



*United States Agency for International Development*

**ASSESSMENT OF PROGRAM IMPACT**

**NIGERIA**

**FY 1993**

**December, 1993**  
**AAO Nigeria**

## ASSESSMENT OF PROGRAM IMPACT NIGERIA - 1993

### SECTION ONE: SPECIAL FACTORS AFFECTING THE USAID PROGRAM

Conditions which influence the attainment of the CPSP strategic objectives have, on balance, worsened over the past year. The most important factors impeding progress are:

**Political Tensions and Uncertainty:** Nigeria has not been able to finalize its political transition from a military government to civilian rule. After successfully undertaking elections for local and state leaders and the national assembly, the transition came to a halt with the postponement of presidential elections, originally scheduled for November, 1992, to June 12, 1993. A joint military - civilian Transition Government installed for this period was largely ineffective. The subsequent June 12 presidential election, believed by most Nigerians and external observers to be the freest and fairest in Nigeria's history, was canceled by the military leaders. An Interim national Government (ING) was appointed for six months with new elections scheduled for February, 1994, but even these tentative steps toward democracy have been scuttled. On November 18, the military again assumed power; all elected bodies have been dissolved. A new constitution is to be written and a national conference called to eventually lead to a democratic government.

Since the cancellation of the June 12 elections, the country has been at a standstill, beset by demonstrations and strikes which have taken a deep toll on primary health care. A.I.D. suspended, and later terminated, the transfer of \$11 million NPA/ESF under a health policy program. The local currency generated from this NPA was counted on to support the A.I.D. primary health care program. While our humanitarian assistance program continued, U.S. sanctions precluded us from transferring funds to the federal government. Other mechanisms were found to obligate FY 93 funds and the program has continued, largely with the elected governments at the State and LGA level, with NGO's and with the private sector. The return of the military to power on November 18 further clouded an already murky situation though, as of the writing of this document, Nigeria is calm and appears to be returning to business.

**Administrative Restructuring - new States and LGAs:** When the AID program began in the mid-1980's, there were 21 States and 350 LGAs. Today there are 30 States and a Federal Capital Territory, and 589 LGAs. The proliferation of political and administrative units affects the program because responsibility for primary health care has been devolved to the local level. LGAs are responsible for mobilizing community support for primary health care, for providing primary health care services, and for maintaining health infrastructure. Family planning services, as an element of maternal and child health care, are included in the primary health care responsibilities of the LGAs. State Ministries of Health, plan and coordinate the state health care systems and

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Political instability resulting from the annulment of the presidential elections and the creation of new States and LGAs present obstacles to achieving program objectives.

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provide training and a range of technical support, including supervision, to Local Government Authorities. Thus, while the creation of new States and LGAs has had beneficial effects - smaller governmental and administrative units have resulted in broader participation in the development process by bringing government closer to the people, and has the potential to increase transparency and accountability in the system - the downside is that the new State and LGAs have a reduced budget for health, inadequate physical and systems health care infrastructure, and little organizational capability.

**Weak Economy:** Although Nigeria was one of the wealthiest African countries in the early 1980's, it is now considered the 13th poorest country in the world. Since 1990, the Nigerian economy has plummeted with increasing inflation and an accelerated devaluation of the Naira, despite the fact that Nigeria is the world's sixth largest supplier of crude oil. The Naira/dollar exchange rate has dropped from 15 to 45+ in less than a year. It is difficult for Nigerian companies to obtain foreign currency to procure medical supplies for the country's health program. Inflation continues to skyrocket due to the government's large deficit financed by the Central Bank. Rising prices eroded the real wage gains of occasional increases in 1991 and led to significant distress among the population.

## **SECTION TWO: PROGRESS TOWARDS OVERALL COUNTRY PROGRAM GOALS**

### **PROGRAM GOAL: More productive Society Contributing to Market-oriented Economic Growth.**

Indicators to measure Goal-level objectives will have to be re-thought. While per capita GDP data is available, it is late in being published, and the figures are questionable. Median annual income and annual average rural wages data are not routinely collected, nor are they reliable when available. Moreover, these indicators will not necessarily reflect productivity. AAO will propose a new set of indicators for the Goal level prior to the preparation of the 1994 API.

### **SUB-GOAL: Reduced Fertility and Decreased Morbidity and Mortality.**

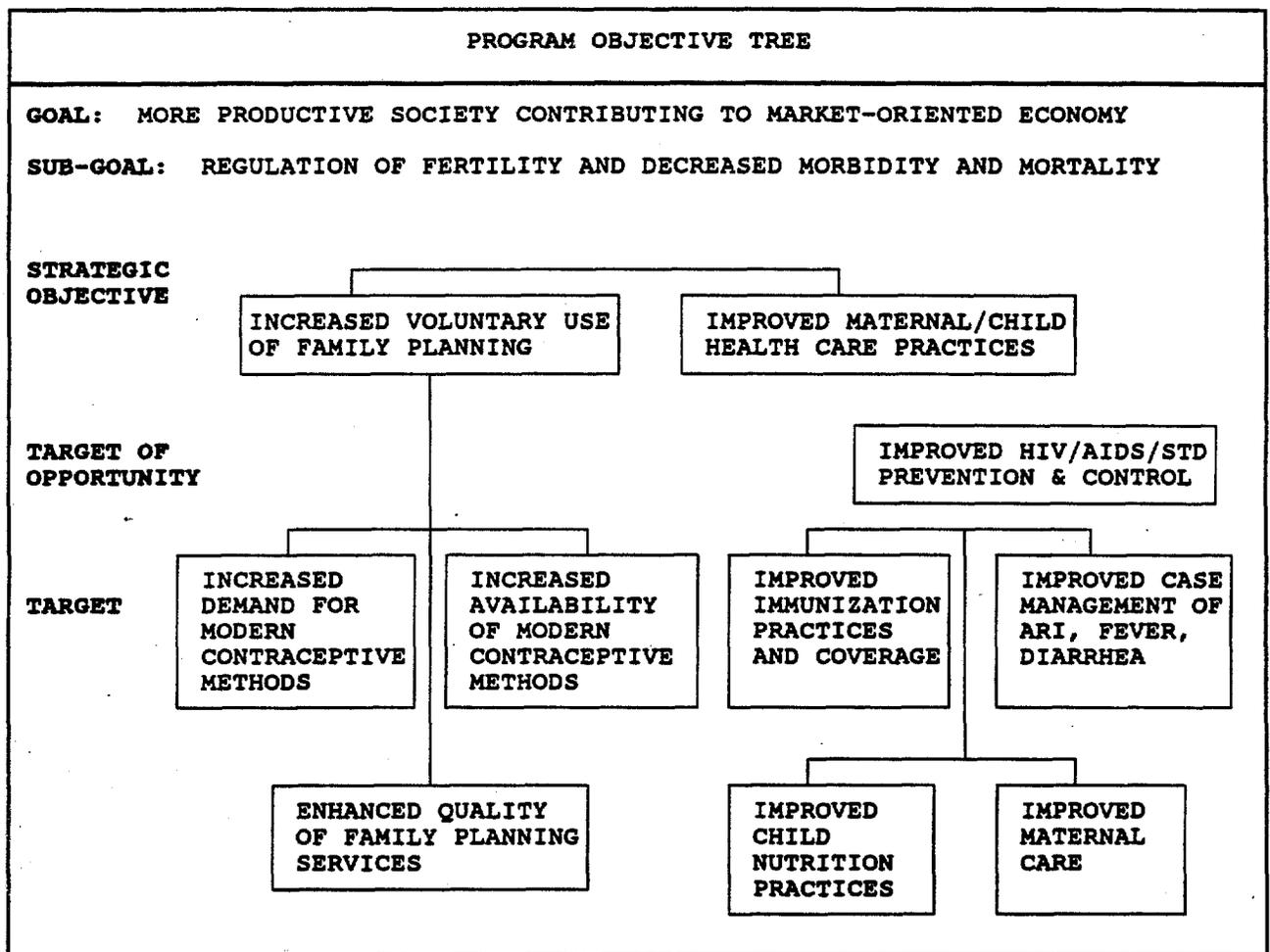
Nigeria has the largest population in sub-Saharan Africa with an annual growth rate of 3.1%. The high fertility rate coupled with the size of Nigeria's population, 88.5 million in 1991, has diminished its economic and social gains, overwhelmed the health and education systems as well as the general infrastructure. In a weakening economy, the idea of smaller families is quickly becoming more acceptable.

