries

2.1. Perceived Effectiveness

PHC is widely perceived as an effective, government-led service that provides essential health services to the people of Nigeria. ACSI/CCCD/Nigeria has achieved a high degree of integration into the national PHC programme and is generally perceived as effective based on an assessment of four key indicators; i.e., (a) development of national policy statements and work plans; (b) implementation of HIS/MIS or special surveys measuring project impact; (c) completion of operations research and special studies assessing program quality and develop solutions; and (d) use of data for making decisions, identifying problems, developing solutions, and confirming project importance at health sector council meetings.

Policies and Work Plans

Nigeria has several clearly worded policy documents that guide the implementation of its PHC program. Foremost is "The National Health Policy and Strategy to Achieve Health for All Nigerians" launched in 1989. This comprehensive document includes maternal, child-care, and

family planning strategy and provides the conceptual framework on which the PHC program is based. It also clearly established policy support for a national health information system and a national health care research (OR) programme.

Nevertheless, there are areas where policies and guidelines are clearly needed, but not yet formulated at any level of authority (Federal, State nor Local). Chief among these is the need for policies to guide the development of cost-recovery programs, while assuring equity in the allocation of health resources. States and LGAs are, with few exceptions, attempting to implement cost-recovery programs, but are doing so without guidelines on: (a) optimal costs (and profit margin) for essential drugs and services; nor (b) utilization of funds collected from the health sector.

In some cases, funds collected from health facilities are being used to underwrite other (non-health) programs; in others, the funds are accumulating in stagnant accounts due to administrative obstacles.

The national policy regarding EPI is clear and the integration of ACSI/CCCD into the Nigerian program has resulted in important modifications of the national vaccination policy. For example, CCCD contributed to the modification of national vaccination policy with the addition of the OPV₀ and TT_{3,5} doses to women of childbearing age as well as the inclusion of Yellow Fever (YF) vaccine as part of the EPI vaccines.

The policy for CDD is less clear and has recently been modified. Initially, the MHSS favored the exclusive use of sugar salt solution (SSS) because this was seen as the more sustainable approach with less dependence on imported commodities. This tendency has now been changed to include the use of oral rehydration salts (ORS) at the facility level. This modification is poorly understood, most facilities are inadequately stocked with ORS, and the application of the new policy has not been widely disseminated. ORS is not seen by service delivery personnel nor clients, alike, as being effective. Clearly, this matter is a prime subject for the health education/communications and continuing education agendas.

While national policies and guidelines for malaria control have been promulgated, their application at the facility level is spotty. Policy guidelines are not fully implemented, especially with respect to chloroquine chemoprophylaxis during pregnancy. There is still overuse of injectable chloroquine and non-chloroquine antimalarials. Most health facilities have posted national guidelines for treatment doses (25 mg/kg), but there is less than full adherence to schedule at secondary and tertiary levels; i.e., hospitals.

Training has been given a high priority in the implementation of the MHSS primary health care policy. A manual, "Guidelines and Training Manual for the Development of Primary Health Care System in Nigeria," has been produced and disseminated by the MHSS Division of Training and Manpower Development to all SMOHs, the LGAs, and various schools of health technology (SHTs). In contrast, health education suffers from the lack of a specific policy. Project staff feel that this gap in policy is due to a lack of clarity about the meaning and role of health education in PHC as well as a failure on the part of the states to develop comprehensive programs capable of implementing effective educational interventions.

National work plans exist for the EPI, CDD and HIS programs that reflect MHSS priorities. Clear-cut guidelines have been developed and practices at health facilities reflect most of the guidelines. At all levels of attention (MHSS, SMOH and LGA), the existence of work plans, however, does not translate into action, especially with respect to mobilization, either for outreach vaccination activities or for supervision. For example, health facility personnel are incorporating OPV₀ dose and TT₃ dose, but not TT₄ and TT₅ doses; nor is there a change in target population to women of childbearing age.

CDD work plans are oriented towards training quantity and do not include an assessment of quality or programmatic impact. While the HIS, however, is still early in development and implementation, its work plan and priorities have been established.

There is concern about the effectiveness of the work plan development process. Donor work plans are occasionally imposed and, thus, do not always meet with MHSS, SMOH and LGA priorities. This tendency contributes to decreased probability of sustainability. In one case, an external donor's work plan promised assistance (cold chain equipment for new LGAs) that was not delivered, while derailing local efforts to purchase the equipment with local funds.

The existence of clear-cut national policy statements, guidelines, and work plans are a necessity, but are not in, themselves, sufficient for sustainability, as other factors impede implementation of policies and completion of planned activities.

HIS/MIS and Special Surveys to Measure Project Impact

Nigeria has been transformed from a "data poor environment" to a "data rich environment". There are extensive efforts under way for the collection of HIS-related data through routine data systems; e.g., M/E, EPID, and sentinel surveillance sites. In addition, many surveys have been conducted to refine data and validate the routine data collected. Data on vaccine-preventable diseases is readily available, but data on the mortality trends due to diarrheal diseases, for example, is not routinely collected, nor used in the assessment of CDD activities. Hospital discharge data is collected and shows promise as a good source of retrospective data to permit disease trend analyses. Because hospital data is seen as useful in some areas, medical records personnel have sought out HIS personnel for technical assistance. Many, on their own initiative, have been entering their hospital data to do analyses. In Enugu State, the medical records personnel, to allow for trend analyses, have been entering data from 1987 through 1990 prior to entering 1991/92 data.

DSN and sentinel surveillance systems are considered by the recipients of data to be useful and effective. Copies of data collected are being distributed to policy-makers at state and federal ministries. National and SMOH levels are now publishing reports on data received and are using the data to stimulate interest. Niger and Plateau states have produced epidemiologic bulletins for the state. Plateau State produced in October, 1992, an Annual Statistical Summary for 1991 and expects the Annual Statistical Summary for 1992 to be available in March/April, 1993. Clearly, the timeliness of reporting has increased. Indications are that there is also a perceived need for the HIS data, with interest in the institutionalization of information-generating activity.

While CCCD provides computers, printers and a starter supply of diskettes and paper, all recipients have been purchasing supplies once the initial starter supply is exhausted. Areas that have received CCCD-funded computers have been training personnel and rapidly computerizing their data bases. Many have begun the routine production of reports and feedback instruments. There are anecdotal reports of other personnel in the health care delivery system (i.e., private sector providers) seeking out assistance and training and use of the CCCD-supplied computers for data entry and analyses related to HIS. Nonsentinel hospitals have requested assistance to computerize discharge diagnoses to analyze trend data. CHAN (private sector) has sought CCCD assistance to develop HIS in CHAN institutions along the same lines as the national system.

However, MIS data are not presently collected, systematically, at all levels of attention. Vaccination distribution data and inventories are not always easily available. ORS packet inventories and distribution data are even less available than for vaccines. No information on ORS packet utilization is being collected. Similarly, information on chloroquine distribution, availability and utilization is

not routinely available. Diarrheal treatment practices have just been included in the M/E health facility assessments. The design of MIS software needed to address these shortcomings is still under development.

HIS is definitely perceived as effective by the health care personnel at LGA, SMOH and MHSS levels as well as by the policy-makers; this situation is contributing to an overall perception of CCCD program effectiveness. MHSS officials express a perceived need for MIS to monitor commodity distribution and utilization as a mechanism for imposing accountability of supplies, but it is unclear whether this need is perceived at the SMOH or LGA levels.

Use of Operations Research (OR) and Special Studies to Assess Program Quality

The national policy has been to support OR, which is perceived as effective by the key MHSS and SMOH policy-makers and administrators. It is too early to determine whether data are being effectively utilized to make decisions, identify problems, and develop solutions. Availability of good data has just started to occur in the past year or so. There is only a thin cadre of trained personnel below the central MHSS level with the capacity to analyze, interpret, use, and package data for use by decision-makers. This is an expressed concern of the MHSS.

The OR review committee meets quarterly as scheduled to review protocols. This committee was originally felt to be a one-man operation directed by the CCCD resident epidemiologist, but after his departure, the quarterly meetings have continued and studies are still being submitted and reviewed for funding. To facilitate and stimulate the OR component, Medline on CD-ROM was installed at the National Medical Library. Additional evidence of the perceived effectiveness is the committee seeking a subscription to the Rockefeller database of medical journals to facilitate literature searches once articles are identified via Medline searches.

New studies are continually submitted for review and funding. Of the OR studies approved by the CCCD project, forty-five have been funded and twenty completed (44%) completion rate. Studies are directed at CCCD target activities/programs, and the results have led to policy changes. Examples of this are the studies on: (a) efficacy of pyrimethamine in pregnant women; (b) effect of malaria chemoprophylaxis on the outcome of pregnancy in Zaria; and (c) quality assurance testing of chloroquine in eastern Nigeria.

As a result of these studies, policy changes have recommended initial treatment of malaria in pregnant women followed by the use of chloroquine prophylaxis (replacing prior practice/recommendation for pyrimethamine prophylaxis); and stricter quality control guidelines for local production and sale of chloroquine.

Additional studies under way address issues that will lead to anticipated, additional programmatic/policy changes, such as recommendations for vector contact reduction methods to reduce morbidity due to malaria, treatment practices for diarrhea, and acceptable weaning foods.

One problem is the limited scope of surveys focusing on specific geographic areas and/or specific target diseases funded by different donors. There is no database at the federal level recording all of the numerous surveys conducted in the country.

A health education assessment was conducted in March 1992 with CCCD support. It has identified five major problems hindering health education in Nigeria and developed realistic and appropriate recommendations. FMOH, States, ARHEC and other players have contributed to the assessment

which generated a great interest at all levels. The MHSS has already started implementing some of the recommendations. The assessment has helped legitimize the previously expressed views of health educators and health education practitioners.

Use of data to make decisions, to identify problems, and to develop solutions

As indicated above, data generated through OR studies funded under CCCD assistance have been used to affect policy changes. The MHSS has recognized the importance of OR for the generation of data to address issues of importance to program activities. To this effect, there is a draft work plan, 1993-1997, for the National Health Services Research program.

HIS data is being utilized for stimulating programmatic as well as policy changes. In one instance, the EPI Coordinator in one state showed a graph of coverages by LGA to the applicable LGA chairmen. Investigations into reasons why coverages were so low in the LGAs revealed that designated EPI vehicles, often, were not available for EPI activities. This led to the reclaiming of the vehicles by the respective EPI programs. This same EPI coordinator plans to send regular EPI data collection/analyses updates by LGA to the LGA chairmen to increase their awareness and support for the EPI activities in their LGAs.

There is some evidence that LGAs are beginning to analyze and utilize their own data. The development of this capability has led to SMOHs now analyzing their own data, rather than sending it to the MHSS for analyses. Coverage data is being used by EPI coordinators at the SMOH level to increase political commitment to EPI activities. Decreasing coverages are also being used by local managers to demonstrate the need for additional resources.

2.2. Integration and Institution-Strengthening

All CCCD-supported activities are well integrated into existing health structures at the national, state and local levels. This is, especially, clear at the national level. There is an EPI division, a CDD division, and a malaria division. Support activities are also operational and integrated at the national level. OR activities have been institutionalized under the auspices of the Planning, Research and Statistics Directorate. The HIS activities have been institutionalized under the M/E division of the PHC Directorate.

An active supervisory system with checklists and decentralized technical and managerial responsibility exists at the peripheral level. Health facility assessments conducted under the aegis of the M/E division have been using checklists to assess activities within each of the programs. While extensive TA has gone into the development of supervisory checklists, the implementation of these has been impeded by the lack of mobilization of supervisory personnel.

Of all programs, EPI has the best developed awareness of supervisory needs. Actual supervision, however, is still not optimal as evidenced by field visits to health facilities and LGAs where review of "visitor books" reveal that supervisory visits by EPI personnel are not consistent. There is minimal evidence of MHSS supervisory visits to SMOH for EPI-related activities and minimal evidence of supervisory visits by any level (MHSS, SMOH or LGA) related to CDD and malaria program activities. There is no documentation of reported supervisory visits as part of the implementation of HIS activities. Supervision of ongoing OR studies is provided by a designated preceptor and the Research Review Committee.

Integration of service delivery at delivery sites is seen by health personnel as desirable. At the PHC level, the same person is responsible for EPI, CDD and malaria activities. However, as the number of personnel in a health facility increases, the possibility of nonintegration of activities increases.

Missed opportunities in health facilities are commonplace. For example, a child attending for treatment of a diarrheal illness and never immunized is not routinely referred by curative personnel to the EPI unit for vaccination for one of the following reasons: (a) through oversight; (b) vaccinations are not being given that day; or (c) vaccinations are not given at that facility. Such a situation does not foster total integration of activities.

2.3. Local Financing, Community Participation, and Private Sector Provision of Services

There is an important relationship among factors such as local financing, community participation, the private sector provision of services, and project sustainability. There is an appreciation at all levels of the Nigerian health structure of the need to develop a sustainable base of financial support for PHC programs through local financing initiatives. Political support for the participation of the private sector in the provision of services is growing. No amount of commitment, however, is likely to overcome the very significant short-term financial constraints faced by Nigeria. This consideration weighs, heavily, against the potential for sustainability of many CCCD interventions without external donor inputs.

There is some evidence, however, of the assumption of project costs by government at all levels.⁸ The MHSS is committed to the purchase of vaccines and has assumed responsibility for all, but OPV provided by Rotary International. Nevertheless, vaccine purchase in 1992 was complicated and delayed by the decentralization process, with several states being late providing vaccine purchase funds. This situation should be corrected in the future with a deduction of vaccine purchase contributions at the Federal level before funds are passed to the states and LGAs.

There is an expressed willingness of SMOHs to budget for the purchase of cold chain equipment. One SMOH budgeted, also, for the purchase of vehicles for EPI use at the LGA level. The MHSS is, however, not committed to the purchase of either ORS packets nor chloroquine. Local production has not been encouraged and, indeed, these essential drugs are still subject to import duties.

The MHSS is purchasing supplies for computers (diskettes, printer cartridges and paper), and the states will be expected to assume the recurrent costs associated with their HIS/MIS units. SMOH and LGAs are also expected to assume the costs of reproducing reporting forms. With the introduction of the new M/E system, printing costs may exceed the financial resources available in many states.

At the federal level, the MHSS is committed to the OR program to the extent of creating and filling a position for the Chairman of the Research Review Committee. Nevertheless, the MHSS has yet to provide financing for OR studies, Research Review Committee meetings, or workshops on research methodologies. In September, 1992, however, the ministry announced an allocation of three million naira to support OR studies. With continued support from NCCCD and activation of the Health System Fund (HSF loan) of the World Bank, the short-term prospects for continuation of the OR program are good.

⁸ See the discussion on HCC contained in Annex H - Economic and Financial Analyses.

Nigerians are quick to declare that "health is beyond value". It is clear, however, that government officials at all levels are coming to the painful recognition that health does have its costs, and the decreasing availability of public funds is having an increasingly negative effect on the provision of health services.

Faced with budgetary trends over which they have little control and realizing that the lack of financial resources has impaired the ability of the health sector to function effectively, health authorities in states and LGAs have become increasingly interested in cost-recovery programs. Officials at Federal, State and LGA levels are coming to the realization that costs for health services will need to be passed on to clients, the ultimate beneficiaries.

There is a consensus that Nigerian communities are willing to pay for services if the quality of the services available can be upgraded. Officials continue to express a concern, however, that indigent persons must, somehow, continue to receive free services. Only the Barkin-Ladi LGA, as part of the BAMAKO Initiative, has a program in place to cover costs for those unable to pay. Several communities have initiated cost-recovery programs with revolving drug funds (RDF) and/or fees for consumable items.

In 1986, each of the six original CCCD Focus LGAs received a N100,000 grant for the health sector. Their experience with this seed money has been mixed. One LGA lost two-thirds of its RDF when it was divided into three new LGAs. Since then, it has operated the fund with enough profit to have a present balance of N119,000. In two LGAs, however, the funds were spent for other purposes; one of these has committed N200,000 (FY92) to restart its RDF, while the other has taken no action to replenish its RDF.

Many health facilities are charging clients for disposable needles and syringes to be used in vaccination activities.⁹ Some health facilities are charging for the health card as a one-time registration fee. Health facilities are only permitted to charge for ORS packets produced locally. Those provided as UNICEF donations are given for free. Chloroquine is paid for as part of the RDF initiative.

It is common for community members to perceive the effectiveness of health interventions sufficiently to contribute to program costs and pay attention to vaccination return schedules. Anecdotal information confirms that significant numbers of mothers in rural areas are regularly securing BCG vaccination for infants less than one year old, including the nine-month booster. Nevertheless, EPI mobilization has decreased, markedly, since accelerated immunization activities ended in 1990; although vaccination coverages have decreased, they have not decreased to 1984 levels.

The private sector is actively involved in the provision of project services, but there are few programs to monitor these services or to assure adherence to basic standards of practice. For example, the private sector provides and charges for vaccinations. Most private sector providers receive their vaccines from the MHSS, but do not report their immunizations. Federal and state governments have not established guidelines for minimum standards of cold chain for private sector providers of immunizations. There is no cold chain inspection program for private sector facilities.

ORS packets are not readily available on the local market. There is evidence that private institutions have supplies of ORS packets and are selling them. Local production of ORS, while feasible, is

⁹ Mothers are, willingly, purchasing needles and syringes to be used in their child's vaccinations. This phenomenon has occurred as a response to dull needles available at the health facilities, as well as an increased awareness and fear of AIDS. In effect, this situation has resulted in an unofficial cost-recovery initiative.

unlikely to be developed without a negotiated long-term commitment to ORS purchase by the MHSS. Chloroquine is widely available in local markets. Donor complementarity and coordination is spotty. There is effective donor coordination for EPI, but none for CDD nor Malaria control.

Effective coordination exists among CCCD, WHO and UNICEF for HIS. The World Bank has only recently become involved under its Health System Fund program and has made overtures to other donors to facilitate coordination. For OR and HIS/MIS, coordination among donors was initiated by the MHSS with a national level meeting in July 1992.

2.4. Relative Strength of Training Interventions

Through ACSI/CCCD/Nigeria, the MHSS has come to realize that training is essential for the continued development and sustainability of the PHC System. A number of indicators are important in this regard: (a) development and implementation of a training strategy; (b) development and implementation of a policy for continuing education; (c) implementation of a supervisory system; (d) use of facility-based training needs assessments; (e) evidence that trainers are being trained in how to train; and (f) project training activities are integrated into existing MHSS training structures.

A training strategy for strengthening PHC and specific programs related to CCCD interventions has been developed, approved and implemented in all of the CCCD focus states. The goal of the strategy is to: (a) develop and institutionalize a system of continuing education for PHC workers; (b) develop the capacity of the continuing education unit (CEU) staff for needs assessment, planning implementation, and evaluation of training programs; and (c) improve the managerial, technical, supervisory, and training skills of LGA supervisors and all categories of health workers in each State.

Ten training modules have been developed based on a MHSS adaptation of the WHO supervisory skills manuals. There is solid evidence of training impact. For example, there was a rapid adoption of policy changes with institution of OPV₀ and TT₃₋₄ when this matter was included in the training curriculum. Also, there is a good training strategy for the HIS and M/E systems with clear improvements in the timeliness of reporting after the establishment of relevant training programs.

This is no evidence, however of a specific policy for health education, due largely to a lack of clarity about the meaning and role of health education in PHC and the failure to plan comprehensive programs leading to effective educational interventions.

There is, however, an increased awareness and acceptance of EPI in the community resulting, in part, from health education and social mobilization efforts. On the other hand, KAP studies showed marked deficiencies in home management of diarrheal episodes by caretakers and inaccurate doses of chloroquine given by caretakers for treatment of presumptive malaria suggestive of deficiencies in health education activities.¹⁰

There is a supervisory mechanism in place to follow up on the training of health facility staff and village health workers. Two days per month supervisory visits are provided by CEU trainers who assess areas that need reinforcement. After six months of assistance, the responsibility for supervision shift to the LGA PHC Coordinators and State PHC Directors.

Supervision, however, seems limited only to training activities. That supervision is a way of strengthening the management of health services is poorly perceived, implemented, and evaluated by

¹⁰ Fegbule, Doyin. Facility-Based Assessment of the Ojo Local Government Area. Lagos State, Nigeria. August, 1992, CCCD.

mid-level, State, and LGA health officers. The MHSS supports the development of a supervisory system at each level, but this has not moved beyond the conceptualization stage. Some LGAs have created the role of district supervisor to assist in the supervision of EPI-related activities. When interviewed on the lack of supervision, Federal, State and LGA PHC officers, all, stress logistics problems as the primary constraints to supervision.¹¹ Nevertheless, there is scant evidence that clear and achievable supervisory strategies have been developed and/or implemented. Disturbingly, occasional informal visits are perceived as supervisory visits.

Barkin-Ladi LGA is the only exception. This LGA is using a comprehensive and well-documented supervisory mechanism for follow-up of training activities and the strengthening of health service management. As indicated earlier, Barkin-Ladi LGA is implementing a comprehensive and integrated approach to PHC through the Bamako Initiative strategy. Team work and management of services are valued by highly committed LGA leaders and health workers.

The M/E PHC health facility assessments have been used to assess training needs in each focus LGA. Training program development and pre/post evaluations are based on these surveys which directly address health workers' performance and skills for conducting EPI, CDD, Malaria, ARI and supervisory programs.

Niger State, after implementing a continuing education program for three years, conducted a post-CEU training health facility survey in July 1990. The survey results revealed a positive impact of its program on both supervisors and health workers performance. Supervisors were shown to have improved in more than five performance indicators and health workers showed improvement in immunization practices and in the treatment of diarrhea and malaria, as well as education of mothers concerning SSS mixtures.

Facility-based assessment surveys conducted in Plateau and Enugu States (1991) and Lagos (1992) indicated significant improvement in technical skills related to immunization and some problems related to case management of children with diarrhea and patient education practices.

Three CEUs have trainers qualified to train and to manage and evaluate training activities. A cadre of trainers have attended a week-long orientation in Niger State, followed by a two-week training of trainers workshop in Lagos directed by the ACSI/CCCD training consultant. The workshops were designed to develop training skills and familiarize the CEU staff with MHSS training materials on immunization, diarrhea and malaria.

Three of the four planned Zonal DTUs have been established; the fourth is expected to be operational by the end of 1992.

The integration of training activities into existing MHSS structures has been problematic. The CEUs are physically situated in state Schools of Health Technology (SHT), official structures in charge of providing pre-service training for PHC. The fact is, however, that the CEUs are actually separate, well-equipped and supported units within the SHTs (which are not well-equipped); this situation has created tensions and works against the ultimate sustainability of the CEUs. The MHSS clearly intends to force the integration of these units; this may be expected to undermine the character and, potentially, the quality of instruction at the CEUs.

¹¹ Vehicles recently provided through ACSI/CCCD have partially addressed this problem.

ACSI/CCCD curricula is integrated into the SHT training program for Community Health Extension workers. SHT trainers participate as core trainers for the CEUs. While the CEUs are intended to complement pre-service training, in practice, they have been limited to providing training to PHC extension workers. Medical, nursing, and management staff are not yet targeted by CEUs, despite perceived needs.

2.5. Constituency-Building through a Process of Mutually Respectful Negotiation

Ultimate sustainability hinges on: (a) the extent to which nationals participate in country assessment as well as project development and modification and clearly view the project as a priority; (b) the degree to which relevant agencies participate in project workshops; and (c) the existence of MHSS procedures to facilitate the inclusion of local concerns and decisions within plans at the national level.

Such indicators characterize the development of constituencies and the institutionalization of a process of mutually respectful negotiations leading to sustainable programs. Constituencies below the federal level are not included in the overall negotiation process. This situation jeopardizes the sustainability of CCCD interventions, ongoing and future.

On a positive note, however, representatives from the state level, as well as federal, have been included in key workshops, evaluations, assessments, and project planning activities. Indeed, on many occasions, project deadlines have been changed and workshops rescheduled to facilitate the participation of key representatives. In general, CCCD interventions, as a whole, have been seen as a priority. Of the various interventions, EPI, HIS, and training are regarded as high priorities, while less emphasis has been placed, for example, on CDD and Malaria control.

The MHSS, generally, assumes a leadership role in the development of key conferences and workshops, and this assures the inclusion of representatives from key agencies. One noted exception is the frequent failure to include agencies responsible for health education programs. This has been most obvious in the experience of the African Regional Health Education Center (ARHEC), a Nigeria-based organization created in 1973 with the assistance of WHO. ARHEC is a unit in the Department of Preventive and Social Medicine of the College of Medicine at the University of Ibadan; it has collaborated, closely, with the University of North Carolina and the CDC to provide in-service training for ACSI/CCCD/Nigeria.

While officials at the MHSS understand, clearly, the importance of integrating local concerns and decisions into national level plans, there is little evidence that this understanding has translated into concrete action, except in the case of EPI. For example, officials at the CEUs have not been involved in the development of the national policy and the training work plan. None of the state or LGA officials have played a significant role in the development of national strategies for EPI, CDD, Malaria, and other components of the PHC program.

2.6. Counterpart Perception of Ownership

Indicators of counterpart perception of ownership include such factors as: (a) project-related decisions being made by organizations representing local constituencies; (b) interventions being developed and modified by participating Nigerian authorities; and (c) increasing assumption of project costs by the communities receiving services.

In the Nigerian context, unfortunately, ownership is not a natural consequence of the constituency-building and negotiation process. Years of dependence on donors following on Nigeria's history as

a colonized country have made it easy for Nigerian authorities to accept the presence of donor activities that may be pivotal to the success of their communities, but over which they have little, or no, control.

These "donor projects" are seen as external entities, not owned by Nigeria. Even when a project is delivering key services and perceived to be improving the lot of the recipients, this subtle but important distinction contributes to a lack of involvement, professional commitment, and a generally laissez faire attitude among workers at every level. Often, this is manifest in permissive attitudes about wastefulness and fraud in the use of projects resources. The potential for sustainability in such cases is low. Time has provided numerous examples of unsustainable, non-Nigerian projects.

This is not the case in projects the Nigerian community sees as its own. Indeed, locally directed interventions have been well run with scrupulous attention paid to the handling of resources and the delivery of services.

Perceived Nigerian ownership of the various ACSI/CCCD/Nigeria components is clear. Nigerians at the federal, state and local levels strongly agree that components such as EPI, CDD, Malaria control, HIS, and training are Nigerian-owned. ACSI/CCCD/Nigeria components address the established needs of Nigerians. This is encouraging and sounds a positive note concerning the anticipated future of NCCCD sustainability.

Another encouraging indicator of NCCCD sustainability is that organizations or bodies representing constituents have assisted in the ACSI/CCCD decision-making process. For example, Nigerian approval of ACSI/CCCD work plans has been sought. Although the process often results in approval, such is not a foregone conclusion as illustrated in the CDD case, where initial CCCD policy directly conflicted with established Nigerian policy. After negotiation, however, the CCCD plan was modified to fit with existing MHSS policy.¹² Somewhere in the process, however, the CDD program still suffers from less than enthusiastic endeavor on both sides.

A third indicator of project ownership manifests itself in Nigerian participation in project development and modification. At the national level, at least, officials feel comfortably included in the project development and modification processes. However, Nigerian official do not appear to be receiving a clear message from donors as to the extent to which Nigerians can affect project development. This is due to a strong national bias that as long as finances continue to be controlled by external sources, a full sense of Nigerian ownership can not be, realistically, attained.

With regard to increased assumption of project responsibilities on the part of community members (beneficiaries) and governmental authorities, CCCD seems to be moving, generally, in a positive direction. This is especially true at the local level where local policy-makers recognize the importance of both PHC and the need to be fiscally responsible.

In localities, such as Barkin Ladi LGA, where the RDF has been established and the community has taken charge to the point of requiring patients to purchase needles and syringes for immunizations, the potential for sustainability is encouraging. Other LGAs are also experimenting with RDFs.

While progress has been impressive, to date, much still needs to be done in the project development stage to clarify who is responsible for assuming which costs and at what point in time.

¹² This experience occurred at the national level, the extent to which the same process might be followed successfully at the state and local levels is unclear.

B. Considerations for the Enhancement of Sustainability

Responsibility for progress toward sustainability must be fixed.

This truism is captured in a Nigeria folk-saying; i.e., *That which is everyone's business is no one's business*. Officials at every level express a good understanding of the need to enhance sustainability and seem sincere in their stated desire to move the program in that direction, but none see it as their personal responsibility. In several states and LGAs, there is an expressed desire to assume this role. The specific assignment of responsibilities and the negotiation of process and outcome measurements as a part of the project development and negotiation process would enhance, significantly, the ultimate likelihood of program sustainability.

Nigerian participation in the planning process is a desirable step toward sustainability. Enhanced financial contributions by communities would foster sustainability. Both of these considerations lend themselves, easily, to the development of indicators. These functions could be a negotiated responsibility for LGA chairmen and state commissioners.

Programs are unlikely to be sustainable until there is a critical mass of technical personnel available to support them.

No matter how good the program activity, if it depends exclusively on a single person, or a very small core of technical people, its sustainability is threatened.

Nigeria is ripe for a Field Epidemiology Training Program (FETP) to continue capacity-building in the area of "data for decision-making". This is necessary for further development of the HIS and strengthening epidemiologic surveillance capabilities. The HIS will only be sustainable if there is a cadre of personnel capable of using and interpreting the data generated, and responding to it. Trainees would come from the cadre of Directors of Communicable Diseases in the SMOHs, to return as state epidemiologists. In addition, the need for a zonal epidemiologist to assist the states is recognized.

Projects which depend on a heavy inflow of external capital are unlikely to be sustainable.

In 1988-1990, special immunization days were conducted at the National and State levels as part of accelerated immunization activities. This resulted in a rapid increase in vaccination coverages. The accelerated immunization initiative received heavy external financial support to cover the costs of widespread social mobilization campaigns as well as increases in the outreach vaccination activities and supervision at the State and Local levels.

The accelerated immunization initiative ended after 1990, with 1991 marking a return to routine vaccination activities. Since its end, vaccination coverages have returned to levels seen immediately preceding the initiative. There is little debate that accelerated activities did result in increased community awareness of the need for immunizations. The decline in vaccination coverage, however, leads to a cautionary observation that progress made under program activities expensive to operate and relying, heavily, on external assistance have a low probability of sustainability in the absence of donor support.

Given the extremely limited short-term financial outlook in Nigeria, expectations of project sustainability upon the withdrawal of external support should be realistic. This does not preclude, however, a precaution to evaluate the appropriateness of project interventions with respect to eventual recurrent costs accruing to Nigeria's health sector structure.

Donor-supported programs should actively shun interference with, or obstruction of, locally motivated, potentially sustainable and community-responsive primary health care initiatives.

Examples abound where well-meaning, but externally-motivated donor initiatives appear to have derailed local initiatives.

In one instance, a donor organization promised equipment. Local authorities had been prepared to budget for, and purchase, the equipment, themselves, but were told their input would be unnecessary. The promised equipment did not arrive in timely fashion, and the local authorities had to cope with equipment shortages that could have been avoided.

In another instance, a community, influenced by donor exhortations to contribute to a training program, provided funds for participation of their service delivery personnel in CEU programs. The funds used for the training exercise had been intended to buy new beds and mattresses for the local health facility. The local authorities, while grateful for the training opportunity, felt that they had been unduly eased into a position of not being responsive to their local community needs. Their local initiative was thwarted, and they see the donor as having created a problem. Such experiences emphasize the need for "bottom up" inputs into program planning. Expanded dialogue with local program planners will assure project interventions supportive of local initiatives.

In Nigeria, ownership is inextricably linked to financial inputs.

There are two issues here. First, in the Nigerian context, that which is given free has no value. It is likely that past neglect of this guideline has retarded community-level appreciation of many primary health care programs. Secondly, Nigerians believe that if they are not making a contribution to a program, it is not theirs.

There is widespread opinion among counterpart representatives that Nigeria, particularly at the community-level, should make a financial contribution to donor-supported projects providing PHC services. There is a strong concern, however, that the indigent not be denied health care because of an inability to pay for essential services.

In Barkin-Ladi LGA, where the Bamako Initiative is in place, there is an enhanced sense of community ownership because of the fees imposed, and a sense of community empowerment in the provision of services for those who can not pay.

Training programs provide data utilized to enhance ownership, cost-sharing, and the perception of effectiveness.

Data prepared for training programs, when shared with policy-makers, inspires attitudes of ownership and pride in association with an effective program. This phenomenon has impacted, positively, on the budgeting processes in Niger, Plateau, Enugu and Lagos states, all of which are planning increased financial inputs for training in their 1993 budgets. Five other states have, now, decided to implement a continuing education (CE) strategy.

Programs are unlikely to achieve sustainability in the absence of stable leadership.

Clearly, the process of geopolitical formation under way in Nigeria has created a significant problem. State and LGA leadership was disrupted with the creation of new states and LGAs in August 1991. The situation has yet to stabilize. For example, Suleja LGA has had five LGA chairmen in the past year.

While the present problem of political instability in Nigeria is a contextual factor, external to the project, and beyond project control, it has had, and will continue to have, a significant negative effect on progress toward sustainability.

Technical assistance with an objective focused on capacity-building.

The HealthCom experience in Niger state is cited as an example to the contrary. The HealthCom program failed for a variety of reasons, but one of the most important was its exclusive reliance on an external program manager supported by external consultants. The HealthCom experience did not build capacity in its state of operations (i.e., Niger state). As a consequence, the intervention was not sustainable, and there is very little left after the application of substantial inputs.

C. Sustainability Goals and Objectives

For individual project activities, it will be useful to integrate sustainability goals and objectives into periodic work plans as a means for stipulating the roles and responsibilities of recipients and donors in that regard. It is recognized that managerial and financial management capacity at the state and LGA levels require strengthening to accomplish that task. The table below presents a method for measuring sustainability progress.

Goals/Objectives	Objectively Verifiable	Means of Verification	Assumptions
Local assumption of project costs	Budgets demonstrating increased financing of projects from locally recovered costs and local governments funds	Review of actual expenditures and returns from health sector activities	Local political leadership will support the development of cost-recovery programs
Development of a "critical mass" of skilled technical people to support PHC programs	Rosters of program staff	Numbers of trained persons working in PHC programs who pass "competency based personnel assessments" to assure minimal levels of competence	Local authorities will change patterns of staff assignment/posting which currently undermine the utilization of trained persons
Local assumption of project directoral responsibilities	Numbers of approved work plans and project modifications <u>initiated</u> by Nigerian authorities	Ratio of US <u>initiated</u> to Nigerian <u>initiated</u> work plans and modifications	Nigerian authorities will assume an increasing attitude of ownership and will pursue community, not political or for-profit objectives
Limitation of new project initiatives to those which can realistically be absorbed by local finances	Assessment of the potential for government and/or community absorption of costs	Special financing studies	Nigeria's economy continues to expand. Donor programs can be coordinated and this principal applied to all externally funded initiatives
Equity in access to health services	Assessments of community utilization of health services and identification of underserved populations	Special surveys (ie. NDHS)	Equity issues can be integrated into NDHS surveys for 1994, 1998
Enhanced community perceptions of effectiveness	Proportion of community that approves of health expenditures as good investments	KAP and community utilization surveys	Nigerians will perceive improved health as desirable and correlated with their economic well-being
Enhanced local managerial and financial capacity	Numbers of qualified management and finance personnel employed by states and LGAs	Counts from personnel rosters	States and LGAs will provide incentives to obtain and retain the services of financial and program managers

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I. ADMINISTRATIVE ANALYSIS OF PUBLIC SECTOR AGENCIES

A. INTRODUCTION

Constitutionally, the health sector is the responsibility of all three levels of government (federal, state, LGA). The federal level is responsible for policy formulation, technical assistance and provision of services in tertiary institutions. The state is responsible for secondary care in the form of general hospitals (the referral level for the PHC system), provision of technical assistance and training for various categories of health workers. LGAs are responsible for implementation and management of PHC within the framework of federal policies and support of state governments.

For purposes of health sector activities, the MHSS divided the country into four health zones¹ for coordination and liaison between the federal, state and LGAs levels. A zonal coordinator is responsible for each zone.

B. HEALTH POLICY AND LEGISLATION

1. FEDERAL LEVEL

The National Health Policy developed between 1985 and 1986 was based on the national philosophy of social justice and equity and was eventually promulgated in 1988.

The principal aim of the policy was "to provide the Federal, state and Local Government health institutions and their functionaries and other health-related organizations, a formal framework for appropriate national direction of health development in Nigeria". The government formally adopted WHO's "Health for All" PHC strategy in 1986. The strategy is embedded in, and serves to exemplify, the Nigerian health sector's commitment to equity in the distribution of services.

The strategy assigns the following authority to each operational level: (a) the LGA level is responsible for Primary Health Care; (b) the state level is responsible for secondary care in the form of general hospitals and comprehensive health centers (where hospitals do not exist) and the training of health workers, especially those below the level of the doctor; and (c) the federal level is responsible for the formulation of policy and provision of tertiary care in the form of teaching and specialist hospitals.

Both the federal and state levels are responsible for the provision of planning, training, technical assistance, logistics and operational support, and supervision to ensure smooth implementation of PHC strategies at the LGA level.

Since other sectors such as agriculture, information and the Office of Statistics have an impact on health, representation from these areas have been actively involved in intersectoral collaboration to promote PHC. Other strategies adopted include: (a) promotion of community participation in planning, management, monitoring and evaluation of local health systems; (b) strengthening of functional integration at all levels of the health system; and (c) strengthening of the management process for health development at all levels.

¹ Administratively, the zones are considered part of the federal level of government.

2. KEY FEATURES OF THE PHC SYSTEM

One mechanism put in place for the implementation of the stated strategies is the committee system. At the federal level, the National PHC Committee consists of federal, state and LGA officials; health training institutions; community representatives; NGOs; and representatives of related ministries, international organizations, and the donor community.

The committee system is the mechanism for collective decision-making, promotion of community participation, and intersectoral collaboration at each level. There are five tiers to the committee structure; namely, national, state, LGA, PHC committee, and the district and village development committees. The composition of the committees varies, with the Minister of Health and Social Services being the Chairman of the National PHC Committee; and the state commissioners and LGA chairmen being the heads of their respective state and LGA PHC committees. The district and village development committees are chaired by village heads.

Informants from the MHSS view federal and state coordination of PHC activities as appropriate and report that the LGA level, the most important for PHC implementation, is less coordinated due to the instability of LGA/PHC Committee chairmanships caused by the frequent rotation of LGA chairmen and the insufficient experience of local PHC coordination staff. The PHC Committee System has had varied degrees of success in the different localities.

In LGAs, such as Barkin Ladi in Plateau state and Egbeda in Oyo state, where the LGA Chairmen are committed to PHC and have been in place for about a year, the committee system at the village, district and LGA level has functioned well, with regular meetings and feedbacks. In Igbo-Etiti LGA (Enugu state), where the political leadership has been unstable with recent impeachment of the LGA Chairman and constant political upheavals coupled with demonstrated lack of commitment to PHC, the committee system has been nonfunctional with few meetings at village, district and LGA levels.

A factor responsible for poor coordination at the LGA level, recognized by PHC coordinators and other cadres of staff in managerial positions, is that they, themselves, lack management training. The continuous creation of new LGAs has also contributed to the thinning out of managerial staff, as competent personnel is spread over an ever larger number of LGAs.

As part of a deliberate effort to ensure sustainability of PHC, the Primary Health Care Development Agency of Nigeria (PHCDAN) has been created. The PHCDAN will be expected to work through structures similar to those of the parent PHC department at the MHSS; i.e., through PHC zonal offices, states and LGAs.

It is yet unknown how this structure will improve the level of coordination currently existing between states and LGAs since PHC zonal Coordinators — whose function is to supervise PHC activities in the zone — often by-pass states to establish contact with LGAs. Because of the sheer number of LGAs within a zone (Zone A, for example, has 153 LGAs) combined with problems of transportation and logistics, the PHC zonal Coordinators can not do a thorough job without involving the states.

There appears to be a general lack of awareness about the newly created PHCDAN, particularly, at the state and LGA level. While the idea of the PHCDAN is, generally, accepted at all levels, it would appear that consultations during its conceptualization were restricted to federal and zonal levels. Omission of the operational level (i.e., the LGAs) in this critical decision-making process runs counter to the concept of community participation.

3. SPECIAL NATIONAL PROGRAMS

As part of efforts to mobilize the nation for social justice, self-reliance and economic sufficiency, three agencies have been created within the presidency as follows:

- **DFRRI (Directorate of Food, Roads & Rural Infrastructures)**
Builds and upgrades rural road networks and provides bore holes, especially in guinea-worm infested communities.
- **MAMSER (The Political Education and Mobilization Agency)**
Principally responsible for grassroots political mobilization especially with regards to the political transition program. Has provided support for community mobilization during EPI campaigns. This agency has recently undergone leadership changes and its activities were scaled down.
- **BETTER LIFE FOR RURAL DWELLERS**
Currently absorbed into the National Women's Commission with the sole objective of improving maternal and child health and the income-generating capacity of women.

Information derived from broad representation of federal-level staff indicates that the degree of collaboration between the PHC system at all levels and these health-related agencies requires improvement.

4. STATE LEVEL

The responsibilities at the state level are to provide technical assistance, logistic support, and supervision of LGA/PHC as well as to operate secondary care facilities and train health workers. Most of the policies that have to be made at this level are, therefore, operational in nature; e.g., decisions regarding the number of schools of nursing to be maintained by the state.

5. LGA LEVEL

As indicated earlier, this level is mainly operational and only operational policies are determined here; e.g., the number of days in a week that the immunization clinic will function. Otherwise LGAs, like states, operate within nationally-determined policies. As indicated above with respect to the federal level, there are state and LGA representatives on the National PHC Committee, and states are represented on the National Council on Health, which is the advisory council for policy formulation. Most states have a state Council on Health with the state commissioner as chairman and LGA chairmen, supervisory councilors and heads of PHC departments in the LGAs as members.

6. FEDERAL MINISTRY OF INFORMATION (FMOI)

This ministry is responsible for culture, information, and enlightenment on policies and activities involving the federal government and the cultural arena. The FMOI is the supervisory ministry for media outlets, including the Nigerian Television Authority (NTA), the Federal Radio Corporation of Nigeria (FRCN), and the News Agency of Nigeria (NAN).

These media outlets constitute a multimedia network through which health programs and activities are disseminated. Radio Programs entitled Public Enlightenment on *Family Planning*, *AIDS Prevention*, and the *Expanded Program on Immunization* have featured prominently in recent times.

The Federal Ministry of Information and its outlets have improved on the quality and reliability of their services, as they generate income from services rendered (even to government for maintaining and upgrading their equipment).

7. FEDERAL OFFICE OF STATISTICS (FOS)

One of the tasks of the FOS is to conduct national household surveys. It also provides general and statistical information as required, conducts special surveys, on request, and has recently added a few population and family planning related questions to their regular survey. In the past three years, the Federal Office of Statistics (FOS) has improved the service that it renders, but it has not yet been able to cope with the statistical information demanded of it. Its computers still break down regularly, which has slowed down information-processing and dissemination. The office will perform better once a proper equipment maintenance system is in place. FOS is still one of the few places where data and information can be obtained.

C. RESOURCE MOBILIZATION, ALLOCATION AND UTILIZATION

1. REVENUE MOBILIZATION

The National Health Policy (1988) stipulates provisions for resource mobilization, allocation and utilization. This Policy identified the sources of resources as follows:

- Public sources comprising the federal (budgetary and extra-budgetary); state government (budgetary and internally generated revenue); Local Government (budgetary allocations, grants, fees and levies); and national health insurance and user fees.
- Private sources in the form of employers' provisions, private insurance, NGO contributions, private expenditure on health, and all types of community financing, etc.
- External sources such as multilateral organizations (UNICEF, WHO, World Bank etc), bilateral donors (USAID, ODA, etc.)

Efforts have been made to mobilize additional resources for the health sector. Such efforts include user fees, drug cost recovery schemes, including the Bamako Initiative in government health institutions, planning for national health insurance, community responsibility for disadvantaged families, and community participation and involvement in health program planning. It is difficult to ascertain the exact magnitude of resources that have been mobilized from all sources because of the absence of data on health expenditure by NGOs, private health institutions and households.

Data on governmental expenditure on health are often out of date and are lumped together, thereby making analysis difficult. The government seeks assistance from multilateral/bilateral and external nongovernmental organizations for the implementation of health care. It is estimated that health resource development assistance (all sectors) was 7.1% of GNP in 1990, according to a WHO report addressing "Local Government Focussed Acceleration of PHC Nigerian Experience".

The mechanism adopted since 1990 for the mobilization of resources is the Three-Year Rolling Plan which commits MHSS to already planned projects in order to prevent the occurrence of abandoned projects and also to promote proper planning within the scope of available resources. This Three-Year Rolling Plan is included within the 15-year prospective/long-term plan.

2. REVENUE ALLOCATION

FEDERAL LEVEL

While all three levels of government have jurisdiction to generate revenue, the federal government has the largest bulk of resources. Revenue allocation formulae are used for sharing federally collected revenue between the three levels of government. In June 1992, the formula used to allocate, vertically, the federally collected revenue was as follows: federal (48.5%); states (24%); Local Governments (20%); and the development of mineral producing states 3%, mineral producing states 1.5%, and ecological problems 2%.

The corresponding horizontal allocation formula was broken down as follows: (a) equality among states (40%); (b) population (30%); (c) revenue efforts (10%); (d) land mass/terrain (10%); and (e) social development factor (10%). This last item includes primary and secondary school enrolment, health facilities/beds, water supply, geographical spread and rainfall. The same horizontal allocation formula used for sharing the allocation to states is also applied in sharing the 20% allocated to LGAs.

The table below shows the different allocation of resources over several years. The total allocation to health in the federal budgets between 1972 and 1987 never rose beyond 3.46% of total FG budget. At all levels of government, a disproportionate amount of funds allocated to health recurrent costs are expended on staff salaries and allowances.

Federal Budgetary Allocation to Health (Recurrent and Capital Expenditure), 1972 - 1989 (=N= Million)			
YEAR	TOTAL FG BUDGET (2)	TOTAL ALLOC TO HEALTH (3)	(3) AS % OF (2)
1972	342.50	9.10	2.80
1973	1,384.57	28.22	2.70
1974	2,879.73	52.75	1.83
1975	6,252.90	115.00	1.84
1976	6,849.72	165.59	2.42
1977	10,766.96	223.60	2.06
1978	8,167.19	130.57	1.60
1979	8,510.00	177.41	1.87
1980	11,722.52	266.93	2.00
1981	11,561.70	303.20	2.62
1982	9,877.03	341.72	3.46
1983	10,425.32	313.60	3.01
1984	7,450.17	190.38	2.56
1985	9,579.00	223.75	2.29
1986	12,219.46	360.22	2.95
1987	10,302.34	236.45	2.30
1988	24,367.27	443.113	1.82
1989	30,107.10	452.50	1.50

Source: Federal Ministry of Health, Lagos

EXTRA BUDGETARY ALLOCATION

Since 1986, extra-budgetary allocations have been made to the health sector up to a total sum of 346 million naira between 1986 and 1991. See table below. For example, in 1989, the regular budgetary allocation made by the federal government directly to PHC for both capital and recurrent expenditure was about 20 million naira, while the extra-budgetary allocation of 56 million naira was 160% more than the regular budgetary allocation.

This extra-budgetary allocation is a demonstration of the political commitment of the present regime to PHC. There are serious doubts, however, concerning sustainability as a system of PHC funding once a new civilian administration takes charge, as now anticipated, sometime in 1993. The allocations to PHC have been particularly useful in assisting LGAs meet the challenges of implementing PHC services, especially after the devolution of responsibility for PHC to LGAs.

Federal Government Extra-budgetary Allocation to the Health Sector from 1986 to 1991 (=N= Million)				
YEAR	FOR PHC	FOR SECONDARY FACILITIES	FOR COLLEGES OF MEDICINE	TOTAL
1986	100	-	-	100
1987	22	-	-	22
1988	22	-	-	22
1989	56	-	-	56
1990	60	500	26	586
1991	60	-	-	60
TOTAL	320	500	26	846

Source: Nigerian Experience in LGA-Focussed Acceleration of PHC,
WHO High-Level Analytic Review, Lagos, 1991.

In 1990, the states were to benefit from extra-budgetary allocations. Each had a provision of 25 million naira to upgrade secondary care in order to provide referral back-up for the PHC System. The MHSS Capital Project Unit appointed consultants to visit facilities in each state to carry out a needs assessment. This was done for all the states, with proper documentation of requirements and costing. To date, however, the government has not released the funds.

STATE LEVEL

Federal government allocation has been the primary source of revenue for all the states accounting for between sixty to ninety percent of state revenue. This is augmented by internally generated revenue from various sources such as taxes, licenses, fees, etc. Small amounts are also generated through charges to users of health facilities.

It is difficult to determine the amount of expenditure by external donors, NGOs and private organizations and individuals because of absence of adequate data.

About ten percent of state revenue is allocated to the health sector on the average, and this is shared between the State Ministry of Health (SMOH) and the State Hospitals Management Boards (SHMB).

For example in Plateau state, the funding of the State Ministry of Health is on the decrease. The allocation to health dropped to 3.8% in 1992 from 9.3% in previous years, suggesting the Ministry of Health is now under-funded.

Cuts have been made in funds allocated for transportation and travel allowances. Supervision activities have not been carried out regularly and donor agencies have had to add resources for PHC supervision. An example of this situation was cited in the Plateau state Ministry of Health - Annual statistical Bulletin 1991.

Within the SMOHs, there are no clear criteria for fund allocation to PHC and no costing has been done of the technical and logistic support the SMOHs provide to LGAs. In Niger state; for example, of the total 25 million naira spent by the SMOH midway through 1992, 3.5 million naira (17.5%) was spent on PHC-related activities.

LGA Level

The federal government contributes from eighty to ninety percent of LGA income in several Local Governments; this contribution is supplemented by internally-generated revenue from taxes, licenses, fees, etc. Additional funds are injected into the delivery of services by external donors, NGOs and private organizations/individuals.

In the states surveyed for this study, the percentage of funds allocated to health out of the total budget by the Local Governments visited was about ten percent. However, health care varies in the different LGAs depending on the following factors: (a) commitment of the LGA chairman and head of department of PHC to health;² and (b) donor presence in a specific LGA.³

The legislature approves the budget for health at the Local Government level. The Chairman of Council approves health expenditures. Separate accounts are maintained at the LGA level for each of the donors making payment with bank drafts. Donor funds are channelled directly to LGA project accounts, bypassing the states Ministry of Health. The implication of this mode of disbursement — from the state's perspective — is that their capability to control the LGAs is weakened. Some LGAs now feel they do not need the state's supervisory and technical assistance.

Accounting personnel at federal, state and LGA levels have been trained to administer donor funds adhering strictly to donor guidelines. There are "capability gaps" at the zonal offices with respect to the management of donor funds. This will be strengthened with the new direction of PHC implementation which emphasizes strengthening of the zonal PHC Offices with capable staff, including accountants.

3. RESOURCE UTILIZATION

Concerted efforts have been made by the MHSS to optimize the utilization of scare resources. Such efforts include:

² Bassa LGA in Plateau state, for example, did not have a commitment to PHC and funds allocated to health were diverted to other sectors.

³ In Egbeda LGA, Oyo state, where strong donor presence is strong, the chairman is personally involved in PHC; substantial resources, extensive plans, and staff commitment to health care are evident. Funds for project activities have not been diverted because of the donor's accountability system in place.

- Adoption of an essential drug list.
- Use of standard treatment protocol.
- Improvement in management procedures, including accountability to the community.
- Use of volunteer village health workers (VHWs), etc.

Some health workers have been reluctant to follow the guidelines on case management and to limit themselves to the use of the "essential drugs". Additional training has been done at federal and state level, but more is needed.

4. REVOLVING DRUG FUND (RDF)

All the government facilities (teaching/specialist hospitals, general hospitals and Local Government PHC Centers) now have a cost-recovery mechanism for drugs called the Drug Revolving Fund. This mechanism, if anticipations bear fruit, will ensure that the facilities will always be equipped with drugs and medicaments which are *sina qua non* for good health practice. The MHSS gave each LGA 100,000 naira to initiate its RDF. The success of this fund has varied.

Some LGAs have managed their funds well; others have used the funds for other purposes, or bought drugs under inflationary contracts which depleted funds available for stock replenishment. At the federal and state levels, alike, there have been reports of drug pilferage and fund accounts not being properly kept or funds being diverted, with the result that the fund in question ceased to revolve. LGAs involved in the Bamako Initiative have their RDFs under strict audit controls.

D. ORGANIZATION AND CHAIN OF COMMAND

1. NATIONAL LEVEL

The Health Management Structure at the federal level was reorganized as a result of the provision of the Civil Service Reforms (1988). Three support departments and five professional departments were created. One of the professional departments was the Primary Health Care Department, which has divisions and units handling the eight components of PHC. The eight components were previously divided among four different departments in the Federal Ministry, making it difficult to coordinate policy, program formulation and support.

2. PRIMARY HEALTH CARE DEVELOPMENT AGENCY OF NIGERIA (PHCDAN)

In order to ensure sustainability of the PHC system after the end of this present administration in December 1992, an independent body to handle PHC implementation in the form of an independent, parastatal agency was recommended. As a result of this recommendation, the federal government promulgated a decree establishing the Primary Health Care Development Agency of Nigeria (PHCDAN).⁴ The PHCDAN will function as a parastatal to a new department called Disease Control and Primary Health Care. The operational relationship between the two entities is currently being worked out.

⁴ See Annex N - MHSS Publication: *Primary Health Care Development Agency of Nigeria*.

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Principal functions of the PHCDAN will include: (a) support to health policy; (b) technical support to planning, management and implementation of PHC; (c) resource mobilization; support to monitoring and evaluation; (d) health management development; (e) support to the village health system; (f) health systems research; and (g) technical collaboration and promotion of PHC.

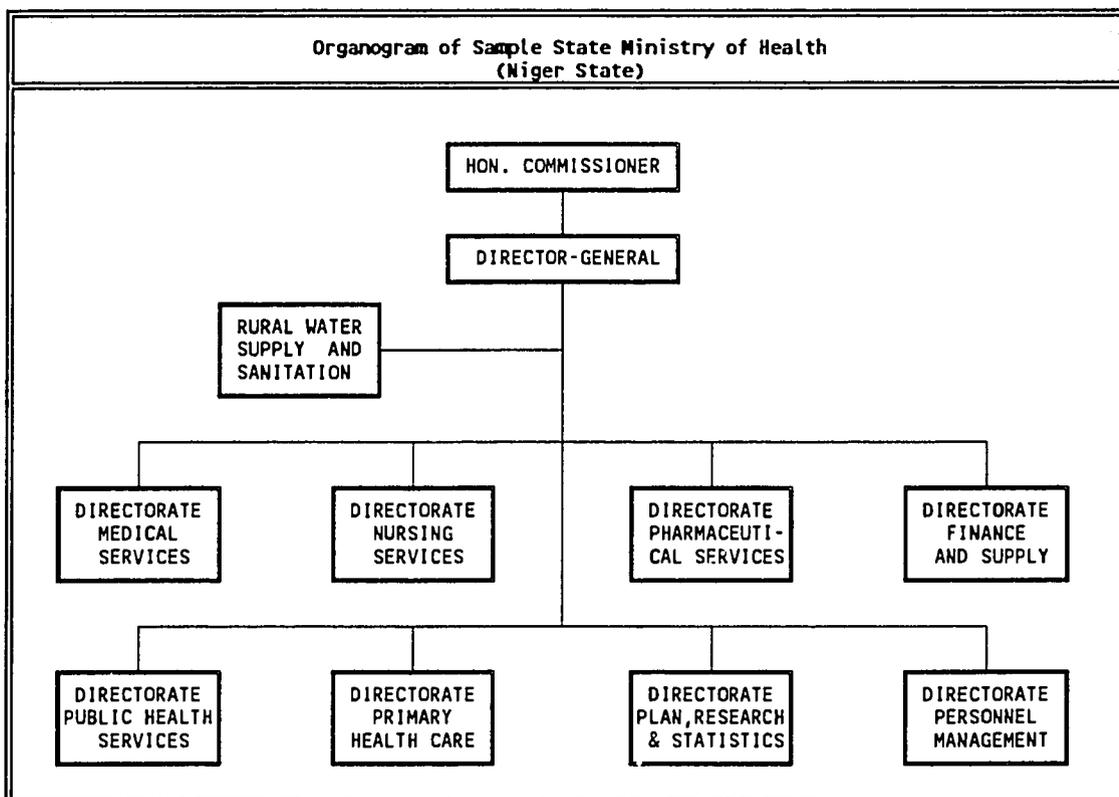
Located in Yaba, the PHCDAN will have three departments: (a) Administration and Finance, (b) PHC Operations; and (c) Planning, Research and Statistics. Federal Technical Facilitators (FTFs) that were originally at the PHC department in Lagos and supervised their states from Lagos will be deployed to the zonal office of the states they supervise. This move should strengthen the PHC zonal offices and ensure adequate supervision and monitoring of the states and LGAs.

3. PHC ZONAL OFFICES

The PHC zonal offices will be responsible to the PHCDAN and will coordinate the PHC activities of the states and LGAs in each zone.

4. STATE LEVEL

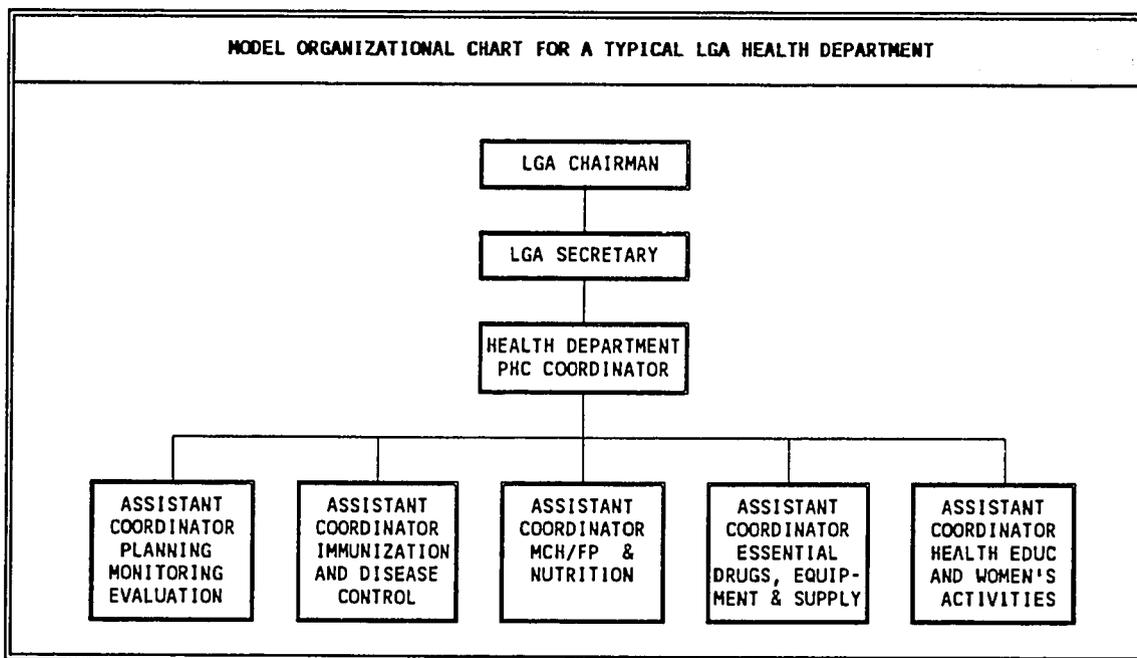
The MHSS recommended that each state create a unified Primary Health Care Department, with the director of the department functioning as the PHC Coordinator to strengthen program support and supervision for PHC at the LGA level. The table below presents an organizational chart for a sample state ministry of health.



Plateau state is an example of a state that has not adopted the recommendation of the MHSS to have a department of PHC. The department of Family Health Services is responsible for Primary Health Care activities and ministry officials confirm that the PHC in the state has focused on Family Planning activities to the detriment of other PHC programs; i.e., water and sanitation, nutrition, etc.

5. LGA LEVEL

Guidelines developed by the MHSS for the reorganization of LGA health departments include unification of all PHC components into one unit designated as "Primary Health Care Department" and possessing the following attributes: (a) head of department (HOD) designated as the PHC Coordinator; (b) assistant PHC Coordinators for each component area; and (c) common administration and budget for all PHC components. The PHC Coordinator should be responsible for all health programs of the LGA. In general, the LGAs have carried out the recommendations of the MHSS by establishing a PHC department under the charge of a PHC Coordinator. The table below presents a model organizational chart for a typical LGA health department.



6. CHAIN OF COMMAND

Since the granting of operational autonomy to the LGAs, there have been problems with chain of command between the states and LGAs. The LGAs no longer readily accept direct supervision or TA from the states. All requests from states now have to be routed through the Deputy Governor's Office, which is responsible for LGAs. This has slowed the process of implementation of some activities, such as training, and has also reduced the LGAs accountability to the state. The SMOH is responsible for monitoring and supervision. The PHC zonal offices and donor agencies also deal, directly, with the LGAs directly, further reducing state control in such areas as M/E and supervision, because the states are not aware of all activities being carried out in the LGAs within their territory.

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7. AIDS CONTROL PROGRAM

The AIDS program is managed by the national AIDS coordinator who reports directly to the Minister of Health. The program has the following components: program management, information, education and communication, epidemiology, surveillance and sexually transmitted diseases, laboratory services and clinical management, and community home-based care counselling.

Most units are inadequately staffed to carry out their activities. The capability of the staff varies. Few individuals at the federal and state levels have managerial training. Other constraints of the program are lack of: (a) political commitment on the part of LGA chairmen; and (b) transportation.

Each state in the federation has an AIDS coordinator who liaises with the federal AIDS coordinator. These coordinators at the state level serve as secretaries to the state AIDS committee and provide technical assistance to the LGAs. The WHO Global Program on AIDS has three technical staff attached to the program in the areas of program management, epidemiology and information, education and communication. The WHO program staff shares offices with their counterparts.

E. MANPOWER, TRAINING AND TECHNICAL ASSISTANCE

1. MANPOWER

Inadequate numbers and quality of personnel at the managerial level have hampered adequate supervision and the monitoring and evaluation of the health care system at all levels.

FEDERAL LEVEL

At the federal departmental and zonal levels, staff turn-over has been minimal over the years. This has allowed for continuity of health programs. Field assessment indicates that most key officials have adequate specialized training and work in their areas of specialty. Most of the top management staff have had management training. The staff strength of the various departments at the federal level is insufficient compared with the volume of work required.

The most recent (until January 1993) Minister of Health was at that post for the past seven years and the current Director-General has been at that post for the past five years. This has ensured direction and continuity of health programs. Staff promotion at the federal level is based partly on seniority, annual performance assessments by supervisors, and promotion interviews.

ZONAL LEVEL

As an example of zonal representation, the PHC zonal coordinator's office (Zone A) in Enugu has a professional and technical staff of four to oversee eight states consisting of 153 LGAs. An assessment of the qualifications of the staff revealed that the office had very few qualified staff to carry out supervisory, monitoring and evaluation activities. Some of these responsibilities have now been assigned to state PHC coordinators. The MHSS plans to deploy Federal Technical Facilitators to the zonal headquarters of the states they supervise. Staff promotion is based on the same criteria as discussed for the federal level.

STATE LEVEL

There have been several changes of Commissioners and Directors-General for Health as a result of frequent changes in state Governors. This has resulted in lack of continuity of approach to health

issues, especially as each newcomer has brought to the job a different background and set of biases as to the way health care should be managed. Some of the states have medical doctors as Commissioners and Director-Generals, while others have nonmedical personnel in those positions.

Various SMOH departments have maintained their senior professional staff over the years, but frequent changes in approach dictated by new government administrations have affected their performance. Some of the top management staff have undergone some form of management training, but indicate that their performance could be enhanced with improved conditions of work, such as transportation. It is a common trend for lower cadre staff to be rotated between departments with short longevity in the departments or units where they have acquired some specialized training. This has often led to job frustration for the individuals concerned.

Departments are not adequately staffed to carry out their various tasks. Furthermore, there is a maldistribution of available professional staff between the various departments. In Plateau state, for instance, the majority of professional staff (80%) were involved in Family Planning to the detriment of other PHC activities. Promotion criteria at the state level is similar to the federal level.

LGA LEVEL

LGAs have power to recruit staff up to Grade Level 06. Higher level staff are recruited for LGAs by the Local Government Service Commission which is based in the state capital and which services all the LGAs within the state. The LGAs, therefore, have little or no power over the recruitment of its own top managers.

A majority of the LGA/PHC Coordinators in the LGAs are assessed by their chairmen as not being competent nor adequately qualified. Seldom has an LGA/PHC Coordinator undergone management training or can manage a program effectively. The reason given for this anomaly is that the coordinators are employed for the LGAs by the Local Government Service Commission. Most indicate that further training on the job would improve their performance.

The number, qualification, and experience of the various cadre of staff vary between LGAs. For example, Barkin Ladi LGA has twelve Community Health Officers (CHOs) compared to three for Bassa LGA, both LGAs being in Plateau state.

