

REVISED VERSION!!!!

USAID-NIGERIA

***RESULTS REVIEW
AND
RESOURCE REQUEST
(R4)
FY 1995-1998***

LAGOS, NIGERIA

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OVERVIEW

Nigeria is a country deep in crisis. In the face of a dramatically deteriorating domestic political environment, a chill in USG-Government of Nigeria (GON) diplomatic relations, an on-again/off-again USAID-Nigeria program, and massive USAID-Nigeria budget reductions, this past year's momentum toward sustainable development was understandably modest. USAID-Nigeria's program performance targets were not met when measured through the limiting prism of existing impact indicators. Realistic prospects for future performance will require a reliable long-term commitment to a USAID program presence in Nigeria , at reasonable budget levels for a country of this size.

In this difficult operating environment, USAID-Nigeria's accomplishments of the past year must be deemed noteworthy -- even if difficult to capture within the R-4 reporting framework. The Mission is taking this opportunity to offer a brief presentation of its broader accomplishments, and the rationale for a program that strives to reach beyond numbers and tackle issues appropriate to this crisis environment, and the USAID stated commitment to crisis mitigation.

A NGO Health-Care Strategy for a Country in Crisis

Several years ago, a senior USAID staff member observed that the Chinese ideogram for “crises” translates as “dangerous opportunity.” Faced with this “opportunity”, USAID-Nigeria successfully evolved a development strategy for today's Nigeria, responsive to US direction and pioneering in its approach to crisis mitigation. The Nigerian crisis situation consisted of:

- Ongoing political repression, replete with suspension of democratic institutions, entrenchment of a brutal military dictatorship, and ongoing human rights abuses.
- Sanctions by the US that heightened tensions between the US and Nigeria, altered the amount and modalities of development delivery and constrained dialogue with government.
- A collapsed Nigerian economy
- A lack of political commitment and will in the GON to provide basic social services -- leading to a collapse of public sector services in health, education, public utilities (e.g. electricity, water, fuel, etc.)
- A high potential for massive civil unrest, with increasing breakdown of law and order.

Sustainable development in Nigeria has long been recognized as in the vital interest of the United States because of the size and economic activity of Nigeria's population, and its demonstrated impact on the stability of other West African countries. This vital interest has been given further weight by the political necessity of maintaining stability in a major oil-producing country and commercial hub whose economy and population movements influence the entire sub-Sahel region. In addition, Nigeria is one of a few African countries where the United States has major business interests.

Nigeria is sub-saharan Africa's most populous nation (exceeding 100 million) and, is growing at an estimated 2.8% annually -- a rate of increase that is undermining its economic development and is negatively impacting the entire region. In recent years, the plight of its vulnerable women and children has worsened. Social sector services have deteriorated and are generally dysfunctional. Poverty and malnutrition are commonplace. Infant and maternal mortality rates (91/1000 live births and between 800 to 1500/100,000 live births respectively) continue among the highest in the world, and immunization coverage has declined to below 30 percent.

The USG, while recognizing the necessity of political sanctions, also recognized the compelling need to distinguish between Nigeria's brutal government and her innocent people. Nigeria's military dictatorship has clearly demonstrated its lack of concern for its citizens. The people of Nigeria are its most tragic victims. The population that USAID programs target -- women, children and the disadvantaged -- do not determine Government policy, do not benefit from the policies of the current government and are the first casualties in Nigeria's retreat from democracy. By working exclusively with NGOs, USAID-Nigeria attempted to place its development assistance program in a "safer place", protected from political pressure. These NGOs are the representatives and advocates for the aspirations of their constituencies and community needs -- supporting democratic participation. USAID-Nigeria successfully adapted to many program constraints -- including the absence of country or project agreements between USAID and the Government of Nigeria (GON), and a USG policy that precluded the transfer of resources to the Government. The latter exacerbated a political climate already critical of the United States. Within the Ministry of Health, however, the Mission built on its established technical relationships. This resulted in the Ministry adopting a position of benign neglect to the activities of USAID-Nigeria and its Nigerian NGO partners. For USAID and its implementing partners, the development environment continued to be permissive, if not optimal.

As noted, USAID-Nigeria's program implementation, since 1994, has been exclusively through non-governmental organizations (NGOs). The family planning program's historic work with Nigeria's philanthropic and for-profit private sector had established important inroads into that community. In the last two years, USAID's program aggressively expanded that engagement and brought into its programs more community based NGOs. This afforded opportunities for important Nigerian NGOs such as the Federation of Moslem Women Associations of Nigeria (FOMWAN), Women in Nigeria (WIN) and Gender and Development Action (GADA) to increase their development contribution.

