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**NIGERIA  
COUNTRY PROGRAM  
STRATEGIC PLAN  
(CPSP)  
1993 - 2000**

**A.I.D. AFFAIRS OFFICE  
LAGOS, NIGERIA  
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**NIGERIA  
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STRATEGIC PLAN  
(CPSP)**

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## PREFACE

Over the past ten years, Nigerians and Americans have worked closely together in tackling a broad spectrum of priority public health issues. Results have been quite positive. Despite severe political and economic troubles over the period, basic health and family planning services reached ever larger portions of the Nigerian public, public health skills have been sharpened, and the intent of the U.S. Congress in establishing the Development Fund for Africa is being well met. Further large-scale collaboration in this sector is anticipated over the next ten years.

Nigerians from many occupations and regions of the country provided data, observations, and most of the judgements underpinning this paper. Strong leadership in the Federal Government of Nigeria's Ministry of Health has guided the collaboration and has established policies to which Americans are strongly committed.

The Nigeria Country Program Strategic Plan results from a concerted conceptual process underway since mid-1991. The CPSP consolidates lessons learned and provides the central analytic background for new A.I.D. projects to be designed for Nigeria in the next several years. It builds, especially, on these sources:

"Nigeria Health and Population Sector Assessment", November 1991;

Project Identification Document, "Nigeria Family Health Services II - Population Project", March, 1992;

Project Identification Document, "Nigeria Combatting Childhood Communicable Diseases Project", March 1992;

AIDSCAP Nigeria Country Plan "Nigeria AIDS Prevention and Control Project", June 1992; and

a wide variety of documentation treating specific technical concerns.

These products reflect combined efforts of the Bureau for Africa (AFR/CCWA & AFR/ARTS), Bureau for Research and Development (R&D/Population & R&D/Health), REDSO/WCA, CDC/Atlanta, AAO/Nigeria staff members, and individual consultants. Special acknowledgement is due the FHS and CCCD project staff, whose excellent performance provides the foundation for this Country Program Strategic Plan.

## EXECUTIVE SUMMARY

Nigeria's prospects for sustainable economic growth are good. Broad-based, market-oriented expansion of the economy and increased emphasis on agricultural production have become much more probable given policy reforms taken by the Federal Government of Nigeria (FGN) in recent years. Evidence suggests that renewed growth may be underway in response to the policy reforms. This growth, however, must surpass Nigeria's high rates of population increase, and yield benefits more broadly to its citizens.

Transition next year from military to civilian leadership under highly competitive political parties will challenge the sustainability of Nigeria's economic policy reforms. This democratic transition may reinforce those reforms and foster broad-based growth, or it may stall—even overturn—present policies before their benefits can be realized by the public. The same is true of the Nigerian government's excellent policies regarding health and population, though these policies seem quite popular. Policy reformers are learning how long it takes to establish an effective mix of policies and program interventions to achieve sustainable economic growth and social development. Nigeria is no exception, but more than for any other country, its success or failure in reforms will reverberate throughout the Africa region.

Living conditions over the past five to ten years in Nigeria for most people have declined. A growing underclass of poor is emerging whose needs and potential contributions have not yet been adequately recognized by the Nigerian elite in allocating public resources. Fairly simple ameliorative systems, like those for primary health care proposed in this strategic plan, can help maintain or stimulate a more active, economically viable labor force and lessen adverse impacts of extensive reform.

After closing in the early 1970s, U. S. development assistance in Nigeria resumed in the mid-1980s in an effort to help Nigerians address growing, basic human needs. Preventive health and family planning was selected as a clearly demarcated development arena in which A.I.D. possessed excellent capabilities, and an arena in which Nigerians were forging policy advances. The decision was a good one. Today, this assistance is beginning to make a difference to millions of Nigerians as levels of childhood immunization, family planning, and a few other health measures are extending to ever larger proportions of the nation. A.I.D. activities in this sector are reflecting well on the U. S.

The AAO/Nigeria is overseeing the close-out of about \$120 million in projects that began in the mid-1980s. Design has begun on three successor projects which would obligate about \$135 million from the Development Fund for Africa (DFA) over the next seven years or so. Annual OYB levels should increase slightly from recent levels of \$11-15 million of DFA funds per year to about \$18-23 million.

All funding will continue to be concentrated on helping Nigerians meet their policy objectives in lowering high fertility, improving reproductive health and reducing infant/child and maternal death rates and morbidities. Geographic coverage will be expanded. New accent will be placed on improving the quality of services. There will be more Nigerian leadership in implementing the program.

The DFA will provide the primary source of funding to carry out the strategy, though about \$30 million may come from other accounts over the period. Because of close collaboration with the Bureau for Research and Development, and the presence of many very capable Nigerians, the AAO/Nigeria will be able to maintain one of the smallest U.S. direct hire personnel profiles in the region.

To assure continued good management of a sizable portfolio with few A.I.D. officers, thorough assessments are underway, to prepare a clear organizational structure for the A.I.D. Affairs Office and for the projects it administers. These studies and recommendations will be reflected in the Project Papers (PPs) to be completed within the next nine months.

This Country Program Strategic Plan (CPSP) follows from the April 1992 decision to raise the level of Bureau for Africa commitment to Nigeria to its highest priority, FOCUS level. The Plan and its approval serves to provide most of the sectoral assessment and analytic background for the projects to be developed, freeing those exercises to focus on implementation plans. Finally, and most importantly, this plan serves the originally intended purpose of a CPSP under the DFA: striking a "contract" between the AAO and AID/W, with a clear framework for AAO/Nigeria appraisal of progress towards agreed upon objectives and AID/W oversight of budget.

Illustrative Long Range Plan by Appropriation Account (\$ Millions)								
<u>Account</u>	1993	1994	1995	1996	1997	1998	1999	Total
DFA	18.0	18.0	20.0	23.0	21.0	20.0	15.0	135.0
Population	2.6	2.5	2.5	2.5	2.5	2.5	3.0	18.1
AIDS	1.0	1.5	1.5	1.5	1.5	1.0	1.0	9.0
Health	0.5	0.6	0.6	0.7	0.8	0.9	1.0	5.1
<u>Total</u>	22.1	22.6	24.6	27.7	25.8	24.4	20.0	167.2
<i>By Special Interest Codes, this portfolio would be about 60% Population and 40% Health/AIDS</i>								

## I AN OVERVIEW OF THE ENVIRONMENT FOR SUSTAINABLE, BROAD-BASED, AND MARKET-ORIENTED ECONOMIC GROWTH

### A. General

Nigeria is the most populous country in sub-Saharan Africa, with probably just under 100 million people in late 1992 and, among all the countries of the continent, ranks fourteenth in territorial size. The country extends from the Gulf\* of Guinea in the South to the Southern fringes of the Sahara Desert in the North, and borders Benin to the West, Chad and Niger to the North, and Cameroon to the East. Its land area of 356,669 square miles equals Texas, Louisiana, and Mississippi combined. Its regions range from tropical rain forest to savannas to semiarid and desert Sahelian.

Independent of Britain since 1960, Nigeria as a modern political entity encompasses a wide variety of cultures, historical backgrounds, and religions. More than most other nations, the peoples of Nigeria are engaged in varied economic activities and distinctive life styles. Nigerians play dominant roles in political, economic and military events throughout the coastal, central and Sahelian regions of Africa.

### B. The National Economy

Nigeria's dynamic, enterprising population and unusual endowments of arable land, minerals, petroleum and natural gas give it high potential for diversified economic development. For twenty years, Nigeria has been one of the world's major oil producers. Reserves of oil and gas will provide large export earnings for decades into the future. In 1990 industry and manufacturing accounted for almost forty percent of total Gross Domestic Product—of which about thirteen percent came from oil and seven percent from manufacturing. Agricultural production (mainly yams, cassava, cocoa, oil palm, rubber, groundnuts, livestock, cereals and cotton) accounted for about thirty-five percent of GDP, which has been rising in recent years, and employed probably sixty percent of the labor force. Services account for about twenty-five percent of GDP, dominated by wholesale and retail trade.

Table 1: Structure of Production/GDP

(WB:WDR)	<u>1965</u>	<u>1987</u>	<u>1990</u>
TOTAL (\$m)	5,380	24,390	34,760
Agric. (% tot)	55	30	36
Industry (%)	12	43	38
(Manuf)	( 5)	( 8)	( 7)
(Oil)	( 2)	(22)	(13)
Services (%)	33	27	25

Rapid expansion in extraction and sale of petroleum during the 1970s profoundly changed Nigeria's economy and the evolution of its institutions and prevailing value systems. Agriculture shifted from net food exporting towards heavy reliance on food imports (e.g., \$500 million in 1985). Major rural to urban migration added to serious declines in agricultural production. At the outset, oil receipts financed extensive public investments intended to heal

national wounds caused by the 1967-1969 civil war, fought to prevent the secession of Biafra. Large capital development projects were undertaken, some without adequate attention to the economic viability or capacities of public agencies to implement them. Chronic political instability, including alternating civilian and military regimes compounded poor economic policies.

With rapid decline of international oil prices in the early 1980s, oil revenues fell from a high of twenty-five billion dollars in 1980 to six billion in 1986. Account deficits increased along with internal debts as spending on large public works and imports continued. The current account deficit reached six percent of GDP by 1983 and the fiscal deficit twice that amount. These deficits were financed by public sector borrowing, rundown of international reserves, and large-scale accumulation of arrears on external trade payments. Importation of nonessential consumer goods decreased foreign exchange reserves. Approximately seventy percent of the country's accumulated foreign reserves were depleted in 1981 alone. Per capita incomes and real wages declined dramatically.

Fiscal austerity in 1984 imposed across-the-board budgetary cuts and administrative controls over imports. Fiscal and external deficits decreased, but the blunt austerity measures exacted considerable economic toll. Reduced supplies of raw materials and spare parts to the import-dependent industrial sector led to widespread plant closures, a substantial drop in capacity utilization, and extensive lay-offs of the work force. Nigerians have endured high unemployment and recession ever since.

In July 1986, in the first year of the new Federal Military Government (FMG) under Major General I.B. Babangida, Nigeria launched an indigenous structural adjustment program (SAP) with the goals of medium- to long-term institutional fiscal and monetary stabilization, and reduction and redirection of state economic intervention seeking greater efficiency by reliance on market allocation of resources. Its main features included: (a) massive devaluation of the Naira through market determined exchange rates; (b) abolition of commodity boards and price controls; (d) privatization of many public enterprises; (e) deregulation of financial and investment regimes; and (f) liberalizing import licenses and rules for foreign investment.

Accomplishments and shortcomings of Nigerian SAP efforts on the whole present a positive, if mixed, picture. The economic policy situation has improved markedly. Though external debt is still increasing (\$20 billion in 1985; \$33.5 billion in early

**Table 2: The Economy Under SAP**

[from CBN]	<u>1981-86</u>	<u>1987-91</u>
GDP Growth (% p.a.)	0.2	5.7
Investment (% GDP)	12.0	6.0
Inflation (% p.a.)	17.0	24.0
Exports/GDP (%)	14.3	18.0
Imports/GDP (%)	11.8	3.8
Budget Deficit (% GDP)	5.3	3.7

1992), debts now have much more manageable interest rates and schedules. Balance of payments improved greatly. Foreign debt at the end of 1991 was roughly equivalent to 100% of the value of gross domestic production. The country repaid \$3.8 billion and \$3.6 billion in scheduled debt in 1990 and 1991, respectively. In 1991 and 1992, Nigeria benefitted from London and Paris Club debt rescheduling and debt forgiveness on the part of the United States (\$86 million) and several European countries. The 1990 balance of payments showed a surplus of \$1.5 billion (tenfold its 1989 balance surplus), due to higher exports during the Gulf Crisis.

As of April 1992, scheduled debt service for 1992 was estimated at \$5.525 billion (seven percent of GDP), but the FMG had only budgeted \$2.279 billion of external debt service—representing thirty percent of the government's projected foreign exchange receipts of \$7.525 billion. Still, these levels of debt payment—combined with commitments to large capital-intensive projects and high present costs associated with creation of new states and the new national capital—leaves the FMG with little money to invest, elsewhere, such as employment-generating productive sectors, and/or education and health.

Government's role in the economy has diminished. By 1988, import bans had been reduced from seventy-four to fifteen items. Numerous public subsidies had been reduced, though petroleum prices on the domestic market are still greatly subsidized, as are fertilizer and seeds. Fifty-four of 110 federal public enterprises had been sold by 1990. The private sector is playing a larger role in the economy. Financial system deregulation promises greater market orientation and more efficient allocation of capital. Ceilings were set on bank credits to increase liquidity; interest rates were about thirty percent in 1990, twenty-one percent in early 1991 and, in late July 1991, had risen again to over thirty percent. Real growth in GDP from 1987 through 1990 averaged an impressive 7.0% per year compared with 0.2%, 1981-1986 (1991 growth was only 4.3%).

The performance of manufacturing and agriculture has not been as vigorous as hoped, but has shown some positive developments. Demand for manufactured goods remains low, leading to large unsold inventories for many consumer products; but major shifts towards import substitution have been fostered and industries with extensive backward linkages to the indigenous economy have expanded (especially textiles, food processing, plastics, rubber products, glass bottles, cement, footwear and breweries). Imports of consumer goods averaged forty percent of total consumption from 1980 to 1985, but declined steadily to only twenty-four percent in 1989, and are expected to be below twenty percent in 1992.

Although limited, available data on agriculture suggest some recovery of production since the SAP. Cash crop exports seem to have improved significantly, but are a small part of overall production. There is little or no evidence of per capita improvement in food crops for domestic consumption. Overall GDP

growth rates in agriculture are estimated to be 2.6% for the 1982-1985 period and 6.0% for 1986-1990; for export crops it was 2.7% and 10.1%, respectively; for food crops it was 2.5% and 1.2%, respectively. Continuing bans on grain imports stimulate internal demand for national production, and also widespread smuggling.

The SAP reforms also probably have reduced the scope of "rent seeking"<sup>1</sup> activity in Nigeria. Though rent seeking is still widespread (and new methods of international fraud have emerged), the adoption of market-based systems for allocation of foreign exchange and imports, and further limitations on extra budgetary expenditures, now constrain the scope for corruption. Rent taking by some individuals may have reached new heights, but the number of persons involved probably has decreased, lessening aggregate effects. The World Bank representative who most influenced the content of the SAP reforms recently said,

*The present size of the rents will, at best, amount to \$2 billion annually or 6% of GDP. This amount pales into insignificance if we estimate that the rents from the import licensing system alone were of the order of \$10 to \$20 billion or 30% of GDP in the pre-adjustment period.<sup>2</sup>*

Nigeria's SAP reforms over the past six years have achieved major improvements in the economic policy environment, changes that bring the country much more closely into alignment with free market values central to policies of A.I.D. and international agencies (e.g., International Monetary Fund, World Bank, and other lenders and donors). However, actual performance of the economy under the SAP reveals several potentially critical shortcomings: (a) low levels of long-term investment and failure to attract external financing; (b) high inflation; (c) continued extreme dependency on oil exports; and (d) deepening impoverishment of the masses, especially the growing proportion at the lowest income levels.

Investment as a percent of GDP is estimated to have fallen from twelve percent (1981-1986) to six percent or below (1987-1991). Domestic investment seems mostly to have been in the areas of banking, finance, mergers and acquisitions, i.e., mostly short-term and not directly productive. Foreign investment has been limited and quite disappointing to Nigerian leaders. World Bank and other advisors to the FGN probably underestimated how much time would be required for reforms to take hold and stimulate long-term investments in the productive sectors. Also, Nigeria still is perceived to be a high risk environment, a judgement exacerbated in recent years by widely publicized fraud and scam activities by a few Nigerians.

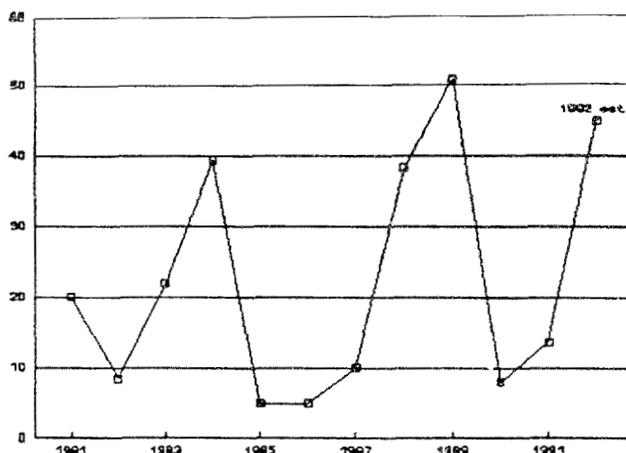
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<sup>1</sup> "Rent seeking" is a term applied in Nigeria (and elsewhere) to the practice of officials taking bribes in exchange for the receipt of import licenses and foreign exchange necessary to engage in business.

<sup>2</sup> Ishrat Husain, quoted by Thomas Biersteker, July, 1992.

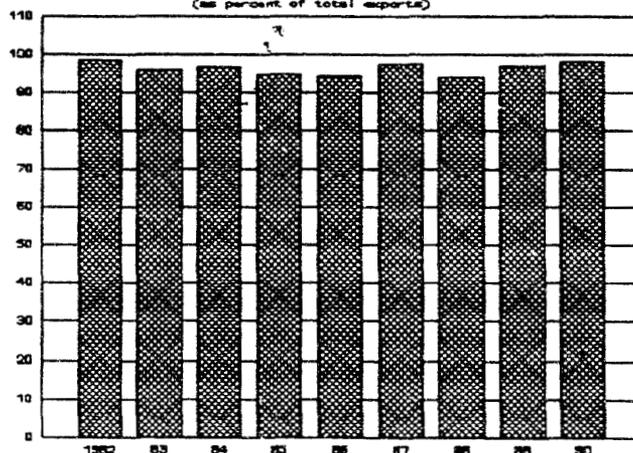
Inflation rates varied widely over the past decade, but averaged seventeen percent during 1981-1986 compared to over twenty-five percent since 1986 (the low level in 1990 can be accounted for, mostly, by the windfall of foreign exchange revenues from the Iraqi invasion of Kuwait). When all foreign exchange price controls were lifted in March, 1992, new inflationary forces were unleashed; Nigerian traders of virtually all goods swiftly raised their prices. The FMG did, however, effect dramatic savings since the spread between official and "parallel" market rates essentially represented a subsidy to the banking system. Inflation may average forty-five percent in 1992.

Figure 1: Average Annual Inflation (%)



The SAP was intended to reduce heavy national dependency on oil through renewed emphasis on other outputs, but there has been no progress on this front. Nigeria's near-term economic recovery heavily depends on international oil prices. Over ninety percent of the country's export income and over eighty percent of government revenues derive from oil sales. The U.S. purchases almost one half of Nigeria's oil exports, and Nigeria is now the third largest supplier of oil to the U.S.—a pattern that could continue for decades as transport of Nigeria's vast reserves of natural gas becomes more feasible.

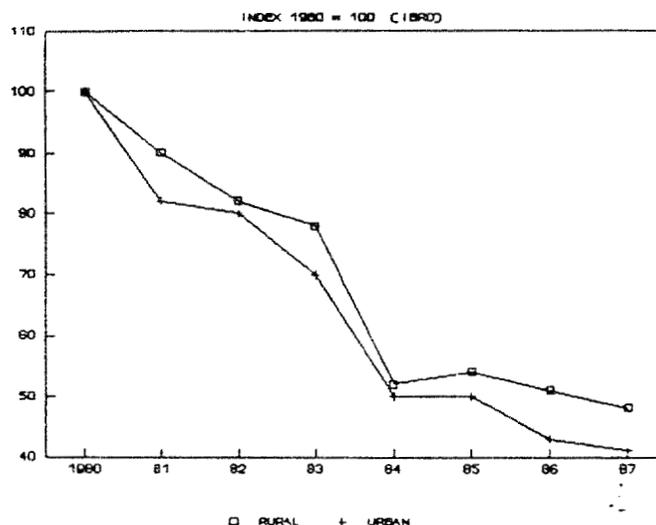
Figure 2: Dependence on Oil Exports (as percent of total exports)



Over the decade of the 1980s, declining world petroleum prices, mostly stagnant agriculture and manufacturing revenues, and rapid population growth were some of the factors that changed Nigerian perspectives painfully from those of an aspiring middle income country in the late 1970s to those of a low income country by the late 1980s. Adverse impacts have been felt more adversely in urban areas, which comprise about thirty-five percent of the population, than in the rural areas, but ordinary wage earners and the poor in the cities and countryside alike have suffered increasingly over

the past decade, despite reforms which really should by now have been improving incomes. Indeed, the cumulative impact of economic conditions and patterns of highly skewed resource distribution in Nigeria over the past decade suggest that serious problems lie ahead—both in terms of human suffering and its likely political fall-out. Most Nigerians are frankly hostile towards the SAP program. It is not widely understood, and is seen by most of the public as devised and imposed by foreigners.

Figure 3: Decline In Real Wages



Nevertheless, in his January, 1992 policy speech, the President of Nigeria emphasized continuing SAP reforms and these economic policy priorities: (a) further public spending decreases; (b) improvement of the exchange rate; (c) emphasis on privatization efforts; (d) less government involvement in economic and commercial affairs; (e) improved financial management in all ministries; and, (f) reduction of the number of ministries from twenty-seven to sixteen. By September, 1992 exchange rates were entirely market-based, and there were only sixteen ministries. Judgement about progress on the other priorities is premature. The President's address to the National Assembly in July, 1992 again explained and strongly reaffirmed that maintaining the SAP must be of highest priority.

In 1991, revenue equal to about one third of GDP passed through the Federal account for distribution through the three tiers of government. The budget share going to each of the states was cut from thirty to twenty-five percent, while the budget allocation for local government authorities (LGAs) was increased from fifteen to twenty percent of the national budget. Both states and LGAs now are expected to finance at least forty percent of their recurrent costs from internally generated revenues.

Federal spending in 1992 is projected at 27.6 billion Naira; fifty-seven percent of this amount is budgeted for recurrent costs and the balance on capital. No more than seventy-five percent of the federal budget will be spent on recurrent costs; personnel costs will not exceed sixty percent of the total recurrent expenditures. GDP growth is estimated at 4.3% (as in 1991, and lower than the 1990 growth of 8.1%).

Most Nigerians worry intensely and with good reason about their country's capacities and future. Indeed, no analysts of Nigeria's development in recent years provide harsher criticism of the country's progress than do Nigerians themselves. Consider President Ibrahim B. Babangida's remarks in 1987 and in 1992:

*"...You will, perhaps, agree that the worst features in the attitude of the Nigerian elite over the last three decades or more have included: factionalism, disruptive competition, extreme greed and selfishness, indolence and abandonment of the pursuit of excellence. Indeed, a companion cult of mediocrity—deep and pervasive—has developed and, with it, a continuous and, so to speak, universal search for excuses to avoid taking difficult decisions and confronting hard work, and a penchant for passing the buck."<sup>3</sup>*

*"...Nigeria remains in every meaningful sense an underdeveloped economy and with a prevailing high degree of structural distortion... It is understandable that this generation of Nigerians is anxious to get rid of underdevelopment and they often behave as if the country is at a par with the advanced industrial economies... The simple lesson of historical experience is that there is no shortcut to progress, whatever contrary claims are made by populist sentiment. The generality of our people must learn that the adjustment program is not simply for the benefit of government, whether military or civilian."<sup>4</sup>*

### C. Transitional Democracy

Nigeria was established as a federation of three regions in 1960 under parliamentary government. A fourth region was established in 1963. These were subdivided into twelve after the first of a series of military coups ended the First Republic in 1966. In 1976, seven new states were created partly to ease transition back to civilian rule. Nigeria's 1979 Constitution established a new federal system closely akin to that in the United States. The Second Republic fell to a military coup shortly after the 1983 elections, with widespread claims of vote rigging, corruption and economic mismanagement. In the past two years twelve new states have been created, now bringing the total number to thirty-one, including the new federal capital, Abuja. The Armed Forces Ruling Council who control the government today have, repeatedly, pledged to hand over all governance to the Third Republic of newly-elected officials in January, 1993.

New states were increased to enhance equitable representation and diminish conflict in the Third Republic of Nigeria. Each state is composed of local government areas (LGAs—equivalent to counties in the U.S.), and many new ones have also been created with the new states. The total now is 593 in mid-1992.

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<sup>3</sup> Address to the Lagos chapter of the Oxford and Cambridge Club in 1987. Cited in Blaine Harden, Africa: Dispatches From A Fragile Continent, Chapter "Big Black Hope," Norton, 1990.

<sup>4</sup> 1992 Budget Speech, January 2nd, 1992.

Very important, during the period of the SAP, the FGN also pursued a vigorous policy of applying precepts of the 1979 Constitution regarding responsibilities of the respective federal political entities. Decentralization of accountability, and devolution of roles definitely has been greatly accelerated over the past few years. Delegation of major responsibilities to the LGA level is intended to reinforce democratic governance by: (a) strengthening the ability of local governments to deliver services; (b) encouraging democratic choice and control; and (c) promoting development of grassroots institutions. Health and education, especially, are state and LGA subjects—not the principal responsibility of the central government.

Over the past three decades, Nigeria's national existence has been tested as severely as any country in Africa—surviving a bloody civil war, highly divisive political upheavals, and several, sometimes bloody, military coups. Nigeria's transition to civilian rule represents a massive experiment in simultaneous political and economic reform. To what extent will the real gains in policy reform since 1986 be preserved under a new democratic, civilian Third Republic? Will democratic forces try to return to a favored past of massive statist interventions with exchange rates, import licenses and central political control? The current military government has consistently promoted the change to a decentralized civilian regime, and has adhered to a planned sequence of events and processes to bring about a genuine and lasting transition.

Despite some apparent abuses of power, like the jailing of vocal human rights advocates, real progress in democratic transition has occurred: (a) the Constitutional Review Committee was established and has actively examined proposals for amendments or a new constitution; (b) the National Electoral Commission was established and given powers to supervise future elections, functioning well to date; (c) local government chairpersons and state governor elections have been held and officials have assumed duties; and (d) members to the state Constituent Assemblies either have been elected by local government councilors or nominated by the Armed Forces Ruling Council to represent various interest groups, such as traditional rulers, women, labor, business, and academia. National political party leaders canceled the results of primary elections in August 1992 when vote rigging in several states was documented; new dates have been set for further primaries (which is an unfamiliar process in Nigeria). The military rulers have stated, categorically, that the national elections for President will be held in December 1992, and the transition will take place in January 1993. The rest will unfold.

#### D. The Demography of Nigeria

In late November 1991, a national population census was finally carried out after being postponed for several years. The census was a vital prerequisite to establishing long-term proportional

representation and will influence future federal government budgetary allocations. The census counted 88.5 million Nigerians on the 27th and 28th of November 1991. AAO/Nigeria estimates the population in November 1992 to be about ninety seven (97) million.<sup>5</sup> Fifteen to twenty percent of all sub-Saharan Africans live in Nigeria. Several Nigerian states have populations larger than most other countries in Africa.

There are over three hundred different ethnic groups in Nigeria with as many different languages and dialects. Larger groups have populations of several million, smaller groups only a few hundred. Although these groups are generally located within distinct geographic areas, there have been contacts and migrations of varying types and degrees of intensity between the different groups throughout history. The ten most important ethnic groups account for about eighty percent of the population. The three predominant ethnic groups are the Hausa-Fulani, largely concentrated in the North; the Yoruba in the Southwest; and the Igbo in the East.

English, Hausa, Yoruba and Igbo are recognized as national languages. Pidgin English is widely utilized as a lingua franca. The population is, almost evenly, divided between Christians and Muslims with, perhaps, twenty percent adhering exclusively to traditional religions.

Approximately 3.8 million births will occur in Nigeria in 1992, possibly accounting for one of every five or six births in sub-Saharan Africa. Even with fairly rapid decline in fertility, Nigeria's population growth and age structure assure that the country will pass 250 million in the next fifty years or so, and probably become one of the most populous countries in the world along with India, China, Indonesia and the United States. Children below fifteen years of age represent almost fifty percent of the population. Projections of age structure show that when 300 million is reached, 35% of the population will be under age 15, and more than 50% under age 20. These high dependency ratios provide the fundamental demographic challenge to improving infant and child care, education, food and jobs. Unless Nigeria slows its rapid rate of population increase, the hope for improving the future economic and social well-being of its people will be defeated. The FMG, A.I.D., and other foreign donors are in full agreement on this analysis and conclusion. Recognition of this situation led Nigerian leadership to promulgate the National Population Policy.

Based on the 1990 Nigeria Demographic and Health Survey (NDHS) and the 1991 Census, the best estimate of annual growth rate is between 2.6% to 2.8%—a population doubling time of about twenty-seven years. Women of reproductive age (15 to 49 years old) constitute

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<sup>5</sup> This assumes a probable undercount of perhaps ten percent, and an annual growth rate of about 2.8%. Results of a 1992 post enumeration survey will further refine the estimates. Also, see "ANNEX D - THE NATIONAL CENSUS - 1991."

approximately twenty-four percent of the population. While two-thirds of the population now live in rural areas (i.e., 100,000 villages with less than 20,000 population), probably half the population will be urban by the year 2020.

The NDHS revealed many findings of programmatic significance. Foremost, Nigeria's traditionally high fertility rates of about seven children born alive to women, on average, may have declined significantly in most of the Southern states during the five years prior to the survey (1986 through 1990), probably to a level of about 6.0 children per woman.

The timing of this apparent decline coincides with the advent and growth of Nigeria's family planning program and A.I.D.'s assistance since 1983. Analysis of the data suggests that delays in first childbearing and earlier completion of childbearing among older reproductive age women contributed to the decline. Use of contraception varies greatly from one area (and ethnic group) to another. There is only limited contraceptive use in the Northern states and, then, almost exclusively among the most educated. Among the better educated, urban women in the Southwestern states, contraception practices result in fertility levels comparable to those in industrialized societies. In general, however, overall knowledge of, and demand for, contraception is low.

The prevalence of use of contraception reported (six percent) does not correlate with the fertility declines reported. Unlike other African countries, factors such as abstinence and/or abortion now seem to exert significant influence on fertility in Nigeria.

Nigeria's very rapid population growth stems from the steady declines in infant and child mortality since the 1960s, as has happened throughout the developing world. However, NDHS and other data now suggest that infant and child mortality leveled off, or possibly rose, over the late 1980s, with estimates of 189/1000 in the 1980-85 period and 192/1000 during 1986-91. Variation in mortality mirrors the variations in use of contraception: the urban and educated enjoy, by far, longer and better life, while those in Northern areas fare worse than those in the South.

Nigerian mortality experience is typical of sub-Saharan Africa, but unfavorable in comparison with low-income countries in other regions of the world. The life expectancy at birth, estimated at about fifty years, is also typical of sub-Saharan Africa, but is about ten years less than that of most other low-income countries. The rate of male and female adult literacy (1985) is limited, respectively, to fifty-four and thirty-one percent. According to the NDHS, in some regions of Nigeria, over eighty percent of adult women have had no formal education. In those same regions, only two percent of adults had completed secondary school. Primary school enrollment (1988) reaches about sixty percent of the school age population, with a male:female ratio of 100:82. There are severe resource problems in education across all age groups.

One of every five Nigerian infants dies before his/her fifth birthday (i.e., 750,000 child deaths annually). The Maternal Mortality Rate is estimated at 15 per 1000 live births. The Crude Death Rate is 19/1000 population. Neonatal deaths are 40/1000. High risk births may account for as much as fifty percent of all infant deaths and from twenty-five to forty percent of maternal deaths. Lack of population-based data on the causes of morbidity and mortality precludes a full understanding of the dynamics of child mortality in Nigeria. High rates of infant and child mortality mainly result from the interactive effects of undernutrition and infection in a population characterized by poverty, illiteracy, and high fertility.

#### **E. Social Costs During Reform: Focusing A.I.D. Assistance**

Despite Nigeria's unquestioned regional political, economic and military importance in Africa, and apparent growing poverty of its masses, few U.S. foreign affairs-conscious people have advocated a strong bilateral development assistance program. Most believe that Nigerians have not yet adequately addressed the reasons for the country's stalled economic and political development.

Over the past thirty years, Nigeria acquired over \$120 billion in earnings from oil and gas exports. Most was invested by the public sector—some of it well, but much of it in large, capital-intensive, economically nonviable projects, often accompanied by outrageous corrupt on. Subsidized, urban-oriented imports led to systematic impoverishment of agricultural production and marketing. When oil prices fell, Nigerians experienced loss of mobility; jobs became scarce; real incomes dropped steeply; fewer children attended schools; rapid population growth imposed relentless pressure to expand provision of public goods. As a result, today, young children are more likely to be born with low weight and endure more malnutrition than did their older siblings only a decade ago.

