

**FINDINGS AND RECOMMENDATIONS  
FOR NIGERIA  
PHN TRANSITION STRATEGY  
MARCH, 1999 - SEPTEMBER, 2000**

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## EXECUTIVE SUMMARY

In response to the elections in Nigeria and the planned return to democratic civilian rule, Keys MacManus, G/PHN/OFPS, and Mary Ellen Stanton, G/PHN/HN, visited Nigeria Feb 13 - 25, 1999 in order to provide recommendations for a 18 month PHN transition strategy.

The problems facing the PHN sector are immense. Child and maternal mortality are on the rise. With the deterioration of public sector services, the continued rapid growth of the population, and the catastrophic increase in the transmission of HIV, Nigeria faces tremendous challenges. Assuming a peaceful transition to democracy and a waiver to decertification so that USAID can re-engage with the public sector, the following general recommendations are offered:

- re-engage with the Nigerian Federal and selected State government through selected, time-limited initiatives--particularly in the area of HIV/AIDS and immunization
- assess critical needs for information, skills, commodities and equipment
- target youth, both as recipients and as active participants in PHN programs
- target programs in selected urban areas to maximize impact
- strengthen promising NGOs and expand their role
- reopen intellectual ties with universities through joint research and service programs
- develop computerized advocacy materials to engage government to allocate resources and to carry out programs to stem the transmission of HIV
- consolidate and expand the family planning program and support the national DHS
- continue support to the National Program of Immunization and use polio eradication efforts to strengthen the routine immunization program
- renew and initiate programs to reduce maternal mortality, including postabortion care
- continue donor collaboration along the highly effective model established by the InterAgency Collaboration Committee for the National Program of Immunization
- carry out an assessment to determine the possibility of a mission program in education
- initiate plans to develop a five-ten year USAID strategy

## ACKNOWLEDGMENTS

From the very beginning of this assignment, the team was blessed with the full support of the AFR and G Bureaus in holding briefing and strategy formulation sessions to refine our tasks. After our arrival in Lagos, the Mission Director, with his wonderful colleagues at USAID and implementing partners, led the creative dialogue with the team--so necessary to the formulation of a practical strategy to guide PHN expansion over the next eighteen months.

The following recommendations for a strategic plan were presented informally to the DCM who took time out of her incredibly busy schedule (three days before the Nigerian Presidential election). For this we thank her.

Finally, to all our Nigerian friends, old and new, we thank you for sharing your thoughts, many of which are incorporated in this document. May it be implemented in peace.

Keys MacManus  
Mary Ellen Stanton

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## **I BACKGROUND**

### **A. PURPOSE OF THE VISIT**

In the R4 Report prepared in March, 1998, USAID/Lagos expressed the need for AFR/Global Bureau assistance in reviewing the entire portfolio for Nigeria in light of the evolving political situation. The need became more apparent with the death of Sani Abacha and the call on July 20, 1998 for a phased return to democracy from his successor as Head of State, General Abdulsalam Abubakar.

In part because of a shortage of operating expense (OE) funds in the AFR Bureau and in part because of the need to focus on programmatic opportunities and challenges in the PHN area during the transition period, an Advisory Team from G/PHN was made up of two senior officers with combined time of over eight years in Nigeria, most recently in 1994. This team had witnessed the rapid nationwide buildup of the PHN program, particularly family planning, in the 1980s and its precipitous decline after the political disaster of 1993.

The task of the Advisory Team was to assess (1) the thrust and coverage of current programs, (2) the level of the remaining infrastructure, including trained staff in both the public and private sectors, and (3) the need for additional efforts in certain immediate and long term crisis situations in the PHN sector.

### **B. METHOD OF OPERATION**

The Advisory Team devoted the majority of its time to discussions with the Mission and Implementing Partner (IP) staff. Multiple sessions were scheduled in both focus groups and one-on-one discussions in two states. Visits were undertaken to discuss issues with administrative and clinical personnel at the state and LGA level. Visits were also made to CAs and other donor-supported efforts. Throughout this process, the team met at length with the major donors, multilaterals, and Nigerian NGOs, most notably the Planned Parenthood Federation of Nigeria (PPFN), the Society for Family Health (SFH), and Community Partnerships for Health (CPH). Before departing, the team debriefed the DCM at the American Embassy.

### **C. CURRENT USAID NIGERIA PROGRAM**

**Democracy and Governance** In FY 1996, a DG program was initiated in Nigeria to strengthen civil society's capacity to effect change under a repressive military regime. Activities have focused primarily upon women's political empowerment, democratic participation and promotion of fundamental human rights. The FY 1998 DG program carried out activities through small grants to 34 grassroots women and youth NGOs in 16 states clustered in the Northwest, Northeast and Southwest parts of the country. Implementing partners are CEDPA and JHU/PCS.