There is a general shortage of all categories of staff at all levels. This has often led to PHC activities not being properly implemented. Even where there are staff, logistics and transportation constraints make implementation difficult. In Igbo-Etiti LGA (Enugu state), for example, there are more women health-workers than men despite the overall shortage of staff. The only Community Health Extension Worker attached to the EPI Unit, for instance, goes frequently on maternity leave; this often affects program implementation adversely.

Posting of health workers to health centers is often based on political considerations, so that some facilities enjoy an excess of staff compared to others. This is the case in Bassa LGA (Plateau state), Egbeda LGA (Oyo state), Nsukka LGA (Enugu state) and Paikoro LGA (Niger state). Instability in the political administration of LGAs occasioned by frequent splitting of LGAs has resulted in frequent transfer of staff and spreading of limited staff among more LGAs.

2. TRAINING

FEDERAL LEVEL

Currently, development of health manpower takes place, to varying degree, at all three levels of government. At the federal level, most departments in the MHSS have responsibility for manpower development as follows:

- The PHC Department Coordinates and regulates the training of Community Health Workers - Community Health Supervisors (CHSs), Community Health Officers (CHOs), and Community Health Extension Workers (CHEWs). Training of CHOs is conducted in nine University Teaching Hospitals, while the CHSs and CHEWs are trained in twenty-eight Schools of Health Technology.
- The Department of Disease Control and International Health is responsible for the development of Health Superintendents for environmental/occupational health and disease control services.
- The Department of Planning, Research and Statistics plans for the development of Health Planners, Statisticians and Researchers. This training is done in selected universities.
- The Department of Hospital Services and Training plans for the development of Doctors, Nurses/Midwives and Medical Technicians. Training takes place in both University and Teaching Hospitals for doctors and Teaching Hospitals for the other cadre.

All health worker training institutions in the country follow national curricula and are regulated by national professional councils/boards. This has been useful in maintaining standards.

MHSS officials, and to a lesser extent state officials, undergo training abroad, mostly in areas where such training does not exist in Nigeria. Apart from the MHSS, donor agencies such as WHO, UNICEF, CCCD, USAID, ODA, etc., have offered training fellowships abroad. Manpower needs are not well-defined. While basic training for various categories of manpower is now stipulated, career development and working conditions are not clearly enunciated. It is felt that the number of staff with appropriate health management training at all levels is low. This deficiency manifests itself in an inability to delegate responsibilities. Simple decisions can not be taken, except by a few officials and this slows down program design, implementation and evaluation.

ZONAL LEVEL

The capability of the zonal PHC office is limited to providing technical assistance to states and LGAs. Little or no training is carried out by this office.

STATE LEVEL

SMOHs control and support training in State Schools of Nursing and Midwifery as well as Schools of Health Technology. There does not appear to be any needs assessment guiding the production of professionals from those state-owned institutions. Some states actually over-produce manpower, so that many well-qualified professionals cannot find jobs.

In Plateau state, the Deputy Governor's Office oversees the training of CHOs, Nurses, Midwives, etc., for LGAs. The identification and selection of trainees is based on political and seniority considerations and not on the requirements of the LGA institutions where they will eventually work.

LGA LEVEL

Training in PHC management is done by the State Schools of Health Technology. LGAs have no training institutions, however, some have organized staff re-orientation workshops to facilitate PHC implementation. Federal Technical Facilitators and consultants from the federal level and donor agencies have provided support for the LGA-level training program. The number of these Federal Technical Facilitators is insufficient for the number of LGAs. States have yet to establish a corps of technical facilitators to supplement federal efforts. LGAs pay salaries of staff sponsored for further or in-service training.

3. TECHNICAL ASSISTANCE

FEDERAL LEVEL

The Federal Ministry of Health is the focal point for donor assistance in the health sector. Many donor projects in the past were developed without government giving a mandate to pull together and achieve common objectives. One of the reasons for this was the fact that there was no health policy in Nigeria at the time projects were formulated. The result of this initial lack of mandate was that most of the donor agencies carried out their own programs, each, in their own manner.

In 1988, the Ministry of Health realized the need to coordinate donor activities and started to hold meetings with all donors in the health sector. An International Health Division was also created in the Ministry. The donor meetings have not been regular, nor frequent, but there has been a more focussed approach in recent years. Some donors have been allocated specific states and LGAs to carry out their activities. This has reduced duplication of activities in states and LGAs. Federal officials express an opinion that the effectiveness of donor coordination and direction depends on a sustained MHSS commitment. Despite the present level of donor coordination, the International Health Division in the MHSS does not have sufficient information about donors. The MHSS needs to develop a database for effective donor collaboration and coordination.

The principal players in PHC view some donor agencies as carrying out their programs with little consultation. More frequent and continuous MHSS dialogue with donors would improve working relationships. Donors should take a greater initiative in that regard.

ZONAL PHC OFFICE

Zonal PHC offices are currently poorly staffed with little or no effective contact with state or donor representatives. PHC zonal office do not invite donors for meetings, except on rare occasions. Various activities are executed at the zonal level without a focal point. A need exists for zonal coordination of activities among all PHC players. This initiative should be taken by the PHC zonal coordinator.

STATE LEVEL

Technical assistance is provided to the states by the donor community, the MHSS and, to a lesser extent, the PHC zonal offices. Uncoordinated donor action frequently occasions duplication of

activities and distract from the normal duties of participating officials. Workshops by donor agencies sometimes run concurrently, involve the same people, sometimes for long periods of time. Complaints have been levied against donor technicians for not sharing data collected.

LOCAL GOVERNMENT LEVEL

The operational place for technical assistance is the LGAs. The MHSS, PHC zonal offices, states and donor agencies provide technical assistance at this level. There is no coordination of activities at this level. The LGAs no longer consider the states as their supervisors, the result is that they open their door to all agencies that are willing to give projects and money. As most LGAs have PHC Coordinators who lack managerial skills, they cannot plan and work with different donors in a way that maximizes donor input and avoids duplication, etc. It is hoped that the Federal Technical Facilitators — when at the zones — will be able to give the necessary direction for donor coordination at this level. State inputs will be crucial for coordination of PHC activities at the LGA level. LGAs with donor assistance are further ahead in PHC activities than LGAs without donor assistance, even in the same state. This situation raises the issue of sustainability of PHC activities when donor assistance is withdrawn.

F. SUPERVISION, MONITORING AND EVALUATION

1. SUPERVISION

FEDERAL LEVEL

Federal supervision of state and LGA PHC activities is carried out, principally, through the office of the PHC zonal coordinator. The major constraints to supervision, seen in all the states visited, are manpower shortage and lack of transportation.

ZONAL LEVEL

Zonal staff have no dependable transport. They are sometimes forced to share a vehicle with a visiting donor, thus making supervision episodic. Zone A, for instance, comprises eight states and 153 LGAs. There are only two vehicles. The situation is similar in the other zones. The Zone A coordinator has had to liaise with state PHC Coordinators in an attempt to maintain supervision of the LGAs. This has not been successful.

STATE LEVEL

SMOHs are handicapped by a shortage of vehicles and have not been able to carry out supervisory functions effectively. Much reliance has been placed on donor agencies such as CCCD and UNICEF for the provision of vehicles. Occasional opportunities for supervisory visits have occurred when representatives of donor agencies want to visit LGAs in company of state PHC Officials. Donor agency representatives have access to their own transport. At times, unfortunately, donor representatives visit LGAs directly without being accompanied by SMOH officials.

In Plateau state, there is a PHC Department in the Deputy Governor's Office, and there is a Department of Family Health Services in the SMOH. LGAs do not necessarily look up to the SMOH for guidance, because of this duplication. This has created problems for supervision, monitoring and evaluation. Another method for the states to monitor PHC activities is through reports from LGA committee meetings. This method, obviously, precludes effective supervision.

LGA LEVEL

The PHC Coordinators draw up plans for supervisory visits to health outposts, but are often unable to visit due to lack of transportation. In some LGAs, even where a vehicle was given by an international donor agency, the PHC Coordinator has no final control over such a vehicle because maintenance costs are met by the LGA Council and the vehicle is used for nonhealth-related purposes. Other methods adopted are through meetings among PHC coordinators, District Supervisors, and Assistant Coordinators, but in the absence of direct observation of operations the facility-level supervision suffers.

2. MONITORING AND EVALUATION

FEDERAL LEVEL

Systems for monitoring health care delivery include: (a) the National Health Information Center, developed by the Department of Planning, Research and Statistics (MHSS); and (b) the PHC Monitoring and Evaluation system operated by the Department of Primary Health Care. Health Information System routine reporting forms are currently being distributed across the country through the zonal PHC Coordinators. The 1991 National Census results have been published, and it may soon be possible to obtain information on global indicators, such as coverage and health status.

ZONAL LEVEL

Zonal offices are responsible for monitoring PHC activities in their respective zones. The zonal office is expected to collect and disseminate information among various federal, state and LGA entities. Zonal offices have not been able to perform efficiently due to lack of adequate personnel, funds, and transportation.

STATE LEVEL

There still exists some lack of clarity as to who is responsible for what. In Enugu state, for example, the M/E Manager in the PHC department and the Head of the Department of Planning, Research and Statistics both receive copies of completed returns from LGAs. Data is collected, but not processed, nor is feedback given to the LGAs. Even where such conflicts do not exist, feedback to the LGA level is rare. Manpower insufficiency, material shortages (e.g., record forms, fuel, etc.) and the fact that states do not give any feedback to LGAs on the results of data collected have all combined to reduce the effectiveness of the Health Information System.

LGA LEVEL

Village Health Workers send monthly and annual records to the LGA/PHC Coordinator through the district health facility. These reports, in addition to health facility data, are forwarded through the state and zonal offices to the M/E unit of the PHC Department in the MHSS. This scheme is constrained by: (a) shortage of forms at the Village/Facility level; (b) inadequate training of staff who need to fill out the forms; (c) lack of transportation; and (d) lack of motivation on the part of the health workers as they rarely get feedback on information submitted.

Donor agencies have established their own mechanisms for monitoring and evaluation through field visits, data-gathering efforts, and trip reports. There is inadequate feedback to the LGA/PHC level.

In B Zone, for example, officials from the state department of planning, research and statistics are quite satisfied with donor support. They report, however, problems of maintenance and doubts of sustainability. Certain donor projects (e.g., CCCD) have played significant roles in the development of the National Health Information System by providing training, equipment, and materials to various levels of the PHC system.

G. COORDINATION AND USE OF DONOR RESOURCES

Coordination of donor agency activity on the part of federal, state and LGA authorities has not been effective. Various arms of government have alleged, also, that the donors do not have extensive consultation with them, either, at the project identification, planning, and implementation phases. Donors have their own complaints. Due to lack of absorptive (including managerial) capacity, Nigeria has not been able to utilize, completely, funds made available by the donors for project implementation, despite its inadequate funding capabilities for health projects.

For example, UNICEF's budget of \$13.5 million for 1987-91 was not completely spent because of bureaucratic bottlenecks in the MHSS and state Ministries of Health. The MHSS is now encouraging direct contact with LGAs to minimize such bottlenecks.

The donors find that decision-making at the federal and state levels is highly centralized. Few officials are involved, and these individuals have huge work burdens. As a consequence of the pressure on these people, they are not always available for donor consultations. This situation has kept donor representatives from meeting the deadlines of their respective agencies and has, also, resulted in lack of adequate input from Nigerian officials in the design of donor projects.

None of the donors are pleased with this situation, and all advocate better dialogue among themselves and government in areas of project identification, design, and implementation. Donors, in general, would welcome the presence of senior Nigerian officials at their seminars, meetings, reviews and consultations. The MHSS and the various SMOHs are now making efforts to coordinate donor inputs in recognition of the fact that the donors are major players in Nigeria health care delivery.

H. Conclusions

1. States, LGAs and donors have little information about the new PHCDAN.
2. The MHSS and donor agencies frequently bypass SMOHs to work directly with LGAs.
3. Inadequate amounts of funds are allocated to health at all levels considering the volume and scope of health activities expected. The bulk of recurrent expenditure is expended on staff salaries and allowances.
5. The commitment of LGA chairmen to PHC activities varies, but is important for successful implementation.
6. Revolving Drug Funds (RDF) have experienced problems linked to leakages, procurement of supplies from inflationary sources and varied levels of accountability.
7. There are no reliable data on total expenditures for health.

8. Standard accountability procedures are established for the Nigerian health system. Special procedures related to accounting for the use of donor funds are useful, where they have been applied.
9. The government has not been able to utilize, completely, funds made available by donors.
10. Routing of state Ministry of Health initiatives through the Deputy Governor's office has created bottlenecks and conflicts, especially when officials in the Deputy Governors office are not health professionals.
11. There is a lack of coordination between the zonal and state PHC officials and donor agencies.
12. Not all states have created a unified PHC department.
14. The fact that senior LGA health professionals are employed by the state (and not the LGA) may create conflicts of interest.
15. While staff strength may be inadequate at all levels, the quality of staff seemed to be more problematic at the zonal and LGA levels.
16. Though PHC training programs have been carried out, problems exist in coordination of training programs, quality/appropriateness of training and utilization of the training.
20. Although improved, the network for Monitoring, Evaluation and Supervision remains weak in analysis and provision of feedback to the field.
21. Decision-making at the federal and state level is highly centralized, and consultations with donors are inadequate.
22. Donor support (by way of vehicles and other supplies) has enhanced implementation of the PHC program.

II. Institutional Capabilities of Private Sector profit-making and nonprofit institutions relative to AAO/Nigeria Portfolio (1994-2000)⁵

According to a recently published report on primary health care submitted to UNFPA in 1990, there were 17,954 medical practitioners, 64,303 nurses, 52,378 midwives, and 5,318 pharmacists registered in Nigeria in 1989.⁶ The number of physicians, nurses, midwives, and pharmacists practicing in the private sector throughout Nigeria is not available, and estimates vary considerably. None of the estimates — 6,000 physicians, 3,500 pharmacists, and 10,000 nurses and midwives — can be

⁵Annex I, entitled "Strategy for the Private Provision of Health and Family Planning Services in Nigeria," presents a more complete discussion of the composition of the private sector and outlines an approach to incorporating private sector resources in the health and population activities supported by AAO/Nigeria.

⁶"Primary Health Care System in Nigeria: Organization, Structure and Functions," (submitted to UNFPA), Africa Health Consultancy Services (AHCS), December 1990, Appendix II, 64.

confirmed. Still, it is clear from anecdotal reports and visual inspection that the private health sector in Nigeria is large, growing, diverse, energetic, primarily urban-based, and difficult to quantify. The private sector in Nigeria is defined as:

- profit-making providers of health and family planning goods and services (groups and individual practitioners, modern as well as traditional health care givers);⁷
- profit-making manufacturers, distributors, and vendors of health and family planning products, and
- nonprofit providers of health and family planning goods and services; e.g., NGOs.⁸

In general, private sector care-givers in Nigeria, like those in other countries, have provided primarily curative services in return for fees from clients or their employers. Primary and preventive services have not been a major feature of the care offered by most profit-making providers, although these services have been a significant portion of the care available through nonprofit providers—especially those operating in rural areas. The "Nigeria Health and Population Sector Assessment" (November 1991), for example, observes that:

- 50% of all health care facilities in the urban areas of Ogun State are private;
- 40% of women using modern contraceptives obtained products and services from the private sector, and
- 18.5% of immunizations given in Lagos State were provided by the private sector.⁹

These data clearly indicate that the private sector is providing some amount of family planning and primary health care services in Nigeria. These activities, however, are not carefully orchestrated by and among private providers and organizations, nor are they monitored and/or documented by or for public sector health officials.

⁷While it is generally true that traditional healers are located more in rural than urban areas, it is difficult to make a clear-cut distinction between the two groups. Many so-called modern providers practice traditional medicine. At the same time, many traditional healers prescribe and dispense modern pharmaceuticals.

⁸Private firms that provide health services but have another activity as their central undertaking; e.g., bottling, banking, manufacturing, oil production, etc., are included among the private sector providers of health services. With the exception of the largest employers in Nigeria, such as Shell, United African Companies, Nigerian Electric Power Authority (NEPA) and the Nigeria National Petroleum Corporation (NNPC), most firms have clinics at the work site that offer primarily first aid and other occupational health and safety counsel and care. Other care is provided by private hospitals, clinics and maternities that hold "retainer" contracts. This approach is an effort by employers to provide services while controlling costs.

⁹D. Gibb et al., "Nigerian Health and Population Assessment," AAO/Nigeria, November 1991, 17.

AAO/Nigeria Experience with the Private Sector.

The FHS Project has enlisted and involved the private sector in the promotion and provision of family planning products and services. Sterling Winthrop Ltd. of Nigeria, a private sector pharmaceutical firm, has worked with the HFS Project to market the "Right Time" condom. Nurses and midwives who are members of the National Association of Nigerian Nurses and Midwives (NANNM) and own, operate or work in private clinics or hospitals have received the training and supplies necessary to offer modern contraceptives and family planning services.

The Planned Parenthood Federation of Nigeria (PPFN), the Christian Health Association of Nigeria (CHAN) and Africare, three nonprofit organizations, have also been involved in the promotion and provision of family planning products and services. In addition, the Enterprise Project and the Options Project, two centrally financed activities, have sponsored efforts to involve private enterprises in supporting and providing family planning programs. To date, however, the private sector has been only minimally involved in AAO/Nigeria's activities in child survival, chiefly through the urban EPI activities in Lagos managed through the centrally-funded (R&D/Health) REACH Project.

Recent discussions with public sector officials and private sector providers indicate that both groups are keen on ensuring that the private sector plays a more active role in the provision of primary and preventive health care. Nigerian public sector officials have repeatedly argued that the private sector should play a more active role in public health programs. In the past, however, the government has relied on regulations, not incentives, to achieve this objective. This strategy has met with only partial success. The shortcomings of this strategy and the government's inability to continue to finance and provide curative and preventive services has spawned new thinking on the role of the private sector.

At the same time, members or representatives of groups or associations operating in the private sector report that private providers — formerly allied in their opposition to government control and direction — are prepared to explore prospects for cooperation with each other and the government. Moreover, these groups are reportedly interested in playing a more active role in primary health care and family planning programs in predominantly urban areas. Providers are aware that clients want low-cost, high-quality products and services that effectively address health care and family planning needs.

The chart on the next page suggests the groups that have been approached and could be involved in the FHS-II and NCCCD projects to provide primary and preventive health care, including family planning information, products and services.

**Provision of Private Sector Primary Health Care and Family Planning
Information, Products and Services**

Illustrative Conduits for Channeling AAO/Nigeria Assistance

<u>Private Profit-making Providers</u>	<u>Private Nonprofit Providers</u>	<u>Health/FP Products</u>
<ul style="list-style-type: none"> - Hospitals/maternalities - Clinics - Maternalities - Private Practitioners - MD - Private Practitioners - MW/RN 	<ul style="list-style-type: none"> - Hospitals (Mission) - Clinics (FP) - Maternalities 	<ul style="list-style-type: none"> - Pharmaceutical Distributors - Retail Pharmacies - Patent medicine vendors - Social marketing outlets
Guild of Medical Directors Association of General and Private Medical Practitioners of Nigeria National Association of Nigeria Nurses and Midwives National Postgraduate Medical College of Nigeria Nurses/Midwives Ass'n Nigeria	Nigeria Association of Non- Governmental Organizations on Health (NANGO) Planned Parenthood Federation of Nigeria (PPFN) Christian Hospital Association of Nigeria (CHAN) National Commission of Women's Societies	Pharmaceutical Society of Nigeria Nigerian Association of General Practice Pharmacists Pharmaceutical Manufacturing Group of the Manufacturing Association of Nigeria Population Services Int'l

Two challenges facing the new projects supported by AAO/Nigeria are (1) to develop and implement strategies that will encourage the sustained participation of the private sector and (2) to document the public health impact of the services provided through the private sector.

The numbers of providers and the practices of Nigerian consumers suggest that the private sector has an important role to play in the AAO/Nigeria projects. However, unlike the public sector, the private sector is difficult to access and involve in public health activities. In general, the private sector, especially profit-making providers, are suspicious of public sector officials and reluctant to provide services that do not generate significant profits. In addition, nonprofit providers, especially groups with religious affiliations, are reluctant to cooperate with each other. Managers of the FHS-II and NCCCD will need to give focused attention to the private sector to overcome their suspicion of the government and each other, to secure their effective participation in primary and preventive health care services, and to measure the impact of their programs on the health of the communities served.

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I. THE SOCIOCULTURAL CONTEXT

The Largest African Nation

Despite previous UN/World Bank estimates in the 120 million range, the 1991 census established 88.5 million as the total population. Nevertheless, Nigeria remains the most populous country in sub-Saharan Africa with an estimated 90,100,000 citizens in 1992. The total fertility rate is 6.0 coupled with a declining mortality rate of about 16 deaths per 1000 as of 1989. Nigeria's population is projected to double in about 23 years. The combination of a high fertility rate and a high although decreasing mortality rate with a low economic base necessitates project intervention.

The population of only one of Nigeria's four health zones is as large as Ghana. The combination of the two most populous ethnic groups is larger than that of any other African nation.

Ethnic Groups

The 250 ethnic groups in Nigeria include three major groups: Hausa/Fulani, Yoruba and Igbo; seven additional very large groups: Ekoi/Efik/Ibibio, Kanuri, Tiv, Ijaw, Edo, Urhobo, Nupe; and twenty-six small groups which nevertheless have a substantial population: Bariba, Bussawa, Dukawa, Kamberi, Kamuku, Gwari, Katab, Ningawa, Jarawa, Berom, Angas, Tangale, Jukun, Mumuye, Longuda, Batta and Chamba, all in the Middle Belt; Kare-Kare and Marghi in the Northeast; the Igbira, and Idoma, along the lower Niger basin; and the Igede, Ukelle, Iyalla and Boki in the East.

Ethnic Differences

Pervasive prejudice against and distrust of other ethnic groups is based on differing beliefs, value systems and roles for the ideal man and woman as well as on nepotism. Since Independence, inter-ethnic rivalry has increased. Not only is the common colonialist enemy no longer a unifying force, more importantly, common ethnic roots have been successfully exploited by politicians seeking votes and personal power. Moreover, within a common ethnic name or language, primordial cultures have distinct sub-cultures whose members often define their self-interest in terms of the sub-culture.

Socialization Trends

Despite rapid urbanization especially since Independence, Nigeria remains a predominantly rural nation with 65% of the population living in 97,000 settlements comprising less than 20,000 people each. However, Westernizing forces have increasingly penetrated the rural areas through communication and development channels including primary education and agricultural extension. The socialization forces of the traditional extended family and gerontocracy have been undermined throughout the country, not merely in the urban areas.

The endurance of polygamy and a heritage of strong, extended family bonds as opposed to conjugal bonds is increasingly being translated into the further disintegration of the family. Westernization and Christianization have effectively undermined the extended family bonds. Poverty and despair in the face of unrealizable risen expectations and the breakdown of traditional patterns of self realization is fostering the further separation of many conjugal families. While most men are trying to retain control of the vestiges of their status and self-esteem, a significant number of husbands have fled to the cities, leaving the woman de facto household heads with full economic responsibilities. In addition, a few women are recognizing that they are supporting or capable of supporting their children and are freeing themselves from familial constraints to create female-headed households.

Significant Numbers of Underemployed and Unemployable

In recent years a combination of an already saturated government bureaucracy and modern economy exacerbated by the baby boom and the economic stagnation and inflation (more than sixty percent

over the last year) induced by the devaluation and deregulation imposed by SAP (Structural Adjustment Program) has fostered significant numbers of underemployed and unemployable youth and young adults. Primary and secondary school dropouts are on the increase nationwide as people realize that education no longer ensures employment and comfort. On the contrary, even for university and technical school graduates, it portends unemployment. Some rural youths have begun refusing to farm with the narrow profit margins even when they can obtain no wage labor. Theft is rampant in the cities and on the rise in the rural areas where even farm crops are now subject to theft.

The "Democratic" Political Process

In August of 1993 the gradual change to a democratically elected government is projected to be completed with the installation of a president. The party platforms of the two parties were designed by the government, "a little to the right and a little to the left". The populace does not believe elected candidates will be responsive to their needs and many, if not most, have not exercised their voting rights. Some candidates have been banned, and unbanned while others have been disqualified at the last minute depriving the electorate of a real choice. The Government canceled the presidential primaries on the grounds of widespread election fraud and prescribed a new electoral procedure.

The LGA, State and Federal Levels of Government

Local Government Authority (LGA), contrary to its nomenclature, is not at the local, grassroots level; it is comparable to a county. Although the LGAs were intended to have 150,000 citizens each, according to the 1991 census their population sizes vary considerably: eight have over 500,000 including Ojo in Lagos State which has over one million; one hundred have over 200,000; and, five have less than 50,000. Most LGAs are divided into three-six districts but the larger LGAs have up to twelve districts.

Citizens elect the Chairman of the LGA Council and a representative from their district. At the grassroots level, decisions are channeled through the traditional rulers selected according to diverse local customs and acting in an advisory capacity. Approximately 110,000 'natural' communities created by the people themselves have been identified throughout the country.

Corruption

A combination of SAP-induced inordinately low civil servant salaries, difficulty in obtaining the release of capital and recurrent funds to operate work plans, lax budgetary controls, non-punishment of financial mismanagement and the willingness of the private sector to pay enormous bribes have contributed to the institutionalization of corruption. The SAP-induced retrenchments and hiring freezes in the formal sector have generated an exploitative employers' market even for experienced graduates except in the banking and oil sectors. As a consequence, private sector employees are also forced to supplement their incomes.

Non-Accountability of Government Officials to the Public

Government officials act as though they are primarily accountable to the federal government because it is the source of continued funding. Taxpayer funds only represent a very small proportion of the budget in comparison to the centrally controlled oil wealth. At all levels of government, the funding is direct from the federal government. Although, some states and some local governments do have significant internally generated funds, even these states source most of their funds from the center. The Olowo Study on Local Institutions and National Development found very little direct accountability of the local government to the public. As an example, the federal government funds the LGAs directly to ensure that funds are not delayed by the state; however, funds for the Ojo LGA health program were held up by the federal government for more than six months in 1992.

II. PROJECT BENEFICIARIES

The Participants as Beneficiaries

In all three projects, the participants who are the basic vehicles for accessing the direct beneficiaries will be the administrative management, technical personnel and volunteers in both the public and private sectors who will receive training, technical assistance, and support for planning, implementation and evaluation of intervention activities. In addition, to officials in the three tier administrative structure, the Federal Ministry of Health and Social Services, (MHSS), the State Ministries of Health (SMOH) and the Local Government Authorities (LGA), participants from local community institutions such as traditional birth attendants and local community health committees will benefit from the project. Benefits will filter into the private sector through various types of NGOs as well as through marketing mechanisms. Numerous NGOs will themselves benefit from training and funds.

Family Planning Beneficiaries

Because spousal, decisionmaking is often undertaken separately by each spouse, four entities separately and collectively are the family planning beneficiaries: the conjugal family, the women, the men and the nation. The beneficiaries of family planning are the conjugal families including the children socialized within them and, on the global scale, the nation and its various levels of government. Reduction in dependents will improve individual living standards and the capacity of government to provide services while reducing destruction of the environment. All Nigerians will benefit from the reduced burden of additional children to feed and educate with the limited resources available. To the extent that families achieve their minimum desired number, they will consider themselves as beneficiaries.

Women are multiple beneficiaries of family planning which offers them the potential to maximize the quality of their family and personal life in several ways. First, family planning has the capacity to prevent a woman from incurring the high risk births and pregnancies which prevail in Nigeria so that she herself can survive and enjoy the increased survival of her children. Second, family planning allows her to avoid rejection of her spouse while spacing their children, thereby hopefully preventing or diminishing diversion of his affection and/or economic resources from the conjugal family. Third, limitation allows her to adjust the number of her children to the available resources ensuring greater physical comfort and reducing strain within the family. Fourth, family planning frees her to time and limit her child bearing responsibilities in such a way as to maximize her own capacities to support herself and her children and to realize herself as a person.

Males are beneficiaries of family planning to the extent that they enjoy the above mentioned benefits accruing directly to their wives and children and to the extent that they are relieved of the burden of supporting additional children.

Resources of the FHS Project will reach women the approximately 17.7 million fecund women between the ages of 15-49, and their spouses and children. Simultaneously, the project is targeting all the women at risk to themselves and/or to their newborn children because of mistimed pregnancies. Based on a study of at-risk women between 1985 and 1990, nearly 80% of currently married women are at risk of illness and/or death to themselves, their newborn child or both because they were too young, too old, too high parity or too frequently pregnant. The FHS and CCCD combined resources will reduce the excessive maternal mortality which is currently around 150 per 100,000. All three projects will reduce morbidity caused by lack of proper medical care for pregnancies, STDs and malnutrition.

HIV/AIDS Prevention and Control: Project Beneficiaries

The direct beneficiaries of the project are the distinct target groups: the university students, commercial sex workers, military personnel and truck drivers in Cross River, Kano and Lagos States, as well as management and staff of some companies as yet to be determined. In the later phases of the project, the direct beneficiaries will also include secondary school students.

The indirect beneficiaries are the entire population of Nigeria. The economic and social impact of AIDS will be significant for individuals, families and communities. Since resources in the health care system will in all likelihood be insufficient to cope with increased number of cases, families and communities will have the burden of care of Persons With AIDS (PWAs). Any meaningful attainment of the project goal of reducing the rate of spread of HIV infection will contribute to easing this burden proportionally.

Resources of the HIV/AIDS Component will reach the target population through existing institutions such as the health care delivery system of the Federal Ministry of Health (MHSS); STD clinics, the primary health care infrastructure, family planning services, school authorities, student groups, the military hierarchy, non-governmental organizations, traditional leaders and religious leaders.

Within the Federal and State ministries of health, STD/HIV and AIDS prevention activities will be channeled through the AIDS control program. The AIDS control committees at both have been deeply involved in sentinel surveillance as well as data gathering concerning STDs as they impact on HIV infection. Channelling activities through these units will further strengthen the National AIDS Control Program in its coordinating role.

Benefits will reach target groups through NGOs. The commercial sex workers will be reached through the Society for Women and AIDS in Africa, Nigeria branch (SWAAN) which has branches in thirteen states including the project states of Cross River, Kano and Lagos. SWAAN already has vast experience in work with CSWS in five states of the Federation. Truck drivers will be accessed through STOPAIDS, an NGO with bases in Kano and Lagos which focusses primarily on long distance drivers. Members of many NGOs will be reached through Speakers Bureau of the NACP NGO Coordinating Committee.

The family planning program has an NGO infrastructure through which benefits could also reach the target groups. PPFN has personnel on the ground in Kano possessing a rich knowledge of cultural sensitivities and prevalent attitudes towards sexuality issues particularly among the predominantly Islamic population of Kano and Jigawa States

CCCD Project Beneficiaries

Although the country as a whole will benefit from the CCCD project, the focus is on nine states. The direct beneficiaries are Nigerian children and infants aged 0-5 (21% of the population), and women of reproductive age (24% of the population) making a combined total of nearly 50% of the population. Child health interventions will target the 4.2 million new borns annually by reducing the current infant mortality rate of 85/1000 and the even higher child mortality rate of 145/1000. Maternal health interventions will reduce the maternal mortality rates which are still very high ranging between 33 and 1,500 per 100,000 and resulting in approximately 40,000 deaths annually. The indirect beneficiary is Nigeria. Reduced child morbidity and mortality through attack on immunizable diseases and control of the most prevalent diseases, such as malaria and acute respiratory illness, will guarantee quality child growth and development. Quality growth and development lead to a productive adulthood which is directly related to a nation's long term social and economic well-being. The national community at large will derive indirect benefit also as a result

of the opportunity to become familiar with the concepts of preventive health, child spacing, prolonged breast feeding and improved infant feeding.

Resources of the CCCD Component will reach the target population, reproductive age women, infants and children with vaccinations and health information, education, and policy statements. Support will continue for vaccination of infants against the six major diseases and yellow fever and for reproductive age women against tetanus. Information and education on management and treatment of diarrhoeal disease by using oral rehydration salts and home fluids will be expanded. Information and education, policy statements and operations research with respect to malaria prevention, management and treatment will be pursued. Information and education in respect of breastfeeding, infant and child nutrition, weaning foods, management of nutritional deficiencies, growth monitoring is a major component. Provision of information, education and policy statements for the treatment and management of children with ARI (acute respiratory illnesses) has been added as a new component.

Obstetrical information and counselling services for the management of pregnancy is another essential component that will interface with FHS.

III. BENEFICIARY AND PARTICIPANT PARTICIPATION IN PROJECT IMPLEMENTATION

Beneficiary and service level participant participation is largely confined to their input into focus group discussions, client and public in-depth interviews, operations research activities, training programs, pre- and post-KAP studies and evaluations. Nigerian researchers will continue to carry out research pertinent to all stages of project implementation and evaluation. Higher level participant participation has been and will continue to be extensive. The projects have been designed in conformity to government policy and requests for project interventions. Government and private sector participants have actively been involved in policy workshops designed to shape the interventions.

NGOs have been and will continue to be involved in project interventions as project beneficiaries and participants. Selected NGOs will receive technical assistance and limited funding to enable them to function as cooperating agencies transmitting their technical knowledge to other participants. NGOs will also be targeted to receive intervention messages within their NGO peer-groups to facilitate the Nigerian participatory, decisionmaking process which involves shared responsibility in risk-taking. Female professionals are being given some preference in the structures that are relevant for the health interventions. Two women are currently deputy directors in the MHSS, one heading the Department of Population Activities (DPA) and the other heading the Nigerian AIDS Control Program (NACP). Within AID and its cooperating agencies, a few women have been appointed at decision-making levels. At present, the highest female position is held by the director of the IEC program.

IV. SOCIOCULTURAL FEASIBILITY

GENERAL BACKGROUND

WOMEN IN NIGERIAN SOCIETY

The Socioeconomic Status of Women

Although women are central to the project interventions, they are considered second class citizens, partially by law but mostly because of the social and cultural climate. The position of women has hardly improved over the last decades, and although there are women who have made considerable individual and personal progress both in the academic and business world, as a group women in Nigeria are clearly under-privileged. This is especially true in the case of the rural women.

In most cultures women do most of the agricultural work, in addition to their normal household chores, including fetching water and firewood, which in certain parts of the country entails walking long distances, in difficult terrain and harsh climatic conditions. Even in the urban areas, most female participation in the labor force is limited to the lower categories.

Wife Seclusion - Purdah

In the cities of the far North, most married women are secluded in their homes; they are, however, allowed to leave their houses for ceremonies, marriages and funerals. Most are permitted to visit relatives and to seek medical care. The strictness with which seclusion is enforced depends upon the husband's wishes and the wife's willingness to comply. There are women who never go out for any social occasion at all, and there are others who simply inform their husband that they are going out. Most women comply with the restrictions of purdah and go out only at night when, in theory, they cannot be seen. They take children with them as escorts and cover their faces with shawls.

In practice, male control extends primarily over the activities of wives and daughters outside the home, mainly by restricting women's spatial mobility. Purdah also restricts access to secluded women by other males. However, men delegate responsibility for the women and children within the home, for they spend very little time at home.

The Legal Status of Women

Regardless of the operative legal system, custom dictates that child custody is the prerogative of the husband. It is extremely difficult for a woman to retain custody of her children in the event of marital separation or dissolution without the cooperation of the husband. Women's behavior in all spheres of life is greatly influenced by their desire to retain custody of their children.

According to various Nigerian constitutions no discrimination is allowed in the rights of citizens irrespective of sex, ethnic group or religion. The Nigerian legal system is very complex and consists of three types of legal system: the so-called modern legal system which theoretically is applicable to all citizens, provided they and the case under consideration do not fall under either the Islamic Sharia system or the customary law system. The Sharia courts are applicable to Muslims in the northern and middle belt states while the customary law system, operational mainly in the rural areas of the south. Customary and Islamic laws discriminate against women. Muslim women do not have access to the full protection of the Sharia system because of lack of knowledge about their legal rights. Customary law sanctions a number of very harsh and cruel practices against women and their bodily and spiritual well-being, and they have no recourse to legal protection from the modern system.

Even in the modern legal system, numerous provisions discriminate against women, not out of principle, but because of traditional and historical inertia. Upon marriage dissolution, women have to prove material contribution to the matrimonial property. Although men are given tax relief for children, none is given to the women who carry the bulk of the burden of children's upbringing. No legal minimum age at marriage has been set. Nor is there any legal provision against spouse battering. The Evidence Act discriminates against women in polygamous marriages.

A number of women NGOs, such as the International Federation of Lawyers (FIDA) and some State Ministries of Social Welfare are providing special counselling services for women, but the services provided reach a very small portion of eligible women. The Federal Government is considering the introduction of modifications in the legal system, including prohibition of certain customary practices.

Governmental Promotion of Women

The present administration vigorously promotes the enhancement of the position and status of women, and is in favor of fully integrating women into the developmental, economic, social and political processes of the country. The National Population Policy contains a section on "the role and status of women in development" to which government decrees and policies are responding. The First National Rolling Plan and Decree No. 30 of December 1989 establishing the National Commission for Women (NCW) clearly state the intention of the Government to integrate women into the process of national development and to remove the religious and cultural constraints on women development by emphasis on higher enrollment rates at all levels of education and income generating activities. Furthermore, some state governments have policies of providing automatic scholarships for female students who wish to pursue further secondary and higher education, especially in technology and science-oriented subjects.

Government is promoting a number of activities to improve the socioeconomic position of women: women in health, women in agriculture, women in education, etc. Progress has been slow and uneven. In June 1990 the NCW was inaugurated under the Presidency with the mandate to coordinate all national, women's activities. The NCW, whose statutory chairperson is the wife of the President, coordinates the Better Life Program (BLP) and Women in Development (WID) activities. State NCW branches have been established under the Governor's Office. At the LGA level branches of the NCW will also be established to coordinate WID activities at the level.

The BLP is a loosely structured organization started in 1987 on the instigation of the First Lady of the Republic with the wives of the governors in the states as State Presidents and substantial extra-budgetary federal funding. This organization was initiated because the national bureaucratic machinery was too slow to respond to women's concerns. Having the support at the highest level of the Federal and States, BLP has significantly contributed to uplifting the position of rural women. BLP has actively embraced the population policy as well as actively promoting PHC, MCH, Family Planning and Safe Motherhood, improving of the social and economic conditions of women, adult literacy and income generating activities.

NGO Promotion of Women's Issues

At the national level there are three main women's NGOs. The National Council of Women Societies (NCWS), founded in 1958, with branches in all States is an umbrella organization for all women groups that wish to affiliate themselves. In some states, the NCWS is very well organized and active in wide variety of fields. The NCWS has been one of the NGOs supportive of the population policy since its inception. They are actively promoting the objectives of the population policy and are in some cases more radical than the policy, especially with regard to minimum age of marriage,

abortion, safe motherhood, the legal position of women, etc. The Kano State branch has been in the forefront of the struggle against vesico-vaginal fistula (VVF).

Female-Oriented International Interventions

The current female-oriented international interventions designed to promote equality and facilitate fertility reduction programs may significantly contribute to the destruction of the nuclear family.

Improvements in Women's Status

Despite the threat women's advancement poses to male preferential treatment, progress has been made in the improvement of the position and status of women. The Government strongly promotes the appointment of women in positions of authority. Although there is no female member of the AFRC and the Federal Cabinet, there are an increasing number of female judges, university professors and ambassadors. Out of thirty-seven Directors General at Federal level, at least nine are women. Until recently a woman was the Deputy Governor of a northern state and currently several women are deputy governors. Each State has at least one female State Commissioner and some female State Directors General. A considerable number of women were appointed as sole administrators of the LGAs.

THE MODIFIED/TRADITIONAL WORLDVIEW

Project Behavioral Change Requirements

All three projects demand a personal and societal reevaluation of core values and self-image including changes in private behaviors; faith in the germ theory of illness; deviation from existing moral authority; belief in ability to control nature with Western rather than occult powers; and, rejection of a pro-natalist and fatalist world view. At a minimum an innovator or an innovating group must have a conception of benefits accruing from behavioral change preferably from successful role models as well as faith in the moral authority of the change advocates.

The Eclectic Modified/Traditional Worldview

Virtually every Nigerian is at least partially estranged from his/her ethnic tradition. Both individuals and their societies are in transition responding to their environment with modified/traditional solutions. In contrast to the homogeneous traditional social environment, the current environment is constantly in flux with individuals operating according to overlapping and ostensibly conflicting value systems determined by their ethnicity, religion and degree of modernization. An individual modifies his combination of modern and traditional as he moves through time and space throughout his life. Even within the same day, an individual may face some situations he perceives as meriting a more traditional response and others as meriting a modern response. All those around him, because of the circumstances of their own socialization, respond according to their own combinations of modern and traditional. In fearful situations, this eclectic worldview manifests itself with both traditional and modern solutions being sought.

The African Worldview

Aspects of African religion persist as a worldview among both Muslims and Christians without their always realizing it. Traditional healers and "medicine men" will thrive and retain many of the old rites in their healing practices. In the Southeast they are known as dibias, the Yorubas refer to them as hahalawos, while in the Northern parts of the country they are known as mallams. Although a mallam is a Muslim teacher/interpreter of the Koran, the mallams referred to here are the category of mallams who have adapted Islam to the traditional concepts; they divine the future and provide

prevention and cures with the text of the Koran. Their methods include preparing talismans with Koranic texts and medicine with the ink used to write Koranic texts on their tablets.

The spiritual dibias, babalawos and mallams serve people as their link to the spiritual world by solving their problems, protecting their health and fertility, and divining their future. The traditional medico-religious influentials have followers in all segments of the society: rich, poor; educated, illiterate; urban, rural; male, female; and, young and old. The spiritual world operates alongside the physical, material world. In the African world view the spiritual world modulates all occurrences and phenomenon that are not perceivable by the biological sense organs of normal people. This spiritual world is as much a presence in the daily life of Africans as the microscopic world is a presence in the daily life of Westerners. In each case, awareness of this invisible world permeates the perception of reality.

In the African worldview, the spiritual world contains good and evil elements and phenomena which can manifest in the physical and material world. Special persons have the knowledge and power to understand, interpret, intervene and ameliorate the evil manifestations of the spirit world. Witches are harbingers of evil. Native doctors, traditional healers, Ifa priests, other priests and priestesses have the knowledge and power to do good, to prevent evil, and to harm evildoers by using a variety of prescriptions. Their prescriptions can be symbolic like breaking an egg at a major road intersection, or concrete like boiling and drinking a combination of herbs. Some prescriptions are preventive; others are curative.

It is legitimate to commission the use of evil powers against someone who is believed to be causing (by similar occult means) ones own suffering--illness, death, infertility, low fertility, failure to produce a son, etc. Jealousy, greed and anger are also recognized as reasons people use occult evil. Since family members remain financially interdependent frequently resorting to mutual assistance and competing for the same resources, people have occasion to believe that their relatives are guilty of jealousy and greed and to suspect them as possible perpetrators of their own suffering.

The distinction between physical and spiritually induced disease conditions is not very clear. Significantly, the traditional doctors, healers, priests are considered more appropriate than the Western health system for spiritually induced conditions. Education enables a person to distinguish physical diseases by explaining the rationale for their symptoms and cure and by increasing a person's understanding of and faith in the Western world view. However, the role of the spiritual increases with the intensity and longevity of an illness even for highly educated individuals.

Witchcraft

The belief in witchcraft influences fertility behavior and maternal/child survival. Witchcraft is practiced by killing one's children or the hated person's children and in some cases the adult enemy as well. If one has only three children, they could all be wiped out at once by witchcraft whereas if one has five, six or more children, one would be able to take precautionary measures once the evildoer had killed some of the children. Thus high parity is perceived by those fearful of witchcraft as a preventive measure ensuring some surviving children. Since witchcraft is also believed by some culture groups to be the cause of child mortality, and specifically the cause of measles and polio, many doubt the utility of Western vaccinations.

The Influence of Traditional Healers

It is estimated that seventy percent of Nigerians recognize and patronize traditional healers. In contrast to Western medical practice, traditional medicine has many advantages from the viewpoint of the patient. The diagnosis and treatment not only conforms to expectations, but also includes

patient responsive counselling. The patient and his relatives participate fully. After narrating his problem, if medicine is the solution, it is the patient who mixes the ingredients. If divination is part of the solution, the result is that the patient is given a rationale he accepts both for the condition and for the remedy. He is also told the prognosis rather than merely being given a prescription for unnamed syrups and tablets. Moreover, the payment is usually fully integrated into the cure in the form of a sacrifice or a token of appreciation that can be paid over time as the resources become available.

Ancestor Cults

Belief in the cult of ancestors persists and especially in consulting them on the continuity of family lineages and in solving family and personal problems. The dead ancestors retain an active identity as members of the lineage, protecting its members, when they are remembered by the surviving generations. Appropriate behavior to retain ancestral approval begins with taking adequate care of the aged dependents and performing the required rituals such as, giving him/her a decent burial.

Many societies believe in reincarnation and some children are named after dead ancestors who are reborn in them. These societies frown on small size families accusing the affected couple of preventing the dead ancestors from enjoying their right to reincarnate, thereby condemning them to be perpetual wandering ghosts. Thus, large families receive approval, and by implication, divine approval as the family is perceived as being blessed.

THE MODIFIED/TRADITIONAL FAMILY AND SOCIETY

Fertility Rather Than Virginity as the Paramount Virtue

In the traditional environment given the African land tenure system, lack of technology and nonuse of draft animals, humans were the most valuable resource; the more humans, the greater the surplus crop and the more distributable wealth in the hands of the patriarch. As the Caldwells affirm, fertility rather than virginity was the central female virtue. Eurasian virginity ensures retention of land ownership within the elite, but in Africa land belonged to the deified ancestors. It could not be hoarded; instead usufruct rights to the ancestral land were withdrawn when the family lacked the people to till it. Power including control over land and economic resources including family members was reserved for the males and for the elders. Older women exerted power over other women and children, but they did this on behalf of the elders. Patriarchs redistributed the majority of the accumulated surplus wealth although adults retained direct control over their subsistence foodstuffs. This system has been greatly modified; nevertheless, it forms the basis for the modified/traditional solutions which continue to evolve.

Infertility

Traditional religious and cultural values have supported high fertility by equating fertility with virtue and ancestral approval and associating little or no fertility with evil. Barrenness rather than loss of virginity is considered a tragedy brought about by occult powers at the behest of the jealous relatives or ancestors or, in some cases, as a manifestation of the sufferer's evil. When barrenness occurs, pregnancy is delayed or infant mortality is very high, ancestral disapproval is attributed as the overriding cause and diviners are usually consulted to identify the cause of the disapproval and appease the ancestors. Barrenness can also be as a result of God's wish since he gives children. A childless adult loses the respect of others. Barrenness is considered a personal calamity, a wasted life.

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High fertility is a source of joy for the parents and grandparents. For the impoverished, it is a traditional source of status. For some, it is the prime source of status, other traditional sources having been eroded. It continues to engender overt praise even when people privately express consternation about the inability of the parents to properly feed and raise the child.

Pronatalist Traditional Marriage

Traditionally, the function of marriage is primarily to ensure the supply of children to the male extended family. Men continue to be under considerable pressure from their natal families to produce children, even to the extent of the family supplying a second wife if the first wife fails to continue to produce. Children are considered as rightfully belonging to their father. A woman "has children for a man"; not for herself. A woman is also expected to defer to her husband and submit to his authority. Among virtually all ethnic groups and religious communities, men are considered the head of the household. Family health and reproductive decisions are the prerogative of the husband even if he fails to supply the necessary funds and even though the wife usually is the caretaker.

Bride price is paid in exchange for the rights to the woman's reproductive capacity and her domestic labor including cooking for her husband and caring for their children. In Igbo culture the high bride price formerly guaranteed the right to the wife's work, although women are now encouraged by their natal families to retain most of their earnings and to assist their natal families. In contrast, the low bride price among the Yoruba only confers the right to the children. The husband is expected to financially assist the wife in setting up her trade and she should use some of the earnings for the family, but she may keep most of her earnings for herself and for her obligations to her own extended family. A Yoruba wife assists the husband if there is a financial need. Among the northern Muslims, traditional practice and Islamic law require that a man provide shelter, food and clothing for his wife and children including visiting relatives of the wife with the wives' responsibility limited to providing a proper dowry for the daughters. Thus, traditionally men had varying degrees of financial obligations which were carried out within the extended family context, but significantly in all ethnic groups, wives are expected to supplement household money with their own farm produce or income in times of need.

The Non-Companionate Marriage Relationship

Polygyny ensures pleasure for the elders and maximization of the number of offspring whereas monogamy threatens the power of the elders, male and female, by tipping the balance in favor of the conjugal couple and the nuclear family.

Extended families and natal families acting through their senior members exert authority over the spouses in a conjugal family. Spouses do not act as a single economic unit. Their finances are separate as are their financial responsibilities which link them to their natal families. Men are greater assets to their natal families because their finances are not divided whereas a woman has varying degrees of obligation to the husband's family as well as to her own.

The extended family hierarchy opposes very close spousal, companionate relationships because of the possibility of diverting resources to the nuclear family. The mother-child bond is the strongest bond. In Hausa/Fulani society even that bond is subjugated to the larger familial interests in the case of the first born son. This mother-son relationship is traditionally an avoidance relationship with the child being fostered to a male relative, usually an uncle.

Many, if not most, Nigerian marriages are minimally companionate or non-companionate, especially for the older generations. At one extreme is the Hausa polygamous marriage. Hausa husbands and wives do not work together, eat together, go out together, share domestic tasks or share the same

friends. Each adult has his/her own bedroom. Each woman's ultimate security is based on her children, her kin and herself. The practice of serial marriage ensures that the household is an artificial construct with changing personnel whose strongest ties may be more with kin and friends elsewhere than with members of the domestic group. Slightly more companionate traditional marriages occur among other ethnic groups and individuals living in non-traditional settings. For instance, some migrants send back home for a bride in order to preserve some of the qualities of traditional life in an alien environment. At the other extreme is the monogamous love marriage. However, many marriages are transformed by time and differing spousal viewpoints into basically non-companionate arrangements with shared socialization only at family affairs.

Marital Sexual Relations

The prime function of marital relations is to produce issue. Among many couples, mutual sexual pleasure is not perceived as a goal much less achieved. To the extent that female circumcision reduces sexual pleasure, it coincides with a social need for the wife to abstain from sexual pleasure for long postpartum periods.

Sexual Networking

Recent work by the Caldwells and Orubuloye with their Sexual Networking Group has established that sexual networking, at least in some parts of Yorubaland, traditionally was at high levels for men and significant levels for women and that contemporary sexual networking continues at high levels but is more diffuse. It now also involves women friends in brothels and is no longer residentially localized. According to the 1990 Ekiti Sexual Networking Survey, sixty percent of the current male sexual activity is extramarital. Consequently, even the one-third of rural Ekiti women who remain virgins until marriage and the one quarter who refrain from extramarital sexual relations are at great risk for sex diseases from their husbands. Furthermore, the AIDS risk is intensified by the urban STD rate of ten percent for current cases and thirty-three percent for past, treated cases.

In traditional polygynous society, so many women were unavailable to so many men that barring priestly abstinence on the part of the men, considerable sexual networking had to involve married women. Men married at thirty; girls were married off young at sixteen or seventeen; divorce was virtually non-existent; and, widows were inherited by their in-laws. Polygyny further reduced the number of women available for marriage and the practice of long female postpartum abstinence (three years) made women unavailable to monogamous husbands for half their fecund lives (16-45 years). Even a polygynous man with two wives would find that thirty percent of the time both his wives would be unavailable. The gerontocracy reserved women for the older, wealthier men. All men were expected to wait until age thirty to marry, at which time their families' helped produce the high bride price.

The Ekiti Study established the existence of considerable sexual networking on the basis of extended in-depth interviews and surveys with the elderly as well as with the currently sexually active. Proscriptions of non-marital sex appear to have applied to the wealthy, especially to those whose first marriage had been arranged at birth and paid for over time. In any case, contrary to the widespread impression that the prevailing pattern of pre-marital sexual relations is a new phenomenon brought about by the breakdown of traditional society, discreet, surreptitious, pre-marital sexual relations were common especially in urban areas in the 1930s with two-thirds of the rural and four-fifths of the urban women sexually experienced prior to marriage. One-third of the rural women reported extra-marital relations with other members of their husband's extended family, usually their brothers-in-law or the son's of co-wives.

The extent and type of sexual networking patterns among other ethnic groups is yet to be examined.

Adolescent Sex

With the major exception of the Far North, the age at marriage has shifted slightly from marrying in the mid-teen years to marrying in the later teens. Among urbanites in Akwa Ibom State, in Lagos and perhaps also in other areas, the age at marriage has shifted much higher to the early thirties for women and the late thirties among men. This shift has been brought about by their risen expectations combined with the refusal of the future wife to live with her in-laws. Even for the educated, urban housing is so expensive that graduates experience great difficulty renting a room and parlor in which to start a family.

Although the age at marriage has risen, this rise has been partially counteracted by pre-marital sex. It is generally believed that pre-marital sex has increased over the last two decades; however, if the Ekiti study findings are valid for other areas, then what appears to be an increase is only an increase in visibility. In the South, despite societal and parental disapproval and denial, premarital sex is widespread and approved by teenagers. Many teenagers have had their first encounter by the age of sixteen. Nevertheless, most adolescents avoid premarital sex and more might avoid it if they were fully informed about the attendant risks.

This change in norms about pre-marital sexual behavior is one consequence of the gradual shift from arranged marriage to marriage of free choice. Young men and women have received more education than their parents and often live, not only in separate residences, but also in separate towns from their parents. The long delay between physical maturity and completion of education puts pressure on the couple. Most young people have been able to prevail upon their families to allow them to marry the person of their choice; however, many families now insist on the woman's becoming visibly pregnant before formalizing the marriage. Although the family relinquished control over the selection of the wife which would have involved examining her family for any defects, the family is adamant that a young man contemplating a monogamous marriage ensure that the fiancée is fertile.

The drawn-out nature of African pre-nuptial gifts and services to the wife and members of her extended family facilitates pre-marital relations and transactional sex. In the eyes of both the society and the couple, a male's ardor is partly defined by the extent and nature of the gifts and money he bestows on his beloved. This association between money and a loving sexual relationship facilitates transition to transactional, sexual relationships without love. A couple may live together when the husband has only paid part of the bride price; however, the family will not consider the marriage completed and the children his property until he has fulfilled all his obligations.

In Makinwa-Adebusoye's 1989 study of five representative urban areas, about fifty percent of the girls and forty percent of the boys had their first sexual encounter before age seventeen. By the end of their teens, the percentages have risen to eighty-two percent for the females and seventy-two percent for the males. Moreover, the trend is for increasing numbers of urban teenagers to be sexually active before age seventeen. While others will promote contraceptives. The faithful will trust and follow the guidance on child spacing and/or limitation methods which is given by their ministers or by influentials in their Bible fellowships and social/charitable organizations. To the extent that techniques are adopted within groups, they will extend to many more users. The innovators within a group will serve as the group's role models ultimately increasing the numbers of role models throughout society.

Despite their high level of sexual activity, less than half of these relatively well educated, urban-wise, young people are sufficiently knowledgeable to protect themselves from unwanted pregnancy. More than a quarter of the respondents indicated that they had not employed contraceptives during their first

sexual encounter because they thought pregnancy was not possible at first intercourse. Only about four percent of the females and two percent of the males were able to correctly identify the safe period on a calendar.

Inheritance

The number of children a woman has indirectly, but nonetheless powerfully, affects the security she can derive from her husband's wealth. Under customary law, a wife never inherits her husband's property nor can she take her children away from her husband's extended family. All property within the house is considered as belonging to the man. In many cases when a man dies, his relatives confiscate his property and sometimes his children, especially if the relationship between them and the wife is less than cordial.

A woman gains access to her husband's wealth through her children. Among the Edo speaking peoples, the first son inherits the assets and liabilities as a sort of trustee for his siblings. Among the Yorubas, the property may be divided per stripes or equally among the children. Among the Igbo, the eldest sons of each wife inherit jointly irrespective of their ages as "trustee" for their full siblings. In Hausa culture, a woman can inherit small portions in her own right as the wife, the mother, the biological grandmother, the daughter, the filial granddaughter or the sister of the deceased; however, the greatest portion goes to the children. In most cases because of the wrath of the family, the properties of persons married under the Marriage Act and who die intestate are still being divided under customary law. Moreover, relatively few men prepare wills because of the cultural aversion to planning for death.

The Marriage Act affords women little economic security. A man married under the Marriage Act can not legally marry under any form of marriage including Customary and Islamic law. Nevertheless, men disregard the law with impunity. They set up domestic arrangements in a separate home with another woman who is considered an "outside" wife. The outside wife or wives children can legally inherit from the man regardless of whether or not the legal wife was aware of their existence. Since such men will likely die intestate or specifically distribute their wealth to include their outside wives and children.

Land Tenure

The land tenure system operating across the major ethnic groups in Nigeria reinforces the desire for many children and particularly for male children, and indirectly becomes a cultural barrier to family planning. Under the customary land tenure system, only males own land and women can only gain access to land through their husbands. Moreover, land that is no longer tilled reverts to the extended family. Thus, each additional child provides the opportunity for acquiring and retaining usufruct rights to additional farmland. In cases where male children are lacking, the family loses its right to the land. Among some peoples, men consider wives an investment because they can gain control over more land and produce by acquiring usufruct rights to family land on behalf of their wives.

In principle under Islamic law, Hausa women are entitled to inherit land and other property, although only half the portion of land inherited by their brothers. In communities where a woman can purchase land under statute law, women largely depend on men for access to land. In general, a man's property and sometimes titles pass to his sons or paternal nephews, brothers or paternal cousins.

The Status of Traditional Rulers

Today virtually all traditional rulers, especially for larger communities, are well educated and have held important business or government positions before being appointed emir or chief. Although

traditional rulers have no formal role in policy definition or making, except in an advisory capacity on matters pertaining to religion and traditional affairs, their support for implementation is crucial and is openly sought after by political leaders and administrators of all levels. They fill the governmental vacuum at the grassroots community level. They also are influential with traditional NGOs as well as formal and informal channels of authority. The 1989 Constitution makes explicit provision for the creation of Councils of Traditional Rulers at State level and spells out their prerogatives and functions.

CONTEMPORARY RELIGIONS

Beyond Animism to Islam and Christianity

Islam and Christianity offer religious world views that expand beyond the geographic confines of traditional religions tied to ancestors and assist the faithful to comprehend a world comprising people from many cultures. Islam has been the official religion of the northern emirates for centuries although the extent of conversion was variable, whereas Christianity was introduced barely 150 years ago; nevertheless, throughout the country many people are first or second generation members of one of these world religions. The majority of Nigerians are very devout; however, for many of the faithful, their conception of these world religions has been influenced by their own African perspectives. These religions support family values and sexual relations within the marriage; consequently, if influentials within their religious communities mobilize their members, they may be willing to actively support forms of the child spacing and anti-HIV/AIDS interventions consonant with their religious beliefs as well as maternal/child health interventions.

The Appeal of Reformist Religions for the Youth

Reformist religions, whether Christian or Muslim, have acquired many young people as adherents but since they follow closely the sacred texts, they are often opposed to modern family planning techniques. The established religions offer the youths little opportunity for freedom from the dictates of the hierarchy of elders whereas the new religions have a more fluid power structure and promote analysis and interpretation of the sacred literature. The reformist religions also offer the opportunity of a blessed marriage without the financial constraints that accompany establishment weddings which often amount to the equivalent of a young man's salary. No dowry is paid, nor is a large party expected. Reformist Islam has the added advantage of freeing youths from genuflecting in deference to the elders; genuflecting has been declared un-Islamic since one should only genuflect for Allah.

The Family Planning Positions of the Churches

Most churches support child spacing for health reasons and have accepted, reluctantly, the necessity of limiting God's children to avoid the terrible consequences of parental financial inability to properly care for the children. Some churches prefer abstinence but permit contraception as a last resort if the faithful are unable to summon enough spiritual strength to abstain sufficiently in order to protect the welfare of their families. The Catholic Church strongly advocates child spacing and limitation but only by the Billings method and abstinence. The Anglican Church has taken no stand for or against contraceptives. Others accept contraceptives as a good solution. Still others actually promote contraception for spacing and limitation. The Baptist Church, the Methodist Church, the Four Square Gospel Church, the Seventh Day Adventist Church are among those churches which have a positive attitude towards contraceptives.

Churches and their affiliated organizations also provide contraceptives in their clinics and refer clients. Many CHAN hospitals and clinics provide contraceptive services. In the middle belt, the TEKAN churches promote child spacing with contraceptives and have been a source of referral for

many women. In Kano, SIM holds weekly women's group counselling sessions open to women of all faiths in which women advise each other on women's problems including the necessity for, types of and sources of contraceptives. The Catholic Church sponsors workshops to teach the Billings method and provides counselling to assist couples trying to use the method. CHAN has just sponsored the development of thirteen booklets on women's health including modern contraceptives; however, opposition by the Catholic Church which represents 60% of CHAN has forced the booklets to be presented under the auspices of a related group of Protestants.

Not all faithful are absolutely clear on permissible methods; however, all accept the Billings method and its variations. Seventh Day Adventists are at the other end of the continuum of attitudes towards contraceptives and also support abortion for health reasons. A few churches disapprove of withdrawal as a shameful method. Some churches such as the Celestial Church of Christ accept family planning but oppose the use of drugs for any purpose including family planning. Others indicate that drugs in general are acceptable for child spacing but volunteered that they must not be hazardous to health.

The Family Planning Positions of the Islamic Sects and Associations

The Muslim community includes the large body of faithful and two important distinct sects, the Ahmadiyyas who believe in the coming of additional prophets and the Izalla who are a reformist sect opposed to the overlay of traditional cultures. Many of the faithful are members of important associations which have congregational and local mosques. Muslim religious-based associations are usually divided into brotherhoods, sisterhoods and youth groups.

The Muslim community has been strongly opposed to contraceptives. Many influential Muslims perceive family as a misguided attempt to control the fate Allah has given them and as submission to a Western or American, Christian plot to control Islam by reducing the numbers of the faithful. Even the Al-Hikmah (Awareness), a four page newspaper published by the University of Lagos Branch of the Muslim Students' Society of Nigeria (MSSN) and launched by M.K. Abiola, a political/financial leader, carried news articles and editorials in this vein in reaction to declarations by the Christian, Minister of Health that abortion should be legalized and men should come forward for sterilization. The MSSN is made up of Muslims from all brotherhoods and the Unilag Branch has a majority of Yoruba members. Similar pronouncements are made in other Muslim publications and by imams preaching to the faithful.

Significantly, Alhaji Usman Faruk, a respected Northern proponent of Islam, published a booklet in 1988 explicating the Western, anti-Islam conspiracy theory in which he also affirmed that Islam permits consensual use of certain contraceptive measures if a mother has already had the experience of becoming pregnant within a month of childbirth. Faruk was Governor of Sokoto-Niger State and also kept the Jama'atu Nasril Islam, the Supreme Islamic Council of Nigeria, alive after the murder of the Sardauna of Sokoto during the January 1966 coup. Faruk was among the leaders who helped in establishing a modern private Islamic preaching and teaching institution in Sokoto known as Islamic Education Trust (IET) which has since been replicated in several states. In his booklet Faruk wrote that Islam permitted, under strict conditions including the one mentioned above, measures "made up of those prescribed for muslims (sic) through Allah's injunction or Prophet's Hadith together with new innovations discovered through time and experience but which are in conformity (sic) with divine guidance" including the rhythm method, withdrawal and the condom, and termination of a pregnancy by means of "oral medicament, injection or any other means if it is established by doctors that further pregnancy by any woman will be injurious to either the unborn baby or the mother or that it may even lead to the death of the intending mother". However, Faruk further cautioned that adoption of family planning because of fear of poverty would be an unIslamic denial of faith in Allah.

Despite the extreme beliefs in the Muslim community, Yoruba Muslims are included among the contraceptors in the Southwest. Furthermore, USAID has co-sponsored workshops with the Council of Muslim Rising Star Ladies at the Ahmadiyya Central Mosque in Ebute-Metta, Lagos for women and for youths at which contraceptives were promoted along with the Koranic rationale for their use. PPFN has also successfully promoted contraceptives among some groups.

Ansar-Ur-Deen is a proselytizing Muslim association with well educated, influential members. It started in the South but has spread throughout the North. Although the association has not made any pronouncement on family planning, some of their influentials have publicly supported family planning on behalf of government. The two former chairmen of the Nigerian Population Commission, both northerners, have been members of this group and they have sponsored conferences and government radio messages on population control.

Nawair-Ur-Deen, another southern-based association, has gone as far as to form a study group on family planning but no official pronouncements have been made.

Ansar-Ur-Deen and Nawair-Ur-Deen will be amenable to self-directed interventions emphasizing the health rationale for spacing. In addition to educational groups, they have social/extension workers (*tabalig*, Ar.) who go out among the people assisting them to resolve their social problems with Koranic guidance.