Nigeria's population growth rate of 3.1% is diminishing its economic and social gains. However, TFR has decreased from 7.5 in 1982 to 6 in 1990. Contraceptive use is increasing substantially.

One indicator of progress towards this sub-goal is reduction of total fertility rate (TFR) from 6.0 (1990) to 5.5 by YR 2000. It was estimated that TFR was as high as 7.5 in 1982. The 1990 NDHS stated that the TFR was 6

births per woman which is consistent with the ideal family size of 6. The 1990 NDHS data on TFR will be updated by the 1994 NDHS which will begin its field work later this year. TFR data is only available through the DHS. Thus, indicators of contraceptive use will be used to measure impact in the FY 93 API, since a rise in contraceptive prevalence rates should result in a reduction of TFRs.

The second indicator is increased life expectancy at birth for males from 49.5 to 51 years by 2000 and for females from 48.5 to 51 years by YR 2000. Great strides have been made through the Nigerian immunization program and child survival activities. The rate of measles is down 28%; pertussis has decreased 21%. However, many problems still persist such as high infant mortality (90/1,000) and childhood mortality (115/1,000). Diarrheal diseases, malaria, TB and, for women, childbirth complications continue to hold life expectancy to low levels. Data for reporting progress in meeting sub-Goal level objectives must wait for the 1994 DHS.



### SECTION THREE: PROGRESS TOWARDS STRATEGIC OBJECTIVES AND RELATED PROGRESS INDICATORS

(Table 1.- Program Logframe for Strategic Objectives and Target Levels Status of Achievements, Nov. 1993 - in Annex 1.

Family Planning. The objective of the Family Health Services Project (FHS - 1987-1994) is to increase the accessibility and availability of family planning information and services throughout Nigeria in both the private and public sectors. Toward the end of 1992, the FHS project began to implement new approaches to direct project resources for greater impact. First, responsibility for strategic planning and implementation was devolved to four Zonal Offices. Second, five key States were selected for intensification efforts, bringing to bear in these States the full range of resources and technical assistance offered by FHS. An assessment of these new approaches can provide insights on ways that the follow-on NFHS can effectively expand and strengthen family planning programs in Nigeria. The achievements of the targets of the FHS project are presented in Table 2, in Annex 1.

Child Survival. The objective of the CCCD project (PACD 9/93) and its follow-on NCCCD project (start date 10/93) is improvement in maternal and child health practices in the public and private sectors. Success of the project is dependent on enhancing the availability and use of PHC intervention strategies already known to be effective such as EPI, CDD, ARI and malaria control. Success also depends on improving PHC infrastructure, especially at the local/LGA level. NCCCD interventions for strengthening infrastructure aim to: (a) improve management of health resources at the local level; (b) foster continuing education and in-service training systems; (c) establish a program of quality assurance throughout the PHC system; (d) strengthen health education and communication (IEC); (e) improve HIS system at all levels; (f) support operations research in the area of child survival interventions; and (g) stimulate private sector delivery of PHC.

NCCCD focuses on nine States programs, 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. The project will intensively with 60 LGAs (of the approximately 120 in the nine States) to develop PHC delivery capacity.

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#### Data Sources for measuring progress

NDHS: 1990, 10,000 women;  
Federal Office of Statistics:  
Nigerbus Surveys: 4,000 respondents every 6 months

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The CPSP identifies several data sources to measure changes in the family planning indicators and targets. The most reliable data source is the Nigerian Demographic and Health Survey of 1990; the next NDHS survey will begin in the summer of 1994. During the interim period, the Mission is using a semi-annual National Contraceptive Prevalence Surveys administered by the Federal Office of Statistics (FOS) to assess progress. Another source is Nigerbus, a bimonthly

omnibus survey of 4,000 adults conducted at 28 locations in 21 States by a Lagos-based consumer marketing research firm working with and closely monitored by JHU/PCS.

The 1990 NDHS provides pre-NCCCD project status levels. Subsequent NDHS reports (1994, 1998) provide with impact levels. In addition, the Mission is using a combination of facility based assessments, household and community surveys, management audits, and sentinel surveillance surveys to assess baseline and annual attainment levels within the NCCCD LGAs. While attainment of project outputs at the national level may appear minimal and slow in coming, it is expected that attainment of project outputs within the focus LGAs will be significant, relatively rapid, and sustainable.

Through the assistance of the HIS activities of both the FHS and the CCCD projects, and other donor efforts, Nigeria is rapidly moving from a data-poor situation into a data-rich nation. Hence, in the narrative that follows the emphasis is on base-line indicators for the NCCCD project, indicators that are available in large part due to A.I.D. support in development of Nigeria's HIS network.

Table 3: CCCD Project Objectives and Achievements is presented in Annex 1.

#### STRATEGIC OBJECTIVE #1: Increased Voluntary Use of Family Planning

Contraceptive prevalence rates (CPR). Despite the political crises which has slowed down project activities over the past six months, and perhaps as a result of the continuing deterioration of the economy, the demand for family planning services is growing rapidly. Among currently married women, use of any method was 5% in 1981 (Nigeria Fertility Study, 1981/82) with 1% modern use. CPR increased to 6% percent in 1990 (Nigeria Demographic and Health Survey, 1990) with 3.5% modern use, a tripling of the rate of modern contraceptive use among married women over the ten year period. Greater increases can be observed among all women of reproductive age where 7.5% use any method and close to 4% use modern methods. In absolute numbers, 750,000 women were using modern contraceptive means in 1990 as opposed to 300,000 in 1981.

Analysis of the Federal Office of Statistics contraceptive prevalence surveys show that from 1990 to 1992, among all women of reproductive age, use of any methods increased from 7.5% to 14.6%; the use of modern contraceptive methods is believed to have increased from 3.8% to 7.8%. In a more recent (April, 1993) Nigerbus sample. 46% of respondents could name specific family planning/child spacing methods that can be used top prevent pregnancy; 11.6% of all survey respondents said that they had used a family planning

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**ACHIEVEMENT:** Contraceptive Prevalency Rates were 5% in 1981 and 6% in 1990. From 1990 to 1992, use on any contraceptive method increased from 7.5% to 14.6%, with the use of modern contraceptives increased from 3.8% to 7.8%.

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method during the last two months. Regionally, this figure ranged from 17% in Lagos to 5.4% in the north.

The dissemination of the National Population Policy in 1988 is partly responsible for this surge (the policy assured individuals, families and the commercial private sector that government supports family planning), though the worsening economic situation is generally credited with being the key motivating factor in the increase in contraceptive use. During this period the FHS project was working at full capacity in providing family planning services and information through the government, NGO and commercial outlets.

Contraceptive prevalence, overall, remains low. However, Nigeria is a vast country with significant economic and cultural differences. The North is largely agrarian, with lower literacy/educational levels, particularly among females, less developed infrastructure, and Muslim influenced. The South is more economically developed, with an industrial base, educational levels among females are higher, and the influence is Christian. These characteristics may help explain the vast differences in CPRs. Data desegregated by region shows that the FHS project achieved its objectives entirely in the Southeast and Southwest, but was less successful in the North. The data, which graphically illustrates the vast regional differences in the country, has generated the development of different strategies in the family planning program.

The FHS project has worked with several levels of government to refurbish and upgrade clinics to provide long-term family planning methods. Efforts have also focused on private sector outlets (clinics, hospitals, patent medicine shops and social marketing of two condom brands). The 1990 NDHS showed that 37% of current users of modern family planning receive their supply from government facilities (in 1990, there were 1,415 public family planning sites; in 1993 there are 1,785 sites). Forty-three percent of current users obtain their services through private sector outlets. The Planned Parenthood Federation of Nigeria (PPFN) provides about 4% of the national users with family planning services. The program is increasing the involvement of the private sector in the program, including strengthening PPFN to provide more and improved services.

The private sector provides mostly temporary methods such as pills, condoms, vaginal foaming tablets while the public sector is the major provider in long-term methods, including IUCDs, sterilization and NORPLANT. Using sales, distribution and consumption data of USAID-financed contraceptives, couple year of protection (CYP) figures can be calculated. These figures standardize all contraceptive use into one measure to allow for: similarity between different contractive types and comparison between project sectors (private/public) and other country programs.

