

SITUATION ANALYSIS OF CHILDREN AND WOMEN IN NIGERIA

2011 UPDATE

UNICEF NIGERIA

Acronyms and abbreviations

AFASS	Acceptability, Feasibility, Affordability, Sustainability and Safety
AfDB	African Development Bank
APOC	African Programme for the Control of Onchocerciasis
ARI	Acute Respiratory Tract Infections
BFHI	Friendly Hospital Initiative
BMI	Body Mass Index
BON	Broadcasting Organisations of Nigeria
CASSAD	Centre for African Settlement Studies and Development
CBOs	Community Based Organisations
CBSC	Communication for Behaviour and Social Change
CDTI	Community Directed Treatment with Ivermectin
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CHEW	Community Health Extension Workers
CLTS	Community-led Total Sanitation
CMAM	Community-Based Management of Acute Malnutrition
CRA	Child Rights Act
CRC	Convention on the Rights of the Child
CSD	Child Survival and Development
CSOs	Civil Society Organisations
CWIQ	Core Welfare Indicator Questionnaire
DDR	Disarmament, Demobilisation and Reintegration
DFID	Department for International Development
DRC	Democratic Republic of Congo
EBF	Exclusive Breast Feeding
ESA	External Support Agencies
ESSPIN	Education Sector Support Programme in Nigeria
EU	European Union
FBO	Faith-Based Organisations
FCT	Federal Capital Territory
FGM/C	Female Genital Mutilation/Cutting
FGN	Federal Government of Nigeria
FLHE	Family Life and HIV/AIDS Education
FLEHI	Family Life and Emerging Health Issues
FMAWR	Federal Ministry of Agriculture and Water Resources
FME	Federal Ministry of Education
FMENV	Federal Ministry of Environment
FMOH	Federal Ministry of Health
FMWA&SD	Federal Ministry of Women Affairs and Social Development
FMWR	Federal Ministry of Water Resources
FOMWAN	Federation of Muslim Women's Association of Nigeria
GEP	Girls Education Project
HCT	HIV Counseling and Testing
HDI	Human Development Index
HIV	Human Immunodeficiency Virus (HIV)
HMIS	Health Management Information Systems
IDPs	International Development Partners
IEC	Information, Education and Communication
ILO	International Labour Organisation
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate

IPD	Immunization Plus Days
IPEC	International Programme on the Elimination of Child Labour
ITN	Insecticide Treated Net
IYCF	Infant and Young Child Feeding
JAP	Journalists Alliance for PMTCT
JAS	Joint Account System
JICA	Japanese International Cooperation Agency
JMP	Joint Monitoring Programme for Water Supply and Sanitation
KAP	Knowledge, Attitude and Practice
LDCs	Least Developed Countries
LGA	Local Government Area
LEEMP	Local Empowerment and Environmental Management Project
LGEA	Local Government Education Authority
LIDFC	Low income–deficit country
LMDGI	Localizing the MDGs Initiative
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MSF	Medicines Sans Frontiers
MTR	Mid Term Review
MUAC	Mid-Upper Arm Circumference
NAFDAC	National Agency for Food and Drug Administration and Control
NASCP	National AIDS and Sexually Transmitted Diseases Programme
NBS	National Bureau of Statistics
NDHS	National Demographic and Health Surveys
NEEDS	National Economic Empowerment and Development Strategy
NEWSAN	National Civil Society Network on Water and Sanitation
NFCNS	National Food Consumption and Nutrition Survey
NGOs	Non-Governmental Organisations
NIREC	Nigeria Inter-Religious Council
NIS	Nigeria Immigration Service
NMC	Nigerian Movement for Children
NOCP	National Onchocerciasis Control Programme
NPC	National Planning Commission
NPopC	National Population Commission
NPF	Nigeria Police Force
NPHCDA	National Primary Health Care Development Agency
NPLC	Nigeria Planning Commission
NSDWQ	Nigerian Standard for Drinking Water Quality
NWRI	National Water Resources Institute
ODA	Official Development Assistance
ODF	Open Defecation Free
ORS	Oral Rehydration Salts
OTC	Out-Patient Therapeutic Care Centres
OVC	Orphans and Vulnerable Children
PEI/RI	Polio Eradication Initiative/Routine Immunisation
PFL	Pour Flush
PHAST	Participatory Hygiene and Sanitation Transformation
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission

PPP	Public-Private Partnership
PRSP	Poverty Reduction Strategy Paper
PSAs	Public Service Announcements
RHRC	Reproductive Health Response in Crises
RUTF	Ready-to-Use Therapeutic Food
RUWASA	Rural Water and Sanitation Agency
RWSS	Rural Water Supply and Sanitation
SAM	Severe Acute Malnutrition
SBMC	School-Based Management Committees
SCN	United Nation Standing Committee On Nutrition
SGBV	Sexual and Gender-Based Violence
SHAWN	Sanitation, Hygiene and Water in Nigeria
SitAn	Situation Analysis of Children and Women
SMART	Standardised Monitoring and Assessment of Reliefs and Transitions
SOMTECS	Social Mobilisation Technical Committees
SON	Standard Organization of Nigeria
SPS	Social Protection Strategy
SSIP	Small Scale Independent Providers
SUBEB	State Universal Basic Education Board
SWAP	Sector Wide Approach
SWOC	State of the World's Children
TBAs	Traditional Birth Attendants
TCF	Tulsi Chanrai Foundation
TFC	Therapeutic Feeding Centre
TFD	Theatre for Development
U5MR	Under-Five Mortality Rate
UA	Unites of Account
UBEC	Universal Basic Education Commission
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPL	Upgraded Pit Latrine
USAID	United States Agency for International Development
UWSS	Urban Water Supply and Sanitation
VIP	Ventilated Improved Pit Latrine
VL0M	Village Level Operation and Maintenance of Hand-Pumps
VVF	Vesico-Vagina Fistula
WANG	WaterAid Nigeria
WASH	Water, Sanitation and Hygiene
WASHCOMs	Water, Sanitation and Hygiene Committees
WFFC	World Fit for Children
WHO	World Health Organisation
WIMAG	Water Investment and Resource Mobilization and Implementation Guidelines
WSMP	Nigeria Water and Sanitation Monitoring Platform
WSSSRP	Water Supply and Sanitation Sector Reform Programme