The Ahmadiyyas, a southern based sect, differ from the other Muslims in that they believe Mohammed was not the last prophet and they are expecting another prophet. The Ahmadiyyas use the radio and television media for expensive campaigns against family planning and other issues they consider anti-Islam. An important Lagos imam who has preached against family planning for the imperialist reasons also preached that family planning constitutes murder on the grounds that once the sperm begins moving, there is the possibility of life. However, abstinence is permitted as is birth control to protect the life of the woman. Moreover, this same imam in his birth control lecture discussed the failure to properly feed children as a form of minimal murder diminishing their chances for survival. The Ahmadiyyas run hospitals and clinics offering free medical care all over the country. Many Kano women attend their clinics because they have female gynecologists. Thus, the Ahmadiyyas have the potential to wield considerable, possibly negative, influence on child spacing as a health issue.

The Izallas, reformists who believe in strict following of the Koran and Islamic traditions which have not been contaminated by local traditions, have many adherents among the youth. Their recently deceased spokesman, Abubakar Gumi a well respected Islamic scholar from within the Hausa/Fulani elite, had no choice but to come out on the issue of family planning since it is of such concern to the youth. According to Gumi, the Holy Prophet never preached against the control of family size, therefore anyone who now attributes anything to the Prophet such as telling people falsely that the Holy Prophet was against family planning, is committing a very serious offence. However, Abubakar Gumi never made any statement about what the Holy Prophet actually said about family planning.

Muslims in the Far North follow the dictates of their imams. The northern faithful have no desire to take personal responsibility for innovation or interpretation of the Koran and wish to avoid any possibility of opposing Allah. The establishment associations in the Far North, Quadriyya and Tijaniyya, have issued no statements on family planning. The opposition of their elders and imams is generally recognized; however, the young members are still asking for answers to their dilemma. The Jama'atu Nasril Islam, a national brotherhood based in i'aduna, preaches responsible family life

style starting with very young people and organizes workshops and seminars on natural child spacing. Some members now teach withdrawal, which is specified in the Koran.

Ideally, further dissemination of information in the Far North should be the responsibility of the Islamic associations. In order to minimize opposition which has been strong and remains strong, especially among commoners who have only heard the negative messages in Faruk's publication, the men should be left in control of introduction of the issues to the women's groups. The Koranic exegesis and sermons preached by imams at the end of Ramadan serve as a major source of guidance to the faithful.

However, other avenues can be explored. In some states Jam'iyyar Matan Arewa (JMA), the Association of Northern Women, which has over 10,000 members in Kano and members elsewhere, will be amenable to actively promoting child spacing among its members. The potential of female Arabic literacy programs for information dissemination on child care and reproductive health should be exploited by incorporating the amount of information the decision makers will tolerate rather than completely foregoing the educational opportunity. Some states and NGOs may be willing to adopt the UNFPA-sponsored, Bauchi State literacy materials which include reproductive health and child spacing issues. Northern branches of the women's associations attached to the armed forces and the police will also be amenable to child spacing interventions. The youth groups attached to the various Islamic associations will also be receptive to child spacing interventions consonant with Islamic tenets.

Despite the positive attitude towards active child spacing among many Muslim influentials, this attitude has not been transferred to the commoners who continue to believe the Koran is opposed to contraception and that family planning is promoted by an anti-Islamic conspiracy.

NON-GOVERNMENTAL ORGANIZATIONS (NGO'S) AS PARTICIPANTS AND BENEFICIARIES

NGO Participant Activity

NGOs have participated in project interventions as service providers and as social mobilizers. Private, nonprofit providers such as mission hospitals and clinics, women's groups, men's groups, employee unions and university programs have played a significant role in Nigerian health care. The Christian Health Association of Nigeria (CHAN) is an umbrella organization for a huge sector of service provision employing 16,000 workers. Planned Parenthood Federation of Nigeria (PPFN) is another large service organization. Community organizations sponsored by government including the Better Life Programme and Women in Development units in each state have been active in recent years. The National Council for Women's Societies is an umbrella organization for many socially committed organizations. Community development associations depend on the human and financial resources of the more fortunate members of communities to send assistance back home from their urban bases.

Ethical NGOs as Target Audiences for Sensitive Behavioral Change

When considering NGOs as target audiences for sensitive, private behavioral change, it is useful to distinguish NGOs which perform a value-clarifying and reinforcing function for their members from the generality of NGOs. Such NGOs may be termed "ethical NGOs" to underscore their concern with the morally correct behavior of their membership. NGOs affiliated to religious and primordial groups bring together their membership for a variety of reasons but their affiliation also ensures that members share common values.

The established and fundamentalist religions with their associated societies and religious education activities provide excellent avenues for behavioral change because their followers are self-selected members who trust their religious and societal leaders. Many ethnic-based town and village unions in the South and among the minorities in the Middle Belt maintain financially responsible, ethical organizations with strong, actualized commitment to their membership. Urban, primordial associations maintain strong ties to the place of origin and are recognized for their integrity, for their social security concerns for their urban membership, for their role in facilitating socialization beyond the confines of the home place and for their development efforts in their home places. Other NGOs are less effective as target audiences for sensitive behavioral change because the values of the members are not shaped and reinforced by each other to the same extent. Despite important exceptions, it is generally true that social, charitable, employment and credit associations are less likely to influence the private behaviors of their membership. Nevertheless, these NGOs may be excellent channels of information and advocates of non-sensitive, behavioral change.

The Advantages of NGOs

Many NGOs are well established organizations with a committed, self-disciplined membership that selects and respects its own leaders. Their membership participates in NGO activities voluntarily; as a consequence, their involvement in intervention activities is generally greater than the involvement of civil servants or employees of large organizations. They can mobilize people from all sectors of life who might otherwise not be reached by government or profitmaking, private sector interventions. They can also attract resources from their membership and the general public which would never be contributed for government activities.

Disadvantages of NGOs

In some cases, NGO leadership present constraints to intervention efficiency. NGOs are often tightly controlled by a small leadership clique so that in fact many members are members in name only and have no sense of ownership. NGO leadership changes frequently, resulting in a change of focus and loss of knowledgeable manpower. Although NGO leaders may agree in general with a project intervention, often their leaders lack the sufficient concrete knowledge of the projects to mobilize the members to take advantage of the interventions and may not even recognize their importance to members.

Spurious NGOs

Some NGOs are controlled by corrupt leaders intent on embezzling funds. Spurious NGOs have been organized and registered in response to the government's efforts to harness the capacity of NGOs to generate development. They generate false or inflated membership lists. Sometimes they perform their stated social function to gain credibility and a government or donor grant but most of the money can never be accounted for.

All NGOs are potential targets for having corrupt leaders gain control; however, ethical NGOs are less likely to have corrupt leadership.

Limited NGO Financial Absorptive Capacity

A very real danger of using NGOs as participants for the interventions is that the large sums of money used to fund the intervention will undermine the NGOs internal organization, destroying the very qualities the NGO intervention is relying upon for success. Reports from Kenya indicate that USAID channelled considerable funds and expertise through VADA, an umbrella NGO, to facilitate its use as an information network only to discover that the funds generated animosities among the NGOs and fostered the growth of spurious NGOs. A similarly destructive NGO intervention occurred in Bangladesh.

Given the prevailing economic suffering and corruption in Nigeria, the potential for absorbing large sums of money without undermining the fabric of an NGO is low. Spurious NGOs are already flourishing in response to governmental and donor efforts to harness the NGO potential. To safeguard against unwarranted destruction of NGO integrity, an intervention with a low financial input at the ground level is essential. Nevertheless, the financial input must be sufficient to respond to the actual expenses incurred by the NGO volunteers.

SOCIALIZATION AND HUMAN RELATIONS

Consensus, Decisionmaking: Freeing Individuals From Personal Responsibility

Decisionmaking is not an individual process; it is made by consensus with no single individual bearing responsibility. A traditional ruler will recommend change only after consultation with a few trusted councilors and then approval by the entire body of councilors. Few individuals dare or desire to be known as innovators even in matters less private than sexual practices. As a consequence, decisionmaking skills and aptitude for taking personal responsibility for one's acts are underdeveloped; instead, compliance behavior and aptitude for consensual, decisionmaking are highly developed.

Indirection

Indirection, rather than confrontation, is the human relations technique adopted to facilitate change. It provides an opportunity for gradual awareness, consideration and possible acceptance of the proposed change as well as the option of evasion, if desired, without loss of face for the parties involved. When seeking the support of an authority figure, the intervention of a respected member of his community who provides access is essential. It assures compliance with traditional norms while requesting support for a change, thereby reinforcing the source of influence whose support is being requested. It also provides the face-saving opportunity to have devised a preliminary response.

An Intermediary to Whom the Targeted Influential Is Obligated

Intermediaries are crucial not merely for their power to provide access to influentials, but also for their power to convince influentials to act. One proceeds by indirection and influence. A common strategy when making a request from an authority figure is to seek out an intervener to whom the authority figure is not in a position to say "no". Although this requires both sociocultural and personal knowledge of the principal figures, it usually ensures cooperation or at least minimal opposition. This person, whether he is a mother, other relative, a co-member of a traditional NGO or someone who has assisted the influential will entreat the influential to cooperate. In such situations, the influential will be constrained not to actively oppose the activities even if he can not be convinced to actively support them and he is likely to be convinced.

Representational Gifts

Representational gifts facilitate a rural traditional ruler's acceptance of responsibility for behavioral change and its sustainability. Strategically, the ruler would prefer not to deviate from tradition on points of form, especially when he is advocating significant behavioral change. Traditional subjects and supplicants bring gifts to a ruler's "messengers/body guards/men-in-waiting" and to the ruler's themselves. These gifts are part of the traditional exchange system.

Human relations techniques in the traditional setting indicate that representational gifts are appropriate. Part of being a "big man", an influential in the community, is the giving of small gifts to dependents of other big men. The influential service provider who introduces a behavioral change program or reintroduces one to a rural community is a "big man". Traditional human relations

techniques also recognize that a ruler's "messengers" will spread the word about the strangers and their project more favorably if their importance is recognized.

Time-Consuming Preliminaries

Patience is essential in obtaining an influential's support, especially in the case of a traditional ruler. The intermediary needs to be convinced of the need for intervention which may take several visits. He then needs to approach the influential. This whole process takes time and may last up to a month in the case of traditional rulers. To rush the process would imply that the approval of the local ruler was not seriously being sought. To go straight to the ruler himself is to fail to accord him respect. In traditional society, seniors are always approached through an intermediary; they are not asked directly for favors, nor are they directly apologized to if one has offended them.

These courtesies can be omitted by Westerners and donors bringing large sums of money for accepted interventions; however, the closer the interventionist's representative is to the culture, the greater the jeopardy to the intervention.

Courteous Non-Cooperation

Lack of obvious opposition to a new project does not necessarily mean success for a project. It is rude to refuse a request; instead, one says "Yes" and fails to perform. An offended ruler who feels his authority has been undermined may undermine the project in order to reinforce his authority. Like the unconvinced ruler, he may inform his own people directly or indirectly of his disapproval. The ruler may also be incapable of delivering whatever is requested but consider it politically unwise to acknowledge his inability.

The Power of Entreating Assistance

All these examples are reinforced by the cultural necessity to entreat people to assist one, rather than to merely ask for an expected service. One must constantly show visible appreciation for a service; not to do so is tantamount to relegating the renderer of the service to a subordinate, server position.

Sanctions and Coercion

The socialization process in all Nigerian cultures has strong authoritarian elements. Compliance behavior is achieved through sanctions or coercion. Children are beaten at home for infractions. In schools, children are beaten or threatened with beating for non-submission of their assignments and for poor performance. Older children have the power to discipline other children. Children quickly develop an outer facade of obedience, deference and respect regardless of their true assessment of their elders. Women are expected to obey and serve their husbands and their in-laws; otherwise the husband and family members will heap blame on them, instigate marital problems and even advocate a second wife.

Institutions also rely on sanctions and coercion. Churches require that all past dues to all affiliated organizations be paid prior to a church service and burial. Sanctions have also been used on behalf of health interventions. Age groups in some Igbo villages have organized to ensure complete EPI coverage by fining any resident who leaves the village for farm or work on EPI day and tracking mothers for cycle non-completion and consequent fining. A recent study of four rural villages demonstrated that the greatest gains in maternity care were achieved in the poorest town because the women's union decided that any woman who delivered a baby at home without a trained birth attendant must pay N25 to the union.

SOCIOCULTURAL INFLUENCES ON ADMINISTRATION

CONSTRAINTS TO SERVICE PROVISION

Ethnic Prejudice

Except for the most educated, targets must be disaggregated ethnically as well as in standard ways. Ethnic affiliations and nepotism are not merely for social and economic gain. Each ethnic group has its own culture and set of values which differ significantly even though they are all grounded in an African worldview with common values recognizable as non-Western.

Distrust and cross-cultural misunderstandings between ethnic groups, ethnic sub-groups, religious groups and social classes hinders acceptance of innovations promoted by them. Citizens have not replaced respect for their elders and clan leaders with respect for the human race in general and their non-tribesmen in particular. Nor has an incorruptible legal system and civil service eliminated ethnic nepotism.

The Need to Ensure Ethnic, Religious and Gender Spread Among Nigerian Researchers and Cooperating Agencies

Attention to the ethnic, religious and gender spread of Nigerian researchers and cooperating agencies is crucial to ensure a balanced analysis of problems and prospects. Southern and, in the case of family planning, Yoruba universities have a longer tradition in educating personnel relevant to health interventions and related research. Consequently, qualified personnel is more readily available among some groups. Conscious efforts are required to locate and foster the academic growth and experience of underrepresented groups.

Rejection of Social Responsibility Beyond Ones Reference Group

Rejection of social responsibility beyond ones reference group has a foundation in reality. Traditional cultures demand full reciprocity among members of ones primordial group. Realistic assessment of current need throughout the nation makes broadening of the scope of traditional social responsibility and reciprocal burden-sharing untenable. To share with all would leave one with nothing; the likelihood of reciprocation from such an anonymous group is minimal and in any case there are not enough resources for everybody. That reliance on reciprocation from the government would be risky is evident from periodic news stories about pensioners who have not received their pensions.

Ethnic prejudice exacerbates this rejection of social responsibility. It also introduces a lack of trust on the part of the clients.

Lack of Universally Accepted Sanctions for Illegal or Unethical Behavior

Neither traditional nor religious sanctions are universally accepted nor have governmental sanctions effectively filled the gap. Traditional sanctions have been effectively undermined by colonialism and Westernization or Islamization. The traditional rulers and councils, the traditional secret societies, and the age groups have all had their power eroded. The modern religions are diverse and in some cases preach that people of other faiths are unworthy of God's blessings and should be forced to convert to their own religion. The legal system and police force lack the capacity to effectively and judiciously impose sanctions for illegal and unethical behavior; they remain underpaid and subject to pressure from the political/military rulers and the wealthy powerbrokers.

The Lack of Accountability of "Democratically" Elected Officials

It is unlikely that democratization of governance will increase the responsiveness of government to the people and their welfare. Democratically elected officials already govern at the LGA and state levels albeit hampered by central government control of their funding.

Elected officials must be responsive to officials in the federal government which is the major source of public revenue. Moreover, their parties were funded directly by the federal government, by a small number of enormously rich, power brokers, and by the candidates themselves rather than by contributions from the public. In multi-ethnic urban areas, migrants and their descendants usually are underrepresented in decisionmaking positions at the Local Government Area and as a consequence may be underrepresented as participants in public sector service delivery.

Lack of Incentive to Excel

Although many superb service providers and managers work in the public as well as the private sector, prevailing attitudes will impinge upon the success of any large scale program. In the majority of cases, government employees have insufficient incentive to excel. Management rewards conformity and support for management rather than performance which unfortunately is often not a major goal of management, especially in situations where performance bears little relation to remuneration. Employees have difficulty identifying with organizations that fail to pay a decent wage and/or have corrupt managers who divert resources necessary to the goals of the organization.

Nepotism and Influence as the Basis for Promotions and Perks

Managers are "big men" who have a responsibility to their respective communities which conflicts with and often takes precedence over their work responsibilities. A "big man" must share his wealth and power just as a traditional chief or head of a family or clan was expected to redistribute the yams or millet brought to him by his people; ceremonies and times of need provided the occasions for redistribution. Similarly, managers are under considerable pressure to provide innovative services, jobs, preferential posting and training to members of their family, village and ethnic group. These forces are frequently brought to bear by people to whom the big man "cannot say no" and result in the mismanagement of clinic equipment, supplies and service personnel.

Peer Group Pressure to Provide Minimal Service

Peer group pressure at the work site often discourages outstanding performance. Co-workers fear quality performance will induce clients to demand similar performance from themselves. Co-workers are reluctant to provide quality service partly because they are aware that they will not be rewarded for their extra work except with an anonymous thank you and an avalanche of demands. To raise the working standards would threaten the system of minimal work and invite anger and retaliation from colleagues.

Rudeness

The rudeness of civil servants including the service providers towards the public which includes the clients has multiple, mutually reinforcing causes. Service providers feel the psychological need to ensure that all involved are fully aware that their own status is in no way diminished by providing the service. They are sensitive to societal awareness that people are expected to serve their seniors in age and status; consequently, they attempt to place themselves in a position of authority as a preventive measure. Moreover, service providers are adopting the prevailing attitude of their employers and of their supervisors towards the public, an attitude of superiority and scorn that was established by the colonialists and has become part of the civil service psychology even though many civil servants have never seen a colonialist. These attitudes are reinforced by a lack of respect for those of other ethnic groups and for the weak.

Operations research has demonstrated the capacity of counselling training to motivate and empower the service providers to modify their interpersonal behavior and to improve the effectiveness of their family planning client counselling.

Necessity of Supplementary Income for Basic Needs

Public servants substantially supplement their inadequate incomes with private activities: selling cloth, jewelry or shoes, etc. to co-workers; contracting to supply items; providing professional services; and/or accepting or extorting bribes. Some civil servants manage by organizing their schedules to maximize per diem. Small amounts of money saved from workshops become important within the prevailing impoverishment.

Subordination of Goals to Human Relations

Nigerian society and individuals are more process-oriented than goal-oriented. This orientation is a constraint to NGO activities and to timely achievement of specific targets. Nigerians are reluctant to achieve goals at the expense of human relations; interpersonal relations and the process get paramount consideration.

Lack of Project "Ownership"

Although participants may perceive a "donor project" beneficial, when the project is perceived to be externally driven and beyond their control, the participants respond to their lack of ownership by continuing the prevailing attitudes to government employment. Their professional commitment and involvement remains minimal.

Transportation Problems

Expenses for vehicle purchase and maintenance for commodity distribution and supervision are excessive relative to Nigerian incomes and to effective service delivery. Vehicles are seldom adequately maintained and funding gasoline poses obstacles. Vehicles are at such a premium that they are often commandeered by government officials and diverted to other duties.

Constraints Imposed by Donor Ethnocentricity

Donor resistance to funding representational expenses undermines budgetary accountability because it leads to juggling of funds, which in turn makes it difficult to convince rank and file members to accept the argument that the grant document is a legal document.

In providing institutional support, certain sociocultural issues as well as donor attitudes and assumptions which impact on the motivation of NGO volunteers, have to be taken into consideration. Some NGOs with experience in fund raising and intervention activities have encountered the ethnocentric unwillingness on the part of the donors to make fund management correspond with the Nigerian norm for proper behavior. The reluctance to appreciate the place of cash incentives and representational expenses in community outreach activities within the sociocultural environment results in volunteers having to spend their own money for intervention programs, in addition to donating their time and skills. This tends to dampen their enthusiasm.

Extra-cultural inappropriate behavior on the part of expatriate consultants is overlooked but it is less likely to be accepted from a Nigerian. Acceptance varies depending upon how close the Nigerian is to the specific culture and how close the culture is to the traditional life style.

Underutilization of Public and Private Sector Clinics

Since the introduction of drug and service fees in public sector clinics, their clientele has diminished. Reports from clinics and the public suggest that without the incentive of free drugs, people are

unwilling to experience the disadvantages of public clinics (including long waits, loss of privacy and inconsiderate service provision) and would rather self-medicate at a chemist shop with a profit-oriented teenage salesperson or visit a nurse or traditional healer. The SAP-induced drastic reduction in disposable household incomes has also affected private sector clinics. They have experienced reductions in their patient load and increasing problems with payment defaulters. Anecdotal reports suggest that economic constraints induce patients to forgo some of their prescribed medicines.

SOCIOCULTURAL INFLUENCES ON FAMILY PLANNING¹

FAMILY PLANNING CONSTRAINTS

Desire for More Children

The major reason for non-acceptance of contraceptives is the desire, expressed by 47.1% of fecund women in the 1990 NDHS, to have more children.

Parents deeply desire to be survived by and buried by their children. They also desire children for security in old age and for their contributions to the family welfare including the welfare of their siblings. Many men, but especially the women who are threatened by polygamy, desire children to ensure support in their old age. Their incomes are insufficient to provide savings and there is no social security system. Moreover, the rampant inflation renders pensions meaningless for the few who are eligible.

Large numbers of children improve the chances of social and financial security for both parents and children. Parents have many children partly in the hope that at least a few will be lucky enough to be successful and will provide financial security for the rest of the family. Siblings provide a chain of assistance, helping to support and educate their juniors. They also ensure better reciprocal support and security throughout life than can be expected of non-sibling relatives, especially with the breakdown of the communal lifestyle of the traditional family. However, studies show that younger children expect to receive less from their own children than has been the social custom.

Large, Family-Size Desires

Most couples desire many children, with four the minimum desired number. The desire to have children, as many as God grants, is a fundamental traditional value which is reinforced by Christianity and Islam. Christianity's support for a large number of children per couple is based on the old testament injunction that exhorts the faithful to, "Go ye, multiply and replenish the earth." The Moslems follow the Prophet's injunction, "Give birth to many children so as to increase the number of followers." Traditionally, all ethnic groups believe in many deities who, if reverently worshipped, bless adherents with children.

A Fatalistic, Religious Attitude Towards Family-Size

Non-numeric responses indicate the widespread fatalism associated with childbearing. The prevailing belief is that children constitute a continuous flow of gifts from divine providence and, as such, none should be refused. It is believed that women have no freedom to choose; it is a choice best left to a Deity or deities. Consequently, the ideal or desired family size is not numerically well defined.

¹Please refer to the section above entitled "Contemporary Religions" for a fuller development of religious views of family planning.

Some Igbos believe that the deity has already placed their children in the womb waiting to be born. These beliefs underlie the traditional aversion to specifying actual numbers of children alive or dead.

Conformity to Perceived Societal Opposition or Disapproval

Perceived, societal opposition or disapproval greatly inhibits contraceptive use because the basis for social change is consensual decisionmaking. Many women endure the consequences of their unmet need for contraceptives rather than expose themselves to the dangers of non-conformity. The socialization process has not prepared them for taking sole responsibility for a controversial decision, especially one that may in any way threaten their ability to procreate. Nevertheless, many women engage in clandestine family planning in both rural and urban areas. Because family planning has not been culturally acceptable, most couples who use contraceptives desire secrecy.

Early Marriage

In the Muslim North, girls are married off extremely young to prevent premarital loss of virginity. Some are even married prior to puberty and many at the onset of puberty. The median age for first intercourse is fifteen years of age and has not been rising.

Parental concern about the possibility of premarital pregnancy in the early teens is a realistic concern. Hausa/Fulani girls begin flirting at age ten and in a rural Zaria area virtually all are married by age fourteen thereby pushing the prevailing age of sexual interest and activity four or more years earlier than in other areas.

Women's Desire for Excess Children in Order to Preserve a Monogamous Marriage

A woman often desires excess children as a way of retaining her husband by sexually enticing him since the rationale for sex within marriage is additional children. Women also believe social pressure will make it difficult for a man to desert a woman who has given him many children. Furthermore, some women hope that the increased financial burden will prevent him from taking on the responsibility of another wife or will prevent another woman from desiring him as a husband.

Serial Marriage, Male Domestic Arrangements with Outside Wives, and Male Remarriage Late in Life

Since each new marriage must be actualized by the birth of children, various patterns of multiple partners contribute to increased child bearing. Serial marriage for both men and women is an Islamic norm and is also practiced in some other ethnic groups. Many husbands take up "outside wives" with whom they set up a home and have children while retaining their original court marriage. Among some ethnic groups, the ideal pattern for the male is to remarry after age fifty, partly in order to ensure caretakers in old age.

Probability of a Baby-boom in the North

In a rural Zaria study in 1990, the desired number of children was 8.4 but when asked to take into account the current economic situation the number was reduced by one child to 7.4. This is a larger family-size than most northern women have been achieving, leaving room for a baby boom in the North once the level of medical care improves.

Preference for Male Issue

The vast majority of Nigerians belong to patrilineal families which desire male issue to ensure the continuity of the family line in an environment where familial extinction occurs and examples can be cited. Male children also bring honor to their parents particularly at burial. In the rural setting, a high number of children, especially males, gives the lineage access to land and political power. Societal pressure for male issue is such that virtually no one really disapproves of a man in a

companionate, registry marriage who succumbs to familial pressure and takes another wife in an effort to obtain male issue. The Hausa/Fulani woman's desire for equal numbers of girls and boys is notable and perhaps related to the financial assistance the children, especially girls, provide as hawkers on her behalf.

Protection of the Husbands from the Impact of the Economic Rationale

Among all cultures, the wife's income is expected to supplement the husband's in times of need; consequently, men are protected from the economic crunch for much longer than women. In competitive polygamous situations, the wives' contributions can be substantial and, in the case of a lower class man, wives may bear virtually all the expenses for their nuclear family. With pervasive poverty, the wives' share has increased significantly even among women in purdah. In the rural areas of the Middle Belt, many husbands have absconded from the rural hardships and child care responsibilities by running off to the city where they work as wage laborers spending all their meager earnings and contributing little or nothing to the support of their wives and children.

Islamic Non-Responsiveness to the Economic Rationale

Despite crushing economic conditions and increasing difficulty in obtaining adequate food, Muslim men in many areas are unresponsive to family planning messages based on hunger or poverty. Among Muslims, their faith dictates that Allah will provide.

Avoidance of Interspousal Communication on Family Planning

A 1990 urban-based survey of innovators in the four zones established that 23.5%, with almost fifty percent among the uneducated, refrained from inter-spousal communication about their family planning intentions or practices. Women with more surviving children, and more sons, are less likely to seek the approval of their husbands before visiting a clinic. Another 1985 rural-based study among the Yoruba indicated that only seventy-two percent of spouses have ever discussed their desired number of children. Among the innovators who discussed family planning with their husbands, about thirty percent reported that the discussion was initiated by their husbands.

Clandestine Use of Marital Contraception by Wives

Female innovators are increasingly using contraceptives for their marital sex in spite of their husbands' opposition. In both urban and rural areas, the increased economic burden of children on the women is seen as the main factor.

Some clandestine, marital contraceptive use has the tacit approval of the husband. Young couples prefer that the wife remains in the marital bed rather than removing herself to stay with her mother or mother-in-law as was the traditional practice. The wives want to prevent the husband from straying to other women or possibly taking a second wife and the husbands no longer have the patience for postpartum abstinence. In such situations, some wives decide to use family planning clandestinely; however, as one Berom woman pointed out, the husbands must realize that they are using some form of contraceptive because they are no longer getting pregnant. Apparently the husbands prefer to appear to be in control and save face by not acknowledging that their wives use contraceptives while continuing to enjoy unrestrained access to their wives.

Clandestine, Extra-Marital Contraception

The association of contraception with marital infidelity undermines efforts to gain societal approval for contraception. Clandestine use without spousal knowledge occurs frequently and must constitute a substantial portion of users. Men have long used contraceptives or paid for abortions for extra-marital relations that they kept hidden from their spouses. Some married women have been their own sexual partners, thereby contributing to male opposition to contraceptives for their wives.

Cost

The cost of family planning services is an obstacle to poor women who wish to practice family planning without their husbands' knowledge and to women who are dependent upon their husbands' resources.

Counterproductive Role Models: Successful Males

Most wealthy men have imitated traditional, wealthy men by marrying additional younger women and fathering additional children. In some cases, these men marry clandestinely, without the knowledge of their spouse.

Fear of Infertility Resulting from Contraceptives

Fear of modern contraceptive devices is very real to the Nigerian woman. She fears the physical effect on her womb. She fears for her reproductive capacity as a woman and for the state of health of the children she will conceive after the contraceptive use. Her fear of barrenness in one's lifetime and even beyond to future reincarnations influences her rejection of sterilization. She also fears deviating from the societal norms in general.

Fear of Rumored Actual and Non-existent Side Effects

Women reject family planning for numerous actual side effects including heavy bleeding, lack of menstruation, hypertension complications, weight gain and the messiness of foaming tablets and jelly. They also fear non-existent side effects including a mobile IUD travelling throughout the body, illness caused by using family planning after childbirth and reincarnation as a sterile woman.

Male Disapproval and the Need to Specifically Target Males

Men have only recently been targeted with IEC through PPFN skits on television and radio. Males lack an acceptable source of contraceptive information except for condom advertisements. Most would be embarrassed to seek out information from clinics since they are associated with female methods. Consequently, much of their real and/or assumed opposition to family planning is based on ignorance. Many men who are psychologically discomfited by loss of control over their wives, oppose family planning because they perceive it as a woman's misplaced desire for control over their family affairs.

Men are preferred as family planning communicators to males not only because they can serve as role models but also because for many men, the women are less effective or even counterproductive. Such men perceive a woman's desire for family planning as a desire to be "free like a man" from the burdens of pregnancy. Post-menopausal women who have become like a men are often given male prerogatives. This fear of female desire for "masculine freedom" is especially strong when the message is coming from female relations.

Lack of Information about Family Planning Methods

In a 1990 study in rural Zaria, only twenty percent had information about how to use family planning and fifty percent reported that they did not use child spacing because of ignorance. In the 1990 NDHS, only twenty percent of the women of reproductive age knew the correct fertile period. One third believed that the fertile period occurred immediately following menstruation and another third admitted their ignorance. Although these figures must have improved between 1990 and 1992, ignorance and insufficient information to induce people to come forward and request child spacing and limiting assistance remains a problem.

Restricted Reach of Clinics as a Source of Knowledge

That the major sources of significant knowledge capable of generating selection of a contraceptive remain the clinics and health facilities (over sixty percent) partially explains the number of uninformed, fecund women. The number of service providing clinics is inadequate. Furthermore, clinic clientele is basically restricted to women with children under three or four years of age. Thus, neither adolescents nor other non-married women are within the clinic reach (except perhaps in cities where anonymity is possible). Moreover, women who no longer have small children because they have succeeded in limiting their offspring for several years through less efficient methods are also for practical purposes not within the clinic reach.

The Lack of Reproductive Health Information for Teenagers

The lack of either in-school or out-of-school reproductive health information for teenagers puts them at unconscionable risk. Many parents and schools especially, but not only, in the North including the Middle Belt will not permit adoption of the Population/Family Life Education (POP/FLE) curriculum which was designed to promote acceptance of the small family.

Even in the schools where the curriculum is not actively opposed, the potential for replicability and sustainability is undermined by the innovative, intervention methodology. Teachers who have been trained for two weeks by master trainers are expected to prepare original lesson plans on the basis of a booklet of guidelines despite the fact that teachers are demoralized because of inadequate salaries and excessively large classes. Moreover, both the methodology and the values clarification modules emphasize assisting students to think for themselves whereas the society prefers that youths abide by the dictates of their elders.

Disruption of Commodity Supplies

Serious shortages of commodity supplies at both federal and state levels have disrupted service and caused commodity substitutions and discontinuance. The causes are mainly managerial (e.g. underestimation of need and consumption levels), absence of back-up arrangements to replenish supplies, maldistribution and delay in approval of funds.

Opposition of the Catholic Church to Modern Contraception

Although the Catholic Church actively promotes spacing and limitation through the Billings Method, only 8,000 people (including many husbands along with wives) have been taught the method after several years of active training using a core of trainers in sites throughout the country and regular promotion over the radio in some states. Moreover, not all trainees have successfully learned and sustained use of the technique which is complex and requires considerable active commitment.

Muslim Opposition to Family Planning

A large body of vocal Muslims consider family planning a Western and Christian plot to exterminate Muslims or at least to reduce their numbers significantly and prevent them from multiplying and having political control over their own destiny. This belief has been imbibed at the grass roots level.

Politicization of Religion and Family Planning in the North

The support of religious leaders in the North would greatly enhance the child spacing programs because their combined, moral authority reaches almost every citizen. Their support would legitimize child spacing which is now largely practiced clandestinely, thus greatly facilitating increased contraceptive use. However, it would be inadvisable at this time to enlist the support of amenable Christian leaders in the North without simultaneously enlisting the support of the Muslim leaders. Concerted Christian support for child spacing may well harden Muslim opposition. Many Christians might also take up a political perspective, opposing the intervention largely because the Muslims were

left free to procreate and increase their population base, thereby increasing their political power in the area.

The Influence of Conservative, Religious Leaders in the Far North

The social order in the Far North is maintained by means of patronage and coercion; both methods are underlined and supported by the system of education and religious belief. Through a monolithic hierarchical system sanctioned by Islam, the Northern traditional rulers maintain a very strong influence on the common people's values, especially the values of those above twenty-five years of age. Since the traditional rulers legitimize their rule through Islam, they are strictly governed by the interpretations of the Koran and the Islamic traditions which are provided by the most respected, and, hence, elderly and usually conservative imams. Islam is an all encompassing religion, dealing with both family and governmental issues; consequently, Islam determines behavior with respect to controversial life-style issues.

This monolithic political/religious structure is currently being threatened by sociocultural transformations that make it simultaneously more amenable and more resistant to change. It is being undermined by the subdivision of the North into smaller states, by Western education of all the elite and many commoners, by the rise of fundamentalist Islamic sects partly fueled by the inability of the system to satisfy the basic needs of the population, and by the inability of the system to absorb the huge population increase.

In addition, religion is being exploited in the North to ensure the political support of all social classes.

Lack of Effective Support for Family Planning from Traditional and Religious Influentials in the North

In the Far North, conservatism, lack of knowledge and fear of having to take the burden of everyone's action contribute to the reluctance of mallams and traditional rulers to promote modern techniques of child spacing. The influentials have no desire to be blamed for any impairment of fertility at the personal level, nor for any relative reduction of the Muslim population at the political level. They also recognize that their credibility may be challenged.

Unfortunately, commoners in the Far North will be reluctant to challenge their religious and traditional leaders who are perceived to be opposed to family planning on religious grounds. They vaguely cite the authority of a mallam from Sokoto or someplace else and are unwilling to take responsibility for interpreting the Koran themselves. A recent study revealed that some persons aware of their own unmet need would willingly adopt family planning if a doctor required it on health grounds or a mallam recommended it.

The credibility of the emirs and royalty in the North with respect to family planning has been seriously questioned by northerners in the not so distant past. About five years ago, the National Population Bureau sponsored a conference at Ahmadu Bello University that backfired upon the establishment. Radical lecturers arranged for simultaneous radio and television transmission of the conference and used that platform to transform family planning into a class issue. The radicals included Usman Bala Usman, a highly respected, radical historian from the Katsina royal family. These lecturers condemned the wealthy establishment for trying to make the lower classes limit their family size while the wealthy themselves continued to father many children. They named the numbers of wives, children and in some cases concubines of the influential northerners and emirs whose families were being supported from the government purse while they were exhorting the commoners not to have more children. They declared that Nigeria had enough money, food and land to care for everyone's children if it were properly distributed. They further countered the argument

that poverty was leading some uncared for children to theft by affirming that the children of the wealthy were the true criminals, stealing from the government on a regular basis.

Ambivalence Among Staff and Decision Makers

As members of the larger society, many of the program implementors, especially junior level health staff, and many of the decisionmakers who must give the program strong support if it is to succeed are themselves ambivalent about the program's fertility reduction aims.

The Probable, Low Priority Status of Family Planning Under Democracy

Elected politicians are less likely to give high priority to an interventionist population policy because of its limited constituency and few visible short-term results.

Importance of Population to Revenue Allocation at State and LGA Level

The horizontal revenue allocation formula is now: equality among states (40%), population (30%), social development factor (10%) and land mass/terrain (10%). Thus, relative population growth impacts significantly on revenue allocated to states and LGAs. Consequently, some LGA and State level officials may decide to block family planning activities in order to increase current and future income exists.

The Dearth of Family Planning, Cost-Benefit Analysis Information for the LGA Level

The dearth of family planning, cost-benefit analysis information for the LGA level impedes progress towards PHC integration of family planning and development of sustainable public sector referral systems. The cost-benefit analysis provided by RAPID modelling for the national level is not directly applicable at the LGA level. Moreover, any LGA level, cost-benefit analysis must take into consideration the fact that a significant proportion of the LGA funding (30%) disbursed by the federal government is based directly on population size.

The Financial Impossibility of Achieving the Population Policy Targets

In 1991 the World Bank estimated that a forty-five percent Total Fertility Rate (TFR) is required to achieve the Population Policy targets and that following a Population Council formula, approximately \$US200 would be required annually throughout the rest of the decade. This amount greatly exceeds commitment by international donors and the difference is unlikely to be assumed by the government. In the past five years, population activities have been allocated only 1.3% of the MHSS budget.

FACTORS CONDUCTIVE TO FAMILY PLANNING

Contraceptive Prevalence Increases Reported by the 1992 FOS/FPS

The September 1992, Federal Office of Statistics, Family Planning Survey (FOS/FPS) reported that the contraceptive prevalence rate (CPR) for Women of Reproductive Age (WRA) is now 20.2 %, having risen from 7.5 in the 1990 NDHS. The CPR for married women using modern contraceptives has risen to 8.3% from 3.5% in 1990. Use of non-modern methods, largely periodic abstinence among married women, has risen to 7.1% from 2.4% in 1990.

The order of magnitude of current, family planning can be estimated based on the 1991 CCCD Management Information Survey estimate that there are 17,702,900 women of reproductive age. Over three and a half million women of reproductive age are using some form of contraceptive. Approximately one and a half million women are using modern contraceptives and another one and a quarter million women are using periodic abstinence.

Profile of Most Likely Contraceptors According to 1992 FOS/FPS

By far the most likely contraceptors are the educated elite. Close to a third of the women with post-secondary education are using modern contraceptives and about another fifth are using a traditional method (periodic abstinence), probably for religious reasons. Thus 52% of the educated elite were using some form of contraception. They are closely followed by women who have completed secondary school with 28.1% modern use and 43.4% total use. Contraceptive use increases steadily with increasing level of education from two percent of women with no education to more than one-quarter (twenty-eight percent) of those who have completed secondary education.

Other attributes of the contraceptors follow common patterns. Urban and peri-urban dwellers are about twice as likely to be contracepting. The percentage of modern method use was generally higher for never married women than for other women. Women between the ages of 20-34 years had the highest percentage of modern contraceptive use. However, only a small minority of teenagers were contracepting.

Dramatic Rise in Knowledge Reported by 1992 FOS/FPS

Knowledge has risen dramatically almost doubling within two years to 83.1% of WRA. The knowledge gap between the North and the South has also been reduced with less than twenty percent of the population left ignorant of a family planning/child spacing method.

The Success of Family Planning in Ibadan

A 1989 CODESIRA supported study of a sample of 1,552 women, half from Ibadan and half from the surrounding rural area, established an urban, modern contraceptive prevalence rate of 47.5% and a rural rate of 8.4%. Significantly, the Family and Reproductive Health Association Clinic at UCH, Ibadan which benefits from effective IEC and a CBD referral system, has a dedicated staff and a longer history than most clinics. Perhaps similar demand creation can be achieved elsewhere.

Promotion of Child Spacing

Promotion of child spacing, rather than family planning, is responsive to health concerns of the people and allows more citizens to adopt modern methods of contraceptive use. The child spacing intervention offers the potential to internalize activist attitudes towards fertility management as opposed to passive acceptance of fate or God's will. It also legitimizes dissemination of contraceptive knowledge in the public and in forums where family planning advocacy would be impossible. To the extent that child spacing encourages maintenance of the conjugal bond, it may reinforce the nuclear family in face of increasing destabilization forces. In so doing, it may reduce women's competitive desire for additional children in order to retain their husbands by satisfying their perceived fertility desires and that of their in-laws.

The child spacing approach will ensure that effective knowledge rather than mere awareness reaches into the masses carrying the program beyond the innovator stage. Even though the dictates of some churches emphasize faith and prayer allowing active child spacing only through the Billings method, they introduce the concept of active, conjugal control over reproduction as opposed to abstinence. Those churches which allow contraceptives as a back-up method will provide another avenue for gradual introduction of the techniques and at least the spread of more concrete knowledge.

Urban-based Willingness to Limit Children

In a 1990 survey of urban-based active spacers, sixty percent said they would stop at four living children without accepting money and fourteen percent said they would accept money and stop. However, only twenty-three percent said they would not stop regardless of the amount of money government paid as an incentive.

Increasing Acceptance of the Economic Rationale for Family Planning

The economic crisis and ensuing diminishing purchasing power has provided the basis for an economic rationale for family planning, especially among men and women whose expectations had risen during the petrodollar boom. A survey carried out among Yoruba women in Ife early in the recession in 1987 demonstrated a genuine reduction in average desired family size from a Nigerian average of 8.36 down to 4.96 as a result of the combined effects of modernization with its concomitant higher costs for children and the economic recession. Among all socio-economic groups, desired family size declined by as much as three to four children between the 1981/82 Nigeria Fertility Study and 1987. Nevertheless, only 11.7% of those women desiring no more children were practicing contraception.

Anecdotal reports from private clinic owners indicate that urban Igbo women have begun to act on the realization that the honors traditionally accorded multiparous women are irrelevant to themselves and their children in this depressed economy. Previously, they enjoyed at least six months of relative rest and honor after the birth of a child during which their husbands outfitted them and their mothers in new clothes while their mothers took over many of their domestic duties. Since the economic crisis, such pleasures have become luxuries in the face of the need to purchase sufficient food and provide minimal clothes and books for school. Instead, additional children bring economic responsibilities that hitherto had been shouldered by their husbands who can no longer cope. Women in other cultures have also reduced their family size preferences.

Rural women with aspirations for their children are also beginning to reduce their family size desires because of the educational costs and the fragmentation of the land due to the rapid population increase.

Elder Children's Admonition That Parents Limit Their Issue

When parents or fathers continue having issue after the eldest have become young adults, these youths admonish their parents to refrain from begetting more issue. They recognize that they will be expected to support the children born late in their parents' life.

The Potential for Family Planning Advocacy and Education in the Churches

Advocacy and education within each church according to its own dictates will allow the faithful to embark on authorized behavioral change moving them from pronatalists to family planners without expecting them to deviate from the teachings of their respective churches. Some churches will confine the intervention to spreading the practice of active family planning using scientific knowledge (Billings, rhythm and to a lesser extent withdrawal) while others will promote contraceptives. The faithful will trust and follow the guidance on child spacing and/or limitation methods which is given by their ministers or by influentials in their Bible fellowships and social/charitable organizations. To the extent that techniques are adopted within groups, they will extend to many more users. The innovators within a group will serve as the group's role models ultimately increasing the numbers of role models throughout society.

The Potential for Advocacy in the Ethnic-Based Development Associations

In the minority areas of the Middle Belt, ethnic-based development associations can be used to target males and females within their gender segregated branches. Such associations bring the more enlightened, educated people together with the uneducated, impoverished men. Child spacing can be promoted in terms of the welfare of the community and in terms of male control over their wife's fertility to ensure conjugal pleasure and well-spaced, healthy children. These organizations have their own information channels and could be relied upon to nominate a male promoter to provide

information and CBD community outreach so that men would not have to rely on their wives to purchase subsidized condoms.

Maternal, Altruistic Love

On account of the maternal, altruistic love for their children and the strong mother/child bond in contrast to the weaker husband/wife bond, many women will space and/or limit their children regardless of the consequences to their conjugal life.

Integrated Services

Integrated Services are preferred by women with children because they can solve several problems simultaneously. Furthermore, they permit the wives to camouflage their trips to the clinic as trips to care for their children.

Male Desire to Avoid Having Disreputable Children

In the traditional setting, no man wants the shame of fathering disreputable children who are irresponsible and roam the streets; yet this phenomenon is occurring increasingly in the rural as well as the urban areas. If a man has too many children and is unable to train and control them, he may regret his large family size. He may also serve as a negative role model for others.

Existence of Hausa/Fulani Innovators

Despite the conservatism of the Far North, the small number of family planning innovators includes the commoners as well as the elite. Young Kano City Hausa/Fulanis who have chosen to break away from the family compound and found nuclear family residences in the suburbs of Kano are among the innovators. They have come in contact with Hausa traders from other parts of Nigeria who reside in the vicinity and have broadened their worldview.

The Reliability of Educated Hausa/Fulani Wives

Survey and research findings indicate that contrary to the prevailing belief, educated Hausa/Fulani women are more reliable as wives and mothers; they remained married longer and divorced less frequently than their unschooled counterparts. Moreover, their knowledge of, belief in, and ensuing use of modern preventives and curative health measures and services enabled them to survive longer and produce more surviving children than their counterparts. The NDHS survey clearly indicates the correlation between lack of education and both stunting and wasting which are caused by a combination of under- and malnutrition complicated by the effects of illness.

The Role of Traditional Rulers in Project Interventions

Traditional rulers, most of whom are now well educated, have the power to mobilize or inhibit community action in support of project interventions.

The Moral Authority of Traditional Rulers

Traditional rulers have the power to legitimize family planning/child spacing and anti-AIDS interventions thereby obviating stigmas that may be attached to the act of becoming an acceptor. When a traditional ruler as the senior authority in the community authorizes and encourages the use of child spacing by technical means, an acceptor can always refer to his authority when defending her decision. The acceptor need not take full responsibility for the decision; the decision becomes one of a loyal follower rather than an individual deviating from the group norms. Moreover, the authority protects the acceptor from condemnation as a non-traditional woman or promiscuous woman.

Respect for Medical Advice

Neither grassroots service providers nor their clients desire to take responsibility for innovative decisions; however, the Nigerbus Surveys indicate the public's readiness to accept the advice of doctors and to a lesser extent other healthcare personnel. Development of a protocol for grassroots community-based distribution (CBD) endorsed by the Society for Obstetrics and Gynecology of Nigeria (SOBGYN) and distributed with the authorization spelled out as an authorization by medical doctors specializing in childbirth and its complications will instill greater confidence in the potential clients.

Persuasiveness of International Professional Organizations

The authority of international professional organizations can be helpful in overturning medical and governmental resistance to public health measures. For example, the International Confederation of Midwives actively supported adoption of Safe Motherhood Initiative (SMI) which calls for midwives to perform medical procedures normally reserved for doctors. The International Federation of Gynecology and Obstetrics (FIGO) accepted the Safe Motherhood Initiative and brought it back to the national body. Without the medical authority of the international body, sensitized doctors and midwives promoting SMI would probably have been unable to overcome opposition from colleagues already concerned about their dwindling incomes and reluctant to share prospective patients with midwives.

SOCIOCULTURAL INFLUENCES ON HIV/AIDS PREVENTION

CONSTRAINTS TO HIV/AIDS PREVENTION

Denial of the HIV/AIDS Threat

Although Nigeria has reached the lower point of the rising exponential curve of the HIV/AIDS epidemic, most people deny that HIV and their personal behavior poses a risk. Some even call it the "American Institution to Discourage Sex".

Misunderstandings on the Nature of HIV and AIDS

Nigerians are becoming increasingly aware of the existence of HIV infection and AIDS. Nevertheless, the disease remains strange and incomprehensible to many. The relatively low number of Persons with AIDs (PWAs) still leaves doubts in the minds of people as to the veracity of the existence of AIDS and of HIV infection in the country.

In a sociocultural environment in which scientific knowledge is still traditionally limited to what can be seen and felt, the concept of an incubation period and the notion of long term, healthy carriers are difficult to explain and to grasp. In nearly all Nigerian languages, local terms for HIV infection and AIDS are yet to emerge. The disease is still being described as "a new disease", "a disease that kills", "a disease without cure".

The Two Levels of High Risk Targets

African societies have two levels of high risk: 1) the standard high risk groups which might better be termed the super high risk groups--the CWSs, long distance truckers, STD patients and homosexuals--who by virtue of their profession, their illness and/or the nature of their sexual activity have a greater chance of contacting and spreading HIV from the smaller number of introduced cases at the early stage of the epidemic than the general population and, 2) the general sexual networking population.

High-risk behavior is not segmented in the society; rather it is integral, if somewhat clandestine, to social networks that involve at different times in ones lifetime, nearly all individuals including respectably married individuals. Although some subsections of the general population are more easily targeted such as the military and the students, the general target population is amorphous and fully integrated into the larger society. Moreover, in sheer numbers it is greater than the more easily targetable audiences with which many of its members interface sexually.

The Extensive Sexual Networking

Aspects of the Nigerian culture influence people's attitudes and behavior in ways that lead to high levels of sexual activity. Male promiscuity and male extra-marital affairs are widespread and tolerated tacitly. The continued belief that long periods of postpartum female sexual abstinence are obligatory for health reasons induces husbands to engage in extra-marital relations. The widespread practice of polygamy increases the spectrum of those involved in multiple sexual relationships. The traditional, transactional element to sex coupled with deteriorating economic conditions is forcing more and more women to engage in multiple partner or casual sexual relations in order to obtain resources and access to opportunities for furthering economic and social ambitions.

The existence of homosexual activity and male, homosexual commercial sex workers (MCSWs) in some areas further compounds the risk factors for HIV infection among spouses and the general population. Though a very sensitive issue, it is common knowledge within at least one society that homosexuality and bisexuality is practiced, particularly among men in the more affluent and aristocratic circles. As a consequence of their status, these men usually have many dependents.

Another risk-compounding factor is the growing trend of adolescent sex. Rapid social change and modernization has engendered increased educational opportunities and resulted in delayed age at marriage while simultaneously undermining parental and societal control over teenagers. Furthermore, the early onset of menarche for female youth deriving from healthier diets has placed girls at risk at a younger age. Of the sexually active teenagers, sixty-five percent of the females and eighty-one percent of the males had sex at least once but not more than three times in the previous month. This rather high level of sporadic sexual activity suggests a high level of impermanent relationships and the likelihood of multiple partners. Thus, these youths are at a high risk for STDs including AIDS.

Different patterns of sexual activity with differing motivations exist and have different implications for social policy. For some young women (married or single), sex is a rational means to a goal; for others not only sex but even pregnancy are instruments for attaining personal advancement and for accessing resources and opportunities for social advancement; for yet another category (particularly adolescent girls) sex is a casual, spontaneous activity. The different motivations for sexual activism among men and women will need to be identified and understood for each target group or sub-population in order to design appropriate IEC messages capable of motivating behavior change.

Commercial Sex Workers and Their Clients

Commercial Sex Workers (CSWs) operate at many levels and both as full and part time sex workers: as residential CSWs working out of hotels or compounds where they have designated managers and rules and regulations; as street walkers and "club" CSWs who meet men at Five Star Hotels; as rural market-based CSWs attending periodic markets; and, as community-based CSWs who work out of their own homes. Homosexual sex workers are usually sent for by their clients through intermediaries.

Itinerant CWSs and Rural Markets in the Chain of HIV Transmission

Itinerant CWSs activity occurs at rural markets. The CSWs arrive for the market day from booking into the local "hotels" adjacent to the market which are mainly for their use, being underutilized during the rest of the week. Rural dwellers bringing stock or produce for sale to wholesalers spend some of their newly acquired disposable income on the CWSs. Since they desire confidentiality, the hotels provide numerous entrances allowing discrete movements. This pattern has been identified in most rural markets in Benue State and in the bigger wholesale markets in Kano and Jigawa states. Further research may establish that this itinerant form of commercial sex working which reaches out to the rural areas also threatens the health of families in other states.

CSW Practice of Leaving Their Place of Origin to Work

Because of the social stigma connected with their profession, the majority of CSWs leave their place of origin to work. Many CSWs consider themselves temporarily employed as CSWs in order to earn capital for another enterprise. Many of the Badagry CSWs were married and their families' were under the impression they were trading. Igbo CSWs in Ado-Ekiti befriended their clients who failed to realize the CSWs had husbands and children elsewhere. The CSW sentinel survey in Hadejia, in which police-coerced, linked samples were taken, indicated that a high proportion of the CSWs were actually indigenes of Benue State.

Patterns of CSW mobility must be established and related to seroprevalence data.

Poor Birthing Practices of Traditional Birth Attendants

Traditional birth attendants who assist the majority of births often place their hands within the mother's vagina and always deal with the afterbirth, all without gloves. In addition, they cut the umbilical cord with unsterilized equipment. These TBAs are at risk of acquiring the HIV virus from one of their clients and of passing it on to many of their clients.

Beer Drinking and Sexual Networking

Drinking of locally brewed beer is a prime source of pleasure in many traditional cultures. Beer drinking and socialization form one of the major attractions of rural markets. Where men and women drink together, the social barriers to extramarital sex become less effective.

Hypocrisy About Clandestine Sexual Networking

The covert nature of sexual networking in the Far North as well as the deep-seated hypocrisy about sexual matters may constitute an obstacle to effective IEC activities and to public education.

The Relative Inaccessibility of Muslim CSWS

The commercial sex workers (CSWs) in the Islamic and traditional settlements in the Kano metropolis are relatively inaccessible. CSWs in Sabon Gari, the part of the city where southern Christian Nigerians reside, usually live in brothels and are easily accessible. However, in Fagge, Brigarde and Hotoro, the CSWs live in gidan matas (women's houses) but do not usually receive clients in the houses. Rather, Yan Daudas (a type of pimp) link them up with potential male clients who then take the CSWs to other locations (usually the hotels in Sabon Gari) for sexual intercourse. In order to reach this category of CSWs, the pimps/Yan Daudas and the magayiyas (older women in charge of the gidan matas) must be used as intermediaries.

Hypocrisy and Cultural Sensitivities About Open Discussion of Sexuality Issues

Hypocrisy and cultural sensitivities about open discussion of sexuality issues prevails among virtually all groups. Community leaders must be sensitized to the problem of HIV/AIDS in their communities in particular and in the country in general. Failure to do this might reinforce prejudices and

misconceptions (particularly as the project involves a condoms promotion campaign) and could cost the project potential allies and local institutional and political support.

Religious Opposition to Condoms

Religious people and community leaders tend to believe that promoting the use of condoms encourages casual sex and extra-marital relationships. This belief is a potential source of opposition to condom promotion. Such opposition could, however, be overcome not only by involving beneficiaries in the development of IEC messages but also by the careful introduction of condoms as a secondary option to abstinence and mutual faithfulness.

The Physical Conditions of Dwellings are Conducive to Virus Spread from Terminal AIDS Patients

The home where terminal caretaking occurs is a potential site of mass infection. All family members participate in caretaking including children. The lack of running water for rinsing soiled cloths and toilets for disposal is compounded by the financial incapacity to purchase luxuries like bleach and other disinfectants on a regular basis or sufficient soap and fuel to sterilize by boiling soiled wrappers and clothing. Moreover, the overcrowding increases the possibility of contact with contaminated fluid and cloths.

Most HIV Positives are Lost into the Community

Currently most HIV positives are lost into the community where they continue spreading the virus because they have no awareness that they themselves are contagious. Testing to date has been for the use of the testers, whether the government or researchers. Hospitals lacking test sites lack follow-up personnel. The sentinel surveys which provide current data on prevalence rates lack the personnel and funding to provide pre- and post- test counselling and long-term follow-up of HIV positives. Some blood samples have been taken without proper identification or with intentional misinformation in the case of some professional blood donors. Some CSW blood donors who have cooperated by allowing their blood to be sampled were not informed of the purpose of the testing nor were they given the benefit of being informed about their positive or negative status.

Culturally, medical personnel and family members are extremely reluctant to inform anyone of an untimely terminal illness. Individuals themselves prefer to remain ignorant of such a calamity. Moreover, it is standard practice for medical personnel to treat patients without naming the disease and explaining the rationale of the treatment.

The responsibility to your social network supersedes responsibility to the public and one's medical ethical responsibility for reporting cases of HIV/AIDS: thus doctors will cooperate with families to camouflage the cause of death. Under-reporting by private clinics that cater to health needs of middle and upper income brackets can be expected to become fairly standard practice.

Fatalism

The pervading fatalistic philosophy of human existence, particularly in Kano and Jigawa states, will inhibit efforts to actively prevent AIDS illness and death.

Unacknowledged AIDS Deaths

Deaths can actually occur and still not be acknowledged as caused by AIDS. This could contribute to under-reporting of AIDS cases and further compound the lack of convincing empirical evidence, an important factor in motivating behavior change.

Skewed Baseline Data

Refusal to acknowledge cause of death at present and in the future skews data of AIDS incidence and will inhibit accurate assessment of project impact since the incidence must already be much higher than acknowledged.

Dearth of Ethnographic Data to Explain the HIV Sentinel Report for November 1991 - March 1992

The HIV Sentinel Report released in August requires rapid ethnographic studies to ensure that significant super-high risk groups are not overlooked in the first phase AIDS projects. CSWs in seventy percent of the fifteen sentinel sites have an HIV prevalence rate of above ten percent: Otukpo, above 50%; Hadejia, above 40%; and three sites above 25% (Enugu, Gboko and Makurdi). STD clinic patients have an HIV prevalence in Hadejia of 23%; in Kano, 15% ; and in Rano, 10%. TB patients in five of the sentinel sites have prevalence rates above 5% (Ikeja, Makurdi, Gboko and Oturkpo) including Kano with above 14%.

Antenatal clinic patient seroprevalence which can be taken as a surrogate for the general population is also rising. In nine states the antenatal patient rate is above 2% including Gwarzu, Kano with 2.5%, Badagry, Lagos with 3.4%; Oturkpo, Benue with 3.7%; Nsukka, Enugu with 4.2% and Hadejia, Jigawa with 5.8%.

The cumulative number of AIDs cases up to July 1992 is 436 including twenty-six pediatric cases. Three-quarters of the cases are males. The number of reported cases has been doubling annually. Almost one quarter of the cases are from Lagos with significant numbers being recorded in Enugu, Borno, Kano, Cross River, Plateau, Adamawa and Kaduna. Thus, many states are fully enmeshed in the epidemic including some of the states not mentioned merely because of the paucity of data provided.

FACTORS CONDUCTIVE TO HIV/AIDS PREVENTION

Government Commitment to AIDS Prevention and Control

Government launched a National War on AIDS in March 1991 providing one million naira to each state and directing that state and local government offices be set up under designated officials termed Coordinators as well as committees with a combination of government and NGO representatives to combat AIDS. These bodies receive technical assistance from the Nigerian AIDS Control Program (NACP) and the National NGO Coordinating Committee of the NACP.

Government Mass Mobilization in the LGAs

The National AIDS Control Programme (NACP) has introduced a mass mobilization strategy in one LGA in each health zone as a model for replication. The strategy is responsive to sociocultural sensitivities and to government inertia. Workshops including AIDS awareness and Trainer of the Trainer sessions are used to mobilize the LGA officials and influentials in a tiered, sequential intervention during a three week period culminating in grassroots mobilization.

Islamic Rulers Ready to Support Intervention

The Emir of Kano has agreed to support a sensitization seminar for traditional rulers to be held in a Guest House. During the seminar the traditional rulers would develop a consensus approach to intervention. The Emir of Gumel has volunteered to publicly advocate condom-use for HIV/AIDS as a health measure.

Combatting HIV/AIDS is Consonant with Islamic Teachings

Islam advocates health and the preservation of life and opposes fornication. Promotion of condoms for HIV/AIDS prevention will not be opposed on religious grounds in the Far North.

Traditional Care Providers Potential Roles

Ethnographic research is necessary to establish the potential roles of traditional care providers in prevention of the spread of HIV, specifically in areas such as the following: the handling of STD cases by traditional care providers; the possibility of establishing a system of identification and referral of HIV infected/STD cases from the informal to the formal health sector; and, the possible role of traditional care providers in community-based counselling services.

SOCIOCULTURAL INFLUENCES ON MATERNAL/CHILD HEALTH

CONSTRAINTS TO MATERNAL/CHILD HEALTH

Need for Greater Programmatic Input from Health Education/Communications Experts

Although the basic premise of Primary Health Care is that increased client knowledge, attitudinal change and adoption of new health practices coupled with minimal medication will maximize health, the expertise operating and providing technical assistance is largely medical personnel rather than education/communications personnel. Greater programmatic input from health/education communications experts is essential in order to achieve appropriate programmatic emphasis on developing effective health education/communications to reach the communities.

Medical Practices Which Reinforce Disbelief in the Efficacy of Modern Health Establishments

Some medical practices reinforce the disbelief in the efficacy of modern health establishments. Normally, little or no information is given to patients and family members about their illness nor about the purposes of medications and treatment. Family members are allowed and often advised to carry away terminally ill patients reinforcing the belief that the scientific health system has limitations. The few occasions when such patients appeared to have recovered even for brief periods have been made into living legends for continuous IEC dissemination to community members. This strengthens the faith in the spiritual world and messengers, while reducing faith in medical science.

A Partially Fatalistic Attitude to Infant and Child Deaths

The death of children is a common phenomenon which people have been forced to accept. For this reason, children are not named until at least the seventh day and in some cultures until the third month to be sure they will truly be members of society. Although witchcraft is an explanation for spontaneous abortion, stillbirths and infant death, another very common explanation is the phenomenon of abiku (Yoruba)/oghanje (Igbo); the child is perceived as preferring the spirit world and refusing to stay with the mother. The child is propitiated to stay and mutilated after death to prevent his return with the next pregnancy.

When a child falls ill and dies, it is accepted that a stronger force brought about the death which might have been averted if the parents had taken strong enough preventive measures. Thus, the concept of prevention exists.

Members of some religions believe that sickness is from God, so the children should be left in His care without special precautions.

Failure of Service Providers to Explain the Nature of the Sickness and the Treatment

Doctors and other service providers refrain from explaining the nature of the sickness and treatment because they rightly fear that patients will self-diagnose and self-medicate, erring in the process. Patients remain ignorant of many common disease syndromes, unable to contribute to their management and frequently discontinue medicine prior to completion of the cure.

Problems Arising from Partial Absorption of Health Messages

Partial absorption of health messages generates unhealthful practices and unrealistic expectations leading to a rejection of the health messages. Belief in the efficacy of oral rehydration is undermined by failures due to incorrect preparation. Belief is also undermined by misinformed expectation that ORT can cure all diarrhea.

Traditional Beliefs Inhibiting New Public Health Interventions

In many areas, teething (fifty-seven percent of surveyed mothers in Niger State) and dirt as well as sweets are believed to be the cause of diarrhea. In fact, excess sweets do cause diarrhea among people unaccustomed to them just as excess pepper causes diarrhea among people unaccustomed to pepper. Consequently, some women reduce or delete the sugar component from the oral rehydration drink, make no attempt to use it at all, or substitute additional salt. In remote villages, sugar is not readily available and is as costly as aspirin.

Modern Practices Inhibiting New Public Health Interventions

Adoption of oral rehydration and rejection of medication except for limited specified cases is being resisted by all levels of the medical services and by the educated population because it contraindicates their acquired academic and practical knowledge. A similar situation is occurring with the new malaria protocol stipulating a full cycle of drugs at the onset of fever. Notification of protocol changes is insufficient to induce behavioral change on the part of service providers and clients partly because they lack sufficient confidence in the MHSS personnel. However in all nations, mere notification is insufficient for most behavioral change.

Non-recognition of Symptoms

In Niger State focus group discussions dealing with disease names revealed that while the Nupe and Gwari recognize dehydration as a serious symptom, the Hausa have no word for defining dehydration and do not recognize it as a condition requiring urgent treatment. Similarly, the Ife Yoruba women do not notice the symptoms for ARI because they are unaware of a separate disease, identifiable by the symptoms.

Rumors about EPI

In focus group discussions, Lagos State mothers averred that measles is always in the body and the function of the immunization is to bring out the measles giving the child a milder case. Some Plateau State refuse to bring their children for immunization because of rumors that immunization causes illness. An Oyo State survey prior to the intensive 1990 EPI campaign, revealed the following rumors: EPI can cause fever, paralysis and even death; EPI is a means of sterilizing women to forcefully reduce population; and, children with minor ailments should not be immunized.

Constant, Communal IEC/Gossip in Favor of Traditional Methods

Each time a child is seriously sick, relatives and friends will contribute their advice as to cause and treatment, often recounting cures achieved through traditional methods, thereby providing reinforcement for these methods.

Belief in the Efficacy of Traditional Healing

In an Ogun State LGA, ninety percent of the TBAs are traditional healers who have added childbirth to their practice. They use herbs and incantations to remove retained placenta and stop ante-partum hemorrhage. The strong belief in their omnipotence as healers, held by both themselves and their patients, places their patients at risk.

The Potential for Incomplete or Faulty Behavior Change as a Consequence of Conflicts Between Modern and Traditional Practices With Overlapping Rationales

Conflicts may arise in the minds of mothers between modern and traditional practices where the rationales overlap unless the mothers acquire a solid understanding of the modern method rationales and their relationships. For instance, among Bornu women contraceptive efficacy is a rationale for prolonged breastfeeding. A mother who adopts contraceptives may decide herself to curtail breastfeeding on the grounds that its contraceptive function is superfluous, thereby placing her child at risk.