CYP Generated 1988-1993						
	1988	1989	1990	1991	1992	1993*
PRIVATE	14,752	64,317	128,332	214,328	217,516	240,318
PUBLIC			433,710	337,848	365,868	210,196
<b>TOTAL</b>	<b>14,752</b>	<b>64,317</b>	<b>172,042</b>	<b>552,176</b>	<b>583,384</b>	<b>450,514</b>

\*Data is only for the time period Jan-Aug.

## **TARGET #1.1: Increased Demand for Modern Contraceptive Methods**

In 1988, the Nigerian Population Policy was enacted. At that time, it was considered "taboo" to discuss family planning in public. Family planning is now openly discussed in all of the media, the result of very successful IE&C efforts largely undertaken by FHS.

The first step in increasing demand is to induce behaviour change through awareness and knowledge creation programs. In 1992, a National Family Planning Logo campaign was launched by the MHSS and the states, with substantial financial and technical support from FHS. The logo was posted at 40,692 sites to identify them as family planning service delivery sites. IEC materials (posters, billboards, danglers and indoor stickers with the message "Child Spacing Services Available Here") were given to each facility. Television and outdoor advertising continue to complement the campaign. In June, 1992, three months after the start of the logo campaign, 30% of Nigerbus respondents had seen the symbol, of which 6% could describe it accurately. As recently as the April, 1993 Nigerbus survey, four months after the advertising campaign ended, 24% of all respondents had seen or heard about the log, and 56% of these could describe it accurately.

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**Achievement:** The family planning logo, developed with the assistance of the FHS project, played a significant role in opening the discussion on family planning.

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More important, as a measure of how attitudes towards family planning are changing in Nigeria, among the 46% of the April, 1993 Nigerbus respondents aware of specific family planning/child spacing methods, over 87% approve of couples who use these methods. Data from a nationwide survey (FOS survey in 1992) shows that, by the end of the campaign in December 1992, 33% of men and women interviewed had heard of the campaign, and 66% of these could describe it accurately. The FOS quarterly survey also reflects an increase in awareness, the most recent data suggesting that 77% of people interviewed have heard of family planning. IEC efforts will henceforth focus on increasing method and source specific knowledge to increase demand for family planning services.

At the clinic level, materials for client instruction and counselling have been produced in several local languages. However, for these materials to continue to be available, it is essential to establish and maintain a system to reprint and re-supply these materials on a regular basis. FHS has worked towards developing this type of system by strengthening the institutional capability of several organizations to develop and produce media and client materials.

## **TARGET #1.2: Increased Availability of Modern Contraceptive Methods**

Availability of contraceptives consists of three factors results from accessibility to health facilities (e.g. distance, trained provider, open during appropriate hours, etc.); access to contraceptives (e.g. commercial outlets); and full range of contraceptives.



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Availability of health facilities: Since 1988, FHS has equipped 1,200 clinics to provide IUCDs and temporary methods (injectables, pills, VFTs and condoms). Before 6/30/94, FHS plans to upgrade 70 clinics to provide the full range of family planning services including VSC and NORPLANT and 187 clinics to provide IUCDs and temporary methods. Improving these clinics should facilitate meeting the rising demand for family planning.

The 1990 DHS report indicates that 31% of clients must go 0-4 miles for services, 14% must go 5-9 miles, and 37% must go more 10 miles. An update of this data will be provided by DHS 94. We have no information, as of yet, on whether distance from services is a major impediment of increased contraceptive use.

Access to contraceptives: During the family planning logo distribution exercise in March-June, 1992, 40,692 sites were identified as actual or potential locations/outlets for family planning products or services. Of this number, 33,180 or 81.5% said that they offer family planning products, services or information. Among this group, 81% said they offer condoms; 71.3% orals; 44.7% VFTs; 25.5% injectables; 14.1% IUDs; and 3.3% sterilization. There are significant regional differences. However, the program has been plagued by commodity stock-outs in both the public and private sector. Of the 33,180 locations identified during the logo campaign as offering family planning services or products, over 28,000 indicated difficulty in obtaining products.

USAID and FHS are working with the FMOH and private sector organizations to ensure that there is enough commodity supply in country, that there is timely distribution to service delivery sites, and that contraceptive needs are forecast and procured enough in advance to avoid stock-outs. FHS is assisting the Ministry of Health to build warehouses, to provide storage of commodities at the zonal level.

The private sector in Nigeria is extremely entrepreneurial and has relatively been untapped by the family planning program. The benefit of the social marketing campaign has greatly enhanced the market for family planning goods. In 1990, 2.3 million condoms were sold annually; in 1993 approximately 3 million condoms are being sold per month. Plans are being developed to also socially market pills in 1994, which will enhance consumers access to the product. The ability of USAID to procure injectable contraceptives will increase the availability of this method, which is well accepted in Nigeria but has been plagued by stock-outs. Lastly, USAID/Nigeria anticipates that NORPLANT, readily accepted in trials over the past five years, will be approved by the Nigerian Food and Drug Commission sometime in late 1993.

Service providers. Since 1988, FHS has trained approximately 15,000 service providers. The main training areas include: interpersonal communication, non-clinical and clinical family planning methods, supervision, management, MIS, financial management and counselling. The project has begun to institutionalize training capabilities by working with university teaching hospitals and establishing of a network of Nigerian trainers.

To increase CPRs, the FHS project has worked with several levels of government and with

NGOs to refurbish and upgrade clinic sites to provide greater access to long-term family planning methods. Efforts have been focused on the private sector outlets (clinics, hospitals, patent medicine shops and social marketing of two condom brands).

The graph on page 10 presents a summary of total quantities of contraceptives shipped into Nigeria from 1988 through 1992.

Full range of contraceptives: FHS has improved the contraceptive method mix by providing more long-term methods to users, such as VSC and NORPLANT. By increasing the facilities that can provide long-term methods, the number of trained providers, IE&C materials at the clinic level client counseling, and commodities supply USAID/Nigeria expects to increase the availability of these services with a parallel rise in contraceptive prevalence rates.

### **TARGET # 1.3: Enhanced Quality of Family Planning Services**

Since 1988, FHS has trained approximately 15,000 service providers and will train an additional 350 before 6/30/94. The main training areas include: interpersonal communication, non-clinical and clinical family planning methods, supervision, management, MIS, financial management and counselling. The project has tried to institutionalize training capabilities by working with university teaching hospitals and establishing of a network of Nigerian trainers. Training of providers is extremely important to increase the quality of care being provided to consumers. In particular, counselling is essential for a client to understand all the options, side effect and make an informed choice. Better counselling practices would dispel rumors and educate the client on what to expect while using a specific method. FHS has trained many cadres of health personnel in counselling and will continue to do so. Counselling and provider attitudes could greatly reduce the present high discontinuation rates. In addition, IE&C materials must be available for client instruction and to identify service delivery points.