**Population, Health and Nutrition** Additionally, USAID continues its longstanding PHN program focused in three major areas: HIV/AIDS/STD prevention and impact mitigation, family planning and maternal and child health. In compliance with the congressional mandate in 1994, USAID/Nigeria changed its efforts from the public sector to the private sector and overall assistance has been drastically reduced since the late 1980s-early 1990s. In addition to proportional cutbacks across the sector, specific activities in childhood nutrition and maternal health have been suspended. As with DG activities, activities have been carried out in regional clusters through NGOs. Implementing partners are JHU/PCS, PSI/SFH, PPFN, CEDPA, AVSC, FHI/IMPACT, CDC, BASICS, and Pathfinder, International.

Since the institution of USAID's private sector approach through NGOs, activities in which both DG and PHN elements have been carried out in the same NGOs have resulted in complementarity and synergy--an innovative aspect of the USAID/Nigeria program.

## II POPULATION, HEALTH AND NUTRITION SITUATION

With an estimated population of 108,000,000 in 1998, Nigeria is the most populous country in Africa. Close to two-thirds of the population live in rural areas. One third of the population is considered below the poverty level where GNP per capita is \$280 per capita. Life expectancy is 55 years for males and 56 years for females.

### A. HIV/AIDS

Nigeria has experienced an exceedingly rapid increase in the transmission of HIV infection in this decade. Current estimates suggest that HIV infection, at estimated prevalence of approximately 10%, now affects 4-5 million Nigerians--more persons than in countries in southern Africa with prevalence rates at 30%. The United Nations Programme on HIV/AIDS (UNAIDS) ranked Nigeria as the second worst affected country in the world in 1997, based on the number of HIV infections. However, with a current seroprevalence estimate of 10%, Nigeria could easily rank first in 1999. Nigeria is rapidly becoming the epicenter in West Africa for the AIDS pandemic.

**Nigeria HIV Prevalence and Estimated HIV/AIDS Cases**

	ANC clients	TB patients	STD clinic attendees	CSWs	HIV/AIDS cases
1991-92	1.4%	2.2%	4.6%	17.5%	600,000
1993-94	3.8%	7.9%	8.9%	22.5%	1,900,000
1995-96	4.5%	13.1%	15.1%	35.6%	2,500,000
1998	8-10%				4-5,000,000

1991-92, 1993-94, 1995-96 = MOH sentinel surveys  
1998 = estimate

The number of reported cases of full blown AIDS increased rapidly from 1,148 in April, 1994 to 10,803 in November, 1997. Although these figures constitute the tip of the ice-berg, they reflect an exponential growth in the magnitude of the AIDS epidemic in Nigeria.

The projected burden of disease, as the HIV infection proceeds to AIDS, will have a major negative impact on economic productivity and result in an immense drain on health care resources--in addition to the suffering of people living with HIV/AIDS (PLWHA) and those persons affected by AIDS (PABA). Nigeria, alone, contributes to 10-12% of the global burden of HIV/AIDS and this is likely to increase in the future.

For every two men in Nigeria who are HIV seropositive, there are three women who are HIV seropositive. With such a high percentage of women with HIV, vertical transmission of the virus is a significant problem and this problem is exacerbated by near universal breastfeeding for up to two years and rare use of Caesarean section and antiviral treatment. In 1997, it was estimated that there were 70,000 new HIV infections in children (13% of the total new infections). In addition, there is a growing problem of children orphaned due to AIDS. In one location in Benue State which relies upon subsistence farming, it is reported that many men have gone or have died, women with the disease are sick and there are not enough hands to tend the farms, resulting in an urgent need for food.

## **B. POPULATION/FAMILY PLANNING**

Nigeria's total fertility rate (TFR) is 6.5%, decreased from 8.2% in 1982. At the current rate, population doubling time is 23 years; 46% of the population is less than 15 years of age.

The modern contraceptive prevalence rate (CPR) rose from 3.8% in 1990 to 11% in 1994. Current information suggests that the current modern CPR is 10.2% among married women. Modern CPR is 19.3% among all females and 29.7% among men and women indicating an increased use of condoms in the past several years. Following condoms, pills are the most popular method.

**CONTRACEPTIVE PREVALENCE RATE (MODERN METHODS)**

Region (n)	Lagos (131)	Southwest (465)	Southeast (435)	Northwest (513)	Northeast (477)
Condom	22.1	35.05	34.48	7.6	14.47
Pills	3.8	5.38	4.6	4.48	3.98
Foaming tablets	.765	-	-	-	-
Injectables	1.53	1.29	1.15	2.34	1.26
IUCD	2.29	1.08	1.15	2.34	1.26
Male sterilization	-	-	-	-	-
Female sterilization	-	.22	-	-	.42
Norplant	-	-	-	-	-
Diaphragm	.76	.22	-	.39	-
<b>Total Modern CPR</b>	<b>31.3</b>	<b>43.23</b>	<b>41.38</b>	<b>15.01</b>	<b>22.2</b>
<b>Total Modern CPR- -excluding condoms</b>	<b>9.16</b>	<b>8.17</b>	<b>6.9</b>	<b>7.41</b>	<b>7.76</b>

RMS FP Spot Survey, 1998-Addendum

It should be noted that this survey only covered seven states and in those states focused heavily in urban areas. Thus, it probably overstates contraceptive use.