In recognizing the necessity of building activities driven by "community insight and direction", USAID-Nigeria had to answer some critical questions:

- (a) how to obtain broad Nigerian participation and direction to both define the problems and their probable solutions;
- (b) how to meld this commitment with the strictures of USG/USAID policies in Nigeria;
- (c) how to construct a supportive implementation environment, combining the considerable resources and energies of the Nigerian NGOs with the resources and technical assistance of the many Global Bureau Cooperating Agencies already working in Nigeria -- most of which have distinct corporate cultures and vertical programs; and
- (d) how to make these Nigerian NGO institutions and programs increasingly sustainable -- financially and otherwise.

Finding workable solutions required intensive field work by Mission staff, and a genuine commitment to hearing the voices of our Nigerian partners. Many meetings and much strategic thinking led to the current set of NGO partnerships. These involve scores of umbrella non-governmental organizations in the 14 USAID focus states, representing perhaps thousands of smaller local organizations with the potential to reach as many as 50 million Nigerians.

The USAID-Nigeria program goes beyond traditional HPN strategies for family planning, child survival and HIV/AIDS. In Nigeria, sustainable improvement in health is inextricably linked to NGO institutional sustainability and equitable democratic participation. Numerous Nigerian NGO institutional strengthening and service delivery partnerships are now established and are a foundation which can meaningfully support Nigeria's sustainable development in the provision of basic health services. By addressing participation of women in decision making and the financial/managerial sustainability of our Nigerian NGO partners -- as well as by strengthening the NGOs' own commitment to providing services -- important inroads to sustainability of our development investments are being made. By strengthening each community organization, the USAID program has been able to maximize sustainability, rather than simply continue a donor dependent delivery model. Through the use of a Rapid Response Fund (RRF), USAID-Nigeria also has been able to react quickly to local development opportunities linked to democratic expression and community self determination, as well as to health care delivery.

The USAID-Nigeria program has always been an element of the USG strategy of pressured engagement. A logical outgrowth of this strategy is USAID collaborative work with other U.S. Government agencies (State, USIS) and with the NGO community in designing an "Increased Democratic Participation and Respect for Fundamental Human Rights Project."

I. FACTORS AFFECTING THE USAID-NIGERIA PROGRAM

(A) Political Factors

Nigeria's Government has been a military dictatorship for most of its 35 years, with only brief experiments with democracy in 1979, 1983 and 1993. An ongoing political crisis that began with the annulment of civilian elections in 1993 has affected all aspects of national life and has crippled the economy. There has been little demonstrable progress toward returning the country to democratic rule. The current military dictatorship, the most malignant in Nigeria's history, has attracted worldwide condemnation by its disregard of the electoral will of its citizenry, as well as its record of human and civil rights abuses. Many civil leaders and journalists have been subject to political detention. The recent hanging of Ogoni activists seeking representation and attention to the environmental degradation resulting from oil exploration drew broad based condemnation. Intimidation, political assassinations and the inability of local authorities to maintain basic law and order are increasingly commonplace -- expanding the potential for widespread civil unrest.

Program stops and starts, consequent from Nigeria's decertification for lack of good faith efforts to control the flow of illicit drugs, have been a major constraint to program implementation over the past two years. For only 7 months in 1994-1995 and for but 2 months in 1995-96 has USAID-Nigeria been able to implement without the Damocles sword of imminent phase down/close-out. This situation has been compounded by the recent heightening of political tensions, threats of increased sanctions, and the internal USG policy debate on continuation of USAID assistance in Nigeria. Other donors, of course, are also struggling to redefine their role in Nigeria. Most have reduced their inputs and, consequently, their program implementation has suffered. Most other donors have also belatedly followed USAID's lead and now moved away from support to government to exclusive support of programs of NGOs.

(B) Budgetary Factors

Other factors that have negatively impacted program implementation include the dramatically worsening Nigerian economy, increasingly widespread poverty, collapse of the public health sector, and the regime's lack of political will to address critical health issues -- such as providing stable funding for primary health care programs or essential drugs and vaccines, and meeting health care workers demands for reasonable compensation and decent working conditions.