The benefits of economic policy reform have been slow in coming. It may be some years before Nigeria's SAP translates into better conditions for the majority of the population. Though the declines in household incomes began years ago, most Nigerians associate growing poverty with the government-mandated SAP initiated in earnest in 1987. Overall progress in free market oriented economic reform could be dramatically arrested in Nigeria's volatile political culture.

The perceived "social costs of adjustment" now endured by the poor and low-salaried urban workers can be mobilized to freeze progress in reform. There are genuine issues of social justice and inequities in the allocation of resources by Nigerian leaders. Just as long-term investments in the economy have been low, so has government investment in the social sectors. A.I.D. assistance could be instrumental, now and in the future, in encouraging and guiding both public and private sector long-range investments to mitigate some of the adverse impacts of Nigeria's economic adjustment.

For nearly ten years, A.I.D.'s focus in Nigeria has been, exclusively, on the health, population and nutrition (HPN) sector, in the belief that this assistance could improve the lives of many millions of people while making important contributions to the country's development. HPN is a sector in which A.I.D. has demonstrated excellent capacities to render effective assistance. A.I.D.'s involvement in Nigeria will remain focused in HPN, with specific attention directed to those sectoral interventions supporting family planning, child survival, and HIV/AIDS prevention. These subsectors involve many aspects and levels of the public and private sector policy, infrastructure and governance—touching the lives of the majority of Nigerians in ways that beneficiaries can directly appreciate.

In Nigeria, public health is a front runner in government presence at local levels, and in public sector reform and decentralization efforts. The determination of Nigeria's leadership to enhance privatization and markets as well as to devolve control over social sectors to the LGAs present strong challenges and opportunities. These initiatives will engage a wide variety of Nigerian institutions and programs, a number of which relate to diverse facets of A.I.D.'s strengths and initiatives related to HNP.

Still, Nigeria presents a dilemma for A.I.D. due to Nigeria's comparatively huge foreign exchange earnings, strong lingering perceptions by investors and donors of mismanagement, and concerns about the sustainability of recent economic reforms in a political environment in flux. At the same time, the country's large population and poor human conditions qualify it for large investments under the Development Fund for Africa (DFA). Indeed, in April 1992, the Bureau for Africa included Nigeria among its high priority, FOCUS countries—for the first time in twenty-five years. However, A.I.D.'s funding and personnel resources for Africa are limited and suggest that A.I.D. should pursue specific strategic objectives in a single sector.

## II IN-DEPTH ANALYSIS OF KEY CONSTRAINTS TO GROWTH AND OPPORTUNITIES FOR REALIZING A BETTER LIFE FOR THE NEXT GENERATION OF NIGERIANS

The broad constraints to economic growth in Nigeria are many and varied, in general terms: heavy reliance on a single commodity (petroleum); inadequate and inefficient agricultural production; and widespread poverty within a broad spectrum of the population deprived of formal education and healthy living conditions.

In accordance with the discussion in the foregoing chapter concluding that A.I.D. can best contribute to economic growth in Nigeria through concentration of program assistance in a single sector, analysis of key constraints to economic growth will be limited to the Health/Population/Health (HPN) sector.

### A. The Role of Health in Nigeria's Economic Development

Three factors influence health status: (a) a declining economy as described in Chapter I; (b) identifiable health and population risk factors, most of which are addressable though culturally appropriate low-cost, effective technologies; and (c) health system inadequacies of both the public and private sectors.

The links between health and economic development are substantial.<sup>6</sup> A child who is chronically ill or malnourished in the first three years of life will never achieve full physical and mental development. Poor health and nutrition in the early years will affect school performance, adult physical and mental development and, in the case of girls, ability to bear healthy, full-weight infants. A mother who is malnourished or sick is more likely to give birth to children who will not survive infancy. A child maturing in poor health into adulthood will develop poor skills and will not become a fully productive member of the labor force.

Better health and nutrition raise workers' productivity, decrease the number of days they are ill, and prolong their potential working lives. Loss of earnings is only a partial measure of output loss; the full cost of such loss includes the value of lost nonmarketable work (such as child care and food preparation), lost earnings of other household members, costs of treatment, etc.

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<sup>6</sup> According to The World Bank (WB): "efforts to reduce poverty are unlikely to succeed in the long run unless there is greater investment in the human capital of the poor." The WB's World Development Report - 1990 - Poverty (Chapter 5, Delivering Social Services to the Poor) links economic growth and productivity to improved HPN services.

Many of the most serious health problems faced by the children of Nigeria, and their mothers, are problems that can be addressed, wholly or partially, by relatively inexpensive and simple technologies (e.g., measles and neonatal tetanus by immunizations, diarrheal diseases by improved hygiene and feeding practices and appropriate use of hydration or rehydration fluids, ARI and malaria by appropriate treatment, etc.). These problems are compounded by the lack of true, insightful recognition among the population and service providers of the scope and magnitude of risk factors related to child morbidity and mortality.

Other emerging health-related problems of critical importance, such as population growth and HIV/AIDS, can be addressed, significantly, through the same, or similar, infrastructures utilized for the adoption, use, and application of basic health technologies supported by appropriate health education of the public and training of service providers.

Rapid population growth besetting limited resources undermines the outlook for economic growth, human development, and the environment. High fertility rates and poverty, together, form a vicious circle that threatens the welfare - or even survival - of much of the Nigerian population, especially children. In addition to the depletion of resources, population growth, particularly when it outpaces economic growth, provokes market failures, leads to the congestion of urban areas, and overburdens public services dependent upon government fiscal support.

As AIDS spreads across the African continent, this human tragedy threatens to impose a crippling burden on Nigeria's people, economy, and already inadequate health care systems. AIDS represents a human and economic disaster of staggering dimensions. Infections strike adults in the prime of life, plus up to one third of all children born to infected mothers. In contrast to malaria and other causes of excess adult mortality, AIDS does not spare the elite. The epidemic is likely to have a detectable, and possibly substantial effect on per capita income growth and welfare for years to come as well as strike down educated talent the country needs for development.

Death arrives for many children simultaneously afflicted with a number of maladies: a combination of measles, pneumonia, diarrhea, and malnutrition is quite commonly associated with under-five deaths in Nigeria. What is not obvious—at least not quantitatively demonstrable—is the precise underlying cause, case by case, of child mortality, especially the role of malaria, pneumonia, and diarrhea as principal agents of pediatric death. Compilation and analysis of various data sources (See Table 3)

**Table 3: Causes of Death**

Diarrheal Disease	20%
Respiratory Disease	16
Malaria	12
Measles	12
Malnutrition	12
Neonatal Tetanus	10
Other Causes	<u>18</u>
	100%

provides a rough, but indicative estimate of cause-specific child mortality in the Nigerian population under five years of age.<sup>7</sup>

Perinatal mortality, a significant problem in Nigeria, reflects the magnitude of high risk births common to all regions of the country, where maternal health and prenatal care are neglected. Neonatal tetanus, transplacental malaria, respiratory diseases, and poor maternal health (including malnutrition) are the prime causes of perinatal mortality in Nigeria, frequently compounded by poor birth spacing and inadequate maternal care.

Childhood morbidity continues to have profound ill effects on Nigerian society, reducing quality of life and adult productivity, and imposing economic costs. Childhood malnutrition has sustained adverse effects on physical and mental capacities throughout life. The NDHS documented significant levels of malnutrition, especially, in the Northern areas of the country. Thirty-six percent of children under five are moderately malnourished; i.e., more than two standard deviations (>2SD) below the median weight for age. Twelve percent are severely malnourished; i.e., >3SD below the median. Both groups are at increased risk of infection-caused mortality.

A number of ailments straddle childhood and adult life. The occurrence of poliomyelitis produces lifelong physical handicaps. Malaria, if not fatal in childhood, reduces productivity in later life; and Yellow Fever may exact its death toll beyond the age of five. Immunization against Hepatitis B at less than six months of age precludes chronic infection, liver disease and hepatic cancer (a major adult killer in Nigeria), thus guarding against severe reduction of adult productivity prior to premature death at an age associated with an adult's most productive years.

Among the Nigerian population at large, the following afflictions were the most commonly reported causes of morbidity from 1985 through 1989: malaria (25), dysentery (20), measles (13), pneumonia (12), gonorrhoea (4), and whooping cough (1). During the same years, the major causes of death from notifiable diseases, as reported, were: malaria (21), measles (16), meningitis (13), pneumonia (9), yellow fever (8), dysentery (6), tuberculosis (2).<sup>8</sup>

Nigerian Demographic and Health Survey (NDHS) data depict a stark reality: with mortality rates of children under five years of age

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<sup>7</sup> This profile must be interpreted with caution. Estimates are based on studies that frequently were aimed at highlighting the contributory, devastating effects of a particular causative agent. Surprisingly few studies reflect the reality of multiple attributes leading to single deaths.

<sup>8</sup> The numbers appearing in parenthesis are factors of magnitude based on a maximum of 75. For each of the five years reported, a factor of 5 was assigned to the most reported disease, a factor of 4 for the second, 3 for the third, 2 for the fourth, and 1 for the fifth.

in the range of 200 deaths per 1000 live births and an estimated maternal mortality rate of 15 maternal deaths per 1000 live births, Nigeria, with its population of nearly ninety million people, carries a significant proportion of suffering and death in Africa—an estimated 750,000 under-five deaths and 42,000 maternal deaths, annually.

Each of these deaths, usually, represents the interaction of multiple socioeconomic, health and disease, and health system risk factors. Correlation of these factors as critical maternal and child health events facilitates an understanding of causation and the identification of intervention opportunities, each of which needs to be assessed re the availability, feasibility, effectiveness and cost of possible program activity.

The following table provides such a correlation.

TARGET GROUP	SOCIOECONOMIC	HEALTH	HEALTH SYSTEMS
Prepubertal Female	Poverty	Undernutrition	Lack of Health Education
Fertile Women	Lack of Education	Conception "too early, too soon, too many, and too late."	Lack of Family Planning Services.
Pregnant Women		Undernutrition, HIV/STDs, Anemia, Malaria, Abortion, Eclampsia.	Lack of Prenatal Care, Failure to Identify Women at High Risk.
Women at Delivery		Delayed Attendance, Obstructed Labor, Hemorrhage, Infection.	Lack of Delivery by Trained Attendant and Referral Backup for Obstetrical Emergencies.
Newborn	Potable Water and Sanitation	Low Birth Weight Asphyxia, Hypothermia, Infections: Neonatal Tetanus, Sepsis.	
Infant		Delayed, Incomplete Breast-feeding; Inadequate Weaning; Infections: Pneumonia, Diarrhea, Malaria.	Inadequate Prevention re: Nutrition Counseling, Immunization, Micronutrient Supplements.
Child		Inadequate Diet; Infections: Measles, Pneumonia, Malaria, Diarrhea; Injuries.	Inadequate Case Management re: Diagnosis and Treatment of Sick Child and Sick Women.

## B. Major Preventive Health Problems in Nigeria

### 1. High Fertility and Lack of Family Planning

Results from the NDHS highlight the facts that fertility in Nigeria is high, and the use of contraception, both modern and traditional, is low. In 1990, only 3.8% of reproductive-age women were currently using modern methods of contraception. Among married nonusers about one in five (22%) said that they intended to use family planning in the future. Slightly more than half of these indicated an intent to utilize contraceptives within the coming twelve months. Only nine percent of childless married nonusers claimed a future intent for use, and only twenty-six percent of those with parity four or greater said they intended to use family planning in the future.

There is, moreover, significant variation by region. In the more urbanized Southwest region, use of modern methods is about eleven percent, in the Southeast about four percent and in the northern regions only about one percent. Extensive regional and cultural differences in Nigeria are reflected not only by wide variation in contraceptive use patterns, but in knowledge about contraception, and in the demand for family planning. Women living in the Southwest and Southeast regions of Nigeria are more likely to know of and use modern methods than women living in the Northwest and Northeast regions where cultural and religious beliefs are barriers to family planning. Religious and traditional village leaders must, themselves, acknowledge the acceptability of family planning before they can be expected to support family planning initiatives among the community at large.

Fertility has declined more rapidly in the South and among educated women. Contraception probably accounts for at least some of the North/South fertility difference. Other factors include education and age of marriage. Most women in the North have no education, while in the South, particularly in the Southwest, women are more likely to have at least some education. Women in the North marry on the average three to four years earlier than those in the South and initiate intercourse two or three years earlier. Not surprisingly, teenage pregnancy is more prevalent in the North.

The NDHS showed that, nationwide, forty-eight percent of married women report that they want to delay childbearing. However, only forty-one percent of married women know of a contraceptive method and only thirty-one percent know of a source for obtaining contraceptives. Contributing to this problem are low literacy rates among women and limited access to information on family planning, particularly in the rural areas.

Of the women in the North who are currently married, fewer than thirty percent are knowledgeable of any contraceptive methodology and fewer than twenty percent are familiar with a source of modern contraceptive procurement. In the Southeast, more than half know

a method of contraception, but only forty percent know a source for modern contraception. In the Southwest, almost seventy-five percent know a method and over sixty percent know a source. Of those married women in the North knowledgeable of contraception, about fifty-five to sixty percent approve of family planning, compared to seventy-five or eighty percent in the South. In twenty to thirty percent of the cases in which a woman approves of family planning, she reports that either she does not know her husband's attitude toward family planning or that he disapproves.

By far the most common reason given for not using contraception is the desire for more children, though this reason is given less frequently by those who are over thirty years of age. The next two most common reasons are religion and lack of knowledge and religion, in that order.

Although cost was mentioned less frequently as a prime factor by NDHS respondents, the relatively high cost of some contraceptive methods is a *de facto* deterrent to family planning for the poorer elements of Nigerian society. Low-cost services for the distribution of affordable contraceptive products are required to meet the needs of the poor, a crucial target for the alleviation of Nigeria's economic and social woes.

Sources of public information on family planning are limited. In all regions other than the Southwest, only twenty percent, or fewer, of the respondents had ever heard a family planning message on radio or television. In terms of the acceptability of family planning messages on radio or TV, substantially fewer in the North found such messages acceptable than did those in the South. The important differences that exist in the various regions need to be taken into consideration in IEC planning.

The lack of mobility impairs the ability of many women to reach service delivery sites. This stems, in part, from religious/social barriers precluding women from choosing contraception and/or visiting clinics, freely, without the presence and/or consent of their partners. Male opposition and/or indifference to family planning is a serious constraint throughout the country, with the strongest negative influence concentrated in the Muslim North. The early age of first marriage for females has significant long-term fertility (and maternal health) consequences.

Factors related to male resistance to family planning and female proclivities leading to early marriage and childbirth need to be targeted by IEC initiatives, with emphasis on specially designed "male motivation" and adolescent programs. Such programs will require support through public policy interventions to build consensus for stimulating barriers to early marriage.

## 2. Poor Maternal Health and Childbirth Practices

The causal relationship between closely spaced pregnancies and high infant mortality is evident in Nigeria. Adoption of appropriate child spacing practices would improve child survival by reducing the number of high risk pregnancies (i.e., pregnancies too soon, too closely spaced, too numerous, or too late in a women's reproductive life). Linked to high fertility is high maternal mortality. The maternal mortality rate in Nigeria is exceptionally high with estimates ranging as high as 15/1000 per live births. The major causes of maternal death are pre-eclampsia, eclampsia, sepsis, obstructed labor, hemorrhage and abortion. These outcomes stem from early marriage and pregnancy, undesired pregnancies, short interbirth intervals, inaccessibility of services, and nonuse of services that are available. The poor health and nutritional status of women and the lack of adequate maternity services are also reflected in the high neonatal mortality rates. As many as half of these deaths are due to neonatal tetanus resulting from low immunization rates and unclean birth practices.

Sexually transmitted diseases (STDs) and reproductive tract infections (RTIs), including pelvic inflammatory disease, are common among Nigerian women in their reproductive years. These illnesses can lead both to infertility and to complications of pregnancy and childbirth to the detriment of both mother and infant. The control of these diseases in Nigeria is difficult due to: (a) lack of trained personnel and laboratory facilities for diagnosis; (b) insufficient finances to support prevention and treatment programs; and (c) inaccessibility of diagnostic and treatment facilities, particularly, for rural women.

Major constraints to effective maternal health services in Nigeria include: (a) the lack of appropriate health awareness among women; (b) the absence of prenatal care for most expectant mothers; (c) a very high percentage of unattended births, or those attending are untrained traditional birth attendants (TBAs); and (d) lack of access to facilities capable of handling obstetrical emergencies. This limits timely recognition of emergencies and referral to a equipped, staffed facility capable of handling obstetrical complications.

Public sector maternal care facilities are beset with problems; e.g., (a) inadequate equipment maintenance; and (b) shortage of materials and supplies, such as gloves, sterilizers, and delivery instruments. Additional factors that militate against pregnant women opting for maternal services at public sector facilities include: (a) the fee recently imposed for maternal care; (b) distance and travel costs to service sites; and (c) language and cultural differences alienating the client from service personnel.

Prenatal and postnatal care is neither available to, nor sought by, the majority of maternity cases in Nigeria. The result is inadequate maternal care and missed opportunities to provide

counseling on nutrition; and family planning information, counseling, and contraceptive services. The situation is most grave in the North where only thirty percent of the women (versus eighty percent in the Southwest) have any contact with public health providers.

### 3. Malnutrition

Maternal malnutrition, along with the large reproductive and work burdens on women, is an important element of the maternal health problem in the country. Combined with inadequate obstetrical care, maternal malnutrition is a major factor in Nigeria having the second highest maternal mortality rate in the world. A 1990 University of Ibadan assessment survey showed that the incidence of malnutrition among mothers as determined by body mass index ( $Wt/Ht^2$ ) was thirty-one percent. The high incidence of low birth weight babies also reflects, in part, the poor nutritional status of pregnant women. Anemia has been found to be a common problem among Nigerian women.

The World Bank identifies Nigeria as one of seven countries in Africa in which more than half of Africa's food insecure population live. In 1986, the Bank estimated that eighteen percent of the total Nigerian population were food insecure because they did not have access to an adequate diet. Food prices as well as the costs of other basic goods have increased, substantially, in the last five years with incomes remaining relatively stable. Between March and June 1992, basic food prices have increased an additional fifty percent putting an even greater strain on households that were not able to meet their families' food needs before the devaluation.

Poverty, preventable and treatable infectious diseases and improper child caring and feeding practices are the major causes of child malnutrition in Nigeria. The NDHS, along with other studies, documented harmful child feeding practices that compromise a child's nutritional status and increase his risk of disease and mortality; e.g., only 1.3 percent of children below three months were being exclusively breast-fed. A child who is not exclusively breast-fed is four times more at risk of death due to respiratory infections and twenty-five times more at risk from deaths due to diarrhea. The NDHS also found that only one third of infants were put immediately to the breast within the first day of life and that only forty percent of infants were being given colostrum, an important source of nutrients and antibodies.

The NDHS revealed that the delayed introduction of complementary foods is a major problem. In the Northeast Zone, two thirds of children were not receiving complementary foods between ages 6-9 months; in the Northwest and Southwest zones, fifty percent were not receiving complementary foods at this age. Improper weaning and young child feeding practices are prevalent in Nigeria where various studies have shown that malnutrition begins before six months of age and sharply increases between 6-24 months. The NDHS

indicated that forty-three percent of Nigerian children under the age of five years were stunted (including 22% severely stunted); nine percent were wasted and 36 percent were underweight. These levels are twenty times the levels expected in a healthy population. Stunting is a result of inadequate nutrition over a long period of time, while wasting represents a current state of acute undernutrition.<sup>9</sup>

The NDHS documented substantial regional differences in nutritional status. Undernutrition is found to be highest in Northern zones, where over fifty percent of the children were stunted, twelve percent were wasted, and forty-five percent were underweight. These rates are some of the highest found in all African NDHS surveys that have collected anthropometric data and indicate the need for immediate action if excessive mortality and morbidity are to be avoided. The high rates of mortality in the North may well be attributed to these very high rates of malnutrition.

Of particular concern are the high rates of wasting in the under-two population: 6.3 percent of infants below six months, 11.2 percent between 6-11 months, and 15.6 percent between 12-24 months. Wasting is directly associated with increased risks of mortality. If infant and child mortality rates are to be reduced, then these high rates of malnutrition must be addressed.

Nigeria is among thirty-four countries identified, worldwide, by WHO where Vitamin A is a public health problem. Studies have documented serious Vitamin A deficiency problems in the North and Western zones, but changes in dietary practices in other areas suggest a more countrywide problem. Evidence confirms that iron deficiency anemia (an associated cause of malaria deaths) is also a major problem in Nigeria both for children and women. Severe iodine deficiency disorders have been documented in specific geographical areas throughout Nigeria. Approximately thirty million Nigerians (mainly women of reproductive age and children under 15 years of age) are at risk of iodine deficiency disorders (IDD). Subclinical iodine deficiency is being increasingly recognized as a preventable cause of decreased mental development.

Malnutrition is a serious problem in Nigeria: it contributes to high levels of child morbidity and mortality and impedes cognitive development, learning, school performance, and income earning potential. Protein-energy malnutrition and micronutrient deficiencies are closely linked to child survival. Undernourished children are more susceptible to illness and to the more serious consequences of illness leading to increased risk of mortality.

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<sup>9</sup> Stunting is defined as being two or more standard deviations below the mean of the international reference population in terms of height for age. Wasting is defined as being two or more standard deviations below the mean of the international reference population in terms of weight for age. Underweight is defined as being two or more standard deviations below the mean international reference population in terms of weight for age.

#### 4. Vaccine-Preventable Diseases

EPI diseases (Tuberculosis, Diphtheria, Pertussis, Tetanus, Poliomyelitis, and Measles) continue to threaten the lives of Nigerian infants and children. Two of the diseases, measles and tetanus may account for up to twenty-five percent of under-five mortality in unprotected children.

Measles effects all unprotected children surviving past the time of passive maternal antibody (usually nine months). On average, three percent of Nigerian children will die from the acute measles or from its complications pneumonia, diarrhea, and undernutrition. Among undernourished populations, measles associated mortality may reach ten deaths per hundred cases or higher. Major cause of disability are undernutrition and blindness. In Nigeria, measles has been associated with a large percentage of cases of kwashiorkor, severe protein calorie malnutrition. Measles vaccine is effective in reducing mortality and in improving health-status even in high risk populations. It is, in all probability, the single most important intervention in preventing childhood malnutrition. In a World Bank Study of Health Priorities,<sup>10</sup> measles immunization was identified as the most cost-effective of potential health interventions.

Neonatal tetanus results from infection of the newborn from unhygienic conditions at the time of birth or in the neonatal period. An estimated one percent of children born in Nigeria to mothers unprotected by tetanus toxoid will die - 35,000 neonatal tetanus deaths annually. Neonatal tetanus can be prevented through immunization of fertile age and pregnant women and through safe delivery practices. Prevention of neonatal tetanus was identified as the second most cost-effective strategy to improve child health in the developing world.

Poliomyelitis effects one of every two hundred children unprotected by vaccine; in the absence of immunization, an estimated 17,500 Nigerian children would be paralyzed annually. This disability has long-term economic and social costs.

Other diseases preventable by immunization include whooping cough (pertussis) a preventable cause of respiratory infection, chronic cough, undernutrition, and mortality (up to one percent of unimmunized Nigerian children), and tuberculosis.

Estimates from an 1989 In-depth Program Review of the EPI and CDD program in Nigeria estimated that over 100,000 deaths are being averted annually due to the ongoing EPI program. Unfortunately, over 200,000 deaths were estimated to still be occurring that could be averted if children under one year of age and women of childbearing age were fully immunized. Of those 200,000 deaths

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<sup>10</sup> Jamison and Mosley, manuscript still at press.

still not being prevented, approximately forty-eight percent are from neonatal tetanus and thirty-seven percent from measles.

Although national strategies have been developed for vaccine-preventable diseases and significant program improvements have been achieved over the last five years in the delivery of EPI vaccines in Nigeria, coverage for the high risk under one population is only in the fifty to sixty percent range. Problems are primarily those of management and implementation: (a) procurement, inventory, and distribution of vaccine, equipment, and supplies, (b) sustained efficient delivery of vaccine services at health facilities and in the community, (c) enlightened public demand for and participation in immunization service delivery, and (d) effective epidemiologic surveillance to assess effectiveness and to identify and solve technical and operational constraints.

### **Hepatitis B Virus (HBV)**

HBV is endemic in Nigeria and carries considerable potential as a serious debilitator within the national work force. Recent studies in three sentinel states have determined a twenty percent level of hepatitis B seropositivity. The same studies found that chronic liver disease and primary hepatic carcinoma are major causes of mortality in the teaching hospitals located in those states. HBV is spread through perinatal transmission, household contacts, sex partners, and contaminated blood supply.

Although the blood-borne liver disease afflicts, mainly, adults, global policy recommends, where possible, immunization against Hepatitis B along with vaccination against childhood diseases. Immunization of infants against Hepatitis B at less than six months of age precludes chronic HBV infection, chronic liver disease, and hepatic cancer. The major constraint to implementation of such initiatives is the cost of the vaccine, currently \$0.50 per dose.

New developments in vaccine production and inoculation techniques, such as mixing HBV vaccine with other EPI vaccines in a single injection, would facilitate the incorporation of HBV vaccine into EPI. Another consideration would be to initiate a strategy of immunizing health care workers against Hepatitis B, since they are at increased risk relative to the rest of the Nigerian population.

## **5. Malaria**

Malaria is one of the major causes of impaired development in sub-Saharan Africa where transmission of *Plasmodium falciparum* is stable and intense. While the exact incidence and mortality of malaria in Nigeria are unknown, malaria is the most common reported cause of outpatient visits in Nigeria and one of the top three causes of mortality. Malaria is the reported cause of twelve percent of hospital deaths in children under the age of five years. As malaria is, in the absence of laboratory diagnosis, attributed to all cases of fever without a definitive cause, and as disease

reporting is incomplete (perhaps only 1% of actual cases), the exact incidence of malaria is difficult to estimate. In a recent CCCD study in Barkin Ladi, 31.5% of children reported an episode of fever in the last two weeks. This is similar to the 32.6% determined in the NDHS. Assuming that a third of fever cases are in fact malaria, the best estimate available from clinical studies, and that fever episodes last on average two weeks, the annual number of malaria fever episodes in children under five may be as high as 45 million episodes per year.

The medical problems caused by malaria include acute febrile illness, chronic disease manifested by anemia and neurologic sequelae, and effects on the pregnant women and her fetus, causing low birth weight and its own risk of infant mortality. The economic toll from Malaria includes the medical and economic costs of taking a child with fever for care (30% of fever cases identified in the NDHS reported receiving treatment for fever), the associated loss of productive time in child caretakers, the tens of thousands of malaria-related hospitalizations, and estimated 100,000 malaria related deaths. Due to the increased energy cost of fever and the appetite depression caused by febrile illness, malaria also contributes to undernutrition. Less well documented is the effect of malaria on the productivity of the work force.

Malaria affects nearly everyone older than six months, with a peak mortality in children ages one to four. 1990 data from sentinel surveillance sites indicated that thirty percent of the malaria cases seen were in the zero to four age group; thirty-one percent between five and fourteen years of age; and thirty-nine percent, fifteen years or older.

Cause of death due to malaria is difficult to ascertain. Reporting below the tertiary level is incomplete. At the tertiary level, cause of death due to malaria is often associated with deaths due to febrile convulsion and anemia. Notwithstanding the lack of quantitative preciseness, it is postulated that malaria contributes, substantially, to morbidity and mortality among children under five years old and women of childbearing age.

Clinical studies carried out in Nigeria have documented increasing resistance of *Plasmodium falciparum* to chloroquine and other antimalarial drugs. As has occurred progressively in eastern Africa, where resistance first developed, the development of resistance to chloroquine, the low cost widely available drug, is associated with increases in morbidity and mortality and the necessity to shift to less widely available and more expensive drugs. This pattern of increasing malaria, malaria related morbidity and mortality, and malaria-related anemia are expected to occur in Nigeria. This will affect both pregnant women, especially in first and second pregnancies (anemia and low birth weight), and children (febrile episodes, anemia, and death). Alternative malaria strategies, both drug treatment and personal protection methods (e.g., insecticide impregnated bed nets), will need to be

assessed with a view toward using the resulting information as a basis for determining appropriate modifications of national policy and programmatic interventions.

## 6. Acute Respiratory Infections

Results from a limited number of ARI studies undertaken in Nigeria indicate that pneumonia illness and deaths from pneumonia are common. Figures obtained from community-based facilities reveal a high incidence of ARI comparable to the highest ranges seen in other countries. The NDHS revealed that cough complaints accounted for thirty-five percent of health facility visits, with higher rates associated with urban areas. In a study in Ile Ife, 20.7% of visits related to ARI. Preliminary data from a recently initiated ACSI/CCCD initiative involving representative tertiary-level facilities suggest that approximately thirty percent of child deaths in such facilities were due to pneumonia. Hospital reporting usually underestimates deaths in infants under two months (the highest-risk age group for ARI) within the population at large. In a community survey, 60% of 108 reported deaths were related to cough, measles, and pneumonia. From all indications, it is safe to conclude that the incidence of ARI is comparable to diarrheal disease and malaria and, consequently, is a major cause of early childhood death in Nigeria.

Acute reparatory infections are both preventable and treatable. Two diseases preventable by immunization, measles and pertussis, may account for up to a third of respiratory deaths. Most other respiratory deaths are due to infections caused by two bacteria treatable by low cost oral antibiotics. Until recently, diagnosis of pneumonia in Nigeria, as in other developing countries, has been difficult because of the inexactness of physical diagnosis and the unavailability of X-ray backup. Research studies carried out of the last few years have identified rapid respirations (>50 per minute) and chest indrawing as sensitive and specific signs of pneumonia. The development of low cost timing devices has further facilitated the ability of primary health care workers to identify cases of pneumonia requiring antibiotics. Although standing orders are available for the treatment of ARIs, most health workers in Nigeria have not yet been trained in current methods of case diagnosis and case treatment. Effective programs to combat pneumonia deaths require the availability of low cost quality antibiotics. Studies currently being carried out by the USAID's CCCD project are showing that wide spread problems in drug availability and quality are addressable through implementation of the Bamako initiative and revolving drug funds. Development of management capacity to handle RDFs is equally important in ARI control to that of clinical diagnosis and treatment.

Ethnographic studies supported by WHO are beginning to clarify issues of community recognition, home treatment, and referral of respiratory infections. Obstacles to effective care involve: (a) recognition of illness by the child care taker, (b) delay in

referral for care frequently due to nonavailability, or delayed permission, of decision-maker, (c) lack of knowledge and experience of health workers in ARI diagnosis and treatment, (d) lack of appropriate drugs, and (e) most importantly a failure in effective communication on care from the health worker to the caretaker.

## 7. Diarrheal Diseases

Diarrheal diseases are a major cause of morbidity and mortality in the under age five population in Nigeria, accounting for approximately fifty to one hundred thousand deaths each year. Annual episodes of diarrheal disease are estimated at 4.3 per child. The NDHS suggests that approximately eighteen percent of all children under the age of five have diarrhea in any given two-week period. Higher rates were indicated in the Northern zones (24% in the Northeast and 26% percent in the Northwest) than in the Southern zones (12% in the Southeast and 9% in the Southwest). These differences probably relate to poverty, lack of education, and lack of access and/or use of safe water.

Diarrhea is caused by a range of infectious agents: viral, bacterial, and parasitic agents. Infections may be acute (less than two weeks) or chronic (greater than two weeks). Much of the morbidity and mortality from acute diarrheas results from loss of fluids (dehydration) which can be prevented by appropriate home and health facility use of Oral Rehydration Therapy (ORT) and feeding.

In Nigeria, Ministry policy limits the use of Oral Rehydration Salts (ORS) to health facilities for use by health workers. Facility surveys have documented problems in health facility ORS use due to problems in availability of ORS packets and in their use by health workers. Ministry policy also calls for home treatment of diarrhea with Salt and Sugar Solution (SSS) with referral of severe cases to health facilities. This policy is based on the Minister of Health's strong conviction that ORS packets represent a commercial entrapment of the poor, "like Nestle's formula", and are inappropriate within the context of Primary Health Care. Most of the deaths from acute dehydrating diarrheas can be prevented through appropriate use of ORT and feeding. Inadequate and inappropriate treatment of diarrhea are major contributors to childhood malnutrition.