**C. CHILD HEALTH**

Each year, some 4.5m children are born in Nigeria; the current population of children under five is estimated at 18m. The under five mortality rate is 191/1,000 live births, a substantial decline from more than 300/1,000 in 1960, but unimproved since 1990. Likewise, the infant mortality is 114/1,000 live births, down from 200/1,000 in 1960, but an increase from 87/1,000 in 1990.

<b>- CAUSES OF CHILD MORTALITY</b>	
Malaria	30%
Diarrhea	20%
Vaccine Preventable Disease	20%
Acute Respiratory Infection	10%
Sickle Cell Anemia	5%
Others	15%

Pediatric Association of Nigeria, 1998

Looking to the future, by the year 2000 HIV/AIDS will contribute significantly to under five deaths and erode gains in child survival.

In addition to mortality, Nigerian children carry a significant burden of morbidity due to disease and malnutrition. 17% of infants are born with low birth weight which puts them at significant risk of succumbing to infection and facing developmental problems. 11% of under fives are wasted (boys and girls) and 58% of boys and 35% of girls are stunted. For school children, the rate of iodine deficiency is 22%, vitamin A deficiency 9%, and iron deficiency anemia 29%. It is estimated that 52% of all under five deaths are associated with malnutrition. For each of the diseases which may result in mortality, there is an enormous morbidity burden related to malaria, diarrhea and acute respiratory infection.

#### D. MATERNAL HEALTH

In Nigeria, estimates suggest that maternal mortality is rising. With a high ratio of 1,000 deaths/100,000 live births, the annual number of deaths is now estimated at 60,000 deaths per year. Nigeria is second only to India in the number of maternal deaths. With less than 2% of the world's population, Nigeria contributes 10% of the world's maternal deaths.

CAUSES OF MATERNAL MORTALITY	
Hemorrhage	23%
Sepsis	17%
Toxemia/Eclampsia	11%
Abortion	11%
Anemia	11%
Malaria	11%
CVD	11%
Hepatitis	3%
Diabetes	2%

Nigeria Federal Ministry of Health, 1996

In addition to the increasing population of Nigeria, which increases the at-risk population of women of childbearing age, unsafe abortion also appears to be on the rise. This is a special and growing problem among youth; 30% of women become pregnant by age 17 and 60% of abortion-related complications occur in adolescent girls. In addition to abortion, there have been anecdotal reports of "baby dumping."

The disease burden related to pregnancy is substantial. Nationwide, 7% of women have vitamin A deficiency and 35% have iron deficiency anemia. For every maternal death, there are 15-20

cases of severe disability including obstetric fistula, ruptured uterus, and pelvic inflammatory disease resulting in sterility. Contributing to the problem of obstructed labor is the widespread practice of Female Genital Cutting (FGC) which also puts girls and women at risk of death and morbidity at the time of the procedure.

#### **E. INFECTIOUS DISEASE**

In addition to HIV/AIDS and vaccine-preventable diseases, other infectious diseases impose a tremendous burden of morbidity and mortality in Nigeria. With few exceptions, there is insufficient information to describe the extent of these problems accurately. Tuberculosis is considered to be on the rise, especially as HIV progresses to AIDS. Malaria poses a very significant health burden. In addition to contributing 30% of the child deaths in the country, it is estimated to be a direct cause of 11% of maternal deaths. Malaria also contributes to adverse pregnancy outcomes including abortion, stillbirth, premature labor and low birth weight.

Information on the prevalence of STDs is very sparse. In 1996, at the time of the HIV prevalence survey, syphilis prevalence was found to be the same as HIV prevalence, 4.5% among pregnant women. Since then, there has been no prevalence survey, even in selected sites, of syphilis or other STDs (with the exception of HIV).

#### **F. YOUTH**

The Nigerian Youth (age 10-24) is adversely impacted by the savage HIV/AIDS epidemic; over 50% of HIV infection in Nigeria is attributable to adolescents and young adults. There has been an increasing number of unwanted pregnancies with a concomitant rise in unsafe abortions and deaths. The health burden falls primarily on girls who carry all of the health consequences of unwanted pregnancies/abortions. Currently there are 36 m. youth under age 24 and their numbers would be expected to increase to 75m. by 2025 without considering the death toll from AIDS. The enormity of these numbers can be appreciated when one considers that the entire population of Nigeria in 1991 was 88m. Of the large number of Nigerian youth who are sexually active, most are misinformed about health risks which they face. Nigerian teens account for 80% of unsafe abortion complications treated in hospitals, in part because they postpone the procedure until late in pregnancy and are much more likely to seek care from untrained providers.

### **III CURRENT SITUATION IN OTHER SECTORS**

**Democracy and Governance** The country remains under military rule. Preparations are being made for transition to civilian government and assembly and senate elections were held during the time of this visit. Voter turnout was low and adherence to fair and free election standards was mixed. Over the past few years there has been rapid growth of NGOs in support of civil society. At this time the capacity of NGOs is limited, but growing. There has been good initial growth of empowerment activities to reach women. The potential of the NGO sector is significant but currently most NGOs are fragile and limited in capacity.