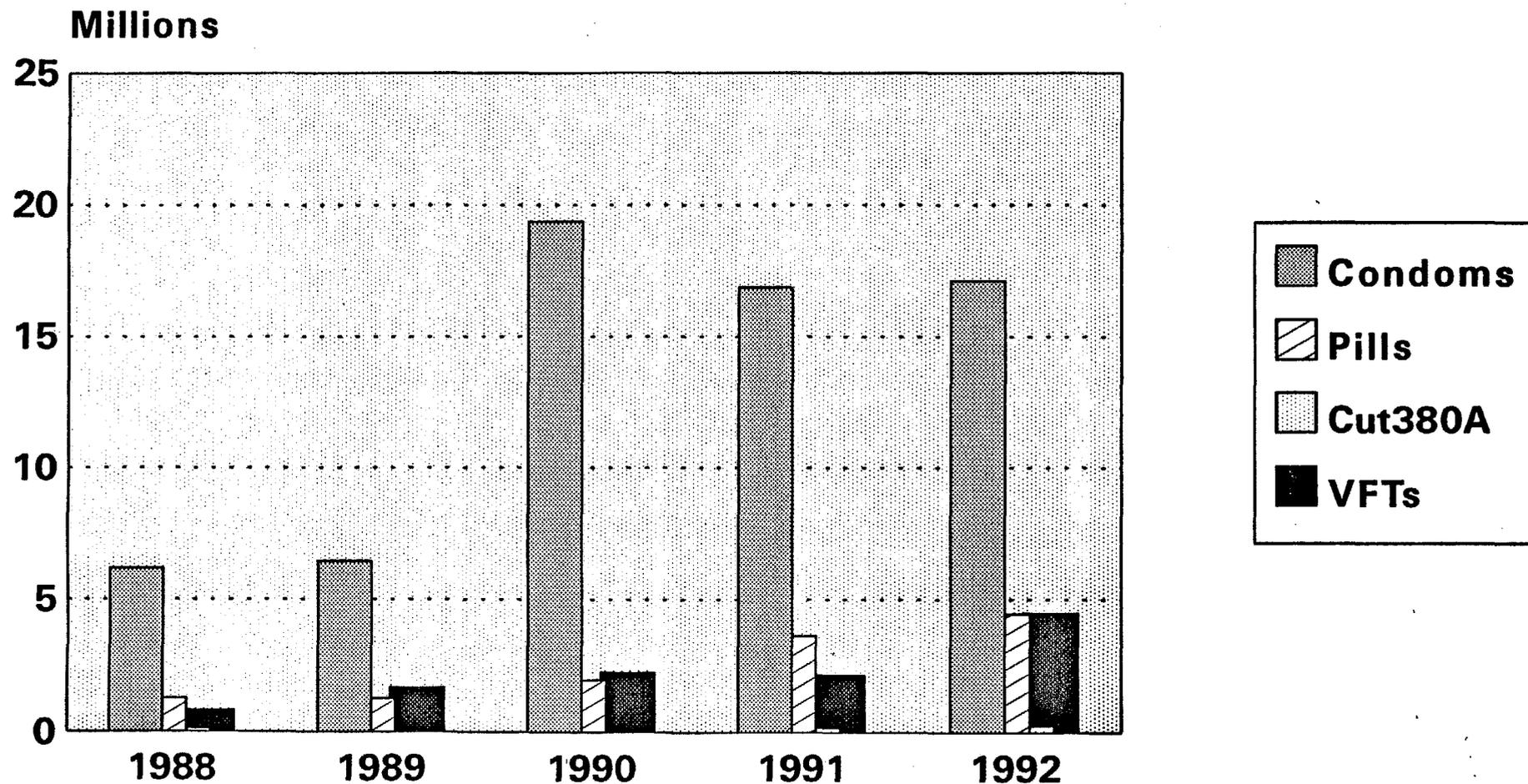
There are many reasons that woman who intend to use contraception, do not; for example, distance to the provider, rude providers, client waiting time, no available supply, side effects religion and husband's disapproval. In recent surveys, it was reported that client continuation of family planning methods is very low. After the first month of use, 30% of clients had not returned and after one year 70% had dropped-out from using contraception.

The Nigerian Family Planning Situation Analysis explored a number of areas concerning the quality of family planning services. Some results from this analysis are presented below.

- ◆ The analysis showed that the client waiting time did not appear to be a barrier to service; 39% of clients had no waiting time; 39% waited less than 30 minutes; and only 5% of the clients felt they waited too long.
- ◆ Duration between the provider and client was substantial: For new clients an average time of 33 minutes was spent with the provider, and for revisits for check-ups and resupply the mean duration was 19 minutes.

# FHS PROJECT COMMODITY SHIPMENTS FROM AID/W TO NIGERIA 1988 - 1992

PRIVATE & PUBLIC SECTORS



- ◆ Mechanism to encourage continuity were used by many providers: 91 % of clients were told by providers when to return and 76% were provided a memory prop for the revisit. However, 62% were not told what to do if there were problems and 43 percent were not to where to go for resupply.
- ◆ Client satisfaction was high when clients were asked about the services they received at the clinic; very satisfied 56%, satisfied 42%. However, clients did not always get what they asked for when they entered the clinic. Approximately 50% of clients who would have preferred another method had an IUCD inserted, 15% received injectable and 14% received combined pill. Not getting one's preferred method may lead to discontinuation, showing client satisfaction may not be as high as clients' initial verbal response, and that there may be provider bias in choice of method.

It is very difficult to estimate the number of complications that arise from family planning. Most IUDs in Nigeria are inserted by nurses/midwives, but they are trained to deal with complications. Doctors, on the other hand, are not trained to insert IUDs but are responsible for complications. FHS is trying to equip more physicians be more involved to deal with these complications.

#### STRATEGIC OBJECTIVE #2: Improved Maternal and Child Health

Nigeria has high rates of infant mortality (90/1000), child mortality (115/1000), and maternal mortality (15/1000). Yet, measurable progress has been made since a 1960 World Bank report which indicated a child mortality rate of 204/1000.

High rates of infant mortality are the consequence of many factors, including socioeconomic conditions, interbirth interval, prenatal care, conditions of delivery, infection, and malnutrition. High child mortality rates reflect the interaction of poverty infection (malaria, ARI, diarrhea), undernutrition, and limited access to quality health care. The first years of USAID project support have vastly expanded the available network of trained PHC providers, equipped facilities and supportive local leaders. The new NCCCD project is poised now to delivery the promise of available, acceptable quality PHC services.

NCCCD has the opportunity to make significant progress in the reduction of child mortality in the project's focus states and LGAs through implementation of planned child-survival interventions. Priority attention is directed to five preventive child-survival issues: immunization, infant and child nutrition, safe motherhood, maternal nutrition, and child spacing. These priorities are translated into targeted interventions, as presented in Table 1.

Each focus state is assigned a Nigerian State Based Epidemiologist (SBE) employed by the project to direct implementation of these targeted interventions at the state and LGA levels.

## **TARGET #2.1: Improved Immunization Practices and Coverage**

The Nigerian immunization program began in 1966. Like so many other developing countries, Nigeria's experience has been characterized by profound swings in the rates of coverage. Immunization rates have gone from an overall high of 80% in 1990, to a current low of 30%.

A series of National Immunization Days (NIDs) became the major instrument for raising the immunization rate from 10% in 1983, to 20% in 1987, and to 75% in 1988. The reports that the NIDs peaked in 1988 when the Federal Government decided to boost the coverage by declaring three consecutive NIDs in March, April, and May. A key feature of these NIDs was the fact that they were financed outside the normal budget of the Federal, State, and LGA health budgets, and details are sketchy about how much was actually spent. Government reports estimate that \$6 million were contributed by States and LGAs. UNICEF was the lead donor, providing financing for the strengthening of the national cold chain, procurement of vaccines, and training of relevant EIP providers. UNICEF's Lagos office reports that between 1990 and 1991 its support to EIP dropped from \$17 million to \$3.2 million, with current spending on EPI remaining low.

Nigeria's volatile and evolving political transition has also contributed to the current drop in immunization rates. While the transfer of key responsibilities to local authorities was seen as a positive step, the fledgling local governments lacked trained personnel (from fiscal planners to service providers) to carry out the program. The Table on page 13 presents the general decline in coverage. The 1990 data reflects the period of intense federal and donor contributions to EPI. The NIDs were preceded by national awareness campaigns; the cold chain system was reinforced; vaccines were centrally procured; local health care providers were rigorously trained in EPI procedures. In 1991, with the decentralization of authority for primary health care services, the main responsibility for EPI was thrust upon the LGAs. Residual effects from the former federally based approach were still impacting immunization efforts (e.g., most cold chain equipment were still functional, health care personnel were still in place). However, LGAs were not adequately prepared to forecast and budget appropriately for vaccines. Thus, implementation of continuous EPI services at the LGA level did not have a smooth beginning. By 1992 new states and LGAs were created (going from a base of 350 LGAs, to a total of 593), with the newly created units deprived of adequate cold chain equipment, trained health care providers, and fiscal planning to support the EPI program...a problem that has yet to be resolved. The 1993 figures are of concern. However, we note the relatively higher coverage rates present in the CCCD focus states. In areas where the percentages are reported as being above 100, there is speculation that the local population was underestimated at the time of the census.

Presently, only two of four national EPI cold stores are functioning and approximately half of the states require new or replacement cold chain equipment. Preliminary estimates from a recently constituted Technical Committee (10/93) which is reviewing the current low EPI rates suggests that about \$27 million will be needed in 1994 to revitalize the EPI infrastructure (particularly the cold chain) and raise coverage rates by approximately 30%.

