



Quarterly Newsletter of the Health Reform Foundation of Nigeria

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Quarterly Newsletter of the Health Reform Foundation of Nigeria

In this Issue

Our focus in this issue is on immunization and maternal health. These issues lie at the core of the Foundation's current thrust. Our current advocacy work is aimed at improving the health and well-being of Nigerian children and women. We are collaborating with a number of development partners to achieve this goal. As example, the Foundation with the support of Johns Hopkins University organized one of the six town hall meetings on immunization. The meeting which was essentially an advocacy exercise sought to promote immunization of women and children. The town hall meeting which was well attended took place in Owerri, Imo State.

The foundation also participated in the National Vaccine Summit in Abuja. The Summit whose main agenda was to underscore routine immunization for women and children attracted policy makers, programme managers and several scholars and representatives of development partners from abroad. A side meeting at the Summit brought together parliamentarians in the West Africa sub-region to draw their attention to the role they can play in budgetary allocation to immunization and also through some other oversight activities in their respective countries.

One of the principal speakers at the National Vaccine Summit who made a powerful presentation was Professor Oyewale Tomori. He provided a lucid insight into factors accounting for our failure to institutionalize routine immunization in the country despite the remarkable achievement of 80% coverage in the late 1980s when late Professor Olikoye Ransome-Kuti was the Minister of Health.

The foundation invited Professor Tomori to distill his PowerPoint presentation into a short piece that can be published in our newsletter. It is with great pleasure that we bring the piece to your attention, believing that the vital issues that are raised in the piece will not only be noted but quickly addressed by the Nigerian authorities at the federal, state and local government levels.

The second piece in this issue is by Professor O. Ogunjuyigbe of the Obafemi Awolowo University, Ile-Ife. It is also an invited contribution to the debate on the most appropriate strategy for tackling maternal morbidity and mortality (MMM) in Nigeria. While the efforts of government at all levels, numerous NGOs, and the development partners are greatly appreciated, it seems that the key to the reduction of MMM in Nigeria is formal education which some responsible authorities in Nigeria seem to loath because of their unwillingness to make education freely accessible to women in particular and the population at large. As can be seen from the piece, education is the key to women's health and empowerment. Data comparing the situation of women in the northern geopolitical and the southern zones lead to this conclusion. No matter the amount of resources that are invested in advocacy work, formal education is the key to behavioural change. Education has made a lot of difference to the lives of women in Muslim countries and Nigeria can borrow from their experience. Free and compulsory up to senior secondary level for all the girl-children in northern Nigeria will bring about attitudinal and behavioural change which will in turn have a multiplier effect on child bearing and rearing practices. Education of women is therefore the key to the much desired goal of reduction in maternal deaths.

Reflections on Routine Immunization in Nigeria

Oyewale Tomori

Introduction

One certainty in the uncertainties of Nigeria is that routine immunization has not been routine. It is not routine presently and it will take a long time before it becomes routine. Routine immunization in Nigeria has appeared like measles spots since 1960 when Nigeria gained independence. With the exception of the Professor Olikoye Ransome-Kuti's era, routine immunization had never been sustained since independence in 1960. In recent years, routine immunization replaced fruitless celebrations of immunization activities that are targeted mainly at the eradication of poliomyelitis with the result that routine immunization coverage flickered like candle light in the gale of winds, leading to the fact that Nigeria's health indices are among the poorest in the world.

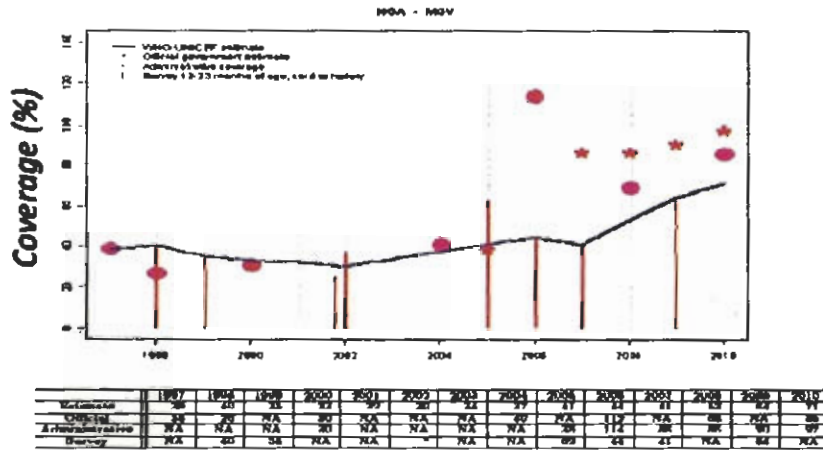
Data Management Issues

In discussing routine immunization coverage in Nigeria, we must first contend with the problem of data management, - from gathering to collation, analyses, and the use to which the data are put. Since we have not paid attention to the collection of data, it is

not surprising that the health of Nigerians remains in the dark ages of underdevelopment. Health planning and interventions are solidly based on unreliable and poor data. The analysis of data has also not fared well and is no better than the collection and collation of data. As example, we have to contend with no less than four sets of immunization data in any year, each different from the other. There are the administrative, official, those derived from surveys, and the WHO-UNICEF estimates.

By and large, the WHO/UNICEF annual estimates of national immunization coverage are generally accepted figures. This is because the WHO-UNICEF process begins with a review of reports of national authorities to WHO/UNICEF and any published survey data. Using these data with due consideration to potential biases and the views of local experts, the two agencies jointly estimate the most likely levels of immunization coverage. The WHO-UNICEF has published the data on national immunization coverage since 1980. The comparative data from different sources for measles containing vaccine (MCV) coverage in Nigeria between 1997 and 2010 is shown in Figure

Figure 1: Reported measles vaccine coverage: Nigeria 1997-2010



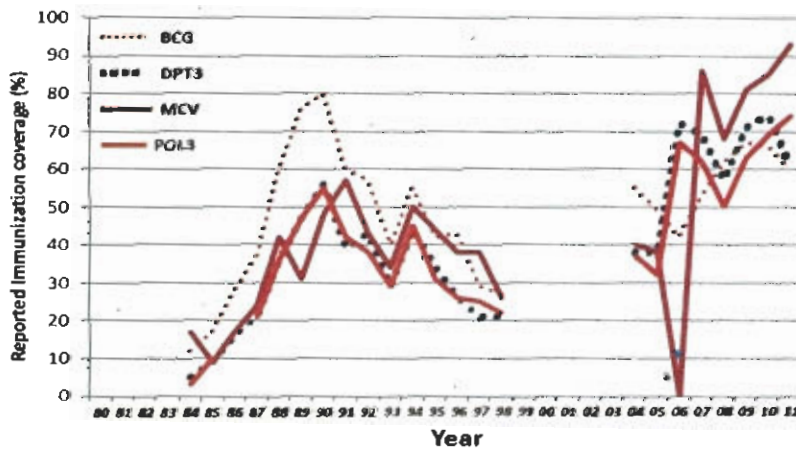
+Note the close agreement between the different sources of data for the period 1997 and 2000, and the wide variation in the data from different sources for the period 2005 and 2010

Immunization in Nigeria

The woeful immunization coverage for BCG, DPT3, Measles and OPV3 in Nigeria between 1980 and 2011 is shown in Figure 2.

For consistency, the WHO-UNICEF estimates³ have been used, except where indicated.

Figure 2: Immunization coverage for BCG, DPT3, and Measles & Polio 3: Nigeria, 1980-2011



Note some general points:

Between 1999 and 2003, for many antigens, not even the WHO-UNICEF system was able to provide an acceptable estimate, because of wide variations among the administrative, official, and survey figures.

Only on rare occasions did Nigeria attain, or surpassed the minimum 80% routine immunization coverage expected for each of the routine immunization antigens. Where these occurred, for examples, measles coverage between 2006 and 2010, it was as a result of special measles campaigns conducted as part of the African WHO Regional measles elimination programme⁴. In subsequent years, after these campaigns, measles vaccine coverage level dipped below the 80% target.

Despite the global polio eradication effort, and with more than 125 polio SIAs conducted in Nigeria, since the eradication programmes started, Nigeria has never attained the 80% target for OPV3 coverage.

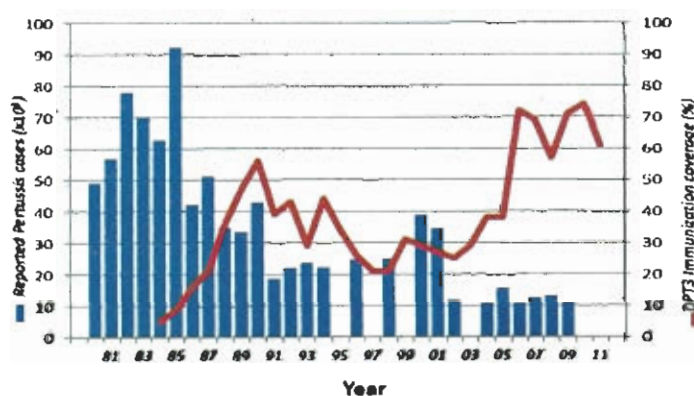
This consistently poor performance is well reflected in the number of reported cases of childhood diseases over the years⁵ which should have been prevented through routine vaccination. At this point, it is pertinent to make a subtle distinction between vaccination and immunization. A vaccinated child is not necessarily an immunized child. The vaccination cannot be equated with immunization, if the child is still vulnerable to the disease for which he or she has received vaccination. There are several

reasons for failure to develop protection after receiving a vaccine. While it may be associated with the individual's response, many vaccine failures in Nigeria arise from poor cold chain and poor vaccination practices.

DPT3 Coverage and Reported Pertussis and Diphtheria Cases

Nigeria did not attain the basic minimum 80% coverage for DPT3, and has continued to report cases of pertussis in the thousands annually^{3,5} between 1980 and 2011. Nigeria reported a total of 910,437 cases of pertussis for the 32 year period, with a peak report of 92,266 cases in 1985 and the lowest number of 10,976 cases in 2005.

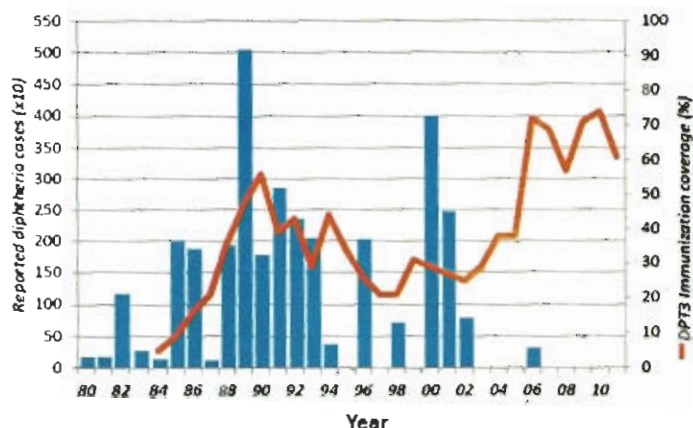
Figure 3: DPT3 coverage & reported pertussis cases: Nigeria, 1980-2011



The total number of diphtheria cases reported over the same period^{3, 5}, was 62,630 cases (see Figure 4). The lowest number of cases

reported was 115 in 1985, and the highest number was 5,039 cases in 1989.