**Literacy and Education** Female literacy is 39% compared to male literacy of 62%. Nationwide, there is more parity in primary school education with 75% of girls and 86% of boys enrolled. There is greater gender disparity in school enrollment in the northern states. It is reported that at the tertiary level, many young women are paying for their education through commercial sex work.

**Environment** In Lagos, significant air pollution is apparent. The land is seriously affected by soil erosion, desertification, and ubiquitous refuse dumps along the roadside. In rural areas, 39% have access to safe water and 31% have access to sanitation; in urban areas 64% have access to safe water and 60% have access to sanitation.

**Economy** The economic situation is extremely poor. Fuel availability in this oil-rich nation is severely limited and distribution is often affected due to strikes, resulting in hoarding and black market prices. Erratic electricity has contributed to industrial production that is reportedly 20-25% of capacity. Unemployment is very high, particularly among young university graduates.

Overall, the UNICEF Director of Field Operations has eloquently summarized the current situation in Nigeria: "There has been a change in what people eat and a change in aspirations for children. There has been an erosion of personal safety and an erosion of expectations."

## **IV MAJOR FINDINGS**

### **A. HIV/AIDS**

**Stigma** While awareness of the problem has increased, there continues to be significant denial of the problem at the individual, community and government levels and stigmatization of individuals with HIV. It is said that many people who test positive "disappear" to follow-up and communities abandon those in need of help. Nevertheless, the progression of the HIV infection to "full blown" AIDS has brought a more realistic perception of this problem. USAID work with NGOs has supported PLWHA to come together. In addition to the important work of providing care and support, the emergence of PLWHA has highlighted and brought a face of reality to the problems which mere numbers alone do not convey. Despite continued strong denial in certain areas, the reality of the problem is now becoming apparent.

**Condoms** There has been an increased demand for condoms in Nigeria. Indeed, the recent seven state spot survey in late 1998 demonstrated that the vast majority (79-97%) have awareness of condoms as a FP method (there is no survey which assesses the awareness of condoms as an AIDS transmission preventive). Furthermore, the same survey indicates that the condom is the most common FP method. This is a major change in method mix since the early 1990's.

**CPR FOR CONDOM ALONE AND  
% CONDOM OF TOTAL MODERN CPR**

	Condom Only CPR	% Condom of Total Modern CPR
Lagos	22%	71%
Southwest	35%	81%
Southeast	34%	83%
Northwest	7%	51%
Northeast	14%	65%

RMS FP Spot Survey, Dec., 1998

Nevertheless, provision of and demand for condoms on a population basis is only one-half as that of Ivory Coast--not nearly sufficient to disrupt the current HIV pandemic.

**Surveillance** The government has not continued the nationwide sentinel surveillance (the last study was done in 1995-96) and that capability has disintegrated. Very recently, it has been reported that WHO/AFRO will support a national surveillance study in 1999. Unlike the previous surveys which used 16 sites and four groups (ANC clients, TB patients, STD clinic attendees, and CSWs), this study will survey only ANC clients but will extend the study to all 36 states in the Federation. This surveillance will provide essential data to understand the extent of HIV spread for targeting programs.

**Prevention** Significant prevention interventions have been undertaken. Posters can be found in health care facilities. UNICEF has produced excellent television short spots and a 20 minute documentary/education program. Contests have been sponsored through youth groups to promote AIDS education. Recently, the death of Fela, Nigeria's popular singer has been publicized; his family members have taken part in AIDS prevention activities. Despite these efforts, far more is needed to address this rapidly growing crisis.

**Care and Support** Recent efforts to start care and support groups have provided a human face to the AIDS problem. Home care is focused on symptomatic relief and treatment of conditions such as diarrhea, fever and respiratory infection. The support component has been especially important. Due to outreach to families and communities, individuals with AIDS are less likely to be abandoned as the disease advances to its final stages. In areas where these pilot programs have been implemented, stigma is decreasing thereby making it more likely that communities will develop prevention and care programs, as well as work together to exhort government to live up to its responsibilities to monitor and mitigate the crisis which goes far beyond its health ramifications.

## B. FAMILY PLANNING

**Policy** The National Population Policy adopted in 1988 continues to provide firm, clear, equitable guidelines and, at the same time, is notable for its flexibility in allowing the introduction of new methods, training modules, and evaluation techniques.

**Infrastructure** Much of the infrastructure developed with USAID support at the state and teaching hospital levels is still functioning well in the twelve states, mostly in the south, where UNFPA has maintained a presence following the USAID pullout in 1993-94. At least rudimentary services are still provided by the LGA level. The appointment and posting of State Family Planning Coordinators and Deputies, a highlight of USAID efforts, has been institutionalized in all 36 states, although it remains unclear what other resources these officers can command at this time. Moreover, they no longer report directly to the Permanent Secretary, but through the MCH Director.

**Training** The intensity of training nurse-midwives previously supported by USAID has resulted in a core of well-trained staff. This core staff, however, will need very short term training to refresh their skills and to add new ones, e.g. emergency contraception and postabortion care. Doctors at the teaching hospitals and selected doctors in the private sector should also be brought up to date. The team understands that pre-service training for medical, nursing and midwifery students is now compulsory, but that is limited to theory.