**ANNUAL EPI REPORT FOR 1993 SHOWING % COVERAGE OF INFANTS**

**NATIONAL AND NCCCD FOCUS STATES**

VACCINE	NATIONAL	ANAMBRA	ENUGU	KEBBI	LAGOS	NIGER	OSUN	OYO	PLATEAU	SOKOTO
BCG	15	10	27		16		68	62	73	
DPT1	13	10	23		17		65	71	27	
DPT2	11	9	24		16		55	49	22	
DPT3	10	8	21		15		54	44	19	
POLIO 0	10	7	23		11		55	49	19	
POLIO 1	12	11	24		17		64	49	40	
POLIO 2	11	9	22		16		56	50	21	
POLIO 3	9	8	21		15		51	27	19	
MEASLES	11	8	19		15		58	50	32	

**ANNUAL EPI REPORT FOR 1992 SHOWING % COVERAGE OF INFANTS**

**NATIONAL AND NCCCD FOCUS STATES**

VACCINE	NATIONAL	ANAMBRA	ENUGU	KEBBI	LAGOS	NIGER	OSUN	OYO	PLATEAU	SOKOTO
BCG	63	45	77	121	44	50	138	136	38	43
DPT1	56	45	136	113	48	49	127	116	32	39
DPT2	51	37	68	97	45	35	115	100	26	35
DPT3	49	36	75	107	41	31	110	94	24	37
POLIO 0	29	17	64	0	30	33	120	98	15	0
POLIO 1	57	47	71	110	47	48	274	111	33	39
POLIO 2	47	37	70	97	44	36	115	94	27	37
POLIO 3	44	36	76	109	41	30	122	88	22	36
MEASLES	49	32	53	127	37	37	122	92	33	52

**ANNUAL EPI REPORT FOR 1991 SHOWING % COVERAGE OF INFANTS**

**NATIONAL AND NCCCD FOCUS STATES**

VACCINE	NATIONAL	ANAMBRA	ENUGU	KEBBI	LAGOS	NIGER	OSUN	OYO	PLATEAU	SOKOTO
BCG	60	48			45	46		127	63	28
DPT1	54	41			53	45		106	53	27
DPT2	48	43			50	37		99	43	26
DPT3	48	53			50	31		99	41	30
POLIO 1	55	55			51	44		105	55	26
POLIO 2	48	42			48	36		102	44	25
POLIO 3	48	53			49	30		98	46	29
MEASLES	48	44			39	34		83	62	37

**ANNUAL EPI REPORT FOR 1990 SHOWING % COVERAGE OF INFANTS**

**NATIONAL AND NCCCD FOCUS STATES**

VACCINE	NATIONAL	ANAMBRA	ENUGU	KEBBI	LAGOS	NIGER	OSUN	OYO	PLATEAU	SOKOTO
BCG	109	62			43	96		160	158	166
DPT1	99	60			47	89		120	127	139
DPT2	81	52			43	66		99	103	127
DPT3	78	54			40	54		97	96	145
POLIO 1	99	59			48	88		122	127	142
POLIO 2	80	49			43	64		99	103	128
POLIO 3	78	55			40	54		100	95	145
MEASLES	91	50			38	67		112	121	162

NOTE: 1. In 1993, kebbi, Niger and Sokoto did not send any routine EPI data.

2. Coverage above 100% could be due to immigration or outmigration, and over reporting or under reporting.

3. In 1991 and 1990 CCCD only had six focus States.

NCCCD efforts, which will be reflected in the work plans now in development, are focused on increasing the local government infrastructure and personnel capacity to effectively implement the immunization program, including procurement of vaccines, and the maintenance of a operational cold chain system.

#### **TARGET # 2.2: Improved Case Management of ARI, Fever and Diarrhea**

Research supported by CCCD indicates that overlap between symptom complexes is common throughout Nigeria (e.g., 90% of children with pneumonia also met the case definition for malaria). During this 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., fever (malaria), ARI, and diarrhea. This is in line with WHO's current emphasis on a more holistic approach to clinical assessment and treatment. One of the NCCCD SBEs has developed a wall chart/flow chart which can be used in clinic settings as a quick reference in implementing this comprehensive approach to initial patient symptom reviews.

Malaria: UNICEF (1990) reports Nigeria's malaria mortality for children under 12 months at 12.5%, and a malaria mortality rate of 7% for children under five years of age.

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.

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.

Control of Diarrheal Diseases (CDD): A FMOH report (1989) estimated 83.2 million annual cases of diarrhea among children under five years of age, with an estimated diarrhea mortality rate of 4/1000 episodes.

The diarrheal disease component of NCCCD 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.

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.

### **TARGET #2.3: Improved Child Nutrition Practices**

Nutritional status is widely accepted as an indicator of general well being. The 1990 NDHS documented both chronic malnutrition (stunting: 39.1%) and acute malnutrition (wasting: 5.0%).

Rates were higher in the two northern health zones regarding chronic malnutrition (NW: 46.1%; NE: 45.8%). Acute malnutrition was highest in the NE at 7.6%. This data reflects the status of children aged 1 to 59 months.

The NCCCD 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 five planned initiatives are breastfeeding promotion, child feeding (weaning), nutrition and the reduction of diarrheal, ARI, and measles mortality, case management protocols, and growth monitoring and promotion.

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.

#### **TARGET 2.4: Improved Maternal Care**

Nigeria continues to have one of the highest maternal mortality rates in the world (800/100,000 births). While statistically strong data is hard to come by, maternal death rates of 1 per 100 deliveries have been postulated. High mortality rates reflect the cumulative risk of high fertility, short birth intervals, lack of attended delivery, lack of referral facilities for obstetrical emergencies. SOGYN, Nigeria's ob/gyn association recommends at least six prenatal visits. However, in Nigeria the majority of women (52%) received only two prenatal visits. In addition, Nigerian women tend to initiate prenatal care rather late in their pregnancy; 42% sought prenatal care in the sixth month of pregnancy.

The majority of all births (61%) take place at home, while 31% occur in a health facility. Maternal mortality is likely to be reduced if a trained medical person attends the delivery. In Nigeria,

- 36% of all births are attended by a doctor,
- 20% of all births are attended by nurse/VHW/TBA,
- 35% of all births are not attended by medical personnel.

In light of these statistics, NCCCD will implement three initiatives to improve maternal care:

1. **Maternal Nutrition** (Clinical and operations research; ethnographic research on constraints to improved maternal nutrition and development and implementation of health education and communications approaches focused on maternal nutrition).
2. **Child Spacing.**
3. **Safe Motherhood** to reduce maternal and infant mortality associated with delivery.

**TARGET OF OPPORTUNITY: Improved HIV/AIDS/STD Prevention and Control Practices**

**Data on HIV/AIDS in Nigeria.** AIDS in Nigeria was put on the national agenda by former Minister, Prof. Ransome-Kuti, who convinced the military president, General Babangida, to hold a national conference to launch a "War on AIDS". The program has moved to the point where there is now wide discussion and good knowledge of AIDS, though accepted thinking continues to be that Nigerians are immune from the disease. A National AIDS and STD Control Program (NACP) is functioning, particularly with A.I.D. support through local currency funds. All 30 States have, nominally, set up AIDS committees and many are undertaking awareness campaigns.

While Nigeria has consistently ranked at the bottom of the list of HIV/AIDS afflicted countries, this may be due to bad data rather than bad blood. Most experts believe that there is gross under-reporting and misdiagnosis. Lack of blood screening equipment continues to be a major impediment both to obtaining data and to stopping the spread of the disease (20% of blood donors have been found to be HIV positive). The rate of infection among commercial sex workers (CSW) is running 40 to 50% of CSWs tested. The observed increase in the number of AIDS cases is a reflection of the HIV status of the nation with a steep epidemic J-curve. Data is beginning to be more refined and accurate. Data from the WHO AIDS surveillance report, Sept. 1993, shows the following:

Cumulative AIDS cases, 1986-93	917
New AIDS cases, 1992	367
1993 (6 months)	212
Males	62%
Females	38%
Pediatric age group	3.5%
20-39 age group	66%

**Mission AIDS intervention:** A.I.D.'s response has been through the centrally funded AIDSCAP project (FHI is the contractor), and a mission/REDSO contract with PSI for condom social marketing. Africare is a sub-contractor to FHI to develop NGO's working in AIDS. The project is working in four states which are most at risk because of population and high industrial and military presence.

While the AIDSCAP project has been slowed because of the political situation, it has been able to undertake the following major tasks:

- establish an office in Lagos, and branch offices in two other States.
- negotiate, fund and begin implementation of three sub-projects with AIDS related NGOs.