Nigeria's economy has been in a downward spiral for two decades. The country has had difficulty servicing its external debt which increased by USD 3 billion in the past year to USD 32.5 billion at the end of 1995. In 1995, the economy grew at a rate of 2.17% up from 1.01% in 1994. While there were slight gains in the agricultural and manufacturing sectors, the economy continues to be heavily dependent on oil. Together, oil and agriculture account for 50% of all economic activity. Double digit inflation rates continue -- driven upward by increases in import duties, high foreign exchange costs and high transport costs from increased fuel prices. Between December 1994 and June 1995, the annual inflation rate rose from 57.0% to 74.3%. The World Bank and the IMF have gone on record with their concerns that the 1996 Nigerian budget is based on unrealistic projections for oil revenues and fails to address key management concerns -- such as the dual foreign exchange market, a need to diversity the economy and make it more "investor friendly."

One point of particular misgiving to all donors has been the Government of Nigeria's budgetary approach to the social sectors. Government budgets for relevant Ministries have been both grossly inadequate and unreliable. During 1995, key Ministries and Departments such as Health and Education received only a fraction of their budgetary allocations for recurrent and capital expenditures. Social sector programs, already in a state of collapse, further decayed. In the same period, the Government established an off-budget Petroleum Trust Fund (PTF) to “invest in social and infrastructure projects for the benefit of the Nigerian people.” Thus far, the PTF has been allocated 55 billion Naira (USD \$640 million) but the take off of its “flagship” projects (including water, sanitation and the supply of essential drugs) has yet to begin. Given the substantial capital resources in the PTF, Government's lack of clarity as to proposed expenditures and the already established pattern of delay in PTF projects, local and international observers are openly skeptical of the PTF's capacity to positively contribute to Nigeria's development.

(C) Health Ministry Factors

As noted, USAID-Nigeria implements its program exclusively through Nigerian and US NGO Implementing Partnerships. GON endorsement of the USAID effort is not sought. The USAID effort, nevertheless, is dependent on Government's continuing willingness to maintain a posture of non-interference and to assure access by NGO providers to essential supplies such as vaccines and contraceptives. Government has not interfered or limited the activities of the USAID- NGO partnerships. In fact, unofficially, the USAID NGO partnerships have been endorsed by cognizant officials and the NGOs have been given some assurance that vaccines and other essential drugs and commodities will be accessible if and when they are required. This is an important positive element in a difficult working environment.

In November 1995, the Ministry of Health convened a National Health Summit with the stated intent to develop a strategic approach to revitalizing the health sector. The lavish and well attended meeting made clear Government's recognition of the problems in the health sector. Simultaneously, it confirmed Government interest and willingness to invest only in tertiary health care capital development schemes rather than rebuilding of infrastructure for basic services, addressing the welfare of health workers or providing essential drugs and supplies.

One issue that the Government Summit could not avoid was the need for the immediate purchase of vaccines to reestablish the collapsed national immunization effort. Initially, the Government proposed to provide PTF funding to the Federal Ministry of Health for vaccine purchases. In the months following the summit, however, inter-departmental disputes undermined this commitment. Responsibility for the multi-million dollar vaccine purchase was eventually vested in the “Family Support Program”, a project headed by Mrs. Abacha (wife of the Head of State). Established protocols for procurement through UNICEF that, in the past, had purchased efficacious vaccines were by-passed and a “private” purchase of vaccine made. When the ordered vaccine arrived in Nigeria, there were widespread concerns as to their efficacy, and the adequacy of the cold-chain and distribution systems. USAID is monitoring the outcome of this situation.

In anticipation of reduced contraceptive supplies from USAID, the Nigerian Population Activities Fund Agency (PAFA), the Department of Population Activities in the Federal Ministry of Health and the Population Commission have been working with the UNFPA and the Planned Parenthood Federation of Nigeria to develop a strategy to obtain adequate contraceptive supplies for national family planning

programs. More than 24 months of effort by PAFA have yet to produce a viable approach to national contraceptive supply, making future availability of modern family planning for those at the lower end of the economic spectrum increasingly questionable.

The constraining factors discussed above, in the context of massive program budget cuts to the USAID-Nigeria program, make it unrealistic to expect USAID-Nigeria to achieve the level of program results originally planned. In the larger context, however, an important model for NGO engagement in health care delivery in “crisis” Nigeria has been established and is important to continue.