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1. Introduction

1.1 Background

Development is about people, and must be people-centred. Women and children are important segments of the human population, and constitute critical links between the present generation and the future. Appropriate investment in women and children's health has been shown to be of great benefit at individual, household, and community levels. Such investment also benefits nations greatly, in terms of poverty reduction, improved national economic performance, and realisation of the fundamental human rights of women and children (UN, 2010). Failure to accord the deserved attention to the health and well being of women and children, on the other hand, carries grave implications. Globally about eight million children die from preventable causes and more than 350,000 women die from preventable complications related to pregnancy and childbirth each year (UN, 2010). As the United Nations Secretary General Ban Ki-moon stated in his foreword to the recently published Global Strategy for Women's and Children's Health, "These are not mere statistics. They are people with names and faces. Their suffering is unacceptable in the 21st century. We must, therefore, do more... Together we must make a decisive move, now, to improve the health of women and children around the world" (UN, 2010). Indeed, with just five years to the 2015 target year for the Millennium Development Goals (MDGs) – a global compact for reducing poverty and improving health and development of especially women and children – there is a need to increasingly channel efforts to improve the health and well being of women and children.

The promotion of human rights is critical to advancing the health and development of women, children, and other population sub-groups as evident in the Universal Declaration of Human Rights. In its promotion of human rights-based analysis the United Nations (UN) provides technical assistance and support to countries to assess and analyse the situation of their people. This analysis identifies, among other issues, the challenges of the most vulnerable and socially excluded groups in society. The capacity of the stakeholders responsible for promoting, protecting, fulfilling and respecting human rights is also identified. UN agencies direct their assistance and support to national and local planning, monitoring and evaluation of programmes. Focus is put on duties and corresponding actions that support the realisation of the rights of all people. The United Nations Children's Fund (UNICEF), as the lead agency on children within the UN, strongly promotes the realisation of the rights of children and women. Its programmes of cooperation are premised, in this respect, on the principles embedded in the Convention on the Rights of the Child (CRC), the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and other international human rights treaties.

The development of a Situation Analysis of Children and Women is a central function of UNICEF's mandate. A Situation Analysis is a programme output that strongly supports national efforts and institutions. It is part of the UN's overall effort to support national capacity for promoting human development and fulfilling the human rights of citizens. The assessment and analysis shows child-relevant dimensions of national development challenges and suggests possible solutions and priority actions (some of which may be supported by the UN). It promotes the analytical use of available data and information from Government, international development cooperation partners and civil society. It should therefore contribute to the building of a progressively stronger evidence base on the situation of the rights of children and women. The Situation Analysis is a major tool for informing policy dialogue and child-focused policy advocacy. It should serve as a key vehicle for advocacy and partnerships that mobilise energy, policies and resources towards the realisation of rights and Millennium Development Goal (MDG) targets for children and women.

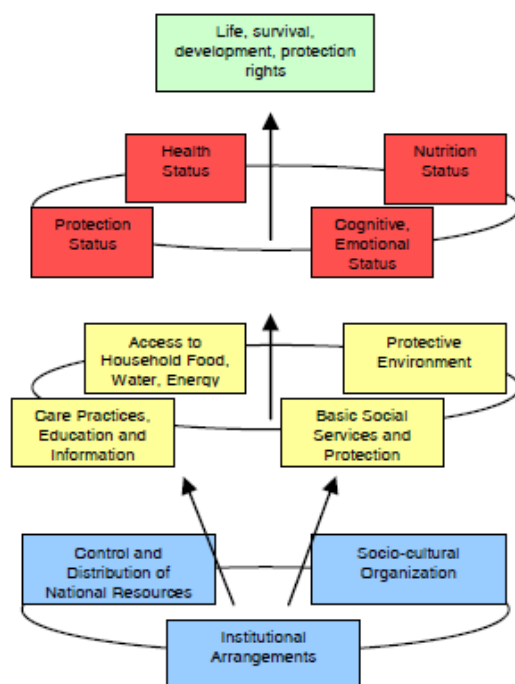
The 2010 Situation Analysis of Children and Women Update builds on the experience of the previous Situation Analyses conducted by UNICEF in partnership with the Government of Nigeria.

These include the 2001 Situation Analysis, the 2004 Update, and the 2007 Situation Analysis. The current 2010 Update aims to review evidence regarding changes in the situation of children and women since the 2007 Situation Analysis.

1.2 Conceptual framework

The general conceptual framework for the Situation Analysis is shown in Figure 1.1. This framework illustrates the multidimensional nature of the rights of women and children, and the relevance of health and well being to the realisation of life, survival, development, and protection rights. It also highlights the inter-relationship between causes and outcomes, and provides a way to cluster multiple causes into a pattern of relationship, and to identify the immediate, underlying or basic (structural) causes.

Figure 1.1 Conceptual framework for situation analysis of women and children



Source: UNICEF, 2008.

1.3 Methodology

The process of conducting a Situation Analysis is normally linked to key national policy processes in a way that it can provide specific policy recommendations and evidence for child rights advocacy, including by partners. While it is neither a baseline survey nor a needs assessment tool, the Situation Analysis provides a reference point and a link to areas of continuing action. Broadly, it provides a snap shot of the country's progress with programming in key sectors and how they reflect the protection of the rights of women and children as well as support their expression. The Situation Analysis is founded on a human rights-based approach (HBRA), which recognizes that the realisation of human rights is fundamental to achieve human development outcomes. The approach also focuses on accountability and identifying those responsible for human rights realisation (duty-bearers), whose capacities to meet their responsibilities must be strengthened, as well as patterns in the relationship between rights holders and duty bearers (see U. Jonsson, UNICEF, 2003).