Figure 4: DPT3 coverage & reported diphtheria cases Nigeria, 1980-2011

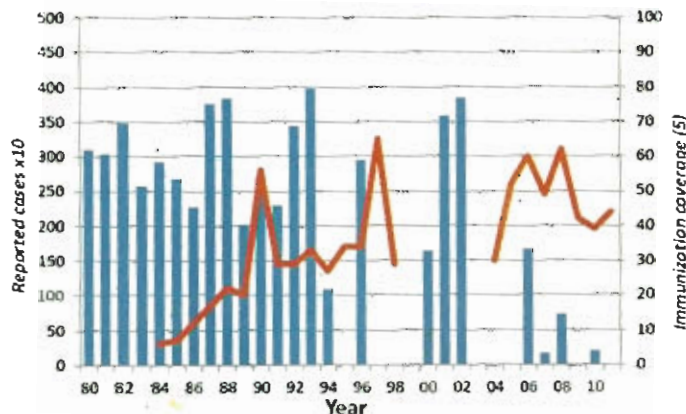


Tetanus Toxoid Coverage and Reported Tetanus Cases

With the tetanus toxoid (TT2) vaccination coverage currently at 44%, and attaining only the highest coverage of 65% in 1997, Nigeria

continues to report cases of tetanus in neonates and adults (Figure 5). Nigeria reported a total of 64, 397 cases of tetanus, over the 32 year period, of which, 45,003 representing approximately 70% of the total number of cases were in adults^{3, 5}.

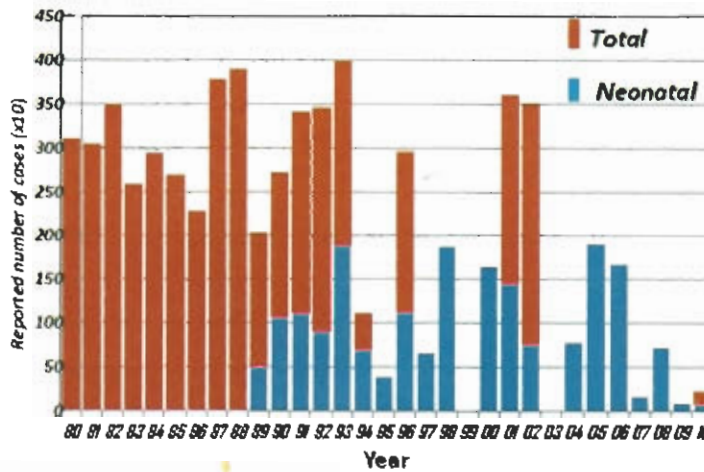
Figure 5: Total tetanus cases and TT2 immunization coverage, Nigeria, 1980-2011



However, between 2004 and 2010, neonates accounted for 5497, that is, 99.6% of all cases reported (see Figure 6). This is a

reflection of the inconsistent and declining DPT3 coverage between 2004 and 2010.

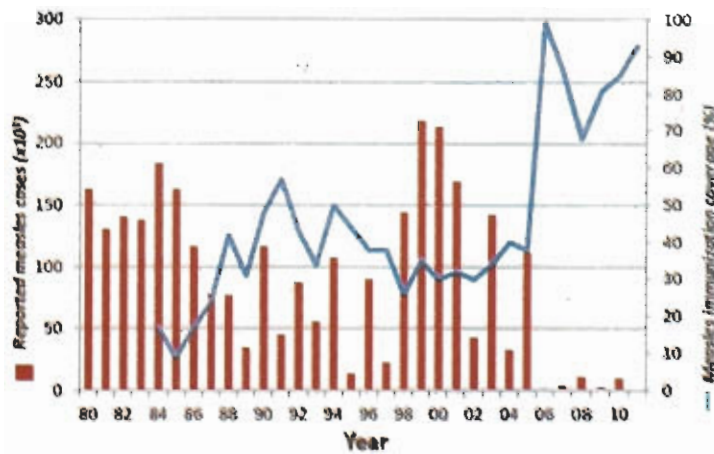
Figure 6: Tetanus Cases, Nigeria, 1980 – 2010



Measles Vaccination and Reported Measles Cases

Until Nigeria’s measles vaccination coverage reached 70% and above, there was no appreciable decline in reported number of measles cases (see Figure 7).

Figure 7: Measles Vaccine Coverage & Reported Measles Cases, Nigeria, 1980-2011



Nigeria reported a total of 2,823, 721 cases of measles, with a peak of 217,151 cases in 1999 and in 2006, Nigeria reported the lowest number (704) of measles cases, ever.⁵ As earlier indicated, the special measles campaigns conducted as part of the African WHO Regional measles elimination

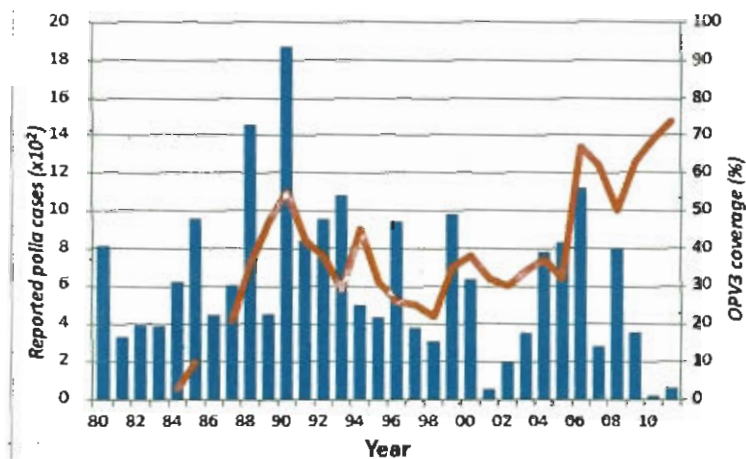
programme² was responsible for the dramatic decline in reported measles cases. However, the decline in measles vaccination coverage from 99% in 2006 to 68% in 2008 resulted in an upsurge of measles cases.

OPV3 and Polio Eradication Issues

Until a year ago, Nigeria was leading the 4 remaining polio endemic countries - Pakistan, Afghanistan, India and Nigeria - countries under the acronym of the word PAIN. In 2012, India did not report a single case of polio and was removed from the list of PAIN countries. This left three countries, - Nigeria, Afghanistan and Pakistan - now

known as the NAP countries. For the period 1980-2011, Nigeria has reported an annual average of 6,350 cases^{3,5}, with 1,873 cases reported in 1990, and the lowest number of 21 in 2010. The number of cases rose to 62 in 2011, and as at June 15, 2012 Nigeria has reported 43 cases of wild poliovirus in 10 States⁶.

Figure 8: Polio Cases and OPV3 Coverage Nigeria, 1980-2011



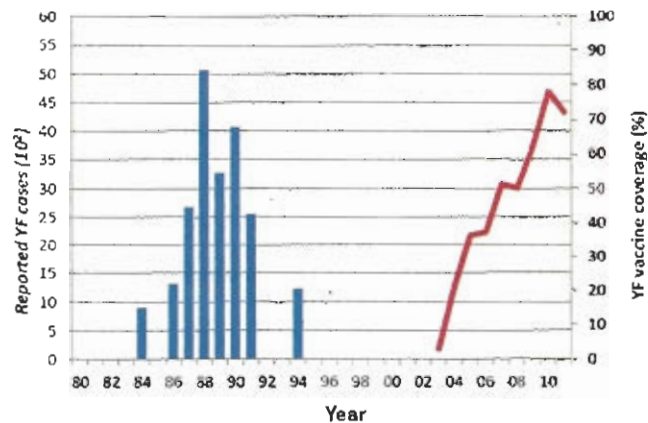
Nigeria began polio eradication initiative (PEI) activities in 1996, and had since then had over 125 polio supplementary immunization activities (SIAs) in the form of national immunization days (NIDs), state immunization days (SIDs) and or Local Government Immunization days (LIDs). In contrast, Ghana succeeded in eradicating polio with just less 20 cycles of SIAs. In Nigeria with her more than 125 SIAs OPV3, coverage swung between a low of 25% in 1996 and 74% in 2011. Some years were very bad as in 1984 when the OPV3 coverage was a miserable 3%. During the period 1996 to 2011 when Nigeria actively commenced PEI activities, OPV3 coverage improved from 25% to 32% over the ten year period between 1996 and 2005. Concerted effort to improve OPV3 coverage through routine immunization began in 2006 with 67% coverage, reaching the current coverage

level of 74% in 2011. But 2008 was a particularly bad year for immunization with a 50% OPV3 coverage. Nigeria is yet to recover from the anti-polio vaccine campaign of 2003 when many northern states boycotted the polio eradication campaign. One of the initial failings of the current polio eradication campaign was the unpardonable neglect of routine immunization activities

Yellow Fever (YF) Vaccination and YF Endemic Status of Nigeria

A total of 211,631 cases of yellow fever^{3, 5} were reported in Nigeria between 1980 and 2011. The worst and most devastating period of YF outbreaks in Nigeria was from 1986-1991 when Nigeria reported a total of 18,967 cases, representing more than 90% of global total number of YF cases (see Figure 9 based on WHO data).

Figure 9: Yellow Fever Cases and Immunization Coverage, Nigeria 1980-2010



Nigeria recorded the two highest number of YF cases: 5,067 and 4,075 in 1988 and 1990 respectively. In the past ten years, routine childhood YF vaccine coverage rose steadily from 3% in 2002 to 72% in 2011, (figure 9). Consequently, Nigeria has not reported a single case of YF for the same period. This may appear to be a success story but remembering that YF disease affects people of all ages, and that the last major YF epidemic occurred in Nigeria more than 10 years ago, one must find another explanation for the zero report of YF cases in Nigeria. Given that Nigeria has an utterly inefficient surveillance system for YF disease, combined with the glaring lack of awareness of the disease among health personnel, and the absence of an effective laboratory diagnostic back up for confirming YF cases, the most logical explanation for the zero reporting of YF cases is that we are not actively looking for the disease, and when we have a suspected case, we have no reliable laboratory system to confirm it.

Factors Accounting for Poor Performance

Routine immunization in Nigeria is far from being routine both in quality and quantity. What then do we do to improve this deplorable situation? What must we do so

that our children and adult populations are protected from diseases that are preventable, and that those receiving the vaccine actually get potent vaccine and not succumb to the diseases they should be protected against?

First, let us rehash the reasons for our poor immunization performance. The crux of our problem is poor quality immunization (routine and supplementary) activities. Several factors are responsible for this, and they include:

- poor and inadequate political commitment
- gaps in funding
- insufficient resources and poorly maintained infrastructures,
- poorly motivated health workforce and a dissatisfied citizenry
- Absence of accountability

Poor and inadequate political commitment

It is not sufficient for political leaders and governments to make adequate provision for immunization activities, they must also ensure that funds that are earmarked are used for the purpose intended. Beyond that, political, traditional, and civil society organization leaders must be personally involved in ensuring that immunization programmes touch children and the

involved in ensuring that immunization programmes touch children and the vulnerable in our society. Occasional media activities and appearances by the leaders do not have long lasting impact on immunization programmes in a country that still suffers from poor communication and supply of electric power. Launching and flagging off immunization programmes at the State House will not get the vaccine to remote corners of the country. There must be personal involvement in the programme by the highest authorities of the different tiers of government. The ministers, governor, commissioners, local government chairmen, supervisory councillors, and the traditional rulers can reach places where the president cannot. Indeed, immunization coverage below a certain level should automatically disqualify an elected official at any level from seeking second term in office.

Gaps in Funding

This is not just about the insufficiency of funds but delay in release or inadequate funds, misappropriation, misapplication, and misuse of the funds that are released funds.

Insufficient Resources and Poorly Maintained Infrastructures

Poor maintenance of infrastructures and resources are other factors. Insufficient number and poorly maintained cold chain facilities and unreliable vaccine supplies (outages, untimeliness in supply, etc.) contribute to poor immunization activities. There is also the issue of low morale of health workers and a dissatisfaction of and disaffection from the citizens with the government.

Absence of Accountability

Corruption has permeated every aspect of our life. There has never been any guarantee that government approved funds will not be

diverted into private pocket in Nigeria. No one is sure of the percentage of funds released that actually get used for the intended purpose. Some fund is diverted into the numerous drain pipes along the tortuous bureaucratic system of government. Lack of responsibility and accountability in our national system has been the foundation of corruption. No one is held responsible or accountable for poor performance or misuse of funds. We will continue to have poor immunization performance and inadequacies in data gathering, collation, analysis and use of data as long as there is no system of accountability in place in Nigeria.