IIA. PROGRESS TOWARD STRATEGIC OBJECTIVES

A. SUMMARY OF DATA SO#1: Increased Voluntary Use of Family Planning

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
Strategic Objective I:						
Increased voluntary use of family planning	Couple years of Protection (CYP)	1.8 million	3.5 mil		6.7 mil	5.3 mil
Program Outcome 1.2	Quantity of Sold Contraceptives:					
Increased availability of modern contraceptives	- Condoms	Condoms = 17 mil	33 mil	45.2 mil	55 mil	
	- Pills	Pills = 2 mil	4 mil	2.4 mil	3.26 mil	
	- IUDs	IUDs = 85,000	130,600	585,000	104,412	
	- Injectables					

ANALYSIS OF DATA

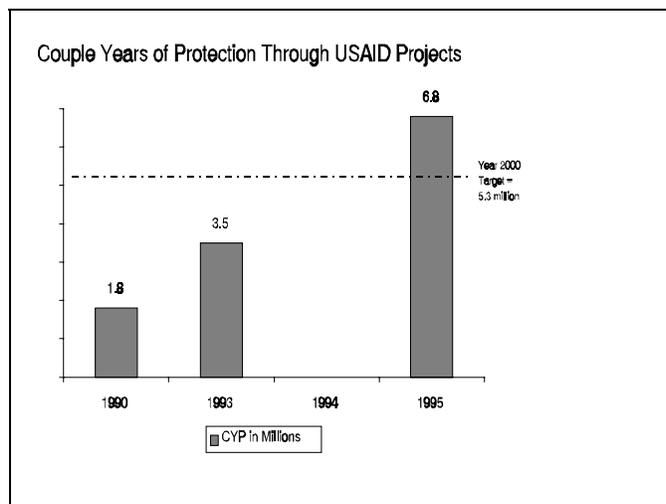
While all indicators for this SO have been retained, only two are reported on for 1995. The mechanisms for the collection of monitoring and performance data were limited and reliable data on key indicators of demand, such as the proportion of women wishing to space or limit their children and the proportion of women with unmet needs for contraception, are not available. Nevertheless, the volume of Couple Years of Protection (CYP) and contraceptive sales generated by the USAID supported portfolio clearly documents that the momentum generated for this SO in recent years continued to accelerate in 1995. Led by a continuing contraceptive social marketing and community based NGO distribution programs, USAID in 1995 provided an estimated 6.7 million CYP -- exceeded the original SO target of 5.3 million CYP in the year 2000.

The successes in this SO are the result of three factors: a) the advocacy, IEC, and distribution activities of community based Nigerian NGO partners and the social marketing program that have enhanced acceptance of modern methods and access to commodities, b) USAID-Nigeria's integrated service delivery strategy promoting family planning commodities through child survival and HIV/AIDS prevention units, and c) no breaks in the supply of commodities for USAID supported programs.

Increased acceptance. Given the economic situation challenging most Nigerian families today, it is not surprising that voluntary use of Family Planning continues to grow. Between December 1993 and June 1994, there was a documented increase of 2% in the contraceptive prevalence rate (CPR) for all modern methods -- from 9.3% to 11.3% (NISH, Nigeria Integrated Survey of Households by the Federal Office of Statistics, June 1994). Anecdotal reports and the rise in commodity sales suggest that the trend toward increased utilization that began in 1990 is continues. Increased awareness and knowledge as well as some liberalization of social attitudes toward the use of family planning are changing behavior. In the October 1994 Nigerbus survey, 88% of those who knew at least one family planning method responded that they approve of those who use family planning or child spacing methods. In the same survey, 49% of those who had heard of at least one family planning method reported that they had experience with some form of family planning or child spacing. Twenty-five percent of respondents reported discussing family planning/child spacing with a spouse in the two months prior to this study. The Federal Office of Statistics survey of households (NISH) reports that the proportion of all women of reproductive age (15-49) currently using family planning methods (all methods) has grown from 8% in 1990 to 22% in December of 1993.

IEC and Advocacy: Information, Education and Communication (IEC) efforts, with an enhanced interpersonal communication thrust supporting the Mission's NGO community-based strategy, have been responsible for a dramatic attitudinal change toward family planning in many parts of the country. USAID-Nigeria's program incorporated a vigorous IEC campaign to promote behavior change through awareness and knowledge creation. Radio and advertising campaigns combined with interpersonal efforts by regional sales representatives, community leaders, and "peer educators" target youth in urban and rural areas. IEC materials (posters, billboards, danglers and indoor stickers with the message "Child Spacing Services Available Here") are displayed in a large number of family planning facilities. The National Family Planning logo has been posted at over 40,692 public and private sites and has become a well-known symbol identifying sites offering family planning services. Over three and a half million copies of IEC materials in local languages for client instruction and counseling have been distributed at the clinic and community levels. Recognizing the need for a focus on specific strategies for Muslim Northern Nigeria, USAID collaborated with Planned Parenthood Federation of Nigeria (PPFN) to develop culturally sensitive information messages.