**Use** One of the least surprising findings of the team was that there is no agreed upon data on use levels since the last Demographic and Health Survey (DHS) on 1990. By far the most surprising finding from a December, 1998 nine state survey was that, when condom use was subtracted, there is very little difference in the modern Contraceptive Prevalence Rate (CPR) among the states in the Northeast, Northwest, Southeast, Southwest and Lagos State. Although the levels for Lagos and the south are disappointing, results from the northern states indicate a remarkable penetration for that most difficult region.

### TOTAL MODERN CPR (MINUS CONDOMS) IN NIGERIA

Lagos	Southwest	Southeast	Northwest	Northeast
9	8	7	7	8

RMS FP Spot Survey, Dec., 1998

The following CPRs, **including condoms**, from West African countries indicates how strong is the demand for family planning throughout the Nigerian Federation, compared to their neighbors.

### WEST AFRICAN MODERN CPRs

Country	CPR	Country	CPR
Benin	3	Burkina Faso	4
Cameroon	4	Ivory Coast	4
Ghana	10	Liberia	5
Mali	5	Niger	2
Senegal	8	Togo	3
Nigeria	10		

Nigeria RMS FP Spot Survey, 1998

All other countries--DHS surveys (most recent)

The recent spot survey indicated a 29.7% modern CPR (range from 15-43%) among males and females, 19.3% among females (much as a result of condom use), and 10.2% among married females only. Although some comfort can be taken from Nigeria's nationwide use rate as noted above, there are indications that there is low demand creation among the younger cohorts with only 1.3% of 15-19 year old married women and 5.1% of 20-24 year old married women using contraceptives

### C. CHILD SURVIVAL

**Breastfeeding** Breastfeeding, while almost universal, is exclusive for only 2% of infants in the first month of life. Breastfeeding is promoted primarily through the Baby Friendly Hospital Initiative (BFHI). Some efforts have been initiated to promote optimal breastfeeding practices at the community level through outreach and support groups. This is no information on the success of these efforts.

**Immunization** After a serious slide in immunization coverage in the mid 1990s, there has been a reinvigoration of the immunization program under the Nigeria Program of Immunization (NPI). NPI is taking a two-pronged approach to support both routine immunization and National Immunization Days (NIDS). The NIDS strategy has been driven by polio eradication efforts and a plan has been developed to increase coverage through a house-to-house campaign in 15 states in April-June of this year. House-to-house polio immunization may include administration of vitamin A, as well. The polio eradication effort funded by USAID, while bringing direct gains with respect to polio, is also being used to strengthen systems used for routine immunization, especially planning, mapping and logistics systems, plus enforcing the positive role that NGOs and youth can play in service delivery and promotion.

**IMCI** Integrated Management of Childhood Illness (IMCI) has been addressed at the federal level with adaptation of protocols and development of job aids; promotion of IMCI at the community level has been limited. It is estimated by UNICEF that there is funding to train only 1% of health care workers annually in IMCI through the approach established by WHO.

## **D. MATERNAL HEALTH**

**Prevention of Unwanted Pregnancy** Use of family planning to avoid unwanted and high risk births continues to be low. Barriers to use of family planning vary. Religious prohibitions are often mentioned, as well as accessibility, cost and fear of contraceptives. Generally, reasons for pregnancy being unwanted are economic or for education goals; the health benefits of family planning are not well appreciated.

**Birth preparedness** Public education efforts, especially since World Health Day in April, 1988 which was also celebrated as Safe Motherhood Day, have stimulated some public education in the area of maternal health. Some community awareness initiatives have started with the intent to inform communities about life threatening emergencies related to pregnancy and birth and to promote planning for transport and payment of fees to access professional care when obstetric complications occur.

**Skilled Attendance at Delivery** Because of the virtual collapse of public sector programming in maternal health facilities continue to be understaffed and quality of care is poor. Currently, the percentage of births attended by trained personnel is low (29% in rural and 60% in urban areas). However, there are numerous small maternities run by midwives in the private sector which provide alternatives, particularly in the south. The poor economic situation and lack of available cash is a barrier to the establishment and use of the services. There are numerous private maternities, particularly in the south which have the potential to improve quality and thereby increase demand for safe delivery services.

**Essential Obstetric Care** The provision of essential obstetric care (EOC) for complications was previously supported by USAID through Life Saving Skills (LSS) training of public sector midwives and midwifery tutors. When USAID withdrew support to the program, UNFPA picked up support and midwives have been trained in ten states, including a number of LGAs. There was no opportunity to assess directly the quality of services now provided by LSS-trained midwives, although midwives visited in Ogun State reported continuation of Life Saving Skills services. Little has been done to date in the area of Post Abortion Care (PAC).

**Surveillance** As is the case in most other developing countries where maternal mortality is high, there is poor surveillance of maternal mortality since most deaths occur individually and at home. The "new" maternal mortality figures (an estimated 60,000 deaths annually) are gross estimates based on models and data from a few sites. One site north of Kano was recently reported to have maternal mortality translated into a ratio at 2500/100,000 live births while certain sites in the south have data which reflected one-fifth that amount.

