

**USAID-NIGERIA  
ASSESSMENT OF PROGRAM IMPACT**

**FY1994**



**LAGOS, NIGERIA**



## TABLE OF CONTENTS

TABLE OF CONTENTS .....	1
SECTION ONE: SPECIAL FACTORS AFFECTING THE USAID-NIGERIA PROGRAM.....	2
A. THE POLITICAL SITUATION IN NIGERIA .....	2
B. STATE DEPARTMENT PROHIBITIONS AND U.S. DECERTIFICATION .....	2
C. ECONOMIC DECLINE AND ADMINISTRATIVE FAILURE IN THE HEALTH SECTOR .....	3
D. DEVELOPING A REALISTIC SCHEDULE FOR THE NIGERIA PROGRAM .....	3
E. STAFF MORALE AND COMMITMENT .....	4
SECTION TWO: PROGRESS TOWARD OVERALL PROGRAM GOAL.....	4
MAINTAINING MOMENTUM WHILE RESTRUCTURING .....	4
SECTION THREE: PROGRESS TOWARDS STRATEGIC OBJECTIVES AND RELATED PROGRESS INDICATORS .....	5
A. FAMILY PLANNING.....	5
STRATEGIC OBJECTIVE #1: Increased Voluntary Use of Family Planning.....	6
PROGRAM OUTCOME #1.1: Increased Demand For Modern Contraceptive Methods .....	7
PROGRAM OUTCOME #1.2: Increased Availability of Modern Contraceptive Methods .....	8
PROGRAM OUTCOME # 1.3: Enhanced Quality Of Family Planning Services.....	10
B. CHILD SURVIVAL .....	10
STRATEGIC OBJECTIVE #2: Improved Maternal and Child Health Practices.....	11
PROGRAM OUTCOME #2.1: Improved Immunization Practices And Coverage .....	11
C. TARGET OF OPPORTUNITY: IMPROVED HIV/AIDS/STD PREVENTION AND CONTROL PRACTICES.....	14
ANNEX A: REVISED INDICATORS AND EXPECTED LEVELS OF ACHIEVEMENT.....	17
STRATEGIC OBJECTIVE #1: INCREASED VOLUNTARY USE OF FAMILY PLANNING .....	18
PROGRAM OUTCOME 1.1: Increased Demand For Modern Contraception.....	18
PROGRAM OUTCOME 1.2: Increased Availability Of Modern Contraceptives.....	19
PROGRAM OUTCOME 1.3: Increase Quality Of Family Planning Services: .....	19
PROGRAM OUTCOME 1.4: Improved Participation Of Women In Health Care Decision Making.....	19
PROGRAM OUTCOME 1.5: Enhanced Organizational Sustainability Of NGOs.....	20
PROGRAM OUTCOME 1.6: Strengthened Organizational Capabilities and Capacity .....	21
PROGRAM OUTCOME 1.7: Enhanced Integrated FP/CS/HIV-STD Services.....	21
SO #2: IMPROVED MATERNAL AND CHILD HEALTH.....	22
PROGRAM OUTCOME 2.1: Improved Immunization Practices And Coverage .....	23
PROGRAM OUTCOME 2.2: Improved Case Management Of Acute Respiratory Infections (ARI), Fever, (Malaria) And Diarrhea.....	23
PROGRAM OUTCOME 2.3: Improved Child Nutrition Practices .....	24
PROGRAM OUTCOME 2.4: Improved Maternal Care.....	24
TARGET OF OPPORTUNITY: IMPROVED HIV/AIDS/STD PREVENTION AND CONTROL PRACTICES.....	25

## **SECTION ONE: SPECIAL FACTORS AFFECTING THE USAID-NIGERIA PROGRAM**

### **A. THE POLITICAL SITUATION IN NIGERIA**

The past year has been characterized by political instability that has touched and altered the lives of Nigeria's people. The impact on USAID's programs cannot be overstated. In November 1993, following a brief four-months period of civilian government, the Military re-exerted its control over the country in a take-over of government. Since then, there has been a reversal of progress towards democratization with a dissolution of political parties and local governments. Government convened a national constitutional convention but without a populist mandate. In the past six months the judiciary system has been suspended by a series of presidential decrees that virtually exempt the Military Government from established rule of law. The Government has not responded to demands for a return to civilian authority by pro-democracy groups and is detaining Moshood Abiola, former Head of State Gen. Olusagun Obasanjo as well as numerous other prominent political figures. Despite outcries from human rights activists around the world there are persistent rumors of widespread human rights violations indicative of the repressive nature of the current military regime. Proscriptions by government have closed several media houses and limited the freedom of the press. Tensions have been heightened by the recent dissolution of the cabinet that did include some civilian leaders. At this writing, the Military regime appears to be tightening its hold and repressions.

### **B. STATE DEPARTMENT PROHIBITIONS AND U.S. DECERTIFICATION**

When Nigeria's Military Government annulled the 1993 civilian elections, the Government of the United States of America articulated sanctions that, among other things, prohibited agreements between the USG and the Government of Nigeria (GON) at any administrative level. On April 1, 1994, President Clinton signed Presidential Determination 94-22 decertifying Nigeria for United States assistance for non-compliance with drug trafficking and interdiction control efforts.

The impact on USAID-Nigeria's programs was immediate and severe. While child survival and AIDS activities qualified for technical exemptions from decertification, the continuation of USAID's family planning program required an Administrator's waiver and Congressional notification. Decertification brought the USAID-Nigeria program to a halt and the Mission went into a close-out mode. USAID Administrator's determination to grant waivers was not effected until June 16, 1994. The terms of the waivers combined with the State Department's prohibition on agreements with Government impelled the USAID-Nigeria to engage fully with non-government organizations (NGO) — a shift already made necessary by the development realities in a country where public sector services had effectively collapsed because of political, bureaucratic and fiscal failure. USAID-Nigeria immediately began restructuring the implementation modalities for the Nigeria program through a Country Program Strategy Update approved by USAID/Washington — but when this was completed and approved FY 1994 was already ending.

### **C. ECONOMIC DECLINE AND ADMINISTRATIVE FAILURE IN THE HEALTH SECTOR**

Nigeria's economy has been in a sharp steady downward spiral for the last decade. This has been exacerbated in recent years. Since the Military take-over, declining revenues, deficit spending, a roll back of structural adjustment and failures of economic reform have resulted in spiraling inflation (estimated to be above 400% p.a. at the end of 1994). Gross Domestic Product (GDP) per capita has declined from \$1000 in 1989 to less than \$300 in 1994.

Nigeria's health and social sector programs, including primary health care services, have been particularly and strikingly hard hit. Across the board, funding has been inadequate. An unfortunate established practice for years has been use of donor funding "in place of" rather than "in addition to" local resources. In the states and local governments, almost all available funding is used to pay salaries and emoluments with little available for capital development. While reliable data on the actual expenditures for health in FY 1994 are not available, it is generally believed that monies spent were substantially less than amounts budgeted. As a consequence, vaccines, ORS supplies and essential drugs are consistently out of stock. This is compounded by significant leakage out of public sector stores. Many states report that, during the recent episodes of civil unrest, facilities were looted and cold chain equipment removed. As a result, the Expanded Programme of Immunizations (EPI) was severely affected. EPI coverage estimated to be 80% in 1990 has now declined to between 30% and 40 % for all antigens.

This was also a year when essential health sector personnel (physicians and nurses), frustrated by administrative delays in addressing concerns, engaged in numerous labor actions in an effort to secure improved working conditions and salaries. These strikes effectively closed Government secondary and tertiary level facilities across the nation — a situation that has yet to normalize. A substantial proportion of the most highly trained and most skilled workers in Government facilities abandoned their posts to seek opportunities in the private sector. For those who remained, late payment of salaries (in some cases six or more months) was the norm throughout 1994. The Civil Service is elementally demoralized. As of this report, Government has not released Nigerian FY 1995 funds to any of its Ministries. In summary, it is accurate to characterize Nigeria's public health sector as "collapsed".