Physical and Emotional Damage of Early Marriage

Because of the prevailing early marriages and pregnancies, short birth intervals, lack of adequate medical attention during pregnancy and delivery and the persistence of some harmful practices, especially ginshiri (a type of episiotomy that may damage the bladder or urethra), a considerable number of women suffer from vesicovaginal fistula (VVF) or rectovaginal fistula (RVF) caused by prolonged and obstructed labor.

Many girls become frigid from their first, excessively young, sexual experiences (girls in Kano are married by age thirteen). Thus, when they become pregnant, they are relieved and would rather breastfeed for a very long period in order to give themselves a rest from the unpleasantness of sexual relations. However, because of fear that the husband will take a new wife, the girls will be unwilling to abstain for too long. This anxiety is based more on fear of diminished economic support than fear of loss of the husband's attention.

Absence of a Tradition of Traditional Birth Attendants (TBAs)

The status and role of TBAs will be influenced in each community by traditional roles. In some areas, no traditional role for TBAs exists and, as a consequence, no traditional gift giving or other remuneration pattern exists. Lacking an expressed demand and some incentive for the extra work and responsibility, some trained TBAs fail to perform. Appropriate incentives and *modus operandi* need to be confirmed for each culture.

The Persistence of Harmful Traditional Practices

Harmful traditional practices which persist include genital mutilation and uvulectomy (a throat excision done in the first few days of life), ginshiri episiotomy, and postpartum boiling bath. Female circumcision occurs in almost every state and is linked with religious and other social values. In many areas the genital mutilation is central to a "rite de passage" which is otherwise pleasurable to everyone involving new clothes, hairstyles and feasting. In some areas, especially Edo, Delta and Benue states, the clitoris is believed to be a threat to the life of the infant if his head touches it during birth. Apart from interfering with sexuality, genital mutilation can cause severe scarring with keloids, chronic infections of the kidneys and urinary tract, coital difficulty, sterility, loss of pregnancy and excessive tearing during childbirth. Complications can lead to infant brain damage and breathing problems, severe maternal blood loss and vaginal-vesica fistula (VVF) and rectal-vesica fistula (RVF).

Uvulectomy was the most commonly performed surgery on children in Kano during the neonatal period and showed a very significant correlation with infant death from neonatal tetanus (67%).

Harmful traditional practices are difficult to eradicate because they are integral to the socialization process and the young woman would have to oppose her elders to refuse the practice. In order to discard those harmful practices which purportedly safeguard the well being of loved ones, even individuals who do not quite believe this tradition must be very convinced and knowledgeable; otherwise, they will be unwilling to risk the possibility that the tradition is valid.

Harmful Birthing Practices/Unassisted Births

In the north, only fifteen percent of the births are assisted by medical personnel. More than half of the births are unassisted and twenty-four percent are assisted by TBAs. Among some Middle Belt cultures, a woman is expected to deliver her child and cut the umbilical cord without screaming or calling for any assistance. In some areas the placental blood is an abomination which must be burned, resulting in the practice of giving birth in the bush to avoid the necessity of burning ones belongings. Physical activity such as fetching water or farming is also believed to facilitate the birth process.

Delayed Ante-natal and Post-natal Care

Among the Yoruba the mean age of the pregnancy at first ante-natal attendance is about twenty weeks. It is not proper for people to know of a pregnancy before it is well established because of fear of the evil eye and its power to abort or otherwise harm a pregnancy. In the Far North, it is difficult for some women to attend a clinic at any time because of the seclusion practice. Moreover, the first forty days after childbirth, they are confined to the house as a protective measure.

The Rarity of Optimal Breastfeeding and Unenlightened Weaning Practices

According to the 1990 NDHS, only 1.3% of babies under three months of age were exclusively breastfed. Most babies receive water, herbal infusions or other liquids from the first day of birth.

The NDHS revealed that delayed introduction of complementary foods is a major problem. In the Northeast Zone, two thirds of children were not receiving complementary foods between the ages of 6-9 months; in the Northwest and the Southwest Zones, fifty percent were not receiving complementary foods at this age. Improper weaning practices and undernourishment are reflected in the high levels of stunting caused by inadequate nutrition over a long period of time and wasting caused by acute undernutrition at the time of testing. The duration of breastfeeding has been significantly reduced, especially among more educated and urban women.

Potential Reduction of Breastfeeding Due to Adoption of Contraception

Many women consider breastfeeding a form of contraception, especially where breastfeeding requires abstinence. Adoption of contraception correlates with reduction of breastfeeding duration, possibly because both correlate with education. Concerted efforts must be made to ensure that women continue prolonged breastfeeding despite adoption of contraception.

Nutritional Taboos

Nutritional taboos associated with pregnancy, childbirth and children also affect the nutritional/health status of mothers and children. Some of the forbidden foods are valuable sources of nutrients such as the following: oranges, snails, plantains, eggs, fish, okra, salt, pepper, palm oil and groundnuts.

Health Care Decisions Being the Prerogative of the Husband

In baseline surveys in five LGAs, health care decisions were made by the father in over seventy-five percent of the cases even though women actually provide the care. Transport of a difficult labor case to the hospital may be delayed while awaiting return of the decisionmaker.

Competing Priorities for Mothers

Even if the husband is contributing, mothers must work long hard hours in order to grow crops and/or earn enough for bare subsistence by trading in the depressed market. Consequently, the decision to take the time to take a child to the health center must be weighed against competing priorities also essential for survival.

Service Delivery Timing, Opportunity Costs and Humiliations

Immunizations, even in large clinics where they are given daily, are often given for only two hours a day. Clients are expected to arrive early, wait for a large group to be present, sometimes listen to a health talk, and by noon the work of the day is completed. Women arriving after 10:30 are usually told they are too late to register. The long wait in the clinic is a serious opportunity cost to the women who require public health medical care. Although a woman might earn only N10 from selling oranges during that period, that N10 would be crucial to her budget; it would finance the evening meal. Only women convinced of the efficacy of the immunizations will undertake these losses. Moreover, nursing and even cleaning staff shout at the mothers, rudely abusing them for their ignorant behavior.

Understaffing of Competent, Health Education Manpower

Health Education manpower is deficient at all levels, especially at PHC service delivery. Less than 20% of the persons who currently hold "health education" positions at the LGA level possess the competencies necessary to assure the appropriate preparation, selection and effective delivery of a health education activity. Only four of the thirty-two health education units (including the Federal units) have graduate level directors which seriously mitigates against their ability to represent health education effectively to policymakers and technocrats in key decisionmaking positions.

Cost Recovery Undermines Health of the Poor

Patient fees have also generated critical delays in seeking health care. The introduction of user fees for maternity care correlates with the three-fold increase in the proportion of complicated obstetric admissions recorded in one of Nigeria's teaching hospitals between 1983 and 1988. During the latter portion of this period maternal mortality also rose by fifty-six percent in the same hospital. Voluntary (premature) discharge from public hospitals to avoid charges has also been reported.

Avoidance of Associated Costs for Immunization Foster Rejection of Immunization

Although women are not expected to pay for the actual immunization serum, they do pay for transport, the opportunity costs of lost time, the prescribed paracetamol to relieve pain and fever, and the syringe. Most women pay for the syringe being aware of the possibility of infection from a reused syringe; however, some forego the paracetamol. The ensuing fever causes them and those about them to reject subsequent immunizations.

Undersupply of Local ORS Sachets

According to 1989 estimates revised to accord with the current population, there are an estimated 315,000 deaths annually due to diarrhoea in children under five. It is estimated that at least 10% of children with acute diarrhoea develop dehydration and require ORS solution to prevent death due to dehydration. Although minimum requirements for ORS would be eight million, only 1.8 million sachets were available. Only forty-two percent of the health facilities visited during the In-Depth

Program Review of EPI/CDD in 1989 had ORS stock and another study reported only 7,600 ORS sachets in FMHSS stores. Thus, the deficit is enormous.

Unsustainability of National, Mass Immunization Campaigns

In 1990, the government at all levels, the NGOs and the donors diverted human and financial resources to a successful EPI campaign that raised the vaccination doses from one million in 1987 to 3.5 million in 1990; however, the figure dropped to 1.5 million in 1991 showing clearly that the coverage rates were unsustainable in part because the success had been at the expense of diversion of resources from other health interventions. Nonetheless, the success of the campaign techniques have been replicated on a smaller scale although hindered by the failure of government funding and personnel focus that distinguished the 1990 campaign.

Problems With Vaccine Logistics

Maintaining a constant supply of vaccines adequately protected by refrigeration remains an on-going problem. The MHHS is continuing to supply vaccines even though states are now expected to allocate money from their own funds for vaccine supply.

Client logistics and opportunity costs in time can be just as difficult in urban areas as in rural areas. Lagos State is the worst dropout state in the nation for EPI.

Service Provider Resentment of New Interventions

Some nursing sisters complain that the Ministry continually sends out directives for new treatment approaches and just expects them to follow the new protocols without explanations.

Service Provider Reluctance to Follow Diarrhea Protocol

The diarrhea protocol is often ignored by service providers who continue routine use of antibiotics and misuse of antidiarrheals. Most facilities lack ORS packets; consequently, the provider is expected to demonstrate the preparation and use of sugar-salt solution (SSS). Instead, service providers continue to prescribe other medications.

Routine, Unnecessary Treatment With Injections

Both the service providers and the clients have an inordinate faith in the superiority of injections over tablets and syrups. Despite directives, the service providers continue to overuse injections.

FACTORS CONDUCIVE TO MATERNAL/CHILD HEALTH

Governmental Initiative and Support for Primary Health Care

The Federal Minister of Health and Human Services has taken the initiative with his Ministry has transformed the health care delivery system to fully incorporate primary health care.

Parental Readiness to Adopt Demonstrably, Successful Interventions

In a northern Cross River village, measles vaccinations in one year were able to reduce the death of children from measles from over thirty children to one child. Following this demonstrable success, immunization was fully adopted.

Preference for Medical Advice

In numerous intervention surveys, doctors are the preferred source of information followed by other medical personnel and then the electronic media with only 10-15% preferring religious and traditional

leaders. This suggests the usefulness of having doctors present messages over the media to reinforce jingles, etc.

The Potential to Harness Patient Propensity to Self-Diagnose and Self-Medicare

The evident desire of patients to self-diagnose and self-medicate offers the potential of establishing areas other than ORS where patients could become the providers of first-line medical care including drug administration as in the case of malaria drugs.

The Potential of TBAs

TBAs participate in almost thirty percent of births in urban areas; therefore, their assistance must be incorporated in any MCH intervention. TBAs may also be able to provide referrals from TBAs patients for tetanus toxoid and for family planning. The Inter African Committee Against Harmful Practices (IAC) has provided TOT and training for over 1,000 TBAs in target LGAs in many states with the good will of the PHC, the BLP and the traditional rulers in order to gain their cooperation in the effort to end harmful traditional practices.

A TBA training and supervisory program attached to a mission hospital in Akwa Ibom State achieved a fifty percent reduction in the high maternal mortality rate of the indigenes. Simultaneously, the number of normal hospital deliveries fell while the number of complicated, operable deliveries (from TBA referrals) increased.

The Cooperation of NGOs

NGOs have cooperated with all the maternal/child health interventions especially EPI where they assisted significantly in mobilizing the population and ensuring that members' children and children of the general public were vaccinated. The Nigeria Association of Non-governmental Organizations of Health (NANGO) has been formed as an umbrella organization for NGOs committed to EPI and other health interventions.

The Acceptability of Mosques as Venues for VVF Awareness Talks

With the endorsement of the Islamic authorities, the National VVF Task Force has promoted awareness by scheduling pre- and post- worship awareness talks in the mosques. Use of the mosque for communal meetings forms part of the Islamic tradition which may benefit more health interventions once the Islamic community coopts them.

The Potential of School Children to Function as Health Providers and Health Educators

Children, even in primary school, function as care providers for their siblings. Consequently, health messages about infant and under-five child care are meaningful to them and can be put in practice. In many cases, parents will accept health messages written into their children's notebooks. Operations research can explore various means of reinforcing the messages including using a doctor who is an authority figure such as the Commissioner for Health as the source of the health messages.

Lessons Learned from the Niger State Primary School Health Clubs

The inadequacies of the HealthCom experience with primary school health clubs in 1990 in Niger State had more to do with the inadequacies of the intervention modalities than with the general concept. Lessons learned include the need to define restricted goals which can be evaluated with a few indicators and without much record taking.

Traditional Breastfeeding Practices

Prior to independence and widespread availability of baby formula in the urban areas, children were breastfed in most areas for three years and in virtually all cases for at least two years. In many

cultures, the lactating mother stayed with her natal family or her mother-in-law during this period of postpartum abstinence. Among the Yoruba, couples were abused if the wife became pregnant while still lactating.

SOCIOCULTURAL INFLUENCES ON IEC

TARGETING THE PEER-GROUP, NOT THE INDIVIDUAL: THE PROPOSED PEER-GROUP AUDIENCE, IEC STRATEGY

An IEC Strategy Targeting Peer-Group Audiences

The IEC strategy should focus on the majority, the potential **peer-requestors--groups and the individuals within them** who conform to group behavioral patterns. The term "peer-requestor" is used here to refer to an individual who will only modify his or her behavior if his peer-group approves of the change. With the sanction of the group, a peer-requestor will come forward to request family planning (or any other health intervention).

The Peer-Group Audience IEC strategy capitalizes on the conformism of the masses to promote behavioral change. The vast majority of Nigerians are discomfited by innovation and prefer to modify their behavior with the approval of their peers and/or influentials as representing their peers. The strategy goes beyond dissemination of messages appropriate for specific peer-groups. It focuses on advocacy and dissemination of information **within the context of the peer-group** using selected NGOs as the **targeted, peer-group audiences**.

Targeting peer-group audiences differs from targeting an individual with messages appropriate for his or her peer-group. Receiving the message within the context of the group and accepting or rejecting it within the context of the group absolves the individual of taking responsibility for the decision. The decision becomes a consensual decision, transforming the hitherto, unsanctioned behavior into morally and socially appropriate behavior.

Although a conformist can more readily reach a decision to modify behavior in the company of members of his/her peer-group, he may also be induced to modify behavior when targeted individually through mass media if the message convinces him that his peers also desire change. Or the conformist may be set on the path of behavioral change, if the message convinces him to discuss the possible behavioral change with his peers. Most IEC operates in these ways. Social mobilization campaigns take advantage of both mass media audiences and peer-group audiences.

Overcoming Strong Resistance to Behavioral Change

The peer-group audience strategy is especially appropriate for inducing people to overcome strong resistance to behavioral change. It assists individuals to take difficult decisions whether these decisions are about family planning or about preparing SSS instead of using an antidiarrheal. If the decision proves unwise, the group rather than the individual will bear the responsibility.

The normal, traditional decisionmaking process involves shared responsibility in risk-taking. Even when an influential promotes behavioral change, he or she coopts the group to take a consensual decision. The greatest obstacle to interpersonal and/or personal decisionmaking is the absence of the sanction of group approval. Individuals experience minimal risk when the responsibility is diffused or allocated to an influential. Moreover, persuasion theory indicates that persons are more suggestible in group or crowd settings than in solitary situations.

Ethical NGOs as the Significant Peer-Groups

For private behaviors, the strategy targets "ethical NGOs" as the **significant peer-groups**. The expression "ethical NGOs" is used here to single out those NGOs which perform a value-clarifying and reinforcing function for their members. In general, NGOs affiliated to primordial and religious groups are among the most appropriate NGOs. Members of primordial groups usually live their personal lives intertwined with their group. Members of religious NGOs usually developed and reinforce their basic values among their religious peers. Hence, these groups are the most appropriate NGOs for sensitive interventions. In contrast, worksite peer-groups, employee NGOs and even many charitable NGOs are usually inappropriate for initial, sensitive, behavioral change because of their modest influence on a person's feelings and attitudes to life.

Ethical NGOs have the capacity to mobilize their membership as a group to adopt AIDs prevention behaviors or to request child spacing, pregnancy postponing and, in some cases, child limiting in accordance with the peer group beliefs. They have this capacity precisely because they are trusted by and responsive to their membership at the ground level. An NGO's effectiveness as a conduit will depend upon the extent to which (a) its influentials coopt the intervention and internalize it within the NGO and (b) the NGO's values diverge from values compatible with family size limitation.

Ethical NGOs can also expand the child spacing intervention beyond the constraints of innovator-oriented and clinic-based service delivery. Using ethical NGOs as the conduit, the program can advance to targeting potential peer-requestors within their peer groups. They can also target individuals and groups who are uncomfortable in the clinic environment which is currently the major outlet for decisionmaking information. Thus, the males, women without infants and toddlers, and unmarried females who rarely benefit from clinic information but are active members of a variety of NGOs will be effectively reached.

NGO Influentials as Change Agents

Each NGO has its own influentials who may or may not be officers of the organization capable of marshaling public opinion using the time-honored and time-consuming human relations techniques. Motivated influentials who recognize the value of behavior modification for their NGO reference group have the potential to function as effective change agents for their NGO membership.

Establishing the Credibility of an Influential

Rapid ethnographic studies and/or interpersonal networking will be essential to confirm that leaders are actually representative and credible influentials. Due to the pervasiveness of corruption in Nigerian society, the people's perception of influentials has undergone radical modifications in some areas. For instance, in Nteje and Ngwo communities in Anambra and Enugu States respectively, the majority of the individuals interviewed failed to perceive religious leaders as individuals who can influence their behavior toward family planning and improved child and maternal health. They rejected the credibility of these influentials. Most of those interviewed were of the opinion that some of these influentials were corrupt and therefore had no right to tell them how to act.

Instead, the informants named influentials of their own choice within their communities from whom they would like to learn about modern family planning and child survival techniques. The distinguishing characteristics of those named include honesty, education, hard work, respect and a demonstrated sense of communal responsibility.

Doctors as Authorities for Health Behavioral Change

For health behaviors, doctors are recognized as the most trustworthy authorities by the respondents in the Nigerbus survey. This survey is a bimonthly advertisers' survey which have incorporated some

family planning questions on behalf of the FHS IEC division. According to the respondents, healthcare personnel are the next most reliable authorities for health problems.

Health Advocacy Networkers

A successful NGO intervention reaching many organizations simultaneously will require full time personnel acting as Health Advocacy Networkers (HANs). Their responsibilities will include (a) identifying influentials who are amenable to mobilizing their reference groups to become child spacers; (b) convincing these influentials to become social mobilizers; and, (c) providing them with the requisite intervention knowledge. The HANs will work at the grassroots level and within the hierarchies of the larger NGOs. They will seek out intermediaries to identify and gain access to influentials. By networking and communicating some of the IEC message, the HANs will identify key cooperating influentials. These influentials will develop the direction and scope of the IEC and mobilization strategy for their own membership within the constraints of their prevailing attitudes and practices.

Such a personnel intensive intervention should be handled by a contractor capable of overseeing the personnel and contributing to message and intervention development. This type of intervention relies heavily on dedicated, well trained and well remunerated personnel with a strong sense of social responsibility, probity and professional commitment. As a consequence, the HANs will need considerable monitoring and supervision. Initially, the contractor may be part of, or an affiliate of, an American contractor. By mid-cycle the contractor should be fully Nigerianized and institutionalized as an affiliate or as a distinct entity from the American contractor. In contrast, NGO expenditures and institutional change will be minimized in order to preserve the status quo which empowered influentials to mobilize membership.

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Information Kits for the Influentials

The influentials in these organizations lack the time and focused concern to conceive and carry out an information and mobilization campaign, much less an ongoing program essential to attract and maintain sufficient behavioral change to transform the norm. They already have agendas for the organizations as well as their own personal responsibilities in their place of work and at home. Furthermore, even if some influentials are already predisposed to and aware of the need for the behavioral modification requisite for the health intervention (child spacing, dehydration prevention, etc.), they may be surprisingly uninformed about the intervention and all its health and cultural manifestations.

Preparation of targeted, information kits consisting of an average of ten pages of information tailored to the familial and health concerns of their NGO members, providing the rationale for the intervention including Nigeria-specific statistics and information, and advocating aspects of the intervention that are compatible with their religious and cultural beliefs will be extremely useful to overworked influentials. Distribution of the kits to key cooperating influentials will facilitate reinforcement of the messages and message dissemination. These kits should also be backed up by the information brochures which will give more comprehensive information for those desirous of pursuing the problem.

Hand-Outs for Members

Some of the information sheets may be appropriate for duplication and distribution as hand-outs to the membership. Fancy art work is not essential if the mobilizers themselves are sufficiently dedicated. The ultimate targets are expected to receive the message positively because they are members of their group rather than because each one individually was attracted by a flyer. They are expected to read the flyers because they provide information that is of intrinsic interest to members. The hand-outs are intended as primarily as message-reinforcing materials.

Government Social Mobilization Campaigns

Campaigns maximize their impact by targeting individuals within the context of their peer-groups. Campaigns are also a vital tool for mobilizing government resources. They absolve all concerned from individual responsibility and they facilitate release of government funds to respond to the urgent, high profile project. The recent, unsustainable but successful, EPI campaign should be criticized for its excesses in mobilizing funds and resources, but not for its methodology.

AUDIENCE CATEGORIES

The Major Audience Categories: The Example of Family Planning

The target audiences in all the program components can be perceived along a continuum from those who refuse to adopt any or all of the services and recommended behavior changes through those who have become total converts. To avoid abstract discussion, the analysis which follows refers to the specifics of the family planning intervention; however, most of the methodology is easily adaptable to the other interventions.

Acceptor/Requestor Categories

The term "child spacing acceptor" is a misnomer. Current acceptors are not merely acceptors who adopt a service offered to them individually; they are "child spacing requesters" who have come forward and requested the service from a provider. The onus is on the client to take the initiative to request family planning advice and assistance. CBD and social marketing have the important advantage of reducing the clients' individual responsibility for initiating the process. Child spacing

requestors can be broadly categorized into innovative requestors, peer-requestors, uninformed non-requestors and hardcore non-requestors. Innovative requestors have individually decided to request child spacing despite widespread disapproval or skepticism towards child spacing among their peers and in the larger society. Peer-requestors are those who join the "bandwagon" of their peers conforming to group norms. Because the highly educated now approve of family planning, people in this social group can be considered peer-requestors. However, most other current requestors are innovative requestors.

Hard-core Non-Requestors

Since the hardcore non-requestors may be operating within a complex web of social, cultural and psychological constraints, attempts to move them straight from non-requestors to requestors may generate serious resistance. A better alternative is to aim at shifting them from non-requestors to potential (undecided) requestors and then on towards fully embracing the behavior to become requestors. Simultaneously, design of both the channels and the messages must take into account minimization of damage possible from influential, hardcore non-requestors.

In the Far North, despite an increase in family planning requestors among the elite, the majority of the faithful can still be categorized as hard-core non-requestors. They should be reached through their own organizations with a cautious, slow-paced program. In this authoritarian society, a combination of religious and medical leaders supported by traditional leaders will have the greatest impact. Initially a workshop with four representatives from each of the religious-based associations is suggested. They should be introduced to maternal child health issues and child spacing. This should be followed by considerable opportunity to question a group leader versed in Koranic approaches to child spacing and capable of refuting their arguments. Without offering any suggestions, the possibility of human and financial resources should be left open should they decide to pursue the issues further.

Other avenues include booklets written from the religious perspective with information on Islam and maternal/child health issues addressed to youths or adults.

Stages of Message Absorption

Audiences absorb the messages in stages. The first stage is the awareness stage which may suffice to generate an unmet need. Innovative requestors may themselves initiate the next stage, the acquisition of enough information for both informed decisionmaking about a preferred method and for access to the method. This second stage, the information stage, involves transmitting enough information about specific techniques and access to the techniques to enable an individual to decide to request a contraceptive. The information stage requires repeated, oral presentations and/or a printed explanations for effective internalization of the information. The third stage, the reinforcing stage, is continual in order to provide the reinforcement essential to prevent backsliding and to clarify questions that arise during use.

THE MEDIA AND MESSAGES

A Protocol for Health-Message Development

A protocol for rapid health-message development needs to be prepared and adopted within the Primary Health Care (PHC) system. Widespread adoption of the ideal methods of health message development is not feasible; the process is too complex and time consuming. Health messages are not merely intervention specific. The messages must also respond to the specific knowledge, attitudes and practices (KAP) of ethnic and religious groups as well as to their effective communication

channels. The IEC strategy for introducing ORT into a community that lacks the vocabulary word or concept for dehydration must necessarily differ from the strategy for a community that is aware of dehydration. Similarly, the strategy for a community that favors cornstarch porridge for invalids differs from the strategy appropriate for a community that favors sour milk.

In accordance with the Health Com methodology, collection and assessment of base-line data for health-message development must go beyond identification of the KAP for a particular health problem. Behavioral analysis is a vital component of health message development. Base-line data must identify (a) the discrete behavioral changes that are possible in the community to combat the health problem; (b) the existing KAPs that are conducive to the requisite behavioral change; (c) the existing KAP that constrain adoption of the requisite behavioral change; and (d) a limited number of discrete behaviors to be changed by the majority of the population. Health message development must also incorporate an analysis of service provider behavior along the lines of the WHO focused ethnographic study (FES) methodology developed to examine cultural perceptions of specific diseases. Once realistically, achievable behaviors have been identified, the standard IEC message development and testing process can commence.

At the community level, the health message development protocol should also provide the opportunity for identifying individuals who may serve as role models and "anti-role models", examples of people who suffered because they lacked the benefits of the interventions. Although the time lag between prevention and benefits mitigates against finding role models for intervention successes, all curative benefits and some preventive benefits will be identifiable such as the virtual eradication of measles in small communities with complete coverage.

Fully developed, prototype health-message protocols prepared specifically for each intervention should form the basis for the rapid health-message development, disease-specific protocols. Each prototype should be ethnic-specific even though this will limit its replicability among the other ethnic and sub-ethnic groups. Moreover, some degree of sensitivity will have to be sacrificed to efficiency and standardization. Standardized questions and focus group discussion questions need to be developed for each health intervention. A procedure for eliminating unnecessary questions and adding crucial questions needs to be developed. A procedure for selecting the smallest sample capable of generating the requisite information also needs to be developed. The objective is feasible, rapid development of messages that are both ethnic-specific and disease prevention and control-specific.

Psychological Profiling

Psychological profiling of requestors and non-requestors involving research techniques such as imaging, in-depth interviews and focus group discussions should facilitate the development of more relevant target-specific messages. The addition of psychological profiling to the already known sociocultural profiling will benefit future IEC campaigns. For instance, a better understanding of the psychological underpinnings of the male opposition to family planning should take us beyond the fear of spousal infidelity to allow the development of messages responding to the ramifications of the threat family planning poses to male dominance.

Psychological audience analysis will also provide the basis for distinguishing the hardcore non-requestors from the uninformed non-requestors who can be reached through awareness and information campaigns. Where religious and sociocultural factors hinder the majority of the people from fully embracing an intervention, psychological profiling of the requestors and the non-requestors will provide the basis for constructing behavioral change messages. Some of the communication strategies may be constructed around the concepts of self-esteem, moral appeal, guilt, explanation,

debt and reward. The general framework is the benefits to be derived from family planning, HIV/AIDS prevention, child survival and maternal child care.

Participatory Message Development

Each message to be communicated should be determined through active participation of the specific target group. Messages will be culturally determined for greater message acceptability and persuasiveness, bearing in mind the oral nature of the Nigerian society. Messages translated into local languages are interpreted on the basis of cultural orientation and beliefs and are, therefore, subject to misinterpretation. Consequently, confirmatory message testing is required throughout a much larger territory than would be necessary in a more homogenous environment.

Private Sector Roles in Message Development

JHU/PCS has used Nigerian-owned, private sector organizations to assist in target group identification and in data processing. They have worked with an advertisers' marketing research company, Research & Marketing Service, Ltd. (RMS), to develop and use questions to test the effectiveness of their IEC interventions as well as to carry out formative research. Initial, informal technical assistance has ensured competency within RMS to carry out contracts ensuring rapidly available, bi-monthly tracking of message impact.

Private Sector Roles in Social Advertisement Production

JHU/PCS has also contracted out production of social advertisements to local production agencies who already possess the expertise and equipment. They are capable of responding much more efficiently and provide a quality of service that is not available and could not be made available in the public sector without enormous input. JHU/PCS handles the pre- and post-testing but the actual scripting, hiring of talent and production is handled by the successful contractor. The popular, public service announcements developed with PPFN were produced by the St. Claire agency.

Private Sector Roles in Distribution

Materials developed by the public sector with JHU/PCS technical assistance have also been distributed by private sector distributors through a contract handled by the MHSS. This public/private partnership facilitated the rapid distribution of leaflets developed by the Federal Health Education Branch.

Electronic Media

Prior to 1990 when the groundwork for IEC messages was being prepared, less than twenty-five percent of currently married women had heard any family planning message on radio or television. Almost seventy-five and fifty percent of the urban and rural women, respectively, affirmed that it was acceptable to have family planning messages on radio or television. Impact studies for the Enugu television drama incorporating family planning messages indicate a high degree of effectiveness. The number of new clinics at local family planning clinics increased steadily and television was named as the source of referral by an average of forty-three percent of new clients each month. More current studies can establish the effectiveness of the advertisements which are now being aired.

The coverage of the population by the modern media is low. The network news, national coverage offers the only national audience coverage. Nigeria has thirty-eight television and forty-eight radio stations. The Nigerian Television Authority (NTA) estimates that its state satellite stations and the state television networks reach about thirty million Nigerians. Ownership of radio and television sets cuts across gender, social class and urban/rural differences. According to the Nigerbus Survey, more rural people (defined as people living in communities of less than 20,000 people and, therefore, including peri-urban communities) own radio sets (83%) than television sets (26%), suggesting the

potential of using the radio network as a channel of reaching the rural population. Drama is the most regularly watched program type by all audience segments.

Television and radio coverage have undoubtedly increased in the last five years. Since the launching of the population policy in 1989, population issues have become an increasingly popular topic with the news media. The presentations are all generally in favor of the full implementation of the policy and the quality of the presentations is improving; however, the human interest aspects are still generally lost in the academic aspects of the presentation.

Nevertheless, the restricted reach of the electronic media must be recognized. According to the 1990NDHS, approximately two thirds of the rural women and one third of the uneducated women have access to neither radio nor television. Moreover, while state radio stations are suitable for targeting sub-populations, the reach of some state radio stations is inadequate to serve all the rural areas.

Private Sector Subvention of Electronic Media Costs and Public Service Broadcasting

Cost of electronic media coverage is likely to increase due to the recent privatization of the government stations. Government and private media organizations donate free time and space to UNICEF messages. This public service concept should be expanded to encompass other family health messages. Equally, private companies should be approached to buy air time and print media space for the dissemination of health messages.

Print Media

Nigeria has about forty major newspapers. Readership estimates range between 5-47%. The majority of the readers including the messengers and secretaries as well as the boss read the office copy. Magazine readership follows the same trend. Concord is the most widely read newspaper throughout the nation but in particular states, the newspaper of that state or region will be the most widely read. Weekly magazines are more popular than monthly magazines. Prime People is the most widely read, soft sell magazine. Newswatch has the largest readership among the news magazines.

The print media are especially important for their capacity to disseminate complex knowledge, to provide the opportunity for review of that knowledge thereby facilitating complete comprehension and internalization, and to be available to the target audience for reference.

Flyers

The distribution of flyers at bus stops to low & middle level income, public transport users provides effective outreach to the informal sector. This technique was used with great success by anti-government sources who distributed a poorly typed list of accusations against the government which contributed significantly to the poverty riots of 1989. If the topics treated are of intrinsic public interest and presented at the Sixth Grade Reading Level, a black and white photocopy could serve the purpose as well as a colorful printed page. Information on reproductive health which would not offend the readership including information on sex diseases and the dangers of mistimed pregnancies can be expected to be discussed among friends. The format might include a story about an individual or couple that suffered because of their ignorance.

The Potential of the Private Sector Profit-making Press to Generate Readership from Human Interest Stories, Dear Abby & Yellow Journalism

The power of the human interest and the celebrity story as well as the Dear Abby type column to attract readership especially in the yellow journalism press warrants fuller exploitation. For the short

period Professor Ronke Akinsete had an AIDS column in The Vanguard, she was inundated by letters. Committed health reporters could benefit from improved skills in presenting behavioral change health interventions, including the uses of human interest stories to sustain interest in their topics. All too often, the newspapers carry excessively long health articles with little human appeal. Full sensitization of the columnists may suffice to increase their proper treatment of these issues.

Editors and owners could benefit from operations research to demonstrate the readership-generation power of health information couched in the appropriate formats for their target audiences.

FAMILY PLANNING-SPECIFIC IEC

Targeting LGA Officials with Rapid II-type Modelling Graphs

Decisionmakers at the federal level were responsive to Rapid II graphs indicating the effect of population on the allocatable funds for government projects and general expenditure on job generation, food, fuel, etc. Since much of the government, intervention-related funding is now directly to the LGAs, LGA officials should be sensitized to the effect population growth has on their budgets and ability to service the basic needs of their constituents. Otherwise LGA officials may oppose child spacing. They may consider it a form of birth control liable to undermine their budgetary allocations which remain substantially dependent upon population size.

However, the necessity and the utility of a video production for LGA level should perhaps be weighed against the utility of laminated charts with five or six focussed, more easily retainable messages and a booklet to facilitate retention and discussion of the messages.

Male Targets

Family planning IEC should target those males most likely to be receptive. Young males who still feel affection for their wives and desire to meet them while they are breast feeding without jeopardizing the health of the infant should be targeted. Middle-aged men whose affection is waning under the social and economic pressures of daily life, but who do not really want to chase other women and/or pay for their sexual services should also be targeted.

Media Messages

The following are suggested as possible messages that might arise from peoples' concerns.

Message Target: Male, Young, Parity 1-2

Possibly Also Rising Middle Age, Parity 3-4

Designed to Promote Family Size Limitation, Including Monogamy For Radio & TV, Cartoons?

Modern child spacing is for your enjoyment. With modern child spacing, you can enjoy meeting your wife without harming your baby. Your wife will never again refuse you because of the children. She'll never refuse you because of what the relatives will say. Child spacing techniques are for you, so you can have pleasure with your wife and still have a healthy family.

Message Target: Male, Rising Middle Age, Parity 3-4

Designed to Promote Family Size Limitation, Including Monogamy For Radio & TV, Cartoons?

Some half-siblings are fighting over who is going to pay their father's hospital bill and who is going to nurse him now that he is ready to be discharged. Brother A tries to tell Brother B how much he should contribute. Brother B objects that they all know he just had to pay for secondary school books

for his three oldest kids. Sister C objects that she spent a lot of money on Father while he was sick prior to hospitalization and that her husband expects other siblings to fulfill their roles. Brother D objects that he had to pay his own way through Technical College without any help from Father and that Father was never around and never helped his mother or his full sister either. Others chime in to say it was the same for them. A Voice Over says, "It isn't always the number of children; sometimes it's the type of relationship that counts."

Message Target: Female, Rising Middle Age, Parity 3-4
Designed to Promote Family Size Limitation
For Radio & TV, Cartoons?

"But Sister, are you sure Brother Ayo (husband) really wants a fifth child? Even gari is so expensive and then books for school and after all that, you will be lucky if you can help the children find work. You know I used to think my husband was running around because I couldn't seem to get pregnant again. It turns out that what he really wanted was to get away from my nagging about books and clothes for the kids. He wanted some fun. He didn't want any more responsibilities even if he didn't want to admit it and didn't want to deal with my family accusing him of not wanting more issue.

Message Target: Teenagers in Schools & Tertiary Institutions
Designed to Promote Condoms

Condoms prevent abortions. They are cheaper and safer.--followed by a life story or statistics about complications.

Message Target: Teenagers
Designed to Promote Safe Sex Including No Sex

Not all sex diseases are curable. Your friend may be carrying AIDS without realizing it. Who knows who his partners' partners' were last year? Abstinence is safest but condoms are better than a slow death from AIDS.

HIV/AIDS-SPECIFIC IEC

Message Content: Abstinence and Fidelity As Well As Condoms

The success of the HIV/AIDS project will depend to a large extent on the content of IEC messages. The sociocultural diversity of the target populations implies that the project must be able to respond to the specific needs of the different groups. Involvement of community leaders, institutions and beneficiaries in the development of IEC activities will ensure that sociocultural sensitivities are respected and that messages will be acceptable and effective in motivating behavior change amongst the different sub-populations.

However, the AIDSCAP Nigeria Country Plan perspective that condoms represent "the most effective means of preventing HIV transmission", contradicts the principle of participatory target group message development. If this perspective is translated into action, it might heavily bias the focus of IEC messages. ABSTINENCE and mutually faithful, stable relationships between uninfected persons are not only currently, culturally acceptable but are also the most effective means of preventing HIV transmission. Condom use remains the most effective means for persons who do not practice and are unwilling to adopt the practice of abstinence and who have multiple partner/casual relationships simultaneously or over time.

Failure to inform the public that condoms only reduce, but can not eliminate, the risk of transmission deprives the public of the opportunity of informed decisionmaking. This opportunity is essential

especially in view of Kenyan reports of 50% contraceptive failure. A condom advocacy strategy that omits or downplays abstinence may be an appropriate, public health strategy among restricted high risk, target groups for whom abstinence is not considered a realistic alternative; however, such a unifocal strategy would be irresponsible for the public as a whole. Moreover, the considerable rate of sexual networking throughout the society indicates that the wider public will rapidly become a high risk target.

The potential, moralistic opposition to the condom promotion component of the project could be overcome not only by involving beneficiaries in the development of IEC messages but also by the careful introduction of condoms as a secondary option to abstinence and mutual faithfulness.

Behavioral Research

The different motivations for sexual activism among men and women will need to be identified in all the States and understood for each target group or sub-population in order to design appropriate IEC messages capable of motivating behavior change.

CCCD-SPECIFIC IEC

Deficient Health Education/Communication (IEC) Program

Health Education/Communication (IEC) must be perceived as central to primary health care by the decisionmakers and service providers. Primary health care with minimal medication and non-professional service providers is becoming increasingly accepted. Yet it is dependent upon an informed public, capable of limited self-care and ready to request service provision without undue delay.

Too few targeted, health IEC interventions have been developed and those that have been developed are inadequately disseminated and replicated. Too many lost opportunities for education persist. Although health IEC was used to obtain the large EPI turnouts, rarely was the presence of mothers at vaccination sites used as an opportunity to ensure that they knew what the immunizations were for and why or where they should go for follow up. Nor were the mothers adequately advised about side effects.

Health talks at clinic sites are often over-ambitious, containing too much information to be reasonably absorbed at one sitting rather than developing a small portion of information in numerous ways to ensure maximum retention.

Formal Sector Health Care Providers as Educators

The formal sector health care providers must be encouraged to facilitate patient faith in their treatments by explaining the nature of the illness and the rationale for the medication or treatment.

Inadequate Dissemination of New Protocols Among Health Providers

The resistance to introduction of the new, primary health care protocols requires concerted Continuing Education (CE) and Health IEC. Given the large numbers of health workers at all levels in Nigeria, IEC may be more effective than relying on CE to communicate with service providers. They may be more likely to learn the modern protocol during a campaign in which they are training NGO trainers. However, in addition to IEC, service providers also need practical experience of the efficacy and superiority of the new protocols to the former, modern health practices. Notification of the protocol changes is insufficient.

Immunization Card as a Reminder

Redesign of the immunization card should be possible to ensure its usefulness as a reminder to the mother rather than merely serving as a document required in order to obtain the immunization.

FORMAL EDUCATION

The Largest, Captive, Mass Audience: Primary School Children

School systems provide a **captive, mass audience**; fourteen million children are currently attending primary school. Schools facilitate annual reinforcement of extended messages to instill comprehension of the messages and their rationales. Classrooms provide the opportunity to impart basic information that can facilitate comprehension of and receptivity to mass media, IEC messages. Failure to provide students with health information represents a lost opportunity.

The "prime messages" in the UNICEF/WHO/UNESCO publication Facts for Life should constitute the basis for the Health syllabuses. The syllabuses should be developed with the prime goal of ensuring retention of IEC messages. Although an educational program which fulfills the important goals of instilling belief in microscopic disease causation and the basic scientific method is needed at both primary and secondary school level, such an ambitious project should not be allowed to interfere with the IEC goals of primary school, health education. The Health syllabuses should be designed to maximize retention of **minimal, core messages targeted at school leavers** at each level rather than to provide the best students with an excellent health education.

Donors should pressure government at all levels to incorporate more effective Health Education as a required subject in the curriculum at all levels. Health is already in the primary school curriculum; however, it is relegated to a minor role, inappropriate to its importance for primary school leavers who constitute the vast majority of the primary school population. Health educators in Niger and Osun States indicate that government needs to do more to promote school health education. Short and long term benefits of in-school education for children include: (a) learning about prevention and control activities, (b) learning how to introduce and reinforce health messages for their parents, and (c) acquiring some health literacy which will facilitate retention of IEC messages received in the future.

The Greatest Obstacle to Effective, In-School IEC: The Teachers

The teachers are the greatest obstacle to effective, in-school Health IEC. They are unmotivated and demoralized by low and irregular pay, excessively large classes, lack of appropriate textbooks and poor facilities. Yet teachers are the major medium of dissemination of IEC within the school systems. To transform the teachers into a modern, Health IEC medium using modern, participatory teaching methods would require an enormous, pre- and in-service education program. Thousands of teachers in the more than thirty thousand primary schools throughout the nation would have to learn new teaching methods and new health information.

Modern methods have been taught to teachers in pre-service education programs since Independence, but they are rarely used in the classroom. Instead, teachers develop lesson notes which are copied on the board for students to copy into their exercise books. After copying, the students memorize the information and reproduce it during exams. This methodology has become the centerpiece of the educational system to the extent that publishers have begun publishing lesson notes for exam preparation. As soon as teachers are hired into the Nigerian educational system, they discard the modern methods they perfected in teaching practice.

Change the Text Rather Than the Teacher and the Method

To be immediately effective, the teaching methodology should follow the existing practice: To minimize the behavioral change required for in-school Health IEC, the prevailing rote-learning method, based on lesson notes copied onto the board should be adopted. If teachers are given the lesson notes, it will be easier for them to impart the health messages than to teach other items in the syllabus. Practical exercises, such as preparing SSS, should be encouraged. However, message development should recognize the constraints in the most disadvantaged primary schools. Consequently, the messages should be designed to be transmitted without the benefit of practical exercises and role playing. Despite glaring deficiencies and an outmoded teaching method, considerable information is currently imbibed by the masses within the schools. More information could be retained if the syllabuses were less ambitious. At the moment, the syllabuses are more ambitious than the foreign syllabuses.

Health Education Incorporated into Adult Literacy

The Bauchi State Literacy Project funded by UNFPA as well as several other literacy projects are incorporating health education including child spacing into their literacy materials. This initiative should be actively replicated.

Teenage Reproductive Health Brochures for the Moralistic Viewpoint

A reconsideration of the function of schools in behavioral change and the immediate, effective utility of the schools as part of IEC strategy indicates the urgency of instituting a constrained, reproductive health education program. A program with minimal goals, it can have a widespread, immediate reach targeting each and every school child. Simultaneously, gradual efforts to improve the quality and spread of the Population/Family Life Education (POP/FLE) curriculum should continue.

Parents and religious leaders promote abstinence outside of marriage and fear that knowledge of sex and contraceptives will induce children to engage in premarital sex. Parents, religious leaders and educational authorities oppose premarital sex because of its immorality and the loss of status associated with breaking the societal standards. They also oppose premarital sex because of the sex diseases that can be acquired, because of consequences of a mistimed pregnancy, because of the possibility of recourse to abortion, and because of the possibility of infertility resulting from an undiagnosed sex disease or a botched abortion. All these are good, health reasons.

A mass education, reproductive health brochure responsive to the prevailing moralistic values and pragmatic concerns can address parental and religious concerns without specifically describing the sexual act or the condom as a safer sex tool. The sexual act can be left, for the time being, inadequately treated in biology class and the condom can be promoted over the air waves. A responsible, minimalist reproductive health education brochure promoting abstinence and describing the negative consequences of premarital sex might immediately be acceptable for use by religious groups and ultimately also prove acceptable for use by school teachers as an supplement or alternative to the POP/FLE curriculum and materials.

Information can be imparted regardless of the quality of the teacher or the methodology if that information is well presented in a written form in a standard and simplified English versions as well as in the local languages regularly read by the targets.

Such a minimalist strategy should be complemented by publication of a teenage brochure with a less negative and more explicit approach to sexuality.

The Constraints to Intervention Receptivity Arising From Low Enrollment, Especially Female Enrollment, in Formal Education

Because of the dependence of the health interventions upon both knowledge and faith in science and empowerment, lack of education limits receptivity to interventions. Thus, low enrollment in formal education affects all three projects. Primary education is reaching fourteen million pupils a year; however, this is only half of the target population. Only about two-three million students proceed to at least some secondary school. Furthermore, the rural illiteracy rate is twice as high as the urban rate.

In 1989 only 44.8% of eligible females were enrolled in primary school out of a total enrollment rate of 63.1%. Although female enrollment in the educationally advantaged southern states like Anambra, Ondo and Bendel was comparable to male enrollment, figures for some "educationally disadvantaged" states were as follows: Bauchi 39.2% (which has a large Christian population); Kano 34.9%; and Sokoto 29.6%.

Female education significantly affects maternal care which is generally poor and variable. For example, women with secondary education received tetanus toxoid injections for seventy-two percent of their births, while only forty-two percent of births to women with no formal schooling benefitted from this preventive treatment. Similarly, antenatal care was provided by a trained healthworker for ninety-one percent of births to women with secondary schooling, but only forty-four percent of births to women with no schooling.

To date, enrollment in an educational institution has been virtually the only way to postpone early Muslim marriage. Its effectiveness is attested to by the correlation between the slight rise in marital age in the North with the period following the leadership of Murtala Mohammed (a highly respected Head of State with a Kano mother who was assassinated early in his rule six month rule in 1976) who enforced a decision that girls must not be withdrawn from school for marriage.

Operations Research to Test Innovative Programs for Retaining Children, Especially Female Children in School

Constraints to female school enrollment in the Far North derive partly from maternal need to benefit from the labor of their daughters to hawk their wares since the Muslim mothers are secluded. Constraints to rural enrollment derive partly from parental need to benefit from the farm labor of their children on a seasonal basis. Operations research should examine innovative timetables with shortened primary school days and/or varied primary school vacations. If deemed necessary, lost time can be compensated for by additional years required for primary school completion.

DISSEMINATION OF RESEARCH FINDINGS

Donor Support for Research

While research may seem a luxury, it is well worth the expense if it contributes to program needs. Because of the possibility of continuing ethnic imbalance among researchers and program implementers, concerted efforts should be made to support the professional growth of Nigerians among the less represented ethnic groups.

Inaccessibility of Donor-Supported Research Findings

The inaccessibility of research findings (donor supported operations research as well as unsubventioned academic research) to Nigerian researchers and scholars severely inhibits research

productivity. Failure to ensure adequate dissemination of research results is wasteful of resources and undermines efforts to institutionalize research.

The current practice of providing a sum for publication and dissemination of research is ineffective. Most research findings are not in Nigerian libraries. Most journals are more than a year out of date and many are several years out of date. Moreover, even old issues of foreign journals with important articles on Nigeria are frequently not on the shelves.

AID-funded documents are also difficult to locate and photocopy. Some documents are missing including the background papers for the 1987 Social Soundness Analysis and several CCCD Operations Research papers although reportedly on file at the Mission Office and at the Ministry of Health, respectively. The FHS library is extremely helpful and merits continued use as a Clearinghouse. However, the lack of an accessible photocopy machine significantly increases the opportunity costs of using the facility. Although the AID-funded MEDLINE service at Yaba has the capacity to identify important articles on Nigeria related to the CCCD intervention, only seven out of thirteen are available in Lagos. The only practical way of obtaining the other articles is to travel to the universities throughout the country where they are available, according to MEDLINE.

Donor Dissemination of Research Findings

Efforts to ensure institutionalization of Nigerian library capacity to store and retrieve journals and documents should continue; however, in the near term they should be backed up by expansion of the responsibilities of donors for direct dissemination of research findings and of the role of the HIIC Library. Donors should require a minimum of five copies of research findings to be distributed to the HIIC Library and important Nigerian libraries including the National Library, the main academic library in the state of the research site, and others to be determined. In order to rapidly expand the resources of the HIIC Library and to take advantage of cooperating agency consultants' knowledge, each consulting team should be required to submit a photocopy or original of each document or publication cited (unless already in the library) in their own document. The HIIC Librarian should be required to attest to compliance with this condition prior to final payment with the proviso that the AAO or his representative may exempt some documents or publications at his discretion.

A Journal of Nigerian Family Health would facilitate the development of quality lecturers for pre-service training by ensuring better lecturers for all programs. Lecturers are hindered by the necessity of publishing for promotion and the paucity of regular journals. In order to exist, Nigerian journals require the authors to pay per word in order to cover costs. Support for the journal would also contribute to dissemination of knowledge, improvement of academic standards, and identification of researchers.

V. PROJECT IMPACT

The three project interventions are designed to induce behavioral change among both beneficiaries and participants. Extensive intervention progress has already been made by FHSI and CCCD as well as by isolated NGO-funded HIV/AIDS activities. Future progress will depend upon behavioral change of groups of people as well as individuals.

Unorchestrated spread of project interventions across states and ethnic groups is improbable, and unlikely without interventions involving technical assistance and social mobilization especially because the visibility of most benefits is delayed. Leadership of religious groups may recognize benefits and

mobilize across state lines. Some government officials and private sector organizations including NGOs have already initiated activities; however, large scale replication comparable to project intervention is unlikely without federal government and/or donor funding of specific interventions. Nevertheless, the projects provide considerable training to participants generating a cadre of professionals with a stake in intervention continuation beyond the life of the project. Personal satisfaction with the results of modified behaviors will sustain the project benefits for those who are capable of purchasing them from the private sector.

Project interventions requiring only modified, traditional behaviors and methodologies rather than fully modernized behaviors and methodologies are more likely to be integrated within the participant and beneficiary population and, hence, more likely to be replicable and sustainable.

The benefits of all three projects will reach Nigerian families by focusing on women and children; however, men will be increasingly targeted for the family planning and HIV/AIDS interventions. However, the projects will not ensure equitable distribution of benefits uniformly across the entire country nor across all ethnic groups. For NCCCD, twelve LGAs have been selected as the initial project sites with replication plans for sixty LGAs throughout the life of the project. These LGAs are located within nine focus states which are distributed throughout the four health zones. A similar focus state approach will be taken with the FHSII project to maximize impact. AIDSCAP has targeted urban areas in three out of the four zones. Both FHSII and NCCCD interventions will impact rural as well as urban areas and AIDSCAP also has the potential to expand to rural areas.

Because the HIV/AIDS epidemic has already reached the rising exponential phase, the limited geographic focus of the AIDSCAP intervention will be incapable of significantly slowing down the epidemic. Furthermore, unless virtually all members of society choose to practice mutually faithful sex and/or safer sex for health, religious and/or ethical reasons, the AIDS epidemic will spread throughout the nation, the pace of spread having merely been slowed down by the project components.

VI. ISSUES IMPACTING ON PROJECT SUCCESS

Throughout the evolving life of each project, attention to the considerations below will influence project success and the degree of positive impact each will have on the target population:

Programmatic Concerns

1. The scope of the evaluation of process and outcome indicators should include quality as well as quantity; omission of quality indicators may result in poorly designed (irrelevant, inappropriate) project activities which waste essential funds and delay intervention success.
2. Deliverables for cooperating agency work plans should be clearly linked to the central project goals as well as linked to their training or institutionalization goals to ensure proper focus.
3. Work plan design and implementation should be sensitive to the dynamics of ethnic, religious and gender differences, prejudices and mistrust among beneficiaries and participants.
4. Concerted effort must be made to ensure that participants are representative of the ethnic, religious and gender differences in Nigeria. An ethnic, religious and gender disaggregated

list of Nigerian counterpart researchers, cooperating agency personnel and the educational institutions producing such personnel is essential to identify the underrepresented groups.

5. Successful interventions rely on continually evolving, expensive, technical expertise; however, funding to the requisite levels is impossible given the magnitude of the problems. Consequently, the development of local agencies providing technical expertise is essential.

Project "Ownership"

6. Concerted efforts must be made to ensure that participants develop a sense of "project ownership". Otherwise, participants will remain uninvolved with a casual attitude towards work. Believing that credit for the project successes will be claimed for others, they refrain from offering suggestions for improvements.
7. Local professional, technical assistance contractors should be promoted to create more stakeholders. They will also contribute to replicability and sustainability. NGO institutionalization should focus on NGOs that function (or are willing and suitable for the requisite modification) as technical assistance contractors. They should provide technical assistance to implementing bodies. Unlike many implementing NGOs, they require at least a core of professional staff to ensure sustainability and replicability.
8. To ensure ownership and counteract fears of Western political, economic and religious repression, introduction of child spacing to Islamic groups should be done by members of each Islamic target group. Similarly, promotion of female education and delayed marriage should be handled by Muslim groups.
9. Concerted efforts must be made to accept participant advice with respect to local cultural practices. For instance, donor reluctance to recognize the legitimacy of representational expenses (beer for informants or gifts for traditional rulers) is counterproductive. For the sake of the project, participants are forced to fund these expenses themselves even though they are substantial from the standpoint of their earning power.

Pragmatic, Constrained Indicators

10. In order to be sustainable and replicable, interventions must be pragmatic. They must have constrained indicators which are realizable in stages and require only minimal changes on the part of both the participating implementors and the targets.
11. Work plans must take full cognizance of the enormity of the behavioral changes being required when new behaviors are combined with new intervention methodologies. Methodologies which rely on individual decisionmaking and values clarification rather than on the standard communal and/or authoritarian decisionmaking, expect the targets to innovate on two levels. Not only are they expected to carry out the new behavior, they must also take personal responsibility for the innovation and its possible negative consequences.

Sustainability and replicability of the POP/FLE curriculum in the school systems may seriously be hampered by the intervention methodology itself. The teachers are not only expected to promote responsible parenthood even though the society has not yet accepted the message; they are also expected to develop innovative lesson plans. The POP/FLE curriculum was designed to be introduced with modern methodologies involving student participation, inquiry and values clarification. These innovative methodologies contradict the prevailing belief that students should obey their elders implicitly.

12. Operations research should clarify the clients' counselling preferences. Nigerian clients may prefer authoritarian counselling based on medical advice as opposed to values clarification counselling for selection of family planning methods. The successes of counselling may be based on needed improvements in basic human relations techniques rather than on client desire for a choice.
13. Minimal, modified/traditional, behavioral changes must be identified and pursued as interim intervention goals. Minimal behavioral change provides a wedge away from traditional practices and puts people on track for more extensive behavioral change. Minimal behavioral change also has greater potential for replicability and sustainability.

For example, adoption of the relatively inefficient "safe period" contraceptive method constitutes an active, self-reinforcing conjugal effort to control birth while maintaining sexual relations. Promotion of this method along with other methods provides couples with a method involving the familiar, traditional abstention while permitting co-habitation and sexual relations. Simultaneously, the couples learn about more effective methods which they will increasingly adopt but which may constitute too great an immediate behavioral change for the majority.

14. Minimal behavioral changes are especially important as indicators for interventions moving beyond the innovator stage with its dependence upon isolated, individual decisions and into the peer-group requestor stage which is dependant upon the majority opinion. Since the majority of individuals are unwilling to distinguish themselves from their peer-groups, intervention success is dependent on mobilizing whole peer-groups.

Behavioral modification within a group requires bringing along the vast majority of the members; therefore, a wide range of gradual changes or "constrained deliverables" should be sought depending upon the sociocultural beliefs of the groups. Within a God-fearing, pronatalist, fatalist environment, some NGOs will only be willing to use non-technological interventions. For these groups, technological interventions may seem presumptuous or sinful but they may be convinced to promote systematic use of the Safe Period (rhythm method). Some will be ready to combine Safe Period with withdrawal or even condoms. In any case, eradication of the prevailing ignorance about the female menstrual cycle is a worthy deliverable that may ultimately serve to make marital, condom use more palatable.

IEC

15. IEC must respond more to the Nigerian (a) need for consensus, (b) respect for authority, (c) capacity to read, (d) lack of information, (e) and, governmental inertia. The audiences must be targeted within the context of their peer-groups by influentials and authority figures. Government information campaigns offer the possibility of mobilizing people and resources for urgent, high profile interventions which would otherwise not take places. To fill the information gap, brochures and flyers with considerable information must be available for different levels of education. Simultaneously, standard mass media interventions should continue.
16. The prime targets for IEC should be individuals within the context of their significant peer-groups. The vast majority of Nigerians are discomfited by innovation and prefer to modify their behavior with the approval of their peers or influentials. Targeting peer-group audiences, rather than individuals, allows the interventions to capitalize on the Nigerian

preference to minimize the discomfort arising from taking responsibility for an innovative, unsanctioned behavior.

17. **Peer-group audiences** should be reached indirectly through their trusted influentials. Professional health advocacy networkers (HANs) should identify influentials who are receptive and capable of assuming the role of mobilizers for their own peers. The HANs should backstop these influentials providing them with information and assisting in the development of a work plan. Minimal funding assistance should be provided for IEC materials.
18. Sensitive behavioral change interventions should focus on those NGOs which perform value-reinforcing functions for their membership (mainly religious and primordial groups).
19. The authority of medical personnel, especially doctors, should be used to reinforce IEC activities.
20. Campaigns are a vital tool for mobilizing government resources. They absolve all concerned from individual responsibility and they facilitate release of government funds to respond to the urgent, high profile project. The recent, unsustainable but successful, EPI campaign should be criticized for its excesses in mobilizing funds and resources, but not for its methodology. They also maximize their impact by targeting individuals within the context of their peer-groups.
21. IEC activities must be prioritized under an overall strategy; however, considerable, diverse operations research activities must be on-going to evaluate alternative activities in response to the diversity of the audience and to the behavioral changes occurring among the audience segments.
22. Health Education/Communication (HE/C) must be perceived as central to primary health care by the decision makers and service providers. Primary health care is dependent upon an informed public, capable of limited self-care and ready to access service providers without undue delay. HE/C interventions targeted to particular sociocultural behaviors must be developed and disseminated and replicated, with the requisite modifications.

High and intermediate level HE/C Nigerian expertise must be assigned central roles in primary health care at all levels.

23. Health messages must respond to the specific knowledge, attitudes and practices (KAP) of ethnic and religious groups as well as to their effective communication channels. For instance, the IEC strategy for introducing ORS into a community that lacks the vocabulary word or concept for dehydration must necessarily differ from the strategy for a community that is aware of dehydration. Similarly, the strategy for a community that favors cornstarch porridge for sick people differs from a the strategy appropriate for a community that favors sour milk.

Behavioral analysis is a vital component of health message development necessary in order to identify a limited number of discrete behaviors to be changed by the majority of the target population. Once realistically achievable behaviors have been identified, the standard IEC message development and testing process can commence.

24. Protocols for rapid intervention specific, health-message development needs to be prepared and adopted within the Primary Health Care (PHC) system. For efficiency, these protocols should be based on fully developed, prototype health messages despite the inevitable limitations of ethnic-specific health messages. The rapid protocols must incorporate measures to correct for ethnic diversity.

Education

25. Pragmatic in-school Health Education responsive to the conditions in the schools should be actively advocated in order to reach the masses who constitute a captive audience within the schools. Student learning materials must be adapted to the prevailing methods of copying lesson notes from the blackboard and memorizing them. In addition, Health Education must be incorporated prominently into the examination systems. Otherwise, the impact of education on the intervention goals will be much less than optimal. Failure to institute pragmatic in-school health education will also restrict project sustainability and replicability.

26. Increased female enrollment in educational programs both in and out of school should be actively advocated.

Operations research should examine diverse methods of increasing enrollment. Shortened school days and/or modified vacation schedules might reduce parental resistance to schooling. Present school schedules conflict with parental need of their children's time and labor to contribute to their own subsistence.

27. Linkage of early marriage and girls education with fertility control is counterproductive in the Muslim North. Most parents are more concerned about protecting their daughters from the real threat of immoral acts since sexual activity is the norm for girls who have attained puberty.

Girls education and delayed marriage both have a significant impact on maternal/child health and merit interventions on health grounds.

28. Instructive brochures constitute an important form of continuing health education for Nigeria's large, literate population. They can fill the information gaps which exist even among the well educated. These gaps undermine project success and contribute to rumors. Brochures and pamphlets can also offer people a comprehensive rationale for interventions and a back-up source of knowledge to refer to should they become interested in an intervention when a health problem arises at a later date.

29. A teenage reproductive health brochure should be prepared for the moralistic viewpoint. A mass education brochure responsive to the prevailing moralistic values and pragmatic concerns about premarital sex can help teenagers to protect themselves. The objectives of the brochure should be minimal; it should promote abstinence and describe the dangers of sexually transmitted diseases. The cooperation of conservative influentials should be sought in its preparation to facilitate use by religious groups and other NGOs.

The Family and Family Planning

30. Interventions that focus on ensuring female self-esteem and economic independence without providing males with similar assistance may contribute to an untimely breakdown of the conjugal family. Similarly, interventions that focus on promoting contraception among women without targeting men risk disrupting the family.

31. Because of their overwhelming influence on the desired behavioral changes, males must be targeted intensively. Interventions should be channeled through male peer-groups, coopting them and allowing them to take the lead rather than forcing them to follow the lead of women or external organizations. Realistic fears of loss of control over the economic and social aspects of their lives prevent many men from seriously considering fertility spacing and limitation.
32. Eradication of the association of contraceptives with promiscuity will free males to approve of spousal use. Legitimization of modern contraceptive use by the peer-group is a vital, goal essential to overcome the prevailing disapproval for religious and ethical reasons.
33. Behavioral research on marital relations and specifically on marital, sexual relations is essential to ascertain their influence on male and female fertility preferences and on patterns of extramarital relations. This research should include an examination of the extent to which extramarital sexual networking is as an alternative to postpartum abstinence (addressable by contraceptives); a response to incompatible sexual relations; a response to peer pressure; and/or other causes.

Research

34. Rapid ethnographic studies (RES) undertaken prior to an intervention are important to identify: (a) relevant attitudes and practices among potential participants and beneficiaries; (b) credible influentials willing to participate; (c) grassroots communication channels; and (d) local role models and "anti-role" models (examples of the consequences of failure to adopt the interventions to be used in interpersonal social mobilization; for instance, victims of polio and AIDS).

It is essential to confirm that leaders are actually representative and credible influentials. Due to the pervasiveness of corruption in Nigerian society, the people's perception of influentials has undergone radical modifications in some areas. The people desire leadership by influentials who are distinguished by their honesty, education, hard work and demonstrated sense of communal responsibility rather than merely by their official positions. The people recognize that officials in religious, primordial and other organizations are subjected to the temptations undermining the wider society.

35. The reliability of research on sensitive, private issues depends on the quality of the research questions and the personality of the researcher. Informants will withhold essential information unless the researcher is able to convey empathy and respect for the informant. Surveys are subject to disinformation, especially when they require an interviewer to record the responses.
36. Research must continue to develop profiles of adopters and non-adopters of the promoted behavioral changes. The profiles should be used to ensure realistic indicators and work plans as well as to provide the basis for the development of IEC messages. Psychological motivations for behavioral change should be considered in developing the profiles.
37. The program significance of increases in contraceptive prevalence among specific populations requires research to explore immediate ways of facilitating replicability. The increased contraceptive prevalence in Bornu following radio spots featuring traditional rulers and the high contraceptive prevalence in Ibadan are among the successes meriting replication.

38. The FHS Library should be expanded into a Health Information Clearinghouse. The HIIC should subscribe to the basic and project-related journals that usually carry articles on Nigeria. A photocopy machine express for the purpose of researchers should be accessible. This would greatly reduce expenses for Nigerians, for whom a day in Lagos is already an expense, and save considerable time (and therefore project money) for American consultants. The possibility of introducing an interlibrary loan type of photocopy service should also be explored.
39. Donors should require a minimum of five copies of research findings to be distributed to the HIIC Library and important Nigerian libraries including the National Library, the main academic library in the state of the research site, and others to be determined.

Financial Issues

40. Further research should be undertaken on cost recovery issues to establish the extent to which: (a) cost inhibits the spread of preventive interventions and causes significant delay in healthcare seeking for the sick child and the pregnant mother; (b) the Bamako Initiative Funding ensures drug availability and is essential as a sustainable funding source; (c) withdrawal of free drugs and especially free contraceptives is counterproductive to maximizing health care delivery; and (d) the influence of the people's will on LGA politicians can be exploited by requiring the allocation of LGA health funds on some sort of quasi-matching grant basis.
41. Measures must be designed to ensure that the poor are not deprived of intervention benefits. These measures must take into consideration the ethnic and religious diversity among LGA communities and within grassroots populations in urban and peri-urban areas.
42. Operations research should explore alternatives to donor vehicles including the viability of transportation allowances for supervision and local, private sector contracts for commodity transport.
43. Nigerian consultant fees and cooperating NGO personnel salaries require a thorough reassessment with a view to possible upgrading. Sustainability for any project requires not only that the salaries are not so high that they can not be sustained after the life of the project but also that they are competitive with salaries of competent, creative individuals with experience and initiative. Where Nigerians are working for and with an American CA, project-driven salary raises should be considered for the Nigerians as well as for the Americans.
44. The involvement of the private sector should be expanded to include more contract work with non-profit and profitmaking technical assistance organizations, research organizations, advertising houses and media businesses.