## **V MAJOR RECOMMENDATIONS**

### **A. ASSUMPTIONS**

- Recommendations for 18 months of transition in the PHN sector is grounded in the assumption that the political situation will be more stable where the government, in cooperation with civil society, provides quality services in an equitable manner in health, education and public safety.
- While many problems can be tackled during the transition, the effort should be focused on areas of national need and where USAID has a comparative advantage.
- Without regular interaction and joint programs with selected government entities, such as the Population Commission, the National AIDS/STD Control Program, the Federal Bureau of Statistics, and the Ministries of Health, Education, Information and Finance, impact will be marginal.
- If programs do not benefit the youth of Nigeria, there will be no sustainable impact.

### **B. CAUTIONS**

- Provide no direct funds to government (but do support selected joint activities with selected governmental entities)
- Provide no direct funds to the private commercial sector
- Keep operations research simple
- Keep proposal requirements for NGOs simple
- Ensure that the majority of funds and programming in HIV/AIDS is for prevention

### **C. FUNDAMENTAL PRINCIPLES FOR THE TRANSITION**

- Consolidate and expand the current levels of demand and services
- Increase quality in private and public systems
- Undertake systematic assessments and complete quantitative surveys for future programming

## **D. GENERAL RECOMMENDATIONS**

**Strengthen Promising NGOs** USAID should capitalize on the new partnerships and creative programs which have initiated programming in communities and involved beneficiaries directly. The synergies between different PHN areas can be enhanced, as well as the synergy and complementarity across sectors. In particular, combining women's empowerment activities in DG programs with women's health programming provides enhanced potential for positive PHN results.

**Focus on Youth** All of the elements in the USAID/Nigeria program have a youth component. However, the youth focus needs to be greatly strengthened, especially in HIV/AIDS and family planning. They are the largest and most vulnerable part of the population. If properly informed and serviced, they can make the most sustainable contributions to the development of Nigeria in the coming century. With some notable exceptions and in spite of seeing their beloved country's struggle for survival, the youth not cynical. Rather, some are bright-eyed boys and girls ready to promote immunization days and serve as peer counselors in the fight against STD/HIV/AIDS and unwanted pregnancy. In addition, they are anxious to complete their education, find employment and establish their own families. It is further recommended that several models for reaching youth be tested during the transition period. These operations research sites should be established in major urban centers.

**Target Urban Areas** In order to maximize impact and demonstrate rapid results, focus in six selected urban areas in key program areas (such as immunization and demand generation for family planning and protection from HIV) should be added to or reinforced in USAID/Nigeria program areas. The nature of the problems are so severe and the potential for rapid results is apparent; quick realization of gains will be an incentive for greater efforts in harder to reach areas.

Emphasis should be in the private sector.

**Implement Operations Research** Many exciting new experiments are being tried in USAID programming and their results in the Nigerian context need to be assessed for cost-effectiveness. For example, the feasibility of training midwives to provide postabortion care and the effect on contraceptive use, the effectiveness of NGO programs to provide home-based care for the sick child, the effectiveness of working with youth as the providers (not just the recipients) of information and services, the effect of advocacy by religious leaders on healthy life practices, etc. need to be assessed. Alternative approaches to overwhelming training and quality assurance needs need to be subjected to scrutiny in order to find affordable and effective options for service delivery.

**Re-establish Intellectual Ties with Universities** Re-engagement with academics will be an important aspect of improving USAID's programs. For example, many of the NGO programs can be improved through ties with academic institutions in order to study the effect of their

experiments in community health care. In addition, joint research and service programs will provide data for policy development.

**Re-engage with Government** As soon as it is possible, USAID should reestablish relationships with government, particularly in key ministries. In order to achieve significant gains in the PHN sector, reinstatement of USAID/GON partnerships is essential. This re=engagement may start in the areas of HIV/AIDS and immunization.

**Assess Critical Needs** Prior to making concrete workplans and contractual arrangements for increased and broadened activities, a situation analysis in the areas of information, skills, training capability, commodities and equipment should be carried out. The capability of teaching hospitals in general and capability of providers to provide youth-friendly counseling and services in particular should be given special focus within this assessment.

**Learn from Successful Programs** While surveys and assessments are underway, send three person teams (USAID Regional Program Manager, chief IP contact, and key leader from the private sector) to Pakistan to see the Green Star system for provision of private sector FP services, to Bangladesh to see excellent operations research system and the low parity prevention family planning program, to Uganda to see the HIV/AIDS prevention program for youth, and to Washington to interact with colleagues and CA counterparts.

**Build PHN into DG Post-election Activities** Where it is feasible, opportunities should be found to educate newly elected officials on PHN problems and provide options and opportunities for them to support PHN programs which will be valuable to their constituents.

**Collaborate Constructively with other Donors** A model established by the InterAgency Collaboration Committee (ICC) for the National Program of Immunization has proven to be highly effective in improving polio coverage through NIDS. Donor partners meet regularly. Their collaboration has enhanced programming and avoided unnecessary duplication of efforts. Application of this approach should be encouraged in other key areas to revitalize family planning and galvanize HIV/AIDS prevention. Likewise, USAID should consider co-funding additional printing of the excellent Life Skills booklets produced by UNICEF for primary and secondary school students.