Concluding Remarks

In conclusion, let me share extracts from a speech I made during the two day meeting of the Working Group on Strengthening Nigeria's Routine Immunization Delivery system held in Lagos in June 2005.

".....on the evening of the day the Senate approved the nomination of Professor Lambo, I was in his house, together with another colleague, Dr. Babaniyi. At that time we were both on a WHO assignment in Nigeria. After the usual congratulatory greetings, the Minister-designate asked us for advice and suggestions on what he should do for the health of the country. Dr. Babaniyi and I told the Minister in two short sentences:

Eradicate polio from Nigeria, and Revamp and sustain routine immunization.

I remember saying that if he succeeded in doing the two things, he would become known as LAMBO the RAMBO of disease prevention and control in Nigeria.

By a fortunate twist of fate, I retired from WHO in August last year and returned to Nigeria. As soon as I arrived, the Minister called me and said: "I will give you some months to settle down, and then you will have to come and join us in eradicating polio from Nigeria and in revamping routine immunization." I have since joined the

Expert Review Committee on Polio Eradication. Today, I am here to join all of you in developing a 'Blueprint for Strengthening Routine Immunization Delivery System for Increased and Sustained Coverage in Nigeria.'

Over the years, Nigeria has set and still maintains track records of sub-quality immunization activities (see Figure 10).

Figure 10: Decades of Poor Quality Immunization Activities

NIGERIA'S TRACK RECORD OF SUB-QUALITY IMMUNISATION



On April 18, 1991 the late Professor Olikoye Ransome-Kuti, who was the Honourable Minister of Health, announced that 80% of Nigeria's eligible children had received full immunization. Not one to keep my mouth shut, and aware of the temptation to rest on our achievements, I wrote an article titled: "Nigeria's EPI Success: Permanent or Temporary? That was at a time when a lot of people did not believe that we had actually made the 80% mark, going strictly by the set criteria. The thrust of the article was twofold:

While agreeing that we might not have made the 80% mark, I thought we should be aware of the significance of our 1990 performance. Again, quoting from the article:

"....Perhaps, more significant than the 80% coverage, is the introduction of such programmes as the National, State and Local Government Immunization Days (NIDs, SIDs and LIDs). The notable achievements of these innovative programmes included:

The administration in 1988 of 15% more immunization doses in 9 days spread over 3 months than during the whole of 1987;

Building up of the political will and commitment in the programmes at ALL levels of government;

Equipping of state health facilities to strengthen infrastructures;

Boosting routine immunization coverage; and Building up of long-term sustainability of the programmes.

On the building up a long-term sustainable programme, the government and non-governmental agencies, as well as WHO, UNICEF, and Rotary International collectively expended more than US\$6 million to set up EPI infrastructures. Today, there are over 12,000 state health sites and 24,000 outreach sites giving vaccinations daily, weekly or monthly. Cold chain stores for the preservation of vaccines are available and operational at national, state, and local government levels. Staff training, programme monitoring and evaluation have not been left out. Various national, non-governmental agencies/organizations, and religious groups, etc., have provided funds for social mobilization. Each group offering and providing assistance in various forms appreciates the significant contribution it is making to the sustenance of Nigeria's future generation".

Two important observations from this ancient article are that, in those days,

The business of vaccination of our children was in the hands of state and local governments, and Existing national and international agencies facilitated the work of state and local governments by supplementing and providing the required funds, logistics, staff training, monitoring and evaluation.

I ended the article with the following questions:

- a. Will 1992 usher in a government with the political commitment to the health of our children?
- b. Can we find in the ranks of the two political parties (SDP and NRC) the person with the single-minded will, the vision and the dedication of Professor Olikoye Ransome-Kuti?
- c. Are we likely to continue to enjoy the support of international agencies for our health programmes?
- d. In the event that external assistance is not forthcoming, shall we have a government that can make necessary structural changes for the improvement of the standard of life of our children?

It is twenty years now since those questions were asked. You all know that it is because we did not get the right answers to the questions that we are still talking about polio eradication and routine immunization in Nigeria. The first sentence of *The Guardian Newspapers* editorial of Monday, May 30, 2005, titled - "*Renewing the healthcare delivery system.*" - read "*The Federal healthcare delivery system is a washout.*" What else can one wash out of such a system?

We have talked enough and far too long about 'sustaining a good healthcare delivery system in Nigeria.' We have said too much about getting an enduring routine immunization for the children of Nigeria. In December 2003, the National Council on Health passed a resolution to ensure that immunization services will be community-owned, community-driven, and community-operated. Everyone knows that federal and state agencies and parastatals are to facilitate immunization at State and LGA levels, but everyone is doing the opposite. States and LGAs have carefully abandoned their duties while federal agencies are filling the vacuum created by the inaction of States and LGAs. The federal agencies are therefore carrying out more duties than they were initially set

up to do. The result is that our children go unimmunized, and are vulnerable to preventable diseases. Today, our Governors wait for Mr. Bill Gates to encourage them to do for their citizens what they were elected to do.

I know this will not be the last commentary on getting our immunization system in order until we hold our leaders, health workers, civil servants, and parents accountable. Preventable diseases will continue to decimate our populations as long as routine immunization remains irregular, inconsistent,

disorganized, wasteful, disorderly, confused and ineffective

We know what to do to improve routine immunization in Nigeria. We know what to do to lift our country from the devastation of preventable diseases. We know what to do to protect our children and our future from the scourge of diphtheria, pertussis, tetanus, polio, measles and several other diseases. We know what to do to lift our country from the dregs of underdevelopment. We are just not ashamed enough, not courageous enough and not or willing enough to do the right thing.

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Professor Oyewale Tomori, former professor of virology, University of Ibadan, former, Vice-Chancellor, Redeemer University, Mowe, Ogun, is currently the Chairman of the Expert Review Committee (ERC) on Polio Eradication and Routine Immunization.

Education as a Determinant of Women's Health Status

P.O. Ogunjuyigbe

Introduction

Achieving good health means more than just being physically free of diseases and infirmities. One must also be mentally and socially healthy. This is in consonance with the World Health Organisation (WHO) definition: "health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO, 2007). The determinants of health include the social, economic, environmental, physical, and individual characteristics and behaviours. So the variables that define health include income, social status, education, physical environment, social support networks, genetics, health services, and gender.

Women's health in Nigeria is among the worst in the world because of the unacceptably high level of maternal mortality and morbidity. Nigeria alone accounted for about 11% of global and 22% of sub-Saharan Africa maternal deaths. The country has the highest maternal deaths in Africa and the second highest in the world after India. The data from the National Demographic Health Survey (NDHS) show that 36% of mothers did not receive any antenatal care; 62% of births occurred without the support of skilled attendants; 56% of mothers did not receive any postnatal care; and about 74% of women have at least one serious problem in accessing health care.

The NPC and ICF Macro (2009) report indicates a maternal mortality rate of 545 per 100,000 live births based on the Nigeria Demographic and Health Survey of 2008, while a more recent estimate in the Lancet by Hogan et.al. (2010) claims that Nigeria's maternal mortality rate in 2008 was 608 per 100,000. Despite concerted efforts to reduce the high levels of maternal mortality in Nigeria, incidences remain high while a very significant proportion of the deaths occur in the northern part of the country.

The situation in northern Nigeria is more critical than in the southern parts of the country due to a number of factors among which are the prevalence of strong cultural beliefs and practices which encourage early marriage and childbirth, poor health seeking behaviour because of the generally poor level of education that further increases the risk of morbidity and mortality. Unless the situation on maternal morbidity and mortality significantly improves in the Nigeria, attaining the Millennium Development Goals (MDSs) of improving maternal health will remain a mirage.

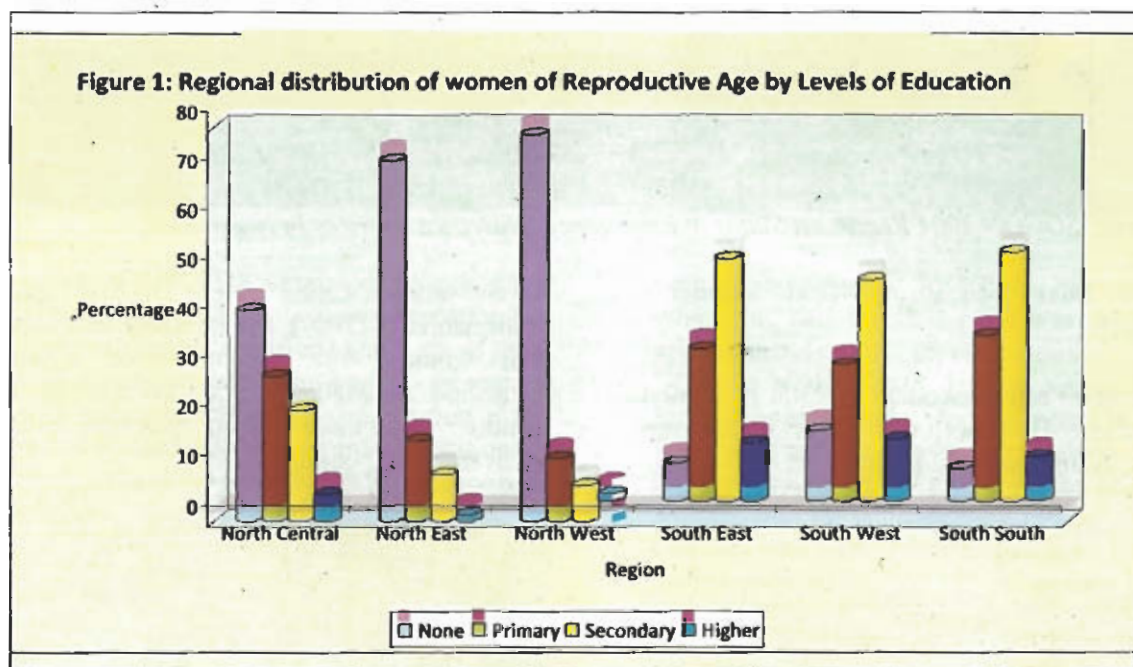
While it is acknowledged that women's health is more than maternal health issues alone and that the determinants of health is multi-dimensional, it is argued in this paper that level of formal education has made a lot of difference when the six geopolitical zones in Nigeria are compared with one another. The paper is about how formal education is critical in improved health status of women

in particular and their empowerment in general.