The Private Sector

45. The private sector should be called upon for assistance in the development, production and distribution of social advertisements. Existing companies possess the expertise and the equipment to fulfill these tasks on a contractual basis. Cooperation between the public and private sectors in these areas should be actively encouraged.
46. Private sector donations to intervention activities and NGOs carrying out intervention activities should be actively pursued for the funds themselves, for visibility, for sustainability

and for replication. Public perception that all problems are being solved by international donors impedes private sector interest in public service support.

Requests are expected and honored by wealthy individuals and companies, often in a public context such as a launching. Public service broadcasting has supported several television series including Roots. Some Nigerian companies report enormous profits and a small group of Nigerians have become enormously wealthy. Banks and multinationals enjoy considerable profits. Oil companies are committed to the social welfare of the environment where their wells are located.

AIDS Prevention and Control

47. Concerted efforts to ensure minimal delay in NGO participant efforts to replicate AIDSCAP model work plans, even at the expense of quality replication, and to assist the NGOs in securing funding from local sources including affiliates of American oil and other multinationals will maximize AIDSCAP impact.
48. The State AIDS Programs can broaden the geographic spread of prevention and control interventions. Selected officials should be included in training workshops for NGOs to facilitate effective expenditure of allocated Nigerian government funds.
49. The AIDSCAP goal of "partner reduction" requires greater specificity in the African context where extra-marital sex is expected of husbands. While partner reduction as a goal encompasses pre- and extra- marital sex, since the vast majority of men and women are married, it is basically a non-judgmental euphemism for "mutual marital fidelity". Partner reduction remains appropriate for targeting pre-marital groups and extremely active, sexual networkers as well as serving as a backup to marital fidelity.
50. Activities designed specifically to overcome the lack of mutual marital faithfulness include promotion of the FHSII goal of increased, marital contraceptive use as an alternative to marital abstinence and promotion of the NCCCD goal of eradication of female circumcision with its negative consequences for mutually pleasurable sexual relations.
51. The general, sexual networking population requires targeted HIV/AIDS prevention IEC messages and behavior change support mechanisms in an effort to minimize the proportion of this group that continues risky sex with awareness but in denial.
52. A rapid ethnographic study to establish the extent and locales of itinerant commercial sex worker (CSW) activity in relation to rural markets where the peasants become clients of CSWs should be undertaken immediately. If the survey confirms that itinerant CSWs are spreading the disease throughout substantial areas of rural Nigeria, a modification of the CSW intervention strategy should be devised to cope with this non-residential, activity.
53. Given the sensitivity of the HIV/AIDS prevention project in Kano and Jigawa states, reliance on local personnel to direct the project and the involvement of indigenous groups and individuals in key program components is essential. The project in Kano should be coordinated by a male, indigenous program officer. A female, married woman would in all likelihood experience restrictions from her husband and male relatives on access to male policy-makers and CSWs, while a single unmarried woman might be stigmatized and looked upon as morally wayward and deviant.

54. Counselling is an important aspect of preventive medicine which, to be effective, must be followed up by tracking and counselling of the tracked partners. This is especially important to prevent the epidemic from infecting spouses and children who cannot otherwise protect themselves. Furthermore, protection of the familial fabric contributes to protection of the terminal health care system in a nation where no governmental or other forms of insurance cover nursing care.
55. Tracking should become an integral aspect of prevention and control. Persons With AIDS (PWAs) may have had many sexual partners who themselves are continuing to infect others without realizing that they are carrying the infection. Tracking is also essential in order to ensure that the caretakers during the terminal stages learn how to control potential infection from contaminated fluids.
56. Research is needed to establish the roles of traditional health care providers in the handling of STDs including HIV/AIDS. The possibility of establishing a system of identification and referral of HIV infected/STD cases from the informal to the formal health sector and the possible role of traditional care providers in community based counselling services must also be considered.

VII. CONCLUSION

Sociocultural factors are central to all three project interventions and will influence their degree of success.

To a very great extent, all three projects demand a personal and societal reevaluation of core values and self-image including changes in private behaviors; faith in the microbe theory of illness; deviation from existing moral authority; belief in the ability to control nature with scientific rather than occult powers; and, rejection of a pro-natalist and fatalist worldview.

This is particularly true for the family planning and HIV/AIDS projects which include behavioral changes actively opposed by large segments of the population; however, sociocultural factors will also impinge upon the success of the maternal/child health project. All three projects require that the beneficiaries be sufficiently convinced of the importance and utility of the health promoting behaviors being advocated and the services being offered to modify their personal behaviors and to come forward for the services despite competing beliefs and priorities.

The requisite behavioral change will take place only as a result of intensive and varied IEC initiatives. The support of credible influentials will be essential. These will often, but not always, include doctors and other medical personnel as well as traditional rulers, religious leaders and, in some instances, political leaders who can legitimize the requisite behavioral modifications. Given the prevailing authoritarian and communal socialization processes, the greatest IEC impact will occur when messages are received within the context of peer-groups.

Because of the vastness of the country and the multiplicity of ethnic groups and modified/traditional attitudes and practices impinging on the success of the interventions, rapid ethnographic studies must supplement epidemiological studies and operations research. The results of these studies should be transformed into specific implementation plans with the assistance of the participants and beneficiaries.

VIII. SELECT BIBLIOGRAPHY

AID. 1990 - 1991. African Child Survival Initiative Bilingual Annual Report.

AID. 1991. Nigeria Health & Population Sector Assessment, Sector Assessment Team. Prepared by D. Gibb et. al.

AID. 1991. Nigeria Polio-Plus: Social Mobilization Grant Final Evaluation, Federal Ministry of Health.

AID. 1991. Nigeria Subsector Background: Diarrhea/Cholera. Prepared by PRITECH, HEALTHCOM, ADR.

AID. 1991. Review of Nigerian Nutrition Sector. Prepared by H. Sukin and R. Essama.

AID. 1991. Vector Borne Diseases and Control Efforts in Nigeria.

AID. 1992. FHS Project, Policy and Evaluation Division: Strategic Planning Workshop Report, Ile-Ife, Nigeria. Prepared by Stella Goings.

AID. 1992. Institutional Assessment of the Planned Parenthood Federation of Nigeria. Prepared by Olabisi Olatokunbo, Mary McGovern, Ernest Petrich, Olabisi Olatokunbo and Eugene Weiss.

AID. 1992. Measles Initiative: Initial Planning Visit. Nigeria: Robert Clay, Stewart Blumenfeld, Robert Steinglass, Caby Verzosa.

AID. 1992. Policy Analysis of the Nigeria Demographic and Survey 1990. FHS, DHS, FOS/Nigeria, JHU, and USAID.

AID. 1992. Strategy for the Private Provision of Health and Family Planning Services in Nigeria. Prepared by J.B. Tomaro.

AID Affairs Office/Lagos. 1992. Nigeria: Country Program Strategic Plan (CPSP) 1993-2000.

AID - AFR/TR/HPN: Atlantic Resources Corporation. 1992. Sustainability Assessment of the Africa Child Survival Initiative (ACSI) Combatting Childhood Communicable Diseases (CCCD) Project, Nigeria.

AID/RH. 1992. Population and Health in Nigeria: An Assessment Based on Recently Available Survey Data. Prepared by J. Chao.

AID/POPTECH/The Futures Group. H. Destler, D. Liberi, J. Smith, and J. Stover. 1990. Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties. Family Planning Services Division.

Abdullahi, Rahmatu. 1986. Self-Concept and Cultural Change Among the Hausa. Ibadan: Ibadan University Press.

-----, ed. 1988. The Muslim Woman: Challenges of the 15th Hijra, by the Muslim Sisters Organisation of Nigeria.

Aborisode, Oladimeji. 1985. Local Government and the Traditional Rulers in Nigeria. Ile-Ife: University of Ife.

Adamchak, D.J. and A. Adebayo. 1987. Male Fertility Attitudes: A Neglected Dimension in Nigerian Fertility Research, *Social Biology* 34 (1-2) 57-67.

Adebayo, A. 1988. The Masculine Side of Planned Parenthood: An Explanatory Analysis. *Journal of Comparative Family Studies* 19 (1): 55-67.

Adeniyi, J.D. and O. Oladepo and I. Olaseha. 1991. Literature Review for Audience Research. JHU/PCS Project. By Priestman Group of Consultants, African Regional Health Education Centre, Department of Preventive and Social Medicine, College of Medicine, University of Ibadan.

Adeokun, Lawrence, A. 1983. Chapter 8: Marital Sexuality and Birth-Spacing among the Yoruba, in Christine Oppong, ed., *Female and Male in West Africa*. London: George Allen & Unwin, 128-137.

Adewuyi, A.A. 1987. Intergenerational Change in Family Size Among the Urban Residents in Ibadan, Nigeria. *Census. January-June*; 43 (1-2): 121-32.

Adigun, I.O., I.M. Olusanmi, E.O. Ishola, G.A. Orokiomle and E.A. Oke (Co-ordinator) 1989. Formative Research on Knowledge, Attitudes, Practices and Media Habits Related to EPI in Oyo State. Research (89/007) sponsored by CCCD Nigeria, HealthCom and the Oyo State Ministry of Health.

Aina, Tade, Florence Ebam Etta and Marian, F. Zeithin, eds. 1992. *Child Development and Nutrition in Nigeria: A Textbook for Education, Health and Social Service Professionals*. Lagos: Federal Government of Nigeria and UNICEF.

Afonja, Simi and Tola Olu Pierce. 1984. *Social Change in Nigeria*. Essex, England: Longman Group Ltd.

Akinnare, M., et. al. 1992. *Child Care and Development in Nigeria: A Profile of Five UNICEF Assisted LGAs*. Draft.

Ampofo, K. 1987. Attitudes Towards Family Size and Family Planning Among Women at an Antenatal Clinic in Maiduguri, Nigeria. *Biology and Society*. December; 4 (4): 183-98.

Ayo, Dele, Kenneth Hubbell, Dele Olowu, Elinor Ostrom and Tina West. 1991. *The Experience in Nigeria with Decentralization Approaches to Local Delivery of Primary Education and Primary Health Services*. Prepared for USAID.

Babalola, Stella, O. 1987/88. Economic Recession and Changing Fertility Preferences. A Case-study of Ile-Ife, Nigeria, *Quarterly Journal of Administration* (Oct./Jan.): 69-83.

-----, 1991. The Effects of Urbanization on Fertility in South-West Nigeria: explanatory role of the proximate fertility variables. A CODESRIA, Dakar supported research paper, October, pp. 1-20.

Barett, David, B. ed, World Christian Encyclopedia, pp. 527 & Table I: Religious Adherence in Nigeria.

Barker, G. and S. Rich. 1990. Adolescent Fertility in Kenya and Nigeria, The Center for Population Options Report of A Study Tour, June - July.

Brownlee, Ann. 1990. Breastfeeding, Weaning & Nutrition: The Behavioral Issues. Behavioral Issues in Child Survival Programs: Monograph Number Four. USAID.

Caldwell, John C. and Pat Caldwell. 1987. The Cultural Context of High Fertility in Sub-Saharan Africa, Population and Development Review, 13 (3):409-435.

-----, John C., Pat Caldwell and Pat Quiggin. 1989. The Social Context of AIDS in Sub-Saharan Africa, Population and Development Review, 15 (2).

-----, John C., Pat Caldwell and I.O. Orubuloye. 1991/2. Changes in the Nature and Levels of Sexual Networking in an African Society: The Destabilization of the Traditional Yoruba System. Sexual Networking Group Report.

Callagy, Thomas M. 1992. Democracy and the Political Economy of Restraint and Reform in Nigeria. Paper prepared for the Project on "Economy, Society and Democracy."

Callaway, Barbara J. 1987. Moslem Hausa Women in Nigeria: Tradition and Change. Syracuse: University Press.

CCCD. 1990. Cluster Survey on Neonatal Tetanus, Kano. Prepared by C.O. Eregie, and G. Ofofwe.

Coles, M. Catherine and Entivisle, Barbara. 1990. Demographic Surveys and Nigeria Women. Signs: Journal of Women in Culture and Society, Winter, 15 (2) 259-261.

CCCD. 1991. Final Report: Acute Respiratory Infections in Nigeria: Results of a Focused Ethnographic Study, Ile-Ife, Nigeria. Prepared by R.P. Wilson, S.A. Asem, B. Adetoro.

CCCD. 1992. Annual Report, 1991 - 92.

CCCD. 1992. Baseline Information on Acute Respiratory Infections (ARI) in Ife Central LGA. Prepared by Egunjobi, Layi and Doyin Fagbule.

CCCD/Health Com Nigeria. 1989. Formative Research on Knowledge, Attitudes, Practices and Media Habits Related to EPI in Oyo State. Prepared by I.O. Adigun, I.M. Olusanmi, E.O. Ishola, G.A. Orokunle.

CCCD/USAID. 1991. Nigeria Bulletin of Epidemiology. Federal Ministry of Health, Lagos.

Dean, S. Gilliland. 1986. African Religion Meets Islam. Lanham, MD: University Press of America.

Destler, Harriet, Dawn Liberi, Janet Smith and John Stover. 1990. Preparing for the Twenty-First Century: Principles for Family Planning Services in the Nineties. Washington, D.C.: Family Planning Services Division, Office of Population, USAID

Ejembi, C.L. and Abayomi Bandipo. 1990. Fertility Pattern and its Determinants Among Rural Hausa Communities in Zaria Environs. Department of Community Medicine, Ahmadu Bello University, Zaria.

Ekwempu, C.C. and D. Maine, M.B. Olorukoba, E.S. Essien and M.N. Kisseka. 1990. Structural Adjustment and Health in Africa. *Lancet*, 336:56-57.

Eregie, Charles O. and Gabriel Ofofwe. 1990. Cluster Survey on Neonatal tetanus: the Magnitude and Epidemiology in Kano Metropolis, Northern Nigeria, Unpublished CCCD Research Grant.

Feyisetan, Bamikale. 1987+. Postpartum Sexual Abstinence, Breastfeeding, and Childspacing, Among Yoruba Women in Urban Nigeria, *Social Biology* 37 (1-2) 110-127.

----- and Anne R. Pebley. 1989. Premarital Sexuality in Urban Nigeria, *Studies in Family Planning*, 20 (6).

Frank, O. 1987. The Demand for Fertility Control in Sub - Saharan Africa, *Studies in Family Planning* 18 (14).

Farooq, Ghazi, M. and Lawrence A. Adeokun. 1976. Impact of a Rural Family Planning Program in Ishan, Nigeria, 1969-72. pp. 158-169.

Faruk, Alhaji Usman. 1988. Family Planning: The Islamic Viewpoint. Nigeria: Paragon Printers and Publishers.

Federal Office of Statistics (FOS)/Nigeria. 1992. Preliminary Report of Family Planning Survey, June & September 1992, National Integrated Survey of Households. In press.

FHS, DHS, FOS/Nigeria, JHU, and USAID. 1992. Policy Analysis of the Nigeria Demographic and Health Survey 1990.

FMOH (FMSS). 1990. Guidelines for Malaria Control in Nigeria.

Gbolahan, A. Oni and James McCarthy. 1990. Contraceptive Knowledge and Practices in Ilorin, Nigeria 1983-88. *Studies in Family Planning* 21 (2).

Goings, Stella A. J., Marjorie Pollack, Kathleen McDavid and Aissetou Lo 1992. Nigeria Sustainability Assessment Report. Prepared for AID Affairs Office/Lagos.

Guyer, J.I. 1992. Representation Without Taxation: An Essay on Democracy in Rural Nigeria, 1952-1990. *African Studies Review* 35 (1): 41-79.

Health Com. 1988. Communication for Child Survival. Prepared by M.R. Rasmuson, R.E. Seidel, W.A. Smith, E.M. Booth.

Health Com. 1988. Communication for Child Survival: Field Note Immunization Coverage in Niger State. Prepared by J.A. McDivitt, P.S. Yoder and C.P. Koepke.

Health Com. 1991. Communication for Child Survival: Final Case Study Evaluation Report. Prepared by P. S. Yoder, and A. Oke.

HERDS. 1990. Primary Health Care System Appraisal in Local Government Areas in Nigeria. Additional Information from Analysis of Survey Data from Two LGAs.

HERDS. 1992. Implementation of the PHC Policy at the LGA Level in Nigeria.

Inter-African Committee (Nigeria). 1992. Your Task Health Magazine: The Magazine of the Inter-African Committee (IAC) Nigeria on Harmful Traditional Practices, 1 (2).

IRD/Macro Systems. 1990. Fertility & Family Planning Results from the Nigerian DHS, prepared for AID/AFR and USAID.

IRD/Macro Systems & Federal Office of Statistics. 1992. Nigeria: Demographic and Health Survey 1990.

Isiugo-Abanihe, U.C. 1990. Characteristics of Family Planning Innovators in Nigeria: Implications for the National Policy on Population. Final Report submitted to the Social Science Council of Nigeria and Ford Foundation.

Jackson, Cecile. 1977. Women's Roles and Gender Difference in Development: The Kano River Irrigation Project.

Jalingo, Ahmadu Usman. 1980. The Radical Tradition In Nigeria, Ph.D. dissertation, University of Edinburgh.

Kim, Young-Mi et. al. 1992. Improving the Quality of Service Delivery in Nigeria. Studies in Family Planning, 23 (2):118-127.

Kisekka, Mere. 1992. Women's Health Issues in Nigeria.

Lapido, O.A. et. al. 1990. Family Planning in Traditional Markets in Nigeria, Studies in Family Planning 21 (6): 311-321.

Makinwa-Adebusoye, P.K. 1991. Adolescent Sexuality/Fertility in Nigeria: A Study of Five Cities. NISER Monograph Series No. 3. Ibadan: NISER.

Makinwa-Adebusoye, P.K. 1992. Chapter 4: Women at Risk, in Policy Analysis of the Nigeria Demographic and Health Survey 1990.

Nnoli, Okwudiba. 1980. Ethnic Politics in Nigeria. Enugu: Fourth Dimension Publishing Co. Ltd.

Nichols, D., et. al. 1986. Sexual Behavior, Contraceptive Practice and Reproductive Health Among Nigerian Adolescents, Studies in Family Planning, 17 (2).

-----, O.A. Ladipo, John M. Paxman, and E.O. Otolorin. 1983. Sexual Behaviour, Contraceptive Practice, and Reproductive Health Among Nigerian Adolescents, *Studies in Family Planning* 17 (2) 100-106.

1990. *Nigerian Medical Practitioner*, Editorial 19:62.

Ogunbekun, Ibukun-Oluwa O. 1991. Which Direction for Health Care in Nigeria? *Health Policy and Planning* 6 (3):254-261.

Okafor, C.B. 1991. Availability and Use of Services for Maternal and Child Health Care in Rural Nigeria. *International Journal of Gynecology and Obstetrics* 34:330-332.

Oloko, B. A. 1990. Secondary Polygyny: Patterns of, and Reactions of, Educated Nigerian Women. A paper presented at the Sexual Networking, NISER, Ibadan, 22-23 March.

----- and A.O. Omoboye. (c. 1991) School Characteristics and Sexual Networking Among Some Lagos State Adolescent Yoruba Students. (TypeScript).

Olukoya, A.A. 1985. The Changing Attitude and Practice of Men Regarding Family Planning in Nigeria. *Public Health* 99 (5): 349-55.

Olowu, D., S.B. Ayo and B. Akande. 1991. Local Institutions and National Development in Nigeria. Ile-Ife, Nigeria: Obafemi Awolowo University Press.

Omu, Alexander E., Sharon S. Weir, Barbara Janowitz, Deborah L. Covington, Peter R. Lamptey and Nadine N. Burton. 1989. The Effect of Counselling on Sterilization Acceptance by High-Parity Women in Nigeria.

Onyekwere, E.C. 1991. Persuasion Strategies in Family Planning Campaigns, in Onyekwere, E.C and E.O. Nwuneli, eds., *Persuasion and Message Design for Population Communication*. UNESCO UNFPA Population Communication Project, Kenya.

Orubuloye, I.O., J.C. Caldwell, and P. Caldwell. 1991. Sexual Networking in the Ekiti District of Nigeria, *Studies in Family Planning* 22 (2) 61-73.

Ottong, J.G. 1988. Fertility Change and Culture in Sub-Saharan Africa: A Study in Zaria, Nigeria, Savanna, 9 (1) Ahmadu Bello University Press, Zaria.

Oyekanmi, Felicia Durojaiye. 1990. An Exploratory Look at the Spread of Sexually Transmitted Diseases in Nigeria. Paper Presented at the Informal Workshop on Researching Sexual Networking in West Africa at NISER, Ibadan, March 21-23.

Pillsbury, B. 1990. Breastfeeding, Weaning & Nutrition: The Behavioral Issues. Behavioral Issues in Child Survival Programs. Monograph Number Four. USAID.

Piotrow, P.T., J.G. Rimon, K. Winnard, D.L. Kincaid, D. Huntington, and J. Convisser. 1990. Mass Media Family Planning Promotion in Three Nigerian Cities, *Studies in Family Planning* 21 (5) 265-274.

Pittin, Renee. 1983. Chapter 21: Houses of Women: a Focus on Alternative Life-Style in Katsina City, in Christine Oppong, ed. Female and Male in West Africa. London: George Allen & Unwin, pp. 291-301.

Population Reference Bureau. 1992. World Population Data Sheet.

REACH. 1991. Urban EPI in Nigeria: A Preliminary Assessment. Prepared by R. Steinglass and K. Olivola.

REACH. 1991. Nigeria ARI Subsector Background. Prepared by R. Weierbach, M. Favon, J. Gibson and S. Redd.

Reham, Nagma and Audu, K. Abashiya. Breastfeeding and Abstinenes among Hausa Women. Studies in Family Planning 12 (5) 233-234.

RMS (Research & Marketing Service, Ltd.). 1992. Family Planning/AIDS Study: June 1992 Nigerbus (RMS Job No. 1012). Prepared for JHU/JPC, Lagos.

RMS. 1992. Family Planning Habits & Attitude Study: September 1992 (RMS Job No. 0719). Prepared for JHU/JPC, Lagos.

Schildkrout, Enid. 1983. Dependence and Autonomy, in Christine Oppong, ed., Female and Male in West Africa. London: George Allen & Unwin., pp. 109-128.

Trevitt, Loma. 1973. Attitudes and Customs in Child Birth Amongst Hausa Woman in Zaria City, Savanna, 2 (2), Ahmadu Bello University Press, Zaria, Nigeria.

Trevor, Jean. 1975. Family Change in Sokoto: A Traditional Moslem Fulani/Hausa City in Caldwell, et. al. (eds.), Population and Socioeconomic Change in West Africa.

Udjo, E.O. 1987. A Determinant of Fertility and Its Cultural Context Among Nigeria's Kanuri. In: The Cultural Roots of African Fertility Regimes, Proceedings of Ife Conference, Feb.- March: 277-91.

UNFPA/Lagos, Nigeria Office. 1991. UNFPA Country Programme, 1987 - 1991.

UNFPA. 1991. Programme Review and Strategy Development Report. Nigeria.

Wilson III, Ernest J. 1988. Politics and Culture in Nigeria. Ann Arbor: Center for Political Studies Institute for Social Research, The University of Michigan.

World Bank. 1989. Nigeria: Primary Education Subsector Study. Africa Region, Western Africa Department, Population and Human Resources Division.

World Bank. 1990. Federal Republic of Nigeria: Implementing the National Policy on Population, Sector Report, Vols. I & II.

World Bank. 1991. Federal Republic of Nigeria Health Care Cost, Financing and Utilization. Volume 1: Subsector Report (Report No. 8382 - UNI), Western African Department Population and Human Resources Operations Division.

World Bank. 1991. Staff Appraisal Report: Federal Republic of Nigeria, National Population Project. Population & Human Resources Operations Division, Western Africa Department.

WHO. 1992. Local Government Focussed Acceleration of Primary Health Care. The Nigerian Experience.

**Strategy for the Private Provision
of Health and Family Planning Services
in Nigeria**

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1. Introduction¹

The "Nigeria Health and Population Sector Assessment" (November 1991) notes that the "private sector in health service delivery in Nigeria . . . is large, diverse and relatively unconnected to the public health care system."² The assessment observes that:

- 50% of all health care facilities in the urban areas of Ogun State are private;
- 40% of women using modern contraceptives obtained products and services from the private sector, and
- 18.5% of immunizations given in Lagos State were provided by the private sector.³

These data clearly indicate that the private sector is providing a significant amount of family planning and primary health care services in Nigeria, although activities are not carefully orchestrated by and among private providers and organizations, nor are they monitored and/or documented by public sector health officials.

The assessment observes that, for a number of reasons, neither the Government of Nigeria (GON) nor A.I.D. has studied in any depth the current and potential role of the private sector in the provision of health and family planning products and services. In light of the Federal Ministry of Health's (FMOH) recent "receptivity to recognizing and working out mechanisms to engage the private sector,"⁴ the assessment suggested that a more "systematic study of private sector health services in Nigeria, including a review of oversight mechanisms," should be carried out.⁵

In general, this brief paper agrees with the assessment's conclusion that "the private sector has been underutilized by donor agencies," and that current conditions in Nigeria present unique opportunities

¹The analysis and approaches suggested in this AAO/Nigeria strategy are based primarily on three studies and assessments: Marjorie C. Horn, Nancy Pendarvis Harris, Susan Krenn, and Marc A. Okunnu, "Private Sector Assessment of the Family Health Services Project," R&D/Population, Nigeria, July 1992; Ernest Petrich, Eugene Weiss, Mary McGovern, Olabisi Olantokunbo, "Institutional Assessment of the Planned Parenthood Federation of Nigeria," AAO/Nigeria, April 1992, and John B. Tomaro and Susan K. Kolodin, "Strategy for Increasing the Private Provision of Health and Family Planning Services in Nigeria," R&D/Health, May 1992.

²D. Gibb et al., "Nigerian Health and Population Assessment," USAID/Nigeria, November 1991, 17.

³Ibid. See also "Federal Republic of Nigeria Health Care Cost, Financing and Utilization: Subsector Report," World Bank, June 1990, "Nigeria Demographic and Health Survey 1990: Preliminary Report," Federal Office of Statistics and Demographic and Health Surveys (IRD/Macro Systems, Inc.), March 1991 and R. Steinglass and K. Olivola, "Urban EPI in Nigeria: Preliminary Assessment," REACH Project, September 16-27, 1991.

⁴Ibid., 17.

⁵Ibid., 33.

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for involving the private sector in health and population activities.⁶ At the same time, it questions the value of undertaking an exhaustive study of the private sector. Rather than study the private sector, this strategy places emphasis on identifying and accessing mechanisms to reach, organize, and involve private sector providers of health services and producers and distributors of health products in a campaign to motivate and supply Nigerians with essential health and family planning services.

A study of Nigeria's robust and complex private health sector could be a valuable piece of research. However, since private sector providers and producers of health goods and services are operating in a rational but less than coordinated manner and USAID/Nigeria's current project development efforts in family planning (FHS-II PID) and child survival (NCCCD PID) are well underway, it is more useful to outline a strategy that suggests how the resources of the new projects, as well as other initiatives, e.g., STD/HIV/AIDS and the central projects of R&D/Health and R&D/Population, can be employed to engage segments of the Nigerian private sector to participate productively and rapidly in the direct provision of information, products and services pertaining to preventive and primary health care and family planning.

The proposed strategy is based on a review of selected technical papers and a rapid but less than comprehensive assessment of the private health care and family planning service sector in Nigeria. The strategy recognizes that FHS-II and NCCCD activities are complementary but not interchangeable and that, unlike donor projects, the private sector approaches clients and their families in terms of their comprehensive health and family planning needs. Consequently, the strategy urges that all assistance to the private sector in primary and preventive health care and family planning be carried out in coordinated manner, and that AAO/Nigeria play a central role in directing private sector activities.

Finally, the strategy stresses the importance of exploring ways to mobilize the private sector to prevent and address the most important health conditions in Nigeria, as reported by the FMOH (see Table 1).

Table 1 ⁷ Leading Causes of Outpatient Visits and Inpatient Admissions		
	Outpatient (%)	Inpatient (%)
Infectious and parasitic diseases	38.2	31.3
Respiratory diseases	12.7	9.8
Pregnancy and Childbirth	----	23.1

The services outlined in the proposed USAID/Nigeria bilateral projects can ameliorate many of these conditions. However, the private sector, especially the profit-making segment, has traditionally emphasized curative services (see Section 5). A focused effort must be made by the government and donors and lenders to encourage the private sector to play an active role in PHC and family planning.

⁶Ibid., 29.

⁷"The National Health Policy and Strategy to Achieve Health for All Nigerians," Federal Ministry of Health, Lagos, Nigeria, October 1988, 51.

In this strategy, the private sector is defined as:

- profit-making providers of health and family planning goods and services (groups and individual practitioners, modern as well as traditional health care givers);⁸
- profit-making manufacturers, distributors, and vendors of health and family planning products,
- nonprofit providers of health and family planning goods and services, e.g., NGOs and PVOs.

Private firms that provide health services but have another activity as their central undertaking; e.g., bottling, banking, manufacturing, oil production, etc., are included among the private sector providers of health services.⁹ With the exception of the largest employers in Nigeria, such as Shell, United African Companies, Nigerian Electric Power Authority (NEPA) and the Nigeria National Petroleum Corporation (NNPC), most firms have clinics at the work site that offer primarily first aid and other occupational health and safety counsel and care. Other care is provided by private hospitals, clinics and maternities that hold "retainer" contract. This approach is an effort by employers to provide service and control costs.

The strategy set forth in this annex focuses on identifying those private associations, organizations and groups that can provide family planning and basic primary and preventive services to primarily urban residents. It also suggests the assistance that could be made available under the new AAO/Nigeria bilateral projects (NCCCD and FHS-II) and carried out with assistance from the centrally-financed projects of R&D/Health and R&D/Population.

At the same time, the strategy recognizes the importance of keeping the public sector informed and involved. The public sector has an important role to play in setting and monitoring standards and providing incentives that induce private sector providers and suppliers to make available goods and services of the highest quality within the limitations of the national economy of Nigeria and the household budgets of its citizens.

⁸While it is generally true that traditional healers are located more in rural than urban areas, it is difficult to make a clear-cut distinction between the two groups. Many so-called modern providers practice traditional medicine. At the same time, many traditional healers prescribe and dispense modern pharmaceuticals.

⁹ In addition to the provision of employee health services, such firms offer a potential for the promotion of IEC initiatives targeted to family planning, AIDS prevention, and child survival objectives through involvement and/or investment in specific undertakings in that regard, including the sponsorship of radio and television programs. The AAO/Nigeria private sector strategy calls for active assessment and exploitation of that potential through continuing dialogue to that end with representatives of the local commercial community.

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2. Basic Health and Population Indicators and the Structural Adjustment Program (SAP) in Nigeria

Until preliminary data from the 1990 census were released, it was estimated that Nigeria had a mid-year population of 118 million in 1990 and a projected population of 123 million in 1992.¹⁰ According to these reports, the population was growing at about 3% annually. Data from the 1990 census suggest that Nigeria has approximately 90 million people and is growing at an annual rate of less than three percent. In spite of the adjustment in the population size, Nigeria continues to manifest high rates of fertility and infant and child mortality. Estimates of infant and child mortality rates are 91.4/1000 live births and 109.6/1000 live births respectively (1990). Maternal mortality is 6/1000 live births. Approximately 3.5% of married women (9.6% - urban and 1.9% rural) are using modern methods of contraception and the total fertility rate is 6.01 (5.03 - urban and 6.32 - rural).¹¹

The rates of population growth, contraceptive prevalence and infant and child mortality reflect marked improvements over those recorded in earlier surveys and census. Still, these are high when compared with some rates in other low-income countries. In addition, as noted in Table 2 below, these national level data mask significant urban/rural differences and north/south disparities.

Category	Total	Urban	Rural	NE	NW	SE	SW
Infant Mortality	91.4	75.4	95.8	87.7	109.8	82.7	84.6
Child Mortality	109.6	58.9	123.8	139.2	151.2	66.5	90.3
Total Fertility Rate	6.01	5.03	6.32	6.53	6.65	5.57	5.46
Use of Modern Contraception	3.5	9.6	1.9	1.3	0.7	3.9	10.5

The most recent "National Survey of Households 1985/86," published in 1989, estimated the average income of urban dwellers at Naira 257 per month and that of rural residents at Naira 220 per month.¹³ However, 58% of urban dwellers earned less than Naira 200 per month; among these

¹⁰"Children and Women in Nigeria: A Situation Analysis," Federal Government of Nigeria and UNICEF, August 1990 and "Federal Republic of Nigeria: National Population Project," Staff Appraisal Report, World Bank, April 1991.

¹¹"Nigeria and the People's Health: A Perspective on the 1990s - Opportunities for USAID Technical Cooperation," 1992, 2-6.

¹²Ibid., 4-6.

¹³Federal Office of Statistics, "National Survey of Households 1985/86," July 1989.

lower income urban dwellers, 59% of cash expenditures went for food. This finding leads to speculation that the conditions facing some periurban residents areas may actually be worse those encountered by rural dwellers.¹⁴

The Demographic and Health Survey (DHS) notes that slightly more than 9% of married women living in urban areas use modern methods of contraception while approximately 2% of women residing in rural areas use modern methods.¹⁵ As reported in the DHS, significant regional disparities also exist for breastfeeding practices, as well as Oral Rehydration Therapy (ORT) and Expanded Programme on Immunization (EPI) services. In general, urban residents in the Southwest and Southeast, who have the greatest access to health services, and women with the highest levels of education exhibit the best indicators; the poorest indicators are found in the rural areas of the Northwest and Northeast and among women with the lowest levels of education.¹⁶

While 30 to 35% of the population currently resides in urban areas, urban growth is estimated to be over 7% annually. This suggests that over half of the population of Nigeria will be urban by the year 2,000. In addition, there is some speculation that the urban population may be younger on average than rural residents.

DHS data and other surveys indicate that health status is generally better in the urban areas of Nigeria. In urban areas, 75 percent of the populations is thought to have access to health services (public and private); only 30 percent of the rural population has access to health services. In addition, almost 60 percent of urban dwellers have access to safe water, while only 25 percent of rural residents have access. Populations living in urban centers, where private sector facilities predominate, have better health status than rural residents. Still, it is not possible to draw a causal association between the presence of private health services and the status of the urban population.

In the urban areas, public sector facilities are prevalent, receive the largest percentage of the ministry's resources, and provide a measurable amount of health goods and services. The private sector health infrastructure operates alongside these facilities, but independently from them. This vast urban network of private hospitals, clinics, physicians's offices and maternities, along with pharmacies, chemists' shops (patent medicine vendors) and other consumer product outlets provides a wide range of health care services and products.

DHS presents some limited information on the distribution of all current users of modern contraception by source of the method, public or private (See Table 3, next page).

Other studies — World Bank Ogun study and the REACH Urban EPI study — suggest that the private sector provides a significant amount of public health service. However, the magnitude and range of these private sector goods and services, as well as their cost/price, quality, and impact on public health is difficult to quantify. With the exception of the few studies listed, there is no systematic information on what is being provided by the private sector in PHC and family planning.

¹⁴"Annual Report: 1990," Planned Parenthood Federation of Nigeria, Lagos, n.d., 11.

¹⁵"Nigeria Demographic and Health Survey 1990: Preliminary Report," Federal Office of Statistics and Demographic and Health Surveys (IRD/Macro Systems, Inc.), March 1991, 9.

¹⁶Ibid., 13-19.

Table 3 Type of Contraceptive Method used (%) by Source of Distribution					
Source of Method	Pill	IUD	Injection	Condom	All Methods
Public	29.2	61.0	44.9	13.6	37.1
Private	61.0	19.8	46.6	52.4	46.2
PPFN ¹⁷	2.3	7.8	3.6	3.7	4.4

The absence of information on private sector services, especially profit-making services, is attributable in part to the traditional tension between the public and private sectors. In the post-independence decades, most Ministries of Health in Africa viewed private profit-making providers as an "unnecessary evil." Indeed, in most newly independent countries, even the nonprofit missionary facilities were only minimally tolerated. Some ministries attempted to suppress private operations; others tolerated their existence, tried to control their prices and limit their services, and did not include them in public health programs.

At the same time, private providers, even nonprofit groups, have been very wary of the public sector. Most have sought to operate without supervision by public health authorities and have been reluctant to share information or to be closely associated with public health campaigns sponsored by the public sector.¹⁸ Consequently, little is known about the contribution that the private sector has made to improving health status. Still, the better health status of urban residents, who usually have greater access to private sector products and services, suggests that private care has made some measurable contribution.¹⁹

As the Nigerian economy has undergone structural adjustment (SAP), public sector per capita expenditures for health care at the federal level have declined from US \$8 (1985) to US \$0.29 (1990). As the Federal Ministry of Health (FMOH) has recognized that operations have to be based on sound managerial and financial principals, efforts have been made to reduce costs and to raise revenues to offset the cost of operations, especially the cost of pharmaceuticals.²⁰ The public sector has begun to charge for other services, although the revenues generated have met only a very small percentage

¹⁷Planned Parenthood Federation of Nigeria.

¹⁸Private sector providers, in spite of their membership in national associations, see each other as competitors rather than collaborator. Most private associations were formed to resist or limit government interference rather than to promote a given program or facilitate cooperation among the members.

¹⁹"Nigeria and the People's Health," op. cit., 8. "The lower rates of undernutrition and mortality in areas characterized by urban, south, and high concentration of private services needs further study. Is access and use of private care responsible for the decreased mortality?"

²⁰See the PRITECH report on seven revolving drug funds. "Drug Revolving Fund Experiences in Nigeria," PRITECH, April-May 1988.

of the cost of operations.²¹ In addition, the public sector has "encouraged employers of labour to participate in financing health care services to employees," and obliquely endorsed the right of the private sector to participate in the provision of health services.²²

The objective of these reforms has been to improve the efficiency and sustainability of public sector services. As a result of these reforms, consumers of health care, both public and private, have been required to meet an increasing percentage of the cost. Also, public sector curative services now compete with those offered by the private sector. This new financial burden comes at a time when most consumers have a diminished ability to meet these costs.

From 1985 through 1991, the Naira has been devalued almost twelve-fold against the US dollar, measured according to the parallel rate.²³ Since most medical equipment and a good percentage of the components needed to produce pharmaceuticals must be imported, an increasing amount of Naira has been required to buy US dollars or other foreign currencies. This cost has been reflected in price increases passed on to the consumer. In August 1991, the urban consumer price index for medical care and health commodities was on average 3.6 times higher than the base period of 1985.²⁴ During the same period, the national minimum wage only doubled.²⁵

As a consequence of cost increases for health care goods and services, service utilization in both the public and private sectors has declined. However, there is little hard data to document this recent trend, but medical providers, pharmaceutical manufacturers, and pharmaceutical dispensers report that many consumers now postpone needed procedures, buy the least expensive drugs (often adulterated, ineffective) or an incomplete course of therapy, and sometimes choose to self-medicate with traditional preparations and therapies.

3. Characteristics of Nigeria's Private Health Sector

As noted above, the private health sector in Nigeria is large, growing, diverse, energetic, primarily urban-based, and difficult to quantify. According to the recently published report on primary health care submitted to UNFPA in 1990, there were 17,954 medical practitioners, 64,303 nurses, 52,378

²¹See the study conducted in 1986 in Ogun State entitled "Federal Republic of Nigeria Health Care Cost, Financing and Utilization: Subsector Report," World Bank, June 1990.

²²"The National Health Policy and Strategy to Achieve Health for All Nigerians," Federal Ministry of Health, Lagos, Nigeria, October 1988, p. 49. "12.6 Within the right of individuals to participate in the economy of the nation, private individuals shall be encouraged to establish and finance private health care services in under-served areas." See also Section 4.

²³The parallel rate refers to the free market *bureau de change* exchange rate.

²⁴"Consumer Price Index: August 1991," Statistical News, No. 157, Federal Office of Statistics, 22 October 1991.

²⁵The data of urban household expenditures for Nigeria (1983/84), taken before the FMOH authorized the collection of fees for services in public health facilities, indicate that 23% of expenditures went for medical expenses. See Steinglass and Olivola, *Op. cit.*, 4.

midwives, and 5,318 pharmacists registered in Nigeria in 1989.²⁶ Precise information on the numbers of physicians, nurses, midwives, and pharmacists practicing in the private sector throughout Nigeria is not available, and estimates vary considerably. None of the numbers suggested — 6,000 physicians, 3,500 pharmacists, and 10,000 nurses and midwives — can be confirmed. In addition, the speculation that one-half of all health personnel trained in Nigeria are practicing in the private sector, primarily the large urban centers of the country, cannot be validated.

In response to the recent and increasingly harsh economic conditions in Nigeria, both public and private sector facilities have experienced declines in patient attendance. Other than for unavoidable emergency care or delivery, many clients have stopped attending hospitals, clinics and maternities. However, the decline may be sharper in the public sector. Physicians and nurses in both the public and private sector report that patients attending private facilities avoid long waiting lines and readily obtain the necessary products and care. In the public sector, there are reports that clients are often told to procure and present a range of materials (dressings, gloves, syringes, antibiotics, etc.) before services can be offered. The cost of time, transportation and products is sometimes more expensive than the fee at a private clinic or hospital.

However, there are reports that private hospitals, clinics and maternities are underutilized. While many of these facilities saw 20 or more patients per day a few years ago, most are presently seeing only ten or fewer clients per day. This recent downturn in patient volume has prompted many facilities to increase charges to meet fixed overheads and to replace commodities and equipment. This action has further dampened patient demand.

The quality of care available in the private sector varies widely. Moreover, there is only some correlation between price and quality. Practitioners working in the same geographical area and operating comparable facilities charge similar fees, even though the quality of care offered may be different.

Those in private practice were trained in a range of modern and traditional systems at different times. Some providers have had no formal training; most have attended medical and nursing schools in Nigeria, Western nations (primarily Great Britain), and many of the countries that comprised the former Eastern bloc. Some have been trained in programs abroad; others have passed their careers in Nigeria. In 1985, the National Postgraduate Medical College of Nigeria introduced a basic program for general medical practice to standardize basic health care practice in Nigeria. The program is, however, only taken by those seeking certification in General Medical Practice. The Nursing and Midwifery Council of Nigeria reviews the credentials of candidates trained abroad and determines whether additional training in Nigeria is required. However, there is no standard curriculum that must be followed by all nurses and midwives.

3.1 Private Profit-making Providers: Physicians

Private profit-making providers are members of the Nigeria Medical Association (NMA), an umbrella group of all licensed physicians, and active in two related sub-groups: the Guild of Medical Directors (GMD) and the Association of General and Private Medical Practitioners of Nigeria (AGPMPN). The GMD, a group of physicians who own and manage private hospitals/clinics, was established in 1990 to:

²⁶"Primary Health Care System in Nigeria: Organization, Structure and Functions," (submitted to UNFPA), Africa Health Consultancy Services (AHCS), December 1990, Appendix II, 64.

- set a code of conduct for practitioners, members of the GMD and members of the AGPMPN;
- keep the . . . citizenry informed of their rights and privileges concerning private medical practice;
- encourage improvement in the knowledge of medical practitioners through medical research and the sponsorship of seminars and symposia;
- standardize the health care delivery systems of private medical practitioners, and of consultation, professional fees and other charges; and
- identify and seek to resolve problems faced by private medical practitioners.²⁷

Members of the GMD generally own and operate some of the larger inpatient facilities that offer a full range of radiological, diagnostic, and inpatient surgery and care. Antenatal and maternity services, including family planning, are also routinely available. The GMD has members in the largest cities of Nigeria; e.g., Lagos, Kaduna, Port Harcourt, and plans to establish state branches.

According to the most recent version of the Nigeria Yellow Pages (1991), there are at least 441 private profit-making hospitals and maternity homes operating throughout the country. Roadside observation alone suggests that the total number may be ten times larger. Since neither the GMD nor the Association of General and Private Practitioners of Nigeria (AGPMPN) has a definitive list of members, only very rough approximations are available. Fees for services at private facilities vary widely depending on the location of the clinic/hospital and the range of services offered. On average, however, the charges at the facilities run by members of the GMD may be among the highest in the private sector (See Table 4, next page).

The AGPMPN is comprised of members of the GMD as well as private physicians who have either a part-time or full-time private office practice. Many work in the public sector and treat private patients in their off hours. Some work on retainer to private companies; others are house staff at the private facilities. Most have admitting privileges at private sector hospitals or clinics.

The GMD or AGPMPN attend three types of clients. The largest group consists of workers covered by insurance plans. These plans entitle employees in the formal sector to receive certain services at those clinics/hospitals or physicians holding "retainer" contracts with their employer. The services offered and the fees paid are negotiated between the employer and the clinic or physician. A second group of clients consists of private individuals who pay "negotiated" fees. The third group consists of members of the doctors' family and friends who expect free treatment and often travel great distances to obtain it.

²⁷"Patients/Clients Bill of Rights and Approved Tariff," Guild of Medical Directors and the Association of General and Private Medical Practitioners of Nigeria, January 1992, 1.

Table 4 Range of Fees for Selected Health and Family Planning Services ²⁸			
<u>Service</u>	<u>Private Clinic or Hospital</u>	<u>Private Maternity (Nursing Service)</u>	<u>PPFN</u>
Registration	50-100	10-30	1
Consultation	50	20	n.a.
Room and Board/day	280-450	30-100	n.a.
Immunization/dose	50	10	n.a.
Malaria treatment	200-250	100-150	n.a.
STD/HIV/AIDS screening	120	n.a.	n.a.
IUD insertion	200-250	50-100	15
Injectable contraceptive	100-120	--	10
Oral rehydration therapy	[free?]	[free?]	n.a.
Normal delivery	1,000-1,500	150-300	n.a.

Health/Family Planning Services and Private Employers. As the cost of doing business has increased, many private sector firms have reduced or eliminated many of the services once offered at on-site clinics. In most cases, on-site facilities that once offered basic health services, e.g., immunizations, etc., are now providing only first aid for accidents and injuries. Only the largest employers in Nigeria; e.g., NNPC, NEPA, Shell, etc., maintain full service outpatient clinics offering family planning and preventive services for workers and their dependents.

Most employers have tried to control the cost of health care for their employees by arranging retainer contracts with a number of different providers who own and operate hospitals, clinics and maternities. Until recently, most employers asked qualified hospitals, clinics and maternities to submit bids. To avoid negotiating with the employers and creating a bidding war among private sector providers, the private clinic operators have tried to fix standard fees for a given range of services (See Annexes 1 and 2). Setting and enforcing fees that are based on a careful estimate of cost has been a principal objective of the GMD.

3.2 Private Profit-making Providers: Nurses and Midwives

Private profit-making nurses and midwives who own their own clinics and maternities are members of the umbrella National Association of Nigeria Nurses and Midwives (NANNM) as well as the

²⁸These data were compiled from a review of the fees published by the Guild of Medical Directors and obtained from interviews with 25 service providers (physicians, nurses and midwives) in several LGAs in Lagos State: upper class - Ikoyi; middle class - Surulere, Yaba, Ebutte-Metta, Idi-Araba, Maryland, and lower class - Mushin and Ikeja. The market exchange rate used is US \$1 equals 16 Naira.

Private Nurses and Midwives Association of Nigeria (PNMAN). NANNM has been a very strong union over the years, often at odds with the FMOH and the NMA over the range of services that nurses and midwives can provide, the focus of care (primary vs secondary), and the need for extensive physician supervision.

National membership of the private association is estimated to be about 10,000, although it is extremely difficult to get precise figures on current enrollment. Unlike the private physicians who are almost exclusively urban-based, many nurses and midwives are resident in the rural areas; still, the largest percentage are located in the middle and lower income areas of the urban centers. In the current economic climate, the services offered by private nurses and midwives are very well frequented. The fees charged by private midwives are often significantly less those of the clinics owned and operated by physicians (See Table 4, above). For example, a normal delivery by a midwife—based in Lagos—can cost as little as N150 (about US \$10). This fee includes antenatal visits. Vitamins, immunizations, and post-partum contraception are additional charges.

3.3 Private nonprofit providers: nongovernmental (NGO) and private voluntary organizations (PVO)

Nongovernmental hospitals and clinics and religious-affiliated institutions have long been involved in the provision of health and family planning services in Nigeria. The estimated number of national and international NGOs and PVOs in health care and family planning operating in Nigeria is unspecified. It is clear, however, that only a handful have a significant level of coverage and impact. The activities of the Family Planning Federation of Nigeria (PPFN), for example, are well known, as are those of the Christian Health Association of Nigeria (CHAN).

The recent assessment of PPFN noted the strengths and deficiencies of the organization.²⁹ The team recommended that AAO/Nigeria and other potential donors endorse and support a phased approach to developing the institutional capacity to deliver family planning services of high quality and to supervise and manage community-based contraceptive distribution programs.

The Christian Health Association of Nigeria (CHAN) is the coordinating body for church-sponsored health care in Nigeria. CHAN was founded in December 1973 by the Christian Council of Nigeria (CCN), the Catholic Secretariat of Nigeria (CSN), and the Northern Christian Medical Advisory Council (NCMAC). Over 260 hospitals, maternities, clinics, dispensaries, and health programs are members of CHAN. Facilities are located among rural periurban communities.

CHAN operates two projects that are directly relevant to the AAO/Nigeria program. One is the Central Pharmacy Supply Project which procures and distributes pharmaceuticals, through a network of strategically placed depots. The other is the Primary Health Care Project which coordinates, promotes, and stimulates primary health care activities among CHAN members through visits, national and regional workshops, and informational mailings.

Supported largely by donations from bilateral and multilateral donors organizations and private foundations, as well as some local contributions, nongovernmental, private voluntary and church-affiliated organizations like PPFN and CHAN usually provide primary health care and family planning services gratis or for very low fees (See Table 4 above). Traditionally, the NGO strategy

²⁹Ernest Petrich, Eugene Weiss, Mary McGovern, Olabisi Olatokunbo, "Institutional Assessment of the Planned Parenthood Federation of Nigeria," AAO/Nigeria, April 1992.

has been to reach those with the fewest means who are most in need. The target groups are the "at risk" or "high risk" populations who do not routinely frequent either public or private profit-making health and family planning services.

Some NGOs; e.g., Rotary, have a focused program that delivers one or more primary health care interventions; e.g., EPI. Frequently, the NGO enters into a formal understanding with the government that allows it to operate in one or more geographical areas of Nigeria. Within the last two years, many of the largest nongovernmental organizations have become affiliated with the Nigeria Association of Nongovernmental Organisations on Health (NANGO), an umbrella network designed to improve the coordination among and impact of the operations of the NGOs. Still in its infancy, NANGO has the potential to raise the overall quality of the services and programs of its members, to enhance their service-delivery capacity, and to distribute and monitor an increased level of donor-provided finance and technical assistance.

In addition to the NGOs and PVOs actively involved in the provision of services, there are some community-based groups that are selling subsidized products. For example, the market women of Ogun are marketing condoms with support from PSI. There are also groups, such as the National Commission of Women's Societies, who are responsible for informing and instructing communities on the importance of primary health care and family planning, mobilizing communities to attend clinic-based services or participate in primary health care programs like vaccination campaigns, and encouraging community members to serve as volunteers in clinic-based programs.

The data in Table 4, above, are only illustrative of the wide range of fees charged by private sector providers. The higher fees at private clinics and hospitals probably reflect higher fixed overhead costs, not consultation fees. The low fees at PPFN recover only a small portion of the total cost of the service. It is revealing that private clinics and hospitals with maternities have a full complement of services while maternities and PPFN have a limited number of services. The different approaches to health care and family planning have different fixed cost implications, as reflected in the fees.

From the client's perspective, the service with the lower fee will probably be purchased, provided it is relatively accessible and perceived to be of "comparable" quality. At this difficult economic moment, Nigerians are probably basing "elective" health care decisions, e.g., obtaining immunizations, on the cost of the service, measured as time lost from work and/or money paid out.

3.4 Pharmaceutical Manufacture and Distribution

At present, there are three unique divisions in the pharmaceutical sector: the formal sector, the informal sector, and the social marketing sector, e.g., PSI. Since 1986, when the IMS stopped publishing in Nigeria, it has not been possible to obtain a precise estimate of either the total Naira value or the number of units of pharmaceuticals sold in Nigeria. The major pharmaceutical manufacturers and distributors compile their own estimates. There is some consensus that Naira 2.5 billion worth of pharmaceuticals were sold in Nigeria in 1990. Sixty percent of the pharmaceuticals sold were over-the-counter (OTC) products.³⁰ The multinationals report that in some cases both profits and the number of units sold have declined, although the Naira value of sales has increased.

³⁰Antacids, analgesics, aspirin, cough mixtures, anti-malarials, vitamins, oral rehydration salts, etc. are all in this category. Over the last several years, as drug prices have risen, OTCs have become a larger percentage of the market.

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The formal sector consists of the multinational and national manufacturers and distributors of locally-manufactured and/or imported products. These firms market their commodities through distributors charged with supplying the retail pharmacists and patent medicine shops. The Nigerian Yellow Pages (1991) lists over 191 pharmaceutical manufacturers or distributors throughout the country, but only about 60 are widely recognized (See Annex 3).

Until recently, when exchange rates for the Naira became unfavorable, pharmaceutical production and pricing was relatively stable.³¹ Since 1987, the cost of operating capital has rapidly increased — current interest rates are 32-34% per annum — and the value of the Naira has decreased. As a consequence, pharmaceutical manufacturing companies have had to pay more Naira to buy the foreign exchange needed to import the finished products or the raw materials used in local manufacture. These increases have been passed on to the distributors who are buying lower quantities than previously. These higher prices have, in turn, been passed on to the consumer.

In Nigeria, the nationally recognized pharmaceutical manufacturers and importers do not have exclusive arrangements with distributors. Under the current difficult economic circumstances, distributors are ordering products that have a high demand in the market, irrespective of their source. Since brand loyalty is not at a premium in Nigeria, the pharmaceutical firms do not depend solely on distributors for orders. Each of the largest firms has a network of representatives who visit private and public sector facilities to promote and sell products.

As prices for pharmaceuticals have increased dramatically, a number of new businesses, involved in the importation and promotion of pharmaceuticals, have appeared in the informal sector. These businesses operate without the requisite authorizations, e.g., a licensed industrial pharmacist, and cut many corners in pursuit of profit. These businesses, whose products can be seen on sale in Church Street, Lagos, specialize in distributing drugs procured in Eastern Europe, India, and the Far East. When compared to the prices of products manufactured locally or imported by the recognized national and multinational firms, these products have very low retail prices. These products are, however, often copies of the ethical products of multinationals, frequently ineffective and adulterated, and sometimes dangerous. In the current economic climate, many consumers and even private pharmacists are accepting the known risks and buying these products in volume.

Since price alone, and not brand loyalty, is influencing purchasing decisions, some of the large multinational and national firms offer their products at prices equal to those in the informal sector. This practice usually drives out or reduces the importation and sale of these products. However, as soon as the prices start to rise, the informal pharmaceutical sector begins to boom.

Social marketing of contraceptives has the smallest percentage of the retail pharmaceutical market in Nigeria. A well-established marketing practice in many developing countries, social marketing generally sells a donated "socially-useful" product for the cost of distribution or at a price affordable to a targeted group of "at risk" consumers. For example, commercial sex workers at risk for AIDS are frequently a target for the social marketing of condoms. In Bangladesh, low-income families have access to a range of health and family planning products at subsidized prices.

³¹A final product pricing agreement, arranged by the Pharmaceutical Manufacturing Group of the Manufacturing Association of Nigeria, the Pharmaceutical Trade Group of the Lagos Chamber of Commerce and Industry, and the Nigerian Association of General Practice Pharmacists, was in effect until 1982. This agreement fixed the suggested retail price as well as the percentages for the retail pharmacist and the distributor.

While profit-making firms frequently complain that social marketing programs reduce their sales, studies indicate that, if targeted properly, social marketing programs reach groups who do not have the means to pay standard retail prices for health and family planning products. Most often, these are periurban and rural residents. Some commercial pharmaceutical firms who have participated in social marketing programs have also found that identification with a "social product" generates considerable good will in the community; this often leads to increased sales of other products and services. The social marketing program itself may not be profitable but participation in the program does have a positive influence on the company's bottom line.

3.5 Pharmacy Practice

While a wide range of outlets may be effective for the distribution and sale of condoms, pharmacies and patent medicine shops may be the most appropriate outlets for distributing the information and products related to primary health care and family planning. In Nigeria, there are an estimated 3,500 pharmacists in the Nigerian Association of General Practice Pharmacists, an affiliated association of the Pharmaceutical Society of Nigeria. These community-based pharmacists own and operate full service pharmacies and smaller pharmacy-like outlets.

The Nigerian Yellow Pages (1991) lists 620 pharmacies throughout Nigeria. Since there may be this many pharmacies in Lagos alone, this number could only represent the larger pharmacies in the country. It is not possible to give an estimate of the patent medicine vendors, although their number is reportedly very large and their influence significant. In addition, while pharmacies are more likely to be located in urban centers and better off neighborhoods, patent medicine vendors are frequently found in the lower income neighborhoods and periurban areas.

Most pharmacies in Nigeria follow the U.S. model; they sell a range of consumer products, as well as pharmaceuticals. Many also sell hospital and surgical supplies. This portion of the business is becoming more common as public sector facilities find themselves in short supply and require patients to present the requisite materials before receiving service.

Some pharmacists report that pharmaceuticals have become a smaller percentage of total sales and total unit sales as prices have continued to rise. These same sources reports that decisions to stock products are based almost exclusively on consumer demand. Rapidly moving low-margin OTC items are preferred over slow moving high-margin ethical products. Pharmacists have also reported that customers presenting prescriptions listing three or more items ask for and purchase only the "most important products."

While unit sales of pharmaceuticals may be down, pharmacists continue to be viewed by customers as knowledgeable health providers. Pharmacists are often called on to recommend a therapy for a given condition and frequently asked to dispense or inject. Such actions are technically unauthorized but do occur, possibly more often now than in the past.

Some pharmaceutical manufacturers and distributors have recognized the important role that pharmacists play in providing health care information. These companies have developed information packets that give technical updates on health conditions, along with product information (See Annex 5). Naturally, the firms provide information on conditions addressed by their product lines. To receive the material, pharmacists are asked to respond to flyers printed in newspapers and magazines or received in the mail. On receipt of the request from the pharmacist, the company forwards the information packet, usually at the rate of one handout per month. This well-proven and reportedly inexpensive approach has been used to identify and supply pharmacists and patent medicine vendors.

In the past, some thought was given to involving pharmacists more systematically in the primary health care program of Nigeria. Reportedly, in the mid-80s the National Control of Diarrheal Diseases (CDD) Program considered training pharmacists in oral rehydration therapy (ORT), establishing ORT corners in pharmacies, and engaging the pharmacists in the promotion and sale of oral rehydration salts (ORS). For unknown reasons, the program was proposed but never launched.

3.6 The Bamako Initiative and the Essential Drugs List (EDL) in Nigeria

Nigeria has in principle embraced the Bamako Initiative (1985) which calls for the introduction of fees sufficient to recover the cost of pharmaceuticals administered in the public sector. If priced properly, drug sales should cover replacement costs, ensuring that the public sector always has adequate financial resources to purchase a supply of pharmaceuticals sufficient to meet demand.

The FMOH has embraced this policy in principle and has developed an Essential Drugs List (EDL), comprised of more than 200 items. By limiting the number of pharmaceuticals procured, Nigeria hopes to obtain economies of scale when purchasing drugs. The states have been encouraged to set up revolving drug funds (RDF) and to purchase according to the EDL. A few of the states; e.g., Bendel State, have experimented with the system.

None of the pharmaceutical manufacturers, distributors or pharmacists working in the private sector have viewed the RDFs and EDL as operational realities. Indeed, most national and multinational firms oppose the imposition of the EDL and there is no indication that the EDL is being actively implemented in either the public or the private sector.

4. Policies pertaining to private sector involvement in Health and Family Planning Services

The present military administration governing Nigeria, scheduled to be replaced by a democratically elected government in January 1993, has initiated major changes in health and population policy. Under the new health policy,³² health services are the responsibility of the almost 600 LGAs. The Federal Ministry of Health defines policy, sets standards, monitors their implementation, and finances the activities of the states and LGAs. The Nigerian Medical and Dental Council, according to President Babangida, is authorized to set and monitor standards for medical education and to define the minimum standards for registering, inspecting, and supervising "all health institutions throughout the country."³³ States are responsible for registering and monitoring the services provided at the public and private institutions within their jurisdiction.

While the role of the private sector is not explicitly defined under the new health policy, "better coordination and integration of public and private medical practice is in the pipeline."³⁴ This statement and those of other officials indicate that the government is aware of the need to involve the private sector and is actively developing and reviewing proposals designed to encourage closer collaboration

³²See "The National Health Policy and Strategy to Achieve Health for All Nigerians," *op. cit.*

³³Ibrahim Badamasi Babangida (President of the Federal Republic of Nigeria), "Address to the Annual General Conference of the Nigerian Medical Association," Durbar Hotel, Kaduna, April 23, 1992, 4.

³⁴*Ibid.*, 5.

between public and private sector providers. At the same time, the government is seeking ways to facilitate and increase private sector involvement in the public health agenda.

In the past, the government has attempted, through regulation and other means, to force the private sector to contribute more to public health. Recently, for example, the government tried to involve the private sector in the national EPI campaign. The government was reportedly prepared to make vaccines and cold chain equipment available to private providers at no cost to them if an agreement could be reached on the fees charged for vaccination services. When the government and private providers were unable to agree on the fees, discussions were suspended and the two sectors went their separate ways.

This example is indicative of the dilemma faced by the government. On the one hand, the government recognizes the need to involve private providers but is aware that regulations are insufficient to achieve adequate participation. On the other hand, without enacting some controls, the government is fearful that "the cost of medical attention ... will reach levels beyond the reach of the common man."³⁵

The National Population Policy (NPP), approved by the Armed Forces Ruling Council in February 1988 and formally issued by President Babangida in April 1989, is formulated to:

- improve the standards of living and the quality of life of the people of Nigeria;
- promote their health and welfare, especially through preventing premature death and illness among high risk groups of mothers and children;
- achieve low population growth rates, through reduction of birth rates by voluntary fertility regulation methods; . . . and
- achieve a more even distribution of population between urban and rural areas.

The policy defines an explicit role for private and non-governmental organizations. These organizations "shall be encouraged to participate in population activities. Due recognition shall be given to their work, expertise and experience. Their resources shall be fully utilized."³⁶ The Director of the Department of Population Activities (DPA), recently affirmed that the national policy recognized that services distributed through government clinics would not be sufficient and considered it "essential . . . to encourage the establishment of commercial distribution outlets."³⁷ According to the Director, the private sector is expected to: raise awareness, deliver services, and invest in population and family planning activities.³⁸

³⁵Ibid., 6.

³⁶"National Policy on Population for Development, Unity, Progress and Self-Reliance," Federal Republic of Nigeria, 1988, p. 26.

³⁷O. E. K. Kuteyi, "The National Population Policy (NPP): what is it all about?" Workshop for Print Media Executives on the National Population Policy and Family Life Education, Otta, April 9-10, 1992, 15.

³⁸Ibid., pp. 17-18.

In spite of the government's favorable policies toward family planning, critical steps remain to be taken to eliminate regulations and taxation schedules that constrain the importation, distribution and promotion of contraceptives and the marketing of family planning services. The government has yet to endorse the importance of including family planning in employer-provided services or to promote aggressively the importance of birth-spacing as an integral component of primary health care. Finally, the government has taken few steps to encourage indigenous NGOs to play a more active role in the promotion and provision of family planning information and services in the communities they serve, or to find creative ways to involve traditional providers and community leaders in the campaign to promote family planning/birth-spacing.

5. Strategy for Incorporating the Private Sector in AAO/Nigeria Projects in Primary Health Care and Family Planning

The Nigeria Country Program Strategic Plan (CPSP) for the 1993-2000 period calls for two projects to continue and expand activities in family planning (Family Health Services II Project) and primary health care (Combatting Childhood Communicable Diseases 2 Project).³⁹ Involving the Nigerian private sector in the provision of information, products and services for basic health care and family planning is a central objective of the AAO/Nigeria program.