Integrated Service Delivery: Integrated service delivery is central to the Mission strategy. By strengthening service delivery organizations that have traditionally limited themselves to child survival and HIV/AIDS prevention, and by promoting the integration of family planning services into their programs, the number of facilities offering voluntary family planning services has been enlarged -- and access to contraception enhanced for millions of current and potential users. The original program called for the refurbishing and upgrading of clinics to provide long-term family planning methods -- activities now largely beyond the fiscal grasp of USAID-Nigeria. On the positive side, 1995 saw USAID-Nigeria and its Implementing Partners put into place an organizational and programmatic framework for assisting non-governmental organizations (e.g. women groups, advocacy organizations,



professional organizations, private hospitals and maternities) to support and sustain expanded advocacy, IEC and quality integrated service delivery -- largely at the community level.

Uninterrupted Commodity Supplies: In the past years, USAID essentially totally financed an uninterrupted supply of family planning commodities through its Social Marketing Program. The volume of contraceptives imported into Nigeria by the USAID project increased dramatically. In 1993, 33 million condoms, 4 million pills, and 130,000 units of IUDs were imported. In 1994, imports swelled to 45.2 million condoms, 2.4 million pill cycles and 585,000 units of IUDs and in 1995 the volume increased to 119.2 million condoms. The volume of imported pill cycles fell to 1.93 million and IUD imports declined to 157,000. In addition, 200,000 doses of Depo-Provera were imported. Owing to reduced resources, marketing of Depo-Provera will not be undertaken.

The bulk of Nigeria's family planning commodities were distributed through USAID's Social Marketing Program. Condom sales increased from 45 million in 1994 to an estimated 55 million in 1995. Free sample distribution was greater than 1 million condoms. The upward trend was also seen in the distribution of pills. In 1993, 3.3 million cycles of pills were sold, increasing to 3.6 million in 1994 and 4.3 million in 1995. Weaknesses in the wholesale and surgical equipment distribution system accounted for a decline in the numbers of IUDs sold. Additional wholesalers were added to the system in October 1995 and a direct mail campaign to providers is reinforcing sales initiatives, promoting the use of sterile gloves and marketing IUDs.

Contraceptives	1993	1994	1995 ¹
Condom	33 Million	45.2 Million	55 Million
Pills	4 Million	2.4 Million	3.3 Million
IUD	130,600	585,000	104,412

The Contraceptive Social Marketing Program (CSM) has been a major force in building a retail market for family planning

goods and services. Nigeria's unsubsidized private commercial sector is vibrant and has the potential to become the major vehicle for delivering family planning services. This potential has not, however, been realized. Approximately sixty percent of current Nigerian users of family planning methods obtain services through private sector and NGO outlets. Recent studies, however, have also shown that the USAID-supported CSM program has become the monopoly market supplier. With its supply of heavily subsidized commodities, the CSM program has increased demand -- but has also effectively taken over the market, driving from the market the private sector suppliers who theoretically should be drawn to the widening consumer base. These same commercial firms estimate that, as long as more than 90% of the market is subsidized, they cannot compete successfully. If the market is not significantly distorted by a subsidized competitive product, they expressed interest in coming back, but at a higher consumer cost. Their expressed rationale does leave some room for subsidization for those most vulnerable - at perhaps 10% of market share. The current Social Marketing approach in Nigeria promises only limited sustainability through cost recovery or drawing in of the true commercial sector. Its important successes in demand generation, however, must be recognized.

C. EXPECTED PROGRESS IN FY 1997 AND FY 1998

The Mission suggests that USAID supported project activities, including CSM, community based NGO efforts and targeted IEC programs, have been of significant value. We are working with the private sector and contraceptive social marketing organizations to re-examine the CSM effort, addressing both the need for continuing contraceptive availability throughout Nigeria and for its most vulnerable populations. Knowledge, attitudes and behaviors have changed; Nigerians in unprecedented numbers are accepting modern family planning methods; USAID and its Implementing Partners have established a “cascade” model for community based service delivery with the potential to deliver family planning to the most underserved populations.