Women's Education Level by Region

The 2008 NDHS survey data on women's educational level show that more than a third (36%) of Nigerian women of reproductive age 15-45 years have no formal education. A fifth (20%) had primary level education and about 36% - secondary level education. Only about 9% of the women had attained post secondary education. A disaggregation of the

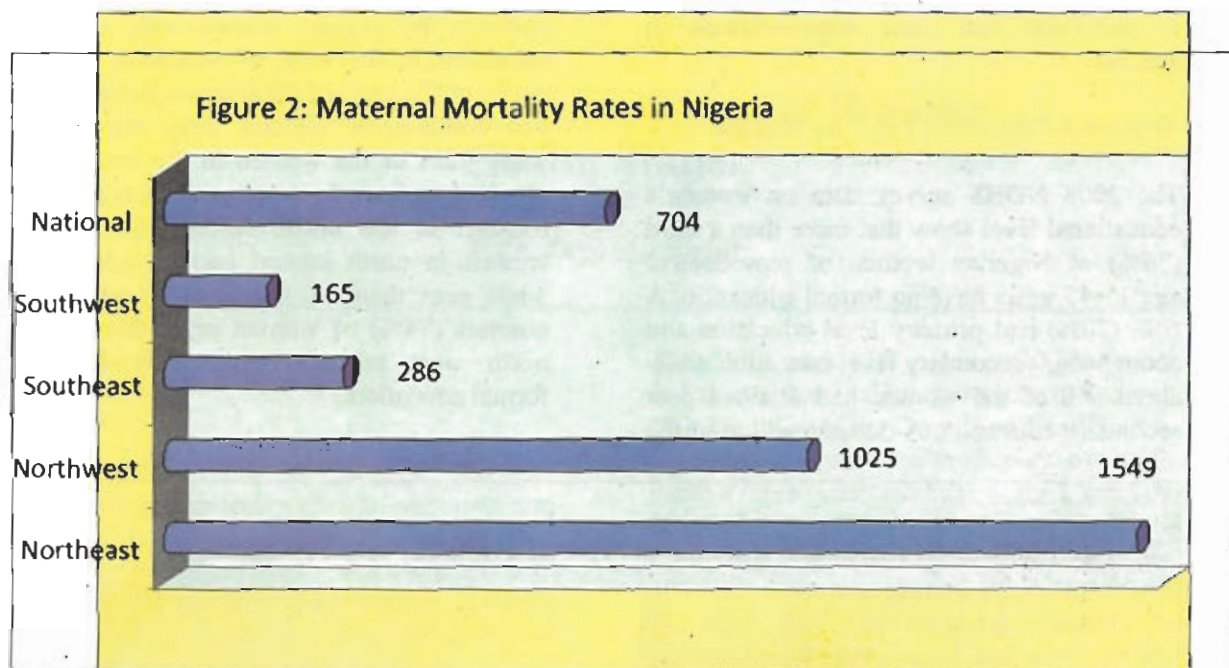
statistics by regions shows wide regional variations in the level of education (Figure 1). Only 6% each of the women in south east and south-south regions were uneducated while 12% of the women in the south west also had no formal schooling. This is in sharp contrast to the north. About 36% of the women in north central had no education, while more than two-thirds (68%) and three-quarters (74%) of women in north east and north west regions respectively had no formal education.



Women's Health Indicators by Region

The Society of Gynaecology and Obstetrics of Nigeria (SOGON) estimated that the maternal mortality rate in 2004 in Nigeria was 704 per 100,000 live births. However, a

regional breakdown reveals wide differences between the north and south, ranging from 165 to 286 per 100,000 live births in the south and 1025 to 1549 per 100,000 live births in the north (Figure 2).



Source: SOGON 2004 Report on Status of Emergency Obstetrics Services in Nigeria

How Does Education Affect Women's Health?

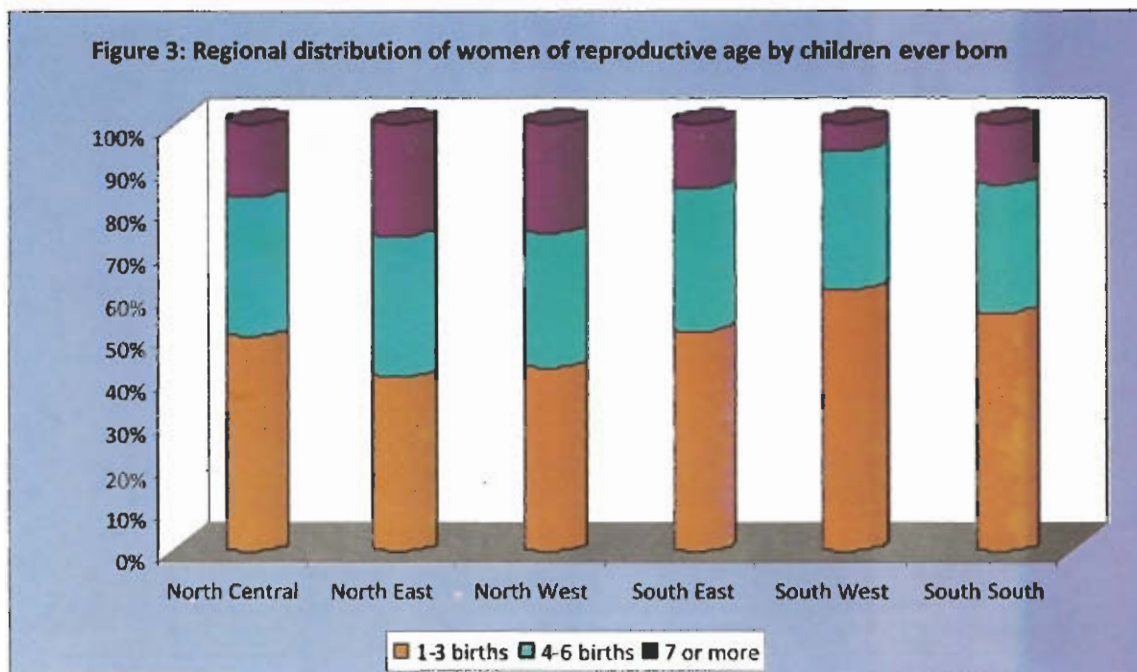
Education affects women's health in myriad of ways. However, this paper focuses on fertility and maternal health.

Education and Fertility

Women who have formal education can control the number of their children, thereby reducing the risks that are often associated with frequent/many childbirths. A Population Reference Bureau factsheet published in 2011 highlights the link between girls' education and health outcomes as reported in

several studies. Citing UNESCO (2010) and Behrman et al (2007), the factsheet indicates that women with secondary or higher education in Mali have an average of 3 children while those without education have an average of 7 children.

The latest NDHS data published in 2009 in Nigeria supports the foregoing. Data on children ever born (among women who delivered in the last five years in the country) show that about 50% of women in the country have had between 1-3 births; a third (32%) had 4-6 births while about a fifth (19%) had 7 or more deliveries.

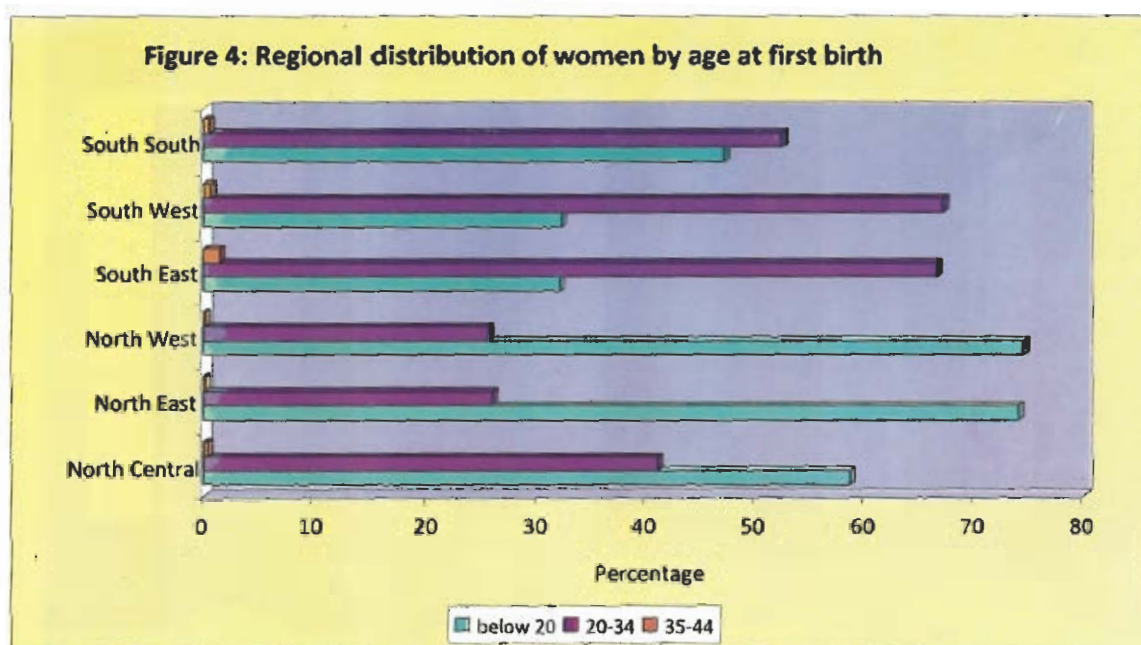


However, 26% of those with no education and 21% of those with only primary education had 7 or more births compared to only 7% of those with secondary education and 3% of women with higher education. The implication of this is that women with none or little education are likely to have too many births in resource poor settings, thereby increasing the risk of maternal mortality and morbidity. It is also apparent that the risk of having too many births is mainly a northern Nigeria trend due to the very high level of women illiteracy in this part of the country relative to the south.

Fertility-related risk that education also mitigates is the timing of childbearing. Pregnancy and childbirth before the age of 18 are considered high risk. The PRB (2011) factsheet also cited a 35-year study in Guatemala which found the link between the years girls spent in school and the timing of childbearing. For each additional year a

young woman spent in school, the age at which she had her first child was delayed approximately six to 10 months. The Nigeria's NDHS 2008 data on age at first birth (among women who delivered in the last five years in the country) show that teenage pregnancy is preponderant among women with no education as 73% of them had their first births as teenagers aged 10-19 years compared to only 12% of women with higher education. Examining the timing of first birth by region shows that it is mainly a northern Nigeria problem (*Figure 4*). About 60% of women in north central and 74% in north east and north west had given birth as teenagers compared to less than 33% in south east and south west and 47% in the south-south. It is reasonable to assume that the three-quarters who became pregnant as teenagers would have been significantly reduced if they had formal education.

Figure 4: Regional distribution of women by age at first birth



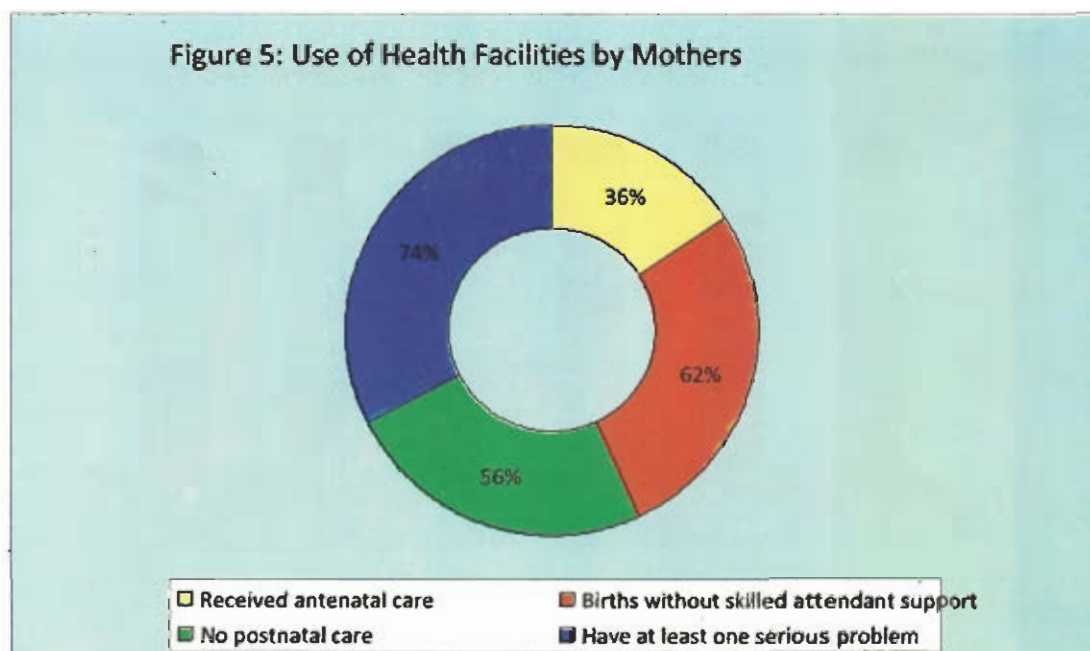
Education and Maternal Health

The PRB factsheet (2011) citing UNESCO (2010) and Psacharopoulos & Patrino (2004) reported that mothers with secondary education are twice as likely to give birth more safely in health facilities as those with no education and it also estimated that every additional year of schooling for 1000 women helps prevent two maternal deaths.