### **D. DEVELOPING A REALISTIC SCHEDULE FOR THE NIGERIA PROGRAM**

In this API, USAID-Nigeria has made a concerted effort to present a realistic appraisal of its program — its limitations as well as strengths. The facts, in some instances, are discomfiting. Nigeria is a country in crisis. In the past 8 months, USAID-Nigeria staff, assisted by the Global Bureau and its CAs, carefully examined USAID's role in Nigeria. This self-examination allowed for no "sacred cows" or "blindness" and required consideration of the entire complex of developmental, political, bureaucratic and economic/fiscal factors that influence our program. The costs of withdrawing support from Government were balanced against the documented — but necessarily longer term

opportunities for health care delivery through Nigerian NGOs (commercial and not-for-profit). Much redirection already has been accomplished and the Mission is pleased with progress to date. However, it is naive and misleading to expect that measurable short-term impact can be produced in a program so altered. The new implementation modalities and their impact must be founded on longer term institutional strengthening and sustainability.

The Mission approached the latter half of FY 94 as a period for redesign of its implementation mechanisms. Much, if not all of FY 95, has been and will be spent re-gearing the implementation machinery to address the unique strengths and weaknesses of NGO programs, maximize programmatic cohesion in achieving Nigeria's Country Program Strategic Plan (CPSP) targets and assuring the adequacy of USAID's own management structure. The fruits of this considerable labor — a substantial program impact benefiting Nigeria's women and children — may not be demonstrated until FY 96. Having said that, we are well along with our partners in developing a more sustainable approach to integrated health care delivery. This approach addresses aspects of USAID's role in Nigeria not emphasized in the past, especially women's participation in health care decision-making, NGO sustainability, the needs of Islamic Northern Nigeria, the requirements of adolescent and urban populations, and greater attention to NGO partnerships that include the for-profit sector.

#### ***E. STAFF MORALE AND COMMITMENT***

USAID-Nigeria worked tirelessly to preserve program momentum and establish new program directions in this most challenging environment. Maintaining staff morale was difficult. The working environment (unpredictable electricity, water outages, national fuel shortages) made life difficult both at work and home. The dedication of the Mission staff was manifest in their seeing an NGO-led implementation strategy not as an obstacle but as a major development opportunity. USAID-Nigeria used this redirection to critically re-evaluate programs (Government and USAID) and Nigeria's developmental context — a necessary first step to constructing a viable private sector alternative in an area traditionally dominated by Government. USAID-Nigeria succeeded in designing a workable implementation strategy. By the fourth quarter of the calendar year, with its revised program strategy submitted to USAID/W, the Mission began developing partnership arrangements between key Global Bureau NGOs (CAs) and Nigerian NGOs.

## **SECTION TWO: PROGRESS TOWARD OVERALL PROGRAM GOAL**

### ***MAINTAINING MOMENTUM WHILE RESTRUCTURING***

The overall goal of the USAID-Nigeria program remains creation of a healthier more productive society. This is supported through voluntary family planning services to limit the rate of population growth, support for child and maternal health programs to reduce excess morbidity and mortality in these vulnerable populations, and (as a target of

opportunity) HIV/AIDS/STD control programs. The Goal and Strategic Objectives have not changed.

As expected, given the many negative factors affecting the program in 1994, USAID-Nigeria made significantly less progress toward its goals than originally anticipated. The preservation of essential humanitarian programs and health care delivery infrastructure in the face of the harsh realities of what is Nigeria today, in itself, is a notable accomplishment. Family planning services and commodities are still available and NGOs continue to work to provide family planning, child survival and HIV/AIDS prevention. The program is not as robust as it was in years past — but is still in place and with considerable untapped potential. With this, there is a new and vigorous USAID-Nigeria engagement with the Nigerian NGO community. We believe this engagement is the foundation for accomplishment of USAID program goals and objectives.

The Mission's program sub-goal: Reduced Fertility and Decreased Morbidity and Mortality is maintained. The shift to an entirely private sector program will require some revision in the indicators for Nigeria. Proposals for these revised indicators are presented and discussed in Annex A of this report.

The process of restructuring USAID-Nigeria programs has been fully participatory and has involved an intensive engagement with Nigerian NGO partners, U.S. CAs, and the USAID/Washington. This process was recently described in a cable on participation.

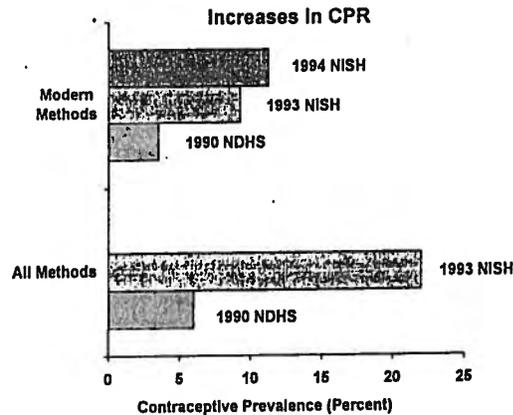
### **SECTION THREE: PROGRESS TOWARDS STRATEGIC OBJECTIVES AND RELATED PROGRESS INDICATORS**

#### **A. FAMILY PLANNING**

Since the last API report (November 1993), the Nigeria Family Health Services Project (NFHS) was authorized at the level of \$65.5 million grant funds for a seven year period. The NFHS Project and its predecessor, the Family Health Services Project (PACD June 30, 1995), both have as their objectives increasing accessibility and availability of family planning information and services throughout Nigeria.

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

Given the challenging situation in Nigeria, USAID-Nigeria is pleased to observe that voluntary use of Family Planning continues to grow. By mid-year, the contraceptive prevalence rate (CPR) for all modern methods had risen to 11.3% (NISH, Nigeria Integrated Survey of Households by the Federal Office of Statistics, June 1994). This is a significant increase over the 9.3% CPR reported just six months earlier (NISH, December 1993) and shows continuation of the trend toward increased utilization that began in 1990. Among all women of reproductive age, the prevalence of long-acting and clinical methods of contraception increased from 2.8% in 1993 to 4.1% in 1994 (NISH December 1993 - June 1994).



This growth is a direct consequence of increased awareness and knowledge as well as some liberalization of social attitudes toward the use of family planning. In the October 1994 Nigerbus survey, 88% of those who knew at least one family planning method responded that they approve of those who use family planning or child spacing methods. This survey, administered by a Nigeria division of the U.S. Gallup Corp., uses a sophisticated sampling scheme to study a 4000 person representative sample every other month. The methodology provides an accurate assessment with weighted variables for urban, rural, sex, age and, geopolitical region. In the same Nigerbus survey, 49% of those who had heard of at least one family planning method reported that they had experience with some form of family planning or child spacing. Twenty-five percent of respondents reported discussing family planning/child spacing with a spouse in the two months prior to this study. The Federal Office of Statistics survey of households (NISH) reports that the proportion of all women of reproductive age (15-49) currently using family planning methods (all methods) has grown from 8% in 1990 to 22% in December of 1993.

The Mission believes that USAID supported project activities, especially the Contraceptive Social Marketing and targeted Information, Education and Communication (IEC) Programs, have had and continue to have significant impact. Important for USAID-Nigeria program direction, sixty percent of current Nigerian users of family planning methods obtain services through private sector and NGO outlets. The Planned Parenthood Federation of Nigeria (PPFN), the largest family planning NGO in the country, alone provides about 10% of the nation's private sector users with family planning services. The rest obtain services and commodities from a wide range of private, NGO organizations.