The 2010 Situation Analysis Update documents progress on the health and well being of women and children in Nigeria with particular focus on the 2007-2010 period, and examines trends observed in light of the Millennium Development Goals (MDGs). It also captures the impact of

political, economic, cultural and other factors on the realisation of rights by children and women. It documents differences based on sex, age, region, and socio-cultural factors to the maximum extent possible. It also addresses issues of vulnerability and equity relating to income, geographical and other socio-demographic basis. The analysis identifies immediate, underlying and structural causes behind progress made and lack thereof, and it situates Nigeria in the sub-regional, regional and global contexts. Within the context of well-articulated development challenges, the Situation Analysis addresses issues, factors and constraints emerging at federal, state and Local Government Area (LGA) levels and their interaction. The analysis also identifies, where possible, opportunities for meaningful participation of rights holders including children, young people, women and people living with Human Immunodeficiency Virus (HIV).

The process of developing the 2010 Situation Analysis update involved a desk review of existing documents, including national surveys and reviews such as the National Demographic and Health Survey (NDHS), the Multiple Cluster Indicator Survey (MICS), the Core Welfare Indicator Questionnaire Survey (CWIQ), the Nigeria Living Standard Survey (NLSS), and the Nigerian Health Review. Several policy documents, research publications, and reports of government agencies were also reviewed, including Nigeria's MDG reports, Country Periodic Report on CEDAW, and Country Periodic Report on Implementation of African Union Charter on Rights and Welfare of the Child. The process also made use of statistical data and relevant information available from UN agencies and other international development partners. Data and information were also obtained from reports and publications by national and local organisations including academia and civil society organizations. Consultations were made with UNICEF, other UN agencies, other international and national development partners, government agencies, and the civil society. Challenges encountered during this exercise include issues of data accuracy, completeness, comparability, and time lag between the generation and dissemination, but careful comparison of data was undertaken and priority accorded to those deemed to have a high level of validity and/or meet national and international standards.

1.4 Structure of the document

While issues of rights are interlinked, this document has been organized in chapters. Each chapter focuses on a distinct issue that contributes substantially to the health and well being of women and children in Nigeria, highlighting progress and achievements made in recent years, particularly between 2007-2010. Each chapter describes the current status in its area of focus and highlights what actions, policies and interventions have been implemented since the last Situation Analysis, and the impact of these interventions on key outcomes especially the MDG targets. Where relevant and available data permit, chapters highlight variations by geopolitical zones as well as by age group, urban and rural locations, economic level (wealth quintiles) and other socio-demographic determinants. The chapters identify the determinants of key outcomes and make recommendations on how gains can be consolidated and existing gaps bridged.

2. Country Environment

2.1 Introduction

The 2001 Situation Analysis of women and children in Nigeria noted that children and women face several obstacles to their health, well being, and overall realisation of rights arising from the structural challenges that had slowed down national development on numerous fronts. Set against the background of the 2001 analysis, the 2007 Situation Analysis noted that the country had recorded progress on a number of political and economic fronts, among others, which had brightened the potential for realising the rights of children and women and would likely have a positive impact on their health and development. On the political front, for example, Nigeria had witnessed successful transition from one democratic regime to another for the first time in the history of the country. Also, the democratic governance structure was being increasingly strengthened. Progress was also reported on the issues of good governance, social justice, and the rule of law. On the economic front, the country had recorded a more stable exchange rate, growing foreign reserves, improvement in several macroeconomic indices, and poverty reduction. The country also received landmark debt forgiveness internationally, resulting in increased funding for MDG-related activities including priority social sector programmes. Greater emphasis on addressing corruption has also been recorded, as evidenced by the establishment of specific anti-corruption agencies.

Yet, as the 2007 Situation Analysis noted, “The level of progress has been rather modest and the rate of change slow in sharp contrast to the high expectations from Nigerians and indeed the international community at the beginning of the democratic dispensation in 1999”. Indeed, measured against its vast natural resources and human endowments, Nigeria’s overall development progress is widely appraised as slow. Its human development ranking, which is poorer than that of several less endowed sub-Saharan African countries, is illustrative. Also, while the country has achieved an average growth rate of about 6 percent annually in the last eight years, the economic growth has not resulted in a significant decline in unemployment and poverty prevalence (UNDP, 2009). Thus, there are still considerable challenges in Nigeria’s socioeconomic development, which has continued to attract the attention of the government and its partners such as the United Nations agencies and other international development partners. Since the period covered by the 2007 Situation Analysis, the government and its partners have continued to develop relevant programmes to improve the national development indices.

This chapter reviews the major socioeconomic development in Nigeria between 2008 and 2010 with particular emphasis on the issues of governance, economic planning, and resource allocation. It highlights the changes that have taken place, especially those that have relevance for promoting and realising the rights of children and women.

2.2 Population and socio-cultural environment

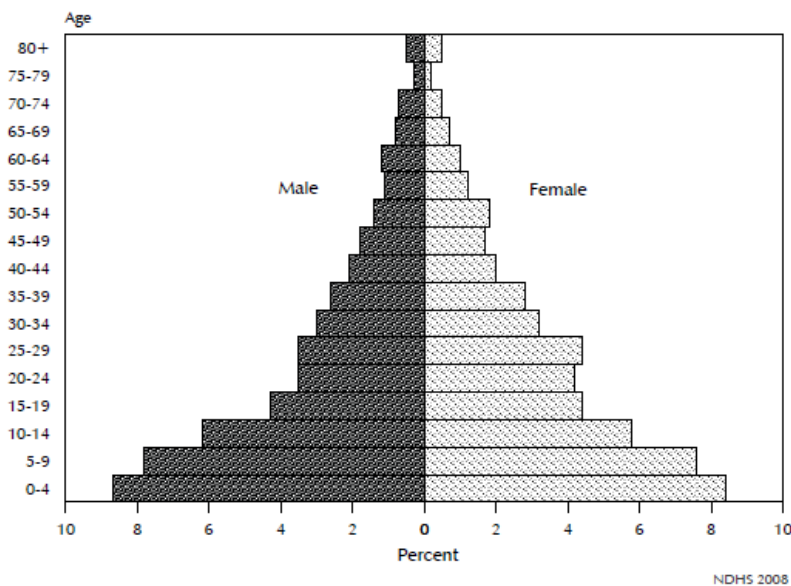
As the National Policy on Population for Sustainable Development (NPC, 2004) notes, “the people of Nigeria are the most important and valuable resources of the nation. They are at the centre of concerns for sustainable development”. While the national housing and population census reported the population to be 88.9 million in 1991 (NPC, 1994), this figure had increased to 140 million by the 2006 census (NPC, 2008) – an increase of 51 million in 15 years. Women constitute approximately 49.2 percent of the Nigerian population (NPC, 2008). The majority of households are rural, about 33 percent of households are urban (NBS & UNICEF, 2007).