Certain bacterial diarrheas, e.g., Shigella, require antibiotic therapy. This has been complicated by increasing antibiotic resistance brought on in part by inappropriate use of antibiotics for acute watery diarrheas. Policy calls for limiting antibiotic use to cases of bloody diarrhea.

Chronic diarrheas are a major contributor to malnutrition and childhood mortality. Their etiology is much less clear, and research is underway in Nigeria, and elsewhere, to understand better the causes and treatment of this condition. It is clear, however, that the inappropriate treatment of acute diarrheas

constitutes, along with measles, a major risk factor in the development of chronic diarrhea.

Facility surveys document inappropriate treatment of diarrhea with multiple drugs (>5 per case in one health facility) as a problem in both the public and private sectors. This frequently includes toxic and potentially dangerous drugs. Incorrect case management is exemplified, as indicated below, by the reported high case fatality rates for cholera in Nigeria, >10 deaths per 100 cases, ten times that expected where appropriate case management is utilized. Upgrading the quality of diarrhea case management is a major challenge for the Nigerian health system.

Diarrhea is clearly a disease for which prevention is a high priority. In a review of potential prevention strategies, WHO has identified four strategies that stand out as highly important and cost-effective: (a) exclusive breast-feeding for the first four months of life, (b) hand washing prior to the preparation of food, (c) measles immunization, and (d) safe water.

## 8. Water and Sanitation

Nigeria is plagued by health hazards and diseases caused by the current low levels of access to safe water supply and sanitation facilities. This situation, while particularly acute in rural areas, does not spare the urban population. Significant numbers of the population live in inadequate housing. Lack of facilities and the overcrowding common to many urban areas exacerbates the problems of inadequate refuse and excreta disposal. Poor personal and environmental hygiene and inadequate control of disease-carrying vectors compound the problem. Many Nigerians still suffer from guinea worm and other water-related diseases. Poor water and/or sanitation conditions throughout Nigeria foster the high incidence of childhood diarrheal diseases, the not infrequent outbreaks of cholera, and the unrelenting prevalence of malaria.

## 9. HIV/AIDS

As the AIDS pandemic spreads across the continent, dramatic increases in HIV infection are now evident in parts of West Africa. Although at an early stage of the pandemic, compared to many of its neighbors, Nigeria is now beset with the HIV/AIDS problem.

In sub-Saharan Africa, the primary mode of HIV infection is by heterosexual contact, followed by perinatal transmission and through the transfusion of infected blood. Results obtained to date suggest that Nigeria is following this pattern.

The disease appears more an urban problem in Nigeria than a rural concern. To date, reported cases are concentrated in the geographic areas with extensive migration patterns and among subpopulations practicing high risk sexual behavior and, more recently, individuals engaging in intravenous drug use.

Because of technological and organizational problems, AIDS surveillance in Nigeria is not yet well developed. The low number of cases reported to date is, probably, more a reflection of under-reporting and misdiagnosis than a low prevalence of the disease. In a recent small survey of Nigerian health staff, over half significantly underestimated the magnitude of the problem.

At present, "surveillance" of AIDS in Nigeria is based on a combination of the WHO clinical case definition and on data generated by twenty-one recently created screening centers. This system was established with WHO/GPA support under the initial National Short-Term Plan.

As of May 1992, 379 AIDS cases and 2,240 cases of HIV seropositivity had been reported to the Federal Ministry of Health. The Minister of Health has indicated that, according to estimates based on recent sample serological surveys, 530,000 persons may already be infected nationwide. Unofficial estimates given by health personnel under circumstances offering anonymity range into the millions.

Although the number of AIDS cases, reported officially, appear insignificant, the rate of HIV infection in the general population is substantial; i.e., 6/1000 population. The rate of infection in selected high risk populations is increasing dramatically. Seroprevalence studies conducted in very high risk populations between 1987 and 1991 revealed rates of one to fifty percent in several prostitute populations nationwide. Screening among blood donors indicate rates varying, widely, from .1% to 6.1% for 1991. Screening of sentinel TB and STD hospital populations conducted in 1991 revealed rates as high as 22.4% for STD patients and 14.3% among TB patients.<sup>11</sup> Of great concern is the fact that among the few studies of high risk populations conducted over several years, it has been shown that the rate of HIV infection is doubling every year and in some cases is progressing faster.

Despite the paucity of data, one thing is certain: the existence of AIDS in Nigeria is now firmly established, and the disease is increasing at an alarming rate. Much remains to be done to strengthen the epidemiological surveillance system to keep track of the progress of the epidemic.

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<sup>11</sup> Tied to HIV infection is the rise of tuberculosis incidence in Nigeria. With growing rates of HIV seropositivity and concomitant loss of the immune system to control infections, tuberculosis will become a more serious problem. There will be a proliferation of more virulent and resistant strains of *Mycobacterium tuberculosis* as well as the atypical mycobacteria as the number of AIDS cases increases.

Four major sociobehavioral factors exacerbate the AIDS problem in Nigeria:

- **Behavioral Factors:** One of the most important factors in the spread of HIV in Nigeria is the high frequency of sexual partner changes. A variety of social and behavioral factors contribute to this behavior. Adults often have multiple sexual partners, partly because polygamy is a social norm, but also because couples are often separated for long periods of time for economic reasons. Sexual activity among adolescents and young adults is high. Prostitution and frequent sexual partner changes are enhanced by poor economic conditions.
- **Demographic Factors:** The population of Nigeria is young, and the proportion of sexually active individuals is high. This factor will play a major role in the progress of the epidemic, both in terms of the rates of transmission and the total numbers of individuals at risk of infection.
- **Biological Factors:** Infectivity with HIV is greatly enhanced (up to tenfold) in the presence of ulcerative STDs. Although the epidemiology of STDs in Nigeria is not well documented, it is widely accepted by local medical authorities that all major STDs are highly prevalent, especially in urban areas and among transient populations. There is a lack of understanding on the part of the general population concerning the link between ulcerative STDs and the facility of HIV transmission. Nontreatment and inadequate treatment of STDs are related to the problem of inadequate access to appropriate care.
- **Political and Economic Factors:** The economic situation of Nigeria is currently stressed under the Structural Adjustment Program (SAP); and, despite ambitious efforts towards democratization, the national economy is stumbling in the attempt to meet the needs of the fast growing population and those of an inadequate infrastructure.

## 10. Major Epidemic Diseases

### Cholera

Cholera is endemic in Nigeria and will remain so as long as environmental conditions permit transmission of *V. cholera*. Early case detection and prompt rehydration of cholera patients can greatly reduce the case fatality rate. Continuing surveillance of diarrhea cases is a key strategy to cholera control in Nigeria. Of major importance is the early identification of outbreaks to ensure appropriate case management and environmental sanitation.

### Yellow Fever

Although there has been a safe, effective vaccine for yellow fever for more than fifty years, the expense of vaccination campaigns and

logistical problems has significantly limited its availability in Nigeria. As a consequence, Nigerians endure episodic outbreaks that require rapid mobilization of the health system.

Large outbreaks of Yellow Fever (YF) with high case fatality rates (i.e., > 40% in hospitalized patients) have been occurring in Nigeria on a yearly basis since 1986. Peripheral health workers have had difficulty with clinical recognition of YF. Institutional inadequacies exist with respect to: (a) disease surveillance; (b) laboratory services and diagnostic facilities; and (c) information about the ecology, population dynamics, and distribution of YF vectors, which has resulted in ineffective vector control.

The consequences of inadequate surveillance can be grave. Outbreaks of YF in Nigeria in 1986 and 1987 were not recognized until three to five months subsequent to onset. The situation, complicated by a large unvaccinated population, resulted in hundreds of otherwise preventable deaths.

Presently, protection against the disease is possible through one dose of YF vaccine in a person's life time. In view of this possibility, Nigeria's EPI health policy was changed in 1990 to include YF vaccination (given at the time of measles vaccination). Nevertheless, this recommendation has not become operational as all YF vaccine presently in-country is being used for epidemic control. To correct this situation, Nigeria is now building a YF vaccine laboratory with an annual production of twenty million doses beginning in 1994, compared to a current annual production of approximately one million doses.

To implement its YF vaccination activities, the FMOH will need to address the following issues:

- adequate availability of YF vaccine until national production capacity is improved; and

- provision of YF vaccine separate from epidemic-related vaccine supplies to allow incorporation of YF into EPI operations.

- improvement of YF surveillance activities;

- improvement of the epidemiological competency to act accordingly with the improved data;

### **Meningococcal (Cerebro-Spinal) Meningitis (CSM)**

CSM is endemic in Nigeria and, as in other countries within the "meningitis belt" of Africa, case fatality due to CSM can exceed fifty percent without early diagnosis, modern therapy, and supportive measures. In addition to endemic transmission, there is the potential for explosive epidemics, which can be devastating in the areas affected. During the 1985-89 period, meningitis ravaged

the Northern states of the Federation resulting in many cases and deaths. During those same years, CSM was the second most reported cause of death among the notifiable diseases in Nigeria. Vaccination programs for CSM should be linked to an efficient surveillance system enabling rapid detection and effective response.

## **11. Other Diseases of Economic Importance**

### **Guinea Worm Disease (Dracunculiasis)**

Dracunculiasis is a painful, debilitating disease prevalent in rural areas utilizing vector-infected drinking water supplies. It can incapacitate an affected person for up to twelve weeks, with serious consequences for agricultural productivity, school attendance, and a mother's ability to care for her children. Results from a search of about 6,000 villages in 1989 discovered more than 640,000 Guinea Worm cases. Subsequent to eradication efforts described in ANNEX C, current data indicate a fall in the number of cases to 150,000. Eradication is projected for 1995.

### **Onchocerciasis (River Blindness)**

Onchocerciasis, also known as River Blindness, ranks among the top four leading causes of world blindness. WHO estimates that Nigeria—with over 100,000 people blinded by the disease—has about one-third of all onchocerciasis worldwide.

The great majority of onchocercial blindness occurs within an East-West belt extending through Central Nigeria between latitude seven to twelve degrees. North of this belt, onchocerciasis rarely occurs. To the South, it seldom causes blindness even in people who are heavily infected with the parasite. Parasitologists are not sure why onchocerciasis causes less blindness in the forested South. Nigeria's river blindness belt includes four distinct regions where onchocerciasis is prevalent. In LGA areas particularly hard hit, more than half of the population is infected with the disease; based on limited surveys, it is estimated that up to twenty percent of the population in some of the hardest hit villages are blind. The majority of blindness occurs in small remote villages lacking access to health facilities. In Southwestern Nigeria, there is a fifth region where onchocerciasis is prevalent, but where blindness from the disease is rare.

## **B. Health System Constraints**

Nigeria has multiple overlapping health systems including: (a) traditional (TBAs, herbalists, and spiritual healers); (b) pharmacists (market women, medicine sellers, and registered pharmacies); (c) private nonprofit (religious missions); (d) private for profit (physicians and private hospitals); and (e) public facilities.

Constraints in the health systems relate to five factors: access, quality, coverage, affordability, and effectiveness. The following table assesses the impact of these factors re each system.

System	Access	Quality	Coverage	Affordability	Effectiveness
Traditional	High	Low to High*	High	High	Low to High*
Pharmacies	High	Low to Moderate	High	Moderate	Low to High
Private Nonprofit	Moderate	Moderate to High	Moderate	Moderate	Moderate to High
Private Profit	Low to Moderate	Low to High	Low	Low	Low to High
Public	Moderate	Low to High	Moderate	Moderate to High	Low to High

\* Documented as "effective" in mental illness.

### 1. Assessment of Needs

The collection of morbidity and mortality data, particularly those related to disease-specific causes of death, is imprecise and incomplete. Public sector health workers are in general overwhelmed by the amount of data collected. Although major efforts involving assistance from ACSI/CCCD and WHO have resulted in development of more effective system for the primary health care program, most health data collected are not appropriately analyzed, reported in a form useable by decision-makers, nor effectively used at the level of collection or by decision-makers.

Quality data adequate to assess health status and trends, and assign priorities are available from sentinel institutions, research studies by investigators in the university system, and a variety of surveys; e.g., the NDHS and the 1991 Census.

### 2. Health and Population Policies

With leadership from the Minister of Health, Nigeria has established visionary policies for both Population and Primary Health Care. Less well defined are the implications of these policies for the overlapping health systems identified above. Defined technical strategies are, in most instances, consistent with those recommended by WHO.

The national policies for PHC, in general, and Population, specifically, have established quantitative targets. Action planning and target setting, however, have not always been realistic in terms of baseline levels, established goals, or methods of measurement.

There are several regulations and practices in Nigeria that unnecessarily create barriers for couples wishing to receive or continue utilization of family planning methods. The question of which providers can distribute certain contraceptive products is a crucial one for client supply. In the past, oral contraceptives were distributed by market women; however, the government has recently banned these women from dispensing pills. In some states, village health care workers can initiate and distribute pills, while in other states they are not allowed to do so. There are no empirical data in Nigeria to suggest that such workers, after proper training, should not be able to initiate and dispense oral contraceptives to women who are appropriately screened.

Convenient procedures for NORPLANT® insertions is another matter begging solution. Currently, only physicians can perform this procedure. If the situation continues, cost will escalate and severely restrict accessibility and availability of that method, with low utilization resulting.

Facile administration of injectable contraceptives is a matter requiring attention. Currently, pharmacists are not allowed to administer injections. Although some, reportedly, do so (e.g., antibiotics); this restriction limits facile administration of injectable contraceptives at point of purchase. On the other hand, standards of practice would be needed to regulate sterile procedures were pharmacists allowed to perform this function.

Prescription pharmaceuticals, including contraceptives such as orals and IUDs can not be advertised, which limits merchandising.

### **3. Implementation Considerations**

Constraints within the health systems involve implementation considerations relating to: management, resource availability, quality of care, and health education.

#### **Management**

With the decentralization of the federal health system in July 1990, the FMOH issued directives giving the LGAs total jurisdiction over primary health care and family planning in their respective areas. This transfer of authority empowered each LGA Chairman and associated PHC Coordinator with full responsibility for determining the level of support that public sector health and family planning activities receive in the individual LGA. This responsibility includes overall management and supervision of programs. Responsible staff, especially at the LGA level, have limited knowledge and experience in basic management skills including personnel, finance, logistics, and administration.

A three-month certificate courses in health planning and management has been developed with three Nigerian universities, with plans to use this course to train LGA managers. The concept of this course

is wanting, however, in the following aspects: (a) the curricula is derived entirely from sources other than those actually involved in the management of LGA services; (b) the curriculum was developed without recourse to field studies to identify LGA management concerns, problems, and requirements; (c) the curricula contains no teaching cases based on the actual circumstances confronting the LGAs; (d) course objectives and desired outcomes are not defined; and (e) the course lacks indicators for effective LGA management that set standards for planning, personnel and financial management, supply and logistics, supervision, and evaluation.

### **Resource Availability<sup>12</sup>**

Nigeria has a tradition of free health care in the public sector. Inflation and shrinking government resources mandate cost-sharing mechanisms for both services and drugs. Currently ninety percent of budgeted funds are utilized to pay salaries. Basic equipment and supplies at most health facilities are not adequate to meet basic needs of safety and service. Initial efforts with the Bamako initiative and revolving drug funds have increased, however, the availability of potent drugs in some areas.

### **Quality of Care**

Public trust, confidence, utilization, and willingness to pay are directly related to perceived quality of the services provided. Over the last five years, the Government of Nigeria—with assistance from UNICEF, WHO, and A.I.D.—has significantly improved the quality of most immunization services and, through focused efforts on continuing education, certain preventive and curative services. However, facility assessments have documented major deficiencies in service delivery at all levels of the health system. Such deficiencies relate to shortages of trained personnel especially in rural areas; the adequacy of training, pre-service and in-service; the availability of resources required for job performance; salary levels; and individual perceptions of job importance, priority, recognition, and satisfaction. At the same time, facility assessments have documented delivery of high quality health services, most often associated with dynamic leadership, appropriate training, a functioning revolving drug fund, regular supervision and active community participation.

While the policies of the current administration emphasize initiatives supported by A.I.D., there has been little attention by the FMOH (and other donors) to the operational effectiveness of the health system. For example, donors have focused on (a) inputs such as supplies and training; and (b) process indicators such as vaccine coverage. Relatively little donor effort has focused on

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<sup>12</sup> For background information, see discussion on Financial and Budgetary Considerations contained in Section 5, "ANNEX B - NIGERIA'S HEALTH SERVICE PROFILE."

program effectiveness and on the details of how the components of the health system actually function and interact.

Studies reveal that attention to the processes of health services delivery produces practical results. These studies suggest that concrete opportunities to improve the system are widespread. For example, a study of health care in Ogun State revealed a correlation among improvements in the quality of services, client utilization of the services, and clients willingness to pay for improved quality.

Although the FMOH has put into place an excellent step-by-step protocol "Standards of Practice" for evaluating and treating a child with fever, results from a study undertaken by ACSI/CCCD to measure the quality of service delivery revealed that many key steps in care were absent in the handling of the majority of cases. Deficiency in quality of service delivery is, also, evident by such circumstances as a cholera case fatality rate in Nigeria ten times higher than in other LDC settings.

Despite an extensive and costly multilevel supervisory hierarchy, quality control and supervisory oversight is inadequate, if not absent, throughout the entirety of the health delivery system. Comprehensive mechanisms for the evaluation and improvement of performance on the part of service delivery personnel and technical staff is lacking at all levels from the FMOH down to the LGAs.

Quality of care shortcomings are a major concern of the national family planning program. Nigeria's size, the decentralized nature of programs and logistical and management constraints make it difficult to provide reliable supplies of contraceptives, coordinate IEC and training with service expansion, and supervise and support service providers. In many cases, community leaders, providers and clients are misinformed. In much of the country, services are limited or uneven. These conditions discourage clientele. Many facilities serve only a few patients daily. Client satisfaction is fragile. It is estimated that up to one third of new acceptors discontinue within the first three months.

Donor assistance, to date, (including that provided through A.I.D.) has focused on training, service delivery, and commodities without sufficient attention given to quality of care issues. Greater attention needs to be paid to upgrading management capacity, including clarification of the roles and responsibilities of clinic staff, proper supervision of that staff, and the monitoring of the quality of service delivery. Training needs to be less technical and more result-oriented with emphasis on developing analytic skills and problem-solving for specific disease conditions. A reliable Health Information System (HIS) is also needed to assess, properly, the effectiveness of program activities and to direct the efficient flow of human, financial, and commodity resources.

## Health Education and Communications

While the performance of health system professionals is important, the future of Nigeria's health will depend, largely, on decisions made at the family and community levels concerning birth spacing, sexual behavior, nutrition practices, recognition of illness, home treatment, and referral. While the PHC strategy provides the framework for effective communication (e.g., Village Development Committees and Village Health Workers), the commitment, skills, and resources required to empower appropriate public health decision-making are lacking and need to be developed and strengthened.

Despite significant resources, there is a basic misunderstanding of what constitutes Health Education; it is often perceived as a simplistic administrative endeavor involving the arrangement of training courses and the distribution of posters. There is little, or no, concept of Health Education as an applied science for the planning and implementation of strategies focused on environmental and health behavior change, nor appreciation of the importance of conducting systematic health behavior risk and community needs assessments prior to the launching of health education activities.

No health education planning is undertaken: (a) to delineate and justify objectives; (b) to modify strategies based on experience and demonstrated needs; (c) to establish mechanisms for the allocation of resources; nor (d) to organize and conduct evaluation of program impact.

### 4. Untapped Potential of the Private Sector

Precise information on numbers of physicians, nurses, midwives, and pharmacists practicing in the private sector is not available, and estimates vary considerably. None of the estimates (i.e., 6,000 physicians, 3,500 pharmacists, and 10,000 nurses and midwives) suggested by well informed sources can be confirmed. Speculation that one half of all health personnel trained are practicing in the private sector, primarily in the large urban centers of the country, can not be validated. The quality of care available in the private sector varies widely. There is no clear correlation between fee structure and quality of service. The extent and quality of training received by private health service providers in preparation for their profession varies widely. Nevertheless, the private sector offers significant potential for expanding health service delivery to the general population throughout the country.

In the past, the private sector<sup>13</sup> has been underutilized due to: (a) skepticism evidenced by elements within both the public and private sectors; (b) distrust on the part of the public sector viewing the private sector as motivated principally by profit; (c) distrust of the public sector bureaucracy on the part of the private sector; and (d) the complexity and lack of readily accessible (or identified) mechanisms for channeling assistance to the various, diversified elements of the private sector.

Consideration of private sector potential should distinguish between nonprofit and profit-oriented entities. Discussion of the private sector in the following chapter will make that distinction.

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<sup>13</sup> Private provision of health care services includes: (a) the commercial private sector; i.e., pharmaceutical and other manufacturers and distributors; (b) private health care facilities, groups and individual practitioners (modern and traditional); (c) large industrial employers; e.g., petroleum companies, utilities and telecommunications parastatals, etc.; (d) the nonprofit private sector comprised of many nongovernmental (NGO) service providers; e.g., mission hospitals; and (e) international, national, and local service and community groups, including a growing number of women's organizations.

### III WHAT OTHER ORGANIZATIONS (OTHER DONORS, PVOS/NGOS, AND HOST COUNTRY PUBLIC AND PRIVATE SECTORS) ARE DOING TO ADDRESS CONSTRAINTS AND TAKE ADVANTAGE OF OPPORTUNITIES IDENTIFIED<sup>14</sup>

#### A. Public Sector Health Care and Family Planning<sup>15</sup>

In theory, the public sector health system is extensive and well-conceived. In July 1990, in line with the administration's general policy of decentralization, the FMOH issued directives that give LGAs total jurisdiction over PHC in their areas. The financial implications, especially the flow of resources and personnel from the federal and state ministries of health to the LGAs, are not yet clear. As it is, recurrent budgets at the state and LGA levels are burdened primarily with personnel costs, leaving few resources for program implementation.

##### 1. Federal Level

Overall responsibility for the health sector rests with the FMOH which: (a) provides policy guidance and strategic support to all the states and to the Federal Capital Territory; (b) coordinates state efforts towards a nationwide health system; and (c) collaborates with the states to monitor and evaluate implementation of the national health strategy. The Ministry has eight departments and in principle is responsible for the following health care services and training institutions: special hospitals (orthopedic, eye, psychiatric); teaching hospitals; national laboratories; communicable and endemic diseases control; international health and quarantine; regulation and surveillance of standard training of health personnel and of health standards; external health relations; drugs and poison control; national intersectoral health care linkages and primary health care support, including national planning, training, technical assistance, and program support.

To support the implementation of Primary Health Care (PHC), the FMOH created a parastatal PHC Agency in June 1992.<sup>16</sup> The sole function of this agency will be development and support of PHC. The agency will be authorized to establish working relationships with donor agencies and organizations. The agency will be located

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<sup>14</sup> This Chapter discusses health sector initiatives in Nigeria in an organizational context. For a presentation of host country and donor (including A.I.D.) initiatives in terms of specific preventive health interventions and functional support activities, see "ANNEX C - THE RESPONSE TO NIGERIA'S HEALTH SECTOR PROBLEMS."

<sup>15</sup> For additional discussion on various aspects of Nigeria's health services, see "ANNEX B - NIGERIA'S HEALTH SERVICE PROFILE."

<sup>16</sup> In August 1992, this measure was still awaiting Presidential ratification.

in Yaba adjacent to the PHC M&E unit and the newly constructed population and AIDS building. Agency staff will function, primarily, through four PHC Zonal offices in Ibadan, Enugu, Kaduna, and Bauchi.<sup>17</sup> The designated Executive Director of the new PHC agency plans to organize the unit into three divisions: Administration and Finance, Service Delivery, and Monitoring and Evaluation. Priority will be given to working with the states to strengthen PHC training, implementation, and monitoring.

## 2. State Level

The Federal Government collaborates with the states to monitor and evaluate the implementation of PHC. Formal linkage between FMOH and the states occurs through the National Council on Health, chaired by the Federal Minister of Health and composed of the state Commissioners of Health.

The state governments are responsible for (a) planning and coordinating the state health systems; (b) operating and maintaining secondary and nonspecialized tertiary hospitals and some primary health care facilities; (c) implementing public health programs; (d) training nurses, midwives and auxiliary staff; and (e) assisting the LGAs with the management and operation of some primary health care facilities.

In the states, responsibility for health programs is shared by the state Ministry of Health (SMOH), the Hospital Management Board (HMB), and the Local Government Authorities (LGAs). In general, the SMOH is responsible for setting policy and standards, whereas the HMB, operational in some but not all states, is charged with the day-to-day management of service facilities. The SMOH is headed by the state Commissioner of Health who is responsible to the state Executive Council and is assisted by the Director General in the SMOH. A Director of PHC usually coordinates support to LGA implementation.

The HMB administers the state's hospitals and in some cases health centers and urban clinics. Its main responsibilities are personnel administration and the financing and management of logistical support systems including drugs, supplies, equipment and maintenance. The HMB is headed by a chairman who in some states reports to the state Commissioner of Health and in others to an independent board. The SMOH establishes the policies under which

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<sup>17</sup> The national public health structure is organized into four zones: "A" Zone = Southeast; "B" Zone = Southwest; "C" Zone = Northwest; and "D" Zone = Northeast. These Zones are arms of the federal authority; their official relationship with the States and LGAs, however, has never been fully articulated and their eventual PHC role is not yet clear. The Zones could possibly serve as the focus for a variety of operational activities, such as regional training efforts. To date, they have been primarily active in family planning activities.

the HMB functions, while maintaining overall responsibility for the state's health programs.

### 3. Local Government Area (LGA) Level

Each of the 593 LGAs in Nigeria since 1990 has become responsible for (a) operation of the health facilities within its area; (b) provision of basic outpatient, community health, hygiene and sanitation services; (c) provision and maintenance of infrastructure to provide health services; and (d) involvement of the local community in support of primary health care. The SMOH coordinates these activities and provides technical support. In each LGA the responsibility for health rests with the Health and Social Welfare Councillor whose unit is typically comprised of four sections: (a) preventive health, including public health, information programs and public sanitation; (b) curative health, including the operation and supervision of health facilities; (c) leprosy treatment; and (d) social welfare. Until recently, states provided special grants or seconded staff to the PHC facilities. As the LGAs attain more autonomy they are also taking control of basic health centers and hospitals. Currently many of the LGAs do not yet have the financial resources, technical staff or managerial competence to carry out the mandate given to them. This is a major challenge to operation of the system.

The LGA PHC system is organized at three basic levels: village, district, and the local government level. Each has a distinct PHC committee that oversees the organization of the program. These committees strengthen the management of the PHC at the various levels by identifying the health and social needs of the community and by planning and implementing the projects. Volunteer health workers (VHW) and traditional birth attendants (TBA) are trained to render PHC services at places of work (including farms), in homes, and at schools. This activity represents the village-level aspect of the PHC structure. Nurses, midwives, and other categories of formally trained health workers run the health clinics, health centers, and comprehensive health centers at both the district and local government headquarters levels.

The village health post is the most rudimentary facility, serving approximately 500 persons. In many cases, a typical health post is located as an annex of a village health worker's residence or a room in the home of the traditional ruler of the area. The village health post is staffed by a VHW who provides both preventive and curative care, including treatment of diseases like malaria, as well as minor injuries. Promotive aspects deal with issues such as family planning, health education on food hygiene, water and sanitation, nutritional assessment of pregnant mothers, and growth-monitoring in infants. VHWs are also responsible for maintaining records of births, deaths and records on attendance at the post.

Dispensaries are under the control of the LGAs and serve populations of about 10,000 people. They are often staffed by Community Health Aides and headed by a Community Health Assistant. The services provided are broader and of greater sophistication than those carried out at the level of Health Post. The services provided are related to the nine components of PHC.

Health clinics are often specially designated health units that serve specific aspects of the health needs in a community such as maternal and child health. Health clinics serve populations of between 20,000 and 50,000 people in rural and urban areas, respectively.

Primary health care centers serve between 20,000 and 80,000 people. A primary health care facility has health posts and dispensaries and satellite facilities through which it administers outreach services. Primary health care centers were formerly managed by the SMOHs, but are now managed by the LGAs. Center staff should include a Medical Doctor and the facility is supervised by a Community Health Officer who is assisted on a regular basis by a visiting Medical Officer in charge of the LGA. Other staff include a Community health supervisor, a public health nurse, community midwives, nurses/midwives, community health assistants, a public health superintendent, a laboratory technician, dispensary/pharmacy technicians, assistant record officers and unskilled workers. The services offered in a health center are all within the scope of the nine component services of the PHC system.

Comprehensive health centers provide broader medical and health coverage than the primary health care centers and serve a larger population than the latter. Whereas primary health care centers serve a range of 20,000 to 80,000 people, each comprehensive health center has a population coverage of between 100,000 and 150,000. Comprehensive health centers are staffed by a resident Medical Officer.

At present, the Ministry of Health reports a total of 7,725 public service delivery points, with 4,342 more in the private sector. Of the public service delivery points, at least 1,492 provide family planning services. Approximately 900 of these provide full services including IUD insertion. At present, there are approximately 2,000 clinically trained FP service providers working in government facilities, though more have been trained and moved into the private sector or changed vocation.

## **B. Private Sector Health Care and Family Planning**

### **1. General**

The private sector in health service delivery in Nigeria is large, diverse and relatively unconnected to the public health care system. For example, little cooperation has existed between the public sector and the many church-related health service providers

in Nigeria; nor has the public sector tried to make use of traditional practitioners, still the preferred providers in some areas, to increase access to health care.

According to a World Bank Study in Ogun State, fifty percent of all health care facilities in urban areas were private, and half of all physicians were practicing in the private sector. The recent Nigerian Demographic and Health Survey shows that sixty-three percent of women using modern contraceptives receive either their supply or related information from nongovernment sources. A recent urban EPI study found that a surprisingly high percentage of immunizations given in urban areas are delivered by the private sector (18.5% of measles immunizations given in Lagos State). The Christian Health Association of Nigeria (CHAN) estimates that thirty to forty percent of all primary health care services delivered in Nigeria are delivered by CHAN member organizations.

Now that the primary health care system has been firmly established and both its strengths and weaknesses recognized, there appears to be more receptivity on the part of the FMOH to recognizing and working out mechanisms to engage the private sector. Although skepticism exists on all sides with public officials viewing commercial providers as being influenced solely by profit motive and private providers being wary of government bureaucracy, there is increasing openness on both sides.

Many possibilities exist for effective partnerships between the public and private sectors in health care in Nigeria. Specific efforts will be required, however, to ensure safety and quality of care delivered through the private sector. This requires standard-setting, regulation, and enforcement by the public sector in several areas, including training and licensing of health practitioners, accreditation of health institutions, and regulation of pharmaceutical and medical products. Mechanisms are in place for some of these areas, but it appears that their strengths and weaknesses have not been systematically studied. A more systematic study of private health services in Nigeria is needed to include, for example, a review of oversight mechanisms and an examination of the private health insurance industry.

Neither the government, nor A.I.D. has studied in any depth the current and potential role of the private sector in health. Nonetheless, in the current economic situation, the Federal Government is actively pursuing privatization in the social services. Specifically, opportunities for collaboration at the secondary and tertiary level are under consideration in the Ministry, supported in part by A.I.D.'s Primary Health Care Support Program. Yet to be tapped is the private sector network in support of primary health care beyond the strong participation of the Planned Parenthood Federation of Nigeria (PPFN) in family planning. The number of private sector delivery points providing family planning services is not known.

Private provision of health care includes (a) the commercial profit-making sector (e.g., private health care facilities, individual practitioners, and a limited number of large industrial employers); as well as (b) the nonprofit sector, which includes many nongovernmental (NGO) service providers as well as international, national and local service and community groups, and a growing number of women's organizations.

## 2. Non-Governmental Organizations (NGOs)

Private, nonprofit providers (mission hospitals and clinics, women's groups, university programs, etc.) have played a significant role in Nigeria. This category of provider is distinguished by: (a) strong nonprofit, service motivation, often with a public health perspective; (b) lower potential for sustainability because of nonprofit status; (c) fewer business and management skills; (d) and a tendency to target lower socioeconomic groups than those addressed by profit-oriented providers.

Mission and other NGO hospitals have a long history of providing health care in Nigeria, as illustrated by the proportion of services still delivered by Christian Health Association of Nigeria (CHAN) institutions.

CHAN, a national umbrella organization for church-affiliated health institutions with a membership of 316 hospitals, maternities, clinics, dispensaries, and health programs with over 2,000 health posts and similar facilities located, nationwide, among rural communities and city slums, CHAN represents a significant national infrastructure. Its members serve an estimated forty million Nigerians; employ 16,000 workers; operate 15,000 hospital beds; and record 12 million outpatient visits per year.