**Assess the Potential for a USAID/Education Program** The needs in Nigeria for education are formidable and especially increased over the past few years. While there are many competing and important demands for attention in Nigeria, education is closely linked to both PHN and DG results. If funding is available, the data should be gathered to develop strategy options.

**Develop a Five-Ten Year USAID Strategy** It is not too soon (based upon assumptions previously stated) to start activities in strategy development for a long term USAID program in Nigeria. The various elements of the program will need careful study and consideration and

should be done in full collaboration with Nigerian partners from the public and private sector, multilaterals and other donors.

## **E. HIV/AIDS**

**Advocacy** There is a critical need to engage the government in policy development and resource allocation for an assault on the problem of HIV/AIDS due to the catastrophic increase in HIV transmission. Education of the new cabinet and the president, new members of the federal assembly and senate, and new state governors and staff on not only the health impact but the results of this disease on all sectors is essential. This can be done through an expert computer presentation (AIM) geared to the national problem and modified for the state levels. The offered assistance of highly respected, former Minister of Health, Dr. Ransome Kuti, may be utilized to take this message personally. Beyond government officials, the messages need to be taken to the NGOs so that the NGOs can, in turn, become informed advocates.

**Policy Development** Attention should be paid to appropriate allocation of scarce resources and the inevitable policy decisions that will come with growth of understanding of the potential of antiviral drugs in pregnancy and vertical transmission of HIV. As USAID regains opportunity to engage in policy dialogue with the GON, support of informed decision making on key issues should be addressed.

**Behavior Change** Since awareness has increased substantially in recent years, the need is now to develop and promote effective behavior change strategies. This should continue through NGOs with special attention to youth groups. The youth can be involved not only as recipients, but also as conduits (e.g. through community-based distribution for information and condoms), of behavior change programs. Continued focus on core transmitters is essential. As soon as possible, USAID should engage with government in this effort.

All the data from the northern states indicate low use of condoms, low use of contraceptives among young married women, and high levels of maternal mortality and HIV infection. It is well known that people of that region give more credence to their traditional leaders than to government officials. It is, therefore, strongly recommended that during the transition phase, the chairmen from the ten Emir's Councils be sent to Uganda to see for themselves the strides made in the fight against AIDS and then on to Cairo for discussions with the leading Islamic authorities and observation of family planning in a totally Islamic setting. They would be accompanied by a well-respected physician from the north, as well as one of Nigeria's leading Islamic scholars. Upon their return, the chief counselors would speak to their respective emirs, who in turn would ask them to enlighten their people.

**Condoms** When funds are available, there is a need for more condoms to meet unmet need. This effort should be well coordinated with other donors and carefully targeted to places of need based upon targeted efforts in behavior change to create new demand.

**Mitigation of the impact to PLWHAs and PABAs** While the majority of resources should be focused on prevention of spread of the virus, model work in support and care with CBOs and NGOs should be continued. In addition, PLWHAs can be brought together to assist them to lay claim to government resources for care of populations affected by this problem. Consideration should be given to supporting CEDPA's new proposal for providing support for women living with AIDS.

**STDs** Because of the lack of information on the prevalence of STDs, USAID should support limited, focused prevalence studies in areas where it implements STD control programs. (If practical, this may be done as part of the effort to field test recently developed, simple STD diagnostics.) Rather than activities to promote syndromic management of STDs, focused STD control should be instituted, starting with syphilis control in ANC clinics.

## **F. FAMILY PLANNING**

**Policy** Except for its role in advocacy at the federal and state levels, there is no need for more support for population policy development in Nigeria.

**Infrastructure/Training** Because of the need to improve quality counseling and services throughout the nation, a joint needs assessment of basic equipment and staff training requirements should be conducted as a priority for planning for any expanded program in the public sector. A special assessment for newly graduated doctors, nurses, and midwives should be conducted. In all training activities undertaken, special efforts should be made to ensure that providers are sensitive to the needs of young clients.

**Logistics and Supplies** Similarly, a needs assessment with five year projections by contraceptive method should be undertaken at the same time. This would include an assessment of the Management Information System (MIS) with a thought to make it less complex. Depending on the size of the assessment teams, the infrastructure, training, and logistics/ MIS assessments could be completed in three weeks, including new activities proposed in urban areas.

**Surveillance** Priority should be given to USAID's provision of significant support for a DHS. Reliable use rates by age and parity, as well as reasons for non-use, are urgently needed as a baseline and, more importantly at this time, as an essential component in realistic planning. In particular, the reasons for the plateau in modern CPR (except for condoms, which have increased) should be examined in order to develop a strategy to overcome this reality.

**Sustainability in Advocacy and Services** Because of the strides which PPFN is making in northern Nigeria, the Missions should work with IPPF, USAID/W and PPFN to improve the sustainability of the PPFN's capability. (PPFN, which provides 13% of contraceptive coverage, now has a chapter in every state with more than a third of them headed by women leaders.)