The increase in CPR in Nigeria is slower than rates being reported from other African countries. There are several important points worth noting. First, Nigeria's population is estimated to be approximately 100 million persons. The small recorded increases in CPR

are the result of new services being provided to large numbers of people. Each percentage increase in Couple Year Protection (CYP) means that services are provided to approximately 315,000 women of reproductive age (15-49 years). Thus at our current CYP prevalence (11.3%), approximately 3.6 million women of reproductive age are using modern contraception — a number roughly equal to the entire population of women of reproductive age in Cameroon and twice the total number in Benin or Cote D'Ivoire.

Secondly, the increases reported occurred despite the absence of an effective system of service delivery in the public sector. USAID-Nigeria has already provided details on the catastrophic collapse of critical public sector health services resultant from civil disruption, job actions and strikes by health workers and widespread fuel shortages throughout calendar year 1994 (Nigeria Program Strategic Update, Nov. 1994). Almost without exception, public sector family planning services and commodity distribution activities were significantly interrupted. Most have yet to resume activities and, therefore, their contribution to the current CYP prevalence is negligible. The Mission is of the opinion that a significant percentage of Nigerians who would have used public sector facilities found access to all or some services in the private sector — but this did not happen early enough to be detected in the June 1994 survey. Were this survey to be repeated today, continued increases in CYP are probable.

Anecdotal data, and broad-based discussions with a cross-section of Nigerian NGO leadership, supported by comprehensive surveys of potential NGO delivery organizations in the commercial and not-for-profit private sector as well as assessments of NGO delivery performance to date, are central to the Mission's reorientation to an aggressive NGO program. In 1995/96, USAID-Nigeria will give added emphasis to assistance to non-governmental organizations (e.g. professional organizations, private hospitals and maternities) to support refurbishing and upgrading of clinics to provide long-term family planning methods. In the past, the private sector provided mostly temporary methods of contraception (pills, condoms and vaginal foaming tablets). Intrauterine devices (IUDs), Depo-Provera and sterilization, introduced through Government hospitals and clinics are only now beginning to be acceptable to private practitioners. With a more aggressive Mission Contraceptive Social Marketing Program, the private sector is positioned to become an even more valuable complement as providers of long-term methods, including IUDs and sterilization.

***PROGRAM OUTCOME #1.1: Increased Demand For Modern Contraceptive Methods***

Analysis of the Federal Office of Statistics quarterly survey (NISH) of June 1994 revealed that 61.3% of Nigeria's estimated 33 million women of reproductive age are knowledgeable of at least one modern method of family planning. This proportion increased from the 57.4% reported in the Federal Office of Statistics (FOS) survey December 1993. Reliable data on other key indicators of demand such as the proportion of women wishing to space or limit their children and the proportion of women with unmet needs for contraception are not available. Anecdotal reports, however, suggest that demand for family planning services is increasing.

Since the adoption of the Nigerian Population Policy (1988), there has been a dramatic attitudinal change in some parts of the country toward family planning. This, in part, is the result of a USAID-Nigeria program that has incorporated a vigorous information, education and communication (IEC) campaign to produce behavior change through awareness and knowledge creation programs. IEC materials (posters, billboards, danglers and indoor stickers with the message "Child Spacing Services Available Here") were distributed to a large number of family planning facilities. Television and outdoor advertising were also utilized including the introduction of brand name condom "spots". The National Family Planning logo, which was posted at over 40,692 public and private sites, has become a well-known symbol identifying sites offering family planning services. The need for a focus on specific strategies for Muslim Northern Nigeria was underscored by the important negative reactions to some of these national messages in that part of the country.

IEC efforts linked to and supportive of the Mission's NGO community-based strategy, continue. Materials in local language for client instruction and counseling continue to be distributed at clinic and community-based distribution levels. Over three and a half million copies of these materials had been re-printed and are ready for distribution through a private sector firm. Mission will augment its reporting base with data from special studies and surveys throughout 1995 and 1996.

***PROGRAM OUTCOME #1.2: Increased Availability of Modern Contraceptive Methods***

The volume of contraceptives imported into Nigeria by the USAID project has increased dramatically. In 1993, 33 million condoms, 4 million pills, and 130,000 units of IUDs were imported. In 1994, imports swelled to 45.2 million condoms, 2.4 million pill cycles and 585,000 units of IUDs. In 1993, a total of 777,255 couple years of protection (CYP) were generated from the use of various family planning methods. Fifty-six percent (436,937 CYP) of this was from the private sector. Using sales and distribution data, CYP for 1994 is calculated to be 829,490. The question of utilization of commodities sold from warehouses, including cross border flows, is being further examined.

Contraceptives	1991	1992	1993	1994
Condom	17 Million	17.5 Million	33 Million	45.2 Million
Pills	2 Million	4.5 Million	4 Million	2.4 Million
IUD	85,000	100,000	130,600	585,000

In the last year, the volume of family planning commodities moved through social marketing efforts has almost doubled — from the 24 million condoms sold in 1993 to 45 million in 1994. In 1993, only 340,000 condoms were distributed as free samples. This increased to 1 million in 1994. One important, but unanswered question, is the degree to which increases in condom sales can be attributed to family planning program efforts versus HIV/AIDS prevention programs. Similarly, the sales of vaginal foaming tablets as

lubricants in parts of Nigeria must be factored in the equation. Population Services International, the contractor for the Social Marketing Program, is conducting user studies to confirm the reasons for the increase in usage. The Mission is aware of the fact that there is some cross-boarder leakage, estimated at less than 5%. Regardless, the sales figures are impressive and could have been exceeded if not for stockouts experienced in mid-summer.

The same upward trend was observed in the distribution of Pills and IUDs. In 1993, 3.3 million cycles of pills were sold, increasing to 3.6 million in 1994. Oral contraceptives (OC) have always been difficult to market and the growth of sales has been slowed by Nigeria's reluctance to permit brand name advertising. USAID is working with the Social Marketing Program to move the process of OC advertising forward and expects to see a major market response in 1995.

In 1993, 14,000 IUDs were sold compared to 75,000 in 1994 — an increase of over 500%. The success of the social marketing program, despite the fact that Nigeria was beset with strikes and civil demonstrations in 1994, is a major accomplishment.

Contraceptives	1993	1994
Condom	24 Million	45 Million
Pills	3.3 Million	3.6 Million
IUD	14,000	75,000

In 1992, over 40,000 public and private sector sites were identified as actual or potential locations/outlets for family planning products or services. Among those sites identified, 81.5% (33,180) offer family planning products, services or information, 81% offer condoms, 71.3% offer orals, 44.7% foaming tablets (VFTs), 25.5% injectables, 14.1% IUDs and 3.3% voluntary sterilization. With the approval and introduction of the injectable contraceptive, Depo-Provera, plans are being developed to start social marketing of this product.

The Social Marketing Program has greatly enhanced the retail market for family planning goods and services. Nigeria's private commercial sector is vibrant and is increasingly becoming the major vehicle for delivering health services — including family planning services. Spot surveys of local pharmacies and distribution outlets have consistently shown that there are numerous brands of pills available to Nigerian consumers. The proportion of the overall market reflected in the sales of USAID-supported programs is unclear but will be the subject of survey research next year.

Since the Family Health Services (FHS) project started, approximately 17,000 service providers have been trained in the areas of clinical/non-clinical family planning services, interpersonal communication and counseling, management, information systems, financial management — 1,348 of these were trained in 1994. As one result of this effort, a network of Nigerian trainers now exists both in the private and public sectors. This investment has established a solid base of trained personnel and service providers. These private sector trainers are an important asset for USAID's NGO-based program. In addition, twelve hundred facilities have been equipped to provide a range of family planning services, from temporary methods to long-term and permanent methods.