5.1 Health Care and the Public and Private Sectors in Nigeria

The chart below presents a framework for understanding the proper roles of the public and private sectors pertaining to the financing and delivery of health care.⁴⁰

This framework suggests that there are a large number of activities (Category 1) that only the government can finance and implement. Category 3 lists activities that the private sector can be expected to provide because individuals have a keen interest in obtaining personal curative care. The services in Category 2 are the most problematic because both the public and private sectors have a role to play. In most cases, these are conditions that "the government has an interest in preventing, but once contracted by someone, both the government and the individual have an interest in curing — the former to prevent further spread and the latter to get well."⁴¹ In general, the categories are distinguished according to an individual's willingness to pay for a given service. If no one is willing to pay, there is no incentive for the private sector to provide the service. Without some stimulus in the form of regulation or finance, e.g., insurance, the private sector will only produce the volume of service that does not require public support/subsidy.

Until recently, the public sector in Nigeria provided and financed activities in all three categories. Recently, however, the public sector hospitals began to charge for services, in effect competing with the private sector. Traditionally, the private sector has focused on providing the services listed in Category 3 but has also provided some of the services listed in Category 2.

³⁹AAO/Nigeria will also be supporting an intervention in STD/HIV/AIDS with assistance from the AIDSCAP Project (R&D/H/AIDS).

⁴⁰Charles C. Griffin, Health Care in Asia: A comparative Study of Cost and Financing, World Bank Regional and Sectoral Studies, Washington DC: World Bank, 1992, pp. 47-48.

⁴¹Ibid., p.48.

<p>Category 1: Public Health Activities Epidemiological data collection Health System Planning/information Health education/communication Regulation, licensing Environmental health <u>Prevention</u> of communicable diseases Public health utilities - water and sanitation</p>
<p>Category 2: Mixed Public/Private Activities Targeted health problems • Family Planning • Maternal/child health • Infant nutrition/growth monitoring • Immunizations <u>Treatment</u> of communicable diseases</p>
<p>Category 3: Private Activities Acute care • Inpatient • Outpatient Laboratory/diagnostic services Hospital services</p>

Current daily attendance at both public and private sector urban facilities is well below past levels. Higher fee schedules in both public and private facilities in the context of continuing falling real incomes and extra taxes could lead to even lower attendance and, in the case of the indigent, denial of access to health care at even public sector facilities.

Private sector fee increases are a logical response to meeting fixed costs in the face of declining attendance. However, if the increases produce even more dramatic declines in patient attendance and private sector employers refuse to pay the higher rates proposed in the retainer contracts, some clients will be denied access to care.

A cursory examination of the private sector suggests that Nigerian providers may be offering inefficient, relatively expensive services because most facilities are small, single practitioner operations. Traditionally, most private providers have located in urban areas, have worked individually, and marketed their services to employers, not consumers. Employees in the formal sector have attended a private clinic accredited by their insurance plan and located in close proximity to their work or residence. Although client satisfaction has been reportedly higher in the private than the public sector, very few private sector facilities have marketed their services with the consumer in mind. The private sector has been relatively passive in the areas of client recruitment and the offering of new services and payment plans, and relatively uninspired in considering new approaches to financing and organizing the provision of health services to a wider clientele.

While the public sector needs to alter policies in the health sector to increase efficiency and ensure equity, the current difficult economic conditions in Nigeria also suggest that the private sector should be approached and encouraged to organize and attract new clients—or at least retain those who attended in the past—by streamlining operations (increase efficiency) and developing and offering a package of low-cost, high-quality primary health care and family planning services.

Nigerian public sector officials have repeatedly argued that the private sector should play a more active role in public health programs. In the past, however, the government has relied on regulations, not incentives, to achieve this objective. This strategy has met with only partial success. For example, the government requires employers to provide health services, although these cover only a small percentage of the total population and provide limited coverage based on the employee's status in the company. In many cases, the services offered are only minimally beneficial from a public health standpoint. At present, employer-provided services are least available to those with the greatest need.

In past studies on the private provision of health services, emphasis has been placed on examining the role that government regulations, subsidies on inputs, tax laws, and legal restrictions have played in influencing the supply of private sector services. Less attention has been given to examining the manner in which governments can influence the demand for services in either the public or the private sector, or the manner in which private sector services are organized, managed, financed and provide care. The government of Nigeria has done little to influence the demand for health services in either the public or private sector.

The government now recognizes its inability to continue to finance and provide services in all three categories and faces a two-fold challenge:

first, the government must ensure that Category 1 activities are adequately financed and provided by public sector institutions;

second, the government must develop proper incentives to ensure that services designated in Categories 2 and 3 are provided and financed on an equitable basis and involve private providers to the maximum extent possible.

The AAO/Nigeria private sector strategy outlined below is based on the conviction that the private sector has a significant role to play in meeting the primary health care objectives of the government. The strategy is designed to secure two broad objectives: (1) to contribute to a redefinition of the roles of the public and private sectors with regard to the financing and provision of health care, and (2) to involve the private sector in the delivery of primary health care, including family planning. The first objective will be addressed through dialogue with public sector officials and closely monitoring the service delivery activities of private sector providers. The second will be achieved by identifying and providing the incentives needed to secure the active participation of the private sector.

5.2 Private Sector Participants in the AAO/Nigeria Program

The discussion in Section 3 above and the chart below suggest that there are several private profit-making and nonprofit organizations already involved or willing take part in the AAO/Nigeria-financed program, and that there are mechanisms through which A.I.D. resources can be channeled to reach private providers.

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Provision of Private Sector Primary Health Care and Family Planning Information, Products and Services		
Illustrative Conduits for Channeling AAO/Nigeric Assistance		
<u>Private Profit-making Providers</u>	<u>Private Nonprofit Providers</u>	<u>Health/FP Products</u>
<ul style="list-style-type: none"> - Hospitals/maternalities - Clinics - Maternalities - Private Practitioners - MD - Private Practitioners - MW/RN 	<ul style="list-style-type: none"> - Hospitals (Mission) - Clinics (FP) - Maternalities 	<ul style="list-style-type: none"> - Pharmaceutical Distributors - Retail Pharmacies - Patent medicine vendors - Social marketing outlets
Guild of Medical Directors Association of General and Private Medical Practitioners of Nigeria National Association of Nigeria Nurses and Midwives National Postgraduate Medical College of Nigeria Private Nurses and Midwives Ass'n of Nigeria	Nigeria Association of Non- Governmental Organizations on Health (NANGO) Planned Parenthood Federation of Nigeria (PPFN) Christian Hospital Association of Nigeria (CHAN) National Commission of Women's Societies	Pharmaceutical Society of Nigeria Nigerian Association of General Practice Pharmacists Pharmaceutical Manufacturing Group of the Manufacturing Association of Nigeria Population Services Int'l

The members of the associations and groups listed are located predominantly in urban areas and have a limited capacity to receive and distribute critical inputs, to monitor the performance of their members, and to collect and forward data for analysis. Yet, channeling assistance through these associations should increase the amount of information, products and services available to private sector urban consumers, enhance the quality and level of primary health care and family planning service offered by the private sector, and improve the institutional capacity, especially the efficiency, of the organizations delivering the information, products and services.

Recent discussions with members or representatives of each of the associations indicate that private providers are prepared to explore prospects for cooperation and interested in playing a more active role in primary health care and family planning programs in predominantly urban areas. Providers are aware that clients want access to low-cost, high-quality products and services that effectively address health care and family planning needs. Many private providers recognize that some managerial and clinical practices have to be changed to attract and retain clients. However, few routinely mention primary health care and family planning information, products and services as a way to promote their services. Even fewer have given any thought to introducing a range of financing plans. Hardly any appear concerned about documenting and improving the quality and impact of private sector services.

Still, given the downturn in employment opportunities in the public sector, steady levels of medical school graduate, and increased competition among private sector providers, as well as competition between the public and private sector, programs that offer private sector providers an opportunity to retain or reclaim existing and attract new clients who can ensure their financial viability may be very well received. The private sector strategy should take advantage of current conditions and strive to achieve the following objectives:

- improve the managerial capacity of selected private sector organizations involved in the delivery of health and family planning services; e.g., state affiliations (Lagos, Enugu, Cross Rivers, Kaduna) of the Association of General and Private Medical Practitioners, Guild of Medical Directors, NANGO, etc.;
- introduce primary health care and family planning information, products and services into urban-based, predominantly curative services;
- upgrade the overall quality of services provided in the private sector, and
- develop and test new approaches to financing health and family planning services in Nigeria.

Since difficult economic times are when people are least likely to take great risks, certain incentives will be required to secure the active and enthusiastic participation of private sector providers of information, products and services. The chart below proposes the range of assistance that could be provided to private sector providers through the AAO/Nigeria program with assistance from other sources; i.e., R&D/Health and R&D/Population central projects, Centers for Disease Control/Atlanta.

Activities in Support of Private Sector Service Delivery and Product Promotion and Distribution
<ol style="list-style-type: none"> 1. <u>Training</u>: <i>clinical</i> - PHC/FP; <i>managerial</i> - clinic management, record keeping, personnel training, drug procurement, etc.; and <i>marketing</i> - services and products). 2. <u>Communication (IEC)</u>: materials to inform and motivate clients, primarily urban residents, and materials to inform and motivate providers to promote PHC/FP (e.g., technical updates) 3. <u>Information Systems</u>: document/manage the flow goods and services 4. <u>Finance</u>: (cost recovery and pricing policy, loans for the purchase of equipment; e.g, lapracators; small grants to test community health plans and "insurance" schemes, and small grants to strengthen PVOs/NGOs 5. <u>Commodities/Logistics</u>: training in commodity procurement and management 6. <u>Monitoring/Evaluation</u>: design and install systems to monitor program operations, and to assess impact of goods and services 7. <u>Research</u>: conduct of surveys, operations research and "special studies"

The extent of the assistance made available should be based on an assessment of the needs and capacities of each association or group operating in the private sector. This assistance will be made available to:

- (1) involve private providers in the delivery of primary health care and family planning services;
- (2) ensure that these providers serve clients in the middle and lower socioeconomic groups;
- (3) increase the efficiency and effectiveness of private sector services (profit-making and nonprofit), and
- (4) obtain data on services delivered and products distributed by the private sector needed by officials responsible for public health programs.

5.3 Family Health Services II (FHS-II) Project

The current Family Health Services (FHS) Project has launched two principal activities through the private sector. FHS has supported the nationwide commercial distribution of contraceptives and fostered service delivery in the private sector through private hospitals, private nurses and midwives associated with the National Association of Nigerian Nurses and Midwives, women's groups, and large employers. The project has provided training in a number of the areas listed above, as well as informational and monitoring materials and commodities.

The Family Health Services II Project should build on the experience to expand the availability of contraceptive products and services.⁴² Resources provided through the new project should be used to strengthen and involve private sector nonprofit profit-making organizations in the delivery of services and the promotion and distribution of contraceptives. Planned Parenthood Federation of Nigeria (PPFN), Africare, CHAN, and PSI are among the nonprofit organizations interested in receiving support under FHS-II. Others willing to provide family planning products and services should also be involved. FHS-II should also expand activities with the private hospitals and clinics and, if possible, with the large employers and unions.

PPFN has been identified to receive the assistance required to expand family planning clinical services in the northern, more traditional areas of Nigeria. While currently hampered by some critical deficiencies,⁴³ PPFN should be given the support required to set up urban and periurban clinics that can provide contraceptive services of high quality and manage and monitor community-based contraceptive distribution systems. Other nonprofit organizations; e.g., Africare, should be engaged to promote family planning clinical services in other areas of Nigeria.

FHS-II should explore the possibility of assisting Population Services International to implement an expanded social marketing program for condoms and pills. PSI has an already established presence in several states of Nigeria and appears to have a commendable record of achievement in the sale of condoms. With assistance, PSI operations in Nigeria could be enhanced. Although Sterling Winthrop is no longer willing to distribute the "Right Time" product line, FHS-II should continue to attempt to identify and involve other pharmaceutical firms in the commercial distribution of contraceptives. FHS-II should identify a profit-making commercial firm willing to market the "Right Time" contraceptive line. Although the "Right Time" condom may not be viewed as a profitable undertaking by one of the pharmaceutical firms operating in Nigeria, other "Right Time" products; e.g., NORPLANT, offer considerable profit potential and one or more commercial firms might have an interest.

Accessing and involving private sector profit-making providers in the delivery of family planning services has been and likely to continue to be a major challenge. While private nonprofit organizations are relatively accessible, the Nigerian profit-making private sector is large, complex, fractious and uncoordinated.

Still, working through one or more of the associations listed above may be an effective way to identify providers interested and willing to participate in project activities. Since profit-making clinics seem to be most affected by the downturn in the economy, some private physicians, especially young physicians, nurses and midwives with new practices, may be most eager to participate. The Guild

⁴²See Horn et al., op. cit., p. iv.

⁴³See Petrich et al., op. cit.

of Medical Directors, an organization of young physicians who own and operate private clinics, should be approached. Some of the members of the GMD may be willing to participate.

While the national offices of the private associations for physicians, nurses and midwives should be informed and, if possible, involved in efforts to increase the private provision of family planning goods and services, it may be more effective to work through the state branches of the national associations. These are frequently better organized and more responsive than the national association. Lagos, Enugu, Cross Rivers and Kaduna state branches of the national associations are reportedly among the best organized.

Since it is unlikely that even the best organized state branches have complete and accurate information on their members, creative approaches to identifying private providers willing to participate in the FHS-II Project will have been implemented. Reaching private providers through announcements in newspapers might be one way to identify physicians willing to participate.

The private sector component of FHS-II should include an assessment of the potential for the local production of contraceptives. The potential for local production or elements of local production should be carefully evaluated.

5.4 Nigeria Combating Childhood Communicable Diseases (NCCCD) Project

The current CCCD Project has not given any attention to involving private providers of goods and services, although the original project design called for the PRITECH Project to work with the private sector. The resources of the project have been directed toward strengthening the capacity of the public sector to deliver child survival and maternal health services, especially at the LGA level.

Like FHS-II, NCCCD should identify and work with profit-making and nonprofit providers of goods and services to increase the volume and enhance the quality of primary health care products and services. The project should conduct an institutional analysis of the Nigerian Association of Nonprofit Organisations on Health (NANGO), a recently formed association of nonprofit groups working in child survival, to determine whether technical assistance and small grants could be made available to expand primary health care services, including family planning. NANGO could be an excellent mechanism to strengthen the management, monitoring and service delivery capacity of a number of nonprofit groups working in Nigeria.

NCCCD should consider initiating a "small grants" program to encourage NANGO members and other NGOs and PVOs to develop service delivery approaches that ensure the widest possible coverage at affordable costs and that provide primary health care services on a sustainable basis. At present, the efficiency and effectiveness of these health care providers are limited by their low level of coordination and their limited managerial and technical capability.

A small grants program could be established to support NGO/PVO efforts to improve the quality, efficiency, and coverage of health care services, and the rapid implementation of new and effective health service delivery mechanisms. All NGOs/PVOs providing primary health and family planning services would be able to submit proposals and compete for grants. Proposals would be judged against criteria which may include the following:

- the presence of a preliminary analysis/plan for sustaining high quality primary health care and family planning services to a significant number of people;

- the definition of an approach to achieving collaboration with other NGOs/PVOs and public sector providers;
- an estimate of the contribution to be made by the NGO/PVO to covering the costs of implementing the proposed program of services;
- a management plan that includes an analysis of existing constraints, technical assistance and training requirements, and a description of the proposed mechanisms for monitoring progress, evaluating efficiency, and assessing the impact of services against quantitative indicators.

The grants would be used to support technical assistance and the implementation of activities needed to increase efficiency and improve management capabilities, and to strengthen the quality and coverage of services. Cooperating Agencies (CAs) working through the NCCCD Project would provide technical assistance and conduct in-country training programs in priority technical and management fields for the staff of the NGOs/PVOs.

NCCCD should also approach the Nigerian Association of General Practice Pharmacists and the Pharmaceutical Manufacturing Association of Nigeria. At present, many pharmaceuticals in the Nigerian market are of questionable quality and beyond the means of many in need. Some of the pharmacists and pharmaceutical manufacturers have recognized the need to increase the availability of low-cost, high quality pharmaceuticals. Some have expressed interest in producing and marketing a kit consisting of three or four essential drugs; e.g., ORS, chloroquine, cotrimoxazole, paracetamol, condoms, contraceptive pills. This concept should be further explored. The project should also assess whether some community pharmacists, based in the larger cities of Nigeria, might be able to serve as distributors and monitors of a community-based program to distribute essential drugs.

Finally, NCCCD should work through one or more of the associations listed above; e.g., Guild of Medical Directors, to identify and involve profit-making providers in project activities. As noted previously, working through the state branches of these national associations may be the most effective way to identify providers.

Those interested in participating are likely to require some clinical and managerial training. The National Postgraduate College of Medicine of Nigeria (NPCMN) has expressed interest in developing and offering a short course on preventive health care. The course would offer basic training in such subjects as PHC and family planning, as well as data collection and the management of a private general practice. Associated with the FMOH, the NPCMN has direct links with the private associations and offers certificates for course attendance. A similar training arrangement should be explored for nurses and midwives, perhaps through the Nigerian Council of Nursing and Midwifery. Both training programs would need to place special emphasis on the quality of care and the importance of collecting and analyzing a limited amount of data.⁴⁴

In the course of clinical and managerial training, providers could be given materials on primary health care and family planning that have already been developed by other USAID-financed projects. Materials could be chosen to complement the course offerings and assembled in an attractive, inexpensive, ready-reference format.

⁴⁴Private providers are aware that information on the cost, extent and impact of private sector goods and services is often minimal in developing countries. Documenting the private sector's contribution to public health would be a major accomplishment.

In light of private providers' immediate concern about income generation and cost-cutting, training sessions supported under the NCCCD Project should include a detailed discussion on pricing and financing strategies for both fee-for-service clients and third party payers, i.e., private firms and parastatals, as well as creative, client-oriented marketing approaches.

5.5 Research and Evaluation

Both FHS-II and NCCCD need to ensure that research and evaluation of private sector activities are given focused attention. The projects should support the conduct of surveys that document the need for private sector services and the context in which private sector health care providers are delivering health and family planning goods and services. In addition, both projects must develop plans to evaluate the activities of and support given to the private sector. Finally, AAO/Nigeria should consider supporting the establishment of a center for research on health care in the private sector.

Surveys should document consumer demand for services, client satisfaction with services received, and provider proficiency and quality of care. The surveys should collect data on providers trained, clients attended, and fees charged at private clinic and hospital sites.⁴⁵ The data collected through surveys of private providers and consumers of primary health care and family planning services can be used to define the range of training and technical assistance required, as well as the incentives that could be offered to encourage private providers to increase the proportion of primary health care and family planning services.

This information has not been routinely collected and analyzed by private sector practitioners. The results of these studies are needed to formulate the questions to be addressed through operations research. OR methodology would assess the impact of price, access, advertising, health promotion campaigns, and perceived quality of care, etc. on demand and consumption of primary health and family planning services. The results of this research would suggest effective approaches to stimulate demand for and use of private sector services.

AAO/Nigeria should support the establishment of a Center for Research on Health Care in the Private Sector in the course of project implementation. Establishing a center would ensure that the private sector becomes and remains a legitimate focus for research and that a Nigerian institution has the capacity to carry on the work.⁴⁶

⁴⁵Client demand and satisfaction could be assessed through surveys that include interviews modelled after Knowledge, Attitude and Practice (KAP) surveys. The surveys should attempt to determine what consumers know, believe and do when seeking health and family planning services. Questions should seek information on what people actually do when seeking health care, and also what they prefer, given a variety of options. Along with a KAP-type survey, it would be useful to conduct a study that analyzes the intra-household distribution of resources in a constricting economy. This type of survey/study could identify how households re-allocate their resources when faced with reduced income or purchasing power. The information collected could be used when developing programs for health promotion and product marketing.

⁴⁶The current FHS project is supporting the establishment of a center for Operations Research at Obafemi Awolowo University (Ile-Ife). The lessons learned from this activity should be incorporated in the design of the center for research on health care in the private sector.

ECONOMIC AND FINANCIAL ANALYSES

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PART A
ECONOMIC ANALYSIS OF THE AAO/NIGERIA PROGRAM: 1993-2000

I. GENERAL ECONOMIC CONDITIONS AND HEALTH

A. **General Economic Situation**

In 1986, Nigeria began its Structural Adjustment Program (SAP). The response to SAP has been encouraging: from 1986 to 1990, real GDP grew at a 5.1% average annual rate compared with only 0.2% from 1981 to 1986. The increase in domestic output was not able to overcome the severe fall in Nigeria's international purchasing power during the 1980s, such that by the end of the decade, real consumption per capita was thought to have returned to the level of the early 1970s. Per capita income declined from \$1000 in 1980 to less than \$300 in 1992. In 1991, real GDP grew 4.3%, as the five year old economic reform program continued to boost agricultural and manufacturing output. Agricultural sector growth was estimated at 5.0%, helped by ample rains and improved fertilizer distribution, while growth in manufacturing was an estimated 6.1%.

B. **Health and Economic Development**

Good health contributes both to and is an objective of economic development. Health status and long life expectancy are important indicators of individual well-being. Health also has an impact on future development prospects. Improvements in health are an investment in human capital formation which are likely to lead to future yields in increased productivity and income. Better health reduces absenteeism at work and absence from school. Healthy individuals require less curative medical care and therefore have more resources available for consumption and investment in other activities. Reductions in infant and child mortality can contribute indirectly to reducing poverty by helping to lower high fertility rates.

C. **Key Factors Affecting Economic Appraisal in Health**

Devaluation: From 1987 through 1992, the naira has significantly depreciated going from 4 naira per dollar to 19 naira per dollar. Since most medical equipment and a good percentage of the components needed to produce pharmaceuticals must be imported, an increasing amount of Naira has been required to buy US dollars or other foreign currencies. This cost has been reflected in price increases passed on to the consumer. Since the parallel market is still higher than the official exchange rate (about a 20% difference), it is expected that the naira will continue to devalue; however, exact trends are difficult to predict. This will reduce the cost-effectiveness of program components heavily dependent on foreign inputs.

Inflation: Nigeria's economy in 1991 was marked by rising inflation stemming from a large government deficit financed by the Central Bank. Consumer prices rose 23% for the year, compared with 3.6% in 1990. Many private estimates of inflation were considerably higher. Rising prices eroded the real wage gains occasioned by the doubling of minimum wage at the beginning of 1991 and led to significant distress among the population. It is difficult to predict future trends in inflation, especially during the transition period to civilian government. Nevertheless, it is quite clear that the real costs of labor are extremely low and that this trend will continue. In general, inflation subtly alters the distribution of wealth by lowering the real value of any input with a fixed nominal cost (e.g. wages, rents). Economic incentives will tend to increase use of lower cost inputs; however, safeguards must be taken to ensure that technical production processes are optimal (no wastage). A

prerequisite of economic efficiency (minimum cost production methods) is technical efficiency (the combination of physical inputs that produce the highest output).

Government Budget Deficit: The trends in foreign exchange rates and inflation stem from a large government deficit financed by the Central Bank. The large public deficit was explained as the result of heavier-than-anticipated external debt service payments, the costs of the political transition and the national census, military expenses in Liberia, development of the federal capital territory and subsidization of several questionable investments. If SAP is maintained, efforts to reduce the budget deficit will resume. This heightens the need to use cost-effective interventions at a scale of activity which are affordable to the nation. Adequate public budget allocations for those aspects of primary health care which are public/merit goods with significant externalities are a feasible, major goal.

Economic Costs of Poor Quality: Reaching maximum cost effectiveness, that is, how well a therapy works in actual field circumstances for a particular population, depends critically on the quality of the intervention in question. According to Tugwell et al (1984), five factors determine community effectiveness: efficacy, diagnostic accuracy, provider compliance, patient compliance and coverage. Jamison and Mosley (1991) in the World Bank Health Sector Priorities Review note that many available estimates of cost per discounted healthy life year gained can only be taken as illustrative of the potential cost-effectiveness of alternative interventions because of the "dilution" effect of factors such as those listed above. They state that actual cost-effectiveness may vary two- to tenfold or greater in any given situation depending on a variety of local factors including quality of care.

For developing countries there is little direct evidence on the cost implications of poor quality, but there is substantial evidence that quality of care is poor and probably results in higher costs of care. For example, Mosley and Jamison (1991) note that the cost effectiveness of ORT in a hospital or clinic setting is approximately \$25 per year of healthy life gained. In contrast, in a community setting the cost-effectiveness falls to \$200 per year of healthy life gained. In the hospital setting, ORT will be used for more serious cases and applied effectively by qualified medical personnel. In the community, mild cases may be treated unnecessarily and home treatment will not be applied as effectively. The A.I.D. PRICOR project found that in Indonesia, 70% of ARI treatments inappropriately included oral ampicillin to cases with symptoms of viral upper respiratory tract infection. In the Pakistan model clinic, 95% received a prescription for antibiotics for viral upper respiratory tract infection. In these cases, antibiotics provide no benefits, may lead to adverse reactions and contribute to the rising prevalence of antibiotic resistance, all of which indicates a wastage of resources. In many cases, low cost solutions exist to rectify these deficiencies. Without appropriate attention to quality of care, the assumed cost-effectiveness of the interventions promoted by the AAO/Nigeria Health Program may be threatened.

II. ECONOMIC ANALYSIS OF THE AAO/NIGERIA PROGRAM: NCCCD

A. Major Project Components

The goals of the CCCD project are to reduce child and maternal morbidity and mortality rates; to increase the life expectancy at birth, and to improve the quality of life and adult productivity of surviving infants and mothers. The strategic orientation of the CCCD project includes five major areas of health interventions, i.e., (a) expanded program of immunization; (b) control of diarrheal diseases including nutritional and acute respiratory infection considerations; (c) malaria control; (d) maternal health and family planning; and (e) HIV/STD surveillance. CCCD delivery implementation activities will be supported by health information systems, health education, training and operations research.

B. Cost-Effectiveness of Program Components

The public health literature acknowledges that although noncommunicable diseases and injury will become more prominent with the epidemiologic transition, the infectious diseases, malnutrition and excess fertility cannot be ignored (Mosley, Bobadilla, Jamison, 1992). It is likely that these will become more concentrated among the poor, leading to the phenomenon of epidemiologic polarization. Tuberculosis is illustrative of a leading disease that is, so far, a neglected health problem in developing countries. In particular, as the burden of noncommunicable diseases increases, governments in collaboration with international donor agencies will need to take great care to assure completion of the unfinished agenda for improving the health of children and the poor in the face of constrained resources. Immunizations and other interventions against infectious diseases offer the greatest gains in healthy life per dollar.

The equity objective of focusing on the poor is generally consistent with efficiency objectives of extending investments in immunizations and other interventions against infectious diseases (Mosley, Bobadilla, Jamison, 1992). Although it has been fairly convincingly shown that the poor suffer more from chronic diseases than do their well-off counterparts, in relative terms, the poor suffer much more from infectious conditions (Briscoe, 1989; Feachem et al, 1992). From both distributional and efficiency perspectives, infectious disease control programs are merited.

Based on a major World Bank (Mosley and Jamison, 1991) study reviewing the cost-effectiveness of interventions addressing major diseases affecting developing countries, the following directions for international aid in the area of service delivery are given: (a) continued strong emphasis on most immunization and family planning programs; (b) enhanced emphasis on - measles immunization, case management of ARI and malaria, control of Vitamin A deficiency, tuberculosis chemotherapy, STD control, anthelmintic chemoprophylaxis, cancer pain control; and (c) increased selectivity in delivery of ORT and BCG in low risk environments. In the short-run, emphasis on program implementation will be important; however, for long-run sustainability, investment in capacity-building (training), and institutional strengthening (e.g. logistics capacity, management) is critical. Although application of the above conclusions are highly dependent on the local epidemiological, administrative and financial context, the health and economic circumstances of Nigeria fall well within the parameters highlighted by these broad studies.

In summary, the NCCCD project is found to have sound economic justification, both in the short-term (expansion of service delivery) and in the long-term (institution and capacity building). The program supports health interventions which are generally accepted to be cost-effective and should be a worthwhile investment for both Nigeria and A.I.D. The outputs from the program are sufficiently valuable as to warrant the expenditure of scarce resources. The project also has merit in terms of enhancing equitable distribution of improvements in health and should continue to extend its services to selected target subpopulations which have not yet participated in program benefits.

III. ECONOMIC ANALYSIS OF THE AAO/NIGERIA PROGRAM: FHS-II

A. Major Program Components

The goals of the FHS project are to encourage a rate of population growth compatible with Nigeria's social and economic development plans, to reduce infant and maternal mortality rates by preventing high risk pregnancies, and to improve the quality of life for mothers and infants surviving childbirth.

The specific approach of the project is to assist the Federal Government Nigeria in the reduction of fertility rates by expanding the availability of family planning services in both the public and private sectors through an integrated program of information, communication, education, training, contraceptive logistics, management and evaluation.

B. Cost-Effectiveness of Program Components

Recent public health and economic demography literature observe that economic growth (as measured by per capita output) in many developing countries would have been more rapid in an environment of slower population growth. Population's adverse impact has most likely occurred where arable land and water are particularly scarce or costly to acquire, where property rights to land and natural resources are poorly defined and where government policies are biased against the most abundant factor of production-labor (e.g. oil-based economies). Emphasis on policies of slowing population growth without simultaneously confronting the other fundamental causes of such problems may well lead to disappointing results. Careful consideration of improvements in macroeconomic policy is required. The National Academy of Science (NAS) concludes that slower population growth would be beneficial to the economic development of developing countries (NAS, 1986, p.90).

Current estimates of population growth in Nigeria are 3.3%. From a societal point of view, many economists view population growth rates above 2% as detrimental to development, a rule of thumb presented in the World Development Report (1984). Nigeria's Population Policy has an ambitious long-term goal for population growth rate of 2% by the year 2000. Notably, the complementary adjustments in macroeconomic policy are also underway under the Structural Adjustment Policy launched in 1986.

In LDCs overall, it is estimated that about a third of the births in the developing country outside China are unwanted and excess fertility would be even higher if births that come too soon were to be included (Cochrane and Sai, 1991). This implies substantial unmet need for family planning. Analyses indicate that in areas where mortality is low or demand to limit family size is 30% or more, the savings from public health and education (universal primary education) expenses alone are sufficient to justify public expenditure on family planning to avert a birth even at a high rate of discount. Where the demand to limit the number of births is lower as in parts of Sub-Saharan Africa, the costs of averting a birth are much higher. Because of this the economic justification for supporting family planning is weakened somewhat, but given much higher maternal, infant and child mortality in these areas, the health justifications are very important. Improved spacing and the deferment of birth until reproductive maturity is achieved are more important for improving child survival than are other high fertility behaviors. In addition, reducing mortality is an important factor in stimulating more demand for family planning. Even in low demand areas, however, at rates of discount of 5% it is justifiable for the public to fully support the prevention of all births that are unwanted by the family (Cochrane and Sai, 1991).

The level of expenditure needed to eliminate all fertility that is unwanted by the family is difficult to calculate. A.I.D. estimated that \$1.5 billion was spent on family planning in 1980 and that \$3 billion would be needed in 1990 (Gillespie et al 1988). A.I.D. estimates imply that substantial increases in funding would still not be sufficient to cover current users plus the usage of all those women who wanted no more children and were not using contraception, if the World Fertility Survey figures are representative of the world as a whole. For these reasons, Cochrane and Sai (1991) propose a higher estimate of \$4.6 billion (in 1987 prices). By the year 2010, the number of currently married women of reproductive age will have doubled according to A.I.D. estimates; therefore, the expenditures on family planning in the developing world are substantially below what is needed to

eliminate unwanted fertility by the estimates of individuals. Substantial increases in expenditures in family planning are needed (Cochrane and Sai, 1991).

In summary, the FHS-II Nigeria project is found to have sound economic justification, both in the short-term (expansion of service delivery) and in the long-term (institution and capacity building). The program supports interventions which are generally accepted to be cost-effective and should be a worthwhile investment for both Nigeria and A.I.D. The outputs from the program are sufficiently valuable as to warrant the expenditure of scarce resources.

The project should continue to extend its services to selected target subpopulations which have not yet participated in program benefits (e.g. high barriers to usage).

IV. ECONOMIC ANALYSIS OF THE AAO/NIGERIA PROGRAM: AIDS PREVENTION AND CONTROL

A. Major Program Components

The major intervention focus of the Nigeria AIDS Prevention and Control Project is on the sexual transmission of HIV, through three strategic components: reducing numbers of sexual partners, improving diagnosis and treatment of STDs and increasing access to and use of condoms. In addition, the project will increase the knowledge of sexual behavior and apply this knowledge to communication strategies for behavior change through behavioral research. The project will target interventions on sub-populations practicing high-risk behaviors. Primary target groups include: commercial sex workers, long distance drivers, and the military. Secondary population target groups include post-secondary students, and urban employed males.

B. Cost-Effectiveness of Program Components

Prevention of STDs and of HIV infection is possible with highly cost-effective interventions (World Bank PHN Notes, 1992). The prevention and treatment of STDs is cost-effective even in poor countries — and would at the same time reduce AIDS. Decision-makers usually underestimate the cost-effectiveness of efforts to prevent STD because the prevention or cure of one case benefits not only the individual affected but anyone he or she might infect in the future. Programs to prevent and control STDs can be extraordinarily cost-effective when the program is highly targeted.

In a country experiencing an HIV epidemic, inexpensive interventions — blood screening, condom subsidies and information, education and communication (IEC) services — can buy more than 6.5 healthy life years per dollar spent (World Bank PHN Notes, 1992). Even for the non-core population, condom subsidies and the treatment of STDs are cost-effective relative to other adult health interventions. However, some interventions should only become a later priority. For example, antivirals to treat AIDS patients or blood screening of the general population where STD prevalence is low and no HIV epidemic exists, buy less than one-half and less than two healthy days per dollar spent, respectively.

National health programs should include, as a minimum, some STD services or STD control programs targeted at "core" urban groups. These services should be subsidized, at least initially, to ensure use. AIDS prevention programs should first exhaust the possibilities for intensified outreach targeted at high-risk core groups before reaching out to the general population. A poor country with per capita GNP of \$300 or less and a cost per clinic hour of less than \$10 should only implement safe-sex programs, treatment of STDs and limited blood screening in urban areas or targeted at core

groups. In a poor country, the only case management option that could save more than a day of healthy life per dollar in the general population group is syphilis treatment.

In summary, the FHS-II Nigeria project is found to have sound economic justification, both in the short-term (expansion of service delivery) and in the long-term (institution and capacity building). The program supports health interventions which are generally accepted to be cost-effective and should be a worthwhile investment for both Nigeria and A.I.D. The outputs from the program are sufficiently valuable as to warrant the expenditure of scarce resources. The project should fully exhaust the possibilities of reaching high-risk target subpopulations before considering expansion to the general population.

V. DISTRIBUTION OF THE BENEFITS OF
AAO/NIGERIA HEALTH PROGRAM

Nigeria continues to have high rates of fertility and infant and child mortality. Estimates of infant and child mortality rates are 87/1000 live births and 109.6/1000 live births respectively (1990). Maternal mortality is 6/1000 live births. Approximately 3.5% of married women are using modern methods of contraception. Total fertility rate is 6.01. Notably there are significant regional differences in these rates, both between urban and rural and between north and south. These regional differences are presented in Table 1. According to the Demographic and Health Survey (DHS), 9% of married women living in urban areas use modern methods of contraception while approximately two percent of women residing in rural areas use modern methods. Similar disparities exist for breastfeeding practices, oral rehydration therapy (ORT) and Expanded Programme on Immunization (EPI) services. The evidence indicates that urban residents in the Southwest and Southeast, who have the greatest access to health services and women with the highest levels of education exhibit the best indicators. Poorest health and family planning indicators are among the rural areas of the Northwest and Northeast and among women with the lowest levels of education (DHS, 1991, p.9).

Even though at present only 30%-35% of the population lives in the urban areas, an urban growth rate of 7% annually means that over half of the population of Nigeria will be urban by the year 2,000. Although the DHS indicates that health status is generally better in the urban areas of Nigeria, concerted efforts will be required to maintain these gains in the presence of large urban growth. Clearly, the cost-effective interventions of the AAO/Nigeria health programs have made important progress in selected parts of the country. Yet AAO/Nigeria will be challenged to maintain and build on this progress in light of current growth trends in the urban areas. In addition, the benefits of AAO/Nigeria programs have yet to reach important segments of the population. For distributional reasons, future AAO/Nigeria programs, especially NCCCD and FHS-II, should not only build on progress, to date, but should target selected population subgroups which have not yet been reached. This may decrease the cost-effectiveness of some of the interventions because these populations are typically harder to reach, but on equity grounds, effort along these lines is merited, to the extent that program resources allow.

PART B
FINANCIAL ANALYSIS OF THE AAO/NIGERIA HEALTH PROGRAM: 1993-2000

Programs which are cost-effective are not necessarily affordable. In choosing the appropriateness of health interventions, cost-effectiveness information must be used in combination with a budget target. Because of the multiple components of the AAO/Nigeria Health Program across federal, state and local governments, a straightforward budget target is not available to assess its financial viability. However, it is possible to determine which factors may threaten the financial sustainability of the Program and to make recommendations for project design to alleviate these concerns.

This financial analysis is organized to identify factors which may threaten the financial sustainability of the AAO/Nigeria Health Program. Factors analyzed include: (a) financial conditions in public expenditure patterns; (b) counterpart contributions; (c) private sector involvement in the health sector; and (d) selected cost-recovery experiences in Nigeria.

I. PUBLIC EXPENDITURE PATTERNS FOR HEALTH (1981-1991)

In the past two decades, Nigeria has considerably expanded its health care system in both the public and private sectors. During the period 1975 through 1984, population per doctor fell from 1:28,000 to 1:6,630 which compares well with other low-income countries. Nevertheless, health services are under severe strain stemming from restricted public expenditures as a result of the economic crisis and poor allocation of available resources between personnel and supplies, and between new investment and maintenance. Nigeria's high mortality rate and low life expectancy are associated with remarkably low utilization of health services, in part due to deteriorating quality of service and in part due to falling per capita incomes.

Significant public expenditures occur at the federal, state and LGA Ministries of Health and Health Departments. Of the total projected capital budget for the 1991-1993 period (2352.441 million naira) the federal government will spend 556.100 million (24%), the state governments will control 1274.818 million (54%), while the local governments will have 521.523 million (22%). Since the federal government expenditures account for only one quarter of total public expenditures, it is important to consider expenditures at all three levels of government. Information is most readily available on federal expenditures; selected information is available for states and LGAs.

A. Federal Expenditures for Health

Recurrent budgets of the MHSS pay for overhead and personnel expenses of the Ministry itself and for grants and subventions to federal teaching hospitals, other tertiary care teaching hospitals, Registration Boards. The capital budget covers major program expenditures.

Real Levels of Health Expenditures: Table 2 demonstrates that in real terms, federal government expenditures have steadily declined during the 1980s. Since the share of the total Federal budget allocated to the MHSS has remained fairly constant, as shown in Table 3, the fall in absolute levels of the federal health budget stem mainly from a fall in government spending in general. In real terms, the 1990 value was about half the 1981 value.

Share of the Total Budget: It is also important to note that allocations to the MHSS have constituted a very small portion of the total federal budget, never reaching even 3%. The 1990 share (2.4%) was almost as large as the highest share reached in 1981 (2.6%)

Recurrent Expenditures: During the period 1980-1991, MHSS actual recurrent expenditures have been consistently above approved expenditures (10 out of 12 years). These figures are shown in Tables 4-5. In 1989-90, special grants to the MHSS and its parastatals for recurrent costs have been allocated for SAP relief (drugs and debts for electricity) and restructuring of salary scales. In 1991 the minimum wage was raised. Salary scales were restructured creating a scale for physicians and a scale for non-medical health system personnel. These special salary adjustments increased allocations for federal parastatals by 20%-23% over initial budgetary provisions. Few of the additional allocations to the parastatals have been designated for non-personnel operating costs, such that in 1991 only 13% of recurrent expenses support non-personnel expenditures.

Capital Expenditures: Actual capital budgets have been larger than planned expenditures in 1986-87 and most recently in 1990-1991 as a result of off-budget capital supplementations from the Presidency. The trend is expected to continue in 1992. In 1990, capital supplementations amounted to 246.237 million naira to fund special projects such as the Primary Health Care Support Program, renovation of selected teaching hospitals, yellow fever vaccine production, National Eye Center, selected centers of medical excellence).¹ In 1991 capital supplementations totaled 229.706 for similar projects (excluding the Primary Health Care Support Program). On average these capital supplementations have increased actual capital expenditures by 63% - 164%.

Key Program Expenditures: As shown in Table 6, regular budgetary allocations to FHC have stabilized around 20% of the total capital budget. A large jump in the PHC budget from 17.85 million naira in 1989 to 83.96 million naira in 1990 was a result of the AAO/Nigeria Primary Health Care Support Program. This increased allocation was not maintained in the 1991 budget which returned to 19.38 million naira. Population activities capture only 1.3% of the budget.

Between 1987 and 1991, the Nigeria allocated 10 million naira for AIDS programming. In August 1991, the President of Nigeria "Declared War on AIDS". He pledged 20 million naira for AIDS for the 1992 fiscal year. This support has been available because of the counterpart funding requirements of the AAO/Nigeria Primary Health Care Support Program, some of which has been designed for AIDS support. Federal funds will be complemented by commitments from each state of 1 million naira and 0.5 million naira from each LGA for a total of 325.5 million naira to launch and implement AIDS activities.

Budgetary versus Off-Budgetary Allocations: In assessing the sustainability of public expenditure patterns it is important to distinguish budgetary versus off-budgetary allocations. Capital supplementations from the Presidency (augmenting regular budgets by 63% - 164%) have been forthcoming, but are unlikely to continue under SAP. Expansionary fiscal policy in 1990-91 (on- and off-budget) have resulted in large budget deficits. Increased pressure to reduce the budget deficit means that the public health sector should focus on increased percentages to the regular health budget for PHC-related activities and AIDS (through the capital budget). However, it should be noted that not all regular allocations to health are captured in federal budgetary allocations. States and LGAs participate substantially in health. State and LGA health expenditures are funded by statutory allocations directly from the Federal Government and by revenues collected internally. Patterns at the state and LGA level are discussed below.

¹ A capital supplementation of 550 million naira to strengthen a secondary-level hospital in selected states was announced in 1990, but is unlikely to be disbursed.

B. State Expenditures for Health

1. Financial Situation

Share of the Total Budget: Most government health expenditures takes place at the State Level. Estimates indicate that less than one-third of expenditures occur at the federal level, over half of government health expenditures occur at the state level and the remaining 20% go through the LGA (Denton et al, 1991). As shown in Table 7, states spend more on their recurrent budgets on health than does the federal government, somewhere around 10%-12%, compared to 2.5% for the federal government. On the capital side, there is substantial variation among states on the portions of total capital budgets allocated to health. States seem to be allocating only slightly larger portions of their capital budget to health than the federal government. Table 8 compares information for four states with the federal share.

Real Levels of Health Expenditures: Evidence from a recent ODA survey of four states is summarized below (Thomas 1992 a-e). Real resources devoted to health services has declined rapidly on a per capita basis since 1985.² As shown in Table 9, the general pattern of declining resource availability is a result of SMOH heavy fiscal dependence on modest budgetary share of declining central government statutory allocations. As shown in Table 10, cost recovery at the state level is a small share of the state's recurrent expenditure on health. Evidence from four states range from 5.11% to 0.56%. Funds raised are often passed onto the state treasury and are not retained within the sector.

Recurrent Health Expenditures: Recurrent expenditure, presented in Table 11, usually accounts for more than 80% of state health spending. Because personnel accounts for a high share of recurrent costs, personnel also accounts for 50-60% of total state health spending including capital. There is a great need to curb investment expenditure and increase recurrent expenditure particularly on non-personnel inputs. Declining budgets for states have cut most sharply into capital and non-personnel recurrent budgets.

Key Program Areas: The state remains responsible for supervision of, support and training for **PHC** activities. However, evidence suggests that states are not allocating sufficient amounts to handle these activities. As shown in Table 12, state allocations to state Ministries of Health (which have responsibility for PHC) in comparison to Health Management Boards (which have responsibility for hospitals) have for the most part diminished substantially. There is a long term need to identify state budget requirements for supporting for PHC, particularly supervision and in-service training for staff in remote areas. Substantial under-funding of state services has meant that the state's role in relation to PHC is inadequately carried out. A similar pattern of under-funding on special programs to support PHC; e.g., **AIDS** and **population** activities is evident in state budgets. However, all states including Abuja have just committed one million naira to launch and implement AIDS activities.

Lack of state funding for PHC has become so critical that the MHSS through the Primary Health Care Development Agency of Nigeria (PHCDAN) has requested that every State Commissioner of Health create a separate account of somewhere between 150,000 - 200,000 naira to fund recurrent costs for support of PHC. In particular, each state should allocate sufficient funds so that one staff member can visit each LGA at least four times a year for five days per visit. If the state makes this commitment, the MHSS will match the allocation naira for naira which the state can spend on other

² These per capita figures may change as census figures are confirmed.

PHC activities. This matching fund mechanism will be in place for two years. In addition, the MHSS has stated that over the next five years, states will fully take over the costs of vaccines for PHC. Eventually, LGAs will be required to assume these costs.

States should offer support to LGAs on key areas of PHC which would not be assumed by the private sector (e.g. water and sanitation, sewage disposal, vector control, occupational health). States should allocate funds to replace the PHC vehicle on a timely basis. Increasing funds for preparation of manuals, in-service training and out-of-state training to maximize returns from existing investments.

2. Financial Management Capacity:

According to a Price Waterhouse (1991) study, federal, state, and LGA Ministries of Health and Health Departments use an accounting system prescribed by a Federal Government approved "Financial Memorandum". Although such accounting systems are able to handle, record, and maintain rollover type advances of funds, they are not designed to easily monitor actual expenses by program area and against program outputs and outcomes. In particular, funds are typically pooled and applied to "needy" areas on demand. An implementation weakness which compounds the difficulty of tracking actual program expenses, as identified by Price Waterhouse, is that cash disbursements are not always followed up by supplier invoices. This means that actual spending may not match cash advances. Personnel skills for traditional accounting and monitoring "efficiency" in expenditures are weak.

Similarly, an ODA study found that the information base on State resource inputs and their use is seriously deficient. There is a great need to improve capacity to monitor levels and patterns of State spending and improved classification of accounts (Thomas, 1992e). There is a lack of a comprehensive data source which aggregates the spending of the MHSS and the HSMB into a consolidated account of sectoral expenditure for current and previous years. In addition, there is obscurity of accounting classifications used in the MHSS and HSMB budgets (Thomas, 1992e). Since utilization levels are so low, the state should provide support monitoring and evaluation of the usage of different level facilities in order to establish patient perceptions of quality of care and price signals from charging patterns. In addition to fulfilling traditional accounting requirements, the financial information system should be able to identify where cost savings might be achieved.

C. LGA Expenditures for Health

1. Financial Situation

LGA Revenues: The HERDs (1992) study indicates that an increasing proportion of LGA revenues has been coming from federal and state governments funding support (1980 - 71% to 1991 -88%). In particular, there has been a consistent increase in the Federal Statutory Allocation to the LGAs. Initially LGAs were receiving 5% of the Federal vertical allocation formula annually. Between 1987 and 1989 LGAs received 10%. In January 1990, this was augmented to 15%. In 1992, LGAs now receive 20% of federal revenue sharing. This represents a 400% increase in the budgetary allocation to each LGA in the Federation. This decision was taken to enable LGAs more effectively to discharge their exclusive responsibilities for PHC and primary education. LGA share of federation account has been paid directly to LGAs and no longer through their state governments. This information is provided in Tables 13-14.

In addition, the health sector receives support through horizontal revenue sharing formulas. In 1990 the horizontal allocation formula included a health criterion for the first time. The number of health facilities were added to primary school enrolment to constitute the "Social Development Factor" component of the horizontal revenue allocation formula. Consequently every LGA in the Federation has received a direct increase in central government funding (the major part of LGA revenue) to better enable it discharge responsibilities in primary education and primary health care.

Share of the Total Budget: Clearly, health is a priority for LGAs; health is a major line item in LGA recurrent budgets. Table 15 shows that in the model PHC LGAs, health accounts for 20%-25% of the actual recurrent budget. The proportions to health have been increasing due to the policy of transfer of responsibility for primary health care to LGAs from the states. Education also receives a sizeable allocation, but its share has been decreasing. Notably, other supporting infrastructure (e.g., electricity, transportation, water) appear to be seriously under-funded. Recurrent expenditures of LGA health sector budgets are heavily skewed towards personnel costs.

Recurrent Health Expenditures: Actual health expenditures from selected model LGAs consist of about 72%- 79% personnel and 4.6% - 9.0% drugs and supplies, 6.4% - 5.7% vehicle operations and maintenance, about 1% for building maintenance and 1% for office supplies. This is given in Table 16. Since actuals in personnel almost always exceed estimates in personnel for overhead costs, it is likely that personnel costs are allocated first and whatever remains is allocated to overhead.

Key Program Areas: LGA health budgets are generally divided into 4 major program areas: administration, preventive services, curative services, and environmental sanitation/social welfare. Since 1989, some LGAs also include a line item for primary health care unit (managerial process activities). Limited evidence, shown in Table 17, indicates that a substantial proportion goes curative care aspects of PHC; however, since 1990 percentages allocated to curative care are decreasing and shares to preventive services and PHC are increasing. All LGAs have been encouraged to commit 0.5 million naira to launch AIDS programs. Not all LGAs have made such commitments at this time.

2. Financial Management Capacity

The findings of the Price Waterhouse (1991) study also apply to LGAs. LGA accounting systems are able to handle rollover type advances of funds, but are not designed to easily monitor actual expenses by program area and against program outputs or outcomes. The HERDS Medicare study on the "Financial Soundness of Primary Health Care Programs of Model LGAs" assessed several aspects of the financial management system including budgeting, accounting, auditing and financial information and control. The study found that the availability of items necessary for sound financial planning and management of PHC are quite low. For an average model PHC, the presence of adequate documentation is only 34.6% for records on LGA sources of revenues, 33.2% for cost by type of expense records, 30.9% for sectoral recurrent expenditure records, 25% for records on cost by program area, and 23.7% for personnel component records. In the model LGAs, which responded to the HERDs study, the best case scenario represented by those model LGAs which responded to the survey, about 62% - 77% had records (not considering the quality of the data). The results show that LGAs, in their financial management, focused more on sources of revenue. Quite clearly, program-oriented financial planning and management together with its corresponding budgeting system is not yet in place in the model LGAs. What is in vogue at the present time is the traditional administrative type of budgeting and a system of financial management which is unresponsive to performance monitoring and to the program demands of efficiency, effectiveness, cost effectiveness and equity considerations. Financial planning and management deserves critical attention in light of the devolution of PHC from the state to the LGA.

II. COUNTERPART CONTRIBUTIONS TO AAO/NIGERIA
HEALTH PROGRAMS: PAST EXPERIENCE

Host country contribution (HCC) may cover operating or capital costs, such as cash, goods, personnel, administrative costs, rent or purchase of material, facility construction, fair value of land, etc. AAO/Nigeria has had three major initiatives requiring counterpart contributions; i.e., ACSI/CCCD/Nigeria, Family Health Services (FHS), and the Primary Health Care Support Program (Nonproject Assistance - NPA). A review of the experience under each of these programs is useful for projecting the possible form and magnitude of HCC to future projects.

Table 18 indicates estimated amounts of HCC attributed to FHS and CCCD from 1989 through mid-1992, utilizing data collected from only four states and nine LGAs. By extrapolation from "actual" estimates obtained from four states to "expanded" estimates involving other states engaged in FHS and CCCD activities, the approximated HCC of \$30.3 million could be projected to a greater magnitude approaching, perhaps, twice that amount.

A. **CCCDI: Counterpart Contributions**

As of mid-1992, HCC to CCCD (contributions from only four states included) is estimated at slightly less than \$23.5 million. These estimates of HCC include both cash and in-kind contributions, but not other donor contributions. Eight major categories of contributions were considered: health facilities, salaries and allowances, vaccines, training, running and maintenance costs, vehicles, equipment, land, building and cash.

By Type of Contribution: Table 19 gives the nature of the MHSS contribution to CCCD. Of the total \$8,191,175, only \$84,175 or 0.01% was spent on salaries, allowances and interventions against malaria and diarrheal diseases. About 99% of MHSS contribution (\$8,107,000) supported the purchase of vaccines through UNICEF.

For the states, salaries and allowances dominated with 48% followed by land and building at 26%, followed by health facilities at 9%, operating and maintenance costs at 8%, vehicles at 8% and training (0.3%). This is shown in Table 20.

Similar patterns in the types of contributions were observed in the LGAs. As shown in Table 21, salaries and allowances dominated the contributions with 38%, health facilities 26%, equipment 14%, land and buildings 10%, operating and maintenance costs 7%.

By Year: The pattern of support for CCCD activities during 1989-1992 is disturbing. Presented in Table 22, in 1989, the support was 28% of total CCCD project expenditures, 40% in 1990, 26% in 1991, and projected to far less in 1992. This pattern may be because PHC has been moved to LGAs and/or because of the serious devaluation of the naira.

In summary, with the exception of MHSS purchases of vaccines, a majority of counterpart contributions at state and LGA are in terms of personnel and facilities already in place. Small counterpart contributions are made for non-personnel recurrent expenditures (operations and maintenance, supplies, equipment, vehicles, commodities). Also, counterpart contributions appear to be falling.

B. FHSI: Counterpart Contributions

According to the FHS project papers, total HCC was estimated to reach \$33.5 million by end of project (July 31, 1992). Current estimates are that \$33,112.537 has been contributed so far. These HCC estimates include both cash and in-kind contributions, but not other donor contributions. Eight major categories of contributions were considered: health facilities, salaries and allowances, vaccines, training, running and maintenance costs, vehicles, equipment, land, building and cash.

By Type of Contribution: Table 23 gives the nature of federal contributions. Table 24 gives the nature of the contributions from the states. For the federal contribution: cash amounted to 53%; private sector sale of condoms and commodities accounted for 26%; salaries and allowances were 17%; and training was 4%.

In contrast for the states, salaries and allowances constituted the largest portion of the contribution (71%), followed by health facilities at 9%, equipment at 9%, vehicles at 4%, training at 3%, maintenance at 2%, land and buildings at 3%. No cash was contributed. These numbers reflect an average of four states. There is some variation between states. For example in Niger state, only 31% went to salaries, but 38% went to health facilities.

In LGAs like the states (Table 21), salaries and allowances dominated the contributions with 38%, health facilities 26%, equipment 14%, land and buildings 10%, operating and maintenance costs 7%.

By Year: The total yearly contributions showed a remarkable increase between 1989 and 1991 (10%, 30%, 37%), presented in Table 22. Projections for 1992 suggest that up to 37% of total contributions would be given.

In summary, with the exception of the MHSS contributions of cash and commodities, a majority of counterpart contributions at state and LGA are in terms of personnel, facilities and land already in place. Small contributions are made for non-personnel recurrent expenses (operations and maintenance, equipment, vehicles, commodities, supplies). However, counterpart contributions appear to be increasing.

C. Primary Health Care Support Program: Counterpart Funds

Situation: The Nigeria Primary Health Care Support Program was initiated in August 1989 as the vehicle for fulfilling the US government's pledge to Nigeria of \$25 million in foreign exchange, made in recognition of Nigeria's aggressive structural adjustment program. The Program commitment called for funds to be disbursed in two tranches of \$15 million and \$10 million upon the satisfactory completion of specified conditions precedent. The Program was subsequently expanded by \$11 million, adding a third tranche and additional program conditions. The total Program of \$36 million was designed to encourage and support major shifts in Nigeria's health policy and structure towards decentralization, preventive care, and reduced reliance of tertiary facilities on public financing.

For the purposes of this discussion, those aspects of the nonproject assistance (NPA) program related to counterpart contributions are highlighted. First, the Program required that the federal government place special allocations of 50 million, 67 million and 67 million (in constant 1989) naira in their 1989, 1990, 1991 budgets, respectively. Second, the federal government was to establish a special account into which the local currency equivalent of each tranche was to be deposited. These funds were to be used for health-related allocations.

Conditions for the first tranche and second tranche have been met. Actions on the conditions precedent for third tranche are underway. It should be noted none of the tranches have been completed on time. Two amendments have been made to the project to extend the program deadline from December 1991, to December 1991 and finally to December 1992. The first tranche was actually disbursed in July 1990. The second tranche has just been approved (November 1992).

For the first tranche in 1989, special allocations (in the form of capital supplementations) were allocated for distribution to LGAs that were willing to engage in PHC activities. In addition, the naira equivalent of 117 million naira for the first tranche of \$15 million has been allocated to health activities (training, LGA support, monitoring and evaluation, MCH/FP zonal support, technical assistance), although documentation of line item program allocations were late. Of particular relevance to AAO/Nigeria is that sizeable amounts of these new supplementary funds will support AIDS (ten million naira), LGAs (twenty-one million naira) and population activities (ten million naira). For the second tranche, a special allocation of \$67 million naira has been added to the 1990 federal budget as can be seen in Table 6. However there has been considerable delay in satisfying another condition for the second tranche, namely, obtaining documentation of the fifty million naira disbursements to LGAs. In addition, there has been some delay in obtaining a detailed plan for the allocation of local currency equivalent of the second tranche as well as documentation of its disbursement. The naira equivalent of the second tranche will support a wide variety of PHC-related activities. Of particular interest are allocations for the Bamako Initiative (twelve million naira), AIDS (twenty million naira) and family planning (ten million naira). For the third tranche, there have been delays in obtaining documentation of additional special allocations to the LGAs, documentation on LGAs receiving disbursements, documentation of the detailed plan for the allocation of the naira equivalent of the third tranche, and documentation of disbursements of the naira equivalent account.

Lessons Learned: Based on the evaluation of the Primary Health Care Support Program (Taylor and Donaldson, 1992), there are several important lessons which may be useful in arranging future counterpart funding arrangements:

- Some policy reforms (e.g. private practice for public physicians) are complex and require time to be designed and legislated. It may be inappropriate to link such reforms with quick counterpart disbursement requirements. The timing of counterpart funding should be carefully integrated with realistic estimates of the time frames for completion of program activities.
- Since documentation of detailed plans for special allocations and corresponding disbursements have been difficult to obtain, there is a critical need to establish mutually agreeable detailed procedures for monitoring counterpart funds, in terms of planned allocations, actual disbursements, and actual spending.
- The management processes within the MHSS related to obtaining and documenting counterpart funds and implementation of corresponding conditions precedent must be strengthened.

In light of the sudden and serious efforts of the MHSS in the remaining few months of a long process to satisfy all conditions precedent for all three tranches, management of donor coordination with the MHSS should take high priority, be fundamentally strengthened, and aggressively implemented to avoid missed opportunities. The MHSS has established the responsibility for donor coordination at the Director-General's office, where coordination across all departments can be addressed. Implementation of these responsibilities should be a high priority.

III. THE PRIVATE SECTOR: THE CURRENT SITUATION

A. **Health and Population Policies on Privatization**

The National Health Policy and Strategy to Achieve Health for All Nigerians (1988) states that "Within the right of individuals to participate in the economy of the nation, private individuals shall be encouraged to establish and finance private health care services in under-served areas." The National Population Policy (1988) defines an explicit role for private, nongovernmental organizations, namely, that they "shall be encouraged to participate in population activities. Due recognition shall be given to their work, expertise and experience. Their resources shall be fully utilized."

The Primary Health Care Support Program required several policy reforms and activities to promote private sector involvement in the provision of health care; e.g., reducing the dependency of tertiary care facilities on government financing by increasing cost sharing and privatization of the health care system. In general, the MHSS has shown willingness to explore and advance private sector financing and provision: study on cost-recovery, private patient and amenity wings, physicians working in the private sector, private physicians using public hospitals for both PHC and FP. A policy recommending that private practice by public sector physicians be allowed during off-hours became law in May 1992.

B. **Current Private Health Sector Activities: Summary**

1. Major Actors

A recent AAO/Nigeria document (Tomaro, 1992) provides a good description of current private sector activities in health-related services. Brief highlights are summarized here. It is important to note that detailed surveys and research on private sector activities are generally non-existent. Evidence so far comes from extensive interviews with major actors in the private sector. For this reason, this discussion of current private sector activities should be taken as suggestive rather than definitive. The private sector includes:

- profit-making providers of health and family planning goods and services (groups and individual practitioners, modern as well as traditional health care givers);
- profit-making manufacturers, distributors, and vendors of health and family planning products, and
- nonprofit providers of health and family planning goods and services, e.g., NGOs and PVOs.

The private health sector in Nigeria is large, growing, diverse, energetic, primarily urban-based and difficult to quantify.

Private profit-making physician providers are members of the Nigerian Medical Association (NMA), an umbrella group of all licensed physicians. Two related sub-groups include: the Guild of Medical Directors (GMD) and the Association of General and Private Medical Practitioners of Nigeria (AGPMPN). Members of the GMD generally own and operate some of the larger inpatient facilities that offer a full range of radiological, diagnostic, and inpatient surgery and care. Antenatal and maternity services, including family planning, are also routinely available. The AGPMPN is comprised of members of the GMD as well as private physicians who have either a part-time or full-time private office practice. Many work in the public sector and treat private patients in their off

hours. The GMD or AGMPN attend three types of clients: workers covered by insurance plans, private individuals who pay "negotiated" fees, and members of the doctors' family and friends who expect free care.

Fees for services at private facilities vary widely depending on the location of the clinic/hospital and the range of services offered. Preliminary evidence suggests that price is not always positively related to quality. However, for the GMD setting and enforcing fees that are based on a careful estimate of cost has been a principal objective.

Private profit-making nurses and midwives who own their own clinics and maternities are members of the umbrella National Association of Nigeria Nurses and Midwives (NANNM) as well as the Private Nurses and Midwives Association of Nigeria (PNMAN). NANNM is a strong union. The fees charged by private midwives and nurses are often significantly less than those of the clinics owned and operated by physicians.

NGOs and religious-affiliated institutions have long been involved in the provision of health and family planning services in Nigeria. The activities of the Family Planning Federation of Nigeria (PPFN) and the Christian Health Association of Nigeria (CHAN) are well known. CHAN is the coordinating body for church-sponsored health care in Nigeria. CHAN operates two projects that are directly relevant to the AAO/Nigeria health program: Central Pharmacy Supply project (procures and distributes pharmaceuticals through a network of depots) and the Primary Health Care Project (coordinates, promotes and stimulates primary health care activities among CHAN members). Supported largely by donations from bilateral and multilateral donor organizations and private foundations, as well as some local contributions, these NGOs usually provide primary health care and family planning services at low fees, often targeting those 'at risk'. Within the last two years, many of the largest nongovernmental organizations have become affiliated with the Nigeria Association of Nongovernmental Organizations on Health (NANGO), an umbrella network designed to improve the coordination among and impact of the operations of NGOs. In addition to NGOs and PVOs there are some community-based groups that are selling subsidized products.

The pharmaceutical sector includes the formal sector, the informal sector and the social marketing sector. The formal sector consists of the multinational and national manufacturers and distributors of locally-manufactured and/or imported products. The informal sector carries on many of the same activities as the formal sector, but without the requisite authorizations. Often their products have lower retail prices, but are suspect in terms of quality. Most pharmacies in Nigeria sell a range of consumer products (including hospital and surgical supplies), as well as pharmaceuticals. Social marketing is the smallest of the three types of pharmaceutical distribution. Through this mechanism, a donated "socially-useful" product is sold for the cost of distribution or at a price affordable to a targeted group of "at risk" individuals.

2. CCCD and the Private Sector

To date, most CCCD-related activities are being financed and provided through the public sector. The current CCCD Project has given very limited attention to involving private providers of goods and services (Tomaro, 1992). Some dialogue exists between local manufacturers of chloroquine and CCCD. The resources of the project have been directed toward strengthening the capacity of the public sector to delivery child survival and maternal health services, especially at the LGA level.

3. FHS and the Private Sector

The current Family Health Services Project has launched two principal activities through the private sector. FHS has supported the nationwide commercial distribution of contraceptives and fostered service delivery in the private sector through private hospitals, private nurses and midwives associated with the National Association of Nigerian Nurses and Midwives, women's groups, and large employers. Although Sterling Winthrop is no longer willing to distribute the "Right Time" product line, FHS-II should make other attempts to identify and involve other pharmaceutical firms in the commercial distribution of contraceptives. The project has provided training in several areas, as well as informational and monitoring materials and commodities.

The IEC component of the FHS project has made important linkages with the private sector. Broadcasting companies, initially parastatals, are increasingly becoming privatized and charging for their services. The FHS/IEC component views NGOs as major vehicle for implementation of IEC activities. IEC is continuing to offer technical and management training to NGOs.

Several obstacles still need to be removed to facilitate private sector participation in population activities: eliminate regulations and taxation schedules that constrain importation, distribution and promotion of contraceptives and the marketing of family planning services; government endorsement of family planning in employer-based services, promotion of birth-spacing as an integral component of primary health care, encouragement of NGOs.