Several CHAN member institutions are recognized as major health care facilities in Nigeria; a number of these have emerged as strong family planning service providers. For family planning activities, CHAN's greatest constraint is in its Roman Catholic membership. To date, this has meant that member institutions must be approached, individually, concerning family planning.

CHAN serves its membership in four areas: (a) administrative and management support and training; (b) procurement and distribution of high quality pharmaceuticals; (c) primary health care promotion and coordination; and (d) a holistic health care project.

Recent and growing economic constraints, however, will continue to put increased pressure on the public sector to find ways to incorporate the NGO network into the health delivery system. Public sector service providers have relied on NGOs, (specifically, PPFN) to provide family planning commodities in times of shortage, for referrals on voluntary surgical contraception (VSC), and have demonstrated the potential for a productive partnership by sharing clinic space. Mechanisms such as CHAN and the National

Association of Nongovernmental Organizations (NANGO) offer an effective means for reaching NGO providers with in-service training and commodities.

In terms of geographic coverage, PPFN and other NGOs are better suited than the public sector to pioneer family planning activities, particularly in the North, where attitudes are less favorable, and programs are still in the developmental stage. PPFN has traditionally played the role of innovator, introducing services in areas where government activities might be politically sensitive and/or viewed as being intrusive. The mission hospitals have a certain moral force which helps legitimize family planning activities, even in conservative communities. These networks will be encouraged by program strategy to reach communities in the North, aided by appropriate IEC targeted in accordance with specific sociocultural considerations.

In view of the number of people who come in contact with the university system as well as the long-term capacity of this strata of the population to influence the general public, university-based facilities and programs offer considerable potential for supporting the overall goals and objectives of the A.I.D. program.

### 3. Community Organizations

Rotary has become synonymous with Polio-Plus and the immunization campaign in Nigeria, and local Rotary clubs are also known for their support of other health sector activities. Many other service organizations with national and international networks are also active supporters of health care at the local level. There are many other regional or local community groups such as the community development authorities which may or may not be accessible through existing networks and religious organizations. Local religious leaders are recognized by many health and family planning advocates as particularly effective means of information, education and communication (IEC).

Women's organizations have also been discovered or rediscovered by government and international organizations. There are proliferating and overlapping groupings of such organizations, including those groups incorporated into the Better Life for Rural Women umbrella supported by the current military government (through First Lady Babangida and the wives of the military governors) and those associated with the National Commission of Women's Societies. In addition, there are local women's organizations and cooperatives such as religious groups and market women's associations, which could be strengthened or supported as a means of promoting and/or delivering family planning, health, and AIDS prevention messages and services.

Specific groups representing high risk individuals, such as commercial sex workers, have been particularly effective for reaching members at high risk of sexually transmitted diseases,

including AIDS, with both information and condoms. This approach has potential for use with specific FP targets, such as teenagers.

Market women have been successful in social marketing and community-based distribution of family planning products. This approach has made it possible for women who would otherwise not have the time to visit a local clinic or who wish to maintain privacy (from their partners, neighbors, etc.) to avail themselves of family planning methods. The Association for Reproductive and Family Health (ARFH) based at the university hospital in Ibadan has pioneered the training of market women in the distribution of contraceptives and the strengthening of women's organizations through management training, orientation in provision of services, creation of income-generating, and operations research activities.

The many and varied community-based organizations offer institutional potential for the grassroots testing of new strategies for the promotion and delivery of primary health care, family planning, and AIDS prevention, with emphasis on IEC, community-based distribution (CBD) and operations research (OR).

#### 4. Commercial Private Sector

Private health providers in Nigeria include a large and growing number of trained modern health professionals (physicians, nurses, midwives, pharmacists, etc.) who operate as solo or small group practitioners, as well as a variety of trained and untrained traditional practitioners such as traditional birth attendants, herbalists and medicine vendors. Modern practitioners can be reached with health information through a variety of methods including retailers, professional organizations and accrediting bodies.

These mechanisms appear to be underutilized but are being rediscovered along with other mechanisms for delivering information of public health importance to the private sector. Examples of effective attempts to reach private practitioners include provision of family planning commodities through nearly 6,000 private health providers and service delivery sites. Africare has recently mounted a program to incorporate private providers into the PHC network in several LGAs.

This initiative is premised on the assumption that private providers are motivated to give good care as well as to make a profit, and that these are compatible and not competitive objectives. It is also clear, however, that private practitioners must be oriented adequately to consider prevention as a noncompetitive objective. For example, private midwives may view family planning as reducing demand for deliveries; or practitioners advocating family planning might fear the loss of clients who regard family planning as a threat to traditional values.

The means for reaching private providers with orientation, training commodities, etc., include the use of professional societies, as is being explored by UNICEF, and provision of family planning through private nurse/midwives associations in eight states. Professional societies such as the Society of Obstetricians and Gynecologists and the National Association of Nigerian Nurse Midwives (NANNM) can be used, for example, to disseminate information through existing channels (e.g., journals, meetings, etc.) as well as to develop in-service training. Drug retailers provide another mechanism for reaching the private sector with information, although this mechanism is more likely to reach pharmacists rather than physicians and nurses working in noninstitutional settings.

### **5. Employer-provided Services**

An area not yet sufficiently explored involves employer-provided health and family planning services. While the modern industrial sector only employs a small number of workers in Nigeria, the larger enterprises offer considerable potential for family planning and AIDS prevention interventions. Examples of such programs include parastatals, such as Nigerian Telecommunications (NITEL) and the National Electric Power Authority (NEPA). In addition, three gasoline corporations (National, Total and Mobil) have trained staff to become family planning providers. These companies receive their commodities through the Transport Workers Association Chapters, or directly from Sterling Pharmaceutical.

Many of the smaller private sector firms, however, have reduced or eliminated services previously offered at on-site clinics. In most cases, on-site facilities that once offered basic health services are now providing only first aid for accidents and injuries. Most employers have tried to control the cost of health care for their employees by arranging retainer contracts with a number of different providers who own and operate independent hospitals, clinics, and maternities.

### **6. Social Marketing and Community-based Distribution**

Introduction and promotion of subsidized preventive health commodities through commercial channels is underway for contraceptive commodities and with condoms for AIDS prevention. However, special efforts compatible with the definition of social marketing must be made to reach consumers at the lower end of the economic scale. Currently the "Right Time" condom does not target this audience and might more appropriately be considered a commercialized product.

Both the FHS project and Population Services International (PSI) have learned a great deal from experiences so far, but many obstacles must be overcome to increase sales and cost-effectiveness. Market imperfections (corruption, adulteration of drugs and other products, lack of regulation and enforcement) hinder current social marketing efforts. A number of social

marketing initiatives have been undertaken through a variety of channels, including registered commercial outlets (pharmacies and shops), patent medicine vendors and community-based distributors (CBD), including market women and other village-based distributors. An innovative approach to selling condoms, for example, is the National Oil Company mini-mart program. Initial CBD efforts have met with both successes and failures. Market women programs and experience with women's groups appear to have been more successful when accompanied by adequate orientation, training and supervision. Some market research activities (NIGERBUS) were conducted prior to the launch of the social marketing program for contraceptives, however, experience has demonstrated the need for additional efforts in that regard.

### C. Other Donor Support for Health Care and Family Planning

1. **World Bank** - Although the World Bank appears to be restraining its industrial and infrastructure investment in Nigeria, its involvement in the health and population sectors is wide and robust. Five projects are either underway or nearing agreement. Two, the \$34 million Sokoto Health Project begun in January 1986, and the \$32 million Imo Health and Population Project, while focusing on state programs, also contain components to strengthen the FMOH's capacity to assist state and LGA health programs and to prepare new policies and projects in health and population. The Essential Drugs project, launched in 1990 for \$68 million, focuses on four states (i.e., Bendel, now Edo and Delta; Cross River; Gongola; and Kwara) and all major urban areas served by the eighteen Federal hospitals. The project supports the FMOH's own efforts to develop procedures to assure an affordable and sustainable supply of safe drugs, especially for primary health care through institution of drug revolving funds and cost recovery policies and procedures supported by technical assistance and management training. Under that project, seed money was provided for "essential drugs" to participating states.

The World Bank's \$70 million Population Project (1992-96) provides assistance to the FMOH's Department of Population Affairs to strengthen family planning efforts of the Ministry and four other Federal agencies, including the Ministries of Education and Information, universities and nongovernmental organizations. Subprojects address service delivery, information, education and communication, as well as financing, monitoring, evaluation and research. No procurement of commodities is planned by the Bank which assumes these will be provided through 1996 by UNFPA and A.I.D.

The Bank has also proposed the establishment of a Population Research Fund (PRF) to be administered by the Nigerian Institute of Social and Economic Research (NISER). Research would focus on sociocultural and economic constraints to implementation of the National Population Policy and on cost-recovery issues.

Especially important for further implementation of PHC decentralization, the Bank's Health System Fund, a \$70 million loan signed in 1990, provides a line of credit to the states for strengthening health delivery systems at the local level. With the transfer of all responsibility for primary health care to the LGA's, some question remains as to how the Fund (developed with the FMOH Department of Planning Research and Statistics) will now operate.

Still to be approved is the First Referral Hospital Fund loan, under which states will select five LGAs with acceptable PHC delivery systems to develop a "first referral hospital" with assistance from the Fund. Procedures and criteria for this loan, in a departure from previous practices, are being developed with the FMOH Department of Hospitals.

Finally, the Bank is working with the federal government's Food and Nutrition Committee and other donors to develop a multisectoral food and nutrition loan. A.I.D. has been asked to support some of the studies for this preparation.

**2. World Health Organization (WHO)** - Working largely with UNICEF in projects involving health and primary health care, the control of diarrheal diseases, the Bamako Initiative and essential drugs, as well as water supply, WHO serves as a technical advisor, with little financial input. WHO has provided critical technical assistance supporting various child survival initiatives; e.g., EPI, CDD and ARI (including a recently completed focused ethnographic survey methodology).

Through its Global Programme on AIDS (GPA), WHO has played a major role in support of AIDS prevention and control in Nigeria. The focus of WHO/GPA assistance has been the development of policies and planning to combat AIDS. WHO/GPA has provided grants to Nigeria in the amounts of \$600,000 and \$725,000 and has pledged an additional \$1,000,000 to implement action plans. The funds have been earmarked for epidemiological surveillance, strengthening of the federal AIDS management infrastructure, and some IEC activities. In addition, WHO/GPA has provided about one million condoms to Nigeria since 1987.

**3. UNICEF** - Under its 1991-1995 Country Program with planned total funding of \$125 million, UNICEF supports interventions to improve child survival and the quality of development and protection of Nigerian children and women. At the national level, the program focuses on policy promotion and management support to the health sector, specifically for primary health care, and especially for immunization and diarrheal disease control. At state, LGA and community levels, UNICEF is providing management support for PHC in LGAs of ten focus states, including development of community-based PHC systems. Other programs strengthen health care support systems including: (a) mass media capacity building; (b) community participation and mobilization of

nongovernmental organizations; (c) support for the development and communication of a national policy on AIDS; and (d) development of sustainable information systems.

UNICEF is also assisting state governments to implement integrated water supply, sanitation and health education projects, including Guinea worm eradication; and to support household food security and nutrition through provision of improved planting materials, training in nutrition and appropriate crop and livestock production techniques, and improved food technology.

In addition to preparing a basic education program, and as a prelude to development of a national policy on working children, UNICEF is sponsoring a small-scale program for women and children to improve the income-generating capacity and living conditions of families with homeless children in Calabar and Kaduna.

UNICEF has been ACSI/CCCD's foremost collaborator in Nigeria, playing an important operational role in the implementation of that project, particularly, with respect to EPI and CDD. From its own budget, UNICEF has provided technical support, vaccines, ORS, training materials, and cold chain equipment. In 1986, ACSI/CCCD provided a five-year \$6 million grant to UNICEF to augment the overall EPI effort.

4. **UNFPA** - In addition to its budgeted \$35 million dollar program, UNFPA is seeking additional funding to support plans: (a) to expand the availability of MCH/FP services to rural areas; (b) to increase contraceptive prevalence to fifteen percent by 1995; and (c) to strengthen the national structures for population planning, coordination, monitoring and evaluation, data collection and population education. Support will be provided as well for AIDS prevention and environment protection. UNFPA's Women, Population and Development projects promote female literacy, the use of family planning facilities, and income generating activities for women.

5. **International Planned Parenthood Federation (IPPF)** supports its national affiliate the Planned Parenthood Federation of Nigeria (PPFN), the largest voluntary nongovernmental organization promoting family planning in Nigeria. The PPFN has a presence in seventeen states and plans to establish clinics in the remainder. Total PPFN expenditures for 1992/94 activities are estimated at \$28 million. Operating mainly in urban areas, PPFN also carries out community-based distribution programs and promotional programs for family planning and women's development nationwide. In addition to the IPPF, the PPFN receives support from USAID and UNFPA.

6. **Rotary International** - Through the aegis of its worldwide Polio-Plus project, the Rotary Club system has played a principal role in the Nigerian EPI. At a cost of over six million dollars, Rotary International has met the entirety of the oral

polio vaccine requirement for the Polio-Plus project in Nigeria. In addition, Rotary International has made a one time grant of \$1.7 million for cold chain equipment. Polio-Plus project activities in Nigeria are funded through contributions of individual Rotarians, local Rotary Clubs, and a social mobilization grant of over one million dollars from USAID.

In Nigeria, Rotarians are currently working in 300 LGAs with an estimated population of sixty million. Rotarians have recruited an estimated 20,000 community volunteers; 7,000 have already been trained to mobilize the population for immunization. Rotarians and their recruited partners (e.g., Boy Scouts, Girl Guides, and Transport Workers) have contributed to EPI implementation through provision of transport for staff and cold chain, social mobilization, and the recording of immunizations given.

7. **Others** - Several other multilateral and bilateral organizations, including the United Nations Development Programme, the European Economic Commission, the Government of Japan are providing assistance to Nigeria's health sector, with particular attention to the area of water and sanitation. The Ford Foundation is also active in Nigeria with program oriented to reproductive health, AIDS prevention, and women's issues.

#### IV A.I.D.'S ROLE AND EXPERIENCE IN ADDRESSING PROGRAM CONSTRAINTS AND EXPLOITING OPPORTUNITIES IDENTIFIED<sup>18</sup>

##### A. Relation to A.I.D. Strategy and Development Fund for Africa (DFA) Priorities

A.I.D. policies and strategies concerning family planning, maternal and child health, and HIV/AIDS are well established.

For three decades, family planning programs have been an essential element of the U.S. development assistance strategy. The objective of A.I.D. population assistance is twofold: (1) to enhance the freedom of individuals in LDCs to choose, voluntarily, the number and spacing of their children; and (2) to encourage population growth consistent with that of economic resources and productivity.

A.I.D. population assistance policy rests on the premise that continued high rates of population growth significantly increase the cost and difficulty of achieving basic development objectives by imposing burdens on economies presently unable to provide sufficient goods and services for the growing population. This strategy recognizes the close linkage of family planning with initiatives promoting child survival and the improvement of education, social status, and income-earning capacity of the female population within a given country.

A.I.D. population assistance strategy emphasizes: (1) dissemination of family planning information and education; (2) training of service providers; and (3) demographic, technical, and social science research and analysis supporting the improvement of family planning policies, programs, and service delivery.

For nearly twenty years, A.I.D. policy has stressed the importance of child survival initiatives. Congressional mandates and Development Fund for Africa (DFA) guidelines have done likewise.

The evolution of A.I.D.'s child survival approach had its origins in the mid-1970s when A.I.D. began to emphasize a primary health care (PHC) approach. The early 1980s saw the development of the PHC concept in A.I.D.'s health policy formulation. Raising the health status of children and their mothers was a primary objective of A.I.D.'s 1982 health policy, although the approach to health care programs was more comprehensive.

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<sup>18</sup> For a presentation of A.I.D.'s role in the overall donor community and host country response to specific preventive health problems and related functional support constraints, see "ANNEX C -THE RESPONSE TO NIGERIA'S HEALTH SECTOR PROBLEMS."

Initially, A.I.D. funded activities aimed at child survival through general health service and PHC projects. In the mid-1980s child survival became a primary focus of A.I.D.'s PHC program. During the past decade, increased national (including Congressional) and international interest has focused on the provision of selected child survival interventions as cost-effective and direct means of improving health and preventing mortality in developing countries.

Specific A.I.D. Health Sector objectives are: (a) reduction of infant and early child morbidity and mortality; (b) reduction of maternal morbidity and mortality; (c) use of child survival interventions as the basis for building a more comprehensive health care system over time; (d) assurance that gains made in improving child survival and health are sustained; and (e) development of new, basic, effective technologies and improved systems for delivery of child survival services.

#### A.I.D. health assistance policy guidance:

Stipulates that the reduction of infant and early childhood morbidity and mortality will be achieved primarily through: (a) increasing immunization coverage; (b) reducing diarrheal disease mortality; (c) improving nutrition in young children; and (d) improving birth spacing and maternal health.

Recognizes that a number of diseases not yet preventable by vaccination contribute to high infant and child mortality. Malaria and acute respiratory infections (ARI) are major causes of death and disability. Thus, A.I.D. policy guidance indicates that malaria treatment and control, and diagnosis and treatment of ARI are essential to the achievement of child survival goals in many countries characterized by conditions similar to those present in Nigeria. These guidelines also identify other factors that may adversely affect the attainment of child survival goals; e.g., AIDS and diseases associated with poor water and sanitation.

Promotes birth spacing, child bearing during the safest part of the woman's reproductive life, prenatal and postnatal care, safe delivery practices and adequate maternal nutrition in order to reduce maternal morbidity and mortality which affects both mothers and their children.

Advocates that child survival interventions are an effective and focused way to lay the foundation for a more comprehensive health care system. Improved training and supervision, logistics, and information systems are identified as important elements of a strong health care system in developing countries such as Nigeria.

Supports promotion of revised national policies which foster improved health financing through resource mobilization, resource allocation, containment of escalating recurrent

costs, and the reorganization of the health services delivery system.

Encourages increased private sector involvement.

Encourages improved coordination among donor agencies.

Promotes operations research to address weaknesses in health technology delivery systems and to improve program efficiency.

Since the mid-1980s, A.I.D.'s child survival strategy has focused directly on twenty-two emphasis countries—one of which is Nigeria—and on those cost-effective interventions (identified above) that have a direct impact on reducing infant and child mortality.

Much of A.I.D.'s child survival strategy for sub-Saharan Africa has been implemented through the regional Africa Child Survival Initiative/Combating Childhood Communicable Diseases (ACSI/CCCD) project (PACD: 9/30/93) in collaboration with the U.S. Centers for Disease Control (CDC). The decade of the 1980s witnessed an extraordinary success in the extension of basic public health services to the child population in sub-Saharan Africa, including Nigeria. The ACSI/CCCD project has participated, substantially, in this success.

A.I.D. policy and its HIV/AIDS strategy for Africa is based on guiding principles reflecting: (a) a regional approach with emphasis on surveillance; (b) African leadership in defining the scale of the problem and the most appropriate national prevention and control measures; (c) the technical leadership and guidance of the WHO/Global Programme on AIDS; (d) concentration on targeted interventions; (e) discouragement of high risk behavior, sexual and otherwise; (f) mobilization of private and voluntary institutions to encourage sustainable interventions at the grass-roots level; and (g) integration of HIV/AIDS interventions into any on-going USAID-sponsored health, population, and nutrition activities.

The Nigeria CPSP adheres to the aforesaid agency policies and strategies; it reflects, also, a logical extension of recent A.I.D. involvement in Nigeria.<sup>19</sup>

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<sup>19</sup> In 1983, following a fifteen year absence, A.I.D. posted a senior officer in Lagos. Initial development interventions consisted of a variety of disparate family planning activities funded and implemented through Bureau for Science & Technology central contracts. In 1987 the Bureau for Africa assumed responsibility for consolidating and funding an expanded family planning assistance package: the Family Health Initiatives Project (FHS) authorized at \$67 million. Child survival activities under the Bureau for Africa's regional ACSI/CCCD program began in 1987 under a \$15 million multiyear agreement with the FMOH. Additional funds for Nigeria became available in early 1989 and were programmed under Non-Project Assistance (NPA) into a three-year Primary Health Care Support Project (\$36 million). By 1991, A.I.D.'s portfolio in Nigeria (almost exclusively in the HPN Sector) totaled about \$118 million in activities.

**B. The Present Child Survival Project**

For the past six years, the Nigerian component of the ACSI/CCCD project has been working, collaboratively, with Nigeria and its other partners (WHO, UNICEF, and Rotary) in implementing child survival strategies. In so doing, ACSI/CCCD has participated in the formulation of Nigerian child survival policies and in the strengthening of mechanisms for implementing the emergent strategy. Support has been provided through three technical and four support strategies. Technical strategies include the Expanded Programme on Immunization (EPI), the Controlling Diarrheal Diseases Programme (CDD), and the Malaria Control Programme. Support strategies include: Health Information Systems, Training, Health Education, and Applied Research. Other areas of A.I.D. child survival program activity include infant nutrition, dietary management of diarrheal disease, weaning food development, and limited interventions in acute respiratory infections (ARI).

Expanded Programme on Immunization (EPI)

CCCD has supported the Nigerian program to immunize 75% of children in the first year of life through: (a) assistance in technical strategy development, training, supervision, and monitoring and evaluation; and (b) a grant of \$6 million to UNICEF for commodity support. An EPI program, which collapsed through poor management in the early 1980's, has been re-established with the implementation of vastly improved decentralized vaccine delivery systems. Coverage in the high risk under-one age group has increased, and disease incidence has fallen. Following the major push to achieve the Universal Child Immunization target in 1990, there was a decrease in coverage in 1991. See Figure 4.

EPI COVERAGE RATES BY ANTIGEN FOR UNDER ONE NIGERIA, 1986 - 1991

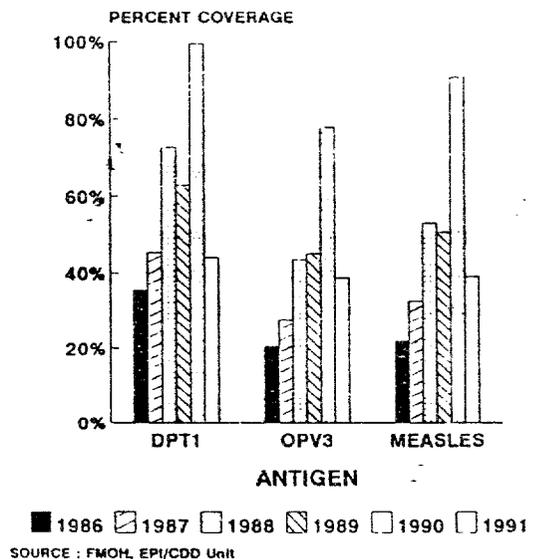


Figure 4

Malaria

At the time of initiation of CCD activities in Nigeria, malaria policy and strategies had not been adapted to the changing

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Over the past several years, the Nigeria program has had an OYB of about \$11 million.



Diarrheal Disease Control

CCCD inputs into diarrheal disease control have been primarily directed at assessing and improving case management practices in the community and at health facilities and in the development of health education in-service training strategies and training materials. Deficiencies in treatment practices, documented by the 1989 In-Depth Review, are being addressed through training courses in case management and continuing education. See Figure 6.

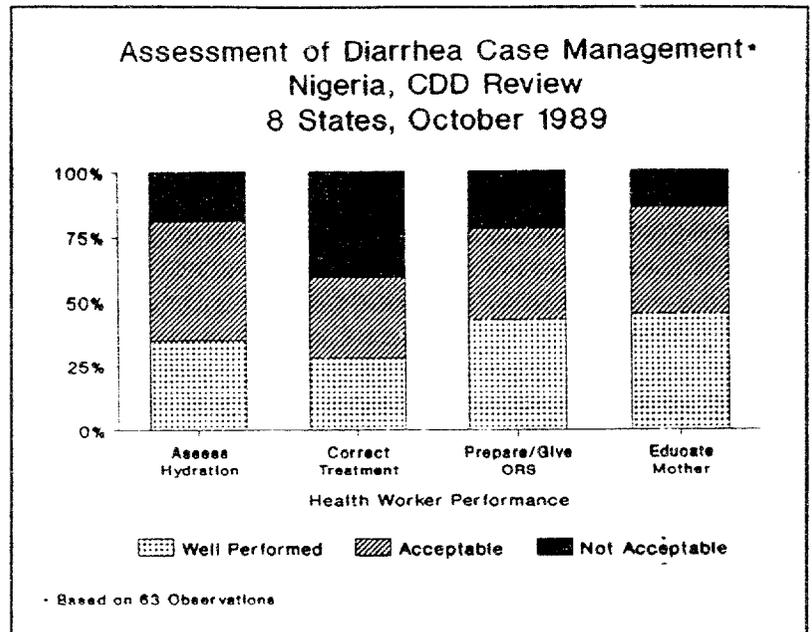


Figure 6

Data collected through 1991 has not yet shown the expected drop in diarrhea deaths and case fatality rates. See Figure 7. This indicates a failure to achieve the desired improvements in case management. Improved case management is a continuing challenge for the health care system in Nigeria.

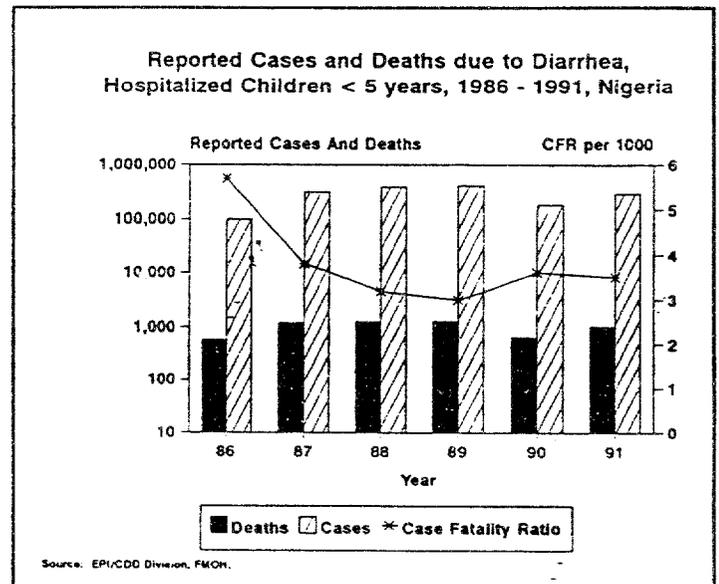


Figure 7

Health Information

The Minister of Health has identified CCCD assistance to the health information effort as a major contribution to health development in Nigeria. Accomplishments have included:

- Establishment of a PHC Monitoring and Evaluation Unit including equipment, software development, and training.
- Development of HIS systems in six state Ministries of Health.

- Improvement of disease surveillance through inclusion of reporting on forty notifiable diseases, the development of a PHC sentinel surveillance system, and the computerization of inpatient data at nine major hospitals.
- Establishment of the Nigerian Bulletin of Epidemiology as a quarterly publication within the Epidemiologic Unit.
- Development of a Medlars bibliographic retrieval capacity at the National Library of Medicine.

### Training

CCCD has strengthened Nigerian capacity for carrying out health facility surveys to monitor quality factors in supply availability, clinical assessment, treatment, patient education, and record keeping. Results led to the establishment in Niger State of a Continuing Education Strategy directed at correcting deficiencies identified in the facility assessments. Based on a Federal Ministry of Health evaluation recommending that CCCD assist other interested states establish continuing education units (CEUs), CCCD is establishing such units in the other eight focus states.

### Health Education

The prime focus of health education activities is to strengthen federal and state health education units. CCCD has utilized the services of the African Regional Education Center at Ibadan University to fund a regional course in health education. Implementation of health education projects developed as part of training has been effective in the upgrading of PHC services in several LGAs. Long-term goals are to upgrade health education capacity at each of the three levels: Federal, State, and LGA.

### Applied Research

CCCD has established a Nigerian Research Program to identify and solve applied problems in PHC delivery. This has included the development of research guidelines, the establishment of a Nigerian Research Review Committee, and the funding of thirty-five research proposals.

### CCCD Evaluation

In March 1991, an independent team of seven consultants responding to an AFR/TR/HPN initiative reviewed the Nigeria ASCI/CCCD program. The review used the following parameters to assess the merits and long-term sustainability of the ACSI/CCCD project: (a) effectiveness of technical interventions; (b) institutional capacity of the host government to implement the project; (c) constituency of project activities; (d) appropriateness and effectiveness of training; (e) health care financing; and (f) national leadership and capacities to negotiate with donors.

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

Training has been a vital support strategy. CCCD has taken the lead in this area, with the full backing of the FMOH and the donor community. Health care financing is being addressed through drug revolving systems (e.g., Bamako Initiative) in accordance with the opinion of the Minister of Health that "free health care is no health care". The review team felt the Minister has been the leading force behind PHC promotion and, as such, has set a historical stage that will not be easily changed.

### **C. The Present Family Planning (FHS) Project**

A.I.D. is a principal source of external support for Nigeria's population and family planning program. The structure of the program results from years of many contractors working in Nigeria in the population and family planning field.<sup>20</sup> The desirability of consolidating efforts and activities to increase efficiency and to avoid duplication led to the current bilateral project; i.e., the \$67 million umbrella Family Health Services (FHS) project initiated mid-1987 (PACD: 6/94). The overall program goal of FHS is to "improve the quality of life by strengthening integrated health care services available through the public and private sector". The specific approach has been fourfold:

**Policy** - strengthen the potential for efficient mobilization of a family planning program through the development of support from influential persons, opinion leaders and constituency groups.

**Information, Education and Communication** - increase acceptability of family planning and increase awareness of options and services.

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<sup>20</sup> As the most populous country in sub-Saharan Africa, Nigeria has been, for more than a decade, a target country for a wide variety of family planning cooperating agencies (CAs) functioning through A.I.D. central contracts. By 1986, at least twenty-seven CAs were undertaking, or had undertaken, family planning activities in Nigeria.

**Public Sector** - strengthen management systems and service delivery capacity at all levels of government.

**Private Sector** - develop and expand private sector initiatives in family planning through a variety of channels including commercial, work place, and private medical facilities.

## **Policy**

In the Policy area, important groundwork has been laid through training and technical assistance designed to enhance institutional capacities (in such areas as data processing and the dissemination of critical information to policy-makers) requisite to the process of strategic planning. Policy development *per se* is not a prime concern (the National Policy on Population for Development, Unity, Progress and Self-Reliance is already formulated and published); rather, the implementation of that policy is the crucial endeavor. Strategic planning is, and will be, a primary tool in the execution of that task.

Constituency-building, including the conduct of a variety of workshops directed to special topics (e.g., early marriage) and/or influential groups (e.g., religious leaders, high police officials, etc.) has been an active FHS ingredient in the policy arena. Another important initiative: fact-finding missions to various states have collected and disseminated vital data essential to program planning and the increase of knowledge and understanding among policy-makers and service providers.

## **Information, Education & Communications (IEC)**

FHS has achieved considerable success in the effort to increase public knowledge of family planning and modern contraception. Specific achievements include: (a) production of a comprehensive set of counseling materials to facilitate in-clinic counseling and standardization of basic family planning information dissemination; (b) the training of more than 200 personnel from Federal and State Agencies in family planning IEC, counseling, materials development, research techniques, and other specialized areas; (c) full-scale SMOH family planning IEC activities initiated in seventeen states; (d) IEC impact monitoring mechanisms formulated utilizing such approaches as clinic data collection, statewide media monitoring surveys, client exit interviews, national household surveys, and the Nigeria omnibus consumer survey; (e) the launching of the FMOH's National Population Logo; (f) the publication of more than fifteen pages devoted to family planning and population issues in the popular weekly news magazine "Newswatch" noted for its wide circulation countrywide; (g) the wide appeal of popular hit songs featuring family planning messages recorded by two of Nigeria's leading singers; and (h) the training of 110 master trainers and 330 teachers from sixty-six pilot secondary schools as part of the family life education activities undertaken with the Nigerian Educational and Research Development Council (NERDC).