The proposed rapid elimination of funding for contraceptives supplies coupled with the massively reduced program funding levels for FY 1996 and FY 1997 (anticipated) make longer-term support of CSM unrealistic. This rapid reduction of support directly jeopardizes the supply of commodities for community based NGO programs still in their infancy. This, in turn, may preclude continuing much of the NGO based family planning activities pioneered in Nigeria. In many cases, the communities served are unlikely to be able to absorb the full cost of these threatened health and population activities. Unless other sources for subsidized services can be identified, family planning services may soon become too expensive for the majority of poorer users. **USAID-NIGERIA CANNOT REALISTICALLY EXPECT FURTHER PROGRESS TOWARD ITS PROGRAM OUTCOMES FOR THIS STRATEGIC OBJECTIVE.**

IIB. PROGRESS TOWARD STRATEGIC OBJECTIVES:

A. SUMMARY OF DATA SO#2: Improved Maternal and Child Health Practices

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 2.1</u>						
Improved immunization practices and coverage	Proportion of children < 1 receiving DPT, OPV3 and measles vaccinations	(1990 NDHS)	(FMOHSS)	(FMOHSS)	(FMOHSS)	
	- DPT3	DPT3 = 20.8%	33.0%	36.0%	<20%	60%
	- OPV3	OPV3 = 20.7%	34.0%	35.0%	<20%	
	- Measles	Measles = 21.0%	40.0%	39.0%	<20%	
	Reduced Measles morbidity	155.1.100,000 (UN)	54,734	95,607	Unknown - Epidemic in North	110/1000
	Paralytic Polio Incidence (5-9) yrs of age)	842 cases 40/100,000 (UN)	1,083	224		2/100,000 *
	Proportion of women delivering who have received TT2 (protective levels of tetanus antitoxin) within the previous 12 months	TT2 = 40.9% (1990 NDHS)	29%	36.0%	2.7%	55%

B. ANALYSIS OF DATA

In FY 1995, USAID-Nigeria retained all the SO Program Outcomes and Indicators for Improved Maternal and Child Health Practices: Improved immunization practices and coverage; improved case management of the sick child; improved child nutrition practices; and improved maternal care. For reasons earlier detailed in this report, the Program Outcomes planned for 1995 were not met.

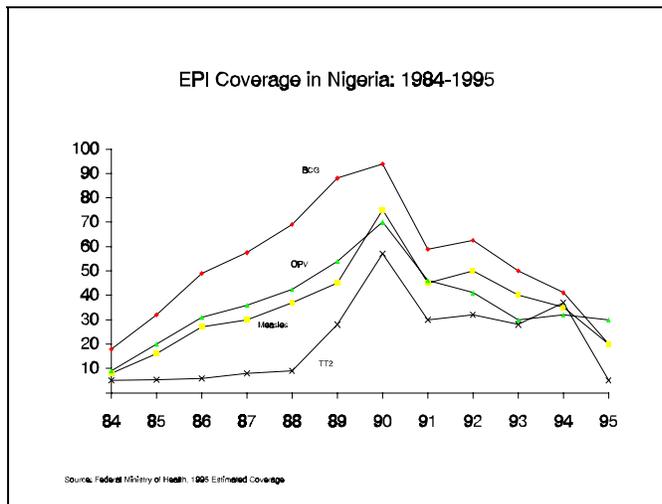
The Mission has elected to report on the current situation by presenting vaccine preventable diseases as a case study of the factors constraining USAID's ability to effect change. Historically, child survival support had been closely linked with the public sector. In 1993, USG policy required a shift of all program activities to the Nigerian NGO community. The 1994 decision of the US government to decertify Nigeria mandated a termination of material support to Government. This shift was justified by a programmatic assessment documenting a long history of lackluster performance in Government based activities. The NGOs were to become the engines of development but the Government of Nigeria was still to be responsible for key program inputs and resources, e.g. vaccines and ORS.

In the months that followed decertification, USAID-Nigeria took the first steps toward expanding its NGO engagement. Start-up activities included (a) a comprehensive assessment of NGO capacity and

capability, (b) creation of US-Nigerian NGO partnerships, (c) development of innovative NGO community based programs focused on the role of women as decision makers, (d) support for service delivery and community mobilization and (e) a concentration of effort and resources on institutional and program sustainability-right from the design stage. Although there were early apprehensions that Government would obstruct these efforts, the Government's response has been one of non-interference -- with positive statements by key health decision and policy makers acknowledging a newly legitimized role for NGOs and the private sector in the national health program. For this, USAID-Nigeria takes credit.