Over the next year, USAID-N will engage with USAID/Washington and others to address the apparent inconsistency of a USAID program encouraging non-barrier methods for family planning which appears to undermine a HIV/AIDS prevention strategy encouraging barrier methods for HIV/AIDS prevention.

***PROGRAM OUTCOME # 1.3: Enhanced Quality Of Family Planning Services***

Improving the quality of clinical services in Nigeria, of necessity, is a key focus of Mission activities. The critical need to directly address basic quality issues was highlighted by the 1992 Nigerian situation analysis that showed as many as 70% of family planning clients failing to return for services after their first year because of their dissatisfaction with the way in which services are provided and a lack of confidence in the skills of service providers compounded by inadequacies in the clinical facilities themselves.

Because public sector facilities were closed by job actions for eight months in 1994, indicator data that might provide insights on the quality of services is generally unavailable. Anecdotal information suggests that much of the infrastructure and equipment for primary health care fell into disrepair or was looted. Clearly, a substantial proportion of trained workers left the system seeking job opportunities in the private sector or outside of the country. In those rare cases where the capacity for service delivery was preserved, efforts to enhance the quality of services was a secondary concern.

Conditions in the private sector appear more encouraging but steps to measure impact are premature. Issues of quality improvement are an ongoing part of the USAID strategy of engagement in the NGO community. This has been supported by a program of resource sharing that has placed key reference documents about quality assurance management in the hands of personnel of approximately 150 NGO service delivery organizations.

USAID supported approaches to quality improvement include the "Quality Assurance" paradigm, the Client Oriented Provider-Efficiency (COPE) program of the Association for Voluntary Surgical Sterilization (AVSC) among others. Their interrelationship is under review. Evaluations of quality in service provision, management and training are components of the NGO assessments being conducted by USAID supported IPs developing proposals for Nigeria.

In order to provide quality services, there is a need to train personnel who will be efficient and client-oriented. Approximately 16,708 clinical and non-clinical personnel were trained under the FHS-I project in clinical and non-clinical family planning services, interpersonal communication and counseling, supervision, management, management information systems, and financial management.

**B. CHILD SURVIVAL**

USAID's Child Survival activities in Nigeria are supported under the Nigeria Combating Communicable Childhood Diseases Project (NCCCD). This seven year activity began in October 1993 with an authorized grant funding level of \$40 million. NCCCD is a key element of the USAID-Nigeria program strategy. Its objective is to improve maternal and

child health practices by focusing on immunization practices, case management of the sick child, maternal and infant nutrition, improved maternal care and improved health management systems.

Given the serious interruption and redirection of program implementation that resulted from Nigeria's year long political and fiscal instability and the consequences of the U.S. decertification of Nigeria, attempts to assess the impact of USAID-Nigeria's child survival program efforts in anything beyond broad statements and anecdotal reports would be disingenuous.

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

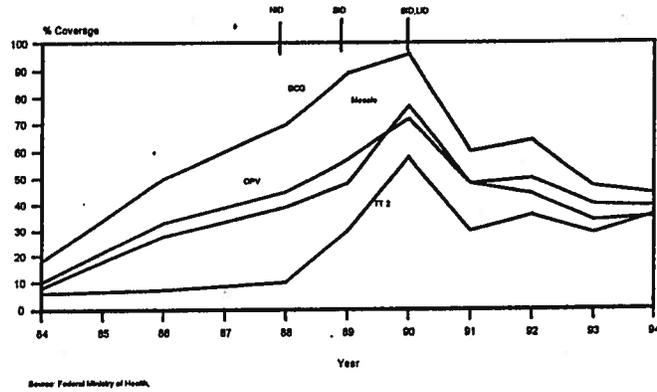
Child Survival support activities were historically closely linked with the public sector. USAID's decision to shift program activities to the NGO sector and discontinue support of Government, required a basic reorientation of the program. Child survival activities with Government partners were phased out, private sector opportunities identified and new implementation and monitoring systems designed. A great deal has been accomplished — but not enough during the three months from July to October 1994 — to allow us to realistically assess impact in FY 1994.

The Mission is encouraged by the intensity of engagement and commitment to results of its Implementing Partners in Child Survival. Their competence in the development of innovative NGO based projects has been a major asset. Given the continued decline in national indicators such as infant and maternal mortality and nutrition, however, we do not expect to be able to demonstrate and document the impact of USAID-sponsored interventions for this target before 1996. We do, however, intend to demonstrate the NGO linkages and strengthening that are a necessary pre-condition to achieving impact. These process indicators are presented in Annex A.

#### ***PROGRAM OUTCOME #2.1: Improved Immunization Practices And Coverage***

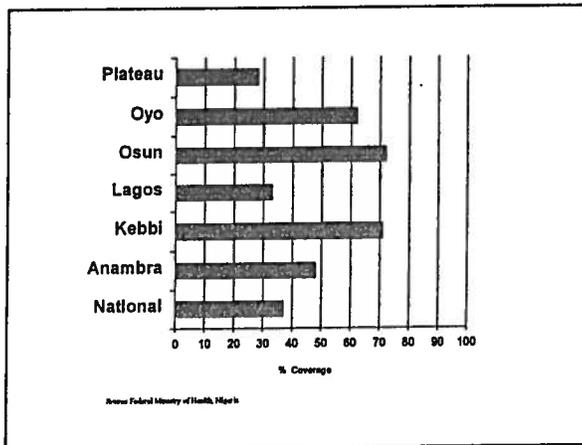
Data available from the epidemiology unit of the Federal Ministry of Health and Social Services (FMOH&SS) shows 1994 immunization coverage as follow: DPT3 coverage at 36%, OPV3 coverage at 35%, Measles coverage at 39% and TT2 coverage for women giving birth is reported to be 36%. Actual coverage may be somewhat lower. The FMOH&SS also reports 95,607 cases of measles and 224 cases of poliomyelitis.

Progress toward USAID program targets for immunization practices and coverage has fallen far below the level anticipated in the CPSP and the last API report. Indeed, EPI coverage has been declining since 1990 and the situation was most certainly exacerbated by political unrest and the collapse of the public health sector in 1994.



The reported cases of measles and poliomyelitis reported in 1994 add to a disturbing trend toward increased numbers of vaccine preventable illnesses since 1990 (due to declining EPI coverage and the accumulation of susceptibles). It is noteworthy that reported cases of measles and pertussis have not returned to pre-EPI (pre-USAID intervention) levels. As a consequence of capacity-building by USAID, Nigeria has been able to maintain EPI coverage at approximately 30%. Our investment in training and cold chain equipment made a difference. Given the impact of economic decline and political instability of the past several years, this achievement must not be minimized.

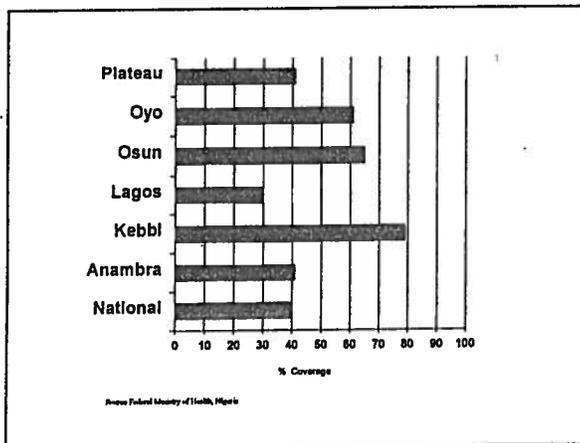
**Figure 3:**  
**Comparison of**  
**National and USAID**  
**Supported States on**  
**Measles Coverage,**  
**Children 0-11**  
**Months, 1994**



During 1994, on-site technical assistance provided through USAID strengthened EPI management capacity in twelve selected states. USAID-Nigeria provided technical and logistics support for Local Immunization Days (LIDs) in four states. This assistance resulted in significant improvements in immunization coverage as compared with national coverage (Figures 3 and

4). In mid-1994, USAID also distributed cold chain equipment and support items to the nine states that were then the geographic focus for the Mission's child survival interventions.