- assist the NACP to run the first HIV/AIDS epidemiology and surveillance course for 30 State AIDS Program Coordinators.
- provide technical assistance to several States on AIDS workshops and awareness campaigns.
- conduct workshops for NGOs participating in the program.

The PSI condom social marketing program has expanded rapidly. In 1988, condom shipments to Nigeria totalled about 5 million pieces for both public and private sectors. In 1993, PSI's conservative estimated need for the private sector alone is 30 million pieces, even before the PSI marketing/advertising campaign begins.

The Nigerbus survey of approximately 4,000 people now includes questions on AIDS knowledge, awareness and practices. In the June, 1993 Nigerbus, 82% of respondents stated that they had heard of an illness called AIDS; 81% thought that AIDS is a significant problem in Nigeria, though 82% thought they could not get AIDS; 54% have made some changes in life style to avoid contacting AIDS; and over half of the respondents have heard about AIDS on radio and TV.

Annex I, Table 1/1

Program Logframe for Strategic Objectives and Target Levels  
Status of Achievements, November, 1993

CPSP OBJECTIVE OR TARGET	CPSP: API INDICATORS ● QA/PROCESS SUB-INDICATORS	BASELINE (as of year and source of data)	Prelim. 1992	Proj. 1994	Proj. 1996	Proj. 1998	Proj. 2000
Strategic Objective 1: Increased voluntary use of Family Planning	Increased CPR among women of reproductive age.	7.5% (1990 DHS)	15%				19%
	Increased prevalence of modern method of contraception ● Increased average number of methods provided per SDP ● Increased proportion of SDPs stocking 6 or more methods	3.8%	6% 4.5 23% (1992 Sit. An)				16% 6.0 >90%
	Increasing prevalence of long-acting and clinical methods ● Increased proportion of women at SDPs who have heard of female sterilization ● Increased proportion of clinics with basic equipment (ie. sterilizers) ● Increased proportion of FP providers trained in VSC counseling	2.3%	57% 55% 11% (1992 Sit. An)				10% 90% 90%
	Increased CYP ● Reduced unmet need for FP ● Increased demand for FP services	1.8 MIL 20.8% 26.8% (1990 NDHS)	3.6 MIL				5.3 MIL
Target 1.1: Increased Demand for Modern Contraception	Increased proportion of all women of reproductive age knowledgeable of at least one modern method of FP ● Increased use of health talk with FP at SDPs ● Increased proportion of new users with FP method preference	43.5%	31% 55% (1992 Sit. An)				80% 90%
	Increased proportion of men knowledgeable of at least one modern method of family planning						60%
	Increased proportion of all women of reproductive age knowledgeable about family planning and approving of family planning ● Increase proportion of women at SDPs who have heard of FP		90% (1992 Sit. An)		85%		100%
	Increased proportion of all men knowledgeable about family planning and approving of family planning ● Decreased % of couples who have never discussed FP ● Increased proportion of women who discussed FP with husband ● Reduced % of couples where husband disapproves of FP	58.1% 41% 2.6% (1990 NDHS)					
	Increased proportion of all currently married women wishing to space or limit their number of children ● Increased proportion of providers recommending methods for spacing ● Increased proportion of providers recommending methods for limiting	48%	47% 54% (1992 Sit. An)				70%
Target 1.2: Increased Availability of Modern Contraception	Increased proportion of all women of reproductive age knowing a source of modern contraception ● Increase proportion of women attending clinic who know FP is available ● Reduced median time to source for FP users	33.2%  30.4 min (1990 NDHS)	77% (1992 Sit. An)				80% >98%

	<p>Increased volume of imported contraceptives</p> <p>Increased number of service sites in public and private sector providing the full range of long-acting and clinical methods</p> <ul style="list-style-type: none"> <li>Reduced proportion of SDPs with no clients</li> <li>Reduced proportion of clients bypassing nearest SDP for services</li> <li>Increased proportion of SDPs offering services 6 or more days/week</li> <li>Reduced proportion of SDPs opening late</li> </ul>	<p>Condoms = 17 MIL Pills = 2 MIL IUDs = 85,000</p> <p>All Private SDPs = 36,771 All Public SDPs = 5,323 (LGA = 4,439; State = 669; Federal = 216)</p>	<p>33 MIL 4 MIL 130,600</p> <p>1,785</p> <p>0% 41% 3% 31% (1992 Sit. An)</p>			<p>46 MIL 10 MIL 650,000</p> <p>&lt;1% 10% 80% &lt;5%</p>
<p><b>Target 1.3: Enhance Quality of Family Planning Services</b></p>	<p>Increased client continuation rates</p> <ul style="list-style-type: none"> <li>Reduced proportion of clients stopping or switching</li> <li>Increased proportion of clinics with privacy</li> <li>Increased proportion of SDPs that are "clean"</li> <li>Increased proportion of clients who received desired services</li> </ul> <p>Increased number of new clients referred by previous clients</p> <ul style="list-style-type: none"> <li>Increased proportion of clients who heard of services from friends and family</li> <li>Increased proportion of clients given IEC materials to take home</li> <li>Increased proportion of FP providers explaining procedures to clients</li> <li>Reduced proportion of client who say they wait too long for services</li> <li>Decreased proportion of clients who wanted another method</li> </ul> <p>Decreased numbers of complications resulting from previously received services</p> <ul style="list-style-type: none"> <li>Reduced proportion of clients at SDPs with complications</li> <li>Reduced proportion of clients with complications due to IUD</li> <li>Increased proportion of providers trained to provide F.P. at SDPs</li> <li>Increased proportion of client given information about problems</li> </ul>	<p>70% after 1 month 30% after 1 year</p> <p>242,283</p>	<p>7% 62% 65% 88% (1992 Sit. An)</p> <p>222,342 20%</p> <p>12% 68% 5% 23% (1992 Sit. An)</p> <p>10% 62% 91% 62% (1992 Sit. An)</p>			<p>&lt;1% 95% 100%</p> <p>60%</p> <p>&lt;2% &lt;5%</p>
<p><b>Strategic Objective 2: Improved Maternal and Child Health Practices</b></p>	<p>Decreased infant mortality</p> <ul style="list-style-type: none"> <li>Reduced number of children even born to teenagers</li> <li>Reduced numbers of small and very small infants</li> <li>Reduced neonatal mortality rate</li> </ul> <p>Decreased child (1-4) mortality</p> <ul style="list-style-type: none"> <li>Increased proportion of children with signs of ARI taken to health facility</li> <li>Reduced prevalence of diarrhea in 2 weeks before survey</li> </ul> <p>Decreased rate of severe malnutrition</p> <ul style="list-style-type: none"> <li>Reduced percentage of children 1-59 mos who are stunted</li> </ul> <p>Decreased rate of high risk births</p> <ul style="list-style-type: none"> <li>Reduced % of births to high risk women</li> </ul> <p>Decreased rate of maternal mortality</p> <ul style="list-style-type: none"> <li>Urban maternal mortality</li> <li>Rural maternal mortality</li> </ul>	<p>90/1000</p> <p>0.3 16.2% (1990 NDHS) 45/1000 (UNICEF, 1990)</p> <p>204/100 (1960 World Bank) 115/1000 (1990 NDHS) 34.6%</p> <p>17.9% (1990 NDHS)</p> <p>9.1% 43.5% (1990 NDHS)</p> <p>79% 38.6% (1990 NDHS)</p> <p>15/1000 6/1000 18/1000 (UNICEF, 1990)</p>	<p>87/1000</p>			<p>75/1000</p> <p>90/1000</p> <p>5%</p> <p>60%</p> <p>10/1000</p>
<p><b>Target 2.1: Improved Immunization Practices and Coverage</b></p>	<p>8 of 10 critical EPI elements performed correctly</p> <p>80% of children &lt;1 have received scheduled DPT1, OPV and measles vaccinations</p> <ul style="list-style-type: none"> <li>Increased proportion of FP clients counseled about immunizations</li> </ul>	<p>14.1% (1990 NDHS)</p>	<p>5% (1992 Sit. An)</p>			<p>80%</p>