## Public Sector

Achievements within the public sector include: (a) management enhancement at the LGA level through management training efforts; (b) the establishment of a network of Nigerian master trainers implementing a training program focused on the improvement of clinical services and management; (c) increased collaboration and coordination of PHC services resulting from intensive network efforts emphasizing organizational development; (d) significant preparatory work (i.e., training for key personnel and the publication of an operations manual) related to the development of a comprehensive Management Information System (MIS); (e) the establishment of an integrated PHC monitoring and evaluation (M&E) system within the MIS; (f) information on commodity status at the clinic level now being reported by the states on a regular basis; (g) improved monitoring and tracking of commodities at all levels; (h) intensive public sector delivery efforts initiated in twenty states, with some degree of coverage nationwide, including several major institutions, the Armed Forces, and the Police; and (i) a general improvement in the quality of family planning service in geographic areas addressed by FHS, thus rendering such services more readily available and accessible to the underserved population.

## Private Sector

Initiatives in the private sector have resulted in significant use of modern contraceptive practices among the population targeted by those efforts; e.g., (a) approximately 70,000 users are served through ten hospital-based units; (b) approximately 63,000 users are served through five NGO initiatives with religious groups and women's organizations; (c) approximately 50,000 users served by programs targeting vendors, commercial associations, and work places; and (d) nearly 4,600 retail outlets are now selling family planning products.

Other achievements in the private sector include: (a) the establishment of commercial channels for two brands of condoms marketed through separate distribution and promotional initiatives; (b) the active participation of the National Association of Nurse-Midwives (NANNM)—including eleven state-level affiliates—in the supervision and service delivery support to private medical providers; (c) collaboration of more than twenty different institutions in the training of approximately seven thousand midwives, nurses, vendors, pharmacists, and pharmacy assistants; (d) family planning training institutionalized in nine training institutions that now harbor a solid core of indigenous family planning trainers; (e) condoms promoted in a nationwide advertising campaign; (f) contraceptive products more readily available to all Nigerians regardless of social grouping, socioeconomic status, or religious affiliation; and (g) the Federal Office of Statistics (FOS) now incorporating family planning questions into its periodic household survey.

Successful training of large numbers of medical personnel in clinical methods of family planning has been accomplished through FHS, thus establishing an extensive nationwide contraceptive supply system in the public and private sectors. Increased public knowledge and support for population matters and family planning through extensive news media and local information, education and communication efforts have also been achieved. Though the results of these and other FHS accomplishments have not yet translated into significant percentages of family planning users, the project has laid essential groundwork. Many cultural/traditional barriers have been penetrated, thus building foundations for future accomplishments in the next phase of USAID population assistance.

The FHS benefitted from a Program Evaluation completed in late 1989 and Management Review in mid-1991. This latter assessment summarized significant progress in family planning in Nigeria, including the overall accomplishments of FHS as follows:

- There is general agreement among policy-makers and the general public that Nigeria's population is growing too fast. There are approximately one million users of modern methods in Nigeria, more than in any other country in Africa. The demand for family planning in Nigeria is clearly increasing, with an unmet need for effective methods, such as pills, injectables, female sterilization and NORPLANT®.
- FHS has established a national orientation with activities nationwide. Family planning has been integrated into the PHC program. Standards of practice have been developed for all service delivery levels. Family life education has been integrated into the secondary school curricula.
- The FHS Management Information System (MIS) for family planning has become a nationwide system and is beginning to produce more reliable and complete results. A network of training centers of excellence and a network of trainers have been established to provide clinical, nonclinical, management, and supervisory training. Extensive family planning training programs are taking place throughout the country.
- Clinical FP service sites equipped totaled 374; nonclinical service sites totaled 2,158. IUCD kits distributed to public sector facilities totaled 1,600. IUCD kits sold through the private sector totaled 1,388.

As is true of most statistics on Nigeria, good, standardized data on FHS program performance have been difficult to obtain, especially, in the private sector. Nevertheless, FHS information specialists assure that data since 1990 have been good and compare well with similar program data in other countries.

Training of people at many levels has been a major objective of the FHS project. Since 1984, about 14,000 people have received training in family planning under A.I.D. auspices. The FHS public sector element has led the effort, but as figure 8 shows, in recent years, the private sector program has contributed a large share.

Figure : People Trained: A.I.D./FHS

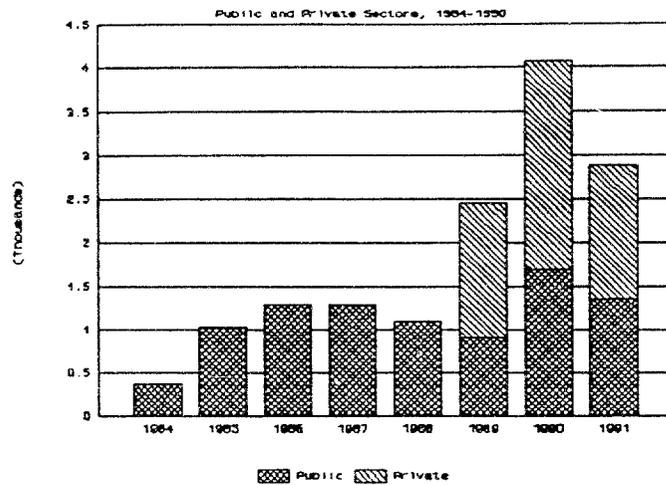


Figure 8

In the absence of good area probability sample surveys, demographers and public health people, frequently, use the statistical measure, "Couple Years of Protection (CYP)," to assess probable program impact. CYP is, also, a very useful management tool for comparing performance among

Couple Years Protection: FHS

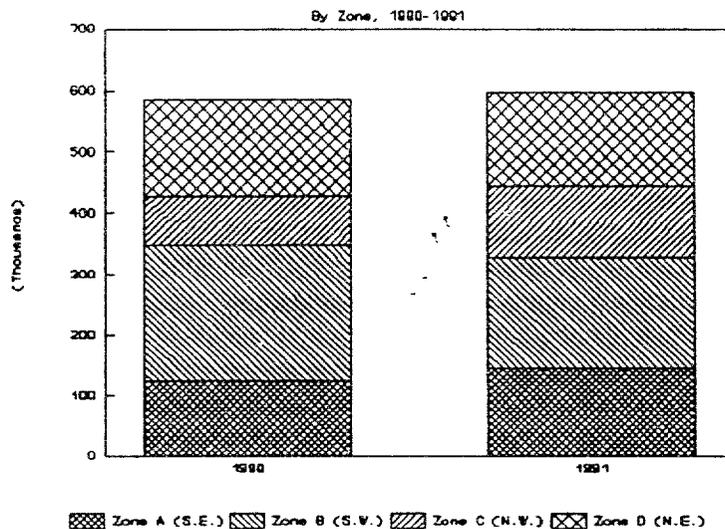


Figure 9

different elements and regions, etc. FHS data on CYPs available since the 1991 Management Assessment show a good deal of variation between the four health zones over the past two years. (Figure 9).

The current Family Health Services project aimed to raise the private sector's level of performance, also a major objective for the successor project. To date, most contraceptives provided by A.I.D. have been delivered through the public sector element of FHS-I. The private sector is providing an increasing proportion of services and commodities in Nigeria. (See Figure 10). Couple years of protection (mostly condoms and pills), show a significant rise in private sector distribution from 1990 to 1991.

Couple Years Protection: FHS

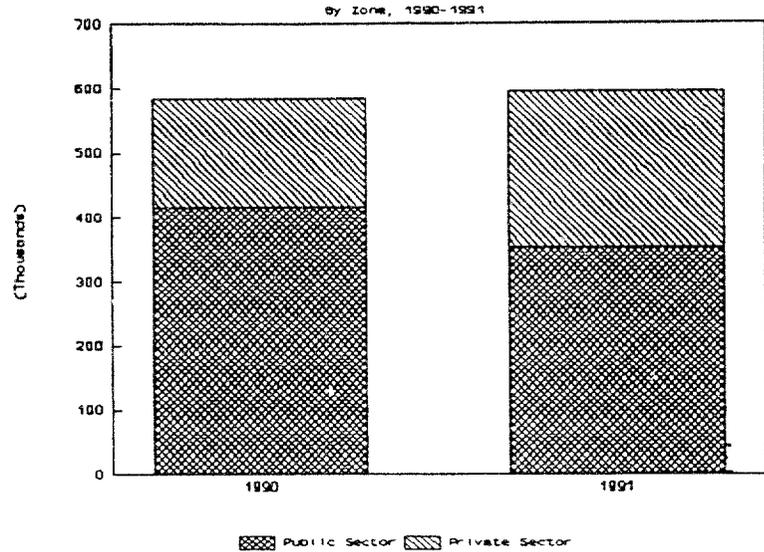
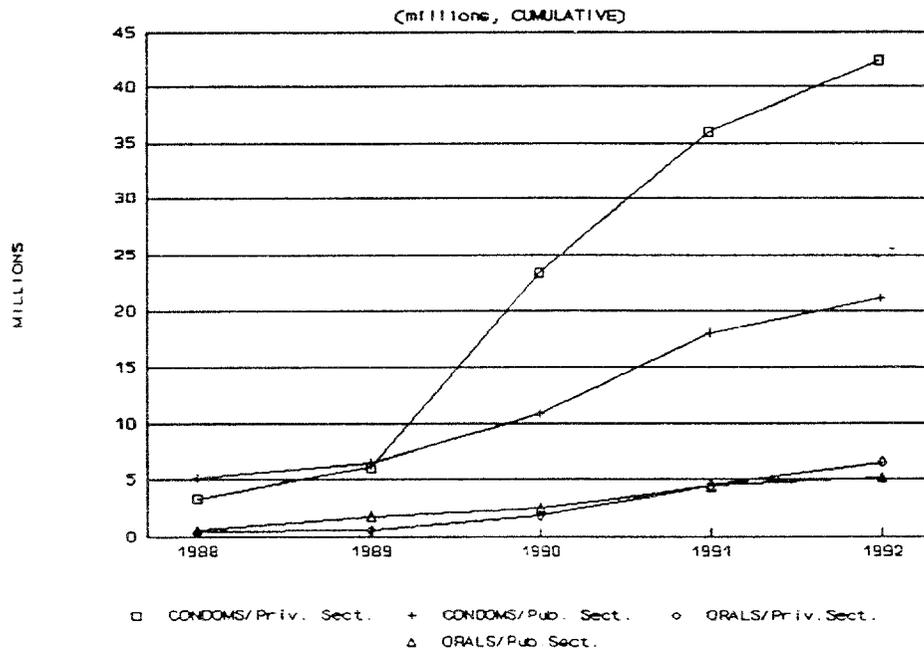


Figure 10

Figure 11 shows the cumulative magnitude of imports of contraceptives, by method and by public and private sector. Condoms in the private sector show a rapid increase in recent years due to expanded marketing. Oral contraceptives are expanding slowly in both sectors.

CONDOMS & ORALS, Private/Public Sector



#### D. HIV/AIDS Prevention

To date, A.I.D. has not provided bilateral support to Nigeria's AIDS control program, but has acted through its centrally-funded projects. The major mechanisms for intervention in the AIDS field have included technical assistance through AIDSTECH and AIDSCOM; the provision of condoms; and indirect support through WHO/GPA.

AIDSTECH began activities in Nigeria in 1987. To control the spread of AIDS in the Cross River State, a commercial sex worker (CSW) project was initiated in 1989 with AIDSTECH support. The project has provided education for nearly 1,300 prostitutes and 2,500 of their sexual partners. At the onset of the project twenty-five percent of the prostitutes never used condoms; after one year of intervention, ninety-seven percent reported use of condoms, at least part of the time. Despite problems in maintaining adequate and regular flow of condoms to the project, nearly 36,000 condoms are distributed monthly in Cross River State. The project has distributed about a half million condoms to high risk persons and has initiated a condom cost-recovery program.

AIDSTECH has, also, sponsored a number of attendees at international meetings and workshops on AIDS. In April 1991, twenty-eight participants from several states attended a workshop conducted by AIDSTECH designed to teach representatives from NGOs how to prepare proposals for AIDS intervention projects. AIDSCOM has sent four missions to Nigeria, primarily, to provide speakers at workshops to mobilize decision-makers.

A.I.D. has been supplying condoms in Nigeria through the Family Health Services (FHS) project, without differentiating whether the condoms are used for family planning or AIDS prevention. Only a small proportion are targeted for AIDS prevention activities.

#### E. Non-Project Assistance (NPA) - The Nigeria Primary Health Care Support Program (NPHCSP)

The NPHCSP was initiated in August 1989 as the vehicle for fulfilling the U.S. government's pledge to Nigeria of \$25 million in foreign exchange-made in recognition of Nigeria's aggressive Structural Adjustment Program (SAP). The commitment called for funds to be disbursed in two tranches of \$15 million and \$10 million upon the satisfactory completion of specified conditions precedent (CPs). The NPHCSP was, subsequently, expanded by \$11 million, adding a third tranche and additional program conditions. The total program of \$36 million was designed to encourage and support major shifts in Nigeria's health policy and structure towards decentralization, preventive care, and reduced reliance of tertiary facilities on public financing.

The primary structural change supported by the NPHCSP (a shift in control of public sector primary health services from the federal and state levels to local government authorities and communities)

has moved forward notwithstanding delays in program implementation. Unfortunately, increased allocation of the Federal Account to LGAs and the general decentralization thrust are occurring during a period of economic decline—when government resources are contracting, and the number of LGAs has been increasing.

The NPHCSP has been helpful in strengthening PHC preparatory activities through special allocations to the LGAs. Progress has, also, been achieved with respect to advancing policy reforms and activities aimed at reducing the dependency of tertiary care facilities on government financing through increased cost sharing and privatization of the health care system; for example, studies have been completed on the privatization of hospital ancillary services, and scopes of work for studies on cost recovery, and private/amenity wings are under development.

Nevertheless, the program has experienced delays in implementation since its inception, and only the proceeds of the first tranche of the program have been disbursed. CPs required for disbursement of the \$10 million provided in Tranche Two probably can be satisfied by the project agreement completion date (PACD) of December 31, 1992. It is unlikely, however, that Tranche Three conditions can be satisfied by that date. Because of delays and uncertainties regarding future CP actions, including the satisfaction of significant reporting requirements, the NPA will probably be discontinued prior to third tranche disbursement.

#### **F. Independent Private Agency Programs**

A number of private agencies independent of direct A.I.D. operational control have implemented in the health sector a variety of interrelated centrally-funded initiatives in Nigeria over recent years. Such interventions have included: (a) Africare re child survival and river blindness control; (b) Rotary International re polio immunization; (c) World Vision Relief and Development re child survival; (d) Johns Hopkins University re health planning and management; (e) Adventist Development Relief Agency (ADRA) re child survival; and (f) Helen Keller International re Vitamin A. These activities have been a welcome additive to the official A.I.D. program.

#### **G. Perspective for the Future**

For the past decade, A.I.D. has focused its Nigeria program on the HPN Sector in accordance with Agency policies and directives derived from Congressional mandates and guidance; the Nigeria CPSP proposes to continue doing so. AAO/Nigeria is finalizing the design of two major projects (FHS-II and CCD2), which will be the principal vehicles for implementing the CPSP. These projects will be supplemented by the proposed HIV/AIDS prevention and control initiative cited above. It is anticipated that the independent private agency programs in child survival and related PHC concerns will continue to support A.I.D. Health Sector strategy in Nigeria.

## V The Proposed Country Development Assistance Strategy, including the "Program Logical Framework": Goal, Strategic Objectives, Targets, and Benchmarks

### A. Program Implementation Strategy

As indicated in the foregoing Chapter, the A.I.D. program in Nigeria will concentrate on the HPN Sector with: (a) two major projects implementing, respectively, family planning and maternal/child health activities; and (b) a third initiative supporting national efforts re HIV/AIDS prevention and control. AAO/Nigeria anticipates, also, that independent private agency programs, such as those mentioned on the preceding page (see Paragraph F), will continue to impact positively on the implementation of A.I.D. strategy in Nigeria.

Implementation strategy mandates close collaboration of effort among the three components of the country program—and the national PHC system<sup>21</sup> as well as the private sector. Long-term improvement of the national PHC system<sup>22</sup> and growth of private sector health care responsibilities are target concerns of the A.I.D. program strategy.

The three program components have a number of common interests warranting common attention; e.g., (a) the increased availability and utilization of improved delivery services; (b) the institutional development of counterpart agencies, including expanded counterpart participation in program implementation; (c) the development of program management capabilities among counterpart personnel; (d) the strengthening of functional support mechanisms;<sup>23</sup> (e) support of program objectives on the part of public opinion leadership; (f) development of cost recovery mechanisms; (g) sustainability of health care service delivery; (h) increased utilization of private sector providers; and (i) the development and operation of effective commodity logistics systems.

**Public Sector Orientation** - Program strategy for strengthening the public sector emphasizes the following:

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<sup>21</sup> Here as elsewhere in the CPSP, reference to PHC implies, specifically, the inclusion of family planning, both with respect to child spacing and modern contraceptive practices.

<sup>22</sup> Implementation of program strategy will involve all levels of the PHC structure descending from the FMOH through the zones and various SMOHs to the individual LGAs.

<sup>23</sup> Implementation strategy calls for a coordinated program approach to strategic planning, HIS, IEC, operations research, logistics, and training.

- Improvement in the capability of the Nigerian health care system to deliver quality family planning and maternal/child health care services to the country as a whole.
- Development of high quality technical skills through in-service and pre-service training programs that stress competency outcomes and problem-solving.
- Utilization of health management training programs that stress operational supervision and other aspects of management specific to the Nigerian health system.
- Development of epidemiological capabilities among Nigerian health professionals.
- Institutionalization of quality assurance within the health system, including the promotion of standard operating procedures and standards of care pertaining to such matters as: immunization schedules, contraceptive methodology appropriate to the individual client; ORT and appropriate feeding for diarrhea illness, antimalarial drugs for fever, and antibiotics for rapid and labored respiration.
- Policy development through appropriate studies (health insurance, local production, etc.), expansion of RAPID-type dissemination of policy issues, and other means of providing data to decision makers.
- Maximization of mutuality of purpose and support among project activities by facilitating interrelated interventions; e.g. family planning service delivery on each occasion mothers present their babies at health facilities. (Note that each project will have its own geographic imperatives; however, substantial overlap of area focus on the part of both projects is deemed feasible, appropriate, and desirable).

Due to the magnitude of the situation in terms of geography, population, and managerial implications, specific health care delivery initiatives will reflect geographic concentration of resources. Assistance to individual "focus states" will target broad responsibilities in such areas of concern as strategic planning, LGA support, HIS, continuing education, health education, EPI operational support, and HIV/STD surveillance. In each Focus State, intensified activities will be implemented at the LGA level. Specific FP, CDD, EPI, malaria, ARI, and nutrition interventions will be undertaken in selected (i.e., "focus") LGAs.

The new CCCD project will start with the nine states and twelve LGAs inherited from the forerunner ACSI/CCCD project. Retention and/or selection of new states will be based upon performance criteria. LGA expansion will take place in accordance with Ministry of Health guidance, the availability of resources, project management capability, and counterpart absorptive capacity.

The Family Health Services II - Population project will recognize the varying potential for the advancement of family planning practices throughout the different regions and among the various societal groupings in Nigeria. This project will focus on specific states and LGAs selected to assure appropriate interventions: (a) leading to increased contraceptive prevalence in the near-term; as well as (b) addressing sociocultural constraints requisite to the laying of groundwork for the substantial increase of modern contraceptive use in the long-term. Selection of specific states and LGAs will take into consideration the loci of CCCD project interventions, with a view to project site overlap to the extent appropriate to the achievement of program strategic objectives.

**Private Sector Orientation** - Program strategy emphasizes private sector involvement as a means for extending health care services to the target population. This strategy focuses on the identification and development of mechanisms leading to: (a) the extensive participation of professional associations, religious groups, and other NGOs; (b) the addition of health and family planning information dissemination and, eventually, service delivery to large employer-based health programs; (c) the expansion of social marketing programs; (d) the participation of private health care providers; and (e) the involvement of the local commercial sector.

**Public/Private Sector Collaboration** - Program strategy foresees the fostering of institutional partnerships between the public and private sectors in such areas as: (a) the development of IEC capacity, including the strengthening of the public sector through more effective utilization of private sector resources; (b) the encouragement of joint operations research on the part of public and private sector researchers, leading to appropriate, broad dissemination of research and pilot study results; and (c) collaboration in the development and operation of an effective and efficient national logistics system(s) for contraceptives and other products vital to program implementation.

## **B. Individual Subsector Strategies**

### **1. Child Survival and Maternal Health**

Program strategy for child survival and maternal health reflects the most important lessons learned from past ACSI/CCCD activities in Nigeria as well as those garnered from the rest of Africa. Implementation strategy calls for the ongoing program to build upon past experience. This strategy focuses on the following:

**Institutional Development** - Strengthening Nigerian PHC and building the institutional capacity of key delivery services is a major component of the A.I.D. Nigeria program strategy.

**Policy** - The review and modification of disease control policies represents a continuing priority within the program strategy. The elaboration of standards of protocol and the

development of appropriate mechanisms for their implementation will be a continuing priority. This will be facilitated by the development of continuing education units in the Schools of Health Technology in the Focus States.

**Quality of Service** - Program strategy focuses on quality assurance, a priority concern as project activities shift from the initial steps of program establishment to the managerial, technical, and functional improvement of service delivery.

**Health Information Systems (HIS)** - Program strategy recognizes that reliable and appropriate information (HIS) is crucial to effective planning, monitoring, and evaluation of program activities. Priority attention will be focused on the establishment and operation of a comprehensive and coordinated HIS at all three operational levels.

**Epidemiology** - The program strategy recognizes the critical need to strengthen epidemiologic capabilities appropriate to each of the three operational levels, including systems development at the Federal and State levels, with the extension of basic epidemiologic skills to the LGA level.

**Health Education and Communication** - Critical as an integrated component of the child survival strategy, health education and communication are more than mere training courses and posters; it is an applied science for the planning and implementation of health behavior change strategies. As such, it offers a scientific approach to the modification of health-related behavior on the part of both service providers and the population. Technically, health education involves two separate initiatives with two separate target audiences; i.e.: (a) "health education" directed to the population at large; and (b) continuing education and training of health workers oriented to their behavior change and improved performance. This concept is a prime tenet of the program strategy, which calls for:

- careful needs assessment prior to the launching of Health Education initiatives;
- routine follow-up and monitoring of the effectiveness of those initiatives;
- institutionalization of Nigerian capacity to perform such functions;
- development of continuing education systems in each state, including the creation of Continuing Education Units (CEU) at Schools of Health Technology located in various states; and
- management training (with emphasis on supervision and monitoring of operational activities) supporting PHC network development at all levels, particularly, at the LGA level.

**Operations Research (OR)**, and the capacity to conduct OR properly, is an essential element of the strategy stressing the development of effective health service programs. OR will provide a sound basis for the design and assessment of specific service delivery interventions. The development of a national OR capability is indicated, with the FMOH responsible for assuring coordination of OR efforts that reflect appropriate priorities.

**Sustainability** - Program strategy addresses the following concerns: (a) the long-term sustainability of the public health care system; and (b) the identification and development of scopes and methods of effort, including appropriate technologies, that can sustain the benefits of health interventions. Program strategy calls for participation in The Bamako Initiative (viz: WHO-inspired drug revolving fund scheme) in collaboration with UNICEF.

**EPI Program Development** - The program strategy:

- recognizes the danger of mass EPI campaigns resulting in the achievement of high coverage, while fostering the likelihood that such high coverage will not be sustained over time;
- advocates (in collaboration with UNICEF) the maintenance of adequate coverage through the strengthening of the "fixed" and "advanced" vaccination center approach in conformance with WHO guidelines; and
- stresses the vital role of community organizations and leadership structures in the identification and tracking through complete immunization of unvaccinated individuals.

**Commodity Requirements** - Implementation strategy will focus on the fact that attainment of project outputs and the effectiveness of technical assistance inputs is dependent, in part, on the availability of appropriate commodities; e.g., didactic materials for schools, medical laboratory equipment (especially with respect to the malaria program), insecticide-impregnated bed nets, ORS, vaccines, cold chain equipment, initial drug supplies to support

the Bamako Initiative in focus LGAs, vehicles, etc. The strategy also gives high priority to the development of systems for the proper management of such commodities.

**New Issues** - Program strategy recognizes that new child survival issues have emerged subsequent to the development of the original ACSI/CCCD project. HIV/AIDS is one obvious example, but ARI and child spacing also require additional attention. ARI has long been recognized as a major problem, but only recently has the technology for addressing ARI become economically feasible. Child spacing has, traditionally, been considered separately from health concerns. Child spacing and child survival interests, however, are not mutually exclusive, but rather synergistic in their methods and outcomes. Infant, child and maternal malnutrition is now recognized as an important factor in the below par health status of the target population. The development of new vaccines and inoculation techniques, including potential new vaccine combinations, are likely to alter and/or expand long-term EPI strategy. Additional new areas of concern to the attainment of strategic objectives may emerge; program mandates will remain sufficiently open and flexible to incorporate appropriate initiatives.

## 2. Family Planning

The rationale for family planning is straightforward: unless couple choice re family size and reproductive health allows Nigeria to slow down its rapid rate of population increase, the hope for improving the future economic and social well-being of its people will be in grave jeopardy.

The basic strategy of this component aims at fertility reduction in the face of formidable constraints, such as the low status of women, early age of marriage, cultural and religious barriers, low levels of education, large family size preferences, contrary male attitudes, weak family planning service delivery institutions, and poor access to services in large parts of the country.

Program strategy will focus on increasing family planning information and services in all parts of the country, with specific interventions tailored to address unique characteristics of each target group. Since A.I.D., alone, cannot possibly meet all the goals of the FMG Population Policy within project time and financial constraints, the A.I.D. program will concentrate on activities that have a high potential for increasing contraceptive use. Priorities for assistance will be identified as part of an ongoing strategic planning process.

Specific strategic considerations include:

**Regional Focus** tailored to meet special ethnic, cultural, language and geographic characteristics of major population groups. For example, in the conservative Muslim North, where family

planning knowledge and use are very low and fertility preference high, priority attention will be given to IEC campaigns to inform and motivate potential users. Such campaigns will stress the health benefits of child spacing and the socioeconomic benefits accruing to families with fewer children. Service delivery modalities will seek to establish linkages with child survival interventions. In addition, the high concentration of people in rural areas in the North argues for more stress on community-based outreach efforts than is needed in the more urbanized Southwest region. The greater contact with public health providers in the Southwest (eighty percent versus thirty percent in the North) for antenatal services suggests more efficient use of that vehicle for expanding services in the Southwest.

**Concentration of Resources within the Regions** - In recognition of the limited resources and absorptive capacity of implementing institutions, program strategy emphasizes the concentration of efforts and resources to achieve the greatest impact possible within each region.

**Quality of Care** - Quality of care is a major concern. Nigeria's size, the decentralized nature of programs and logistical and management constraints have made it difficult in the past to provide reliable supplies of contraceptives, coordinate IEC and training with service expansion, and supervise and support service providers. In many cases, community leaders, providers and clients are misinformed. In much of the country, services are limited or uneven. Such a situation has discouraged clientele enthusiasm. Many facilities serve only a few patients a day. Client satisfaction is fragile. It is estimated that up to one-third of new acceptors discontinue within the first three months. The program strategy calls for resolution of these quality of care issues.

**Method Mix** - Program strategy anticipates gradual modification and upgrading of method mix to the more effective, long-acting clinical methods of family planning.

**Hospitals and Clinics** - These facilities in both the public and private sectors are the principal sources of effective, long-acting methods of family planning. Program strategy targets such facilities as priority participants.

**Management Information Systems (MIS)** - Program strategy recognizes advantages that accrue from equipping managers with timely information on the impact of program activities, including continual assessment of such factors as target population knowledge/approval of modern contraception, client demand, commodity requirements, and distribution patterns.

**Contraceptive Logistics** - Program strategy recognizes the need for special attention to the establishment and efficient operation of a reliable contraceptive logistics system serving both the

public and private sectors. Program strategy calls for: (a) the expansion of social marketing efforts and exploration into the possibilities of greater commercial involvement through marketing, distribution, manufacturing, and financial initiatives; and (b) elimination of duties on the importation of contraceptives.

**Distribution Regulations** - Program strategy focuses on modification of provider regulations to allow: (a) community-based distribution (CBD) workers and market vendors to initiate and dispense oral contraceptives; (b) pharmacists to administer injectable contraceptives under appropriate standards of practice; and (c) nurse midwives to insert NORPLANT®.

**Social, Cultural and Behavioral Factors** - Program strategy addresses a wide spectrum of motivational factors implicated in the expansion of contraceptive use in Nigeria; e.g.:

(a) Religious and other cultural constraints, such as attitudes and beliefs concerning family size and the traditional values attached to children, militate against the use of modern family planning methods within a large segment of the population in Nigeria.

(b) The relatively high cost of some contraceptive methods deters enthusiasm for family planning on the part of a large segment of the population: low-cost services for the distribution of affordable contraceptive products are needed to meet the needs of the poor.

(c) Low educational attainment among women, especially in rural areas, requires greater emphasis on reaching women through the electronic media and through materials designed for illiterates.

(d) Male opposition and/or indifference to family planning is a serious constraint throughout much of Nigeria: special "Male Motivation" programs are required.

(e) The early age of first marriages has significant long-term fertility consequences: specially designed programs are required: (i) to reach adolescent; and (ii) to build consensual support through public policy interventions for stimulating barriers to early marriage.

### **3. HIV/AIDS Prevention and Control**

The overriding strategy of the HIV/AIDS prevention and control component is risk reduction through stimulation of behavioral change. This strategy encompasses the following principles:

- Collaboration among the public sector, opinion leaders, the business and academic communities, and private groups and organizations to mobilize resources and secure community

- Development of Nigerian technical capacity to undertake AIDS prevention programs supported by and utilizing existent local talent and resources, including the institution building of local NGOs to strengthen their response to the HIV crisis.
- Implementation of AIDS prevention and control activities in close collaboration with other components of the A.I.D. program in Nigeria.

Implementation strategy to be undertaken in consultation and collaboration with the National AIDS Control Program, WHO/GPA, other donors, nongovernmental organizations, and other public and private sector institutions focuses on:

- **Policy development:** AIDS prevention programs do not exist in a vacuum. They are shaped by political, economic, and social factors, including the policies of resource holders and political and community leaders. Leaders must be informed and mobilized to support interventions. Exposure of key opinion leaders to the global threat of AIDS and related problems and programs elsewhere in the world will enlighten such individuals re the demographic, economic, and social impact of AIDS and the cost-effectiveness of intervention programs.
- **Condom programming:** As barriers to the transmission of HIV and STDs, condoms are currently one of the more effective defenses in the fight against AIDS. Ready availability of condoms is required to assure regular and effective utilization. A reliable supply, an efficient distribution network, and affordability are essential components of an effective AIDS prevention program. Condom social marketing will enhance availability and affordability to the general public and among special high risk groups.
- **Reduction of STDs:** STD prevention and control will play an important role in the prevention and control of HIV infection, even after AIDS treatments and vaccines become available. Ulcerative STDs facilitate the transmission of HIV. Diagnosis and treatment of STDs interrupts the chain of transmission and reduces the chances of HIV infection during sexual contact. The strengthening of the STD/HIV/AIDS surveillance system will generate reliable data for analysis and programming of interventions and upgrade STD case identification and management in targeted states and communities.
- **Behavioral research:** Behavior change related to HIV transmission has not been as successful as expected. Despite several decades of experience with family planning, understanding of human sexual behavior is limited. The social and behavioral sciences provide tools to help understand how behavior changes can be effected and how interventions should be designed. Local research is required to increase (a)

understanding of the constraints to sexual behavior change and (b) the effectiveness of intervention strategies.

- **Behavior change communication:** Communication programming in combination with other activities can lead to changes in behavior at the individual and community levels. Programs which attempt to increase knowledge alone are not sufficient to bring about sustained behavior change. Interventions within the industrial, military and commercial sectors, with youth, commercial sex workers, long-distance truck drivers and others in the transport sector will strengthen awareness through HIV/AIDS counseling services targeted to behavior change.
- **Evaluation:** Evaluation initiatives will stress appropriate data collection and analysis along with the combination of complementary qualitative and quantitative methodologies to measure the process, outcome, and impact of interventions.