The 2006 census reported the national annual population growth rate as 3.2 percent as against the previous rate of 2.8 percent reported based on the 1991 census. The current rate means that Nigeria

is one of the fastest growing economies in the world. This has significant implications for socio-economic development, particularly the provision of adequate basic social services that will support the health and development of the population - especially for children, women and other vulnerable groups. At the current growth rate it would take only 22 years for the population of Nigeria to double itself. Based on the annual growth rate, Nigeria's population was projected to be 151 million in 2008 and 161 million in 2010. Considering the rate of the country's economic development, it is unlikely that Nigeria can adequately respond to an additional population of 10 million, within a two-year period.

Nigeria has a youthful population structure with 45 percent of the population estimated as being less than 15 years of age, while only 4 percent are 65 years and older (NPC & ICF Macro, 2009). This population composition confirms the low life expectancy in Nigeria. Nigeria's population pyramid, which is a graphical representation of the age and sex distribution, is broad based and tapers rapidly upward; it depicts a situation of high fertility and high rate of childhood death (Figure 2.1). With women accounting for about half of the total population, women together with children clearly constitute the majority of the population in Nigeria. This fact has implications for development management and resource planning and allocation. The high proportion of women and children in the total population makes a compelling case for policy-makers to accord priority, focus, and proportionately allocate resources to women and children's issues – a case made even more compelling by the social vulnerability of women and children. The 2007 MICS reported Nigeria's dependency ratio, expressing persons aged below 15 years or above 64 years as a ratio of those aged 15 to 64 years, as 0.95 for urban areas, 0.91 for rural areas, and 0.91 nationally (NBS & UNICEF, 2007). This denotes an economic burden on the productive age group, which is worse in the urban compared to rural areas.

Figure 2.1 Population pyramid



A persistent high birth rate combined with a gradually declining childhood mortality rate accounts for Nigeria's high population growth rate. As NDHS reports have shown, the total fertility rate for Nigeria has remained above five for decades: 5.9 percent in 1991 (FOS & IRD/Macro, 1992), 5.2 percent in 1999 (NPC & ORC Macro, 2000), 5.7 percent in 2003 (NPC & ORC Macro, 2004), and 5.7 percent in 2008 (NPC & ICF Macro 2009). Analysis of trends in age-specific fertility rates, however, shows a steady decrease in all age groups over the 20 years preceding the 2008 NDHS. A high fertility rate has significant negative implications for the health and well being of mothers and children. It is associated with increased maternal mortality as well as childhood morbidity and mortality. It also imposes increased economic challenges on households, thereby impacting on the

family as a whole. The results of the national surveys also consistently show that fertility rates are higher in the more economically disadvantaged rural areas compared to the urban areas. In 2008, the fertility rate was 6.3 in the rural areas compared to 4.7 in the urban areas. Also, the fertility rate is higher in the northern geo-political zones, which have higher incidence of poverty, than in the south. With the share of Nigeria's population tilted in favour of both the north and rural areas, it means that many more children are born and live in the areas with the greatest socio-economic and developmental challenges – environments where their rights are more likely to be compromised.

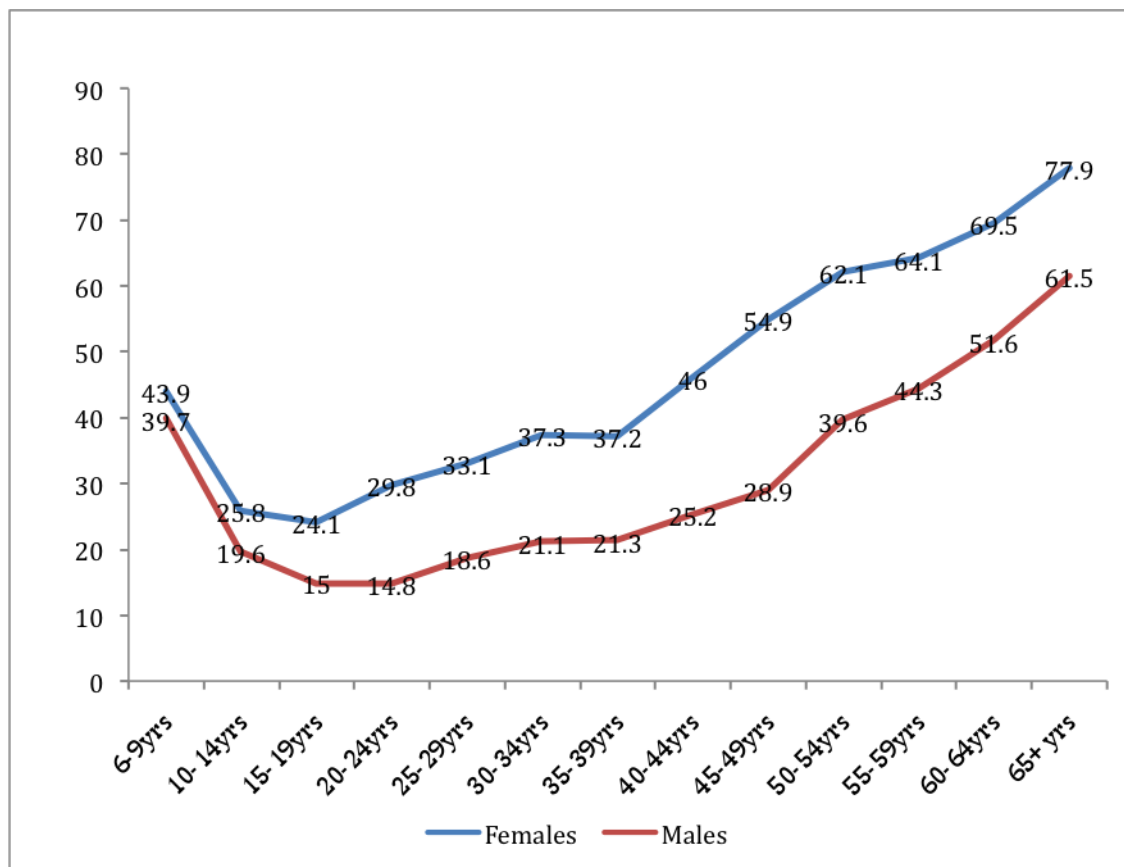
Underlying the high fertility rates is a cultural emphasis on the value of having a large family. For example, almost 60 percent of women with four living children and almost 70 percent of men in the same situation in 2008 still wanted to have another child (NPC & ICF Macro, 2009). The mean ideal number of children as expressed by women of reproductive age (15-49 years) in 2008 was 6.1 children. There was a difference between age groups as it ranged from a mean of 5.5 for age group 15-19 to 7.3 for those between the ages of 45 and 49 years. The mean ideal number was higher for women in the north compared to the south, ranging from 4.6 in the South west to 8.1 in the North east. Rural-based women expressed a higher ideal number of children (6.7) compared to their urban counterparts (4.6). Educational level and wealth quintiles were negatively associated with ideal number of children: women with no formal education desired on average 8.0 children compared to 4.3 for those with post-secondary education. Those in the lowest quintile desired 7.8 children compared to 4.5 children desired by those in the highest quintile (NPC & ICF Macro, 2009).