Education and Antenatal Care

The data from NDHS show that 36% of mothers did not receive any antenatal care; 62% of births occurred without the support of skilled attendant; 56% did not receive any postnatal care and about 74% of women of reproductive age had at least one serious problem in accessing health care (see Figure 5 below).

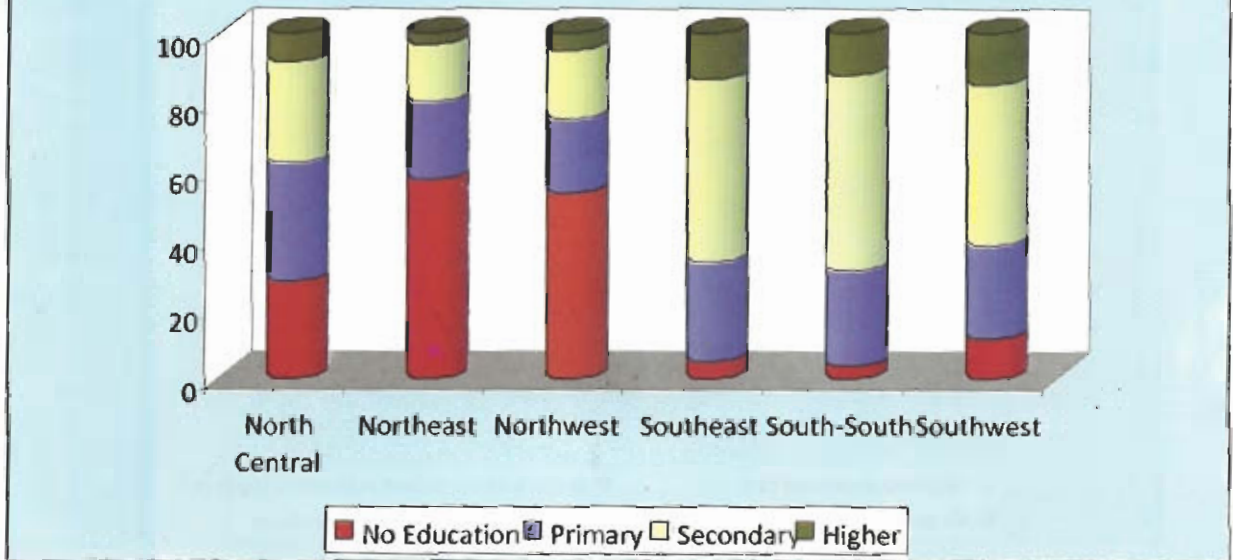
Figure 5: Use of Health Facilities by Mothers



Although the 2008 NDHS report suggests that the proportion of the births assisted by skilled attendants has slightly increased in the country, the situation is still a far cry from the numbers needed to achieve reduction in maternal deaths. For instance, as shown by the NPC and ICF Macro (2009) data, only 39% of births were attended by skilled personnel. Of this, 87% happened in both the south west and south east as against just 10% and 16% respectively in the north west and north east. The proportion that did not receive antenatal care range from 26% in the north central to 67% in the north west while the range is between 7% and 19% in the south east south south (figure 6). Also as much as 90-98% of the women in the north east took the risk of not delivering their babies in a health facility and also delivering without the assistance of a skilled provider respectively

The NDHS data show that very insignificant proportions of women of reproductive age in the three northern zones received antenatal care from skilled health workers. However, the proportion of these women increased progressively as level of education increases. This suggests that improving educational attainment is central to efforts to improve maternal health in the country and especially in the northern zones. Educational attainment is a significant variable that affects attitude and perception of health risks among women. The use of maternal health services, especially during the antenatal period and during delivery, is critical to the reduction of maternal deaths. However, this cannot be achieved without appropriate improvement in women's access to, and level of education.

Figure 6: Educational status of women by skilled health attendant during antenatal care



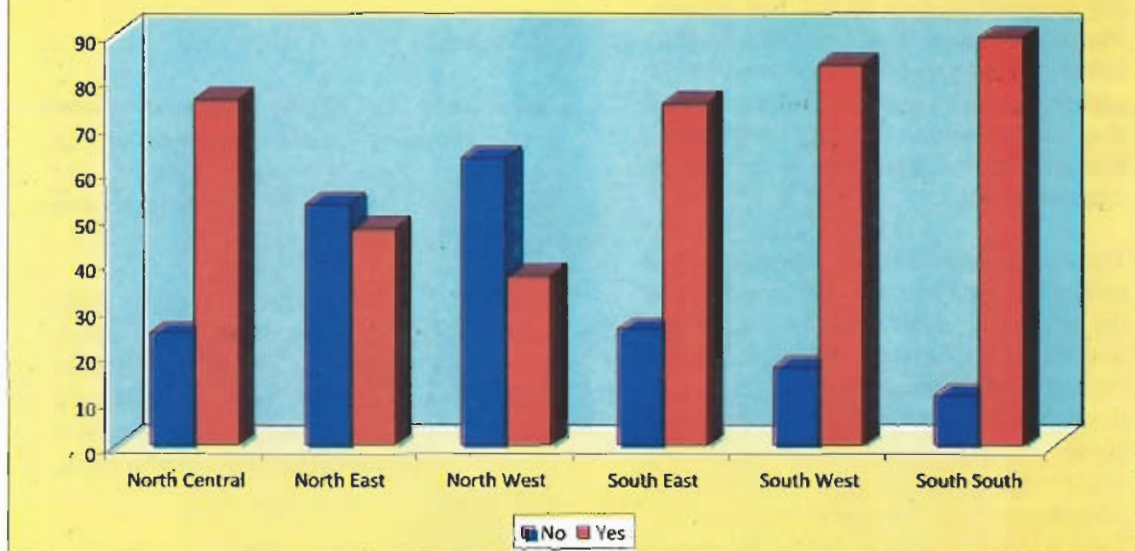
Education and Women Empowerment

Several studies have documented the immense power that men wield in household decision-making, including decisions that affect women's reproductive health. For instance, Adewuyi (1999) reported that spousal permission is important in some parts of Nigeria before a woman with obstetric complications attends to health care. Furthermore, any male member must accompany her to the clinic in the absence of the male household head. The Prevention of Maternal Mortality Network (PMMN) (1992) reported that swollen feet during pregnancy, which could be indicative of eclampsia, is

seen as an indication that the baby will be a boy or twins in some parts of Nigeria.

The 5th Millennium Development Goal is to promote gender equality and empower women. Although the MDG recommended indicator for measuring progress towards this goal is the ratio of girls to boys in primary, secondary and tertiary educational institutions, the indicators of women empowerment that are used here are: (i) involvement in household decision-making and (ii) justification of wife beating. Greater involvement of women in household decision-making in a patriarchal society like Nigeria is a positive indicator of empowerment.

Figure 7: Regional distribution of women of reproductive age by their involvement in family decision-making



Women's reproductive health implies that they are able to have a responsible, satisfying, and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Nationally, 62% of the women are involved in at least one important household decision-making. The least involvement of women in important household decision-making is recorded in the south east where a quarter of the women (25%) were not involved in any decision-making. The situation in north central is similar to the southern zones. However, more than half of the women in north east and north west were not involved in any decision-making at all, not even decisions about their own health. The women in these two northern zones have limited power and hardly contribute to decision making. Less than 30% of the women reported involvement (either alone or jointly) in virtually all decisions. In contrast, at least 50% of the women reported involvement in any decision in north central and in each of the three southern zones (Figure 7). The reason for the low level of women involvement in decision making in the north east and north west zones is the

high level of illiteracy among women. If women are educated, they will have knowledge of basic health care and will be in position to help others to maintain and improve their own health. A woman can be aware of harmful conditions if she is educated. Despite the fact that education is seen as the basis for the full promotion and improvement of the status of women (Ojobo, 2008), Nigerian women, especially those in the northern zones, still suffer a lot of constraints and inhibition which militate against their personal and national development. The poor health status and high rates of maternal mortality and morbidity observed in these northern zones can therefore be linked to their low level of participation in family decision making and poor educational status.

Concluding Remarks

The above discussions strongly suggest that education is a critical variable in terms of women's health and female empowerment. As evidenced from available statistics, some of which have been highlighted above, the wide variations in maternal health indicators

between the north and the south of the country are mainly due to the educational gap between women in the two regions. Statistics show that health seeking behaviour in appropriate places will well-nigh depend on education. Education will also lead to improved family health and is also an essential ingredient in the women empowerment.

The empowerment of women is a necessary pre-requisite for overcoming the prevailing high maternal morbidity and mortality rates in the country. The capacity of women can be enhanced through formal education. As portrayed in some studies, female are generally underrepresented in educational programmes and related jobs (Erinosho, 1994; Kahle and Meece, 1994). Education enhances women participation in family decision-making. Women who have strong household decision-making authority will be at reduced risk of maternal morbidity and mortality relative to those with no authority. This suggests that the stronger the authority of women in household decision-making the stronger their voice in households, – a voice that is heard in matters relating to their healthcare, heard on matters relating to household expenditure and ability to initiate moves to obtain healthcare without necessarily waiting for 'administrative clearance' from adult males within the husband's family.

Available evidence shows that the northern zones of the country remain the major part where the fight against maternal morbidity and mortality must be won if Nigeria is to join the committee of nations where pregnancy and childbirth is safe. NDHS and other relevant data indicate that the risk of having children at too close intervals and of having too many births is significantly higher in the northern zones. Similarly, the probability that a woman will not use life-saving maternity services – for antenatal, delivery and skilled assistance during

delivery – is very high in the northern part of the country.

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HERFON'S Photo News



Participants at the Ogun State Seminar, Abeokuta



From Left: Dr.O. Oyekoya (ZPO/SW), A participant from Ogun State Ministry of Community Development, Hajia S. Balogun(ES, OGWEFC), Professor Lai Erinoshoh (ES, HERFON), Mrs. Eki Inneh-Oloko (Chairperson, OGWEFC) and another participant at the Ogun State Seminar in Abeokuta



Dr Nkem Enc, Programmes Manager HERFON making presenting on the National Health Bill



Front row right: Dr. C.Okafor; Dr. R. Nriagu; HERFON SE ZPO, Chris Amalu; Nat. Prog. Mgr., Dr. Nkem Enc; Executive Secretary HERFON, Prof. Lai Erinoshio; HERFON Anambra State Chairman, Hon. Henry Onyekwelu; Dr. Ikeji Anayo; Mrs. Okedo



First dose of Pentavalent given to Baby Christabel by Dr. Sampson Parker, Hon. Commissioner for Health supported by the Executive Director and Chief Executive Officer, National Primary Health Development Agency, Dr. Ado Muhammad



Participants at the Grantsmanship Workshop, Top Rank Hotel, Garki, Abuja



Stakeholders Workshop at Abakaliki, Ebonyi State



Participants at the PRRINN sponsored Advocacy Trainer of Trainers Workshop, Abuja



Rtd. Justice Paul Elechi presenting a paper on Legislating for Improved Budgeting in Health, Abakaliki



The Communication Consultant to SuNMaP (2nd from left) and Dr James Kolo, HERFON Consultant (2nd from right) with members of HERFON at Rafi LGA



SuNMAP: HERFON members with the District Head of Bichi,(First left): Usman Mohd Haske, Muhd Sagir, Abu-Bakr H Aliyu, The District Head of Bichi, Dr. Musa Saad, The RBM focal person, The H E and the secretary to the District Head.