**Figure 4:  
Comparison of  
National and USAID  
Supported States on  
DPT3 Coverage,  
Children 0-11  
Months, 1994**



plan of action for EPI. The Five-Year Plan calls for a combined approach, emphasizing strengthening of routine immunization services and the implementation of selective, decentralized local government immunization days (LIDs) to accelerate EPI coverage. USAID-Nigeria is in the process of developing proposals with NGOs that will support community level interventions initiated under the Five-Year Plan.

USAID-Nigeria's strategy focuses on support to develop, strengthen, and monitor private sector (both non-profit and commercial) participation in immunization activities. In the 1996 API, we will report on private sector contributions toward increased immunization coverage. Anecdotal information on collaboration between the private sector/NGO community and the FMOH&SS suggests that NGO based programs can "deliver the goods" and that USAID's target of 60% immunization coverage may be achievable within its geographic focus areas. For example, in mid-November 1994, the FMOH&SS gave 1.4 million doses of measles vaccine to the Christian Health Association of Nigeria (CHAN), a network of Christian medical missionary groups. A total of 1.2 million doses of the vaccine were dispensed through the CHAN network, primarily in Plateau State and surrounding middle-belt areas. CHAN made a concerted effort to include Muslim-sponsored health facilities in this outreach activity. The FMOH&SS, the donor community at large and USAID noted the efficiency of this endeavor. There was no major failure in the CHAN cold chain system (thus ensuring vaccine efficacy) and adequate HIS reporting systems to track, record, and report on this immunization activity. USAID hosted a meeting among CHAN, the FMOH&SS, the Primary Health Care Development Agency, World Health Organization (WHO), and UNICEF in late November 1994, to support further exchange of information among the key players in immunization activities; to review the status of vaccine availability, potency, HIS reporting, and — most importantly — to discuss inclusion of additional private sector NGOs in EPI activities.

The Mission has examined the reasons for lack of progress in achieving its Child Survival targets in the past year. In addition to factors related to the difficult and unstable political environment already discussed, we note three factors contributing to both the decline in immunization coverage and the non-availability of accurate EPI data: (1) The shift of responsibility for EPI activities from the federal level of the FMOH&SS to the local

USAID joined with other international partners as an active member of the National Emergency Committee on EPI. This Committee produced a "Five Year National Plan of Action for Boosting EPI Coverage and Attainment of Measles Control, Neonatal Tetanus Elimination, and Eradication of Poliomyelitis in Nigeria," — Nigeria's first concrete attempt at a long-term

government level, (2) The creation of new States and local government areas (LGAs), and (3) The reduction of EPI funding from donor organizations.

At the local government level, adequate personnel, financial support, and physical infrastructures were not in place to meet the demands of implementing EPI as responsibility for the program was shifted from the Federal level. This was complicated by the fact that the technical support systems of the National Primary Health Care Development Agency (NPHCDA) — designed to provide critical assistance to the local governments — faltered from the start.

The second factor was the creation of twelve additional states and almost three hundred local government areas (LGAs) between 1992 and 1994. When essential supplies and equipment were inequitably distributed among newly created States/LGAs and older States/LGAs, the cold chain system broke down. During 1994, widespread strike actions limited the ability of the remaining public health staff to maintain, supervise and monitor their already marginal cold chains. As a result, it has not been possible to ensure vaccine potency, at any level.

The third factor, magnitude and impact of cuts in donor funding were not trivial. UNICEF was once a major source of support for Government Programs — contributing \$10 million toward the EPI effort in 1992. With the end of Universal Coverage of Immunization (UCI) support declined to \$1.2 million per annum in 1993 and 1994. This year (1995) UNICEF is expected to provide only \$1.5 million. With decertification and sanctions, USAID has redirected its input to support programs of NGOs.

### C. TARGET OF OPPORTUNITY: IMPROVED HIV/AIDS/STD PREVENTION AND CONTROL PRACTICES.

USAID's programs have been supported through the centrally funded AIDSCAP/FHI project and a USAID contract with Population Services International (PSI) for condom social marketing. The political crisis which engulfed the nation in the later part of 1993 and most of 1994 slowed down AIDSCAP project activities. Selected sub-projects have now

been approved for implementation reflecting the Mission's optimism that AIDSCAP/FHI's recently renewed commitment (and staffing actions) supportive of a customer friendly approach in working with Nigerian NGOs will be productive.

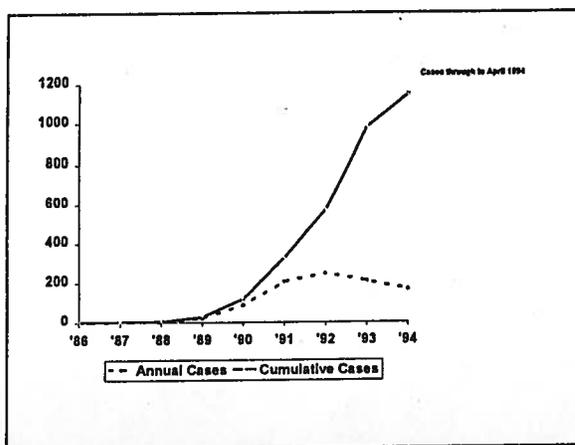


Figure 5: Reported Cases of Full Blown AIDS by Year.

<i>AIDS Distribution By Sex And Age Group</i>	
Males	62%
Females	38%
Pediatric age group	3.5%
20-39 year age group	66%

Data on AIDS in Nigeria is deceptive. Because Nigeria's population is very large (approx. 100 million), prevalence rates are low and Nigeria is consistently ranked at the bottom of the list of HIV/AIDS afflicted countries. However, in recent years, the numbers of infected persons have grown dramatically in spite of misdiagnosis, under-reporting and delays in reporting. This has led many to observe that Nigeria may be a major contributor to the pool of HIV infected individuals in sub-Saharan Africa.

The last two National HIV sentinel surveillance surveys were conducted in 1991/92 and 1993/94. Between these two dates, the HIV prevalence rate increased from 1.2% in 1991 to 3.8% in 1994. By mid-1994, over 1000 cases had been confirmed. As in other African countries, heterosexual sexual transmission continues to be the major problem.

Percentage increase in HIV prevalence Rate in Nigeria by Year and Group			
Sentinel Group	Prevalence Rate in 1991/92 (%)	Prevalence Rate in 1993/94 (%)	Percentage Increase
Ante-natal Clinic Attendees (ANC)	1.2	3.8	217%
Commercial Sex Workers (CSW)	17.5	21.3	22%
Sexually Transmitted Disease Clinic Attendees (STD)	4.8	10.0	108%
Tuberculosis Patients (TB)	2.9	7.8	169%

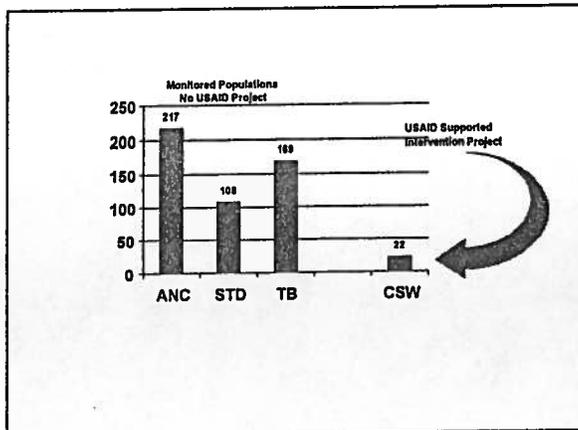
The prevalence rate among commercial sex workers in some parts of the country is now as high as 50%.