Currently married urban women are three times as likely as their rural counterparts to use a contraceptive (26 percent compared to 9 percent respectively) (NPC & ICF Macro, 2009). The higher risk of childhood death in rural compared to urban areas could also contribute to the higher rural fertility rate. For example, the under-five mortality rate is 121 deaths per 1,000 live births in the urban areas compared with 191 deaths per 1,000 live births in rural areas. Rural women and women in the northern parts of Nigeria have lower access to prenatal health care than the rest of the population. Low levels of immunisation, malnutrition and high prevalence of childhood diseases and malaria are generally blamed for the high rate of child mortality in the country. For the 2005-2008 period, the infant mortality rate was 75 deaths per 1,000 live births, the infant mortality rate was 88 deaths per 1,000 live births, and the under-five mortality rate was 157 deaths per 1,000 live births. Comparison of the 1999, 2003, and 2008 NDHS figures indicates that although the childhood mortality rates in the country are still high, they have generally been on the downward trend (NPC & ICF Macro, 2009).

The level of education in a population is a great determinant of its potential to thrive, propel economic development, and move the country forward in development terms. In recognition of this, Nigeria's National Policy on Population for Sustainable Development states as follows: "Every Nigerian has the right to information and education, which shall be directed to the full development of human resources, dignity and potential, with particular attention to women and children" (Principle 5, p. 18 in NPC, 2004. Available data, however, show a significant gap between this policy and the actual educational status of the Nigerian population. An analysis of the household data presented by the 2008 NDHS showed that educational attainment of female household members lagged behind that of males in all age groups (Figure 2.2). The proportion of the male population aged 6 years and above with no education was 27.7 percent compared to 39.9 percent among females of the same age. Up to a quarter of young females between the ages of 10 and 19 and almost a fifth of boys of the same age group years had no education (NPC & ICF Macro, 2009). On the whole, Nigeria has a large out-of-school population that is gradually decreasing due to increasing school enrolment figures. However, as the 2010 Education for All (EFA) Global Monitoring Report has noted, although Nigeria is moving in the right direction in terms of improving net enrolment ratio for primary education, the progress is "at a snail's pace" (p. 67, UNESCO, 2010). Overall, the EFA Report projects that Nigeria's adult literacy (age 15 years and

above) will increase from the 2000-2007 figure of 72 percent to 79 percent by 2015. For women this represents a change from 64 percent to 74 percent, and for men a change from 80 percent to 85 percent (UNESCO, 2010).

Figure 2.2 Males and females aged six and above who have no education (percentage)



Source: NPC & ICF Macro, 2009.

Significant geo-political disparities are evident in the country’s educational achievement. For example, while MICS reports that 56 percent of women aged 15-24 years were literate, it varied from 5 percent in Yobe to 95 percent in Imo State. The Northern zones, particularly the North east and North west, significantly lagged behind the Southern zones in educational attainment (Table 2.1). The United Nations Educational and Scientific and Cultural Organisation (UNESCO), reported in 2010 that 86 percent of the lowest educational quintile in Nigeria was in two regions, the North west and North east, which accounted for 43 percent of the population. The report also noted “In Nigeria, poor Hausa girls face some of the world’s most severe educational deprivation. Some 97 percent of 17-22 years-olds had fewer than two years of education and just 12 percent of primary school age Hausa girls attended primary school” (p. 152). Poverty is another major factor associated with educational inequity. Among females 6 years and above 74 percent in the lowest wealth quintile had no education compared to only 8 percent in the highest wealth quintile. The pattern is also similar for males, with figures of 62 percent and 4 percent for the lowest and the highest quintiles respectively (NPC & ICF Macro, 2009). This situation regarding Hausa girls also reflects the effect of poverty intersected with social and cultural practices, beliefs, and attitudes regarding education as well as gender issues. There are also wide discrepancies in educational achievement between females in urban and rural areas, as reflected in the data shown in Table 2.1.

Table 2.1 Females age six and above by highest level of schooling attended or completed, percentage

Background characteristic	No education	Some primary	Completed Primary	Some secondary	Completed secondary	More than secondary
Zone						
North Central	39.3	23.8	10.9	12.4	7.1	4.8
North East	65.5	15.9	5.9	6.5	2.8	1.3
North West	67.5	13.1	6.8	4.6	3.1	1.5
South East	20.8	23.2	13.8	17.4	15.9	7.6
South South	14.9	22.0	15.7	22.3	16.2	7.9
South West	21.5	19.2	13.5	17.6	17.4	9.9
Residence						
Urban	22.0	19.2	11.3	17.2	17.5	11.4
Rural	48.9	18.7	10.6	10.8	6.5	2.5
National	39.9	18.9	10.9	12.9	10.2	5.4

Source: NPC & ICF Macro, 2009.