From right Chairperson HERFON Ebonyi State, Mrs. Ugo Uduma; Executive Secretary HERFON, Prof. Lai Erinoshio; Justice Paul Elechi Rtd.; Dr. C.O. Okoye; Nat. Prog. Mgr., Dr. Nkem Ene; HERFON SE ZPO, Chris Amalu; Secretary Ebonyi State, Mr. John Oko

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Obafemi Awolowo University, Ile-Ife, Nigeria*

**The National Health
Sector Reform Coalition
(NHSRC) Meeting,
D'Rovans Hotel, Ring
Road, Ibadan, Oyo State**

The Health Reform Coalition comprising Allied Health Professionals, Registered Trade Unions, Nigerian Medical Association, NGOs, the Media, and other stakeholders was invited in December 2011 by the Foundation to a meeting at the Obudu Mountain to give them an opportunity to voice their reservations on the National Health Bill. Because the discussion was inconclusive, the Foundation organized a follow up meeting which took place at Valencia Hotel, Abuja in March 2012.

Once more another meeting took place at D'Rovans Hotel Ltd, Ring Road, Ibadan, Oyo State on July 4, 2012 to put finishing touches to the review of the Bill.

The Participants noted as follows:

1. The National Health Bill when passed into law will improve Health care delivery in Nigeria
2. National Health Bill being returned to the National Assembly is an opportunity for stakeholders to make necessary input for possible amendment
3. The need for the various Health Professional Groups to reach consensus on some key areas of concern in the Bill:-
4. The need to insert a sub-section on the composition and expansion of the Federal Ministry of Health in the Bill (Section 2, NHB)
5. Composition of the National Council on Health
6. Composition of the technical committee of the National Council on Health
7. Need for the establishment of the National Tertiary Hospital Commission to be conveyed through a separate Bill in line with existing procedure.

1. Harmonisation of the composition of the Federal Capital Territory Primary Health Care Board (Section 11)
2. Composition of the National Health Research Committee
3. Composition of the Ethics Committee and the sequence/ordering of the clauses (Sections 32, 33 and 34).
4. Need to insert a clause providing for the regulation on retention, disposal and/or destruction of patients' record (Section 25).
5. Need to insert a clause providing for the determination of the safety and suitability of blood and blood products for transfusion (Section 53).
6. There were extensive deliberations on the above areas of concerns among the participants and they reached agreement through consensus on all of the areas with the exception of the following:
 7. the composition of the Federal Ministry of Health,
 8. exclusion of the provision of an establishment of the National Tertiary Hospital Commission in Bill, and
 9. The composition of the National Health Research Ethics Committee which though agreed upon but not by consensus.

The Participants resolved to articulate the decisions reached as proposal for possible amendment in a memorandum that will be presented to the National Assembly for consideration.

HERFON Partners Ogun Community Women Empowerment and Child Care Forum (OGWECF) on Capacity Building Seminar

The Ogun Community Women Empowerment and Child Care Forum (OGWECF), a non-governmental organization based in Ogun State with a mission to build the capacity of grassroots women to achieve better health for women and children in the community organized two capacity building seminars at Ijebu-Ode (May 8-9, 2012) and Abeokuta (June 28-29, 2012). The former was held in Legan Hall, Opposite Gateway Hotel, Ijebu-Ode and the latter in Edola Presidential Hotel, Moshood Abiola Way, Leme, Abeokuta.

Objectives:

- To increase awareness of communicable diseases in the community among women
- To educate women on early detection and appropriate management of common communicable diseases
- To build the capacity of women as health educators and advocates in their community.

Attendance:

Each of the seminars was well attended, with four hundred and fifty women drawn from the local government of the catchment areas.

The Key participants at the Ijebu-Ode seminar included:

- Dr. Andrew Mbewe who represented the WHO Country representative

- Dr. Adebajo, Special Assistant to the Commissioner of Health, Ogun State,
- HRH Dagburewe of Idowa, Oba Y.O.Adekoya, OON
- HRH Alaye of Odogbolu Oba Onagoruwa
- Alhaji Ayinde Gbadamosi, Director of Planning, Research and Statistics, Ogun State Ministry of Community Development and Cooperatives
- Mrs. Seye Fatundimu, Assistant Director of the Ministry of Planning, Research & Statistics
- Chairman of Action Congress of Nigeria in the East Senatorial Zone
- Mr. R.O. Oshonuga, FOMWAN representative
- Mr. A.A. Aina, Ogun State Primary Health Care Board
- Professor Lai Erinosh, HERFON Executive Secretary
- Dr. Olabode Oyekoya, HERFON Zonal Programme Officer
- Dr. Ogunsola, HERFON Ogun State Chapter
- Mrs. Kushanu, HERFON, Ogun State Member
- Mrs. Eki Inneh -Oloko, Chairperson, OGWEFC
- Hajia Sherifat Balogun, Executive Secretary, OGWEFC
- Mr. Olakunle Soremekun, Programme Manager, OGWEFC
- Mrs. Folashade Adekoya – Representative of the World Health Organisation
- Alhaja Junaid – Representative of state Ameerah, Foundation of Muslim Women's Association of Nigeria (FOMWAN)
- Mrs. Seye Fatundimu – Asst. Director, Ministry of Community Development & Cooperatives
- HRM Oba Festus Makinde – Olu of Igbehin land
- HRM Oba Taofeek Kayode Owolabi – Olu of Obafemi, Egbaland
- Olori Bosun Dosunmu – Olori of Olowu of Owu kingdom
- Chief (Mrs.) Sunmonu Akinwale – Seriki Iyalode of Owu Kingdom
- Mrs. Akinuga – Director, Ministry of Community Development and Cooperatives
- Alhaja Tawakalitu Oderinde – FOMWAN
- Mrs. Bankole – Health Officer, Abeokuta South Local Government
- Mrs. Fashina – Chief Matron, State Hospital Abeokuta
- Chief Gabriel Sonde – Chairman, Obafemi Community Development Council
- Prof. Lai Erinosh – Executive Secretary, HERFON
- Dr. Olabode Oyekoya – Zonal Programme Officer (South west), HERFON
- Dr. Atinuke Duze – Medical Officer of Health, Abeokuta North Local Government
- Mr. J. O. Idowu – Nutrition Officer, PHC Board, Ogun State
- Mrs. Eki Inneh -Oloko, Chairperson, OGWEFC
- Hajia Sherifat Balogun, Executive Secretary, OGWEFC
- Mr. Olakunle Soremekun, Programme Manager, OGWEFC

The second seminar in Abeokuta attracted the following:

- Mrs. Aishat Olaniyon - Representative of the wife of the state governor.
- Dr. Alonge - Representative of the Commissioner for Health
- Mrs. Yemi Olanrewaju – Permanent Secretary, Ministry of Community Development & Cooperatives.

Commissioned papers were presented while the participants had ample time to raise questions. The presenters included:

- Alhaja Oderinde, FOMWAN
- Mr. A.A. Aina, Ogun State Primary Health Care Board
- Dr. Atinuke Duze, MOH Abeokuta North LGA
- Mr. J. O Idowu, Nutrition Officer, Ogun State Primary Health Care Board

Free Medical Check-Up/Test

Highlights of the seminar included free medical screening for women at each location and also distribution of Long Lasting Insecticidal Nets (LLINs) among participants.

The seminars received support from the following:

- Federal Ministry of Health
- Ogun State Ministry of Health
- Odeneke Kehinde Foundation
- Health Reform Foundation of Nigeria (HERFON)
- Federation of Muslim Women's Association of Nigeria (FOMWAN)
- Support to National Malaria Programme (SunMap)
- Mothers Life-Line Foundation (MLLF)

HERFON Holds Round Table with Journalists on the National Health Bill

The Health Reform Foundation of Nigeria (HERFON) recently organised a round table with journalists on the National Health Bill. The purpose of the round table was to provide them in-depth understanding of the provisions of the National Health Bill with particular attention on the areas of major concern to stakeholders. The National Health Bill was passed in May 2011 by the 6th National Assembly and forwarded to the President for assent. But in June 2012, the President returned the Bill to the National Assembly for reconsideration. It is speculated that the cost of implementing the provisions of the bill may be one of the major reasons for the President's refusal to sign the bill. Other contributory factors may be the dissenting voices from some Health Professionals, the Religious Community, and Civil Society Organizations concerning some of the provisions in the bill. These groups have used the media extensively to voice their opposition. The Media on the other hand have in the process of reporting not provided clear and objective review of the bill. The round table provided an opportunity for journalists to interact with some stakeholders and clarify the areas of concerns. The Round table which held at D'ROVANS Hotel, Ibadan, Oyo State on Thursday 5th July, 2012 had in attendance 15 journalists on the health desk of both print and electronic media (namely: Independent Newspapers, This Day, The Guardian, The Sun, Leadership, The Nation, Daily Trust, The Vanguard, Punch, Tribune, Radio Nigeria, African Independence Television, Channels Television, NTA network news and the Broadcasting Corporation of Oyo State). The major high points at the meeting include a presentation on the National Health Bill by Dr. Nkem Ene, Programmes Manager

(HERFON); and panel discussion with representatives of health professional groups and unions. Evaluating the event, the journalists held that round table was engaging, well packaged and organized. Also, that it was worth letting the media understand the issues on the Health bill better and the need to pass it into Law.

HERFON Join Other Health Partners to Launch Pentavalent Vaccine in Nigeria

Nigeria took a step forward in reducing child morbidity and mortality to save the lives of more children as Pentavalent vaccine was officially launched in Nigeria by the Executive Director and Chief Executive, National Primary Health Care Development Agency (NPHCDA), Dr. Ado J. G. Muhammad on the 22nd of June 2012 at Eneka Village, Port Harcourt, River State.

Pentavalent vaccine is a combination of five vaccines-in-one that prevents diphtheria, tetanus, whooping cough, hepatitis B and haemophilus influenza type B, all through a single dose. With this introduction, nearly 400,000 cases of haemophilus influenza type B would be prevented with about 27,000 lives saved annually in Nigeria. Haemophilus Influenza type B (Hib) is a pathogen of infants and young children that causes invasive bacterial diseases (pneumonia, meningitis, septic arthritis, sepsis) and accounts for 95% of the life threatening Haemophilus influenza infections in infants. The Federal Ministry of Health has been delivering the immunization program by providing various vaccines against preventable diseases namely DPT, Polio, Measles, BCG and TT since 1991. The HepB was introduced in 2002.

With funding from the Global Alliance for Vaccine Initiative (GAVI), the Nigerian government, the Federal Ministry of Health and its Departments and support from WHO, UNICEF, Health Reform Foundation of Nigeria (HERFON) and other stakeholders, Pentavalent vaccine was introduced as a new vaccine under the routine Expanded Programme on Immunization (EPI) in an effort to achieve MDG 4.

HERFON was among major health stakeholders/partners that attended the flag-off of the five-in-one vaccine. The foundation was represented by Dr. Nkem Ene (Programmes Manager) and Mrs. Rebecca Ogbimi (Zonal Programme Officer for South-south Zone). The late Senator Gyang Dantong (Chairman Senate Committee on Health who was recently adorned a champion of immunization in Nigeria by HERFON) was also in attendance.

Other key development partners and institutions which delivered goodwill message on the occasion include Rotary Plus, Traditional rulers, National Council of Women Societies, MDGs Office, Presidency, Junior Chambers International and GSK. Eminent traditional leaders, Development Partners, Captains of Industries and NGOs attended the colourful ceremony.

Speaking at the launch of the vaccine in Eneka Primary Health Centre in Rivers state, the Executive Director of NPHCDA, Dr. Ado Muhammad said that the Federal Government had spent over one billion naira in the last two years to expand the nation's cold chain infrastructure at all levels in preparation for the new vaccine introduction. Furthermore, he explained that over ten million doses of the pentavalent vaccines had been paid for by the Federal Government for distribution to the following thirteen states and FCT in the first instance: Jigawa, Kaduna, Adamawa, Bauchi, Kwara, and FCT, Plateau, Enugu, Anambra, Rivers, Edo,

Akwa-Ibom, Ekiti, and Lagos States. Phase II covering 12 states will commence in May 2013 while Phase III is planned 11 states in May 2014.