In response to the Mission's commitment to integration of health care delivery, AIDSCAP is now focusing on three geographic clusters (fourteen states) which offer opportunities for collaboration with other Implementing Partners (IPs) e.g. Pathfinder, CEDPA, CDC, Mothercare, BASICS.

Activities supported include:

1) The CSW behavior modification sub-project with a performance target of 6000 CSWs and 100,000 of their partners, in Cross River State. CSWs and their clients are sensitized to condom use as one means of risk-reduction. Vocational and adult literacy programs are integral to this project, offering the CSWs a means to further reduce the risk associated with sex work.

CSWs are empowered/encouraged to seek safer means of livelihood. It is a measure of



**Figure 6:**  
Effects of USAID Intervention on Percentage Increase in Rates of HIV Prevalence 1990/92 to 1993/94

the success of this project that other organizations, both governmental and non-governmental, have now begun to work with this high risk group throughout the country. From the two most recent National HIV sentinel surveillance surveys carried out by the Federal Ministry of Health in 1991/92 and 1993/94, these interventions may have indeed slowed down the rate of transmission of HIV among this target group.

2) The Nigerian Youth AIDS sub-project with a target of 36,000 youths in 17 post-secondary institutions, in Cross River State. Students, through peer health educators (PHEs), are made aware of the relationship between other sexually transmitted diseases (STDs) and HIV transmission, proper use of condoms for prevention, and the need for early diagnosis and prompt treatment of any STD. The student resource centers and PHEs serve as condom outlets.

3) The long distance drivers' sub-project has a target of 5000 itinerant drivers. Through PHEs and outreach workers located in the motor park health booths, drivers are made aware/reminded of the risks involved in having casual and/or multiple sex partners.

As previously noted, the PSI condom social marketing program is expanding impressively. Condom sales in Nigeria have been brisk. USAID estimates that as many as 75% of condoms sold are used to avoid HIV/AIDS and STDs.

USAID continues to play a leadership role in the development and sponsorship of HIV intervention programs in the country.

## **ANNEX A: REVISED INDICATORS AND EXPECTED LEVELS OF ACHIEVEMENT**

The recent portfolio restructuring to an exclusively private sector program has required a rethinking of the continuing appropriateness of the indicators being used to assess the impact of USAID-assisted interventions. When these indicators were established, periodic Demographic and Health Surveys were to be the primary source of information, supplemented by data generated from individual projects and the FMOH&SS HIS system. This expectation was reasonable with USAID firmly engaged with the public sector, financing activities to improve the system and with easy access to available public sector data. It was planned that information on 14 of 26 indicators for the two major Strategic Objectives be derived from the Nigeria Demographic and Health Survey (NDHS).

As USAID develops its implementation relationships with the private sector, the impact of USAID-assisted interventions will be subject, at least initially, to the collective reach of the implementing Nigerian NGOs. This collective reach will be more clearly defined in mid-1995 as the Mission's Implementing Partners design and submit multi-year programs. Many of the Nigerian NGOs will be state "umbrella" organizations. The three new Program Outcomes reflecting initiatives in private sector institutional strengthening, institutional sustainability, and women's empowerment will require appropriate process and impact indicators to quantify progress. The Mission expects that program impact will initially be modest, reflecting the sphere of action of its NGO partners and the need to strengthen institutional delivery capacity. Accordingly, the Mission has revised the CPSP indicators (developed in 1991/92) and is now relying primarily on information collected by the projects themselves. When the NDHS is conducted in Nigeria, it will provide some, but not all, of the information required to assess the impact of USAID-assisted interventions.

The following are the revised targets and notional indicators the Mission considers appropriate based on its current assessment of achievable implementation progress for each Strategic Objective (SO).

## **STRATEGIC OBJECTIVE #1: INCREASED VOLUNTARY USE OF FAMILY PLANNING**

All four indicators for this SO have been retained. A significant portion of the momentum generated for this SO in recent years will be maintained. This confidence is based on the fact that USAID finances and manages, through its NGO partners, all the primary program inputs — the most critical one being contraceptives.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<b>SO 1:</b> Increased voluntary use of family planning	Contraceptive Prevalence Rates (all women) - modern methods - long acting and clinical methods	3.8% (1990 NDHS) 2.3% (1990 NDHS)	9.3% 2.8%	11.3% 4.1%		19.0% 10.0%
	Couple years of Protection (CYP)	1.8 million	3.5 mil			5.3 mil

### **PROGRAM OUTCOME 1.1: Increased Demand For Modern Contraception**

With the restructuring of the IEC approach to support program delivery through “programs of NGOs,” the number of IEC indicators has been reduced to one. Three national rather than five national indicators will now be used to monitor progress for this Program Outcome. NDHS data will be used to supplement project data to assess progress in this Program Outcome.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<b>Program Outcome 1.1</b> Increased demand for modern contraception	Increased proportion of all currently married women wishing to space or limit their number of children	47.9% (1990 NDHS)				70%
	Reduced proportion of currently married women with unmet need for family planning services	20.8% (1990 NDHS)				5%
	Increased proportion knowledgeable of at least one modern method of family planning - all women - all men	43.5% (1990 NDHS)	57.4%	61.3%		80% 40%

**PROGRAM OUTCOME 1.2: Increased Availability Of Modern Contraceptives**

Two of the three earlier national indicators have been retained. One IEC indicator (measuring the impact of a vertical IEC program) has been dropped. Project data will be the primary source of information for these two indicators.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 1.2</u> Increased availability of modern contraceptives	Quantity of Imported Contraceptives: - Condoms - Pills - IUDs - Injectables  Number of Private Sector Service sites providing a full range of long acting and clinical methods	Condoms = 17 mil Pills = 2 mil IUDs = 85,000	33 mil 4 mil 130,600	45.2 mil 2.4 mil 585,000		60 mil 10 mil 650,000

**PROGRAM OUTCOME 1.3: Increase Quality Of Family Planning Services:**

All indicators have been retained at the national level at this time. Project data will be used to assess progress.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 1.3</u> Enhanced quality of family planning services	Client continuation rates - after 1 month - after 1 year  Proportion of new clients referred by previous clients  Proportion of clients with complication resulting from previously received services	70% (one month) 30% (one year)  242,283  20% (FHS/Policy)				75% 35%  40%  10%

**PROGRAM OUTCOME 1.4: Improved Participation Of Women In Health Care Decision Making**

This additional Program Outcome reflects USAID's commitment to additional indicators that go beyond women's knowledge of and physical access to health services and family planning. This Program Outcome addresses the often neglected variable of women's ability to participate in and influence health and family planning decision-making in her own interest. It is recognized as a longer term strategy that, not unlike the first years of family planning in Nigeria, will be fraught with difficulties — including cultural obstacles and institutional hesitancy. Failure to address this attitudinal barrier is a probable obstacle to sustainable health delivery and family planning achievement. Five indicators have been tentatively proposed for this Program Outcome. It is expected that most of the information necessary to assess progress will be project generated through surveys and operational research. Because this is a new intervention area, it is recognized that programmatic content must evolve in the course of project implementation. The five proposed indicators are expected to be constructively challenged and revised as the

program activities for this outcome are clarified. Although developed with significant assistance from local sociologists, as well as through review of the considerable body of Nigerian literature, the indicators are intentionally suggestive rather than conclusive. Baselines are being established.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<p><u>Program Outcome 1.4</u></p> <p>Improved participation of women in health care decision making</p>	<p>Proportion of women exposed to new bodies and sources of information; e.g., literacy training, magazines and newspapers, fact videos, public lectures, etc.</p> <p>Proportion of women earning income (in both formal and informal sectors)</p> <p>Proportion of women who feel it is their right to make financial decisions affecting their own health.</p> <p>Proportion of household expenditures that reflect woman's self-defined basic needs.</p> <p>Proportion of household decisions based on inter-spousal /intra-familial communication with woman's opinion given greater weight.</p> <p>Proportion of women able to organize household budgets</p> <p>Proportion of women and men who no longer act based on traditional beliefs limiting women's choices of foods during pregnancy.</p> <p>Proportion of income generating women who determine expenditure of that income.</p>	<p>1995 Baseline being determined.</p>				