**Demand Creation** An innovative strategy should be developed to reach vulnerable youth groups (age 10-19), as well as other portions of the population. This is an essential component of a successful program to increase use of modern family planning methods. The innovative program recently designed by CEDPA should be considered for funding as an excellent vehicle for demand creation.

## **G. CHILD SURVIVAL**

**Immunizations** In addition to continuing with assistance to sustain the success of the polio eradication program, continued effort should be made to capitalize on this program where possible, to strengthen routine immunization programs. This should be continued with NGOs and also reinstated with the government as soon as re-engagement is approved.

**IMCI** Since 80% of child deaths are from causes which are not vaccine-preventable, attention to the problems of malaria, diarrhea, and acute respiratory infection must be addressed. USAID could provide technical assistance to test new approaches to integrated management of childhood illness in order to decrease the burden of cost and training time associated with training. Distance-learning approaches, simulations, and the like should be tested in order to find feasible approaches for caring for sick children at the clinic level.

**Nutrition** Wherever possible, Vitamin A supplementation should be "piggy-backed" onto immunization programs, including the NIDS. In addition, the community education programs through NGOs provides an excellent opportunity to educate parents on the elements of a good diet so that, within economic possibilities and food availability, nutrition diets can be selected and given to children. Special emphasis should be placed on weaning diets.

**Breastfeeding** USAID should provide technical assistance to develop policy with respect to breastfeeding in the face of the growing HIV pandemic. This may involve descriptive and operations research to form a basis upon which to make these decisions. In addition, community efforts to support appropriate exclusive breastfeeding should be supported and models should be tested for to find the most cost-effective approaches.

**Malaria** As malaria is the largest killer of children in Nigeria, malaria prevention strategies such as use of insecticide-impregnated bednets should be tested. Furthermore, technical assistance through USAID's Africa Integrated Malaria Initiative (AIMI) in collaboration with WHO's Roll Back Malaria (RBM) Initiative should be sought in order to stimulate malaria reduction efforts.

**Newborn Care** A large proportion of neonatal deaths results from poor health and nutritional status of the mother during pregnancy and inadequate care during labor and delivery. Where and when maternal care programs are initiated, careful attention should be paid to integrating key beneficial newborn care practices. In addition, newborn immediate and ongoing care should be incorporated/expanded into education programs of the NGO programs.

## H. MATERNAL HEALTH

Within the USAID Strategic Objective, "improved maternal and child health practices," as soon as the budget allows, USAID should reinstitute its activities to promote maternal survival. Working with other donors and the GON, with technologies already available and a strong cadre of professional nurse-midwives in private and public service, Nigeria has the potential of experiencing significant declines in maternal mortality.

**Surveillance** The majority of scarce resources should be reserved for behavior change and service delivery. Nevertheless, since current nationwide data is lacking, the planned DHS module on maternal mortality will provide important information on the severity of the problem.

**Birth Preparedness** Current work with NGOs and CBOs should be expanded to provide information to the community on recognition of complications, decision making to access services, and methods of saving/securing money for transport, drugs and fees necessary to obtain care at the referral level. It is essential that activities to generate demand for and use of services be linked with the availability of 24 hour referral level service. Risk assessment should not be promoted as a primary approach to ensuring maternal survival; rather, awareness of pregnancy as a risk factor for all should be promoted.

**Safe Delivery** While there remains a strong preference for home birth, efforts should be focused upon providing access for all women to the care of a skilled birth attendant (nurse-midwife or doctor) for delivery. Particularly in the south, this may be promoted through the support of the private maternities linked through state chapters of the Private Nurses and Midwives Association of Nigeria (PNMAN). Initiatives which may increase clientele and improve services (through continuing competency programs, peer review, accreditation, etc.) should be tested. Private midwives can also be assisted with basic business skills and small loans to set up or expand their practice. A partnership between CAPS (the new private sector Global Bureau CA for social marketing) and CEDPA might be very productive. Where there is stronger preference for home birth as in the Muslim north and throughout Nigeria in rural areas, provision of skilled home birth care can be initiated and tested. (Certain countries in Northern Europe have excellent maternal health statistics even where domiciliary delivery is the norm.)

**Essential Obstetric Care/Postabortion Care** USAID should renew its technical assistance to improve training capacity in Life Saving Skills, potentially through a partnership with a current CA and the ACNM (which developed LSS training and has longstanding experience in working with African midwifery associations). While this was done in the public sector with clinical midwives in teaching hospitals as well as midwifery tutors, new efforts should also engage midwives in the private sector through PNMAN. Furthermore, partnership should be re-established with the Nurses and Midwives Council and, possibly, the National Association of Nigerian Nurses and Midwives (NANNM). Because of the sensitivity surrounding abortion and, by extension, postabortion care, operations research may be employed in order to test provision of PAC (including postpartum FP) in Nigeria and bring results of the experiments to decision-

makers for policy determination. In addition to training, an additional effort should be made to assist in putting into place quality assurance mechanisms. These are dependent on approved standards of care which should be assessed and regularly reviewed. Furthermore, technical assistance may be offered to review and improve the management information systems (especially patient records and facility registers) to improve ability to identify complications in order to institute therapy, as well as to monitor treatment of complications and pregnancy outcome.