As part of the preparedness for the introduction of the vaccine, the Executive Director disclosed that seventeen thousand health workers have been trained to administer the pentavalent vaccine in over eight thousand health facilities. Health workers have been trained for the task while supplies of vaccines and injection equipment are available. Finally, the cold chain and logistics are being strengthened.

In a remark at the occasion, the WHO Representative in Nigeria, Dr. David Okello represented by Dr. Patricia Tanifum congratulated Nigeria for the introduction of the pentavalent vaccine. He observed that child mortality is still high in Nigeria even though some progress has been made. Dr. Okello noted that pneumonia is one of the major killer diseases in infancy and it is responsible for 17% of all under-five deaths; therefore, pneumonia control is one of the priorities for Nigeria to achieve MDG4 goals. Penta prevents pneumonia in children. Hence, the introduction of pentavalent vaccine into the routine immunization schedule for Nigeria is not only imperative but a step in the right direction.

In his speech at the launch, Rivers state Governor, Dr. Rotimi Amaechi said his administration has introduced free universal health care for all in the state to drive home his commitment to healthy citizenry. Amaechi who was represented by the Commissioner for Health, Dr. Tamunoiyriari Parker, also announced a special programme of cash incentives for pregnant women on antenatal visit to state health care facilities.

At the occasion, Dr. Nkem Ene, HERFON's Programmes Manager felicitated with Nigeria for embracing pentavalent and noted

in her speech that supporting the improvement of child survival needs urgent attention and commitment by all. As part of the Foundation's mandate to contribute to the continuous efforts towards MDG4, HERFON is partnering with the International Vaccine Access Centre (IVAC) of the John Hopkins University to influence parliamentarians on improved funding of immunization in Nigeria and equally make them champions and advocates of immunization. She further called on partners, non-governmental organizations, and Nigerian citizens to support the effort to completely eradicate the several child killer diseases in our communities. Dr. Ene pointed at the need to strengthen partnership with Ministry of Education to ensure that no child gets admitted into any school unless he or she is vaccinated starting from the pre-school. She further stressed the need to step up advocacy and social mobilization programme after the launch in order to boost community uptake of the vaccine.

Speaking also as a HERFON endorsed champion and advocate on immunization, Chairman Senate Committee on Health, the late Senator Gyang Dantong assured Nigerians of the Senate Commitment to scale up its oversight functions to ensure maximum benefits of funds allocated for health of Nigerian children in particular and the populace in general. Dr. Dantong urged Nigerians to donate generously towards vaccine for immunization and advocated immunization of all Nigerian children.

The programme Manager, Global Alliance for vaccine immunization, Geneva; Dr. Par Eriksson emphasized the need for health worker and all stakeholders to ensure that every Nigerian child is vaccinated.

Highlight of the occasion was the official administration of the pentavalent vaccine to Baby Christabel Emmanuel as the first Nigerian Child to be so vaccinated by the

Representative of Governor Amaechi and his health commissioner, Dr. Tamunoyoriari Parker supported by the Executive Director and Chief Executive Officer, National Primary Health Development Agency, Dr. Ado Muhammad.

Pentavalent vaccines, Nigeria's expanded programme on immunization now has a new schedule which are antigens BCG, OPVO, HepBO (at birth) OPV (3 doses), Pentavalent (3doses), Measles and Yellow Fever.

Today, the Pentavalent vaccine has replaced the DPT vaccine administered at 6, 10, and 14 weeks and HBV administered at birth, 6 and 14 weeks. With the introduction of the

Quarterly Capacity Building on Hands-On Workshop on Quantitative Data Analysis in Social and Health Research

Call for Application

Introduction

One of the key responsibilities of researcher/planner/lecturers is to produce knowledge. Yet they can only do so if their capacity is fully developed to produce papers that are publishable in scholarly journals of repute. Unfortunately, vast numbers of Nigerian scholars lack the capacity to produce quality papers largely because they have not been able to master the skill in data analysis. Often they conduct research, collect data but are unable to use appropriate software to analyse their data and also use appropriate statistics to interrogate their data.

Today, many planners/scholars are disappointed when their papers are rejected by international journals in their field due to weaknesses in data analysis. Instead of mastering the skill needed to produce quality papers, they often resort to self-sponsored

publications which are not peer reviewed. Nigerian universities are currently awash with poor quality publications which are passed by lecturers through the Appointment and Promotion Committee of their institution for elevation of lecturers to higher positions.

It is undeniable that the development of the capacity of lecturers in data processing and analysis will stand them in good stead as they will be able to produce paper and place their names and that of their institution on the map of international scholar/scholarship. This is the *raison d'être* of this proposal. It is to develop the capacity of interested persons in quantitative analysis of their research materials.

Specific Objectives

The specific objectives are to:

- a. Enlighten participants on the place of research and publications in professional staff development;
- b. Develop their ability in the use of SPSS and EPI Info
- c. Teach them data entry and analysis, and also how they can manage their research data.
- d. Expose them to funding agencies

Methodology

The workshop will be interactive and participatory. Attempt will also be made to encourage hands-on approach.

- a. It will start with formal introduction to Quantitative research design in the social sciences; followed by practicum on data entry, data cleaning, data management; and finally the application of SPSS and EPI Info in the processing social research data.
- b. Participants will be subdivided into groups for exercises;
- c. SPSS and EPI Info will be loaded into their personal computers;
- d. Practical demonstration on how to use the software will be undertaken; and,
- e. Evaluation of the impact of training will be ascertained.

Course Content

The Place of Research and Publication in Staff Development

Key Elements of Quantitative Research

This presentation will provide an overview of quantitative research method.

Data Entry

The presentation will focus on preparation of code book and entry of data

Data Cleaning

Attempts will be made to explain how to clean data that have entry errors.

Data Analysis

Practical on data analysis using SPSS and EPI Info

Report Writing

These are extremely important in research and deserve to be addressed by prospective grantees. The focus will be on:

- Preparation of dummy tables
- Analysis, using appropriate software/techniques

Evaluation of Workshop

This is to ascertain impact of workshop.

Ethics in Research

Ethics which is about what is morally right must be addressed in research. This is because of past atrocities in research work. Examples are the experiments conducted the Nazi doctors on Jews, the Tuskegee experiments in the United States etc. Everyone is required to ethical principles in research. The following will be discussed:

- Respect for persons, community etc
- Beneficence – ensuring that no harm is done
- Distributive justice – equality of individuals and that the benefits and risks should be distributed fairly

Venue: Abuja

Date: September 10-12, 2012

Number of Participants: 40 per round

Duration: 3 days (4 nights)

Cost: N40,000 (to include two tea/coffee breaks and group lunch for the participants).

Certificate: Certificate of participation to be issued¹

Required Equipment: Participants will be advised to bring along their laptop to the workshop.

Report of Advocacy Activities in SuNMaP States

Health Reform Foundation of Nigeria (HERFON), one of the implementing partners of SuNMaP programme has been attempting to increase community awareness and the demand for effective malaria treatment and prevention in all SuNMaP states (Niger, Katsina, Kano, Anambra, Ogun, Lagos, Yobe, Enugu, Kaduna and Jigawa).

HERFON TAs in the targeted states are expected to organize Advocacy forum/visits to community leaders, the media houses, heads of health care facilities, state Legislature, and LGA officials to discuss issues around malaria control in their respective states.

The key 'tasks' in most of the States are as follows:

- increase budgetary allocation for malaria control activities at all levels of government;
- increase community involvement/awareness/access in/to

¹ Only those who attend all sessions will be awarded certificate that will be issued by the Academy.

all malaria commodities, reduced cost/free airing of malaria activities, and

- retention of trained malaria control staff for at least two years and or more.

What follows are reports on state-wide activities:

Niger State

Four of the local government Chairmen and the Legislature in the state believed that the problem of funding can be solved by creating a subhead in the recurrent budget for malaria activities. They promised to take necessary action to actualize this goal.

The head of health care facilities promised to improve their supervisory roles and also ensure prompt submission of the data on the use of commodities in their various facilities while the

community leaders promised to monitor clinics in their domain on the availability or otherwise of malaria commodities and also brief their subjects during community meetings.

Kano State:

The HERFON TAs identified the following advocacy issues in the state:

- Advocacy Issue 1: Poor implementation of the memorandum of agreement on routine preventive malaria control.
- Advocacy Issue 2: Incessant transfer of trained malaria control desk officers and focal persons. For instance, the staffs that are trained by SuNMaP to support malaria programmes in PHCs and LGA health facilities are transferred to other health care facilities and/or

assigned duties where the acquired skills on malaria are not utilized.

- Advocacy issue 3: The Local Government Councils procure and distribute out-dated mono-therapy instead of the combination therapy for the treatment of malaria.
- Advocacy Issue 4: Weak leadership support and participation of community leaders in Malaria Programme.

Ogun State:

The Advocacy Team visited 5 LGAs and media houses and found that inadequate funding and free airing of malaria control activities in the state were the major tasks.

The visits yielded result as the two media houses visited the team and also agreed to free air programmes or waive the production costs of jingles as their own contribution towards malaria control in the state.

The LGA Executives claimed that they have insufficient funds to implement activities due to the temporary nature of the current LGA leadership (viz., in form of caretaker committees).

The Speaker of the Ogun State House of Assembly promised to support the allocation of more funds during appropriation to malaria control activities in the next fiscal year.

Katsina State:

The following advocacy issues were identified at the state level:

- Incessant transfer of trained Malaria Control Desk Officers and focal persons;
- Weak leadership and participation of officers of state RBM team in malaria activities in the state;
- Lack of budget line for malaria control activities in MOH budget

resulting in poor-implementation of the state malaria annual operational plan; and,

- Weak leadership support and participation of local government Executive and community leaders in malaria programme.

The Advocacy team visited the State's Ministry of Health, Ministry of Local Government and Chieftaincy Affairs, Local Government Service Commission, Ministry of Finance, SPHCDA and 6 LGA Executives to make case on the above issues with a view to getting relevant officers/political office holders to be committed to improving the system.

HERFON Ebonyi State Chapter Holds Stakeholders Meeting

HERFON Ebonyi State Chapter organized a one-day Stakeholders Consultative Meeting in Abakaliki, Ebonyi State on 24th July, 2012. The aim of the meeting was to consult other stakeholders in health and to seek their support and collaboration in improved funding for health in the state.

Evidenced-based reports show that Ebonyi State has consistently allocated 1% of total state budget to health in the past five years, a situation that is unacceptable to HERFON Ebonyi State Chapter.

In an effort to correct this situation, HERFON Ebonyi State Chapter is currently engaging the Ebonyi State Government and other groups to improve funding for health.

A meeting which took place at the Conference Hall of the Ebonyi State Teaching Hospital, Abakaliki led to a

consensus on the following observations and recommendations:

Observations:

1. Ebonyi State is rich in human and material resources for better health budgeting
2. There are still poor health indicators in Ebonyi State though masked by the national figures if not disaggregated
3. Inadequate budgetary allocation to health is capable of derailing the attainment of Health Sector Reform (HSR) and MDGs
4. Poor budget implementation especially at the state and Local Government levels contributes significantly to poor quality of health delivery system.
5. All arms or tiers of government are required to contribute (especially the legislature) to improve health budget while the Executive contributes to adequate budgeting implementation
6. The elimination of childhood infectious diseases depends heavily on full immunization of all children below 5 years
7. The current immunization status of 67% is still far from the target of 80%.
8. Nigeria is making very slow but steady progress in the health sector reform towards the attainment of the MDGs.
9. HSR and National Strategic Health Development plans are the way forward in the march toward MDGs.
10. Continuous public enlightenment campaign, outreach and advocacy are still required for sustained immunization coverage.