***PROGRAM OUTCOME 1.5: Enhanced Organizational Sustainability Of NGOs***

Four indicators have been established for this Program Outcome, with information for assessing Program Outcome to be generated by the projects. This new indicators reflect the Mission's commitment to aggressively work with the private sector foster long term sustainability and continuity. It also reflects the Missions commitment to challenge the U.S. CAs to plan and work toward non-disruptive exit strategies — recognizing that USAID's assistance is necessarily finite.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 1.5</u> Improved organizational sustainability of selected NGOs	Proportion of organizations with written guidelines to transfer leadership positions to trained successors  Proportion of organizations with written policies and management procedures accessible and in use.  Proportion of organizations with documented linkages to multiple sources of managerial training.  Proportion of organizations reducing dependence on single donor support and enhancing resource base through community generated revenues.	1995 Baseline being determined.				

***PROGRAM OUTCOME 1.6: Strengthened Organizational Capabilities and Capacity***

Three indicators have been established to monitor progress in this new Program Outcome. All assessment data will be project generated. These indicators will be further refined based on organizational experience.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 1.6</u> Strengthened capacity and capability of selected NGOs for health delivery services.	Numbers of management training programs for second level NGO staff  Numbers of organizations with full and adequate staffing to meet financial monitoring requirements.  Proportion of NGO staff who are volunteers	1995 Baseline being determined.				

***PROGRAM OUTCOME 1.7: Enhanced Integrated FP/CS/HIV-STD Services***

This new Program Outcome focuses on "quality" as well as "quantity" through measuring client satisfaction and cost effectiveness. Four indicators have been proposed for this Program Outcome, with all assessment data to be generated by the projects.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 1.7</u> Enhanced Integrated health services (maternal and child health, family planning and HIV/AIDS/STD control and prevention).	Proportion of USAID/IP service delivery mechanisms (all levels) offering integrated services.  Proportion of clients serviced obtaining integrated services through USAID/IP supported service delivery mechanisms (all levels)  Time clients spend to access services  Program costs per unit of service delivery	1995 Baseline being determined.				

### **SO #2: IMPROVED MATERNAL AND CHILD HEALTH**

Unlike SO #1, USAID and its IPs do not control all the critical inputs for the realization of the outcomes for this strategic objective. For example, USAID does not finance vaccines and drugs, both essential inputs. USAID and its IPs will probably depend on the GON which has a monopoly in the importation of vaccines. Clients will be expected to participate in cost recovery schemes to achieve all four Program Outcomes retained from the 1992 CPSP.

The five national indicators of the 1992 CPSP have been retained even though impact outcome, particularly for child survival and EPI, is acknowledged as subject to important variability resultant from GON policies and procedures. NDHS data will be used to supplement project data generated from special surveys and routine information collection.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>SO 2</u> Improved maternal and child health practices	Infant Mortality Rate  Child mortality rate  Prevalence of severe malnutrition among children under five years (Wasted: weight for height index below -2SD)  Proportion of currently married women at high risk for child bearing (women <18 or >35; birth interval <24 mos; parity >3)  Maternal Mortality Rate	91.4/1000 (90 NDHS)  192.4/1000 (90 NDHS)  9.1% (1990 NDHS)  79.1% (1990 NDHS)  15/1000(1990 NDHS)				87/1000  90/1000  7.5%  70%  10/1000

**PROGRAM OUTCOME 2.1: Improved Immunization Practices And Coverage**

Four of five national indicators from the 1992 CPSP have been retained and most of the data will come from project records.

The activity indicator on EPI elements has been dropped. The precariousness of vaccine supply may well be accentuated because middle level EPI and cold store managers limiting vaccine access to the private sector, in violation of official FMOH&SS policy. There are, however, encouraging recent reports suggesting Governments commitment to making vaccine reliably available to the private sector, albeit selectively.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 2.1</u>						
Improved immunization practices and coverage	Proportion of children <1 receiving DPT3, OPV3 and measles vaccinations	(1990 NDHS) DPT3 = 20.8% OPV3 = 20.7% Measles = 21.0%	(FMOHSS) 33.0% 34.0% 40.0%	(FMOHSS) 36.0% 35.0% 39.0%		60%
	Reduced Measles morbidity	155.1/100,000 (UN)	54,734	95,607		110/1000
	Paralytic Polio Incidence (5-9 yrs of age)	842 cases 40/100,000 (UN)	1,083	224		2/100,000*
	Proportion of women delivering who have received TT2 (protective levels of tetanus antitoxin) within the previous 12 months	TT2 = 40.9% (1990 NDHS)	29%	36.0%		55%

\* Because of WHO's Global Polio Eradition Program

**PROGRAM OUTCOME 2.2: Improved Case Management Of Acute Respiratory Infections (ARI), Fever, (Malaria) And Diarrhea**

All three 1992 CPSP national indicators for this outcome have been retained. It is expected that data from facility and community surveys will supplement NDHS surveys.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 2.2</u>						
Improved case management of the sick child. ARI, fever (malaria), and diarrhea.	Proportion of children <5 yrs who received correct home management of diarrhea by care provider	60% (NDHS)				80%
	Proportion of children <5 yrs who received correct home management of diarrhea by care provider	30%				60%
	Proportion of children <5 yrs seen at health facilities with ARI, fever (malaria), and/or diarrhea who received care meeting standards for clinical assessment, treatment and parental counseling.					40.0%

**PROGRAM OUTCOME 2.3: Improved Child Nutrition Practices**

All three indicators from the 1992 CPSP have been retained, with project surveys expected to provide data to assess the impact of this intervention rather than of relying exclusively on NDHS.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 2.3</u> Improved child nutrition practices	Proportion of infants exclusively breast-fed for first four months of life	1.0% (1990 NDHS)				5.0%
	Proportion of mothers feeding nutritious food to infants 6-9 months	70.0%	43.0%			70.0%
	Prevalence of stunting among children under age five years (Stunted: height for age index below -2SD)	43.1% (1990 NDHS)				40%

**PROGRAM OUTCOME 2.4: Improved Maternal Care**

All four indicators have been retained. Community surveys by projects will be used to supplement NDHS data to assess the impact of this intervention.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 2.4</u> Improved maternal care	Proportion of women with at least two visits to trained health providers during pregnancy.	58.6% (1990 NDHS)				75.0%
	Proportion of births attended by trained attendant	43.6% (1990 NDHS)				50.0%
	Proportion of post-partum women counseled and offered family planning services	<10.0%				25.0%
	Proportion of post-partum women accepting modern family planning methods	<5.0%				20.0%

## TARGET OF OPPORTUNITY: IMPROVED HIV/AIDS/STD PREVENTION AND CONTROL PRACTICES

All three indicators from the 1992 CPSP remain valid and have been retained. Additional indicators directed to behavioral change are being developed.