2.3 Cultural characteristics and rights

Nigeria is an ethnically and culturally diverse country, with about 374 identifiable ethnic groups (NPC & ICF Macro, 2009). The *Hausas* in the north, the *Yorubas* in the southwest, and the *Igbos* in the southeast are the three largest ethnic groups: together, they make up more than half of the country's population. While the country's rich cultural diversity is a source of pride and strength, it also poses challenges. Ethnic differences have sometimes led to inter-tribal and/or inter-community tension; some of these conflicts were violent in nature. Issues of land tenure, resource control, economic marginalisation and deprivation have featured prominently in inter-ethnic clashes.

In terms of religion, Nigeria is a pluralist country with three main religions – Christianity, Islam, and African traditional religion. Nigeria's constitution guarantees freedom of religious beliefs and practices. The population of the core north, consisting of the North east and North west zones, is almost completely Islamic whereas the population of the South south and South east zones is almost completely Christian. The population of the North central zone consists of almost two-thirds Christians and one-third Muslims (Singh et al., 2004). Muslims comprise about one third of the population in the South west. Adherents of African traditional religion are found all over the country, although in much smaller numbers than Christians and Muslims. While all three main religions preach harmonious living and peaceful co-existence, religious pluralism can challenge Nigeria's social stability and its hard-won democracy. An example of this is the colliding religious and cultural beliefs of new radical Christian evangelical and fundamentalist Muslim sects (Uzoma, 2004). Religion, indeed, has been a major factor in a number of violent conflicts that the country has witnessed over the years. It is important to note, however, that while some of these conflicts are motivated by religion, for example the *Boko Haram* religious uprisings in some parts of northern Nigeria in 2010, at other times religion is used as a cover for disputes over land, other resources, and political struggles.

Women and children are often the first casualties of communal conflict. Violent conflict in particular, often leads to mass internal migration of affected communities after destruction of lives and property. Such displacement often leads to breakdown in family structures and support systems with children and women suffering neglect and insecurity furthering their vulnerability to discrimination and dangers. Women and female children also become victims of rape and other forms of gender-based violence in situations of civil strife and violent uprisings. Women and children are usually deprived of their breadwinner as a result of death or serious injury, with significant negative impact on the economic health and overall well-being of the family. In an effort to survive economically in such situations, women and girls may be forced to resort to prostitution,

thereby increasing their risk for contracting HIV and other sexually transmitted infections. Children may also be forced into child labour or become victims of child trafficking in the aftermath of losing their caregivers in violent conflict. Children, women, and indeed the entire household may suffer lifelong traumatic social and psychological consequences due to armed conflict. Violent conflict can cause violations of the rights of girls and women and prevent them from fulfilling their aspirations as well as those of their families.

Unfortunately, Nigeria has experienced an increased number of violent inter-ethnic clashes in recent years in various parts of the country. The Jos crisis is an example of where a once serene and peaceful town has witnessed recurrent clashes. During the 2008-2010 period the Jos metropolis experienced more violent inter-ethnic clashes than perhaps at any other time in its history. The core issue is lack of tolerance between the Hausa-Fulani, who are predominantly Muslim, and the “indigenes” who are predominantly Christian (with Berom, Anaguta and Afizere as the three major native tribes). The planting and detonation of bombs at several locations in the town of Jos on Christmas Day 2010 marked a new and more dangerous development. There are significant gaps in the authorities’ capacity to handle such episodes effectively and prevent new attacks. The political will to identify and deal decisively with perpetrators also appears to be weak or lacking on the part of the government. Bombing was also experienced twice in Abuja in 2010, with the first occasion being the 50th anniversary of the country’s independence from the British (1st October 2010). Delta State also witnessed a bombing. On the other hand, The Niger Delta, which has been a hotbed of violent community actions, has experienced some respite in the last two years following the offer of amnesty to militants in the region and initiation of a rehabilitation programme for them by the federal government.

Cultural practices in Nigeria have drawn much influence from the three main religions – Christianity, Islam and African traditional religion. Across cultures, many common traits can be observed in areas such as value systems, property (land) rights, marriage rites, women’s rights, and social justice. These cultural practices are promoted and sustained by traditional authority, a system of leadership that pre-dates colonial rule. While traditional authority has undergone modifications to accommodate the authority of modern government, it still remains powerful and influential in the lives of Nigerians - so much so that highly educated persons and holders of office in modern government are increasingly being recruited into the offices of traditional authority. At the helm of traditional authority is usually one traditional ruler supported by a group of advisers.

Traditional rulers are generally the custodians of culture for the individual communities. They are the symbol of absolute authority and normally hold office for life. They are given due recognition by government and in some respect they still represent the people as they seek to advance the people’s dreams and aspirations. While the influence of traditional rulers in the urban south on the day to day living of the people is somewhat minimal, traditional rulers exert significant authority and influence in rural areas of the south. Traditional rulers have immense influence in the north over the civil and religious lives of the people, providing leadership in general affairs as well as spirituality. The Sultan of Sokoto, for example, is the spiritual leader of the *Muslim uma* and his exalted office carries with it considerable political authority. Traditional rulers in the south, while not carrying the same level of spiritual authority as those in the core north, also have some specific leadership roles in the context of traditional religion. Traditional rulers may also play an important role in influencing politics and policies of government, although largely informally. While they do not have a constitutionally defined role, traditional rulers are often consulted formally and informally by political leaders and leaders of government owned companies. While political leaders have authority over traditional rulers in that they approve their appointments and pay their salaries, traditional authority exercises influence over modern political leaders through the award of traditional titles. Overall, therefore, traditional institutions still matter a great deal in Nigeria and do enjoy the approval and trust of the population to different degrees. There has been an increased

demand for constitutional roles for traditional rulers, whose authority in principle has been limited by the fact that their appointment is subject to the approval of the modern government at various levels.