The decline in immunization coverage that began in 1990 continued into 1995. Currently coverage for all major EPI vaccines is estimated to be below 20%. A recent study in Lagos State showed that coverage of pregnant women with TT₂ was only 2.7%.

In November of 1995, the Federal Ministry of Health convened a National Health Summit to develop a framework for addressing critical health and social sector needs. While many of the meetings participants remained focused on the development of expensive and generally inappropriate tertiary health care facilities, the critical status of the deteriorated EPI program could not be put aside. Government officials became fully aware of the potential for epidemic disease.



As a follow-up to this "summit", the Federal Ministry of Health and UNICEF approached Government for funds to purchase the needed vaccines. Responsibility for vaccine purchase was assigned to the "Family Support Program", a project developed by Mrs. Mariam Abacha, the wife of the Head of State. The purchased vaccines were shipped to Nigeria but according to several government functionaries, they arrived in sub-optimal storage containers. On arrival in Lagos, some 10 million doses of vaccines were distributed to two Government central stores in Lagos and Kano equipped to handle only 2 million doses each. The technical competence of the Family Support Program to manage the NPI is very much in question - and the subject of open debate within Government, the donor and commercial communities.

In January, reports of epidemic illness occurring in Northern Nigeria began filtering into the Ministry of Health and donor agency offices. Currently, three epidemics; cerebro spinal meningitis, measles, and cholera are raging though the middle belt and northern states of Nigeria. An estimated 15,000 to 20,000 cases of CSM with as many as 3,000 deaths have been reported by workers who have visited Kano. Reports from members of international teams from UNICEF and WHO confirm the outbreaks and report that there are significantly more cases than the official reports. Nigeria is now experiencing what will undoubtedly be recurrent, severe epidemics of vaccines preventable illnesses. Giving the deteriorated state of the public health sector and the questions surrounding vaccines and essential supplies, there is little to assist local health workers struggling to contain the outbreaks. International Agencies: Medicine San Frontiere, UNICEF and the World Health Organization are trying to respond to this emergency.

C. EXPECTED PROGRESS IN FY 1997 AND FY 1998

USAID's ability to fully achieve its Program Outcomes for child survival is at risk. USAID and its Implementing Partners have established an operational framework for sustainable, integrated community based service delivery with the potential to vastly increase the access of Nigerian populations to immunizations, diarrhea disease treatment programs and other life saving interventions. USAID however, does not control critical material resources and inputs such as vaccines and ORS. NGO partners, however dedicated and organizationally prepared to deliver programs, cannot make things work without access to essential supplies. Given the current political environment, the absence of proven Government commitment, and the realistic input requirements versus the reduced USAID funding levels anticipated for FY 97, USAID support of child survival activities cannot fully yield the planned sustainable progress towards this Strategic Objective.

IIC. PROGRESS TOWARD STRATEGIC OBJECTIVES:

A. SUMMARY OF DATA TO#1: Improved HIV/AIDS/STD Prevention and Control Practices

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
Target of Opportunity						
Improved HIV/AIDS/STD prevention and control practices	Availability of condoms (1)	17 million	24 mil	45.2 mil	55 mil	
	Proportion of men and women knowledgeable of HIV transmission	47% (FOS 1993)	54% (NB)	55%		80%
	Proportion of men and women altering attitudes and behaviors concerning HIV transmission	21% - 30% of target CSWs consistently use condoms in high-risk situations				
	Proportion of men and women who are able to identify signs and symptoms of common STDs and who know where to seek treatment					
	(1) No segregation of condoms for Family Planning and HIV/AIDS					

B. ANALYSIS OF DATA

The USAID-Nigeria funded AIDSCAP program was initiated in October 1992. As originally conceived, the primary target groups were commercial sex workers (CSWs), long-distance truck drivers, men in workplaces and youth in tertiary educational institutions. Based on a recent assessment, this targeting has now been modified to allow the AIDSCAP to more fully integrate into the larger USAID-Nigeria health care delivery program. This will expand impact through collaborations with the broader range of established Nigerian NGO partnerships. In 1995, USAID continue to support its HIV/AIDS prevention activities through the centrally funded AIDSCAP/FHI project and the USAID-Nigeria grant with Populations Services International (PSI) for condom Social Marketing. The AIDSCAP program employed three main strategies: (1) behavior change through peer health education (PHE), (2) sexually transmitted disease (STD) management emphasizing syndromic diagnosis and treatment, and (3) promotion of condoms. 1995's activities focused on program implementation in the three initially designated states, with selected activities introduced in neighboring states. A gradual expansion to the 14 USAID target states is envisaged. Activities included:

- Lagos State:** Nigerian dock workers, STD/AIDS intervention by NFEMP,

- Cross River State:** BCC intervention with CFW by NIU (Women of Courage), Nigerian youth intervention by NYAP, prevention of sexually transmitted of HIV/AIDS among long distance transport workers by FAFA, and

- Jigawa State:** College based STD/HIV peer education project and HIV/STD prevention and education among long distance drivers by STOPAIDS.