4. AIDS Prevention and Control and the Private Sector

Nigeria already has a history of NGOs actively responding to the AIDS challenge. The National AIDS Committee has encouraged NGOs and has created a post to coordinate NGOs working on AIDS. At the local level, NGOs are work in coordination with State local PHC units. Most NGOs working on AIDS are small organizations with little funding and poor work plans. The National AIDS Committee has organized several training workshops for some of these NGOs.

IV. SELECTED COST RECOVERY EXPERIENCES

Some states and LGA within Nigeria have been experimenting with various forms of cost-recovery over the past five to seven years. It is more prevalent in the southern than in the northern zones. For the purposes of the discussion, those experiences most related to the AAO/Nigeria health program are highlighted here.

A. **Cost Recovery in Family Planning**

In a recent survey of cost-recovery initiatives for family planning commodities, preliminary evidence shows that eleven of the sixteen states visited are charging for family planning commodities, two are making arrangements to start charging while three states are not charging at all. The latter are in northern Nigeria. There is tremendous variation in the way user fees are set, how monies are collected, where they are retained and how they are used. The effects on acceptor rates are mixed; however, a majority of the state experiences seem to suggest that the acceptor rate has not been seriously affected.

The IEC component of the FHS project has also begun to undertake cost recovery-type of activities, in large part because broadcasting companies, currently parastatals, are being privatized. Broadcasting services, previously viewed as an in-kind contribution of the federal government, must

now be paid for. FHS/IEC is investigating commercial sponsorship for advertisement and printing of messages developed by through the public sector. Media houses may also offer discounts for IEC activities.

B. The Bamako Initiative

In 1988 a National Task Force was set up by the Minister of Health to guide the implementation of the Bamako Initiative (BI) strategy, starting with four LGAs. By the end of 1991, twenty LGAs have been included (for a total \$3 million UNICEF funds). It is expected that by 1995, BI will reach 69 LGAs in ten states, covering a population of about 17 million people. Three of the current CCCD LGAs are also BI LGAs. These include Barkin-Ladi in Plateau, Kaura Namoda in Sokoto, Ife Central in Oyo.

District (sub-LGA) and village communities are working to improve Mother and Child Health and Primary Health Care coverage through the provision of essential drugs and the development of community financing systems. BI is based at the community level and emphasizes community participation. When the Bamako Initiative was introduced in 1989, important initial steps had already been established under the essential drug program of PHC. The unique elements which the Bamako Initiative brought to Nigeria are primarily the added impetus of using drug revolving funds to generate surplus funds for community level use PHC/MCH. Since BI is designed to support PHC activities, all components of PHC including those supported by AAO/Nigeria (EPI, MCH, CDD, nutrition, family planning, AIDS prevention and control) should actively consider appropriate levels and means of participation.

The MHSS is strongly committed to the Bamako Approach. MHSS funds have been designated to support it, although disbursement of these funds have somewhat unpredictable and management of its contribution could be strengthened. Through the naira equivalent of the second tranche of the AAO/Nigeria Primary Health Care Support Program, twelve million naira are allocated for the AIDS program.

UNICEF has estimated that the start-up costs for the an ideal LGA program (with a population of 300,000) is \$250,000 in the first year and \$125,000 in the second year. This is an ideal scenario package and includes essential drugs, lab equipment, transport and logistics, monitoring and supervision, administrative equipment, initial training, community mobilization, advocacy, other facility equipment, technical assistance. Clearly, these initial costs are expensive, especially in view of the fact that there are almost 600 LGAs to be covered. Options to reduce these initial costs should be considered. UNICEF is suggesting three modalities for donor support: (a) comprehensive support for expansion of BI to new LGAs; (b) continuing support for existing BI LGAs; or (c) technical assistance support for critical aspects of BI. It is likely that ODA will join the MHSS, UNICEF and WHO under the Bamako Initiative supporting selected aspects of start-up costs for ten LGAs in 1993.

The program is too young to determine its ultimate success; however, an evaluation conducted by the London School of Hygiene and Tropical Medicine indicates that initial progress has been good. Some LGAs are reporting surpluses, but it is not clear to what extent this is happening. Some LGAs have experienced decapitalization. In addition, to identifying more realistic start-up costs requirements, success depends on firm commitments from LGAs, not only in terms of infrastructure but motivation and accountability. So far, states have not been involved in BI. As the number of LGAs expand, state involvement will become important, especially in terms of drug procurement. Since the World Bank Essential National Drug Program is directed at the State Level plans should be developed to ensure integration of these two initiatives.

V. FINANCIAL SUSTAINABILITY OF THE AAO/NIGERIA
HEALTH PROGRAM: A SUMMARY OF CONCERNS

A. **Federal Level:**

1. Budget allocations to the health sector are small, both as a proportion and in absolute terms.

Federal expenditures for health services account for a small portion of total federal expenditures, never reaching even 3%. Absolute levels of federal spending for health have fallen primarily as a result of a fall in government spending in general. In real terms, 1991 actual total MHSS expenditures are only 44% of 1981 expenditures.

2. Allocations to personnel are high, threatening efficient combinations with non-personnel recurrent costs.

Although MHSS actual recurrent expenditures have been consistently above approved expenditures, much of the additional expenditures have been for personnel expenses. Expenditures for non-personnel recurrent items are seriously threatened, accounting for only 13% of the recurrent budget in 1991.

3. Increased percentages of the regular MHSS budget for PHC, population activities and AIDS Prevention and Control are necessary.

The MHSS has benefitted over the past five years from substantial capital supplementations (off-budgetary); however, a majority of the funds are directed to secondary and tertiary health care activities. In regular budget allocations, primary health care is allocated about 20% of the budget. This has been fairly stable over the past five to ten years. Population activities capture only 1.3% of the budget in the past five years. Allocations to AIDS have generally come in the form of special allocations. Promises have been made for twenty million naira.

B. **State Level:**

4. Real resources devoted to health services has declined rapidly on a per capita basis since 1985.

The state is heavily dependent on the modest budgetary share of declining central government statutory allocations.

5. Personnel accounts for 80% of state recurrent spending.

Declining state budgets have cut most sharply into capital and non-personnel recurrent budgets.

6. Although the states remain responsible for supervision, support and training in LGA PHC activities, evidence suggests that states are not now allocating sufficient amounts to handle their PHC responsibilities.

State allocations to state Ministries of Health (which have responsibility for PHC) in comparison to Health Management Boards (which have responsibility for hospitals) have for the most part diminished substantially. This is partially a result of devolution of PHC to the LGAs, but it is widely believed that state PHC responsibilities have suffered.

There is a long term need to identify state budget requirements for supporting PHC. The MHSS has creating a matching fund program to encourage such allocations.

7. States also appear extremely deficient in their capacity to monitor levels and patterns of state spending.

Traditional administrative budget practicing are now being used, but they are not designed to track expenditures according to priority programs such as PHC.

C. LGA Level

8. An increasing proportion of LGA revenues is coming from federal and state statutory allocations.

The vertical allocation formula has increased LGA share from 5% before 1987 to 20% in 1992 to provide LGAs with the necessary resources to effectively discharge their exclusive responsibilities for primary health care and primary education. In 1990, the horizontal allocation formula included a health criterion for the first time. Although these increases are critically needed, they create a dependency on the federal government. (share of LGA revenue from state and federal allocations, 1989-91: 85%).

9. LGA health budgets are heavily skewed to personnel (72%-79%).

10. Although, on average, health accounts for 20%-25% of total LGA recurrent budgets and the proportions to health appear to be increasing, there is no clear delineation of resources required for PHC.

11. Financial information and managements systems for LGA health sector activities are grossly lacking.

Traditional administrative budget practicing are now being used. In light of the devolution of PHC to the LGAs, these deficiencies must be remedied.

D. Counterpart Contributions

12. With the exception of MHSS purchases of vaccines (99%), a majority of counterpart contributions at the state and LGA level for CCCD are made in terms of existing personnel, land and buildings and facilities (state: 82%, LGA: 73%). Lack of counterpart contributions to support non-personnel recurrent expenditures (operations and maintenance, vehicles, equipment) may threaten the sustainability of program benefits.

13. With the exception of MHSS contributions of cash and the purchase of commodities (83%), a majority of counterpart contributions at the state and LGA level for FHS are made in terms of existing personnel, land and buildings, and facilities (state: 83%, LGA: 73%). Lack of counterpart contributions to support non-personnel recurrent expenditures (operations and maintenance, vehicles, equipment) may threaten the sustainability of program benefits.

14. The Primary Health Care Support Program has provided useful learning experience for obtaining substantive counterpart funding. **First**, the timing of counterpart funding should be carefully integrated with realistic estimates of the time frames for completion of program activities. **Second**, there is critical need to establish mutually agreeable detailed procedures for monitoring counterpart

funds, in terms of planned allocations, actual disbursements and actual spending. **Third**, management of donor coordination within the MHSS should take high priority, be fundamentally strengthened, aggressively implemented to avoid missed opportunities.

E. The Private Sector:

15. The current CCCD project has given limited attention to involving the private sector.

Although initial efforts to strengthen the capacity of the public sector for child survival activities are justified, in light of pressures to reduce public budgets, long-term sustainability of the benefits of child survival initiatives will require tapping to some extent, the private sector both in terms of the provision and financing of services.

16. In light of limited MHSS support for population activities, continued strong collaboration with the private sector is necessary.

17. NGOs have already been active in AIDS Prevention and Control. However, they require substantial support in terms of technical and management training, development of strategies and work plans. Advocacy for AIDS programs is required at all levels of government.

F. Cost-Recovery Initiatives:

18. Although full cost-recovery (total recurrent costs) is generally not a feasible goal for PHC-related activities over the next seven years for many communities, the potential of cost-recovery to sustain critical elements of primary health care has yet to be realized. Most initiatives are still unable to cover even non-personnel recurrent costs.

19. Cost-recovery mechanisms tend to be weak in financial information systems, financial management, transparent accounting tools, strategies for the allocation of revenues.

These weaknesses are recognized in initial Bamako Initiative efforts, family planning cost-recovery systems and other experiments. Since the Bamako Initiative is viewed by the MHSS as a major mechanism with which to improve the financial sustainability of all components of PHC, it is critical that these weaknesses be addressed.

VI. FINANCIAL SUSTAINABILITY: RECOMMENDATIONS FOR THE NEXT AAO/NIGERIA HEALTH PROGRAMS, 1993-2000

A. General Guidelines for Financial Sustainability

Clearly, financial sustainability is only one factor contributing to the overall sustainability of the benefits of the AAO/Nigeria Health Program; however, for the purposes of this document, the recommendations below focus on how to ensure that when AAO/Nigeria donor support diminishes, sufficient national resources are in place to continue generating program benefits.

There are two major dimensions to consider to ensure the financial sustainability of the AAO/Nigeria Health Program (1993-2000).

First, the AAO/Nigeria Health Program should ensure that program costs are increasingly being assumed by national resources.

Second, the design of the AAO/Nigeria Health Program should incorporate a mix of national public and private sectors both in terms of resources and provision in a way which promotes financial sustainability, efficiency, equity, and adequate quality of health services.

Guidelines for identifying an efficient mix of public and private sector resources and provision to support health sector activities are found in Table 25. These guidelines are derived from the basic principles of economics of health and are widely used to design health programs. Various services and goods are fall in categories 1, 2, or 3 depending on the market conditions for that service or good. To the extent that the market for the service/good approaches competitive conditions, private provision and financing of the service will generate efficient amounts (e.g., Category 3). In contrast, category 1 services and goods are those which are affected by externalities, are merit or public goods, or for which competitive conditions are not met; i.e., are such that only the government can finance.

Four scenarios are possible in the public-private sector mix. Public resources can be channeled through either public or private providers. Similarly, private resources can be channeled through either public or private providers. As shown in Tables 26-28, category 1 services are publicly provided and financed (the public sector). Category 2 services can be provided through subsidized private organizations (privatizing the provision), or through public providers for which private payment is required (privatizing the financing). Finally, category 3 activities are provided and financed by the private sector (full privatization).

In addition, the public-private mix of services must also be guided by concerns for equity. Government resources are required to ensure that the benefits of the health programs are distributed according to politically-determined definitions of equity. In general, the AAO/Nigeria Health Program should ensure that sufficient mechanisms are in place to provide services to those that are at high risk, and unable to pay. Evidence from the DHS on regional differences in health status suggests that much still needs to be done to ensure equitable distribution of the health benefits of the AAO/Nigeria Health Program.

B. Recommendations

Following these basic premises, the specific recommendations are given below. They pertain to increasing the role of national resources, and to adjusting the public-private sector mix of resources in the provision and financing of health services to improve efficiency and equity. A summary of the concerns for financial sustainability and corresponding recommendations is given in Table 26.

Federal Level:

Recommendation #1: Within the context of the AAO/Nigeria Health program, increased allocations of the MHSS budget for primary health care, population activities and AIDS Prevention and Control can be increased primarily through additional counterpart funding requirements. The design of the Program should include increasing, but feasible portions of MHSS counterpart funding to directly support each component of the AAO/Nigeria program. Further recommendations about counterpart funds are given in item 4 below.

State Level:

Recommendation #2: All components of the AAO/Nigeria Health Program should work with the State Ministries of Health in selected states to put in place financial information systems, and strengthen financial management skills to ensure that adequate amounts are being allocated in state

budgets to fund state responsibilities for PHC including supervision, support and training. Each program component should work with the selected states to estimate on a regular basis the resources required at the state level to continue program activities and to incorporate such information in an integrated financial management process for the health sector.

Within this process, each program component should work with selected states to identify more efficient allocations of resources while maintaining the quality of care, and ensure adequate funding for critically needed components (especially non-personnel recurrent costs). Financial management methods should be used which identify not only the flow of funds to PHC over time (basic accounting), but which can link outputs and outcomes of the programs to their resource costs to monitor efficiency and appropriateness.

Flexible guidelines on minimum budgetary allocations and expenditure for primary health care might be developed, including the major components of those budgets, such as personnel and non-personnel costs, and major program areas. Careful attention must be paid to the requirements of current civil financial administration systems to identify where improvements in financial management methods are feasible and acceptable. Such recommendations are in line with general MHSS Health Policy and current MHSS matching fund mechanism to encourage adequate PHC budgets at the state level.

LGA Level:

Recommendation #3: All components of the AAO/Nigeria Health Program should work with the LGA Health Departments in selected LGAs to put in place financial information systems, and strengthen financial management skills to ensure that adequate amounts are being allocated in LGA budgets to fund LGA implementation of PHC. Each program component should work with the selected LGAs to estimate on a regular basis the resources required at the LGA level to continue program activities and to incorporate such information in an integrated financial management process for the health sector.

Within this process, each program component should work with selected LGAs to identify more efficient allocations of resources while maintaining the quality of care, and ensure adequate funding for critically needed components (especially non-personnel recurrent costs). Financial management methods should be used which identify not only the flow of funds to PHC over time (basic accounting), but which can link outputs and outcomes of the programs to their resource costs to monitor efficiency and appropriateness.

Flexible guidelines on minimum budgetary allocations and expenditure for primary health care might be developed, including the major components of those budgets, such as personnel and non-personnel costs, and major program areas. Careful attention must be paid to the state requirements of current civil financial administration systems to identify where improvements in financial management methods are feasible and acceptable. Such recommendations are in line with general MHSS Health Policy and current increased statutory allocations to LGAs to support the implementation of PHC.

Counterpart Contributions (Federal, State, LGA):

Recommendation #4: Federal, state and LGA governments should be required to support increasing proportions of total project costs with counterpart contributions to support all components of the AAO/Nigeria Health Program. Feasible commitments should be determined in light of the current strain on health sector budgets, yet they must be viewed as vital inputs to program sustainability. It is unlikely that the federal government will be able to fund, fully, all recurrent costs by the end

of project, but progress should be made from current levels of 25-37% to around 50-60%. Both cash and in-kind counterpart funding should be considered. Since health is on the concurrent list, letters of commitment for counterpart contributions will be required from MHSS and each of the focus LGAs and States.

Recommendation #5: Although personnel and facilities will continue to be important contributions from all three levels of government, increasing commitments to provide counterpart funds for non-personnel recurrent costs are strongly recommended, especially at the state and LGA level. Non-personnel counterpart contributions should include allocations for purchase of commodities, supplies, equipment, vehicles, and support of operations and maintenance. Since many of the non-personnel expenses are affected by foreign exchange rates, estimates of counterpart contributions for these items should take into consideration future devaluation of the naira, to guarantee that minimum real levels of these items continue to be funded, but are still the within the means of Ministries of Health and Health Departments.

Recommendation #6: The timing of counterpart funding should be carefully integrated with realistic estimates of the availability of counterpart funding and reasonable time frames for completion of program activities. Counterpart fund requirements should be integrated as much as possible into Rolling Plans and budgets.

Recommendation #7: Detailed and mutually agreeable procedures for monitoring counterpart funds, in terms of planned allocations, actual disbursements and actual spending must be established. Separate bank accounts for AAO/Nigeria and counterparts should be considered.

Recommendation #8: The management processes related to obtaining and documenting counterpart funds, including legal and administrative requirements, should be strengthened at the federal, state and LGA levels. The MHSS has established the responsibility for donor coordination at the Director-General's office. Implementation of these responsibilities should be a prerequisite for initiating future AAO/Nigeria Health Programs.

The Public and Private Sector Mix for NCCCD³

Recommendation #9: NCCCD should begin to encourage private sector involvement in both the provision and financing of health care.

9a: The Public Sector (Public Resources and Public Provision): Public resources for NCCCD should be focused on those activities which fall in category 1. Specifically, the public sector should continue to support improvement of health care delivery systems in terms of the development of health information systems, health systems planning, health education and communication, regulation and licensing, community-wide water and sanitation interventions, training (technical, management), institutionalization of quality assurance, policy development, epidemiologic capacity and capabilities, implementation of operations research, procurement and distribution of commodities (didactic materials, laboratory equipment, impregnated bed nets, ORS, cold chain, initial drug supplies, vehicles).

Broader public support (ranging across the types of activities listed under categories 1,2 and 3) may

³ The approaches suggested here follow closely the ideas found in Annex I - Private Sector Strategy.

be required for targeted populations (high-risk or unable to pay) or for which there are major deficiencies in market conditions (e.g., inadequate information, insufficient demand or supply). According to the Demographic Health Survey, there is tremendous regional variation in the health status of children and mothers. Public funds should continue to support activities in those areas which have not yet experienced the benefits of CCCD interventions and ensure that mechanisms are set in place to ensure that those unable to pay receive adequate services.

9b: Privatizing the Provision (Public Sector Resources and Private Provision): Public resources can be channeled either through the public or private sector. In conjunction with federal counterpart resources, every attempt should be made to engage private providers and organizations in CCCD-related activities and strengthen their delivery of NCCCD-related services in terms of clinical and managerial training, IEC, information systems, commodity procurement and management, monitoring and evaluation. In some cases, the public sector can contract with private organizations to implement some of their activities (e.g., development of health communication and health education materials, provision of some preventive health services). Training of traditional birth attendants should be pursued. CCCD should focus its efforts on those private provider networks which offer reliable services and are committed to PHC. Some networks to consider include the Nigerian Association of General Practice Pharmacists, the Pharmaceutical Manufacturing Association of Nigeria, Pharmaceutical Society of Nigeria, Guild of Medical Directors, Association of General and Private Medical Practitioners of Nigeria, the National Association of Nigeria Nurses and Midwives, National Postgraduate Medical College of Nigeria, the Private Nurses and Midwives Association of Nigeria. CCCD might investigate possibilities for social marketing some of its commodities such as impregnated bed nets (once tests for effectiveness are complete).

Public support to nonprofit organizations which focus on high risk populations and the very poor should be a priority. Examples include the Nigeria Association of Non-governmental Organizations on Health (NANGO), Christian Hospital Association of Nigeria (CHAN) and the National Commission of Women's Societies.

9c: Privatizing the Financing - The Bamako Initiative (Private Sector Resources and Public Provision): It is beyond the scope of CCCD to attempt full scale cost-recovery mechanisms for CCCD-related activities. In addition, cost-recovery should be pursued on a limited basis, at least initially for preventive services. Also, cost-recovery for CCCD-related activities should not be viewed independently of cost-recovery for PHC in general. Since the BI is endorsed by the MHSS and is intended to provide overall financial support to PHC/MCH, it provides an appropriate environment for NCCCD to contribute to efforts in cost-recovery. NCCCD should consider providing technical assistance to the start-up activities of Bamako Initiative LGAs. In light of concerns to ensure the financial sustainability of CCCD activities, it would be appropriate to provide technical assistance to the BI for development of financial information systems and financial management skills for LGAs and communities. Results of a financial audit of BI (Coopers & Lybrand, 12/92) should be reviewed when they become available.

According to the breakdown of start-up costs specified by UNICEF for each LGA, something on the order of \$40,000 per LGA could make a significant contribution. NCCCD should focus its efforts on LGAs where CCCD, BI and perhaps FHS and AIDS Control are working, perhaps reaching up to 20 LGAs by the end of project.

9d: Full Privatization: (Private Sector Resources and Private Provision): NCCCD should strengthen ongoing dialogue with private provider organizations to encourage the delivery of EPI, ARI, CDD, malaria treatment in the private sector at adequate levels of quality. NCCCD should

establish regular communication links with private organizations such as the Nigerian Association of General Practice Pharmacists, the Pharmaceutical Manufacturing Association of Nigeria, Pharmaceutical Society of Nigeria, Guild of Medical Directors, Association of General and Private Medical Practitioners of Nigeria, the National Association of Nigeria Nurses and Midwives, National Postgraduate Medical College of Nigeria, the Private Nurses and Midwives Association of Nigeria, Nigeria Association of Non-governmental Organizations on Health (NANGO), Christian Hospital Association of Nigeria (CHAN) and the National Commission of Women's Societies.

Public and Private Sector Mix for FHS⁴

Recommendation #10: FHS-II should continue to encourage private sector involvement in both the provision and financing of health care.

10a: The Public Sector (Public Sector Resources and Public Provision) Public resources for FHS-II should be focused on those activities which fall in category 1. Specifically, the public sector should continue to support improvement of family planning delivery systems in terms of the development of health information systems, health systems planning, health education and communication, regulation and licensing, training (technical, management), institutionalization of quality assurance, policy development, implementation of operations research, procurement and distribution of commodities (didactic materials, laboratory equipment, supplies, vehicles).

Broader public support (ranging across the types of activities listed under categories 1,2 and 3) may be required for targeted populations (high-risk, high barriers to usage, unable to pay) or for which there are major deficiencies in market conditions (e.g., inadequate information, insufficient demand or supply). According to the Demographic Health Survey, there is tremendous regional variation in contraceptive prevalence. Public funds should continue to support activities in those areas which have not yet experienced the benefits of FHS interventions, or for which there significant barriers to contraceptive usage. In addition, public resources are necessary to ensure that mechanisms are set in place to provide access to family planning to those unable to pay.

10b: Privatizing the Provision (Public Sector Resources and Private Provision) Public resources can be channeled either through the public or private sector. In conjunction with federal counterpart resources, every attempt should be made to continue to engage private providers and organizations in FHS-related activities and strengthen their delivery of family planning services in terms of clinical and managerial training, IEC, information systems, commodity procurement and management, monitoring and evaluation. In some cases, the public sector can contract with private organizations to implement some of their activities (e.g., development of health communication and health education materials, provision of some preventive health services). For example, PPFN is being positioned to break new ground for family planning activities in the North. Where family planning is a particularly sensitive issue, working through NGOs rather than public sector providers may be a more acceptable mechanism for introducing the provision of family planning than the public sector because they can be more discreet and preserve the privacy of clients. It should be noted that MHSS has given cash grants to support the activities of NGOs such as PPFN and the National Council for Population Activities.

⁴ The approaches recommended here follow closely those found in Annex I - Private Sector Strategy.

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FHS-II should attempt to work with the Nigerian Association of General Practice Pharmacists, the Pharmaceutical Manufacturing Association of Nigeria, Pharmaceutical Society of Nigeria, Guild of Medical Directors, Association of General and Private Medical Practitioners of Nigeria, the National Association of Nigeria Nurses and Midwives, National Postgraduate Medical College of Nigeria, the Private Nurses and Midwives Association of Nigeria.

Public support to non-profit organizations which focus on high risk populations, groups with high barriers to usage, and the very poor should be a priority. Examples include the Nigeria Association of Non-governmental Organizations on Health (NANGO), Christian Hospital Association of Nigeria (CHAN) and the National Commission of Women's Societies. FHS-II should consider expand social marketing efforts of condoms and pills through Population Services International.

10c: Privatizing the Financing - Cost Recovery (Private Sector Resources and Public Provision). The FHS-II project might consider supporting ongoing experiments in cost-recovery of family planning commodities in three respects. First, it should work with states to develop guidelines for the institutional aspects of these mechanisms. Selected pilot efforts might be supported. Second, the IEC component of FHS-II should continue to identify sponsorship of family planning advertisements and printing materials. Third, since the BI is strongly endorsed by the MHSS and is intended to provide overall financial support to PHC/MCH, it provides an appropriate environment in which cost-recovery for selected family planning commodities can be integrated. FHS-II should consider providing technical assistance to the start-up activities of Bamako Initiative LGAs. In light of concerns to ensure the financial sustainability of FHS activities, it would be appropriate to provide technical assistance to the BI for development of financial information systems and financial management skills for LGAs and communities. Results of a financial audit of BI (Coopers & Lybrand, 12/92) should be reviewed when they become available.

According to the breakdown of start-up costs specified by UNICEF for each LGA, something on the order of \$40,000 per LGA could make a significant contribution. FHS-II should focus its efforts on LGAs where FHS, BI and perhaps FHS, and AIDS Control are working, potentially reaching up to 20 LGAs by the end of project. Cost-recovery for family planning should be encouraged in those areas where family planning is more accepted. Cost recovery may not be immediately appropriate in areas where there are high barriers to usage; however, long-term potential for cost recovery should be considered.

10d: Full Privatization (Private Sector Resources and Private Provision) FHS-II should strengthen and involve private sector nonprofit and profit-making organizations in the delivery of services and the promotion and distribution of contraceptives. This will be challenging since the Nigerian profit-making private sector is large, complex and uncoordinated. Planned Parenthood Federation of Nigeria (PPFN), Africare, CHAN, and PSI are among the nonprofit organizations interested in receiving support from FHS-II. FHS-II should also expand activities with the private hospitals and clinics and, if possible, with the large employers and unions. PPFN has been identified to receive the assistance required to expand family planning clinical services in the northern, more traditional areas of Nigeria. FHS-II should identify a profit-making commercial firm willing to market the "Right Time" contraceptive line. The economic feasibility of local production of contraceptives should be investigated.

The Public and Private Sector Mix for HIV Prevention and Control

Recommendation #11: AIDS Prevention and Control Program should continue to encourage private sector involvement in both the provision and financing of health care.

11a: The Public Sector (Public resources and public provision): Public resources for HIV Prevention and Control should be focused on those activities which fall in category 1. Specifically, the public sector should support the improvement of STD/HIV/AIDS surveillance systems, strengthening of STD prevention and diagnostic services, linkages with condom quality assurance system created in Nigeria with assistance from PATH and WHO/GPA, improvements of condom forecasting and logistics management, examination of potential of condom local production capacity, policy development, behavioral research, and evaluation, health education and communication, regulation and licensing, training (technical, management), implementation of operations research, procurement and distribution of commodities (didactic materials, laboratory equipment, supplies, vehicles).

11b: Privatizing the Provision (Public resources and private provision). Public resources can be channeled either through the public or private sector. In conjunction with federal counterpart resources, every attempt should be made to continue to engage private providers and organizations in HIV prevention and control-related activities. In particular, support (competitive seed grant program) should be given to national and local NGOs. This includes managerial and technical training, institution-building, social marketing of condoms. Private organizations should be encouraged to work among target groups including commercial sex workers and their clients, the military, long-distance drivers, post-secondary students and urban men.

11c: Privatizing the Financing (Private resources and public provision) Cost-recovery of condoms has already been introduced among some of the target populations. In general, cost-recovery should be introduced after target populations demonstrate effective and consistent use (about 3-6 months). Since the BI is strongly endorsed by the MHSS and is intended to provide overall financial support to PHC/MCH, it provides an appropriate environment in which cost-recovery for AIDS commodities (e.g. condoms) and drugs for STDs can be integrated. The AIDS project should consider providing technical assistance to the start-up activities of Bamako Initiative LGAs. In light of concerns to ensure the financial sustainability of AIDS activities, it would be relevant to work with the BI to develop financial information systems and financial management skills for LGAs and communities. Results of a financial audit of BI (Coopers & Lybrand, 12/92) should be reviewed when they become available.

According to the breakdown of start-up costs specified by UNICEF for each LGA, something on the order of \$40,000 per LGA could make a significant contribution. The AIDS project should focus its efforts on LGAs where AIDS, BI and perhaps CCCD and FHS are working, perhaps reaching up to 20 LGAs by the end of project.

11d: Full Privatization (Private resources and private provision) The AAO/Nigeria program in HIV Prevention and Control should facilitate private financing and provision of the condom promotion and distribution, diagnosis and treatment of STD and any other related program activities. Active dialogue and collaboration with NGOs are already underway.

BIBLIOGRAPHY

- Allen, S. et al. Nigeria AIDS Prevention and Control Project October 1992.
- Atlantic Resources Corporation. "Sustainability Assessment of the Africa Child Survival Initiative (ACSI) Combatting Childhood Communicable Diseases (CCCD) Nigeria" 1992.
- Biersteker, T. "Evaluating Nigeria's Structural Adjustment Program and the Prospects for Economic Recovery After the Political Transition" July 1992.
- Briscoe, J. (ed.) Adult Health in Brazil: Adjusting to New Challenges. Report No. 7807-BR. Washington D.C.: The World Bank, 1989.
- Callaghy, T. "Democracy and the Political Economy of Restraint and Reform in Nigeria" April 1992.
- Cochrane, S. and Sai, F. Health Sector Priorities Review: Excess Fertility The World Bank HSPR-09. January 1991.
- Coker-Smith International Asso. Inc. "Accounting for Counterpart Costs Related to Implementing Family Health Services and Combatting Childhood Communicable Diseases Program in Nigeria" September 11, 1992.
- Denton, H. Akin, J. Vogel, R. Wouters, A. Federal Republic of Nigeria: Health Care Cost, Financing and Utilization. October 1991, The World Bank.
- Demographic Health Survey: Nigeria, Summary. 1990.
- Feachem, RGA, Kjellstrom, T., Murray, C., Over, M., Phillips, MA. The Health of Adults in the Developing World. Oxford: Oxford University Press for the World Bank, forthcoming, 1992.
- Gillespie, Duff et al. "Financing the delivery of contraceptives: the challenge of the next twenty year." Washington D.C. The Demographic and Programmatic Consequences of Contraceptive Innovations Committee on Population, National Academy of Sciences, October 1988.
- HERDS Medicare Limited, "Implementation of the Primary Health Care Policy at Local Government Area Level in Nigeria: Report of a Policy Research Study in Relation to the Primary Health Care Support Programme" August 1992.
- Jamison, D. and Mosley, H. Health Sector Priorities Review: Selecting Disease Control Priorities in Developing Countries. the World Bank, 1991.
- Mako, IV. "Survey Report on Family Planning Commodities User Charges Situation in 16 States" FHS project, October 1992.
- McPake, B. Hanson, K and Mills, A. Experience to Date of Implementing the Bamako Initiative: A Review and Five Country Studies. London School of Hygiene and Tropical Medicine. 1992.
- Mosley, WH. Bobadilla, J., Jamison, D. Health Sector Priorities Review: The Health Transition: Implications for Health Policy in Developing Countries. World Bank. April 1992.

- National Academy of Science Population Growth and Economic Development: Policy Questions. 1986.
- Olowu, D. Wunsch, J. "Local Governance and USAID Health Projects in Nigeria." October 1992.
- Pioneer Associates Ltd. "Administrative Analysis of the Nigerian Public Health Sector." October 1992.
- Price Waterhouse. Report on the Review of FMOH, SMOH, and LGA Accounting & Procurement Systems. August 1991.
- Taylor, R. Donaldson, D. "Nigeria Primary Health Care Support Program: Project Status and Evaluation Report for USAID/Lagos" May 1992.
- Thomas, M. "Public Expenditure and Sector Strategy Review: Health Expenditure at State Level: Kano State." The World Bank and ODA. July 1992a.
- Thomas, M. "Public Expenditure and Sector Strategy Review: Health Expenditure at State Level: Benue State." The World Bank and ODA. July 1992b.
- Thomas, M. "Public Expenditure and Sector Strategy Review: Health Expenditure at State Level: Lagos State." The World Bank and ODA. July 1992c.
- Thomas, M. "Public Expenditure and Sector Strategy Review: Health Expenditure at State Level: Plateau State." The World Bank and ODA. July 1992d.
- Thomas, M. "Public Expenditure and Sector Strategy Review: Health Expenditure at State Level: Critical Issues in the Financing and Management of State Level Health Services in Nigeria: the experience of Benue, Kano, Lagos and Plateau States." The World Bank and ODA. July 1992e.
- Tomaro, J. "Strategy for the Private Provision of Health and Family Planning Services in Nigeria." September 1992.
- Tugwell, P. Bennett, K. Sackett, D. Haynes B. "Relative Risks, Benefits, and costs of interventions. In: Warren, K., Mahmoud, A. (eds) Tropical and Geographical Medicine. New York: McGraw-Hill. 1984.
- UNICEF. "The Bamako Initiative in Nigeria: 1992 - 1995" Bamako Initiative Country Series, #8.
- UNICEF. "The Bamako Initiative in Nigeria" 1991.
- AAO/Nigeria. Nigeria Country Program Strategic Plan (CPSP): 1993-2000. Lagos, August 1992
- US Embassy/Lagos. Foreign Economic Trends and the Implications for the United States. July 1992
- WHO. Local Government Focussed Acceleration of Primary Health Care: The Nigerian Experience. 1992.
- World Bank PHN Notes. Population and Human Resources Department of the World Bank, Vol 2(4). March 1992.

Table 1
 Infant and Child Mortality Rates,
 Total Fertility Rate and Contraceptive Use

	Total	Urban	Rural	NE	NW	SE	SW
IMR	87	75.4	95.8	87.7	109.8	82.7	84.6
CMR	109.6	58.9	123.8	139.2	151.2	66.5	90.3
TFR	6.01	5.03	6.32	6.53	6.65	5.57	5.46
0-5 yrs Chronic undernutri.-(%)	43	35	46	52	50	37	36
Use of Modern Contraception (%)	3.5	9.6	1.9	1.3	0.7	3.9	10.5

Source: Demographic and Health Survey - Nigeria: Summary, 1990.

Table 2
 MHSS Capital and Recurrent Actual Expenditures,
 1981-1990
 (in nominal and 1987 Naira millions)

Year	Recurrent	Capital	Total	Total 1987 naira	Relative to 1981 (%)
1981	153.437	142.119	295.556	692.169	0.0
1982	182.203	120.541	302.744	658.140	-4.9
1983	153.262	116.639	269.901	476.017	-31.2
1984	168.107	42.808	210.915	266.644	-61.5
1985	177.181	45.360	222.541	261.813	-62.2
1986	245.769	131.457	377.226	419.606	-39.4
1987	229.136	125.557	354.694	354.694	-48.8
1988	379.588	117.254	496.842	321.580	-53.5
1989	381.784	119.958	501.742	215.803	-68.8
1990	485.143	419.746	904.889	362.536	-47.6
1991	675.607	412.325	1,087.932	385.791	-44.3

Source: Federal Ministry of Health and Human Services

Table 3
MHSS Percentage of Total Federal Expenditures (Actual)

Year	Recurrent	Capital	Total
1980	2.5%	1.4%	1.9%
1981	2.8%	2.5%	2.6%
1982	2.5%	1.5%	2.0%
1983	2.7%	2.0%	2.3%
1984	2.1%	1.1%	1.8%
1985	2.6%	0.3%	1.1%
1986	3.6%	1.4%	2.4%
1987	2.5%	0.8%	1.4%
1988	2.4%	1.2%	2.0%
1989	1.5%	4.7%	1.8%
1990	2.1%	3.1%	2.4%

Source: Federal Ministry of Health and Human Services (1980 data for April-December only).

Table 4
Budget Allocations and Actual Expenditures, MHSS
(millions of naira)

Year	Plan			Actual		
	Recurrent	Capital	Total	Recurrent	Capital	Total
1980	119.8	110.4	230.2	112.6	77.9	190.4
1981	155.8	183.4	339.2	153.4	142.1	295.6
1982	143.6	186.0	329.6	182.2	120.5	302.7
1983	143.6	170.0	313.6	153.3	116.6	269.9
1984	139.1	51.3	190.4	168.1	42.8	210.9
1985	167.7	49.4	217.1	177.2	45.4	222.5
1986	239.2	81.2	320.4	245.8	131.5	377.3
1987	166.9	69.5	236.4	229.1	125.6	354.7
1988	259.9	183.2	443.1	379.6	117.3	496.8
1989	359.7	126.0	485.7	381.8	120.0	501.7
1990	401.1	257.0	658.1	485.1	419.7	904.9
1991	619.4	156.3	775.7	675.6	412.3	1,087.9

Source: Federal Ministry of Health and Human Services. 1980 figures for April-December only.

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Table 5
FMHSS Budget Actual Allocations
as a Percent of Approved Expenditures, 1980-1991

YEAR	Actual Percent of Approved		
	Recurrent	Capital	Total
1980	94%	71%	83%
1981	99%	78%	87%
1982	127%	65%	92%
1983	107%	69%	86%
1984	121%	83%	111%
1985	106%	92%	103%
1986	103%	162%	118%
1987	137%	181%	150%
1988	146%	64%	112%
1989	106%	95%	103%
1990	121%	163%	138%
1991	111%	84%	106%

Source: Federal Ministry of Health and Human Services (1980 figures for April-December only).

Table 6
MHSS Actual Capital Expenditures by Program (Million Naira)

Year	PHC	Population	Disease Control & Int'l Health	Hospital Service and Training	Other	Total
1981	50.85	0	2.09	87.52	1.67	142.12
1982	10.90	0	3.13	104.22	2.30	120.54
1983	14.04	0	4.10	96.32	2.18	116.64
1984	8.29	0	1.84	27.98	4.70	42.81
1985	6.29	0	2.86	34.55	1.67	45.36
1986	42.44	0.30	11.23	64.38	13.11	131.46
1987	22.00	0.31	6.59	65.40	31.26	125.56
1988	15.76	0.79	14.22	79.50	6.99	117.25
1989	17.85	1.98	13.96	74.56	11.60	119.96
1990	83.96	2.19	23.69	288.36	21.55	419.75
1991	19.38	6.73	29.13	?	?	412.32
% share 81-85	19.3	0	3.0	75.0	2.7	na
% share 86-91	22.0	1.3	7.6	62.6	7.8	na

Source: Federal Ministry of Health and Human Services. "Other" includes Departments of Finance and Supplies, Personnel Management, Planning Research and Statistics, plus Outstanding Liabilities and Policy and Management.

Table 7
Percent of Total Recurrent Expenditure Allocated to Health by
Federal Government and Selected States, Actuals

Tier of Govt	81	82	83	84	85	86	87	88	89	90
Federal	2.8	2.5	2.7	2.1	2.6	3.6	2.5	2.4	1.5	2.1
State										
Imo	9	11	9	9						
Ogun	11	12	12	15						
Ondo	12	11	13	12						
Oyo	11	9	9	8	8					
Sokoto	9	10								
Benue					18	14	14	12	10	5
Kano					12	16	16	15	16	15
Lagos					12	11	11	11	14	9
Plateau					11	16	12	8	7	10

Thomas 1992a-d; Denton et al. 1991; MHSS.

Table 8
A Comparison of the Percentage Share of the
Federal and State Capital Budget devoted to Health, 1985-1991

	1985	1986	1987	1988	1989	1990	1991
Federal	0.3	1.4	0.8	1.2	4.7	3.1	-
States							
Benue	0.4	2.1	3.5	1.5	6.0	3.1	6.9
Kano	13.1	9.7	12.0	7.4	12.2	4.5	5.0
Lagos	1.04	1.6	0.66	0.31	1.31	13.5	6.88
Plateau	62.0	25.8	18.4	1.8	6.9	10.4	1.0

Source: Thomas, 1992e.

Table 9
Per Capita Public Health Expenditures,
Federal Government and Selected States, in 1987 Naira

	1985	1986	1987	1988	1989	1990	1991
Federal	2.6 (a)	4.1 (a)	3.4 (a)	2.9 (a)	1.9 (a)	3.1 (a)	2.4 (e)
State							
Benue	17.5 (a)	16.1 (a)	12.1 (a)	7.0 (a)	6.0 (e)	4.8 (e)	5.7 (e)
Kano	17.0 (a)	11.9 (a)	15.9 (a)	10.4 (a)	9.2 (e)	7.1 (e)	5.5 (e)
Lagos	23.0 (a)	23.0 (a)	17.8 (a)	10.5 (a)	7.8 (a)	13.8 (a)	10.0 (e)
Plateau	16.7 (a)	13.1 (a)	16.0 (a)	8.9 (a)	5.7 (e)	16.6 (e)	5.9 (e)
LGA							
Akure	-	-	-	-	3.6 (a)	3.0 (e)	3.7 (e)

Source: Thomas, 1992-a-d; Federal Ministry of Health and Human Services; Akure Local Government estimates.

Note: (a) actual expenditures, (e) estimated expenditures
 Expenditures adjusted to 1987 naira using consumer price index.

Table 10
A comparison of the Percentage Share of State Recurrent Health
Expenditures Covered by State Recurrent Revenue

State	1985	1986	1987	1988	1989	1990	1991
Benue	0.57	0.38	0.49	0.84	0.60	0.70	1.24
Kano	6.07	6.52	5.33	na	4.04	3.59	na
Lagos	0.71	0.53	0.56	0.46	-	-	-
Plateau	4.66	8.16	2.81	3.16	3.96	2.73	5.39

Source: Thomas 1992e.

Table 11
 Recurrent and Personnel Health Expenditure as percentages
 of Total (Capital plus Recurrent) Health Expenditures,
 Selected States

States	81	82	83	84	85	86	87	88	89	90	91
Benue Rec/T Per/T					98	94	84 61	86	76 57	88 68	67 49
Kano Rec/T Per/T					65 35	71 43	70 30	81	66 35	91 48	
Lagos Rec/T Per/T			92 64	97 74	94	87	94	94	90	48	74 54
Plateau Rec/T Per/T					69 56	58 46	64 50	94 63	88 51	84 62	
Imo Rec/T Per/T		48	87	100 74	99 74						
Ogun Rec/T Per/T	82 60	94 84	96 89	97 93	99						
Oyo Rec/T Per/T	83 54	90 75	90 76	77 72	93 83						

Source: Thomas 1992a-d; Denton et al 1991.

Note: Rec/T = Recurrent/Total

Per/T = Personnel/Total

Table 12
 Ministry of Health as a Percent of
 Total MOH and Health Management Board Budget
 for Selected States, 1984-1991

STATE	1984	1985	1986	1987	1988	1989	1990	1991
Benue	na	57 a	54 a	26 a	22 a	31 c	20 c	26 c
Kano	na	20 a	24 a	39 a	20 a	14 c	13 c	8 c
Lagos	na	18 a	26 c	30 a	19 a	21 a	30 a	22 c
Plateau	na	36 a	22 a	25 a	34 a	51 c	64 c	44 c

Source: Thomas 1992 a-d. Note: a = actual; c = estimate

Table 13
Contribution of Source of Revenue for Average Model PHC LGA:
Summary

Source of Revenue	Percent of Revenue			
	1988 (actuals)	1989 (actuals)	1990 (actuals)	1991 (est.)
Statutory Allocation (Fed, State)	71.2%	82.9%	84.8%	88.2%
Internally Generated Revenue	28.8%	17.1%	15.2%	11.8%
Total	100.0%	100.0%	100.0%	100.0%

Source: HERDS Medicare Limited, "Implementation of the Primary Health Care Policy at Local Government Area Level in Nigeria: Report of a Policy Research Study in Relation to the Primary Health Care Support Programme" August 1992, p. 257.

Table 14
Percentage Contribution of Source of Revenue of Model PHC LGAs

Source of Revenue	1988 Actuals	1989 Actuals	1990 Actuals	1991 Estimates
Federal Statutory Allocation	60.9	72.2	78.3	80.6
State Statutory Allocation	9.3	3.3	6.5	2.5
Other Grants: SBA/PHC State	1.0	7.4	-	5.1
Licenses, Fees, Fines	10.0	4.1	3.3	2.9
Community Services	9.2	5.7	2.1	3.8
Property, Tenement Rates	4.8	2.7	6.6	2.6
Taxes	2.3	2.5	0.4	1.5
Investment Revenues	1.6	0.6	1.5	0.7
Rent on LGA Property	0.2	0.0	0.2	0.0
Special Dept Rev.	-	-	-	-
Others	0.7	1.5	1.1	0.3
TOTAL	100.0	100.0	100.0	100.0

Source: HERDS Medicare Limited, "Implementation of the Primary Health Care Policy at Local Government Area Level in Nigeria: Report of a Policy Research Study in Relation to the Primary Health Care Support Programme" August 1992, p. 255.

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Table 15
Percentage Distribution of Recurrent Expenditures in Model PHC LGA

SECTOR	1988 (actuals)	1989 (actuals)	1990 (actuals)	1991 (est.)
Administration	29.6	30.0	41.9	17.4
Agriculture	3.5	5.9	5.3	4.0
Commerce/Industry	0.6	2.6	0	1.5
Education	26.2	10.3	3.3	27.7 ¹
Health/Sanitation	22.0	20.3	25.5	15.0 ²
Transportation	5.7	6.9	0	3.8
Electricity	0.3	0.9	0	1.6
Community Development	1.3	8.3	8.2	1.8
Water	0.5	0.7	0	0.6
Treasury	9.7	13.9	15.6	10.4
Others	0.6	0.2	5.2	16.2
Total	100.0	100.0	100.0	100.0

Source: HERDS Medicare Limited, "Implementation of the Primary Health Care Policy at Local Government Area Level in Nigeria: Report of a Policy Research Study in Relation to the Primary Health Care Support Programme" August 1992, p. 263-4.

Table 16
Percentage Distribution of Recurrent Expenditures of Health Sector
by Type of Expense for Selected Model LGAs, 1989-1991

Expenditure Category	1988 Actual	1989 Actual	1990 Actual	1991 Estimate
Personnel	78.5	78.9	72.4	56.4
Drugs, Medical Supplies	4.6	8.1	9.0	11.1
Vehicle Operations & Main.	6.4	5.7	6.0	7.1
Building Main.	1.3	1.1	1.0	1.8
Office Supplies	0.7	1.5	0.7	1.8
Others	8.5	3.8	10.9	21.8
Total	100.0	100.0	100.0	100.0

Source: HERDS Medicare Limited, "Implementation of the Primary Health Care Policy at Local Government Area Level in Nigeria: Report of a Policy Research Study in Relation to the Primary Health Care Support Programme" August 1992, p. 272.

¹ Estimates are always much higher than actuals. The percentage indicated here is felt to be a sizeable overestimate.

² The actual allocations to health have generally been higher than the estimates, an unusual pattern.

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Table 17
 Distribution of Recurrent Health Expenditure by Program
 for Model LGAs, 1988-1991

Cost Centers	1988 actuals	1989 actuals	1990 actuals	1991 estimate
Administration	-	8.6%	20.5%	0.5%
Preventive Services	29.0%	23.5%	30.7%	33.9%
Curative Services	48.5%	49.1%	45.9%	39.1%
Environment Sanitation, Social Welfare	19.8%	18.8%	2.9%	19.5%
Primary Health Care Unit	-	(est) 1.6%	(est) 9.5%	7.0%
Total	100.0%	100.0%	100.0%	100.0%
No. of LGAs	4	7	2	14

Source: HERDS Medicare Limited, "Implementation of the Primary Health Care Policy at Local Government Area Level in Nigeria: Report of a Policy Research Study in Relation to the Primary Health Care Support Programme" August 1992, p. 273.

Table 18
 Summary of Host Country Contributions, 1989-1992
 FHS and CCCD programs
 (From Sample of Four States and Nine LGAs)

Project/Source	Contribution
<u>FHS</u>	\$11,445,079
Federal	1,715,988
States (four)	8,424,808
LGAs (nine)	1,304,283
<u>CCCD</u>	\$18,887,575
Federal	8,191,175
States (four)	8,087,834
LGAs (nine)	2,608,566
TOTAL	\$30,332,654*

Source: Coker-Smith International Asso. Inc. "Accounting for Counterpart Costs Related to Implementing Family Health Services and Combatting Childhood Communicable Diseases Program in Nigeria", September 11, 1992, p. 19. (Mathematics corrected by editor).

* Breakdown of HCC by source: MHSS - 33%; SMOHs - 54%; LGAs -13%.

Federal Ministry of Health and Human Services
Type of Contributions to CCCD (US\$)

Items	Total	Percent
Salaries	70,814	01
Malaria	11,161	-
Diarrhea	2,200	-
Vaccines	8,107,000	99
TOTAL	8,191,175	100

Source: Coker-Smith International Asso. Inc. "Accounting for Counterpart Costs Related to Implementing Family Health Services and Combatting Childhood Communicable Diseases Program in Nigeria" September 11, 1992, p. 23.

Table 20
State Contributions to CCCD (US\$)
Four Sample States

Item	Total	PERCENT
Health Facilities	715,924	9
Salaries & Wages	3,864,306	48
Training	31,732	-
Operating & Main.	657,547	9
Vehicles	647,333	8
Equipment	100,146	1
Land & Building	2,070,846	25
TOTAL	8,087,834	100

Source: Coker-Smith International Asso. Inc. "Accounting for Counterpart Costs Related to Implementing Family Health Services and Combatting Childhood Communicable Diseases Program in Nigeria" September 11, 1992, p. 26.

Table 21
Type of Contribution of LGAs to CCCD and FHS
Nine Sample LGAs

Item	Total	Percent
Health Facilities	1,029,056	26
Salaries & Wages	1,438,863	37
Training	56,344	1
Operating & Main.	282,729	7
Vehicles	166,121	4
Equipment	545,786	14
Land & Buildings	393,950	10
TOTAL	3,912,849	100

Source: Coker-Smith International Asso. Inc. "Accounting for Counterpart Costs Related to Implementing Family Health Services and Combatting Childhood Communicable Diseases Program in Nigeria" September 11, 1992, p. 28.

Table 22
Percentage Contributions of Federal Government
to Total CCCD and FHS Expenses, By Year

Project	1989	1990	1991	1992 (est)
CCCD	28	40	26	1.4 (est)
FHS	10	30	37	37+ (est)

Source: Coker-Smith International Asso. Inc. "Accounting for Counterpart Costs Related to Implementing Family Health Services and Combatting Childhood Communicable Diseases Program in Nigeria" September 11, 1992, p.21-22.

Table 23
Federal Ministry of Health and Human Services
Type of Contributions to FHS (US\$)

Items	Total	Percent
Salaries	240,964	14
Private Sector Condoms	443,170	26
Training	66,434	4
Cash	914,860	53
Equip & Maintenance	7,597	-
DPA Salaries	22,811	3
Office Space	20,152	-
TOTAL	1,715,988	100

Source: Coker-Smith International Asso. Inc. "Accounting for Counterpart Costs Related to Implementing Family Health Services and Combatting Childhood Communicable Diseases Program in Nigeria" September 11, 1992, p. 21.

Table 24
State Contributions to the FHS project
Type of Contribution
Four Sample States

Item	Total	Percent
Health Facilities	773,062	9
Salaries & Wages	5,984,743	71
Training	241,426	3
Operating & Main.	160,092	2
Vehicles	308,895	4
Equipment	726,506	9
Land & Buildings	229,543	3
Cash	0	0
TOTAL	8,424,808	100

Source: Coker-Smith International Asso. Inc. "Accounting for Counterpart Costs Related to Implementing Family Health Services and Combatting Childhood Communicable Diseases Program in Nigeria" September 11, 1992, p. 23.

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Table 25
The Role of Public and Private Sectors in Health Care Services

Category 1: Public Health Activities	Epidemiological Data Collection Health System Planning/Information Health Education/Communication Regulation and Licensing Environmental Health Prevention of Communicable Diseases Public Health Utilities: Water and Sanitation
Category 2: Mixed Public/Private Activities	Targeted Health Problems: Family Planning Maternal/child health Infant nutrition/growth monitoring Immunizations Treatment of communicable diseases
Category 3: Private Activities	Acute care: Inpatient and Outpatient Laboratory/Diagnostic Services Hospital Services

Source: Griffen, C.C. *Health Care in Asia: A Comparative Study of Cost and Financing*.
World Bank Regional and Sectoral Studies, Washington D.C.: World Bank, 1992, 47-48.

Table 26
Financial Sustainability: Concerns and Recommendations

Factors Affecting Financial Sustainability	Recommendations
1. Small federal budget allocations to health (<3%)	1, 4
2. Fed. health budget for personnel are high (80%)	1, 4, 5
3. Low regular federal budget allocations to PHC	1, 4
4. Falling p.c. public health budgets @ state level	4
5. State health budget for personnel are high (80%)	4, 5
6. Insufficient state expenditures for PHC	2, 4
7. State deficiency in financial management of PHC	2
8. LGA dependence on fed. & state statutory alloc.	4
9. LGA health budget for personnel are high (79%)	4, 5
10. Lack of defined budgets for PHC at LGA level	3, 4
11. LGA deficiency in financial management of PHC	3
12. Low state/LGA CCCD counterpart for non-personnel	4, 5
13. Low state/LGA FHS counterpart non-personnel	4, 5
14. Strengthening of timing, management and accountability of HCC	6, 7, 8
15. CCCD limited involvement with private sector	9a-d
16. FHS continued involvement with private sector	10a-d
17. Strengthening of NGOs involved in AIDS Program	11a-d
18. Increasing potential of cost-recovery	9c, 10c, 11c
19. Strengthen financial management within cost recovery	9c, 10c, 11c

ILLUSTRATIVE COMMODITY LISTINGS

Category: Data Processing Equipment			
Procurement Agent: CDC			
Item	Cost/Item	Number	Total Cost
Desktop Computer-Zenith486DX	\$2,500	42	\$105,000
Printers - Okidata 391 +	\$500	42	\$21,000
Printers - Diconix 180	\$350	8	\$2,800
U. Power Supply's	\$400	60	\$24,000
Zenith Notebook Computers	\$3,000	10	\$30,000
<i>Software</i>			
WordPerfect	\$300	42	\$12,600
Lotus 123	\$300	42	\$12,600
Harvard Graphics	\$300	42	\$12,600
Laplink	\$80	8	\$640
Epilinfo	\$50	42	\$2,100
Printer Cables	\$10	75	\$750
Hard Disk Replacements	\$350	15	\$5,250
Addit. 5.25" drives	\$100	8	\$800
Okidata Ribbons	\$3	4175	\$12,525
Diconix Ink Jet cart.	\$5	717	\$3,585
Addit. 3.5" drives	100	7	\$700
Printer Head Replacements	100	20	\$2,000
Hard Disk Replacement Laptop 60meg	350	3	\$1,050
			<i>Subtotal HIS</i> 250,000
			<i>Shipping. Ins. etc. (20%)</i> 50,000
			TOTAL 300,000

Category: Clinical, Laboratory, and Training Equipment

Procurement Agent: UNICEF

<i>Items</i>	<i>Number</i>	<i>Total Cost</i>
Steam Sterilizer	667	\$94,901
Steam Ster. Instruction Book	667	\$1,454
Gasket for "	162	\$1,014
S. Valve for "	162	\$846
Handle for "	162	\$907
Instrument Boiling Pan	690	\$80,399
Disinfect. Instruments	372	\$4,687
Kerosene Stove	522	\$63,799
6 Liter Basin	416	\$4,959
Basic MCH Clinic Kit	391	\$162,468
PHC Nurse Kit (for STD)	34	\$5,165
Prof. Midwife Kit	102	\$14,285
Aux. Midwife Kit	75	\$7,222
TBA Kit	102	\$4,394
Hypo. needle 23 G/12	1,256	\$2,160
DPT/M syringe/10/autocl	1,258	\$14,442
Needle BCG reconstit./12	629	\$1,912
BCG Needles /12	1,227	\$2,356
BCG reconstit syringe	627	\$477
BCG Syringes/10	627	\$10,584
Microscope - monocular	245	\$81,482
Lens paper	512	\$348
Wax Pencil for Slides	372	\$186
Microscope Slides (72)	1,900	\$5,852
Cover Slips	540	\$216
Slide Forceps	219	\$613
Vert. Jar / 10 slides	219	\$753
Alcohol Lamp	219	\$569
Ice Pack Freezer	178	\$232,194
Refrigerator Maint/Repair Kit	199	\$6,487
2.8 L Vaccine Carrier	1,333	\$44,349
Spare icepacks for "	254	\$117
Cold Box/24 icepack	712	\$200,649
Spare ice packs for "	172	\$5,962
Ice-lining Vaccine Refrigerator	162	\$232,151
Thermostat for "	54	\$391

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Capacitor for "	54	\$562
Starting Device for "	54	\$227
Compressor for "	54	\$4,972
Surface Level for "	129	\$49
Dial Thermometer for "	129	\$10,668
Birth Atlas Flip Chart	18	\$984
Hemoglobinometer set	1,351	\$8,646
Pipette for " spare	743	\$646
Hgb-meter spare tube	743	\$788
Overhead Transparencies (100)	156	\$2,544
Overhead Transp. Pens	210	\$588
Overhead Projector (220)	110	\$23,140
Projector Screens slide & overhead	56	\$4,063
Chalkboard	160	\$2,221
Nutrition/Birth Flannelograph	489	\$2,210
Gas Electric Refrigerator 220	383	\$478,133
Refrigerator Repair Tool Kit	122	\$198,360
Spare Refrigerator Thermostat	179	\$8,087
Speculum small	72	\$501
Speculum medium	72	\$510
Speculum large	72	\$264
Table examination, 2 section, pad	42	\$11,540
Kidney Basin	930	\$2,186
Sterilization Test Tape Roll	900	\$4,896
Lancets disposable 1000	155	\$4,941
Albumin Test Kit	549	\$1,867
Beastfeeding Dev. C.	18	\$559
Feeding Ch. West Africa	18	\$1,005
Protein Calorie Malnutrition	18	\$621
Slide Projector 220V	91	\$26,665
Lamp for "	91	\$308
Magazine for Slide Projector	91	\$194
Fetal/placen./cord demo.	18	\$610
Kwashiorkor management	18	\$471
Retinol 200,000/500/bottle	1,338	\$33,356

Syphgmanometer - adult	154	\$4,444
Spare valve for "	121	\$92
Spare bulb for "	121	\$81
Growth Monitoring Charting	28	\$817
Pinard Feto-scope	2,781	\$5,729
Newborn Care in Africa	18	\$625
Anat. Ch. Pregnancy	18	\$463
Preg. Childbirth, Newborn	28	\$342
Nut. for Dev. Countries	58	\$1,062
Helping Health Workers Learn	57	\$457
Childbirth Simulator	18	\$3,327
Arm Circumference Insertion Tape/50	2,249	\$32,206
Infant/Child Ht. Board	9	\$2,589
Salter Scale	1,349	\$49,131
Scale Infant Metric Clinic	359	\$42,764
Nasal Aspirator/infant	1,261	\$857
Clinical Thermometer	1,688	\$3,646
TBA scale birthweight indic.	1,886	\$21,161
Nasal Feeding Tube 8 Fr. Inf.	320	\$221
Exam Gloves/NS/Med/10pr	214,750	\$201,865
		<i>Cost</i> \$2,500,000
		<i>Shipping, Fees, etc.</i> \$500,000
	TOTAL	\$3,000,000

Category: IEC Equipment for Private Sector Initiatives Procurement Agent: PAF		
Items	Number	Total Cost
Overhead Transparencies (100)	100	\$1,631.00
Overhead Transp. Pens	124	\$347.20
Overhead Projector (220)	200	\$42,072.00
Projector Screen for Slide & Overhead	200	\$14,512.00
Chalkboard	975	\$13,533.00
Slide Projector 220V	200	\$29,302.00
Projector Stand Aluminium	200	\$19,236.00
Lamp for "	300	\$1,014.00
Magazine for Slide Projector	250	\$532.50
Voltage Regulator	250	\$32,822.50
Projector for Computer Monitor	20	\$35,000.00
Video Recorders PAL/SECAM	10	\$20,000.00
Video Players (Multisystem)	40	\$40,000.00
	<i>Cost</i>	<i>\$250,002</i>
	<i>Plus 20%</i>	<i>\$50,000</i>
	TOTAL	\$300,000

Category: Vehicles Procurement Agent: PAF		
Vehicles x 65	TOTAL	\$1,000,000

CCCD2 Activities - Years 1 and 2	Duration	Start	End
Year 1 Activities beginning in 1993	1.62 y	04/Jan/93	30/Aug/94
*CDC PASA executed	0.00 m	31/May/93	31/May/93
*Review of tech. strategies - EPI, Mal, CDD/ARI/HIV/STDs/TB (Annual)	2.00 m	11/Jan/93	15/Mar/93
*Begin activities in 12 new CCCD LGAs	6.00 m	04/Mar/93	03/Sep/93
*Explore methods for PHCDA to support state/LGA PHC	3.00 m	02/Feb/93	05/May/93
*Update/dist. tech. guidelines to pub. & priv. sector (Annual)	5.00 m	01/Jul/93	03/Dec/93
*Baseline info. for monitoring & evaluation of CCCD2 Project	8.00 m	04/Jan/93	08/Sep/93
*Continuing Education	1.48 y	04/Jan/93	11/Jul/94
Establish/equip/train 4 State Cont. Ed. Units	8.99 m	04/Mar/93	08/Dec/93
Revise/develop & test "sick child" training materials	1.00 y	01/Jul/93	11/Jul/94
Field testing of facility-level lessons for supervisors	1.00 y	01/Jun/93	08/Jun/94
Curriculum dev. course for Cont. Ed. Unit / SHT tutors	3.00 w	20/Jul/93	09/Aug/93
Dissem. training mats. to CCCD states & SHT in non-focus states	2.00 m	02/Feb/93	05/Apr/93
CEU/LGA Continuing Education (Annual)	5.00 d	04/Jan/93	08/Jan/93
Training administration course for CEU/SHT tutors	3.00 w	15/Nov/93	06/Dec/93
Contacts w/ CE progs of Nurses' Ass'n, CHAN, Teaching Hosps	3.00 m	04/Jan/93	07/Apr/93
Publication of CEU Newsletters/updates (ongoing)	3.00 m	04/Jan/93	07/Apr/93
Supply CEU libraries/ equip clinical practice sites	6.00 m	04/Mar/93	03/Sep/93
Ident. inst'l. for off-shore training / 1 official trained / year	1.00 m	11/Oct/93	09/Nov/93
*Health Education	17.70 m	04/Jan/93	08/Jul/94
Design MPH & ADHE level training at ARHEC	8.00 m	04/Jan/93	08/Sep/93
Recruit/hire 2 Health Ed. Specialists	3.00 m	03/Feb/93	06/May/93
Finalize SOW for ARHEC technical services	2.00 w	04/Jan/93	15/Jan/93
ARHEC conducts Community Ed TOT for FHEB	2.00 w	05/Apr/93	16/Apr/93
Baseline HE data collection done/presented to Village Dev. Committ	8.00 m	01/Nov/93	08/Jul/94
Determine training status of LGA HE officers (with CEU) / train as n	2.00 m	04/Jan/93	08/Mar/93
Pilot Modifiable Risk Factor System in Oyo State	8.00 m	26/Jul/93	31/Mar/94
Vehicles, books, journals for States, LGAs, FHEB	3.00 m	04/Jan/93	07/Apr/93
SMOH/LGA training materials finalized by FHEB / begin TOTs	5.00 d	04/Jan/93	08/Jan/93
*Health Information Systems & HIV/STD Surveillance & DDM	1.62 y	04/Jan/93	30/Aug/94
Estab. HIS office in each focus state & train staff	6.00 m	04/Jan/93	08/Jul/93
Pilot use of Child Survival/Family Planning computer commodity. mg	1.00 y	12/Feb/93	22/Feb/94
Begin integrat. of the current HIS systems - PHC with Disease Cont	4.00 m	19/Oct/93	22/Feb/94
Identify local collaborating institution for applied epidemiology traini	3.00 m	01/Jul/93	01/Oct/93
Computer training in HIS software packages	1.00 y	20/Aug/93	30/Aug/94
Epidemiology short course with Univ Ibadan	3.00 w	11/Oct/93	29/Oct/93
Workshop on Operations Research proposal writing	5.00 d	07/Jun/93	11/Jun/93
2 MOH officials to Interl. EIS course (yearly)	1.00 m	11/Oct/93	09/Nov/93
Study use of data at state & LGA levels	4.00 m	08/Mar/93	07/Jul/93
HIV/STD surveillance course for state AIDS Prog. Coordinators	1.00 m	12/Nov/93	14/Dec/93
National HIV sero-survey & dissem. results	3.00 m	04/Jan/93	07/Apr/93
2 MOH officials to AIDS Surv course (yearly)	1.00 m	09/Aug/93	08/Sep/93
4 lab staff to Abidjan to study Proj RETRO-CI lab strat & methods	3.00 w	12/Oct/93	01/Nov/93
HIV Universal precautions dissem. to protect health workers and cli	3.00 m	04/Jan/93	07/Apr/93
Develop workplan for strengthening HIV/STD surveillance	3.00 m	01/Jul/93	01/Oct/93
Dev. plan for integration of PHC info. from WHO, UNICEF, World Ba	3.00 m	02/Feb/93	05/May/93
Assessment of decision-making process Fed, state & LGA levels	3.00 m	04/Jan/93	07/Apr/93
Training in rapid assessment for comm. problems/concerns (DDM)	2.00 m	09/Sep/93	09/Nov/93
Assessment of Central Public Health Lab & zonal labs	3.00 w	04/Jan/93	25/Jan/93
*Private Sector	11.32 m	04/Jan/93	22/Dec/93
Define private sector policy agenda / begin studies & dialogue	6.00 m	04/Jan/93	08/Jul/93
Ident. institut. as Center for Research of Health Care Private Sector	1.00 m	04/Jan/93	03/Feb/93
KAP studies of private sector clients/providers	3.00 m	10/May/93	10/Aug/93
Assess instit. capacity of private sector	3.00 m	20/Sep/93	22/Dec/93
*EPI/CDD/ARI/Malaria/Nutrition	1.06 y	04/Jan/93	04/Feb/94
Examine means for continuing urban EPI Lagos State	4.00 w	15/Jul/93	11/Aug/93