As custodians of the people's culture and respected leaders, traditional leaders may play an important role in health development activities and social development issues and are therefore in a position to influence issues relating to the rights of women and children. One important recent example in this respect is the role of traditional rulers in promoting child immunisation in Nigeria. The support of the traditional leaders turned the tide in a situation where the people had earlier largely refused immunisation, and as a result the immunisation rate has gone up significantly. Traditional leaders in the north are also increasingly approached by health and development professionals seeking support for their programmes in the hope of furthering their acceptance. For example, there is increasing advocacy targeted at traditional rulers in the north to win their support for various issues related to children and women, including family planning and child spacing programmes, girls education, discouragement of child marriage, and abolition of child trafficking.

Culture and religion influence the position of a person in the family and also in the community. In fact, in many Nigerian cultures, the rights of children and women are very clearly demarcated and understood. The level of participation of children and women in household decision-making processes and their rights to inheritance and ownership of strategic resources such as land differ from one culture to another, and do have implications for their welfare. In many other areas of practice there is apparent convergence or commonality between many Nigerian cultures in terms of the place of children and women. It is generally held that children cannot lay claim to rights of their own, but must 'grow out of their childhood' to gain their rights as adults. Children's rights are privileges to be dispensed by the adult members of the household and the surrounding community. For example, as the 2008 NDHS reported, women's involvement in decision-making increased with age from a low 15.6 percent among adolescents aged 15-19 to a much higher 36.1 percent among women aged 45-49. Women play important roles in their communities across all Nigerian cultures. These include traditional home keeping as well as fundamental biological and social roles of child bearing and rearing. Traditional home keeping is made more labour intensive and difficult by the absence of modern facilities such as piped water, piped gas for cooking, and electricity to help preserve food and cooked meals for later use.

The burden of traditional home keeping in a typical household is borne almost exclusively by mothers and their daughters. Under the stress of modern life, whose effects have spread to rural areas, the role of women has expanded to include making a financial contribution to the family. This participation has been aided in large part by rising urbanisation and educational attainment and also for reasons of necessity, such as widowhood. The socio-economic status of households is an important factor affecting the roles played by women. Women in poor households have less decision-making power than women in rich households. Financial contribution to the household by women increases their probability of participating in decision-making. Interestingly, the 2008 NDHS reported that nearly 75 percent of women and about 66 percent of married women who earned cash income decided on their own how to spend the money, while 16 percent of women and 20 percent of married women decided jointly with someone else or their husbands. It is reasonable to conclude from the foregoing that the greater the contribution of a married woman to household expenditure, the higher the likelihood of an independent or joint decision with the husband on the use of funds. In terms of geopolitical zones, women in the South west and North west are considered to have greater autonomy over the use of their earnings than women in other zones. Employment and income earning capacity are therefore a major means of empowerment for women. Education is the major instrument for access to employment and income; the educational disadvantage of women limits their employment opportunities, income earning capacities, and ability to assume expanded roles, including decision-making in homes. To date, educational

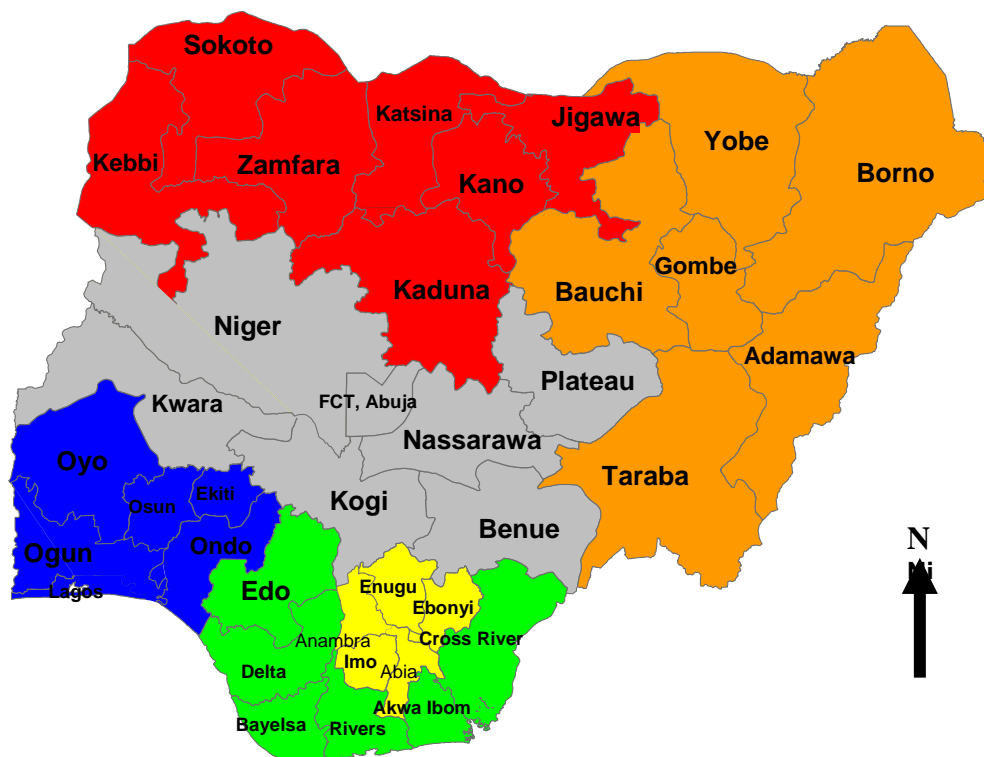
attainment of females remains lower than that of males in Nigeria – in the northern zones this difference is particularly striking.

While a number of cultural beliefs and practices in some Nigerian communities, such as widowhood rites, denial of access to inheritance, and female circumcision, negatively affect the realisation of rights of children and women, Nigeria’s culture also supports the well being of children and women, and promotes their rights. These cultural resources include strong family networks that encourage pooling of resources and responsibility sharing that help cushion the burden of childcare on the parents. Examples of such responsibility sharing include foster care, financial support to economically disadvantaged family members from more economically endowed relatives, and community-wide assistance to the vulnerable in times of need such as disasters and conflicts.