In addition to these longer term projects, additional smaller NGO conceived and led interventions were undertaken through a Rapid Response Funding (RRF) mechanism. In each such instance, the RRF made it possible for the NGO partners to move quickly to capitalize on unplanned opportunities to enhance their reach to target groups.

Reliable data on the impact of HIV/AIDS/STD prevention and control activities is generally unavailable. However, anecdotal and field reports make it clear that this project has had a significant outreach, with large numbers alerted to the danger of AIDS. For example, 24,200 persons were reached at a special event -- the AIDS charity concert on "World AIDS Day." The NGO partners that sponsored a special drivers social and the AIDS charity concert saw this as an innovative way to break the monotony of formal lectures and talks for "enlightenment". Another NGO partner reached approximately 5,000 students with group education sessions in Cross River State. Several of the NGO partners had worked to establish condom outlets and IEC, care and education programs. In each case, the IEC efforts were supported by condom distribution -- with an estimated 1 million condoms distributed free of charge in 1995.

The HIV/AIDS program has had far reaching impact, especially among vulnerable female populations. For example, in Calabar, a project that began as an AIDS awareness and risk assessment activity with commercial sex workers (CSW) and the owners of hotels supporting CSW trade has had significant and potentially sustainable impact on both knowledge and behavior. Recognizing the increasing risk that HIV poses for them and their clients, the CSW's began enforcing a "condom only" policy at local brothels. These women, socially among the most disempowered in Nigeria, used their newly acquired knowledge

and negotiating skills in a collective effort to mandate behavior change among their clients. They received support in this effort from the hotel/brothel owners who, breaking with the traditional posture that “the client is always right”, agreed to the changes the CSWs demanded. Within a two year period, the proportion of these CSWs reporting that their clients always use a condom rose from 12% to 60%. Surveys show that the CSWs now see the clients that use condoms as “responsible”, charge more for their services and have reduced their average number of clients per day from 10 to an average of 5 per day. Of necessity, clients are coming to accept condom use as a Calabar standard.

AIDSCAP has also been a Mission leader in identifying the constraints to women's decision-making - important to all health care delivery and acutely important to reducing HIV/AIDS transmission. Their work, and identification of knowledgeable Nigerian NGO partners, offers considerable potential for addressing the underlying social condition and attitudes that undermine the thesis that “Knowledge is Power”.

C. EXPECTED PROGRESS IN FY 1997 AND FY 1998

While data was not available at the time of this report for key target indicators, USAID is of the opinion that substantial impact has been achieved through grassroots outreach via Nigerian community based NGOs. The prospects for a continued strong performance in FY1997-98 must be more guarded. This is because any IEC program that enhances knowledge and changes attitudes about HIV/AIDS must be supported by an adequate supply of condoms if there is to be a reduction in disease prevalence. The current and anticipated budgetary constraints for the USAID-Nigeria program will jeopardize the flow of AIDS condoms. If USAID-Nigeria, or other donors, are unable to provide this essential commodity support, sustained progress to achieving the target and objectives for 1997/98 will be compromised.

III. STATUS OF MANAGEMENT CONTRACT

A. STRATEGIC OBJECTIVE CHANGES OR REFINEMENTS

USAID-Nigeria's future directions are currently under review and will be decided in collaboration with USAID/W and REDSO/WCA staff. It is anticipated that the new program will be smaller in funding level, staff size and programmatic outreach.

B. SPECIAL CONCERNS OR ISSUES

C. 22 cfr 216 ISSUES AND SCHEDULE

IV. RESOURCE REQUIREMENTS

A. PROGRAM FUNDING REQUEST BY STRATEGIC OBJECTIVE

B. PROGRAM MANAGEMENT REQUIREMENTS: OPERATING EXPENSES (OE) AND STAFFING

C. FIELD SUPPORT FROM GLOBAL BUREAU