Task Name	Duration	Start	End
Year 3 Activities beginning in 1995	4.49 y	02/Jan/95	19/Aug/99
EPI/CDD/ARI In Depth Review	1.00 m	03/Feb/95	07/Mar/95
Begin activities in 12 new CCCD LGAs/graduate 12 LGAs	1.00 y	06/Mar/95	14/Mar/96
Strengthen Emergency Preparedness & Response capacity	7.00 m	06/Feb/95	12/Sep/95
Strengthen Center for private sector research	3.00 m	04/Jan/95	07/Apr/95
Test child-feeding protocols in focus LGAs	6.00 m	05/Apr/95	09/Oct/95
Pilot growth monitoring activities in selected LGAs	3.00 m	13/Nov/95	16/Feb/96
Breastfeeding policy developed	3.00 m	07/Jul/95	09/Oct/95
Maternal nutrition surveys	5.00 m	07/Jul/95	08/Dec/95
Expand Baby Friendly Initiative to PHC & communities	2.50 y	04/Jan/95	04/Aug/97
Begin two-year Epidemiology training w/ collab institution	4.00 y	05/Jul/95	19/Aug/99
Quality Assurance awareness & skills training	3.00 m	02/Jan/95	05/Apr/95
Development of national nutrition policy	4.00 m	07/Apr/95	09/Aug/95
National HIV serosurvey - dissem results	1.00 y	02/Jan/95	11/Jan/96
Begin "small grants" program to NGO/PVOs	3.50 y	02/Jan/95	12/Aug/98
Seminars for LGA leaders on use of data for health & budg	3.00 m	07/Jan/95	08/Sep/95
Conduct national HIV serosurvey / dissem results	3.00 m	02/Jan/95	05/Apr/95
Expand malaria surveillance sites	6.00 m	04/Apr/95	06/Oct/95
ARI training units established at 4 zonal DTUs	3.00 m	02/Jan/95	05/Apr/95
Establish ORTU/corners in all hospitals in focus LGAs	1.00 y	02/Jan/95	11/Jan/96
Strengthen inventory control at peripheral level	8.00 m	02/Jan/95	07/Sep/95
Begin integret. private non-profit facilities in routine HIS	3.00 m	07/Aug/95	07/Nov/95
Implement private sector loan program	3.00 m	02/Jan/95	05/Apr/95
External Management Review	1.00 m	10/Jul/95	08/Aug/95
Dissem. findings of completed OR	2.00 m	02/Jan/95	06/Mar/95
Improve quality of PHC & hospital HIS data	6.00 m	02/Jan/95	07/Jul/95
Support SMOH short courses in STD management	4.00 m	06/Apr/95	08/Aug/95
Vitamin A OR on prevention & Rx ARI/diarrhea/measles	2.00 y	06/Mar/95	27/Mar/97
Year 4 Activities beginning in 1996	3.49 y	04/Jan/96	11/Aug/99
Upgrade state AIDS/STD diagnosis & treatment	3.00 y	08/Jul/96	11/Aug/99
Child nutrition guidelines incorp. into CEU and SHT educati	1.00 y	05/Apr/96	17/Apr/97
Institutionalization of Nigeria Bulletin of Epidemiology	0.00 m	30/Dec/98	30/Dec/96
Analysis of "lessons learned" from init. implem. of LGA pla	3.00 w	05/Aug/96	23/Aug/96
Health mgmt training for LGA and State PHC leaders	1.00 m	04/Jan/96	05/Feb/96
Upgrade provider skills on obstetric emergencies	8.00 m	07/Jan/96	14/Feb/97
Imple. state plans for NNT and polio eradication	6.00 m	06/Feb/96	09/Aug/96
Assess use of OR findings for policy formulation	3.00 m	05/Jan/96	09/Apr/96
Results of PHC M&E systems analysis incorp. in workplan	3.00 m	08/Jul/96	08/Oct/96
Strengthen del. of Health Ed through primary schools	2.00 y	01/Mar/96	26/Mar/98
Instit. of nat'l & state commodity mgmt system	0.00 m	15/Oct/96	15/Oct/96
Dissem. findings of completed OR	2.00 m	08/Jul/96	06/Sep/96
Year 5 Activities beginning in 1997	5.92 y	02/Jan/97	10/Feb/03
EPI/CDD/ARI In Depth Review	1.00 m	09/Jan/97	09/Jul/97
Dev/dissem private sector tech. updates	1.50 y	02/Jan/97	21/Jul/98
Evaluate degree of feedback of HIS info & its use at local le	3.00 m	03/Feb/97	06/May/97
Graduate 12 LGAs	1.00 y	02/Jan/97	14/Jan/98
Strengthen Emergency Preparedness & Response capacity	7.00 m	04/Mar/97	07/Oct/97
Begin two-year Epidemiology training	5.50 y	09/Jan/97	10/Feb/03
Offshore Health Ed material dev. training	9.00 m	07/Apr/97	14/Jan/98
Nutrition OR on cost/effectiveness of community nut. interv	1.00 y	07/Apr/97	17/Apr/98
* Governance - QA	3.00 m	02/Jan/97	07/Apr/97
National HIV serosurvey - dissem results	1.00 y	08/Jan/97	18/Jan/98
Safe Motherhood policies & guidelines disseminated	6.00 m	02/Jan/97	09/Jul/97
ARI training for improved hospital management of ARI	8.00 m	03/Feb/97	08/Oct/97
Develop Health Ed. standards of practice for PHC progs.	9.00 m	09/Sep/97	18/Jan/98
Malaria prevention/control training	3.00 m	07/Jul/97	07/Oct/97
External Management Review	1.00 m	05/Mar/97	03/Apr/97
Review of results of social marketing studies/dissem. findin	2.00 m	03/Mar/97	01/May/97
Institut. Cont. Med. Library Medline & journal database syst	3.00 m	15/Aug/97	18/Nov/97
State HIS feedback bulletins estab in 9 states	0.00 m	03/Mar/97	03/Mar/97
Evaluate sentinel surveillance system	3.00 m	03/Mar/97	03/Jan/97
Year 6 Activities beginning in 1998	1.86 y	02/Jan/98	03/Dec/99
EPI/CDD/ARI In Depth Review	1.00 m	27/Jul/98	25/Aug/98
Graduate 12 LGAs	1.00 y	02/Jan/98	13/Jan/99
Offshore HIS software training - 3 persons	6.00 m	02/Jan/98	08/Jul/98
Assess Emergency Preparedness & Response Capacity	1.00 m	04/Feb/98	06/Mar/98
Publication/dissem of OR to date	6.00 m	01/Jan/99	03/Dec/99

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CCCD2 Activities - Years 1 and 2	Years	
	1993	1994
Year 1 Activities beginning in 1993		
*CDC PASA executed	△	
*Review of tech. strategies - EPI, Mal, CDD/ARI/HIV/STDs/TB (Annual)	■	
*Begin activities in 12 new CCCD LGAs	■	
*Explore methods for PHCDA to support state/LGA PHC	■	
*Update/dist. tech. guidelines to pub. & priv. sector (Annual)	■	
*Baseline info. for monitoring & evaluation of CCCD2 Project	■	
*Continuing Education		■
Establish/equip/train 4 State Cont. Ed. Units	■	
Revise/develop & test "sick child" training materials	■	
Field testing of facility-level lessons for supervisors	■	
Curriculum dev. course for Cont. Ed. Unit / SHT tutors	□	
Dissem. training mats. to CCCD states & SHT in non-focus states	■	
CEU/LGA Continuing Education (Annual)		■
Training administration course for CEU/SHT tutors		□
Contacts w/ CE progs of Nurses' Ass'n, CHAN, Teaching Hosps	■	
Publication of CEU Newsletters/updates (ongoing)	■	
Supply CEU libraries/ equip clinical practice sites	■	
Ident. instit. for off-shore training / 1 official trained / year		□
*Health Education		■
Design MPH & ADHE level training at ARHEC	■	
Recruit/hire 2 Health Ed. Specialists	■	
Finalize SOW for ARHEC technical services	□	
ARHEC conducts Community Ed TOT for FHEB	□	
Baseline HE data collection done/presented to Village Dev. Committees		■
Determine training status of LGA HE officers (with CEU) / train as needed	■	
Pilot Modifiable Risk Factor System in Oyo State		■
Vehicles, books, journals for States, LGAs, FHEB	■	
SMOH/LGA training materials finalized by FHEB / begin TOTs		■
*Health Information Systems & HIV/STD Surveillance & DDM		■
Estab. HIS office in each focus state & train staff	■	
Pilot use of Child Survival/Family Planning computer commodity. mgmt system	■	
Begin integrat. of the current HIS systems - PHC with Disease Control		■
Identify local collaborating institution for applied epidemiology training	■	
Computer training in HIS software packages		■
Epidemiology short course with Univ Ibadan		□
Workshop on Operations Research proposal writing	■	
2 MOH officials to Inter'l EIS course (yearly)		□
Study use of data at state & LGA levels	■	
HIV/STD surveillance course for state AIDS Prog. Coordinators		□
National HIV sero-survey & dissem. results	■	
2 MOH officials to AIDS Surv course (yearly)		□
4 lab staff to Abidjan to study Proj RETRO-CI lab strat & methods		□
HIV Universal precautions dissem. to protect health workers and clients	■	
Develop workplan for strengthening HIV/STD surveillance		■
Dev. plan for integration of PHC info. from WHO, UNICEF, World Bank, CHA	■	
Assessment of decision-making process Fed, state & LGA levels	■	
Training in rapid assessment for comm. problems/concerns (DDM)		■
Assessment of Central Public Health Lab & zonal labs	■	
*Private Sector		■
Define private sector policy agenda / begin studies & dialogue	■	
Ident. institut. as Center for Research of Health Care Private Sector	■	
KAP studies of private sector clients/providers	■	
Assess instit. capacity of private sector		■
*EPI/CDD/ARI/Malaria/Nutrition		■
Examine means for continuing urban EPI Lagos State	■	

Task Name	Years					
	1995	1996	1997	1998	1999	2000
Year 3 Activities beginning in 1995	[Bar]					
EPI/CDD/ARI In Depth Review	[Bar]					
Begin activities in 12 new CCCD LGAs/graduate 12 LGAs	[Bar]					
Strengthen Emergency Preparedness & Response capacity Fed and St	[Bar]					
Strengthen Center for private sector research	[Bar]					
Test child-feeding protocols in focus LGAs	[Bar]					
Pilot growth monitoring activities in selected LGAs	[Bar]					
Breastfeeding policy developed	[Bar]					
Maternal nutrition surveys	[Bar]					
Expand Baby Friendly Initiative to PHC & communities	[Bar]					
Begin two-year Epidemiology training w/ collab institution	[Bar]					
Quality Assurance awareness & skills training	[Bar]					
Development of national nutrition policy	[Bar]					
National HIV serosurvey - dissem results	[Bar]					
Begin "small grants" program to NGO/PVOs	[Bar]					
Seminars for LGA leaders on use of data for health & budgetary decisi	[Bar]					
Conduct national HIV serosurvey / dissem results	[Bar]					
Expand malaria surveillance sites	[Bar]					
ARI training units established at 4 zonal DTUs	[Bar]					
Establish ORTU/corners in all hospitals in focus LGAs	[Bar]					
Strengthen inventory control at peripheral level	[Bar]					
Begin integrat. private non-profit facilities in routine HIS	[Bar]					
Implement private sector loan program	[Bar]					
External Management Review	[Bar]					
Dissem. findings of completed OR	[Bar]					
Improve quality of PHC & hospital HIS data	[Bar]					
Support SMOH short courses in STD management	[Bar]					
Vitamin A OR on prevention & Rx ARI/diarrhea/measles	[Bar]					
Year 4 Activities beginning in 1996	[Bar]					
Upgrade state AIDS/STD diagnosis & treatment		[Bar]				
Child nutrition guidelines incorp. into CEU and SHT education		[Bar]				
Institutionalization of Nigeria Bulletin of Epidemiology		[Bar]				
Analysis of "lessons learned" from init. implem. of LGA plans		[Bar]				
Health mgmt training for LGA and State PHC leaders		[Bar]				
Upgrade provider skills on obstetric emergencies		[Bar]				
Imple. state plans for NNT and polio eradication		[Bar]				
Assess use of OR findings for policy formulation		[Bar]				
Results of PHC M&E systems analysis incorp. in workplan		[Bar]				
Strengthen del. of Health Ed through primary schools		[Bar]				
Instit. of nat'l & state commodity mgmt system		[Bar]				
Dissem. findings of completed OR		[Bar]				
Year 5 Activities beginning in 1997	[Bar]					
EPI/CDD/ARI In Depth Review			[Bar]			
Dev/dissem private sector tech. updates			[Bar]			
Evaluate degree of feedback of HIS info & its use at local level			[Bar]			
Graduate 12 LGAs			[Bar]			
Strengthen Emergency Preparedness & Response capacity Fed and St			[Bar]			
Begin two-year Epidemiology training			[Bar]			
Offshore Health Ed material dev. training			[Bar]			
Nutrition OR on cost/effectiveness of community nut. interventions			[Bar]			
* Governance - QA			[Bar]			
National HIV serosurvey - dissem results			[Bar]			
Safe Motherhood policies & guidelines disseminated			[Bar]			
ARI training for improved hospital management of ARI			[Bar]			
Develop Health Ed. standards of practice for PHC progs.			[Bar]			
Malaria prevention/control training			[Bar]			
External Management Review			[Bar]			
Review of results of social marketing studies/dissem. findings of com			[Bar]			
Instit. Cent. Med. Library Medline & journal database system			[Bar]			
State HIS feedback bulletins estab in 9 states			[Bar]			
Evaluate sentinel surveillance system			[Bar]			
Year 6 Activities beginning in 1998	[Bar]					
EPI/CDD/ARI In Depth Review				[Bar]		
Graduate 12 LGAs				[Bar]		
Offshore HIS software training - 3 persons				[Bar]		
Assess Emergency Preparedness & Response Capacity				[Bar]		
Publication/dissem of OR to date				[Bar]		

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ILLUSTRATIVE TRAINING PROGRAMS

NCCCD IN-COUNTRY TRAINING PROGRAM		
Type of Continuing Education	Category of Health Workers	Number
Training of Trainers (Skills)	CEU/SHT HIS, M/E, HE Staff	120
Supervisory Skills (Admin)	CEU/SHT Staff	45
Supervisory Skills (Supervsn)	CEU/SHT Staff	45
Annual CEU/SHT Continuing Ed	CEU/SHT Staff	540
Training Management	CEU Staff	36
PHC Trng Program Admin	CEU/SHT Staff	18
Program Administration	CEU/SHT Staff	180
CEU/LGA MHSS Superv'ry Skills	LGA Mgrs, Heads/Facilities	2,025
CEU/LGA Annual Continuing Ed	LGA Mgrs, Heads/Facilities	7,650
In-service Curricula Develop	CEU Staff	144
Pre-service Curricula Develop	CEU/SHT staff	630
PHC District Management	LGA Managers	432
PHC Management Workshops	LGA Managers	225
SMOH Trng @ LGA/Facilities	Peripheral Health Workers	4,950
LGA Facility Continuing Ed	Peripheral Health Workers	7,650
LGA/Peripheral Level Training	CHAN Periph Health Workers	2,575
Nurse-Midwife Training	NAANM Nurse-Midwives	640
PHC Training for Physicians	UTH Physicians	700
Patient Education Workshops	Peripheral Health Workers	350
HIS/Health Mgt CE	Zone/SMOH/LGA PHC/PRS Offs	142
Data Processing CE	LGA PHC M/E Staff	90
Data Processing CE	LGA Health Facility Wrkrs	420
Disease Notification Systems	State/LGA Disease Control	800
AIDS/STD Surveillance	State/LGA Staff	70
Disease Control Techniques	State/LGA Epidemiologists	70

HE/C Methodology	SMOH/CEU/LGA PHC Staff	35
Nutrition Strategy	SMOH/LGA PHC Staff	420
Treatment of Sick Child Method	SMOH/LGA PHC Staff	420
Cold Chain Maintenance	SMOH/LGA EPI Staff	420
Malaria Prev/Cont Techniques	SMOH/LGA PHC Staff	1,260
PHC M/E Orientation	SMOH/LGA M/E Staff	840
Quality Assurance Awareness	MHSS/SMOH/LGA Staff	440
Quality Assurance Skills Trng	MHSS/SMOH/LGA Staff	440
Governance PHC Management	LGA Staff	2,000
Governance PHC Advocacy/Sensit	LGA Chairpersons/Dept Dir	1,200
Health Sector Management	NGO, Pvt Sector Personnel	75
Clinical Practices	NGO, Pvt Sector Personnel	75

OFFSHORE TRAINING: SHORT-TERM			
Type of Training	Type of Personnel	Persons	P/M Trng
<u>Third Country</u>	***	***	***
Health Management	CEU/SHT Staff	12	24
PHC Operations	CES/SHT Staff	12	24
HE/C Materials Develop	State/LGA HE/C Staff	6	12
<u>United States</u>	***	***	***
Health Econ/Fin	Pvt Sector Rsrch Prof	4	36
<i>HIV/STD Surveillance</i>	<i>MHSS/SMOH/LGA HIS Staff</i>	3	6
<i>HIS Software Utiliz'n</i>	<i>MHSS/SMOH/LGA HIS Staff</i>	3	3
<i>M/E Methodology</i>	<i>MHSS M/E Staff</i>	3	3
<i>Disease Control</i>	<i>SHOH/LGA Epidem'logists</i>	8	24
<i>HE/C Materials Develop</i>	<i>State/LGA HE/C Staff</i>	4	4

NOTE: Training items shown in italicized redline will be arranged and funded under the PASA with CDC.

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
GOAL Healthier Society	<u>Measurements of Goal Achievement</u> <ul style="list-style-type: none"> ● GDP/capita ● Median Annual Income ● Annual Average Rural Wages 	Federal Office of Statistics and World Bank and IMF Reports. DHS Surveys, 1990/94/98; World Bank and UN Surveys and Reports.	Factors beyond project control will support EOPS in the attainment of the Project Goal. Means of measuring goal attainment will be available prior to project end.
SUBGOAL Reduced Fertility and Increased Morbidity and Mortality	<ul style="list-style-type: none"> ● Reduced Total Fertility Rate from 6.0 (1990) to 5.5 by YR 2000. ● Increased life expectancy at birth for males from 49.5 to 51 by YR 2000, and for females from 48.5 to 51 by YR 2000. 		Achievements of other projects, funded by A.I.D. and other donors, particularly those addressing family planning and maternal/child health materialize as anticipated.

NOTE: The Project Goal and Subgoal equates with the Program Goal and Subgoal of the Nigeria Country Program Strategic Plan (CPSP) for 1993-2000.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>PURPOSE</p> <p>Improved Maternal and Child Health Practices in the public and private sectors</p>	<p><u>Conditions that will indicate purpose has been achieved: End of Project status.</u></p> <ul style="list-style-type: none"> ● Decreased infant mortality from 90/1000 in 1990 to 75/1000 by YR 2000. ● Decreased child (1-4) mortality from 115/1000 in 1990 to 90/1000 by YR 2000. ● Decreased rate of severe malnutrition (wt/ht) from 9.1% in 1990 to 5% by YR 2000. ● Decreased rate of high risk births (women < 18, interbirth interval < 24 mos, parity > 3, age > 35) from 79% in 1990 to 60% by YR 2000. ● Decreased rate of maternal mortality from 15/1000 live births in 1990 to 10/1000 by YR 2000. 	<ul style="list-style-type: none"> ● DHS Surveys, 1990/94/98. ● DHS Surveys, 1990/94/98. ● DHS Surveys, 1990/94/98; Community Surveys. ● DHS Surveys, 1990/94/98. <p>● Sisterhood surveys as part of DHS.</p>	<p>There will be continued political and financial support at federal, state, and LGA levels and in the private sector for maternal and child health care.</p> <p>Factors beyond project control will support the attainment of EOPS.</p> <p>Other donor contributions continue to complement project as a means to reach overall objectives.</p> <p>Means of measuring the attainment of EOPS will be available prior to project end.</p> <p>Clientele access health care facilities in sufficient numbers and frequency to attain EOPS.</p>

NOTE: The Project Purpose equates with Strategic Objective 2 of the CPSP.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>OUTPUTS ¹</p> <p>1. Improved Immunization Practices and Coverage</p>	<p><u>Magnitude of Outputs</u></p> <ul style="list-style-type: none"> ● 8 of 10 critical EPI elements performed correctly by YR 2000. ● 80% of children < 1 have received scheduled DPT3, Polio x4doses and measles vaccines by YR 2000. ● Measles morbidity reduced 65% from pre-immunization levels by YR 2000. ● Polio incidence reduced to 1/1000 by YR 2000. ● 75% of parturient women surveyed in past 12 months have received protective levels of tetanus antitoxin. 	<ul style="list-style-type: none"> ● Biennial facility surveys on sample of health facilities. ● Annual coverage est. based on < 1 reported vaccinations; DHS Surveys, 19/90/94/98. ● Coverage x vaccine efficacy. ● Annual sentinel surveillance. ● Serologic surveys 1993/98. 	<p>There will be continued political and financial support at federal, state, and LGA levels and in the private sector for maternal and child health care.</p> <p>Factors beyond project control will support the attainment of EOPS.</p>
<p>2. Improved Case Management of ARI, Fever (Malaria) and Diarrhea</p>	<ul style="list-style-type: none"> ● Increased correct home case management of fever by child caretakers from 60% in 1990 to 80% by YR 2000. ● Increased correct home case management of diarrhea by child caretakers from 30% in 1990 to 60% by YR 2000. ● 80% of children < 5 seen at health facilities with ARI, fever (malaria) and diarrhea received care meeting standards re clinical assessment, treatment and counseling by YR 2000. 	<ul style="list-style-type: none"> ● DHS surveys, 1990/94/98; Community Surveys. ● DHS surveys, 1990/94/98; Community Surveys. ● Biennial facility surveys on sample of health facilities. 	<p>Other donor contributions continue to complement project as a means to reach overall objectives.</p> <p>Means of measuring the attainment of EOPS will be available prior to project end.</p>
<p>3. Improved Child Nutrition Practices</p>	<ul style="list-style-type: none"> ● Infants 0-4 mos exclusively breastfed increased from 1% in 1990 to 10% by YR 2000. ● Mothers feeding nutritious food to infants 6-9 months increased from 70% in 1990 to 90% by YR 2000. ● Vitamin A and Iodine deficiency in < 5s decreased (to be determined). 	<ul style="list-style-type: none"> ● DHS surveys, 1990/94/98. ● DHS surveys, 1990/94/98. ● DHS surveys, 1990/94/98. 	<p>Clientele access health care facilities in sufficient numbers and with sufficient frequency to attain EOPS.</p>
<p>4. Improved Maternal Care</p>	<ul style="list-style-type: none"> ● Pregnant women with 2 prenatal visits from trained health provider increased from 52% in 1990 to 75% by YR 2000. ● Births attended by trained attendant increased from 30% in 1990 to 50% by YR 2000. ● Postpartum women informed and offered birth spacing information and services increased from < 10% in 1990 to 25% by YR 2000. ● Postpartum women using modern methods of contraception increased from < 5% in 1990 to 20% by YR 2000. 	<ul style="list-style-type: none"> ● DHS surveys, 1990/94/98. ● DHS surveys, 1990/94/98. ● DHS surveys, 1990/94/98; Biennial facility surveys on sample of health facilities. ● DHS surveys, 1990/94/98. 	

¹ The objectively verifiable indicators for the Project Outputs are applicable to Focus States and LGAs specifically addressed by A.I.D. program interventions.

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<p>5. Improved Planning and Management of Public and Private Health Systems</p>	<ul style="list-style-type: none"> • Annual work plans and budgets developed • Project specific data collected and analyzed • IEC programs and strategies designed, implemented and analyzed. • Program and policy decisions supported by Operations Research • Health facilities stocked with adequate supplies • Health facilities are staffed with trained personnel 	<ul style="list-style-type: none"> • Copies of plans and budgets • Project reports • IEC materials and reports • Studies • Health facility surveys 	
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NOTE: Project Outputs 1 thru 4 equate with the Targets of Strategic Objective 2 of the CPSP; Project Output 5 is an extension of the CPSP Cross-cutting Target.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>INPUTS</p> <p><u>A.I.D.</u></p> <p>Tech Assist</p> <ul style="list-style-type: none"> • CDC PASA 7.1 • CA Buy-ins 7.3 • Other TA 2.0 • Admin Sup 3.4 <p>Participants 0.3</p> <p>Commodities 4.3</p> <p>Local Costs</p> <ul style="list-style-type: none"> • Prg Opns 12.1 • Local TA 2.5 <p>Audit 1.0</p> <p>Total \$40.0</p> <p><u>HCC</u></p> <p>Federal Govt 4.3</p> <p>State Govt 9.5</p> <p>LGAs 5.0</p> <p>\$18.8</p> <p>=====</p> <p>TOTAL \$58.8</p>	<p><u>Implementation Target</u></p> <p><u>Strategies to Strengthen Infrastructure in Support of Technical Interventions</u></p> <ul style="list-style-type: none"> • Management of Health Resources at the Local Level • Continuing Education (CE) • Quality Assurance (QA) Standards • Health Education/Communications (HE/C) • Health Information Systems (HIS) • Operations Research (OR) • Private Sector Initiatives <p><u>Major Child Survival Interventions</u></p> <ul style="list-style-type: none"> • Prevention <ul style="list-style-type: none"> • Timing of Births • Safe Motherhood • Maternal/Child Nutrition • Expanded Program on Immunization (EPI) • Case Management of the Sick Child <ul style="list-style-type: none"> • Malaria • Control of Diarrheal Diseases (CDD) • Acute Respiratory Infections (ARI) 	<ul style="list-style-type: none"> • AAO internal program documentation • Project progress reports • Interim and final evaluations • Financial reports • Site visits and facility inspection reports 	<ul style="list-style-type: none"> • A.I.D. funding availability and obligations made in timely fashion • Counterpart in kind and budgetary contributions are forthcoming as anticipated

**PRIMARY HEALTH CARE
DEVELOPMENT AGENCY OF
NIGERIA.**

**FEDERAL MINISTRY OF HEALTH
AND HUMAN SERVICES**



LAGOS, 1992

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1. INTRODUCTION

Since 1986, the Federal Ministry of Health has pioneered the development of a national health system based on primary health care. Intensive efforts have been made by means of technical, financial and material assistance from the Federal level to assist LGAs in strengthening their PHC system. Village health systems have been developed, using local volunteers appropriately supported by the LGA health team, health districts have been organised by means of appropriate demarcation of area, formation of district health teams and upgrading of a facility to act as district headquarters and point of referral; houses have been numbered and home-based records placed in many communities to establish an address system, facilitate referral and follow-up of patients and also to facilitate channelling of specific interventions to those needing them. The managerial process for health development has been strengthened at all levels with an emphasis on community participation. This has included setting up committees at village, health district, LGA, state, zone and federal levels. The committees have specified management functions suited to each level. An essential drug scheme and drug revolving fund has been set up in at least 90% of the former 303 LGAs.

Training for these tasks has been conducted on an unprecedented scale by means of workshops that were calculated building blocks of skills at all levels. A PIIC monitoring and evaluation system is being vigorously pursued and strengthened in all

The proposed functions of the PHC Development Agency are outlined in the section which follows. At this point it may be helpful to first of all outline the continuing functions of the Ministry of Health as regards Primary Health Care.

1.2 On-going Responsibilities of the Federal Ministry of Health and Human Services

The Federal Ministry of Health is responsible for:

- (a) primary health care policy;
- (b) designing of health strategies, programmes and interventions;
- (c) providing management guidelines for PHC programme implementation;
- (d) basic PHC training: development of curricula, conduct of examinations, inspection of PHC training institutions, certification of PHC trainees etc;
- (e) setting standards for PHC training and service delivery;
- (f) integrating data on PHC into the national health information system
- (g) providing financial support to PHC implementation.

services or to integrate new components into them;

2.1.2 Resources Mobilization

- (a) to mobilise resources nationally and internationally in support of the programmes of the Agency,
- (b) to conduct or commission studies on resource mobilisation for health and issues of cost and financing, with particular reference to equity.

2.1.3 Support to Monitoring and Evaluation

- (a) to monitor the development of the nation's PHC programme so that it keeps as much as possible within the guidelines set out for its development in the National Health Policy and PHC Guidelines and Training Manuals;
- (b) develop guidelines and design frameworks for periodic evaluation of primary health care at various levels;
- (c) monitor the monitoring and evaluation process nationally, with particular respect to the development of capabilities at LGA level to analyse and make use of monitoring and evaluation data for management decision-making.

-
- (b) pay special attention to the involvement of women and grass-roots women's organisations in the village health system.

2.1.6 Health System Research (HSR)

- (a) promote and support problem-oriented HSR as a tool for finding better ways for the provision of essential care as a component of health for all, in particular the introduction of HSR in the LGA health system and the support of the other levels of this effort;
- (b) to undertake or commission HSR/operations research into the functioning of PHC programmes;
- (c) to respond to requests from government and other agencies in organising special studies by mobilising experts who will respond rapidly and in depth to guide legislative and administrative action.

2.1.7 Technical Collaboration

- (a) to stimulate universities, NGOs and international agencies to work with LGAs in nurturing their capacity for problem solving;
 - (b) to develop LGA capacity to seek technical collaboration, including from other LGAs, in developing and imple-
-

Health for All;

- (b) re-orient health professionals towards PHC by means of conferences, seminars, and other meetings;
- (c) support the documentation of PHC through commissioning of case studies, reviews, books, articles, newsletters and other media productions as appropriate;
- (d) establish Resource Centres to serve as national and zonal depositories of information on PHC implementation;
- (e) organize seminars, reviews and other meetings to promote PHC and share experiences in implementation, with a view to strengthening LGA health systems;
- (f) provide annual reports which are widely disseminated on the status of PHC implementation nation-wide

2.1.9

To undertake any other functions that may arise or from time to time be assigned to it.

2.2 Organization of the Agency

To be able to perform its functions effectively, the Agency will be an administratively autonomous Agency under the

**The Secretary, who will be the
Executive Director of the Agency;**

**The Federal Director of Primary
Health Care;**

**A Representative of the Conference
of Principals of Schools of Health
Technology;**

**A Representative of the Conference
of Provosts of College of Medicine;**

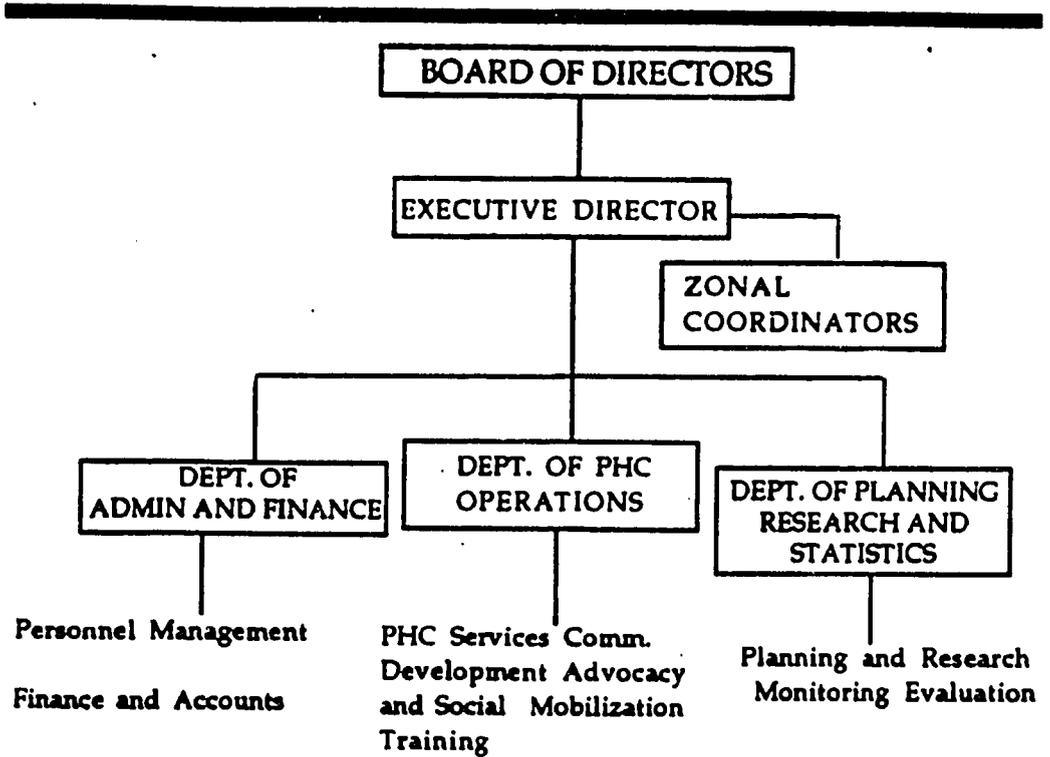
**A Representative of the Conference
of Principals of Community Health
Officers' Training Institutions;**

**A Representative nominated by the
Nigerian Medical Association;**

**A Representative of the National
Association of Nigerian Nurses and
Midwives;**

**One State Ministry of Health
Representative from each PHC zone,
nominated by the National Council
of Health; in rotation to serve for a
period of 3 years.**

**One LGA Representative from each
PHC zone, nominated by the
Conference of LGA Chairmen, in ro-
tation to serve for a period of 3 years.**



2.2.3 Zonal Level

The Offices should collaborate with the State Ministries of Health to strengthen LGA PHC systems;

To be effective in providing LGAs with technical assistance, it is proposed that the zonal offices be organized along the same lines as the LGA PHC Departments are currently organized. The zonal offices, are therefore, proposed to be constituted as follows:

monthly reports from all LGAs and States, promotion of feedback to these levels;

Development of capabilities at LGA level to analyse and make use of monitoring and evaluation data for management decision-making

Writing periodic zonal reports and widely disseminating the same;

Establishment and maintenance of zonal resource centre

Serving as focal points support of PHC project formulation in LGAs in the zone.

EPI/CDD/ARI/CCD

Coordination of the integration of EPI and diarrhea diseases, ARI and communicable diseases control programmes (guinea worm, TB and leprosy, onchocerciasis, schistosomiasis and AIDS) in the PHC systems in the zone.

The above organizational structure entails strengthening the zonal offices considerably. The resources needed at this level include personnel, office accommodation, transportation and increased financial allocation to ensure that fieldwork will go in the LGAs unhindered.



FEDERAL MINISTRY OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE HON SECRETARY FOR HEALTH

Hon Secretary for Health: Dr. Christopher. G. Okojie OFR, LSM (Nig), FMCGP, Dip. ATMF (Johns Hopkins)

Federal Ministry of Health and Social Services
Federal Secretariat Phase II
PMB 12597 Ikoyi, Lagos
Federal Republic of Nigeria

Telephone 01-684405
01-681321
Telefax 01-684098

Your Ref.....
My Ref..... MH 3614T2/27
Date..... 11th March, 1993

Mr. Eugene R. Chiavoroli,
AID Affairs Officer,
USAID,
1601 Adeola Hopewell Street,
Victoria Island,
Lagos.

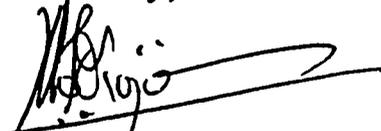
Dear Mr. Chiavaroli,

REQUEST FOR USAID FINANCING FOR NIGERIAN CCCD

Over the past six months, USAID and my Ministry have worked closely in outlining a project in Child Survival. We have reviewed the experience of the ASI/CCCD Project through which USAID has provided funding to Nigeria's Primary Health Care Programme, and developed a Strategy and Programme for continued support, over the next seven years, to be provided through the Nigerian Combatting Childhood Communicable Diseases (NCCCD) Project. It is my intention that the NCCCD Project should continue to provide support for the Expanded Programme on Immunization (EPI), Infant and Maternal Nutrition, Safe Motherhood, Malaria, Control of Diarrheal Diseases (CDD) and Acute Respiratory Infections in Children. In addressing the important causes of infant and child mortality and morbidity, support would be given to human resource development, health information systems, quality assurance standards and management. I am pleased to note that the new Programme, that is, the Nigerian Combatting Communicable Childhood Diseases (NCCCD) would increase support to private sector initiatives to deliver primary health care, particularly in rural areas.

I wish to stress that the programme outlined in the NCCCD Project Paper is important to our goal of delivering good quality health care to the mothers and children of Nigeria. I am therefore, hereby requesting that USAID should finance this (NCCCD) Project.

Yours truly,


Dr. Xto G. Okojie, OFR
Secretary for Health &
Social Services

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ANNEX P

WAIVER FOR SOLE SOURCE PROCUREMENT TO UNICEF

Subject: Justification for Other than Full and Open Competition for Cold Chain, Clinical and Laboratory Commodities from UNICEF

a. Background:

The project's purpose is to assist the Federal Republic of Nigeria in its efforts towards a healthier and more productive society and a decrease of morbidity and mortality. Support of the Nigerian health sector has been a central focus of AAO/Nigeria's program for nearly ten years, in accord with A.I.D. policies and Congressional mandates. Since 1986, when the initial Combatting Childhood Communicable Diseases (NCCCD) Projects was launched with financial support from the Africa Bureau Regional Child Survival Initiative (ACSI), AAO/Nigeria has encouraged and financed the introduction of child survival interventions as a means for building a comprehensive health care system. In support of this project, the NCCCD project design calls for the procurement of cold chain, clinical and laboratory equipment with an estimated cost of \$2.5 million to support project activities closely related to, and in coordination with, the UNICEF program in Nigeria.

b. Authority and Justification:

Handbook 15, Chapter 6, Section F.4, states that UNICEF procurement requires: (a) authorization of Code 899 geographic source; (b) non-competitive procurement; and (c) Code 899 if U.S. flag transportation service is not available from Copenhagen as UNICEF cargo is ready and available for shipment. Each of the three requirements are addressed hereafter.

First, per Handbook 1, Supplement B, Chapter 21.E.1, Geographic Code 935 is the authorized source for the procurement of goods and services under the Development Fund for Africa. Since the Geographic code 899 source is encompassed in Geographic code 935, no waiver is required.

Second, with respect to non-competitive procurement, section 6F (4) of Handbook 15, states that A.I.D. financed UNICEF procurement is regarded as a host country contract, and provides that Handbook 1, Supplement B, chapter 12(c)4(a)2(c) governs waivers.

Under Handbook 15, chapter 6, paragraph 4c (consistent with the grounds stated in Handbook 1, Supplement B, chapter 12(c)4(a)2(c)), the following is to be considered as a basis for the justification:

for waiving competition:

"Whether adherence to competitive procedures would result in the impairment of the United States Foreign Assistance program or would not be in the best interest of the United States."

For the following reasons, adherence to competitive procedures would not be in the best interest of the United States: 1) Procurement from UNICEF offers worldwide acceptability under uniform, understandable labeling, conformity with other ongoing donor local programs, quality assurance, and prompt delivery; 2) Given our previous contracting experience with UNICEF (under the ACSI/CCCD project in Nigeria), and given the time sensitivity of the project, working with this known entity will make implementation planning more expedient; 3) UNICEF can provide the commodities at low prices and therefore at a substantial savings to A.I.D. UNICEF prices are one-quarter to one-tenth the cost of items available in the United States; and 4) the UNICEF items will be compatible with other ongoing national and donor-supported health programs in Nigeria.

Third, for the required transportation waiver, FA/OP/TRANS will determine whether a U.S. flag vessel is available for the commodities to be provided under this project, and prepare a waiver if necessary.

PRECEPTS FOR PROJECT SUCCESS

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Introduction

Nigerian participation and ownership of NCCCD is essential to project success. In order to benefit the people of Nigeria, the project and its components must be equitable and sustainable when donor support is withdrawn. Responsibility for sustainability is shared by USAID/Nigeria and representatives of Nigerian government at the Federal, State and LGA levels.

Project success is dependent upon modification of local perceptions and behavior that influence beneficiary willingness to adopt and maintain effective public health practices.

In addition to the technical aspects of project implementation, continual dialogue among the various partners will be necessary to assure the sustainability of socially acceptable, equitable, and effective health programs that provide high quality services and improve the health and well-being of the Nigerian people. This must be accomplished in an environment which simultaneously facilitates a phased reduction of U.S. inputs (both technical and financial) over the life of project and increases participation of the private sector.

The parties to this Agreement recognize that a number of factors are critical to sound project implementation and agree that adoption of corresponding precepts will encourage project success:

1. Nigerian Perception of Project Ownership and the Planning Process

Recognize that Nigerian government at its various levels must assume responsibility for, and ownership of, all project components with all deliberate speed.

Agree that USAID-supported programs will actively seek to avoid interfering with or obstructing locally motivated, potentially sustainable and community-responsive primary health care initiatives.

Agree that USAID/NCCCD will continue to support local initiatives and priorities.

Recognize the necessity of ensuring that the planning process facilitates meaningful participation of Nigerian counterparts.

Agree to enhance access to the exchange of information and ideas among the federal, state, and LGA levels of Nigerian government and NCCCCD offices.

Agree to pursue the possibility of establishment of NCCCCD offices within ministries at the federal and state level.

Agree to develop an agenda for the planning process, fixing deadlines and responsibilities with ample lead time.

Recognize that programs are more likely to be sustained if planned at the community level, thus reflecting community priorities.

Agree that NCCCCD should continue to seek local input prior to the initiation of the planning process or the introduction of an externally generated work plan or program.

Agree that the project work plan development for LGA and State focused activities must include negotiation of agreements and conditions.

Recognize that to be sustainable and replicable, interventions must be pragmatic.

Agree that work plan objectives and indicators must include constrained indicators and staged indicators which require only minimal changes with respect to the participating implementors and the targets.

Recognize the need to negotiate and fix responsibility for assuring progress toward sustainability as a part of the project negotiation and implementation process.

Agree to negotiate and fix responsibility for progress toward sustainability as a required element of the periodic work plans to be completed as required for project implementation.

Agree to incorporate clearly delineated sustainability responsibilities into the job requirements of all NCCCCD and government managerial personnel at the federal, state and local levels.

Recognize that program sustainability will be significantly enhanced by assigning responsibilities and negotiating process and outcome measures as a part of the project negotiation and implementation process.

Agree to integrate sustainability-related objectives and indicators in NCCCCD supported work plans.

Agree to integrate sustainability-related objectives and indicators into the project evaluation criteria for NCCCCD and each component element.

Agree that the evaluation of process and outcome indicators should include quality as well as quantity.

Recognize that an effective means should be established to measure progress achieved toward the attainment of sustainability goals and objectives.

Agree that sustainability goals and objectives will be integrated into negotiated instruments, including work plans, stipulating the roles and responsibilities of both recipients and donors in that regard.

Agree that the managerial and financial management capacity at the state and LGA levels requires strengthening to undertake an effective assessment of the progress made towards achieving sustainability goals and objectives.

2. Financial Management and Accountability

Recognize the need to strengthen the management processes of the federal, state and LGA governments related to obtaining and documenting counterpart funds, including legal and administrative requirements.

Agree to adhere to the requirements of current civil financial administration systems to identify where improvements in financial management methods are feasible and acceptable.

Recognize the need to institutionalize financial information systems and strengthen financial management skills in the LGA Health Departments in selected states.

Agree that each program component will work with the selected states and LGAs to estimate, on a regular basis, the resources required at the state level to continue program activities and to incorporate such information in an integrated financial management process for the health sector.

Agree that within this process, each program component will work with selected states and LGAs: (a) to identify more efficient allocations of resources while maintaining the quality of care; and (b) to ensure adequate funding for critically needed components (especially non-personnel recurrent costs).

Recognize the need to link program outputs and outcomes to resource costs to facilitate the monitoring of program efficiency and appropriateness.

Agree to develop and adopt financial management methods which identify not only the flow of funds to PHC over time (basic accounting), but which can link program outputs and outcomes to resource costs to facilitate the monitoring of program efficiency and appropriateness.

Recognize the necessity of ensuring that when USAID donor support diminishes, sufficient national resources are in place to continue generating program benefits.

Agree that program costs must be increasingly assumed by national resources.

Agree that work plans supported by NCCCD will incorporate a mix of public and private efforts both in terms of resources and provision that promote financial sustainability, efficiency, equity, and adequate quality of health services.

3. Counterpart Contributions

General: All Levels of Government

Recognize that federal, state and LGA governments must provide increasing, but feasible, proportions of total project costs with counterpart contributions (cash and in-kind) to support each component of the USAID Health Program.

Agree to consider developing flexible guidelines on minimum budgetary allocations and expenditure for primary health care, including the major components of those budgets, such as personnel and non-personnel costs, and major program areas.

Agree that each level of government will be required to tender tangible evidence of commitment for counterpart contributions.

Recognize that although economic constraints will inevitably prevent some project interventions from achieving sustainability, project activities may continue in the absence of USAID support, if the government values such activities sufficiently to seek other sources of funding. Such activities may potentially be viewed as sustainable with qualifications based on financial limitations.

Agree that NCCCD component programs will include a negotiated process for a phased increase in the local absorption of project costs with the proviso that local contributions will be commensurate with the communities' ability to pay.

Recognize that the timing of counterpart funding should be carefully integrated with realistic estimates of the time frames for completion of program activities.

Recognize that counterpart fund requirements must be integrated as much as possible into rolling plans and budgets.

Recognize that mutually agreeable detailed procedures for monitoring counterpart funds, in terms of planned allocations, actual disbursements, and actual spending must be established.

Agree that Nigeria will work towards a gradual, phased assumption of the costs of primary health care by the recipients of services and their communities.

Agree that the timing of counterpart funding will be carefully integrated with realistic estimates of the availability of counterpart funding and reasonable time frames for completion of program activities.

Agree that measures must be devised and followed in each work plan to ensure that equity in the allocation of resources and in access to health care is preserved.

Recognize that since many non-personnel expenses are affected by foreign exchange rates, estimates of counterpart contributions for these items will take into consideration future devaluation of the naira to guarantee minimum real levels of these items continue to be funded.

Recognize that given financial constraints, lower cost strategies and project activities should be encouraged.

Agree that NCCCD should include an assessment of the potential for financial sustainability as a criteria for evaluating program activities.

Agree that operations research should explore alternatives to donor procurement of vehicles, including: (a) the viability of authorizing transportation allowances for supervision; and (b) the tendering of local, private sector contracts for commodity transport.

Agree that operations research should be undertaken on cost-recovery issues to establish the extent to which: (a) Bamako Initiative funding ensures drug availability and is essential as a sustainable funding source; and (b) charging for drugs and contraceptives, customarily provided free of charge, will benefit health care delivery.

Recognize that allocations to personnel are high, threatening efficient combinations with non-personnel recurrent costs.

Recognize that lack of counterpart contributions to support non-personnel recurrent expenditures (operations and maintenance, vehicles, equipment) may threaten the sustainability of program benefits.

Recognize that although personnel and facilities will continue to be important contributions, increasing host government commitments to provide cash and in-kind counterpart funding for non-personnel recurrent costs are essential for sustainability.

Agree that budgetary increases should be devoted to non-personnel recurrent items to correct the imbalance.

Agree that non-personnel counterpart contributions will include allocations for purchase of commodities, supplies, equipment, vehicles, and support of operations and maintenance.

Agree that each year increasing amounts of the recurrent costs of NCCCD implementation will be assumed by host country contributions.

Recognize that the management processes related to obtaining and documenting counterpart funds, including legal and administrative requirements, should be strengthened.

Agree to establish detailed and mutually acceptable procedures for monitoring counterpart funds, in terms of planned allocations, actual disbursements and actual spending.

Agree to establish separate bank accounts for USAID and counterpart contributions.

Federal Level

Recognize that federal budget allocations to the health sector are small, both as a proportion and in absolute terms.

Agree that Federal expenditures for health services should receive a higher portion of total federal expenditures.

Recognize the need for annually increased PHC budgetary percentages above the current level of approximately twenty percent of the regular MHSS budget.

Recognize that work plans must include increasing, but feasible, portions of MHSS counterpart funding in direct support of each component of the NCCCD program.

Recognize that the federal government should support increasing proportions of total project costs with counterpart contributions.

Agree that MHSS commitment to provide increased counterpart contributions to project costs is an essential element of consideration to be reexamined at each stage of proposed incremental funding.

State Level

Recognize that real resources devoted to health services have declined rapidly on a per capita basis since 1985.

Recognize that the state is heavily dependent on the modest budgetary share of declining central government statutory allocations.

Recognize that the states remain responsible for supervision, support and training in LGA PHC activities and that state allocations for PHC have suffered relative to state allocations for Health Management Boards.

Agree that each participating state must allocate sufficient amounts to handle their PHC responsibilities.

Recognize the long-term need to identify state budget requirements for supporting PHC.

Agree that participating states must also participate in the MHSS matching fund program which is intended to encourage PHC allocations.

Agree that States will establish mutually agreeable effective procedures for monitoring levels and patterns of state spending.

Agree that adequate allocations in state budgets to meet state PHC responsibilities, including supervision, support and training are essential to the effective implementation of those responsibilities, NCCCD will provide technical assistance to the State Ministries of Health in selected states to put in place financial information systems and strengthen financial management skills.

Agree that periodic work plans developed for NCCCD activities at the state level require specification of counterpart contribution supporting program operations.

LGA Level

Recognize that an increasing proportion of LGA revenues derive from federal and state statutory allocations, thereby creating a dependency on federal and state largesse.

Agree that LGAs should participate with federal and state government in matching grant programs designed to enhance PHC.

Recognize that LGA health budgets are heavily skewed to personnel costs amounting to 75% of budgets.

Recognize the need to formulate a clear delineation of the percentages of total LGA recurrent budgets required for PHC.

Recognize that financial information and managements systems for LGA health sector activities are grossly lacking.

Recognize that traditional administrative budget practices are not designed to track expenditures according to priority programs such as PHC.

Recognize that increased funding for PHC must come from local sources.

Agree that NCCCD will provide technical assistance to the LGA Health Departments in the selected LGAs to put in place financial information systems, and strengthen financial management skills to ensure that adequate amounts are being allocated in LGA budgets to fund LGA implementation of PHC.

Agree that NCCCD will assist selected LGAs to estimate, regularly, the resources required at the LGA level to continue program activities, with a view to incorporating such information in an integrated financial management process for the health sector.

Agree that within this process, USAID/NCCCD and the selected LGAs will identify more efficient allocations of resources while maintaining the quality of care, and ensuring adequate funding for critically needed components (especially non-personnel recurrent costs).

Agree to develop mutually acceptable financial management methods which identify not only the flow of funds to PHC over time (basic accounting), but which can link outputs and outcomes of the programs to their resource costs to monitor efficiency and appropriateness.

Agree to take into consideration the state requirements of current civil financial administration systems to identify where improvements in financial management methods are feasible and acceptable.

Agree to establish criteria for selection and retention of LGAs in the NCCCD program, an important criterion being demonstrated willingness on the part of the LGA to fund within its financial means an appropriate share of project costs.

Agree that periodic work plans developed for NCCCD activities at the state level require specification of counterpart contribution supporting program operations.

Private Sector

Recognize that long-term sustainability of the benefits of primary health care initiatives will require participation of the private sector for, both, the provision and the financing of health care services.

Recognize that private sector donations to intervention activities and NGOs carrying out intervention activities should be actively pursued for the funds, themselves, for visibility, for sustainability and for replication.

Recognize that donations are solicited from and honored by wealthy individuals and companies, often in a public context such as a launching.

Recognize that public perception that all problems are being solved by international donors impedes private sector interest in public service support.

Agree that for the Full Privatization group (i.e., private resources supporting private provision of services), NCCCD should strengthen ongoing dialogue with private provider organizations to encourage the delivery of EPI, ARI, CDD, malaria treatment in the private sector at adequate levels of quality. NCCCD should establish regular communication links with private professional organizations involved in health care.

Agree that all levels of government should encourage private sector involvement in both the provision and financing of health care.

Agree that the public sector should contract with private organizations to implement some of their activities (e.g., development of health communication and health education materials, provision of some preventive health services).

Agree that in conjunction with FGN counterpart resources, significant efforts should be taken to engage private providers and organizations in NCCCD-related activities and strengthen their delivery of NCCCD-related services in terms of clinical and managerial training, IEC, information systems, commodity procurement and management, monitoring and evaluation.

Agree that involvement of the private sector should be expanded to include more contract work with non-profit and profitmaking technical assistance organizations, research organizations, advertising houses and media businesses.

Agree that public support to non-profit organizations which focus on high risk populations and the very poor should be a priority.

Agree that mobilization of private sector support for specific activities should be continued and strengthened.

4. Cost-Recovery Initiatives

Recognize that it is beyond the scope of NCCCD to attempt full-scale cost-recovery mechanisms (such as the Bamako Initiative) for NCCCD-related activities.

Recognize that although full cost-recovery (total recurrent costs) is generally not a feasible goal for PHC-related activities over the next seven years for many communities, the potential of cost-recovery to sustain critical elements of primary health care must be realized.

Recognize that most initiatives are still unable to cover even non-personnel recurrent costs.

Recognize that cost-recovery mechanisms including financial information systems, financial management, transparent accounting tools, and strategies for the allocation of revenues must be systematically strengthened.

Agree that mutually acceptable cost-recovery mechanisms including financial information systems, financial management, transparent accounting tools, and strategies for the allocation of revenues must be adopted according to a set timetable.

Agree that cost-recovery should be pursued on a limited basis, at least initially for preventive services, and that cost-recovery for NCCCD-related activities should be viewed as an integral component of cost-recovery for PHC in general.

Agree that the public sector should continue to support improvement of health care delivery systems in terms of the development of health information systems, health systems planning, health education and communication, regulation and licensing, community-wide water and sanitation interventions, training (technical, management), institutionalization of quality assurance, policy development, epidemiologic capacity and capabilities, implementation of operations research, procurement and distribution of commodities (didactic materials, laboratory equipment, impregnated bed nets, ORS, cold chain, initial drug supplies, vehicles).

Agree that broader public support may be required for targeted populations at high-risk and/or unable to pay, or for which there are major deficiencies in market conditions (e.g., inadequate information, insufficient demand or supply).

Agree that public funds should continue to support activities in those areas which have not yet experienced the benefits of NCCCD interventions and ensure that mechanisms are set in place to ensure that those unable to pay receive adequate services.

5. Personnel and Technical Expertise for Sustainability

Recognize that sustainability is dependent on the availability of a critical mass of technical personnel to support project activities.

Agree to develop and adopt revised personnel policy guidelines at each service level of public health care to: (a) facilitate the development and retention of a critical mass of skilled technical personnel in key service delivery and support systems; and (b) institute competency-based assessments of personnel performance as a criteria for promotion/retention of health workers.

Agree that NCCCD will continue to assist in training personnel.

Agree that NCCCD will strengthen the capacity of national training program and will seek to expand a nationwide model.

Agree that the GON at each level will ensure "competency-based" assessments and assignments of personnel.

Recognize that: (a) successful interventions rely on costly technical expertise, which must be responsive to continually evolving situations; and (b) funding availability to requisite levels is not possible given the magnitude of problems arising.

Agree to promote the development of local professional, technical assistance personnel and agencies for the provision of such personnel.

Agree to review Nigerian consultant fees and cooperating NGO personnel salaries, periodically, to ensure salaries sufficiently competitive to attract and retain competent, creative individuals with experience and initiative, while taking into consideration the need for sustainability.

Agree that USAID and NCCCD should consider increased support for the expansion and institutionalization of Continuing Education Units (CEUs).

Agree that training programs should be extended to include doctors, nurses and support personnel in both the public and private sectors.

Agree that NCCCD will provide technical assistance to the Bamako Initiative (BI) for development of financial information systems and financial management skills for selected LGAs and communities within USAID/Nigeria's geographic sphere of operations.

Recognize that technical assistance must always have the objective of capacity building.

Agree that NCCCD should continue, and enhance, its efforts to rely on local technical expertise.

Agree that the job responsibilities of NCCCD program managers must include seeking, gaining and enhancing participation on the part of their counterparts.

Agree that where local experts lack practical experience or where unique technical abilities are required, external technical assistance should be sought to support the development of the local capacities and the phasing out of external sources of technical assistance.

Recognize that better management of training programs will increase effectiveness.

Agree that proper identification of training needs, preferably on the initiative of states and LGAs, is a prerequisite for provision of, or participation in, a training program.

Agree that strict pre-training qualifications will be prerequisites for participation in a training program with the proviso that members of underrepresented groups may be given special consideration.

Agree to streamlining training with similar objectives.

Agree to use appropriately qualified trainers and training materials.

Agree to monitor utilization of acquired skills.

6. Intervention Replication

Recognize that spread of project interventions across states and ethnic groups will be largely dependant upon funded interventions involving technical assistance and social mobilization.

Recognize the need for provision of additional resources to facilitate technical cooperation among developing LGAs.

Recognize the need to identify the most effective project activities for expansion and replication.

Agree to devise means by which progress made in one community, district, LGA, or state can be replicated to the benefit of a larger beneficiary population.

Recognize that the development of the HIS, M/E and DPRS units have resulted in widespread official recognition by Federal and State Health officials that data are essential to program planning, implementation and evaluation.

Agree to ensure that local data is collected, analyzed and used for decision-making.

7. Equity and Sociocultural Considerations

Recognize that work plan design and implementation must be sensitive to the dynamics of ethnic, religious and gender differences and mistrust among beneficiaries and participants.

Agree to cooperate in the preparation of an ethnic, religious and gender disaggregated list of Nigerian counterpart researchers, cooperating agency personnel and educational institutions producing such personnel to identify the underrepresented groups.

Agree that concerted effort must be made to ensure that participants are representative of the ethnic, religious and gender differences in Nigeria.

Agree that a concerted effort must be made to ensure that work plans are developed with the full participation of the beneficiaries ensuring the representation of the affected ethnic, religious and gender groups.

Recognize that Nigeria has a diversity of ethnic groups and modified/traditional attitudes and practices which impinge on the success of the interventions.

Agree that timely ethnographic studies must supplement epidemiological studies and operations research.

Recognize that USAID is required to ensure that the benefits of the health programs are distributed according to politically-determined definitions of equity.

Agree to ensure that sufficient mechanisms are in place to provide services to members of all ethnic groups and religions that are at high risk and unable to pay regardless of their place of residence.

Agree that operations research should be undertaken on cost-recovery issues to establish the extent to which cost inhibits the spread of preventive interventions and causes significant delay in the seeking of health care for the sick child and the pregnant mother.

Agree that operations research should be undertaken with respect to Bamako Initiative funding in a variety of LGAs of varying financial and social conditions to confirm: (a) the role of BI as a sustainable funding source; and (b) the uninterrupted availability of drugs to clientele.

Agree that operations research should be undertaken to explore whether the withdrawal of free drugs and, especially, free contraceptives is counterproductive to the provision of effective health care to women and children.

Recognize that sociocultural factors are central to all project interventions and that their degree of success will be affected, significantly, by the degree of responsiveness to sociocultural constraints and incentives.

Recognize that project interventions requiring only modified, traditional behaviors and methodologies rather than fully modernized behaviors and methodologies are more likely to be integrated within the participant and beneficiary population and, hence, more likely to be replicable and sustainable.

Agree to identify minimal, modified/traditional, behavioral changes and pursue same as interim intervention goals providing a wedge away from traditional practices and putting people on track for more extensive behavioral change.

Recognize that IEC must respond more effectively to the Nigerian (a) need for consensus, (b) respect for authority, (c) governmental inertia, and (d) literacy level.

Agree that individuals must be targeted within the context of their peer-groups by influentials and authority figures.

Recognize that government social mobilization and information campaigns offer the possibility of mobilizing people and resources for urgent, high profile interventions which would otherwise not take place.

Agree that campaigns should be used with the proviso that personnel and resource allocations ensure that other activities continue.

Recognize that mobilization of the people is dependant upon the active participation and advocacy of their credible leaders.

Agree to carry out research to identify: (a) the people's choice of public opinion leadership on matters of health and health care; and (b) the means by which to induce the seeking of advice and assistance from such opinion leaders.

Recognize that efficient mobilization of the people is possible through Non-Governmental Organizations (NGOs).

Agree to identify influentials within NGOs who are recognized as leaders and willing to mobilize their peer-group to adopt healthful behaviors.

Agree that planning and the definition of specific work plans must seek the input of participating NGOs.

Recognize that NGOs which perform value-reinforcing functions for their membership (mainly religious and primordial groups) have a greater potential for inducing sensitive behavioral change interventions among their membership.

Recognize that government social mobilization and information campaigns foster the mobilization of people and resources for urgent, high profile interventions which would otherwise not take place.

Agree that campaigns should be used with the proviso that personnel and resource allocations are planned to ensure that other activities continue.

Recognize that LGA politicians may be responsive to the peoples' desire for good health.

Agree that research should be undertaken to pursue ways of translating the people's will into the allocation of greater portions of LGA funds to health.

8. Beneficiary Education

Recognize that health education is essential for project success and sustainability because all interventions depend upon informed beneficiaries who have become convinced of the effectiveness of primary, prevention-oriented health care programs.

Agree that the beneficiaries must be educated, formally or informally, about the requisite health practices including how to carry out the practices and an acceptable rationale for changing their behaviors despite competing beliefs and priorities.

Recognize that Nigeria has a large, literate population that remains, to a considerable extent, uninformed about modern health practices.

Recognize that the formal education sector provides a captive IEC audience which has been underutilized for health education and that failure to institute effective in-school health education will restrict project sustainability and replicability.

Agree that pragmatic in-school Health Education responsive to the conditions in the schools should be actively advocated.

Recognize that women are the prime health caretakers for their families and that female education has a significant impact on maternal/child health.

Agree to advocate and foster action leading to increased female enrollment in educational programs both in and out of school.

Recognize that opposition to female education is, partially, due to the conflict of school schedules with the child's potential and/or de facto contribution to the family's basic subsistence.

Agree to advocate operations research to examine diverse methods of increasing enrollment including shortened school days and/or modified vacation schedules to reduce parental resistance to schooling.

Recognize that delayed marriage, partially facilitated by female education, contributes to the improved health of the young mother and her children.

Agree to promote delayed marriage to protect the lives of mother and children.

9. Donor Coordination

Recognize that management of donor coordination within the MHSS should take high priority, be fundamentally strengthened, and aggressively implemented to avoid missed opportunities.

Recognize that donor coordination between USAID/NCCCD, the public sector at all levels, and other donors is essential to minimize duplication and thereby maximize scarce resources.

Agree that all USAID-sponsored activities, including NCCCD, will fall within a coordinated and mutually supportive donor effort.

Recognize that donor coordination responsibilities must be clarified and fulfilled by an appropriate authority delegated by the MHSS.

Agree that implementation of donor coordination responsibilities is essential to sound program management.

Agree that the office delegated authority for donor coordination will be supported in its role of collecting and collating data on donor activities and expenditures.

Recognize the need to clarify the relationships between donors and the three levels of government.

Recognize that the PHCDAN must undertake extensive consultations at the state and LGA levels, and with the donor community, to ensure appropriate inputs into the evolution of the PHCDAN.

Agree that the zonal PHC coordinator will hold periodic meetings with donor agencies and state PHC coordinators to plan and review donor activities within the zone.

Recognize the need for current data on donor support to be collected at the state level and, periodically, forwarded to the PHCDAN on a regular basis.

Agree that each state will have a Donor Coordination Committee, chaired by its Commissioner for Health, to coordinate the inputs of all donor agencies.

Recognize that donor-sponsored research has been inadequately disseminated within Nigeria.

Agree that donors will ensure that a minimum number copies of research findings are distributed to important Nigerian libraries, including the National Library, the main academic library in the state of the research site, and other recipients to be determined.

Agree that donors must accept responsibility for the distribution of the research documents and publications they produce.