	<p>Measles morbidity reduced</p> <p>Polio incidence reduced</p> <p>75% of women delivering have received protective levels of TT in last 12 months</p> <ul style="list-style-type: none"> <li>Increased proportion of women with TT 2 or more at delivery</li> <li>Tetanus morbidity</li> </ul>	<p>155.1/100,000 (UNICEF, 1981-86)</p> <p>40/100,000 (UNICEF, 1981-86)</p> <p>40.9% (1990 NDHS) 2.9/100,000 (UNICEF, 1981-86)</p>					<p>1/1000</p> <p>75%</p>
<p>Target 2.2: Improved Case Management of ARI, Fever (Malaria) and Diarrhea</p>	<p>Increased correct home case management of fever by child caretakers</p> <ul style="list-style-type: none"> <li>Malaria under 1 mortality</li> <li>Malaria under 5 mortality</li> </ul> <p>Increased correct home case management of diarrhea by child caretakers</p> <ul style="list-style-type: none"> <li>Increased proportion of mothers who know about ORS</li> <li>Increased proportion of mothers who used ORS for child's diarrhea</li> <li>Est. proportion of population with access to ORS</li> </ul> <p>80% of children &lt;5 seen at health facilities with ARI, fever(malaria) and diarrhea received care meeting standards re: clinical assessment, treatment and counseling by year 2000</p> <ul style="list-style-type: none"> <li>Increased proportion of children with fever taken to health facility</li> <li>% within four kilometers of health services (urban/rural)</li> <li>Est. number of cases of diarrhea among children &lt;5 yr</li> <li>Est. diarrhea mortality among children &lt;5 yrs</li> </ul>	<p>60%</p> <p>12.5% 7% (UNICEF, 1990)</p> <p>30%</p> <p>14.4% 12% (1990 NDHS) 25-30% (FMOH, 1991)</p> <p>30% (1990 NDHS) 75%/30% (UNICEF, 1990) 83.2 million 4/1000 episodes(FMOH, 1989)</p>					<p>80%</p> <p>80%</p> <p>80%</p>
<p>Target 2.3: Improved Child Nutrition Practices</p>	<p>Infants 0-4 mos. exclusively breast-fed increased from 1% to 10%.</p> <ul style="list-style-type: none"> <li>Increased proportion of FP clients counseled about breast feeding</li> <li>Increased proportion of women breast feeding on first day</li> <li>% mothers breast feeding children 12-23 mos (urban/rural)</li> </ul> <p>Mothers feeding nutritious food to infants 6-9 months increased from 70% in 1990 to 90% by Yr. 2000.</p> <ul style="list-style-type: none"> <li>Average daily protein intake in grams</li> </ul> <p>Vitamin A and Iodine deficiency in &lt;5s decreased</p>	<p>1%</p> <p>49.9% (1990 NDHS) 52%/69% (1990 UNICEF)</p> <p>70%</p> <p>43 gms.</p> <p>Vitamin A = N/A Iodine = 39%</p>	<p>1.3%</p> <p>5% (1992 Sit. An)</p>				<p>10%</p> <p>90%</p>
<p>Target 2.4: Improved Maternal Care</p>	<p>Pregnant women with 2 prenatal visits from trained health providers increased from 52% in 1990 to 75% in year 2000.</p> <p>Births attended by trained attendants increased from 30% in 1990 to 50% by year 2000.</p> <ul style="list-style-type: none"> <li>Reduced proportion of births with no one in attendance</li> </ul> <p>Postpartum women informed and offered birth spacing information and services increased from &lt;10% to 25% by year 2000</p> <p>Postpartum women using modern methods of contraception increased from &lt;5% in 1990 to 20% by yr 2000</p>	<p>52%</p> <p>30%</p> <p>67.7% (1990 NDHS)</p> <p>&lt;10%</p> <p>&lt;5%</p>					<p>75%</p> <p>50%</p> <p>25%</p> <p>20%</p>

<p><b>Cross Cutting Target: Improved Planning and Management of Public and Private Health Systems</b></p>	<p>Public Sector personnel at the Federal, State and LGA level will routinely: develop workplans and budgets, monitor the collection and analysis of project specific data, design implement and assess IEC programs and strategies; use OR to address relevant MCH/FP program and policy issues; implement and monitor effective logistics systems; ensure sufficient numbers of staff are trained; collect analyze and disseminate epidemiological and program data related to AID supported interventions.</p> <ul style="list-style-type: none"> <li>● Increase proportion of SDPs with service statistics</li> <li>● % FP facilities reporting/month</li> <li>● Increased proportion of SDPs with client records in "good condition"</li> </ul> <p>Private sector personnel will routinely offer clients MCH/FP services the comply with practice standards; provide data to the FMOH on client acceptance of MCH/FP services</p>		<p>84% (1992 Sit.An) 11.8% (NPHCDAM&amp;E) 85% (1992 Sit. An.)</p>				
<p><b>Target of Opportunity: Improved HIV/AIDS/STD Prevention and Control Practices</b></p>	<p>Increased availability of condoms</p> <p>Improved knowledge, attitudes and behavior concerning HIV transmission</p> <p>Increased identification and treatment of HIV, AIDS and STDs.</p>						

## FHS PROJECTS TARGETS AND ACHIEVEMENTS

ANNEX I  
TABLE 2/1

	<i>MAJOR FHS I TARGETS</i>	<i>FHS ACHIEVEMENTS</i>
1.	<p>A national contraceptive prevalence rate of approximately 12%</p>	<p>The 1992 FOS contraceptive prevalence survey indicates a total CPR of 14.6% with 7.8% of this attributed to modern method use.</p>
	<p>80% of the population aged 15-49 will have a knowledge of family planning concepts. Attitudinal changes favoring smaller family norms. IEC activities/materials developed to support private and public family planning services. National, state and LGA level action programs developed for private and public sector.</p>	<p><u>General:</u> The 1992 FOS contraceptive prevalence survey indicates that 77% of the population of reproductive age is aware of family planning as a concept. The RMS 1992 Nigerbus data indicates that of respondents who know about family planning, over three quarters approve of it.</p> <p><u>Specific:</u> Two national multimedia campaigns implemented in collaboration with PPFN and the FMOH. Over 6,000,000 motivational and information materials produced and distributed to more than 30,000 public and private sector health facilities and outlets. Multimedia campaigns executed or ongoing in 15 states Produced over 1,000 television, radio, newspaper/magazine advertisements, feature programs and live dramas. Standard curricula developed and used for training in counseling; FLE; materials development and formative research. Training video produced to complement counseling training. 1,200 press kits for journalists produced and ready for distribution. Public relations and other activities with journalists supported. Over 30 workshops for journalists, traditional and religious leaders and other special target groups executed. Audiovisual equipment provided to over 30 institutions.</p>

2.	<p>Family Planning information, services and/or commodities provided through approximately 2,000 private sector outlets. 70% of contraceptive users served through the private sector. Distribution network established to provide private interests with commodities. Private sector trained in providing family planning information, services and/or commodities.</p>	<p><u>General</u> Over 6,600 private sector health facilities and outlets have been provided commodities and training for personnel</p> <p><u>Specific</u> More than 4,500 distributors and trading companies are selling family planning commodities. Nearly 30 trainers equipped to train private sector providers. 2,250 nurses from private sector trained in clinical services including IUCD insertion. 4,395 pharmacy personnel trained in family planning methods and counseling. Over 1,400 vendors trained to provide family planning counseling and services. Advertising campaign executed for Right Time Condom. OCs advertised through trade journals.</p>
3.	<p>Family planning and health-related information and services provided through at least 3,600 public service delivery points. 30% of contraceptive users served through the public sector. Clinical service delivery points equipped. Public sector health personnel trained to provide improved information, services and program management. Management systems for family planning programs developed and/or improved.</p>	<p><u>General:</u> Over 3,000 public sector staff trained in service delivery and 500 facilities equipped for family planning services including IUCD insertion.</p> <p><u>Specific:</u> Standards of Practice for family planning developed and distributed in collaboration with Federal Ministry of Health. Standard family planning curricula developed, pretested, and finalized for pre-service training in Schools of Midwifery and Schools of Health Technology. Curriculum development underway for Schools of Nursing and Medical Schools. Standard curricula developed for CSPs, CHEWs, VHWs and physicians. National MIS system for family planning developed and operational under primary health care system. Training provided in public sector for 1,623 midwives; 84 physicians; 1,415 CHEWs; 1,062 VHWs. Refresher training provided for 219 midwives and 50 physicians. Management, supervisory, MIS, organizational development and commodities management training provided for over 1,500 public sector employees.</p>