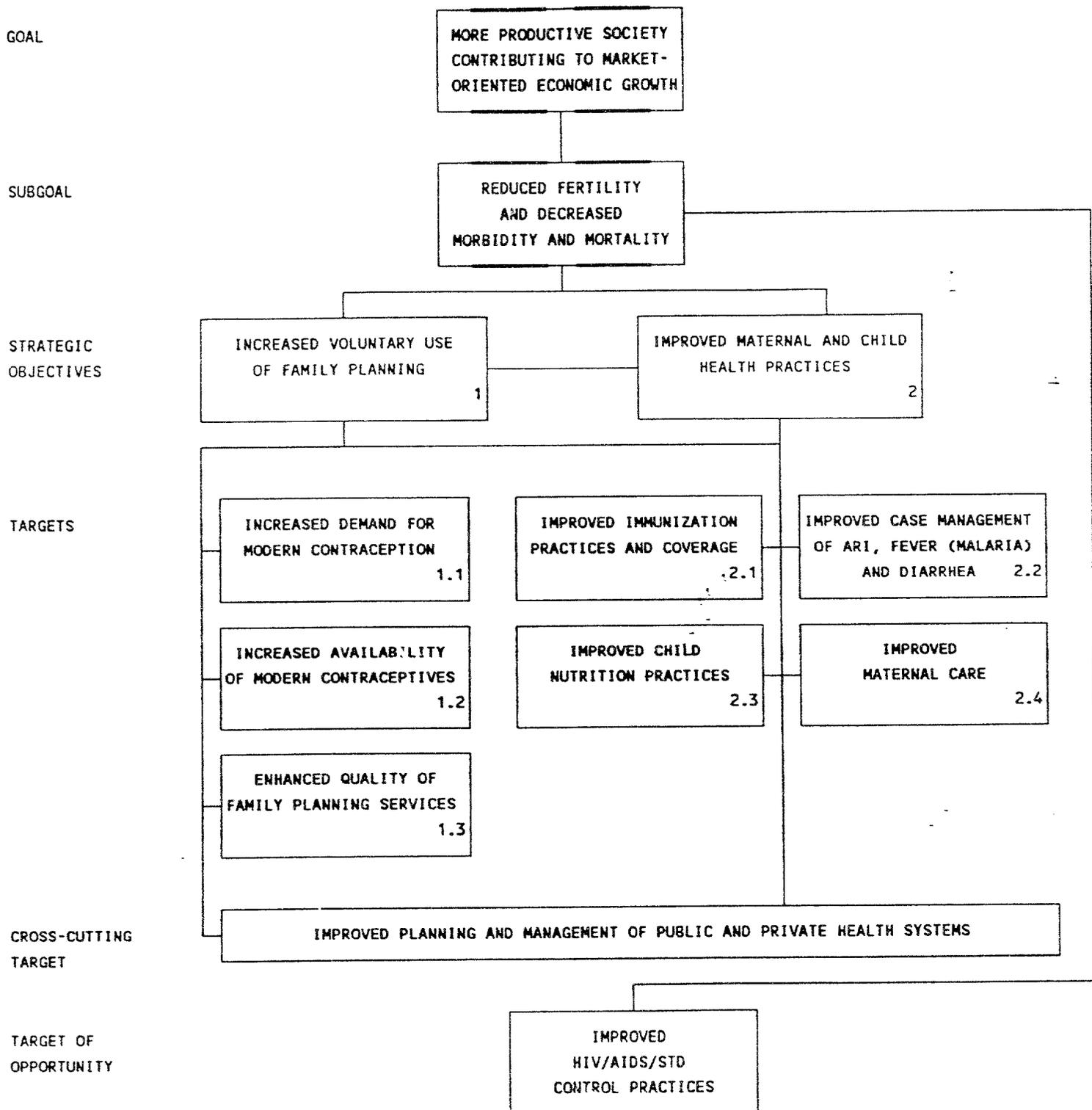
Implementation strategy calls for:

- The provision of assistance to the National AIDS Control Program (NACP) to strengthen its coordinating role in the national fight against AIDS in Nigeria.
- The concentration of project activities in specific geographical locations (i.e., Kano/Jigawa, Cross River/Rivers and Lagos States) with high incidence of HIV/AIDS and large at-risk populations. During the course of project implementation, consideration will be given to the desirability and feasibility of extending HIV/AIDS activities collaterally into FHS and/or CCCD Focus States and LGAs.

C. **Program Logical Framework** consists of:

- **Program Objective Tree** (see the following page).
- **Program Logframe** (see APPENDIX - PROGRAM LOGFRAME).
- **Program Logical Framework Narrative**, (page 77).

**AAO/NIGERIA  
PROGRAM OBJECTIVE TREE**



**Program Goal: More Productive Society Contributing to Market-Oriented Economic Growth**

Progress towards achievement of AAO/Nigeria's program goal will be monitored by tracking the following benchmark indicators:

- Per capita Gross Domestic Product.
- Median Annual Average Income.
- Annual Average Rural Wages.

Better health is desirable as an end in itself. Better health also imparts economic benefits. Historically, as levels of economic development and growth vary among countries, so do key indicators of their peoples' health status. Over the long haul in countries with low income and poor average health status, economic growth is an important, possibly essential, ingredient in achieving higher, sustainable levels of health. A.I.D. policies under the DFA favor this view.

Administratively driven interventions can achieve rapid improvements in social sector indicators, at least for some period of time and to some higher levels—relatively independent of prevailing economic growth patterns (e.g., Cuba). A.I.D. policies and experience with assistance in family planning and child survival over the past two decades support this view.

Better health will not, of itself, induce economic growth, but health factors do condition the rate and level of a nation's economic performance. Underlying tenets of this CPSP are based on the premise that deliberate policy and program interventions improving the quality of health and human reproduction in Nigeria will enhance potential for higher levels of economic performance at the individual, household and community levels; to the extent that Nigerians establish an environment conducive to economic growth, the implementation of AAO/Nigeria's CPSP will assure that health factors are a lesser constraint to economic performance than would, otherwise, be true.

"Per Capita GDP" is a conventional measure of economic growth and will be monitored. However, as argued in Chapter I, fairly rapid growth in per capita GDP has occurred in Nigeria since the SAP in 1986, during which period living standards for most people continued to decline.

"Median Annual Average Income" constitutes a superior measure of "typical" levels of income and better reflects changes over time in income at the household level. This measure is not readily available, but with special effort, in collaboration with the Federal Office of Statistics and the World Bank, baseline estimates can be made and trends in this indicator can be monitored.



health status. Its interpretation is parallel to that of the TFR: it indicates the number of years a newborn infant would live if prevailing age patterns of mortality at the time of its birth were to remain constant throughout its life. Usually, this measure is based on fairly complete vital registration systems or on special large surveys adjusted by information from national censuses. It is always sensitive to changes in infant mortality rates, especially in developing countries where these rates are high.

The CPSP, therefore, chose Age-Specific Mortality Rates (ASMRs), at the national level, as the indicator of program impact at the subgoal level. ASMRs, within the project areas, will be used as indicators of impact for Strategic Objective 2.

### **Strategic Objective One: Increased Voluntary Use of Family Planning**

Attainment of this strategic objective implies significant attitudinal and behavior change among Nigeria's population with respect to traditional societal values regarding large family size and use of family planning. Government and opinion leaders and other role models will exert significant influence over the outcome of program initiatives, the success of which also will be highly dependent upon the enactment and implementation of Government policy decisions. In addition, coordination with other international donors working in Nigeria (e.g., The World Bank, UNFPA, and UNICEF) will be crucial to the overall success of the national family planning program.

Progress toward the achievement of Strategic Objective One will be monitored by tracking the following benchmark indicators:

- Increased contraceptive prevalence rate for all methods of contraception
- Increased prevalence of modern methods of contraception
- Increased prevalence of long-acting and clinical methods of contraception
- Increased couple years of protection

The emphasis in A.I.D.'s family planning initiative will be to increase overall prevalence of contraceptive use. However, particular emphasis will be placed on the use of modern contraceptives (i.e., orals, IUD, female sterilization, injectables, condoms, NORPLANT®) and especially on the long-acting and clinical methods (i.e., IUD, female sterilization, injectables, and NORPLANT®), which yield the greatest protection against unwanted pregnancy.

The benchmark indicators outlined above will allow A.I.D. to monitor the changes in use of various types of contraceptives as

well as in couple years of protection (CYP), an indicator routinely used in assessing the degree of use of family planning services. The data necessary to track these indicators will come from Demographic and Health Surveys, Federal Office of Statistics (FOS) surveys, and service statistics gathered in the HIS.

Strategic interventions will be implemented within all four zones of the country. In each of the zones, a limited number of states will be selected for more intensive implementation efforts. A distinct strategy will be developed for each of the country's four zones. Given this implementation scenario, and considering the extensive assistance to be provided at the Federal level, the project's impact area can be considered nationwide. However, since implementation strategies will differ somewhat from zone to zone, reports on project indicators at the strategic objective and target levels will be desegregated by zone where possible, in addition to being reported at the national level. Also, selected linkage studies will be conducted in states targeted for intensive assistance. These studies should indicate whether local-level activities result in improved and sustained results.

## **Targets under Strategic Objective One**

### **1.1 Increased demand for modern contraception**

To increase the contraceptive prevalence rate in Nigeria, it will be essential first to increase women's and men's knowledge about family planning, to build approval for family planning, and ultimately to generate demand for family planning.

Benchmark indicators: The proportion of all women of reproductive age knowledgeable about at least one modern method of family planning; the proportion of men knowledgeable about at least one modern method of family planning; the proportion of all women of reproductive age who are knowledgeable about family planning who also approve of family planning; the proportion of men knowledgeable about family planning who also approve of family planning; and the proportion of currently married women who wish to space or limit their number of children.

The last indicator is considered to be an indicator of "demand" and can be tracked through the DHS. Data on women's knowledge and approval of family planning also can be obtained from the DHS. Data on men are not currently available but can be gathered through the FOS surveys and in future rounds of the DHS.

The knowledge indicator was chosen based on the assumption that knowledge is prerequisite to approval. The knowledge and approval of both men and women are essential for the success of a family planning program. In turn, it is assumed that although a woman's knowledge and approval of family planning may not be prerequisite to her having a desire to space or limit her children, they certainly will influence how she is, likely, to respond to these

desires (i.e., whether or not she will do something to control her fertility).

Increases in each of these indicators will be achieved by conducting IEC activities focusing on building knowledge about and changing attitudes toward family planning and by providing quality family planning counseling. In IEC activities, particular attention will be given to the special challenges of youth and men.

### **1.2 Increased availability of modern contraceptives**

Increasing the currently low number of those who know a source of modern contraception is an issue of IEC. However, as more people learn the source of services, it is essential that there be an adequate in-country supply of contraceptive products of choice available from conveniently located sites in both the public and private sector. Also necessary are an effective logistics system, adequate stock inventory control, and affordable prices.

Benchmark indicators: The proportion of all women of reproductive age knowing a source of modern contraception; the volume of contraceptives imported into Nigeria; and an increase in the number of service sites in the public and private sector that can provide a full range of services.

Knowledge of source data are available from the DHS. Volume of contraceptives imported by A.I.D., the primary donor for contraceptives, is available from project records. Information on the number of service sites and types of services provided has recently been collected during the Family Planning Logo distribution. Follow-up surveys will be necessary to assess the changes in numbers and types of service sites.

### **1.3 Enhanced quality of family planning services**

To increase and sustain the use of family planning services in Nigeria, it will be important to ensure that services are of high quality. When services are of high quality, it is more likely that a client who receives the service will return for services again as well as refer his/her friends to the service. In addition, quality services will result in fewer cases of complications that might be due to either poor technical skills of the service provider or inaccurate information being given in how to use a contraceptive method.

Benchmark indicators: Client continuation rates, numbers of new clients referred by previous clients, and extent of complications resulting from previously received services.

Information on these indicators can be tracked in the public sector through service statistics (HIS). Situation analyses can provide data on a sample of both private sector and public sector services. Collecting data on all private sector service sites will not be

possible. Although the data on these indicators will be difficult to obtain, the importance of "quality" as a factor in service use necessitates that an attempt be made to collect as much data as feasible on these indicators.

**Strategic Objective Two: Improved Maternal and Child Health Practices.**

Attainment of this Strategic Objective implies infrastructure development, the broad strengthening of service delivery capabilities, increased participation in PHC by families and communities, and biologic factors effecting disease epidemiology, which, to considerable extent, are subject to factors beyond A.I.D. program control. Among other variables, sufficient time and resources will be required for necessary infrastructure to be upgraded before substantial progress in disease morbidity and mortality can be expected. The role of other major donors (e.g., the World Bank, UNICEF, and WHO) is crucial to successful pursuit of this objective.

Pursuant to a FMOH request, the current CCCD project is focused on nine states identified by the FMOH for project assistance. Within those nine states, twelve LGAs are currently receiving assistance. Future CCCD activity will increase the total number of focus LGAs approximately sevenfold within the next seven years. In addition to intensive activity in selected LGAs, the program will strengthen focus state health systems providing assistance to LGAs. The nine states currently targeted have a total population of approximately 29 million, or thirty-three percent of Nigeria's population.

Progress towards the achievement of Strategic Objective Two will be monitored by tracking the following benchmark indicators:

- Decreased Infant Mortality Rate
- Decreased Child Mortality Rate
- Decreased Rate of Childhood Malnutrition
- Decreased Rate of High Risk Births
- Decreased Maternal Mortality Rate

For monitoring and reporting purposes, project management will track benchmark indicators as follows:

- Each benchmark indicator will be determined by a supplemental cluster drawn from focus LGAs as part of the NDHS.
- Target area indicators will represent the averaged combined progress of Focus LGAs and states, weighted according to population size.

## Targets under Strategic Objective Two:

### 2.1 Improved Immunization Practices and Coverage

Effective EPI implementation requires: a technically sound, epidemiologically relevant policy; adequate logistical support systems, especially for transport and cold chain equipment; adequate vaccine supply; quality vaccine delivery by trained, motivated, culturally sensitive, supervised health personnel; good management; and a target population presenting for inoculation.

Benchmark Indicators: Percentage of immunization meeting quality assurance standards; coverage according to recommended schedule for infants; measles incidence; measles mortality; polio incidence and levels of protective levels of tetanus antitoxin in pregnant/recently delivered women.

### 2.2 Improved Case Management of ARI, Fever (Malaria) and Diarrhea

Effective management of the sick child requires: in the home - a capability to recognize illness; knowledge of appropriate care for mild illness; and knowledge of the need for and ability to utilize referral services for severe illness; and at health facilities - personnel trained in clinical assessment, treatment, and counseling; availability of drugs, supplies, and equipment; and a management system that provides culturally sensitive, technically correct, efficient services.

Benchmark Indicators: Percentage of mothers reporting correct home treatment of fever; percentage of mothers reporting correct home treatment of diarrhea; and percentage of ill children with ARI, fever (malaria), and diarrhea attending health facilities who receive correct clinical assessment, treatment, and counseling.

### 2.3 Improved Child Nutrition Practices

Attainment of this target implies: community knowledge of and advocacy for effective nutritional practices; trained service personnel counseling families and communities in appropriate nutrition; expectant mothers presenting for prenatal care to receive advice re nutrition during pregnancy; expectant mothers having access to and receiving adequate nutritional intake; mothers presenting for postnatal care to receive infant feeding instruction; and mothers knowledgeable of sound infant nutritional practices.

Benchmark Indicators: Percentage of infants under age four months who are exclusively breast-fed; percentage of mothers feeding nutritious food to infants age six to nine months who are given complimentary nutritious foods; percentage of children deficient in micronutrient (vitamin A and I) receiving supplementation.

## 2.4 Improved Maternal Care

Attainment of this target implies: community and health facility trained and supervised personnel; women presenting for prenatal, delivery and postnatal care; identification and referral of high risk cases to facilities capable of handling high risk mothers; pregnant women receiving two doses of tetanus toxoid and taking appropriate malaria prophylaxis; and routine prenatal health monitoring services providing information concerning proper infant care and nutrition practices.

Benchmark Indicators: Percentage of pregnant women presenting at clinic for at least two visits prior to giving birth; percentage of births attended by a trained attendant; percentage of postpartum women informed about spacing and offered services; and percentage of postpartum women using modern method of contraception.

### **Cross-cutting Target Applicable to both Strategic Objectives: Improved Planning and Management of Public and Private Health Systems**

The objective of A.I.D.'s program in Nigeria is to increase the voluntary use of modern family planning practices throughout the country and to improve the quality and accessibility of maternal and child care services in the focus states and LGAs. To ensure that the interventions supported under the program are sustainable in terms of operations and benefits, the capacity of the health system, both public and private, to design, implement, and assess specific activities in MCH/FP must be enhanced.

Improved management will be achieved by strengthening functional components of the health system at the Federal, State and LGA levels, as well as in the private sector. Strategic planning and budgeting, health information systems (HIS), information, education and communication (IEC), operations research (OR), logistics, and training are the specific functional areas that will be addressed under the A.I.D.-sponsored program. *However, strengthening the health system is not an end in itself but the means by which family planning and MCH products and services will be successfully introduced by health professionals and accepted and used by clients.* The Nigerian health system will have an enhanced capacity to design, implement and monitor the A.I.D.-sponsored interventions, but not necessarily all interventions implemented through the health system.

Benchmark indicators to measure the extent to which the public sector health system has an enhanced capacity to design, implement and evaluate MCH/FP services:

Where A.I.D. programs in family planning and maternal and child health are being implemented,

- public sector personnel at the Federal, State, and LGA levels will routinely:
  - develop annual work plans and budgets; monitor the collection and analysis of project-specific data;
  - design, implement, and assess I.E.C. programs and strategies;
  - use OR to address relevant MCH/FP program and policy issues;
  - implement and monitor an effective logistics system to ensure that facilities are stocked with adequate supplies of the necessary commodities;
  - ensure that sufficient numbers of staff receive proper training and that properly trained staff are available, and
  - collect, analyze and disseminate epidemiological and program data related to the A.I.D.-sponsored interventions in family planning and MCH (immunizations, control of diarrheal disease, ARI, infant and child nutrition, and maternal health).
- private sector personnel will routinely:
  - offer clients FP and MCH services that comply with the practice standards of the FMOH of Nigeria, and
  - provide data to the MOH on client attendance at PHC services including the acceptance of family planning.

Facility surveys, conducted by ministry personnel, will be used to identify the factors that facilitate and/or constrain the design and implementation of family planning and maternal and child health services in the public and private sectors. In addition, annual work plans and budgets will be examined, the OR program will be assessed, the logistics systems will be audited, health manpower needs, training and availability will be reviewed, and the system for collecting, analyzing, and disseminating epidemiological and program data will be evaluated.

The A.I.D. program has limited ability to address and remedy all the deficiencies of the public and private health systems in Nigeria. The improvements proposed through the program are modest and designed to enhance, minimally but significantly, the operational capacity of the two parallel health service delivery systems.

Since A.I.D. has more experience in working with public health systems that have a structure and accessibility greater than the multiple private sector systems, e.g., non-profit, traditional, and profit-making, a broader range of improvement is anticipated in the public sector, as is specified in the benchmark indicators. Still, operational difficulties in the public health system could well result in the course of the implementation of recent legislation defining the authority and responsibility of the different levels of the system and by the establishment of the proposed National Institute for Primary Health Care.

Unlike the public health system, the private sector is diverse, unstructured, and difficult to reach and influence. Private providers of every stripe are independent and determined to resist any effort to control and/or monitor the services each provides. Private providers are united only in their opposition to government interference. Agreements on such issues as standards of practice do not exist and most private providers are unfamiliar with FMOH policies on such topics as diarrheal case management, essential drugs, etc. A.I.D. program objectives are, therefore, modest and focused on motivating private sector providers to offer an increased level and quality of PHC services, including family planning (birth spacing), and to share their data on client attendance with the public health officials.

If the forms are simple, private providers may be induced to submit data on PHC services. Improvements in the quality and quantity of private sector PHC services are expected to result from the attendance of private providers at training courses (CE) offering instruction on appropriate standards of practice and quality assurance of health services.

**Target of Opportunity: Improved HIV/AIDS/STD Control Practices, including:**

- Increased Availability of Condoms.
- Improved Knowledge and Attitudes Concerning HIV Transmission.
- Increased Identification and Treatment of HIV/AIDS and STDs.

Given the demand for extraordinary behavioral change required of an effective HIV/AIDS prevention and control program in Nigeria, coupled with the contemporary economic circumstances of Nigeria, it is not practical to expect, within the next five years, a fully sustainable program geared to that end.

Nevertheless, Nigeria's vulnerability to the spread of HIV/AIDS throughout Central and West Africa and the relationship of the AIDS problem to the other components of the A.I.D. program in Nigeria, together, provide a compelling justification for a HIV/AIDS/STD

prevention and control intervention to be included as a major component of that program.

Designation of such an intervention as a "target of opportunity" (in lieu of Strategic Objective) reflects the doubtfulness of program sustainability upon which would depend the viability of A.I.D.'s manageable interest in the successful implementation of an effective national HIV/AIDS prevention and control program.

Sustainability implies involvement of the target population in meaningful, consistent, and durable fashion. First and foremost, this will require enthusiastic participation of the target population in a drastic modification of individual behavior rooted in personal beliefs and private life styles not easily altered.

Beyond profound behavior change, the question of institutional and financial sustainability invokes a number of issues, also, characterized by their own problematic nature. These issues include:

- Technical sustainability, or the use of simple, fully-tested, appropriate program intervention methodology.
- Financial self-sufficiency of program interventions.
- Policies that fully support program interventions.
- Technical and managerial personnel, appropriately trained and fully operational in pursuit of program goals.
- Adequate material resources (e.g., STD drugs and condoms) to sustain comprehensive intervention in targeted geographic areas. Availability and affordability of STD drugs is a key concern, as is access to adequate STD treatment and prevention counseling for high risk groups.

Finally, the ultimate success of Nigeria's HIV/AIDS prevention and control program will depend upon: appropriate Government policy implementation and resource allocation; the effective participation of a wide variety of local public and private sector institutions; and significant financial and technical assistance from the donor community.

## VI PLANS FOR IMPLEMENTATION: LEVEL AND USE OF RESOURCES; MONITORING, REPORTING AND EVALUATION; AND POLICY AGENDA

### A. Level and Use of Resources

#### 1. Budgetary Considerations

With the exception of \$4.2 million budgeted in FY93 for buy-ins to R&D/POP central contracts<sup>24</sup> supporting the current FHS project (and an ongoing annual \$200 thousand requirement for 620-ATLS (AFR Training for Leadership and Skills Project), mortgages on the current portfolio will be met with FY92 funding. The annual \$2.5-\$3.0 million central procurement of contraceptives is a continuation of an ongoing requirement under new program initiatives. The annual \$200 thousand (FY92/93) requirement for PD&S will drop to \$100 thousand for FY94 and beyond.

Due to nonsatisfaction of certain Conditions Precedent (CP), primarily of a reporting nature, AAO/Nigeria anticipates curtailment of the Nigeria Primary Health Care Support Program financed under NPA. A deobligation/reobligation of approximately \$11.0 million is anticipated mid-FY93.

Beginning with FY93, the annual DFA funding level for Nigeria is \$18 million. At present, this level appears appropriate to the program design currently underway. Eventual obligation and commitments for the new projects may, however, require an increase to approximately \$20 million, annually, as early as FY95. It is anticipated that design analysis during the course of Project Paper development for the new portfolio, particularly with respect to CCCD2, will identify additional project implementation requirements exceeding the financial magnitudes estimated at the PID level.

The PID for the CCCD2 project was prepared assuming a five-year, \$20 million project. Project Paper analyses now underway point to an LOP of seven years: (a) to correspond with the PACD of FHS2 and the target date established by the World Summit for the Child in 2000; and (b) to satisfy technical requirements identified by the Project Paper design effort. Therefore, CCCD2 now contemplates a project of seven-year duration at a \$50 million funding level.

The HIV/AIDS situation in Nigeria is fluid and changing; A.I.D. initiatives in HIV/AIDS prevention and control are just getting underway; the ultimate requirements for stemming the mid- to long-term HIV/AIDS threat in Nigeria are unknown. The magnitude of an appropriate A.I.D. response to the evolving AIDS threat during the full time frame of the 1993-2000 CPSP is uncertain at this time. For the time being, AAO/Nigeria will not develop a bilateral

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<sup>24</sup> \$2.0 million for 936-3042 (Pathfinder); \$2.0 million for 936-3048 (SEATS); and \$200K for 936-3060 (FP Evaluation).

project<sup>25</sup> for its HIV/AIDS prevention and control initiative, but will obtain assistance from the central AIDSCAP project.

Initial funding for all three projects under design is scheduled for FY93. Financial resource requirements, currently, identified for the new program are indicated in the following table.

Activity	LOP	Bilateral Funding \$Million	R&D Central Funds \$Million
FHS2	7 Yrs	70.0	22.0
CCCD2	7 Yrs	50.0	-
HIV/AIDS	5 Yrs	10.0	3.5
		130.0	25.5

The Operations Expense (OE) budget increases from \$600 thousand in FY92, to \$670 thousand in FY93, to \$970 thousand in FY94. This increase is required to meet costs of additional staff needed to monitor and implement the increased program portfolio. AAO/Nigeria plans to bring on board the following additional personnel: one USDH HPN Officer, one US PSC, and two FN PSCs. Much of the budget increase in FY94 is attributable to space leasing requirements.

## 2. Management of Program Resources

AAO/Nigeria will manage program activity through an appropriate project management structure that will facilitate AAO's dialogue with Nigerian government and other entities involved in policy formulation, program planning, and project implementation and monitoring. Nigerian government counterparts in project management will be located at the federal (FMOH), regional (Zonal Coordinators), state (SMOHs), and LGA levels.

Operational guidance integral to project management will address: (a) technical support requirements; and (b) program development initiatives. An administrative support structure will be organized to meet the local personnel, administrative, contracting, and financial requirements of the entire program portfolio.

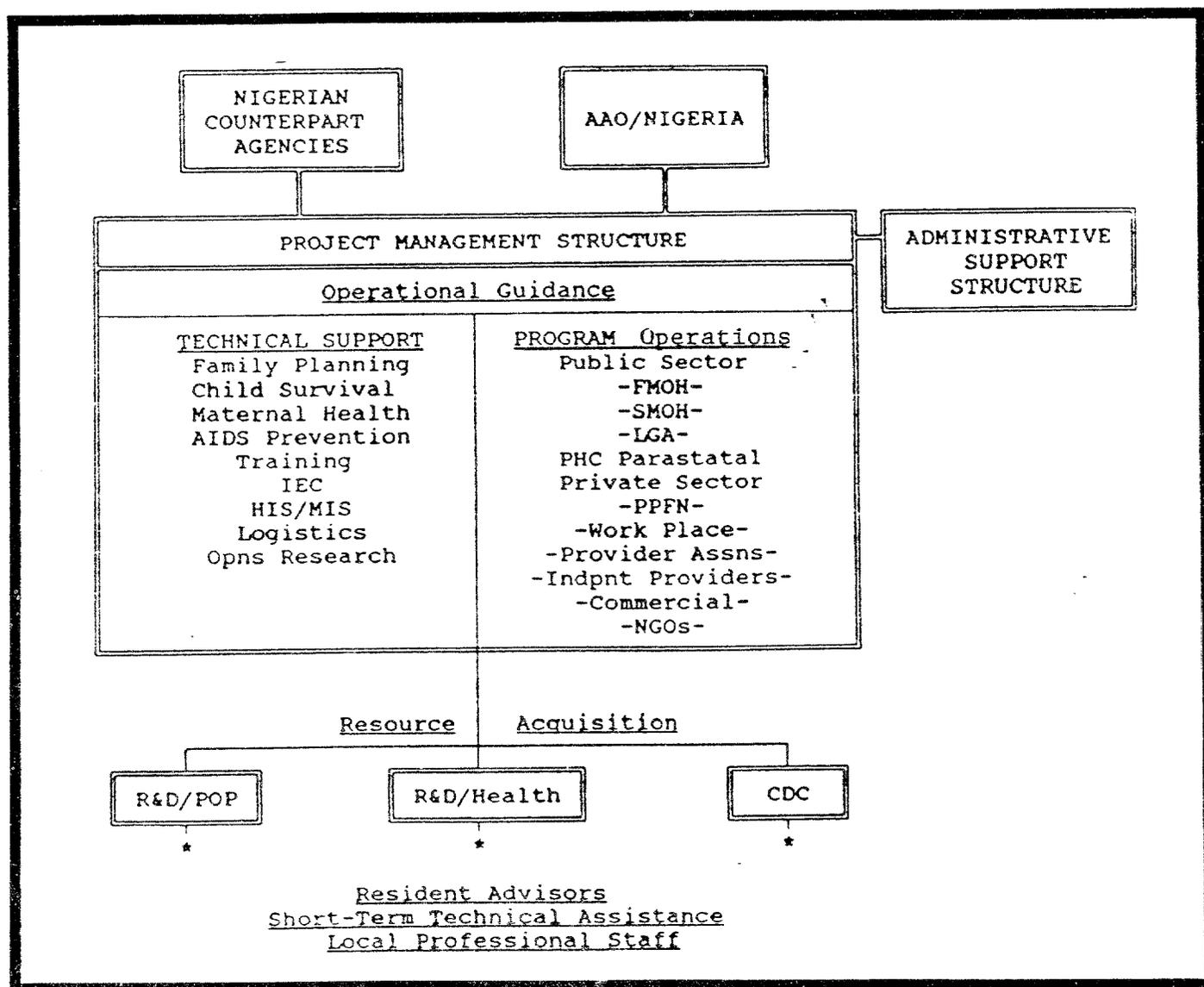
Implementation plans call for substantial utilization of: (a) Office of Research & Development technical resources through central contracting mechanisms; and (b) Centers for Disease Control (CDC) technical inputs obtained through PASA arrangements. Short-term and long-term technical assistance for the CCD2 project will be provided by CDC and the R&D/Health central projects, as appropriate to their respective comparative advantages. R&D/Health resources will be accessed through bilaterally-funded buy-ins and centrally-funded core activity.

<sup>25</sup> The desirability of developing a bilateral HIV/AIDS Prevention and Control Project is a subject of continuing AAO/Nigeria consideration.

To support implementation of the FHS2 project, R&D/POP will centrally fund \$22.0 million of Cooperating Agency activity in Nigeria; an approximately equal magnitude of buy-ins to the central contracts will be financed with bilateral funds. The Central Contraceptive Procurement project will be accessed for approximately \$3.0 million of procurement, annually, in support of the family planning and HIV/AIDS prevention and control projects.

With the exception of condom procurement through the Central Contraceptive Procurement project and the HIV surveillance initiative of CDC, AIDSCAP will (for the time being) implement, virtually, the entirety of the HIV/AIDS intervention, either through use of its own central funds (\$3.5 million), or bilateral program buy-ins. AIDSCAP will subcontract with appropriate American and Nigerian NGOs, as required, to implement selected project activities.

The following schematic illustrates program management structure.



## B. Monitoring, Reporting and Evaluation

Monitoring of program implementation will be undertaken by AAC/Nigeria and officials from the FMOH, the state MOHs, and the participating LGAs. Activities will include periodic visits to operational sites and activities at all levels: (a) to review work plans; (b) to assure quality of health care delivery; (c) to assess management capability; (d) to verify the availability of drugs, contraceptive products and other commodities; and (e) to ascertain the magnitude and frequency of client utilization and coverage impact.

A comprehensive compilation and assessment of baseline data emerging from ongoing program activity will provide detailed guidance for transition from former projects to the new. This undertaking is integral to design strategy and encourages current projects to maintain momentum during the transition period.

Monitoring and evaluation responsibilities will be assumed by all levels of the public health delivery system.

**Federal Ministry of Health** - Representatives of participating directorates and operational units will meet annually to review the status of program implementation, the technical soundness of strategies, and the needs for applied research. Epidemiologic data and technical guidelines will be disseminated in the Nigeria Bulletin of Epidemiology.

**State Ministries of Health** - State HIS data on PHC, service delivery, tracer diseases, and notifiable diseases will be utilized to monitor program implementation and disease reduction. Continuing Education Unit (CEU) performance-based criteria will be used to monitor training needs and the effectiveness of training inputs. Participating states will meet, annually, to share implementation experiences and their plans for the coming year. States will provide an annual report on vital statistics.

**Local Government Areas (LGAs)** - LGAs will monitor, yearly, the implementation of their work plans and establish targets for the coming year. Appropriate indicators will be developed and utilized.<sup>26</sup> Supervisory visits and facility needs assessments by the state CEU will be used to assess compliance with quality standards.

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<sup>26</sup> The LGA monitoring system developed in Ife Central LGA (through which each health care facility monitors six indicators of performance) will be further developed and institutionalized within all participating LGAs.

community involvement, basic health statistics, financial resources, infrastructure, and logistics. Furthermore, health planners recognized that most of the deaths and serious illnesses affecting Nigerians were due to conditions easily preventable or treatable with simple remedies. It also recognized that communicable diseases, especially those associated with inadequate environmental sanitation and poor personal hygiene, predominated and were often compounded by malnutrition. Health planners concluded that the high rates of morbidity and mortality could be substantially reduced by a more rational application of available resources. Concern about the role of the public sector in provision of services mounted during this period as the Nigerian economy fell, stringent actions were imposed, and many leaders in the medical and health fields migrated to other countries.