Recommendations:

1. HERFON hereby calls on Ebonyi sons and daughters in positions of authority at national, sub-national and Diaspora to act as ambassadors of the reform process.
2. HERFON and State Ministry of Health should constitute a research committee that will routinely analyze state data for use by policy makers.
3. All governments should ensure full release of health budget.
4. Community participation is key to all Health Plan especially for budgeting in primary health care, so that a bottom up budgeting is institutionalized.
5. Every level of government, - Federal, State and Local Government should increase their health budget to 15%, - the level recommended by the WHO.
6. Every level of government should urgently implement all the components in their strategic health development Plan as this is the best way forward in the attainment of MDGs.
7. All effort should be made to approve and sign the National Health Bill (NHB)
8. Ebonyi State House of Assembly should increase and improve budgetary provisions for health to at least 15% of the state budget in line with WHO recommendation for the good of our people.

HERFON Anambra State Chapter Stakeholders Meeting

HERFON Anambra State Chapter organized a Stakeholders Consultative meeting in Awka on the 25th July 2012 on the establishment of Anambra State Primary Health Care Development Agency. Some of those in attendance were:

1. Mrs. S. Ikedigwe, Representative of ASATU
2. Rev. Fr. Peter Onuegbu, Representative of Religious Group
3. Mrs. Rose Oranye, Representative of Media
4. C. Uche Okoye, Representative of Local NGO
5. Mr. Lambert Okeke, Representative of Professional Bodies
6. Mr. D.C. Uche, Representative of Professional Bodies
7. Dr. R. O. Nriagu on behalf of State HERFON Member
8. Mr. Henry B. Onyckwelu, State Chairman HERFON
9. Representatives of Private Health Practitioners

The participants observed as follows:

1. Budget is not monitored/supervised or even implemented and logistics are not effective to determine budget performance.
2. Issue of headship and conflicting policy regulation
3. Administrative bottlenecks in accessing/releasing the budget
4. Health budget is less than 15% of the overall budget

5. Maldistribution of equipment
6. Poor service delivery and irregular hours of service
7. Poor attitude of health workers
8. Poor management of personnel/staff on motivation, monitoring, supervision and discipline
9. Inter-cadre and professional squabbles
10. Lack of coordinated data flow
11. NHMIS – Poor routing of data to appropriate quarters
12. Poor utilization of existing data
13. Poor community involvement in health issues/programmes

Recommendations

1. That high powered advocacy group should be formed to meet and discuss with key functionaries on how to address lack of accountability.
2. That the delivery at PHC is fragmented.
3. That the management of human resources usually split between the LGAs while finances are controlled by SMOH
4. That advocacy should be extended to other stakeholders who were not in the meeting who may be able to influence the decisions of the state government.
5. That the Anambra State Primary Health Care Development Agency should be established without further delay.
6. There should be co-ordination of data collection, sharing and distribution in the state.
7. That there is urgent need for state government to put in place a crack team of monitoring and evaluation officers in health sector in the state in order to ensure sustainability and functionality of all that are put in place in the state's health programmes.

8. The State Government should ensure training and retraining of health workers.
9. That adequate incentives, remunerations, better working environment be put in place in the state in order to reduce the brain drain of professionals in health.
10. There is need to employ more competent health professionals and also solve the inter-professional squabbles at the Local Government level.
11. That Anambra State should increase its annual budgetary allocation to health which has been between 1.4% 1.6% in the past three years.

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Acquisition for the Knowledge Management Unit

The Foundation is continuously developing its Knowledge Management Unit from meager to richer collections on child and maternal health in particular and health in general. We have also newspaper cutting on various health issues. Below is the list of recent acquisition for use by the foundation in particular and the public at large.

S/N	Issues	Year Published
1	African Journal of Reproductive Health Volume 1 Number 1	March, 1997
2	African Journal of Reproductive Health Volume 1 Number 2	September, 1997
3	African Journal of Reproductive Health Volume 2 Number 1	April, 1998
4	African Journal of Reproductive Health Volume 2 Number 2	October, 1998
5	African Journal of Reproductive Health Volume 3 Number 1	May, 1999
6	African Journal of Reproductive Health Volume 3 Number 2	October, 1999
7	African Journal of Reproductive Health Volume 4 Number 1	April, 2000
8	African Journal of Reproductive Health Volume 4 Number 2	October, 2000
9	African Journal of Reproductive Health Volume 5 Number 1	April, 2001
10	African Journal of Reproductive Health Volume 5 Number 2	August, 2001
11	African Journal of Reproductive Health Volume 5 Number 3	December, 2001
12	African Journal of Reproductive Health Volume 6 Number 1	April, 2002
13	African Journal of Reproductive Health Volume 6 Number 2	August, 2002
14	African Journal of Reproductive Health Volume 6 Number 3	December, 2002
15	African Journal of Reproductive Health Volume 7 Number 1	April, 2003
16	African Journal of Reproductive Health Volume 7 Number 2	August, 2003
17	African Journal of Reproductive Health Volume 7 Number 2	December, 2003
18	African Journal of Reproductive Health Volume 8 Number 1	April, 2004
19	African Journal of Reproductive Health Volume 8 Number 2	August, 2004
20	African Journal of Reproductive Health Volume 8 Number 3	December, 2004
21	African Journal of Reproductive Health Volume 9 Number 1	April, 2005
22	African Journal of Reproductive Health Volume 9 Number 2	August, 2005
23	African Journal of Reproductive Health Volume 9 Number 3	December, 2005
24	African Journal of Reproductive Health Volume 10 Number 1	April, 2006
25	African Journal of Reproductive Health Volume 10 Number 2	August, 2006
26	African Journal of Reproductive Health Volume 10 Number 3	December, 2006
27	African Journal of Reproductive Health Volume 11 Number 1	April, 2007
28	African Journal of Reproductive Health Volume 11 Number 2	August, 2007
29	African Journal of Reproductive Health Volume 11 Number 3	December, 2007
30	African Journal of Reproductive Health Volume 12 Number 1	April, 2008
31	African Journal of Reproductive Health Volume 12 Number 2	August, 2008

32	African Journal of Reproductive Health Volume 12 Number 3	December, 2008
33	African Journal of Reproductive Health Volume 13 Number 1	March, 2009
34	African Journal of Reproductive Health Volume 13 Number 2	June, 2009
35	African Journal of Reproductive Health Volume 13 Number 3	September, 2009
36	African Journal of Reproductive Health Volume 13 Number 4	December, 2009
37	African Journal of Reproductive Health Volume 14 Number 1	March, 2010
38	African Journal of Reproductive Health Volume 14 Number 2	June, 2010
39	African Journal of Reproductive Health Volume 14 Number 3	September, 2010
40	African Journal of Reproductive Health Volume 14 Number 4	December, 2010
41	African Journal of Reproductive Health Volume 15 Number 1	March, 2011
42	African Journal of Reproductive Health Volume 15 Number 2	June, 2011
43	African Journal of Reproductive Health Volume 15 Number 3	September, 2011
44	African Journal of Reproductive Health Volume 15 Number 4	December, 2011
45	African Journal of Reproductive Health Volume 16 Number 1	March, 2012
46	African Journal of Reproductive Health Volume 16 Number 2	June, 2012
47	African Journal of Reproductive Health Volume 16 Number 3	September, 2012
48	African Journal of Reproductive Health Volume 16 Number 4	December, 2012
49	Contemporary Obstetrics & Gynaecology. For Developing Countries.	2003
50	Profile of Sexual and Reproductive Health of Young Adults and Adolescents in Edo State of Nigeria: A situation Analysis Report: <i>Initiative of Policy Project/USAID and Women's Health and Action Research Centre</i>	2003
51	Critical Issues in Reproductive. Health & Rights in Nigeria.: <i>ISBN: 978-35481-3-1</i>	2002
52	Contemporary Issues in Reproductive Health in Nigeria. <i>Occasional Working Paper Series</i>	1999
53	Identify priorities for research & documentation on Adolescents Sexual Reproductive Health in Nigeria <i>ISBN: 978-978-916-889-7</i>	February, 2011
54	Research and Documentation in adolescent Sexual and Reproductive Health. – A summary of methods and processes	2011
54	Prospects for a Malaria Vaccine 9th James Ogonor memorial lecture delivered by Professor P.O Uadia	January, 2012
55	Women's Health and Rights in Nigeria: The way forward <i>A Paper Presentation at the Public Lecture in Honour of Dr. Abel I, Former INEC Chairman and Marking the 10th Anniversary of Women's Health and Action Research Centre (WHARC) delivered by Professor O.A Ladipo</i>	

56	Phytomedicine in Nigeria: past, present and future	2011
57	Traditional Medicine in Nigeria: The Way Forward. <i>1st Professor James Ogonor Memorial Lecture delivered by Dr. U.S Inyang</i>	2004
58	Constraints and Opportunities: Meeting the Challenges of the Beijing Process in Nigeria. <i>Proceedings of a Seminar on the Beijing +5 Review Process held in Benin City, Nigeria (12th and 13th July 2001)</i>	2001
59	The Use of Traditional African medicine in the management of HIV/AIDS <i>2nd Professor James Ogonor Memorial Lecture delivered by Charles Wambebe and Karniyus Gamaniel</i>	2005
60	HIV/AIDS in Nigeria: What You Should Know Revised Edition :ISBN: 978-35481-2-3	2004
61	Legal Constraints to Adolescent Sexual and Reproductive Health Rights in Nigeria <i>Occasional Working Paper Series delivered by Joy Ezeilo</i>	1999
62	A Review of the Medicinal Plants Used in the Management of Sickle Cell Anemia <i>3rd Annual Professor James Ogonor memorial Lecture delivered by S.A Adesanya and Abayomi Sofowora</i>	2006
63	Management of Infertility Amongst Nigerian Couples: The way forward <i>Lecture Delivered by Dr. Sylvester Ojibo</i>	2007
64	Primary care Versus Primary Health Care: Clarifying the Confusion and Resolving the Conflict. <i>First Annual Professor Ransome-Kuti International Policy Dialogue in Primary Health Care and Reproductive Health delivered by Adetokunbo O Lucas</i>	June, 2006
65	Why should Africa's Women Continue Crying for life? <i>Second Annual Professor Ransome-Kuti International Policy Dialogue lecture delivered by Professor Frederick Torgbor Sai</i>	May, 2007
66	The Control of HIV/AIDS, in Nigeria: The Journey so far <i>Third Annual Professor Ransome-Kuti International Policy Dialogue, lecture delivered by Professor Babatunde Osotimehin</i>	June, 2008
67	Concepts of the Aetiology and Management of Mental Illness: A Comparison of Western and Traditional Medicine <i>6th Professor James Ogonor Memorial Lecture delivered by Professor Roger O.A Makanjuola</i>	January, 2009
68	Ethics, Bioethics and Environment in Healing Designs <i>Fourth Annual Professor Olikoye Ransome-Kuti Memorial Lecture delivered by Professor Wole Soyinka</i>	June, 2009
69	Maternal Mortality in Nigeria in Nigeria: The past, The present and The future <i>Lecture Delivered by Professor Kelsey A Harrison</i>	August, 2009

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Health Reform Foundation of Nigeria, located at #60 Lobito Crescent, Wuse II, Abuja, Nigeria is an independent membership organization with branches in FCT, thirty six states, and Zonal Offices in the six geopolitical zones of the country. Among the objectives of the organization are to: (a) advocate, facilitate, support and monitor health reform in Nigeria; (b) foster collaboration and co-ordination for health sector reform and promote fellowship among members; (c) build capacity for health sector reform and in particular organize or sponsor a sustained change agent training; and (d) promote and conduct research, write policy analysis and briefs and generate data to influence and inform health sector reform in Nigeria.

Its vision is to be the leading independent non-governmental organization advocating for health sector reforms, better health outcomes, and development while its mission is to promote better health for all Nigerians.

The organization welcomes as members, individuals that are committed to the reform of the health sector. HERFON seeks to achieve its broad objective through advocacy, capacity building, partnership and evidence generation. The Members of the Board of Trustees are:

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