4.	<p>A capability for policy implementation and strategic planning for the national family planning effort.</p> <p>National, state and LGA family planing program policies, strategies and action plans established.</p> <p>Positive support from influential and constituency groups and NGOs for family planning expansion.</p> <p>Establishment of processes for evaluation policy and program acceptability.</p>	<p><u>General:</u></p> <p>Over strategic planning and constituency building workshops executed with government officials, religious and traditional leaders and non-governmental organizations.</p> <p>Numerous studies undertaken to assess cost recovery, leadership opinion and contraceptive requirement trends.</p> <p><u>Specific:</u></p> <p>Further Analysis Group convened and supported to produce and publish Policy Analysis of the Nigeria Demographic and Health Survey.</p> <p>Over 1,300 representatives of government, non-governmental, and religious and traditional groups oriented on family planning and the population policy.</p> <p>Strategic planning workshops conducted in ten states; Fact Finding missions conducted in eight states.</p> <p>Publications of "Pop Talk" and "Family Health" developed and distributed to over 5,000 constituency groups and opinion leaders.</p> <p>Population policy translated and printed in three vernacular languages.</p> <p>Public sector cost recovery survey conducted.</p>
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## Nigeria ASCI-CCCD Achievements 1992-93

Major Interventions/Strategies	Achievements in the Last Year
<p><b>Expanded Program on Immunizations (EPI)</b></p>	<ul style="list-style-type: none"> <li>• Sponsored LID activities in key focus LGAs (ie. Ojo)</li> <li>• Sponsored local theater drama to facilitate campaigns in eight LGAs</li> <li>• Technical assistance to FMOH in administrative re-organization of EPI program.</li> <li>• Technical assistance to EPI teams in focus local governments to develop cold chain management strategies.</li> <li>• Inventory of EPI supplies and cold chain equipment in focus LGAs</li> <li>• Procurement of EPI and Cold Chain equipment for focus LGAs</li> <li>• Coordination of EPI program activities with UNICEF</li> <li>• Collaborated with WHO on investigations of Measles epidemics in Plateau state.</li> <li>• Conducted training in cold chain maintenance for LGA workers</li> <li>• Supported preliminary work on urban EPI strategy for 11 LGAs in Lagos State</li> <li>• Study of EPI coverage (including TT) in Barkin Ladi LGA.</li> <li>• KAP study of mothers and EPI in Plateau state.</li> <li>• EPI managers/supervisors training in Plateau and Enugu states.</li> <li>• EPI technical/management skills training for PHC workers in Niger, Plateau and Enugu States.</li> <li>• Developed protocol for "Missed Opportunities" Study in Kaura Namoda LGA</li> </ul>
<p><b>Control of Diarrheal Diseases (CDD)</b></p>	<ul style="list-style-type: none"> <li>• Established ORT corners in health facilities in focus states and LGAs</li> <li>• Established ORT demonstration and training units in Osun and Kaduna States.</li> <li>• In-service training and supervision of ORT clinical trainers in Niger State</li> <li>• Collaborated with WHO in CDD program managers training course.</li> <li>• Finance and logistics support for distribution of 300,000 sachets of ORS for use in northern Nigeria.</li> <li>• Study of diarrheal incidence and mothers knowledge of SSS in Plateau State.</li> <li>• CDD Management/supervisory skills training for LGA managers in Plateau, Enugu and Niger States</li> </ul>

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<p><b>Malaria/Fever</b></p>	<ul style="list-style-type: none"> <li>• Malaria and vector control training of patent medicine vendors in Enugu, Lagos, Osun and Oyo States.</li> <li>• Technical case management training for facility health workers through state CE programs.</li> <li>• Supported impregnated bednets and curtain research study in Nsukka LGA.</li> <li>• Equipped research study site in Enugu State.</li> <li>• Technical assistance to local research team in malaria control.</li> <li>• Provided technical assistance to update national Malaria control guidelines.</li> <li>• Logistics review and drug quality studies in Plateau state.</li> <li>• KAP study of treatment and referral practices among mothers of young children.</li> <li>• Participated in National Malaria technical meeting in Port Harcourt.</li> </ul>
<p><b>Training/Continuing Education</b></p>	<ul style="list-style-type: none"> <li>• Trained community health workers on used of home-based records and clinic master cards.</li> <li>• Local dissemination of facility assessment survey findings in Sokoto, Niger and Kebbi States.</li> <li>• Technical assistance for incorporation of CE program into CHAN network. (CHAN provides 40% of health care services in Nigeria)</li> <li>• Developed proposal for TOT training of CEU tutors from Nigeri, Palteau, Enugu and Lagos States.</li> <li>• Routine CE training for LGA managers and health workers in focus states and LGAs.</li> <li>• Supported model community CE committee in Niger State.</li> <li>• Collaborated with PCV on review of CEU coordination activities.</li> <li>• Supported HIV/AIDS surveilland workshop in May 1993.</li> <li>• Sponsored four Nigerian officials at CDC International HIV/AIDS surveillance course in U.S.</li> <li>• Conducted orientation training for staff of Lagos State School of Health Technology</li> <li>• Training for model LGA based CE program in Ojo LGA.</li> <li>• Collaborated with Project REACH in EPI/TOT workshop ;anning.</li> <li>• Supported publication of CEU bulletins in focus states.</li> <li>• Field tested patient education training materials for LGA managers and facility health workers.</li> <li>• Established CEUs in Kebbi and Oyo States</li> </ul>
<p><b>Health Education</b></p>	<ul style="list-style-type: none"> <li>• Equipped Niger and Plateau State Health Education Units</li> <li>• Collaborated with FMOH on study of "Effective Health Education Interventions in Nigeria"</li> <li>• Supported development of Modificable Risk Fastor Tracing Systems (MRFTS) by African Regional Health Education Centre (ARHEC)</li> <li>• Supported mobilization of LGA community development committee in Egbeda LGA</li> <li>• Conducted 40-cluster community survey in Barkin-Ladi LGA, Plateau State to focus on immunization coverage, diarrhea and fever treatment practices, breastfeeding and weaning practices, and nutrition.</li> </ul>

<b>Operations Research</b>	<ul style="list-style-type: none"> <li>• Explored OR reseach potential for case management of sick children at ABU Hospital in Zaria</li> <li>• Developed algorithm and wall chart on Management of the Sick Child.</li> <li>• Provided computer equipment and support for FMOH OR secretariate .</li> <li>• Supported quarterly OR secretariate meeting to review 14 proposals resulting in approval of nine studies.</li> </ul>
<b>Institutional Development</b>	<ul style="list-style-type: none"> <li>• Established new CCCD field offices in Plateau and Niger State</li> <li>• Conducted National Sustainability Assessment</li> </ul>
<b>Health Information Systems/Management Information Systems</b>	<ul style="list-style-type: none"> <li>• Maintained NICARE system. Continued support for development of local MIS competence in use of NICARE data.</li> <li>• Published National Nigerian Bulletin of Epidemiology (Vol. 2, No. 3)</li> <li>• Published special edition of quarterly "Health Watch" Bulletin to issue alert about Lassa Fever Outbreak and control guideleines.</li> <li>• Established editorial board for Niger State "Health Scope", a joint quarterly HIS/Continuing Education newsletter , Lagos State "Bulletin of PHC and Disease Control" and Plateau State Bulletin</li> <li>• Provided computer equipment for CHAN, Jos with training for staff in use of EPID and NICARE</li> <li>• Provided computer equipment and staff training for FMOH Epidemiology division for monitoring vaccine supply and distribution at National Cold Store (Oshodi)</li> <li>• Provided computer software update for Commodities Logistics Management unit.</li> <li>• Support for Lagos State HIS coordinating committee</li> <li>• Technical assistance for computerization of Hospital records at Lagos Mainland Hospital and Minna General Hospital, Niger State (includes production of reports)</li> <li>• Published disease notification data for key LGAs and States.</li> <li>• Technical assistance to Federal Ministry of Health, Dept. of Planning, Research and Statistics for analysis of notifyable disease reports.</li> <li>• Field tested supervisory check list for Montoring and Evaluation activities in Primary Health Care.</li> <li>• Conducted quarterly HIS workshop at Kaduna field office for State and LGA based HIS staff on use of EPID and NICARE.</li> <li>• Technical and financial assistance to FMOH for training of State and LGA workers for PHC Monitoring and Evaluation.</li> <li>• Established computer training centers at Sokoto SMOH and Othman-Danfodio University Teaching Hospitals.</li> <li>• Participated in PHC Sentinal Surveillance Training Workshops for Zones C &amp; D.</li> </ul>