## **2. Current Situation**

The current health system and many key health programs of the Nigerian Government were initiated during the oil boom before its collapse, during which time Nigeria planned for the State-administered delivery of health and other social services on a grand scale.

As a result of the current economic decline, the approach to health services has been revised to emphasize (a) decentralization, (b) cooperation with nongovernmental organizations and other elements of the private sector, (c) increased support of primary health care (PHC), (d) more emphasis on quality, and (e) new approaches to financing health services.

The Nigerian health system is one of the largest in the developing world. There has been surprisingly little direct attention given to the effectiveness of the health system per se. Standards of care protocols are comprehensive and adequate; however, compliance with these standards on the part of health workers is erratic, resulting in deficiencies in quality of care. Too frequently, staff time is poorly managed and supervisory quality assessment ineffective. Client satisfaction is often wanting. Long waits for service are a common client complaint.

There is no systematic collection of vital statistics such as birth or death registry data. Nevertheless, the limited statistics available indicate a generally poor state of health within the population. Notwithstanding the lack of preciseness of statistical data, it is not imprecise to indicate that the general pattern of health and disease in Nigeria is dominated by infectious diseases, malnutrition, and high fertility.

Fifteen years after initiation of its Basic Health Services System, Nigeria continues to experience excessive child morbidity and mortality and an extremely low level of modern contraceptive use. Utilization of available health services is low, in part because of

the low quality of the services and the nonavailability of drugs. Health prevention measures are inadequate. Budgets for health services have declined in real terms and are insufficient for staff costs, much less for operational programs.

Pilot efforts to enhance and expand service delivery in the public sector have not proved sustainable, with minimal spinoff noted to date from activities supported by the Government or donors. Yet the needs for health services are growing even as the ability of most Nigerians to pay their full cost is shrinking rapidly. Approximately 15% of the urban population and 30% of the rural population do not have access to modern health care.

In contrast to this discouraging picture, Nigeria's private sector--traditional and modern, commercial and voluntary--is vigorous; and the human resources base, in terms of a trained professional health staff in both public and private sectors, is broad. The Primary Health Care system, as refocused and strengthened since 1988 under the current Minister of Health, is outstanding in concept and, in many ways, in execution. The country's National Population Policy, although possibly overambitious, is widely accepted and its implementation is intensifying. Cost-recovery programs in health and family planning (focused primarily on drug revolving funds and subsidized commercial marketing, rather than fees for services) are underway, widespread and seemingly accepted. The potential for such programs funding primary health care is readily recognized. Finally, decentralization of primary health care, although mandated with little preparation in terms of staffing and financing, is well underway and offers potential for real community participation in health services.

The task thus becomes how to mobilize these strengths to remedy the weaknesses discussed above to improve access and utilization of appropriate health care, leading in turn to increased child survival, lower fertility and improved quality of life for Nigerian families.

### **3. Health Service Delivery Structure**

In 1986, the Federal Ministry of Health (FMOH) enlarged and reorganized its health care system. The Fifth National Development Plan (1987-1991) formulated a national health policy based on three levels of care with emphasis on Primary Health Care (PHC) as the means for achieving health for all Nigerians by the year 2000 through the integration of preventive and curative services at the community level.

#### **Primary Health care**

The provision of care at this level is largely the responsibility of Local Governments with the support of State Ministries of Health in accordance with overall national

health policy. Private medical practitioners also provide health care at this level.

### **Secondary Health Care**

At this level, specialized services are provided to patients referred from the primary health care level through outpatient and inpatient services of hospitals for general medical, surgical, and pediatric care; and community health services. Secondary health care is also available at the district, division and zonal levels of the State. These facilities are to be supported by adequate laboratory, diagnostic, blood bank, rehabilitation, and physiotherapy.

### **Tertiary Health Care**

This service consists of highly specialized treatment by university teaching hospitals and other special hospitals which provide care for specific diseases, conditions of specific groups of persons, e.g., orthopedic, eye, psychiatric, maternity and pediatric hospitals.

The Fifth National Development Plan recognized that in discharging the responsibilities assigned under the constitution, the Federal, State, and Local Governments must coordinate their efforts to provide citizens with effective health services at all levels. Formulators of the plan anticipated that State governments would be guided by this policy and, with available resources, could provide an acceptable level of health care with special emphasis on preventive services.

In addition to stipulating the above levels of care, the Fifth National Development Plan postulated that to assure primary health care services appropriately supported by an efficient referral system, State Ministries of Health must review the resources and facilities available at the secondary and tertiary levels. Although high priority was accorded to primary health care, recognition was thus given to the need for strengthening the secondary and tertiary levels.

In this regard, the federal government's long-term goal is for all Nigerians eventually to have easy access not only to health care facilities at the primary level but to those at the secondary and tertiary levels as well. Finally, the plan recognized that to assure client access within the referral system, particular attention must be given to the needs of remote and isolated communities which have special logistical problems.

## **4. Primary Health Care**

Primary Health Care (PHC), based on the principles contained in the internationally recognized Alma Ata Declaration, is considered the

cornerstone of the nation's health system, with child survival activities being an important part of its mandate.

According to the Alma Ata Declaration, PHC is defined as:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community and through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-determination. It forms an integral part of the country's health system, of which it is the social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close to where people live and work, and constitutes the first element of a continuing health care process.

PHC incorporates the following components: health education; food supply and nutrition; water and sanitation; maternal and child health, including family planning; immunizations; prevention and control of endemic diseases such as malaria, acute respiratory diseases, and AIDS; appropriate treatment of minor illnesses and injuries; and provision of essential drugs.

Based on the Alma Ata declaration, the Nigeria Primary Health Care (PHC) Policy was designed to:

- a. address the programmatic requirements of the various subsectorial initiatives;
- b. reflect the economic conditions, and the sociocultural and political characteristics of the communities as well as the application of the relevant results of social, biomedical and health systems research and public health experience;
- c. address the main problems in the community, providing promotive, preventive, curative, and rehabilitative services;
- d. involve, in addition to the health sector, all related sectors and aspects of the state and community development, in particular agriculture, animal husbandry, food industry, education, housing, public works, communications, water supply and sanitation and other sectors, and demand the coordinated efforts of all of those sectors;
- e. promote maximum community and individual self-reliance and participation in the planning, organization,

operation and control of primary health care, making fullest use of Local, State, Federal Government and other available resources; and

- f. develop, through appropriate education and information, the ability of communities to participate.

#### **5. Financial and Budgetary Considerations**

Health sector expenditures are made at all three tiers of government. The primary source of funds for public expenditures on health, however, is revenue generated at the federal level. Overall, the Federal Ministry of Health assumes a minuscule share of total recurrent federal budget allocations, having dropped from 2.6% during the 1980-88 period to 1.5% in 1989 and 1.8% in 1990. The recurrent federal health budget for 1990 was 485 million naira (i.e., \$30.3 million at an exchange rate of 16 naira per dollar).

Despite the policy emphasis on PHC, the lion's share of the recurrent federal health budget goes to specialized institutions at the tertiary health care level, which received 86% of that budget during the 1987-90 period. For any given year, approximately 85% of the funds going to the tertiary level institutions are destined to meet personnel costs. In 1990, personnel costs accounted for 81% of the entire recurrent federal health budget, leaving only 19% for operational purposes.

The FMOH capital budget for the Five Year Plan (1975-90) was 1,752 million naira (\$110 million at an exchange rate of 16 naira per dollar), 22% of which (381 million naira) was allocated for primary health care; 66% (1,161 million naira) for hospital services and training.

At the State and LGA level, each State Ministry of Health must compete with other State ministries for its share of the funds deriving to the State. Based on the limited data available, it is estimated that on the average among the various States, perhaps, seven percent of the funds available to the States and nine percent of the those going to the LGAs are utilized for health investment purposes. Those percentages, although rough estimates, are considerably higher than those applicable to the federal level. This suggests that the closer the decision-makers are to the population, the more likely the health budget as a share of the total budget will be higher.

The ways and means to meet recurrent costs within the overall Primary Health Care (PHC) system is a major issue facing the national health care system. The World Bank addressed that issue intently in its financial analysis of health care costs in Nigeria,

published in October, 1991.<sup>1</sup> That report offers recommendations and guidelines for improving cost recovery procedures, based on model simulations in one state (i.e., Ogun State).

At the micro level, the [public health] sector faces a woefully inadequate system of cost recovery. Lacking resources, especially drugs, the sector provides a poor level of service, despite the availability of trained staff.<sup>2</sup>

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

Better service means that health care facilities must have more medical supplies, more drugs, and a well-trained and committed work force. Another important conclusion is that management capability needs to be significantly strengthened before an extensive cost-recovery program is attempted.<sup>3</sup>

Although the World Bank report concludes "that more intensified cost recovery in the public health care sector is an objective both desirable and achievable",<sup>4</sup> the overall presentation of data is not conclusive with respect to any significant degree of financial sustainability achievable within the near future. In fact, the simulations demonstrate that a favorable balance between costs and revenues depends much on the assumptions applied to key variables.

This highlights the need for carefully identifying the key variables and their relative costs and targeting improvements selectively.<sup>5</sup>

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

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<sup>1</sup> Document of the World Bank, Report No. 8382-UNI, Federal Republic of Nigeria - Health Care Cost, Financing and Utilization (in two Volumes). Western Africa Department, Population and Human Resources Operations Division, the World Bank, October 18, 1991.

<sup>2</sup> (I:108-09)

<sup>3</sup> (I:84)

<sup>4</sup> (I:116)

<sup>5</sup> (I:116)

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

The World Bank will take the lead with regard to (a) ascertaining the feasibility of new approaches to the solution of health financing issues and (b) elaborating the mechanisms by which to institute those approaches. One of the first, major steps in that regard might involve the conditionality associated with the disbursement of funds under the new World Bank Population Loan.

With regard to the A.I.D. program in Nigeria, future analysis will explore *inter alia* the potential for cost recovery, particularly, with respect to the revenue generation potential associated with the distribution of ORS packets, bed nets, and health cards, as well as specific service delivery interventions such as vaccinations. Analysis will consider the World Bank guidelines regarding cost recovery strategy; i.e., (a) improvement of cost recovery through higher fees consistently applied; (b) protection of the poor from excessive financial burden; (c) encouragement of fee collection through revenue retention at site; (d) assurance of an adequate supply of drugs; (e) enhancement of the referral system through clear price signaling; (f) reduction of the share of recurrent costs spent on personnel; (g) coordination of public and private health sector supply; and (h) establishment of effective management information systems.<sup>6</sup>

The scenario for self-financing sustainability does not suggest a likely denouement in the foreseeable future. Health/family planning programs in Nigeria face a situation characterized by: (a) a large segment of the target population comprised of individuals with exceedingly low purchasing power; (b) a large segment of the target population located in rural areas deprived of services from either the public or private sector; (c) a social setting where the status and education of women is so low that essentially women have no cash income nor freedom of choice; (d) a private sector health care system sustained by a thin strata of clientele with purchase power at parity with the cost of private health care of quality; and (e) a governmental financial situation capable of providing only limited social services to a large and growing population.

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<sup>6</sup> (I:117-19)

With respect to item (e), the World Bank report states:

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

Examination of the state and local data for the early 1980s shows that expenditure on nonrecurrent costs (such as maintenance, medical supplies and drugs) has been cut back to the barest minimum, while personnel costs have increasingly dominated recurrent outlays.<sup>7</sup>

Notwithstanding further program design efforts, or feasible modification of implementation modalities, it is not likely that donor assistance programs in Nigeria will lead to self-financing host country programs in the health sector within the present decade.

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<sup>7</sup> (I:108)

**ANNEX C**  
**THE RESPONSE TO NIGERIA'S**  
**HEALTH SECTOR PROBLEMS**

**Preventive Health Interventions**

**1. Family Planning and Reproductive Health**

In response to the adverse developmental and economic impacts of high fertility and rapid population growth, in 1988 the Federal Republic of Nigeria formally adopted the National Policy on Population for Development, Unity Progress and Self-Reliance. Technical and financial support to develop this policy was provided in large part by A.I.D., the World Bank and UNFPA. A.I.D. has been the largest contributor to the promotion of family planning delivery services in Nigeria.

The targets set as part of the National Population Policy are quite ambitious and possibly unattainable within the time frame contemplated, but they are indicative of the Government's serious commitment to the program. The FMG's Policy on Population calls for achieving a total fertility rate (TFR) of 4.0 in the year 2000. In 1990 the TFR was 6.0 and falling, especially in southern states, in urban areas, and among the more educated.

The FMG's population policy implementation strategy addresses family planning and fertility regulation, maternal and child health, the role and responsibilities of men in family life, the role and status of women in development, children and youth, population education and information, spatial distribution of the population and population training, data collection, and research.

The coordination of activities relating to the National Population Policy is the responsibility of the Department of Population Activities (DPA) established in 1988. The government's position is that the lead role in population should be made by the health sector. Hence, with the transfer of responsibility for primary health care to the Local Government Areas, family planning activities in the public sector will be increasingly dependent on the level of commitment to family planning on the part of those who deliver primary health care at the local level.

In addition to the public sector, family planning information and delivery of services are offered through a wide variety of nongovernmental sources. According to the NDHS, 36.7% of contraceptive users receive their methods through government facilities, 47.2% through the private sector, 4.3% through Planned Parenthood Federation of Nigeria (PPFN), and the remainder through religious organizations, friends and relatives.

Among other activities under its current five-year, \$35 million program, UNFPA is promoting an increase in prevalence of use of contraception supported by a number of other population and family planning interventions. The World Bank has recently launched a \$70 million loan program to support implementation of the National Population Policy. The primary focus of this assistance will be information dissemination and the provision of population-related services, with emphasis on the integration of family planning into existing maternal/child health care.

Other donors who contribute substantially to efforts in population include (a) the Ford Foundation, exploring innovative approaches to reproductive health and other women's issues; and (b) the International Planned Parenthood Federation (IPPF) working through the Planned Parenthood Federation of Nigeria (PPFN), with noteworthy strengths in IEC and service delivery.

## **2. Maternal Health**

To date, support for the Government's work in this area has come largely from UNICEF, Ford Foundation and Africare. UNICEF has focused on the training of traditional birth attendants and has strengthened the Schools of Health Technology. In addition, UNICEF supports studies in the promotion of breast-feeding and baseline studies of micronutrients. Furthermore, UNICEF supports MCH activities by assisting with the implementation of the Bamako initiative. UNICEF will undertake baseline surveys in eight states over the next five years. Ford Foundation has been active in women's reproductive health through the support of local governments, NGOs and women's organizations. Africare has launched a two-year project with the Imo State Ministry of Health, the aims of which are to study the causes of maternal morbidity and mortality and to promote the use of services by trained service providers. These promotional activities will be carried out at the community level by Village Health Workers (VHW).

## **3. Nutrition**

At the initiation of the World Bank, the Government of Nigeria is in the process of preparing a national nutrition program for multidonor funding. The World Bank is working through the National Food and Nutrition Committee, a multisectorial coordinating organization composed of representatives from all Ministries, universities, professional associations, and the private sector concerned with food and nutritional issues. With technical assistance from the World Bank, USAID, and UNICEF, the committee has drafted a work program to advance project preparation. This program includes a comprehensive package of preparatory activities, studies, and pilot activities. Each participating donor organization will fund individual preparatory activities.

For planning purposes, approximately \$20 million in IDA funds will be available to support nutrition activities including infant and child feeding, deworming of primary school-age children, interventions to address IDD and Vitamin A deficiencies along with a large IEC component. It is expected that Bank funding would be available in 1994.

The initial collaborative World Bank/A.I.D./UNICEF mission came to Nigeria in April 1991 to work with the Committee to outline a coordinated donor effort to support the development of a national nutrition program. A.I.D. has provided consultancies to assist the Committee prepare initial proposals for studies and analyses critical to national program development. UNICEF has committed funds to the staffing and equipping of the Secretariat of the Committee and the implementation of several initial studies and pilot interventions.

UNICEF has a large Household Food Security and Nutrition program in Nigeria. It is targeted at forty-six LGAs in eight focus states. The program is aimed at increasing the availability of staple foods throughout the year, introducing improved planting materials and systems and improving child care and weaning practices. Their program has four major projects including food and nutrition policy development, food production, food processing and storage, and infant and young child feeding, including operations research as a basis for food and nutrition policy development.

This program is implemented in partnership with the Ministries of Agriculture, Health and Education and parastatals such as DFRRI, MAMSER, Better Life for Rural Women, and others. In 1991, UNICEF launched its Baby Friendly Hospital initiative to change detrimental hospital practices that negatively influence exclusive breast-feeding. Work is underway with the FMOH, Division of Hospital Services.

UNICEF plans to build on previous efforts in household food security, including the introduction of new and improved varieties of planting materials (improved cassava varieties, soybean seeds, and palm oil seedlings), training of women farmers in new technologies for food processing, storage and marketing, and facilitating access of farmers' groups to land, credit, and extension services.

In addition to these multilateral donors, NGOs are also implementing community-based food and nutrition programs. AFRICARE, supported with A.I.D./W child survival funds, has been implementing one of the most effective community-based nutrition activities and has had a significant impact on improving nutritional status of children in the target communities. This project has focused on development of a weaning food (eko elera), improvement of child feeding practices, and growth monitoring. At

the request of other LGAs and Imo state, this project will be expanding in 1993 with additional A.I.D./W funding.

#### **4. Expanded Program of Immunization (EPI)**

Close collaboration between the FMG's Ministry of Health, UNICEF, A.I.D., and CDC over the past six years produced major improvements in national vaccination coverage rates: from twenty percent of children immunized against six leading diseases in 1985, to sixty percent in 1991. The goal is to reach and then sustain an eighty percent level. Vaccine procurement is currently a federal function, along with policy issues. States presently develop strategies, distribute vaccines, and train and supervise LGA staff. LGAs manage and finance local activities, including community mobilization. The evolving decentralization of the PHC system has uncertain implications for the EPI program.

Through the CCCD project, USAID has: (a) supported continuing development of a national monitoring and evaluation system; (b) provided a six million dollar grant to UNICEF; (c) initiated development of a PHC sentinel surveillance system; (d) provided technical support to Schools of Health Technology; and (e) supported (through the HEALTHCOM project) the federal health education unit.

The CCCD strategy has recently shifted, at the request of the government, towards a focus on nine states with concentration on: (a) the provision of assistance to one model LGA in each state; (b) support for state-wide continuing education activities; and (c) improvement of state-wide health information systems.

For the past eight years, UNICEF has given priority to EPI support in its health program in Nigeria, providing critical supplies, vaccines, equipment, and even operational support. A reduction in logistical support for EPI is now expected, with expanded support for communications. Rotary International also provides polio vaccine and some logistical support.

Due primarily to the relatively high current cost of the vaccine, there are no present plans within the FMOH or the donor community to add vaccination against the Hepatitis B Virus to the Nigeria EPI.

#### **5. Malaria Control**

Progress in malaria prevention and control has been limited since there is no simple technological intervention. Complex, community-level efforts are required to control the mosquito vector and to achieve appropriate treatment.

Within the FMOH, the National Malaria and Vector Control Division (NMVCD) provides nationwide coordination of malaria control

activities. Under the NMVCD, the National Malaria Technical Committee meets semiannually to review program development and disease/treatment trends. Individual LGAs, in coordination with state government, are responsible for implementing control programs with local resources and personnel.

Guidelines for the control of malaria in Nigeria were developed by the Technical Committee and approved by the National Council on Health in 1989. The strategic approach emphasizes increased availability and quality of early diagnosis and treatment of malaria and encourages the widespread adoption of personal protection measures, such as impregnated bed nets. Currently, a major study of insecticide-impregnated bed nets and curtains is being carried out in Nsukka.

The major nongovernmental program addressing malaria in Nigeria is the CCCD project. CCCD/FMOH malaria control activities are concentrated in nine "Focus States", including: Anambra, Lagos, Niger, Oyo, Plateau, and Sokoto. Focusing on training of personnel, particularly at the state and LGA level, in malaria diagnosis, treatment, patient education, and referral, the CCCD project helped the FMOH develop a new malaria training module for mid-level and peripheral health workers. The model was pretested in Niger state and, subsequently, approved for use throughout the country.

With assistance from USAID/CCCD, the FMG has reviewed and revised its malaria strategy with priority being given to reduce malaria-associated mortality in children under five. This policy review has been undertaken as a coordinated effort of Ministry Officials, University Faculty, and the pharmaceutical manufacturers.

In the area of training for health education, the Nigerian Government developed with the African Regional Health Education Center (ARHEC) of the University of Ibadan a month-long course for LGA level workers on health education for malaria control.

## **6. Control of Acute Respiratory Infections (ARI)**

The FMOH has recognized ARI as a major child survival issue and has sanctioned a national program. National activities will be grouped with EPI and CDD. At the local-level, services will be integrated within PHC. Planning for the implementation of services is presently limited to five selected LGAs.

To date, CCCD has provided only limited technical assistance in ARI. One CCCD model LGA, Ife-Central, has been designated for development of an ARI program. UNICEF will support three additional model LGAs where ARI interventions will be developed. WHO has provided important technical support for ARI but its support for training has been limited.

## 7. Control of Diarrheal Diseases (CDD)

Diarrheal diseases are managed through the PHC system, beginning with village-level volunteer health workers. By policy, the distribution of ORS packets is limited to health care facilities. Surveys have shown widespread shortages throughout the system; one survey indicated that sixty-three percent of the participating facilities had no stock. Both locally manufactured 600 ml packets and externally procured one-liter packets are used. The single Nigerian manufacturer has a capacity of two million packets, but private sector distribution channels are largely undeveloped.

Since 1987, CCCD has trained more than 350 health professionals in clinical or program management topics related to diarrheal disease control. A total of six operational research proposals were approved in this area and the quality of care was studied and improved in fourteen facilities. HEALTHCOM has provided limited technical assistance in materials development. The ADDR project is supporting development of an applied research capacity through four Nigerian universities, and the National Institute for Medical Research. UNICEF has provided ORS packets, but far short of estimated needs.

## 8. Water and Sanitation

Nigeria was a signatory to the International Drinking Water Supply and Sanitation Decade (1981-1990) and participated in the Global Consultation on Water for All by the year 2000 in New Delhi in 1990. The Nigerian government has committed itself to resource allocation leading to improved rural drinking water supply and sanitation.

In 1981, the Federal Department of Water Resources started a national bore hole program as part of the International Drinking Water Supply and Sanitation Decade. The Federal Ministry of Agriculture, Water Resources and Rural Development drew up a master plan for water supply in 1984. Overlooking sanitation and providing only limited support to reticulated systems for communities of 20,000 inhabitants and over, the Plan excluded smaller rural communities that contain up to sixty percent of the population.

In 1986, the Government set up a Directorate for Food, Roads and Rural Infrastructures (DFRRI) to empower rural areas and reduce the disparities between the countryside and towns. As part of a nationwide water and sanitation program, the government mandated all states to provide at least 250 communities with water points during each phase of operation. By the end of the first phase in mid-1989, the program had reached 5,000 of the 111,000 communities in the country.

The Federal Ministry of Water Resources (FMWR) was created in January 1990 from the former Ministry of Agriculture, Water Resources and Rural Development. It has the responsibility of formulating national water policy. The FMWR is expected to introduce water legislation and coordinate the rational use of water for human consumption and agriculture. The implications of the January 1992 FMG reduction in number of ministries for national water supply policy are not yet clear.

Other Donors, primarily UNICEF and UNDP, have taken the lead in the water and sanitation area in Nigeria. USAID's role in the sector has been and will remain limited. UNICEF-assisted water projects have helped build the most important body of water/sanitation sector experience in Nigeria. Emphasizing provision of low-cost and simple water points to rural communities, UNICEF recently began preparation of training modules designed to transfer responsibility for well operations and maintenance to local communities. In the area of sanitation, UNICEF trains artisans and establishes slab construction units with revolving funds.

UNICEF's Master Plan of Operations for 1991-1995 continues to emphasize a strong commitment to increasing access to rural water supplies, as well as safe sanitation in 155 LGAs.

The UNDP/World Bank-supported project now operating in Plateau State (to be expanded to five other states) has a total budget for three years of three million dollars from UNDP and a matching contribution from the government in local currency. In contrast to UNICEF's emphasis on technology, the UNDP/World Bank project emphasizes institutional needs and community capacity development. This is evident in the following: (a) the project developed a state-level committee consisting of the DFFRI, the Ministry of Health, and various water boards and authorities; (b) extensive effort directed to reorientation of state and LGA staffs for the development of community management capability; (c) emphasis on the training of LGA staff in supervision and quality control, including development of extension agents as trainers of community committees; and (d) institution of hygiene education and community participation as cornerstones of the project.

## **9. HIV/AIDS Prevention and Control**

Early cases of AIDS were reported in Nigeria in 1986/1987. Subsequently, for about two years, the Government of Nigeria limited its action to studying the situation through the National Expert Advisory Committee on AIDS (NEACA) created in 1986. With the financial and technical assistance of WHO/GPA, a Short-Term Plan (STP) was designed to generate data and assess the AIDS situation. Twenty-one testing centers were established. This was followed by a Medium-Term Plan (MTP), which included strategies: (a) to prevent sexually transmitted diseases; (b) to avoid transmission of AIDS through blood and blood products; (c) to

control perinatal transmission; and (d) to reduce the impact of AIDS through appropriate management of AIDS cases, HIV positive individuals and contacts. While the MTP focus on sexual transmission was not as extensive as might be expected, the MTP clearly states the importance of NGO involvement in the fight against AIDS.

To date, most of the AIDS programming effort has been devoted to the preparation of the STP and MTP and to the collection of epidemiologic information for raising the conscience and awareness of policy decision-makers. This has been followed by the planning and organization of the federal and state health structures to address the problem. A number of training activities have taken place, several workshops have been organized and limited IEC activities have been conducted.

In 1989, The Secretariat of the National AIDS Prevention and Control Program was created in the Department of Disease Control and International Health of the Federal Ministry of Health. The Minister of Health acts as the Chairman of the National AIDS Committee. The National AIDS Program Coordinator, reporting directly to the minister, oversees and coordinates both the Federal and National AIDS prevention Programs. In May 1991, the Government decided that the AIDS program should be decentralized, with AIDS activities integrated into the States' primary health care (PHC) infrastructure.

The National AIDS Prevention and Control Program is consistent with the overall FMOH policy of decentralization and integration into the primary health care infrastructure. It is envisioned that at the State level, an AIDS Committee will be formed as a subcommittee of the State Primary Health Care Committee; and similarly at the local level, an AIDS Action Committee will be formed as a subcommittee of the PHC Committee.

To support the States and LGAs, the FMOH will develop programs in the following areas: IEC, epidemiology/surveillance/research, program management, laboratory procedures, clinical care and counseling, and NGO coordination. These areas will be mirrored by appropriate units at the state and local level. Significant progress is not evident subsequent to this plan being announced in August 1991. There is scant indication of any AIDS prevention activities or any knowledge and awareness among public health providers at state or LGA levels.

According to the Minister of Health, the Government of Nigeria spent a total of 4.5 million Nairas (i.e., approximately \$230,000 at today's exchange rate) for AIDS programming from 1987 through mid-1991. During the same period, donor assistance totaled

approximately \$3.5 million, including \$1.325 million from WHO/GPA.<sup>1</sup>

When the President of Nigeria "Declared War Against AIDS" in November, 1991, he pledged 20 million Nairas (approximately one million dollars) of the federal budget for AIDS programs in the coming fiscal year. At the same time, he urged the states to allocate funds from their operating budgets to combat AIDS at the local level.

Response to AIDS in the private sector has been ad hoc. Nigeria has a long tradition of voluntary associations active in many fields, particularly, in the health sector. Some of the better established health NGOs have integrated AIDS into their programs, and a large number of small NGOs have recently been created to focus, specifically, on AIDS.

The National AIDS Committee has encouraged this effort, but support has been mostly moral rather than financial. A post has been created within the National AIDS Committee to coordinate the work of NGOs working in the AIDS field and to facilitate communications among organizations. Plans have been drawn for NGOs' to work in coordination with local PHC units.

Most of the NGOs oriented to AIDS are small organizations with meager funding and poorly-defined plans. The National AIDS Committee has organized several training workshops for some of these NGOs and has included them in the pilot training of trainers and the conduct of community campaigns at the LGA level.

Despite the shortcomings and modesty of effort to date, independent NGO efforts demonstrate considerable potential for replication and expansion. NGO programs, to date, have received support from various foundations and donors; i.e., Ford Foundation, The Canada Fund, UNICEF, the Japanese Embassy, WHO/GPA, and A.I.D. through AIDSTECH. In addition, AFRICARE has been active in AIDS policy development as well as training of NGO personnel in Nigeria through a grant from USAID/Nigeria. NGO activities range from the STOPAIDS project (supported by the Ford Foundation and the Canada Fund) targeting "car parks," which provides education and condoms to drivers, transport union leaders, long-distance travelers, market women, adolescents, and hawkers; to the Society of Women and AIDS in Africa project supported by AIDSTECH in Cross River State to promote safer sex practices among prostitutes; to a number of

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<sup>1</sup> WHO/GPA has taken the lead in the donor community. The European Economic Community (EEC), the British High Commission, the Canada Fund, the Japanese Embassy, the Ford Foundation, A.I.D., Africare, and a variety of other expatriate professional and religious organizations have provided a number of small AIDS prevention activities, focused on IEC and/or relevant social research. The UNFPA and UNICEF programs for the next several years contain budgetary line items for funding IEC and social research addressing HIV/AIDS.

proposed activities developed by the Federation of African Medical Students (FAMSA), the Center for Education for the Prevention of AIDS and Drug Abuse (CEPADA), the Prison Officers Wives Association (PROWA), and others. NGO-based AIDS activists are becoming aware of additional intervention programs being tried elsewhere in Africa (such as counseling programs, employer-based programs, and others) and are seeking support to mount additional efforts in AIDS prevention.

## **10. Major Epidemic Diseases**

Nigeria's response to epidemic disease outbreaks has been characterized by inadequate surveillance and slow reaction. There is no substantial national epidemiologic capability to assure timely coordinated action in the face of emergency situations. Major efforts are underway, however, to develop effective notifiable disease surveillance systems for the detection of outbreaks of such diseases as cholera, meningitis, and yellow fever.

In 1990, the FMOH addressed, somewhat, the recurrent threat of yellow fever (YF) by adding YF vaccination to its EPI policy. Unfortunately, this policy has not become operational due to a current scarcity of YF vaccine. Pilot efforts to include yellow fever vaccination as part of EPI activities in some of the CCD focus states and LGAs has dramatically increased the numbers of Nigerians vaccinated against yellow fever in those select areas. Expansion of this pilot effort can be expected subsequent to increased availability of YF vaccine resulting from a current effort to augment local production capacity.

## **11. Other Diseases of Economic Importance**

### **Guinea Worm Eradication**

The FMOH and the Carter Center's Global 2000 Project established a Federal Secretariat in 1988 to coordinate the Nigerian Guinea Worm Eradication Programme (NIGEP). The goal of the program is to eradicate Guinea Worm disease by 1995. The Federal Secretariat under NIGEP is responsible for providing technical assistance and resources, informing the States on Guinea Worm policies and procedures, and coordinating international activities.

With technical leadership from the Carter Center's Task Force for Child Survival and major inputs from multilateral, bilateral, PVO, and commercial companies including US Peace Corps, the Nigerian Guinea Worm Eradication Programme has through active surveillance identified the infected areas, distributed mesh water filters to every household in infected villages, established monthly active surveillance for disease, identified water sites for treatment with antilarvacidal agents, and initiated a multifaceted program of

health education.

Each state has its own Guinea Worm Eradication Programme (GWEP), which is decentralized from the NIGEP, working through the LGAs to the village level. NIGEP works closely with the Primary Health Care programs in the LGAs to ensure that active cases are properly treated and recorded. In the past year NIGEP, facilitators have worked with each state NIGEP Task Force to train nearly 7,000 enumerators who carry out monthly village level surveys.

UNICEF, in collaboration with Global 2000, focuses its Guinea Worm efforts in ten Nigerian states. Its primary strategy is to promote clean drinking water through health education and development of water supply and storage systems. UNICEF and Global 2000 have jointly trained over 6,000 village-based health workers in health education for Guinea Worm control and 1,700 health workers in prevention and management; supported the production of safe storage jars; and established LGA monitoring and surveillance systems.