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<p><u>Target of Opportunity</u></p> <p>Improved HIV/AIDS/STD prevention and control practices</p>	<p>Availability of condoms (1)</p> <p>Proportion of men and women knowledgeable of HIV transmission.</p> <p>Proportions of men and women altering attitudes and behaviors concerning HIV transmission</p> <p>Proportion of men and women who are able to identify signs and symptoms of common STDs and who know where to seek treatment.</p> <p>(1) No segregation of condoms for Family Planning and HIV/AIDS</p>	<p>17 million</p> <p>47% (FOS 1993)</p>	<p>24 mil</p> <p>54% (NB)</p>	<p>45.2 mil</p>	<p>55%</p>	<p>80%</p>

## Annex (A), Table (1)

Program Strategic Objectives and Targets  
Status of Achievements

CPSP Objective/Target	CRSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<b>Strategic Objective 1:</b> Increased voluntary use of family planning	Contraceptive Prevalence Rates (all women) - modern methods - long acting and clinical methods  Couple years of Protection (CYP)	3.8% (1990 NDHS) 2.3% (1990 NDHS)  1.8 million -	9.3% 2.8%  3.5 mil	11.3% 4.1%		19.0% 10.0%  5.3 mil
<b>Program Outcome 1.1</b> Increased demand for modern contraception	Pincreased poportion of all currently married women wishing to space or limit their number of children  Reduced proportion of currently married women with unmet need for family planning services  Increased proportion knowledgeable of at least one modern method of family planning - all women - all men	47.9% (1990 NDHS)  20.8% (1990 NDHS)  43.5% (1990 NDHS)				70.0%  5%  80% 40%
<b>Program Outcome 1.2</b> Increased availability of modern contraceptives	Quantity of Imported Contraceptives: - Condoms - Pills - IUCDs - Injectables  Number of Private Sector Service sites providing a full range of long acting and clinical methods	Condoms = 17 mil Pills = 2 mil IUCDs = 85,000	33 mil 4 mil 130,600	45.2 mil 2.4 mil 585,000		60 mil 10 mil 650,000
<b>Program Outcome 1.3</b> Enhanced quality of family planning services	Client continuation rates - after 1 month - after 1 year  Proportion of new clients referred by previous clients  Proportion of clients with complication resulting from previously received services	70% (one month) 30% (one year)  242,283  20% (FHS/Policy)				75% 35%  40%  10%

Annex (A), Table (1)

Program Strategic Objectives and Targets  
Status of Achievements

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 1.4</u> Improved participation of women in health care decision making	<p>Proportion of women exposed to new bodies and sources of information; e.g., literacy training, magazines and newspapers, fact videos, public lectures, etc.</p> <p>Proportion of women earning income (in both formal and informal sectors)</p> <p>Proportion of women who feel it is their right to make financial decisions affecting their own health.</p> <p>Proportion of household expenditures that reflect woman's self-defined basic needs.</p> <p>Proportion of household decisions based on inter-spousal /inter-familial communication with woman's opinion given greater weight.</p> <p>Proportion of women able to organize household budgets</p> <p>Proportion of women and men who no longer act based on traditional beliefs limiting women's choices of foods during pregnancy.</p> <p>Proportion of income generating women who determine expenditure of that income.</p>	1995 Baseline being determined.				
<u>Program Outcome 1.5</u> Improvements in the organizational sustainability of selected NGOs	<p>Proportion of organizations with written protocols to transfer leadership positions to trained successors</p> <p>Proportion of organizations with written policies and management procedures accessible and in use.</p> <p>Proportion of organizations with documented linkages to multiple sources of managerial training.</p> <p>Proportion of organizations reducing dependence on single donor support and enhancing resource base through community generated revenues.</p>	1995 Baseline being determined.				

Annex (A), Table (1)

Program Strategic Objectives and Targets  
Status of Achievements

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 1.6</u> Strengthened capacity, and capability of selected NGOs for health service delivery.	Numbers of management training programs for second level NGO staff Numbers of organizations with full and adequate staffing to meet financial monitoring requirements. Proportion of NGO staff who are volunteers	1995 Baseline being determined.				
<u>Program Outcome 1.7</u> Enhanced integrated health services (maternal and child health, family planning and HIV/AIDS/STD control and prevention).	Proportion of USAID/IP service delivery mechanisms (all levels) offering integrated services. Proportion of clients obtaining integrated services through USAID/IP supported service delivery mechanisms (all levels) Time clients spend to access services Program costs per unit of service delivery	1995 Baseline being determined.				
<u>Strategic Objective 2</u> Improved maternal and child health practices	Infant Mortality Rate Child mortality rate Prevalence of severe malnutrition among children under five years (Wasted: weight for height index below -2SD) Proportion of currently married women at high risk for child bearing (women <18 or >35; birth interval <24 mos; parity >3) Maternal Mortality Rate	91.4/1000 (90 DHS) 192.4/1000 (90 DHS) 9.1% (1990 NDHS) 79.1% (1990 NDHS) 15/1000(1990 NDHS)				87/1000 90/1000 7.5% 70% 10/1000

Annex (A), Table (1)  
 Program Strategic Objectives and Targets  
 Status of Achievements

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 2.1</u> Improved immunization practices and coverage	Proportion of children <1 receiving DPT3, OPV3 and measles vaccinations - DPT3 - OPV3 - Measles  Reduced Measles morbidity  Paralytic Polio Incidence (5-9 yrs of age)  Proportion of women delivering who have received TT2 (protective levels of tetanus antitoxin) within the previous 12 months	(1990 NDHS) DPT3 = 20.8% OPV3 = 20.7% Measles = 21.0%  155.1/100,000 (UN)  842 cases 40/100,000 (UN)  TT2 = 40.9% (1990 NDHS)	(FMOHSS) 33.0% 34.0% 40.0%  54,734  1,083  29%	(FMOHSS) 36.0% 35.0% 39.0%  95,607  224  36.0%		60%  110/100,000  2/100,000*  55%
<u>Program Outcome 2.2</u> Improved case management of the sick child, ARI, fever (malaria), and diarrhea	Proportion of children <5 yrs who received correct home treatment of diarrhea by care provider  Proportion of children <5 yrs who received correct home treatment of diarrhea by care provider.  Proportion of children <5 yrs seen at health facilities with ARI, fever (malaria), and/or diarrhea who received care meeting standards for clinical assessment, treatment and parental counseling.	60% (NDHS)  30%				80.0%  60%  40.0%
<u>Program Outcome 2.3</u> Improved child nutrition practices	Proportion of infants exclusively breast-fed for first four months of life  Proportion of mothers feeding nutritious food to infants 6-9 months  Prevalence of stunting among children under age five years (Stunted: height for age index below -2SD)	1.0% (1990 NDHS)  70.0%  43.1% (1990 NDHS)	43.0%			5.0%  70.0%  40.0%

Annex (A), Table (1)  
Program Strategic Objectives and Targets  
Status of Achievements

CPSP Objective/Target	CPSP Indicators	Baseline (Year, Source)	1993	1994	1995	2000
<u>Program Outcome 2.4</u> Improved maternal care	Proportion of women with at least two visits to trained health providers during pregnancy.	58.6% (1990 NDHS)				75.0%
	Proportion of births attended by trained attendant	43.6% (1990 NDHS)				50.0%
	Proportion of post-partum women counseled and offered family planning services	<10.0%				25.0%
	Proportion of post-partum women accepting modern family planning methods	<5.0%				20.0%
<u>Target of Opportunity</u> Improved HIV/AIDS/STD prevention and control practices	Availability of condoms (1)	17 million	24 mil	45.2 mil		
	Proportion of men and women knowledgeable of HIV transmission	47% (FOS 1993)	54% (NB)		55%	80%
	Proportions of men and women altering attitudes and behaviors concerning HIV transmission					
	Proportion of men and women who are able to identify signs and symptoms of common STDs and who know where to seek treatment:					
	(1) No segregation of condoms for Family Planning and HIV/AIDS					

\* Because of WHO Global Polio Eradication Program