The Peace Corps has provided seven volunteers to work with NIGEP at the LGA level to engage in health education and surveillance activities.

### **Onchocerciasis Control**

Onchocerciasis is treatable with an antiparasitic drug; e.g., ivermectin or Mectizan. Through the efforts of Global 2000 and the drug manufacturer, supplies are being provided cost-free, in a geographically-phased manner, to facilities with the capacity for following the treatment protocol.

The National Onchocerciasis Control Program (NOCP) is coordinated by the FMOH's Communicable and Infectious Disease Division. State ministries of health have established their own control programs, which are highly decentralized with limited federal supervision and support. The majority of active control projects are small and organized by international donors/NGOs who provide resources and technical expertise. The FMOH has, however, embarked on ivermectin mass distribution programs of its own in four states.

Distribution of the drug ivermectin has become the most common control measure in Nigeria. Virtually all vector control efforts have been stopped. All ivermectin distribution programs must be approved first by the FMOH and then by the Global 2000 Mectizan Expert Committee at the Carter Center before the drug is made available for distribution. UNICEF has ivermectin distribution activities in four States and is working in twelve endemic LGAs.

A major donor to the global onchocerciasis program, A.I.D. is sponsoring an ivermectin delivery program in four West African countries. As part of this program, A.I.D. has supported a AFRICARE initiative in Nigeria. Through local representation in

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Nigeria, AFRICARE collaborates with state and local government agencies and NGO health programs to design, implement, and evaluate sustainable strategies for mass distribution of ivermectin. A.I.D. has funded a bilateral AFRICARE program for ivermectin distribution in the states of Taraba and Adamawa. AFRICARE also implements a privately funded activity in Kwara state.

### **Functional Support Activities**

#### **1. Information, Education & Communication (IEC)**

Promotional, motivational and educational activities of the National Health Policy are implemented by all levels of the Government system. Both the Federal Ministry of Health (FMOH) and the Federal Ministry of Information (FMOI) conduct IEC activities. Within the FMOH there is a Health Education unit housed in the PHC Department and an Information, Education and Communication section housed in the Disease Control and International Health Department. Each State Ministry of Health has a health education branch, and in some States there are LGA health education officers who are responsible for implementing health education at the LGA level. There are also some clinic workers supervised by nurses who do health education in clinics. The primary IEC activities of the Public Sector are the production and provision of print materials, community mobilization and health education.

A study has been commissioned by the DPA to survey all ongoing IEC activities in the Health sector. The survey will be used to coordinate IEC activities amongst the implementing agencies including international donors.

USAID is supporting the IEC component of the FHS project and some health education activities of the CCCD project. Major activities of the FHS/IEC component include: (a) training in materials development, counselling and personal communication skills; and (b) development, implementation and monitoring of national and state IEC projects, including clinic outreach, community mobilization, print material production and distribution, and mass media planning. Linkage formation and team-building between the public sector and other agencies such as media houses are key functions of FHS/IEC. CCCD works with the Public Sector on IEC activities and collaborates with the Africa Regional Health Education Center (ARHEC) in Ibadan to train people in health education planning and management.

The 1991-95 UNICEF program consists of four Advocacy and Social Mobilization projects; i.e., advocacy, mass media capacity building, community participation, and empowerment and mobilization of NGOs. All projects include significant IEC components.

UNFPA has proposed several IEC activities for 1992-96 including

population education in secondary schools; the establishment and strengthening of State-level IEC committees for planning, coordination and monitoring of population IEC activities; the training of DPA's IEC personnel; and further sensitization of policy makers, religious leaders and traditional rulers in support of the National Population Policy.

The World Bank is funding several IEC projects. One project with the Health Education branch of the PHC is intended ultimately to increase family planning related knowledge, attitudes and practices through the strengthening of the health education infrastructure. A project with the Department of External Publicity and Public Enlightenment of the FMOI will focus on public awareness activities in support of family planning. Yet another project, with the Population Education Department of the Nigerian Educational Research and Development Council (a parastatal under the Federal Ministry of Education), will develop and test a primary school-level family life education program.

## **2. Health Information Systems (HIS)**

Notwithstanding the fact that demographic data are still limited and inadequate for comprehensive planning purposes, there are currently at least four health information systems operating in Nigeria, including: (a) a sentinel surveillance system; (b) a notifiable diseases routine reporting system; (c) the Primary Health Care system; and (d) an inpatient hospital reporting system.

The sentinel surveillance system reports monthly on eleven diseases, the notifiable diseases system reports monthly on forty communicable diseases, and the PHC system reports monthly on seven diseases.

The Monitoring and Evaluation (M&E) Unit of the PHC Department has received from the CCCD project intensive technical and material assistance for its HIS. The M&E has recently developed an integrated comprehensive MIS/HIS in collaboration with FHS. This system includes a family planning form.

Health data from the private sector are very scarce, even though that sector is meant to participate in the notifiable disease reporting system. Efforts to rectify the situation are underway; specifically, HIS linkages with CHAN grouping a predominant segment of the private sector providers.

In addition to the above HIS systems, the FHS Project has been operating its own family planning management information system which was meant to cover both the private and public sector. The original system was expected to provide appropriate data for monitoring of family planning activities and for managing logistics and commodities. This system has not been fully successful in either arena, especially in the private sector. Efforts to improve

the collection of family planning data continue.

The health data currently being collected would be more useful to health planners and policy makers were the data analyzed and reported appropriately. With regard to the data collection, itself, the multiplicity of HIS systems means that health workers at every level must spend a great deal of their time (which could be spent with clients) filling out forms. Until the advent of the newly created Nigeria Bulletin of Epidemiology, there was scant feedback to the field. As a result, many of the workers filling out the forms do not have a good understanding of the purpose of the forms, nor do they know how to use the data collected. Validation of the current information systems remains an open issue.

ACSI/CCCD/Nigeria is presently involved in strengthening the health information system at the FMOH, SMOH and LGAs in the following major areas: (a) the PHC Monitoring and Evaluation System of the Department of Primary Health Care (PHC); (b) the Notifiable Disease Reporting System of the Epidemiological Division of the Department of Disease Control and International Health (DCIH); (c) the 150 site PHC Sentinel Surveillance System (PHC and DCIH); (d) the Secondary and Tertiary Hospital Disease Surveillance System (presently eight sites); and (e) improved management of commodities such as vaccines, drugs, and family planning commodities at all levels. In the five above named systems, the approach involves the accurate and complete recording, reporting, and use of data at the facility and LGA level, combined with the appropriate development of simple user-friendly computer systems at the State and Federal levels.

All systems are being developed in collaboration among the two currently funded USAID activities (i.e., ACSI/CCCD and FHS) and those of the host government and other key agencies involved in HIS-related issues, such as UNICEF, WHO, and the World Bank.

**ANNEX D**  
**THE NATIONAL CENSUS - 1991**

On March 19, 1992, President Babangida announced the provisional results of the Census conducted November 27-29, 1991. The President stated that he was satisfied with the conduct of the Census.

The population of Nigeria was reported to be 88,514,501 million people. The released figures give totals distributed by state and sex. More detailed information on age distribution, occupation, etc., will not be released until the Spring of 1993. This lack of further information limits the analyses that might be carried out to establish relevant rates and to assess, more accurately, specific population groups.

**1. Census History in Nigeria**

Historically, census-taking in Nigeria has been surrounded by controversy. There have been eleven attempts to hold a census since 1883, and each was given to contention. The 1952 census was viewed as a tool of the colonial government to increase revenues and perpetuate the Establishment. Cultural beliefs which view the counting of children as taboo contributed to inaccuracies. The results of the 1962 Census were not released subsequent to widespread leaking of the figures; this led to a political imbroglio. Another Census was held in 1963; that one was followed by allegations that the figures for the northern region were grossly inflated. The 1963 census was eventually accepted after a court verdict. The 1973 census figures were completely rejected as having been manipulated and inflated. The controversy of that census has been cited as the reason for the overthrow of the military government of General Gowon. Census-taking in Nigeria has always been highly politicized, because population figures have been associated with revenue allocation and constituency representation. The tendency of various political interests has been to manipulate and inflate figures to ensure a larger share of revenues and to increase the number of seats in government. To defuse cultural contentions, the 1991 census omitted questions on religion and ethnicity.

There is a consensus among different groups that: (a) the 1991 Census was well conducted and the most thorough yet taken in Nigeria; and (b) the figure of 88.5 million is realistic.

**2. Issues Raised by the 1991 Census**

Various issues have been raised concerning the provisional figures released:

(a) The figure of 88,514,501 is much less (i.e., 33 million) than the 122 million figure previously used by the United Nations.

Because of the decreased denominator: income per capita goes up albeit, slightly; population density goes down from 125 to 96 persons per square kilometer; and the ratio of physicians and health services per capita improves. Various aspects of government planning will need to be adjusted in view of the reduced population figure.

(b) The census reports that men outnumber women (50.32 percent men to 49.68 percent women). This is contrary to the most common demographic situation where women usually outnumber men. There are more women than men in eleven states, but they are outnumbered in the other nineteen states. In Niger State, the number of men exceeds that of women by eight percent. This finding is questionable; women live longer than men, and many men died during the Biafra civil war. A clearer picture will emerge when the figures on sex/age distribution become available.

(c) States in the wet coastal areas (other than Lagos), such as Oyo, Anambra/Enugu, and Imo, appear to be less densely populated than some of the states in the Sahel hinterland; e.g., Sokoto, Katsina and Bauchi. This is not consistent with the overall population distribution between the Sahel and coastal Africa, the Sahel usually being the most thinly populated.

(d) The high level of economic activity and urbanization in some of the southern states is not associated with a correspondingly larger population.

(e) A population growth rate of 2.1% has been suggested in the media, implying that population growth is much less than the 3.2% growth rate currently used.<sup>1</sup> The figure of 2.1% is the average

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<sup>1</sup> The mean annual growth rate of 2.1 percent suggested in some quarters has provoked a media debate as to whether the national population policy launched in April 1988 is still relevant.

Alhaji Shehu Musa, the recently retired Chairman of the Nigeria Population Commission and now Presidential aspirant, is reported to have said to the press that Nigeria is not faced with a population explosion, as previously thought, and that he was skeptical as to the relevancy of the national population policy.

Dr. Kuteyi, the Director of the Department of Population Activities in the Federal Ministry of Health, has reiterated through the media that the cornerstone of the national population policy was not population control per se, but an initiative designed to improve the quality of life of the citizenry; to reduce the high maternal mortality rate resulting from women having too many births, too young, or too old, and too close; and to decrease infant and child mortality resulting from births too close together.

Dr. Sulaiman, the Executive Director of Planned Parenthood Federation of Nigeria, has also countered the position of Alhaji Musa by stating that notwithstanding the lower census figure, the problems of high unemployment and the overcrowding of schools still prevail.

annual rate and assumes linear growth. It is, in fact, the percentage change between 1963 and 1991 divided by twenty-eight years.

Population, however, grows exponentially. The last three accepted census figures are: 1952/53 - 30.4 million; 1963 - 55.7 million; and 1991 - 88.5 million. Application of exponential growth to these figures would yield the following annual intercensus growth rates: 5.5% for 1952/53 through 1963; 1.7% for 1963 through 1991; and 2.7% for the overall period between 1952/1953 and 1991. The intercensus annual growth rate of 5.5 percent between 1952/53 and 1963 appears unrealistic. The growth rate of 2.7 percent between 1952/53 and 1991 appears more appropriate and is closer to estimates from national surveys.

Based on an estimated growth rate of 2.7 percent, the 1963 census figure could be estimated at approximately 41 million, which is strikingly close to the 1962 figure of 42 million that was rejected. Application of the 2.7 percent growth rate would yield population figures for other years, as follows: 49.4 million for 1970; 64.7 million for 1980; and 84.8 million for 1990.

(f) The reduced population figures support extensive professional opinion that the growth rate (whatever the actual percentage) is influenced, significantly, by the practice of abortion. Although abortion is illegal in Nigeria, anecdotal evidence and institutional accounts of numerous cases of botched interventions suggest that the practice is widespread.<sup>2</sup> The

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The current government remains committed to the national population policy.

<sup>2</sup> The subject of abortion is debated, emotionally, throughout Nigeria. Editorials and news articles, in print and on television, abound. Quite apart from the divergence of opposing moral and legal opinions, the prevalence of the practice is acknowledged on all sides. Legal and societal considerations hinder the broad collection of data and reporting. Reliable statistics are not available. The magnitude of the practice is not known. The limited data available derives, mainly, from reporting on medical complications resulting from ill-fated abortion attempts. Piecemeal information indicates that unwanted pregnancies are many, illegal abortion is not uncommon, and the consequences, far too often, are death and suffering on the part of the women concerned.

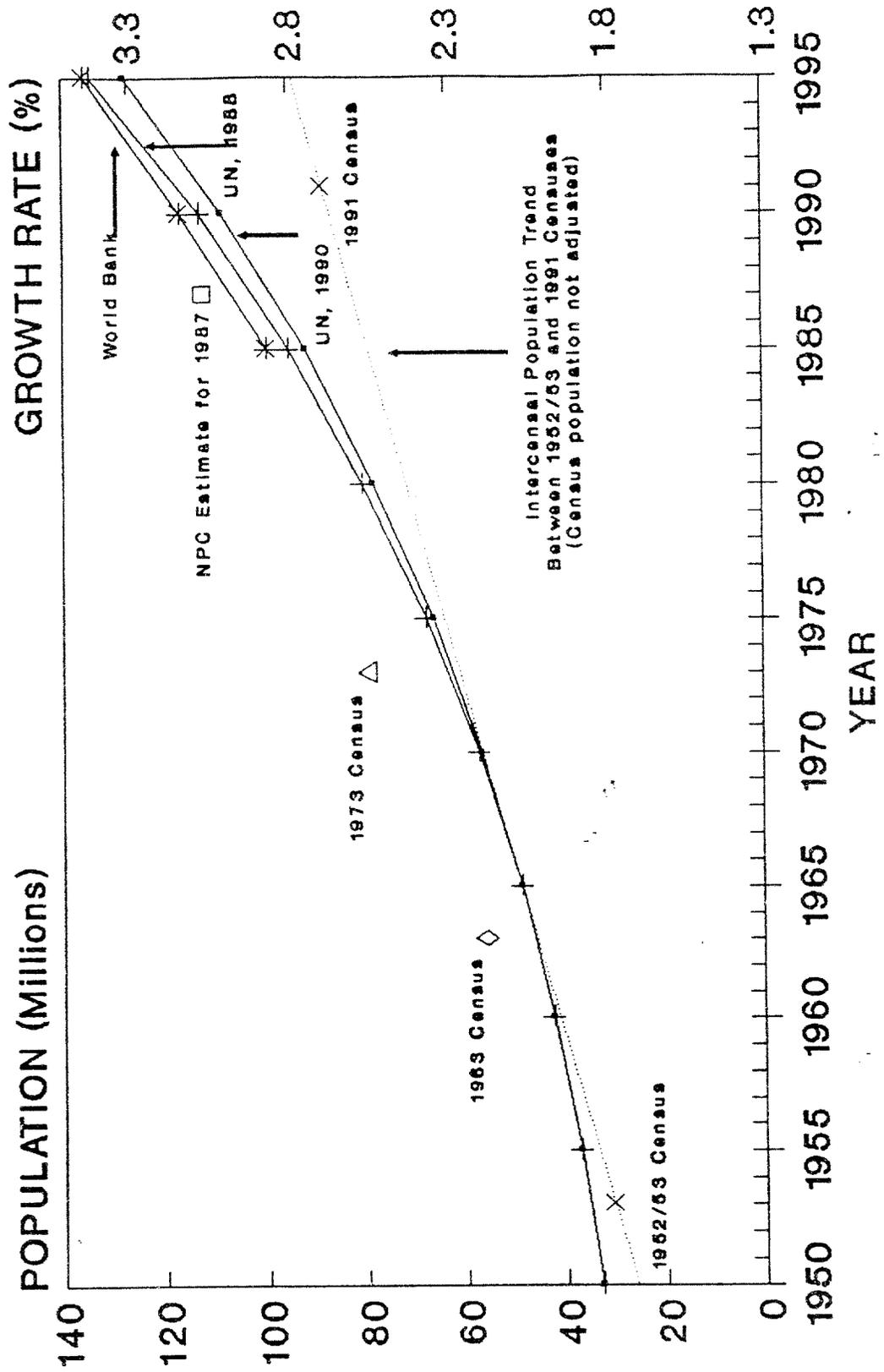
In November 1991, one newspaper article quoted a local medical doctor, who opined that 50,000 illegal abortions take place, annually, in Lagos alone. The Federal Minister of Health announced in August 1991 that 20,000 deaths occur, annually, as a result of interventions to end pregnancy; half of these are reported to involve teenagers. On another occasion, the minister indicated that fifty percent of maternal deaths in Nigeria result from induced pregnancy termination.

Over the past decade, research studies on the attempted termination of pregnancy have appeared with regularity in national and international medical journals. Usually, these studies report the experience of a single hospital; most advocate better family planning services, including easy access to contraceptives and routine sex education, and liberalization of antiabortion laws. The statistics

# NIGERIA

## POPULATION LEVELS AND TRENDS, 1950-1995

### Estimates from Various Sources



subject of abortion is one of open public debate. It is not untrue that abortion plays a *de facto* birth control role in contemporary Nigeria and, to some degree, reduces the fertility rate.

(g) Notwithstanding the issues related to the growth rate and the practice of abortion, all evidence points to a high fertility rate in Nigeria. The World Fertility Survey and the Nigeria Demographic Survey both result in very high total fertility rates (TFR); i.e., 6.3 and 6.0, respectively. Such a high TFR, coupled with a declining mortality rate, would support the plausibility of a 2.7 percent growth rate, or higher.

Unfortunately, the mortality rate is difficult to ascertain. Nigeria has no reliable data on mortality trends; however, the World Bank 1991 report estimates that the crude death rate went down from 23 deaths per 1000 in 1965 to 16 deaths per thousand in 1989.

### 3. Implications for Maternal and Child Health in Nigeria

Nigeria still remains the most populous country in sub-Saharan Africa.

Maternal, infant and child mortality rates are still high. The accessibility of health services to the predominant rural population remains inadequate.

The national TFR of 6.3 and the average countrywide contraceptive

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vary, but the accounts are similar: gynecological admissions are frequently associated with induced abortion, deaths are all too common, and the patient is usually under twenty years of age.

Sample abstracts of studies from individual hospitals have indicated:

Illegally induced abortion cases presented at a rate of 4 per 1000 deliveries. Seventy-one percent of the patients were 20 years or younger and eight out of ten were nulliparous. The death rate was 179 per 1000 cases involving induced abortion.

22.4% of maternal deaths were entirely due to abortion. Abortion deaths featured as the second most important cause of death (after malignancies) and accounted for 26.6% of gynecological admissions. The majority of the fatal cases (59.4%) were induced in the second trimester of pregnancy. Almost 60% of deaths from abortion occurred in teenagers. Abortions accounted for 72.4% of maternal deaths in teenagers.

Induced adolescent abortion is a major cause of maternal and gynecologic death. Illegally induced abortion cases presented at a rate of 105 per 1000 deliveries. Abortions of all types constituted 28.4% of all gynecologic admissions. 60.8% of induced abortions cases involved adolescent girls; only 9.8% were married; 37.5% previously had one to three induced abortions, or one to two term pregnancies.

prevalence of 3.8% for modern methods reported in the NDHS are in no way affected by the new census figures.<sup>3</sup> The high fertility rate is associated with a high growth rate. With a growth rate of 2.7 percent, the population will double in twenty-six years. Nigeria still has a population problem.

Nigeria is still characterized by its low-income economy. It has been assumed by some observers that because the population base has decreased, gross domestic product per capita has increased. This is not so. With the recent floating of the naira and the official exchange rate dropping from 10 naira per dollar to 18 dollars, the Gross Domestic Product has gone down in dollar value. The Gross Domestic Product (GDP) for 1991 is estimated at 94.3 billion naira. Per capita income is 1,065.5 naira; at the current exchange rate of 18 naira per dollar, this converts to 59.2 dollars.<sup>4</sup> In addition, the external debt for Nigeria is 35 billion dollars; i.e., 395.5 dollars per capita. There are no significant economic gains from the reduced population figure. The economic situation for Nigeria remains grim.

#### 4. Conclusion

A.I.D. program objectives in Nigeria are relevant. They address the related problems of: (a) high infant and child mortality resulting from preventable diseases; (b) high risk pregnancies endangering the lives and well-being of both mothers and infants; and (c) the detrimental consequences of an unabated high fertility rate. Maternal/child health remains a priority; there is a large unmet need in that regard. Demand for quality PHC services is likely to increase as the economic situation worsens.

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<sup>3</sup> The NDHS reports TFR at 6.7 in the North and 5.6 in the South. The same source puts modern contraceptive prevalence at 10.5% in the Southwest; 3.9% in the Southeast; 1.3% in the Northeast; and 0.7% in the Northwest.

<sup>4</sup> The World Bank normally uses a three-year moving average of exchange rates to compute the value of GDP.

**APPENDIX - PROGRAM LOGFRAME**

**Nigeria  
Country Program Strategic Plan**

**Program Logframe at the Goal and Subgoal Levels**

Objective Levels	Indicators	Data Sources/Frequency
<b>Goal: More Productive Society Contributing to Market-oriented Economic Growth</b>	<ol style="list-style-type: none"> <li>1. GDP/capita</li> <li>2. Median Annual Income</li> <li>3. Annual Average Rural Wages</li> </ol>	Federal Office of Statistics and World Bank and IMF Reports.
<b>Subgoal: Reduced Fertility and Decreased Morbidity and Mortality</b>	<ol style="list-style-type: none"> <li>1. Reduced Total Fertility Rate from 6.0 (1990) to 5.5 by YR 2000.</li> <li>2. Increased life expectancy at birth for males from 49.5 to 51 by YR 2000, and for females from 48.5 to 51 by YR 2000.</li> </ol>	DHS Surveys, '90, '94, '98; World Bank and UN Surveys and Reports.

## Program Logframe for Strategic Objectives and Target Levels

**Indicators for Strategic Objectives and related Targets  
are only applicable to Focus States and LGAs specifically  
addressed by A.I.D. program interventions**

Objective Level	Indicators	Data Sources/Frequency
<p><b>STRATEGIC OBJECTIVE 1:</b></p> <p>Increased Voluntary Use of Family Planning</p>	<ol style="list-style-type: none"> <li>1. Increased CPR among all women of reproductive age from 7.5 (1990) to 19 by YR 2000.</li> <li>2. Increased prevalence of modern methods of contraception from 3.8 (all women of reproductive age) (1990) to 16 by YR 2000.</li> <li>3. Increased prevalence of long-acting and clinical methods from 2.3 (all women of reproductive age) (1990) to 10 by YR 2000.</li> <li>4. Increased couple years of protection from 1.8 million (1990) to 5.3 million by YR 2000.</li> </ol>	<ol style="list-style-type: none"> <li>1. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> <li>2. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> <li>3. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> <li>4. HIS; quarterly household survey; FOS.</li> </ol>
<p>Target 1.1</p> <p>Increased Demand for Modern Contraception</p>	<ol style="list-style-type: none"> <li>1. Increased proportion of all women of reproductive age knowledgeable of at least one modern method of family planning, from 43.5 (1990) to 80% by YR 2000.</li> <li>2. Increased proportion of men knowledgeable of at least one modern method of family planning, from the baseline level (to be determined) to 60% by YR 2000.</li> <li>3. Increased proportion of all women of reproductive age, knowledgeable about family planning, approve of family planning, from the baseline level in 1990 (to be determined by special DHS analysis; 71% for currently married women) to 80% by YR 2000.</li> <li>4. Increased proportion of men, knowledgeable about family planning, approve of family planning, from the baseline level (to be determined) to 60% by YR 2000.</li> <li>5. Increased proportion of all currently married women wishing to space or limit their No. of children, from 48% (1990) to 70% by YR 2000.</li> </ol>	<ol style="list-style-type: none"> <li>1. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> <li>2. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> <li>3. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> <li>4. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> <li>5. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> </ol>
<p>Target 1.2</p> <p>Increased Availability of Modern Contraceptives</p>	<ol style="list-style-type: none"> <li>1. Increased proportion of all women of reproductive age knowing a source of modern contraception from 33.2% in 1990 to 80% by YR 2000.</li> <li>2. Increased volume of imported contraceptives from 17 million condoms in 1990 to 45 million in YR 2000, from 2 million cycles of pills 1990 to 10 million in YR 2000, and from 85,000 IUD's in 1990 to 650,000 by YR 2000.</li> <li>3. Increased number of service sites in public and private sector providing the full range of long-acting and clinical methods (baseline and exact targets to be determined).</li> </ol>	<ol style="list-style-type: none"> <li>1. DHS Surveys, '90, '94, '98; quarterly household survey/FOS.</li> <li>2. Bills of Lading; FHS II/quarterly reports.</li> <li>3. Logo distribution survey; follow-up surveys.</li> </ol>
<p>Target 1.3</p> <p>Enhanced Quality of Family Planning Services</p>	<ol style="list-style-type: none"> <li>1. Increased client continuation rates (baseline and target to be determined).</li> <li>2. Increased numbers of new clients referred by previous clients (baseline and exact target to be determined).</li> <li>3. Decreased numbers of complications resulting from previously received services (baseline and exact target to be determined).</li> </ol>	<ol style="list-style-type: none"> <li>1. HIS; situation analysis.</li> <li>2. HIS; situation analysis.</li> <li>3. HIS; situation analysis.</li> </ol>

**Program Logframe for Strategic Objectives and Target Levels**

**Indicators for Strategic Objectives and related Targets  
are applicable to Focus States and LGAs specifically  
addressed by A.I.D. program interventions**

Objective Level	Indicators	Data Sources/Frequency
<p><b>STRATEGIC OBJECTIVE 2:</b></p> <p>Improved Maternal and Child Health Practices</p>	<ol style="list-style-type: none"> <li>1. Decreased infant mortality from 90/1000 in 1990 to 75/1000 by YR 2000.</li> <li>2. Decreased child (1-4) mortality from 115/1000 in 1990 to 90/1000 by YR 2000.</li> <li>3. Decreased rate of severe malnutrition (wt/ht) from 9.1% in 1990 to 5% by YR 2000.</li> <li>4. Decreased rate of high risk births (women &lt;18, interbirth interval &lt;24 mos, parity &gt;3, age &gt;35) from 79% in 1990 to 60% by YR 2000.</li> <li>5. Decreased rate of maternal mortality from 15/1000 live births in 1990 to 10/1000 by YR 2000.</li> </ol>	<ol style="list-style-type: none"> <li>1. DHS Surveys, '90, '94, '98.</li> <li>2. DHS Surveys, '90, '94, '98.</li> <li>3. DHS Surveys, '90, '94, '98; Community Surveys.</li> <li>4. DHS Surveys, '90, '94, '98.</li> <li>5. Sisterhood surveys as part of DHS.</li> </ol>
<p><b>Target 2.1</b></p> <p>Improved Immunization Practices and Coverage</p>	<ol style="list-style-type: none"> <li>1. 8 of 10 critical EPI elements performed correctly by YR 2000.</li> <li>2. 80% of children &lt;1 have received scheduled DPT1, Polio and measles vaccines by YR 2000.</li> <li>3. Measles morbidity reduced 65% from preimmunization levels by YR 2000.</li> <li>4. Polio incidence reduced to 1/1000 by YR 2000.</li> <li>5. 75% of women delivering have rec'd protective levels of tetanus antitoxin in last 12 months.</li> </ol>	<ol style="list-style-type: none"> <li>1. Biennial facility surveys on sample of health facilities.</li> <li>2. Annual coverage est. based on &lt;1 reported vaccinations; DHS Surveys, '90, '94, '98.</li> <li>3. Coverage x vaccine efficacy.</li> <li>3. &amp; 4. Annual sentinel surveillance.</li> <li>5. Serologic surveys '93 and '98.</li> </ol>
<p><b>Target 2.2</b></p> <p>Improved Case Management of ARI, Fever (Malaria) and Diarrhea</p>	<ol style="list-style-type: none"> <li>1. Increased correct home case management of fever by child caretakers from 60% in 1990 to 80% by YR 2000.</li> <li>2. Increased correct home case management of diarrhea by child caretakers from 30% in 1990 to 60% by YR 2000.</li> <li>3. 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 YR 2000.</li> </ol>	<ol style="list-style-type: none"> <li>1. DHS surveys, '90, '94, '98; Community Surveys.</li> <li>2. DHS surveys, '90, '94, '98; Community Surveys.</li> <li>3. Biennial facility surveys on sample of health facilities.</li> </ol>
<p><b>Target 2.3</b></p> <p>Improved Child Nutrition Practices</p>	<ol style="list-style-type: none"> <li>1. Infants 0-4 mos exclusively breast-fed increased from 1% in 1990 to 10% by YR 2000.</li> <li>2. Mothers feeding nutritious food to infants 6-9 months increased from 70% in 1990 to 90% by YR 2000.</li> <li>3. Vitamin A and Iodine deficiency in &lt;5s decreased (to be determined).</li> </ol>	<ol style="list-style-type: none"> <li>1. DHS surveys, '90, '94, '98.</li> <li>2. DHS surveys, '90, '94, '98.</li> <li>3. DHS surveys, '90, '94, '98.</li> </ol>
<p><b>Target 2.4</b></p> <p>Improved Maternal Care</p>	<ol style="list-style-type: none"> <li>1. Pregnant women with 2 prenatal visits from trained health provider increased from 52% in 1990 to 75% by YR 2000.</li> <li>2. Births attended by trained attendant increased from 30% in 1990 to 50% by YR 2000.</li> <li>3. Postpartum women informed and offered birth spacing information and services increased from &lt;10% in 1990 to 25% by YR 2000.</li> <li>4. Postpartum women using modern methods of contraception increased from &lt;5% in 1990 to 20% by YR 2000.</li> </ol>	<ol style="list-style-type: none"> <li>1. DHS surveys, '90, '94, '98.</li> <li>2. DHS surveys, '90, '94, '98.</li> <li>3. DHS surveys, '90, '94, '98; Biennial facility surveys on sample of health facilities.</li> <li>4. DHS surveys, '90, '94, '98.</li> </ol>

**Program Logframe for Cross-cutting Target**

**Indicators for Cross-cutting Target  
are applicable to Focus States and LGAs and  
specifically designated FMOH and SMOH functions**

Objective Level	Indicators	Data Sources/Frequency
<p>Improved Planning and Management of Public and Private Health Systems</p>	<p>1. Public sector personnel at the Federal, State and LGA level will routinely:</p> <ul style="list-style-type: none"> <li>● develop work plans and budgets;</li> <li>● monitor the collection and analysis of project-specific data;</li> <li>● design, implement, and assess I.E.C. programs and strategies;</li> <li>● use Operations Research to address relevant MCH/FP program and policy issues;</li> <li>● implement and monitor an effective logistics system to ensure that facilities are stocked with adequate supplies of the necessary commodities;</li> <li>● ensure that sufficient numbers of staff receive proper training and that properly trained staff are available;</li> <li>● collect, analyze, and disseminate epidemiological and program data related to the A.I.D.-supported interventions in MCH/FP.</li> </ul> <p>2. Private sector personnel will routinely:</p> <ul style="list-style-type: none"> <li>● offer clients MCH/FP services that comply with practice standards of the FMOH;</li> <li>● provide data to the FMOH on client acceptance of MCH/FP services.</li> </ul>	<ul style="list-style-type: none"> <li>● facility-based surveys on a sample of health facilities - public and private, annually.</li> <li>● service records and reports, quarterly.</li> <li>● internal review and management audits, '95, '98, '00.</li> <li>● training records and reports, as conducted.</li> </ul>

**Program Logframe for Target of Opportunity**

**Indicators for Target of Opportunity  
are applicable to Selected Geographic Areas**

Objective Level	Indicators	Data Sources/Frequency
Improved HIV/AIDS/STD Prevention and Control Practices	<ol style="list-style-type: none"><li>1. Increased availability of condoms.</li><li>2. Improved knowledge, attitudes, and behavior concerning HIV transmission.</li><li>3. Increased identification and treatment of HIV, AIDS, and STDs.</li></ol>	<ul style="list-style-type: none"><li>● records of condom procurement, importation, and distribution.</li><li>● pharmacy surveys on condom purchases.</li><li>● review of CDC monitoring reports on STD prevalence.</li><li>● AIDSCAP implementation and program evaluation reports.</li></ul>