2.4 Political economy and governance

The Nigerian federation consists of 36 states and the Federal Capital Territory of Abuja. Each state is divided into Local Government Areas (LGAs), and at present there are 774 local councils. The Federal Government operates at the apex of the governance structure. States and LGAs operate the second and third tier respectively. For operational convenience, the country has been divided into six geo-political zones: North east, North west, North central, South east, South west and South south (Figure 2.3). This zonal classification is used for the execution of some national programmes and in determining certain political appointments/representations at the federal level. However, these zones have no constitutional basis and, therefore, no particular political or even economic significance and intra-zonal activities are rare.

Figure 2.3 The geo-political zones of Nigeria



- North East
- North West
- North Central
- South East
- South West
- South South

Although LGAs are recognised by the constitution, the extent of autonomy they are to enjoy from their respective state government remains an unsettled issue. The commitment of the Local Government Councils to the development of their areas of jurisdiction has also remained debatable. Although the constitutional roles of the three tiers of government appear well defined in principle, in practice the roles can be unclear in a number of areas including health, education, and provision of water and sanitation that are on the concurrent legislative agenda, much to the detriment of the welfare of the population.

2.4.1 Political situation

The presidential election held on 21 April 2007, which declared the presidential candidate of the People's Democratic Party, Alhaji Umaru Musa Yar'Adua as the winner with 70 percent of all valid votes (24.6 million votes), marked Nigeria's first successful transition from one democratic regime to another. The result of the election was, however, not without controversies in terms of freeness and fairness. President Yar'Adua, in his inaugural address on 29 May 2007 acknowledged that the election that ushered him into the office was not flawless; he accompanied the admission with the setting up of a committee on electoral reform to improve the electoral process and ensure credibility. The new government emphasised commitment to the rule of law and due process and declared a 7-point agenda focusing on energy, security, wealth creation, education, land reform, mass transit, and the Niger Delta. The agenda is expected to launch the country on the pathway of becoming one of the world's largest economies by 2020 (Vision 20:2020).

The health problems experienced by President Yar'Adua posed a major challenge to effective governance at the federal level during his 35-month period in office, as he had to undertake repeated trips abroad for medical treatment. In the words of a national magazine, the president's prolonged illness "was a distraction in the exercise of his mandate, which made it impossible for him to govern a nation beset with gargantuan challenges in economy, electoral system, road infrastructure, education, health, among others" (Tell, 2010). President Yar'Adua left Nigeria unannounced on 23 November 2009, reportedly to receive treatment for a severe heart condition in Saudi Arabia and was never seen in public thereafter until his death on 5 May 2010.

The president's absence from the country for a period of three months for medical treatment, without handing over formally to the Vice President in writing as demanded by section 145 of the 1999 constitution, created a power vacuum and constituted a major political challenge. The National Assembly resolved the challenge on 9 February 2010 by employing the "doctrine of necessity" in passing a resolution that presidential power be transferred to the Vice President, Dr. Goodluck Azikwe Ebele Jonathan, to serve as the Acting President with all the accompanied authority. President Goodluck Jonathan was immediately sworn in as the country's President. The emphasis of President Jonathan's government is on the reform of the power sector, ensuring credibility of the electoral process, and the sustenance of peace and development of the Niger Delta. Efforts in these areas appear to be on course: plans for restructuring the power sector have been made public and negotiations undertaken with foreign partners; a new Chairman, widely acknowledged for his credibility, has been appointed for the Independent National Electoral Commission, and an amended constitution with a modified electoral process has been signed into law; and the rehabilitation programme for ex-militants in the Niger Delta is being actively implemented.

The electoral system has also received a boost by a series of court judgements in gubernatorial election petitions that have affirmed the independence of the judicial system. The various court judgements have resulted in the sacking of the previous governors of Osun, Ondo and Ekiti States – who are all from the ruling party (PDP) and they have been replaced with candidates of rival parties. Re-election has also been ordered in some states by the court.

2.4.2 Economic situation and poverty

Nigeria is the eighth largest oil exporter in the world and Africa's second largest economy. The global economic crisis of 2009 also affected the Nigerian economy. However, the reforms initiated earlier in the decade have strengthened the country's capacity to manage the crisis and avert the boom-bust pattern characteristic of past oil cycles. Provisional data from the National Bureau of Statistics (NBS 2010) indicate that the Gross Domestic Product (GDP) at 1990 constant basic prices grew by 5.1 percent in the first half of 2009 compared with 5.2 percent in the corresponding period of 2008. The growth was driven by the non-oil sector that expanded by 8 percent and contributed 85.6 percent to the GDP.

At 215.3 (1990=100), the provisional aggregated index of agricultural production increased by 5.4 percent, compared with 4.8 percent in the corresponding half of 2008. Activities in the industrial sector declined as the index of production at 115.23 at 1990 prices fell by 2.9 percent below the level in the first half of 2008. The poor industrial performance reflected the deficient infrastructural facilities, especially electricity supplies. Crude oil production including condensates continued to decline; average production dropped by 0.18 million barrels per day (mbd) below the level in the first half of 2008 to 1.76 mbd in the first half of 2009. The projected growth for 2010 was 4.4 percent and 5.5 percent in 2011. The increase in the growth rate is expected to be propelled by recovery in oil prices, which now oscillates around \$82 per barrel. Oil accounts for about 80 percent of fiscal revenues and 95 percent of exports. Oil revenues fell by 7.8 percentage points of GDP in 2009, moving the fiscal account from a surplus of 3.8 percent of GDP in 2008 to a deficit of 5.2 percent in 2009.

Without doubt, the monetary policy coming from the Central Bank Governor Mallam Sanusi has a positive outlook on the economy, which has been growing at the rate of 7.3 percent and attracts investments mostly in the petroleum sector. The revised estimate for the real Gross Domestic Product by the National Bureau of Statistics indicates that the economy grew by 7.23 percent in the first quarter of 2010, against 6.7 percent for the previous year. This is impressive when compared with the world economy, which was expected to be growing at the rate 3.9 percent in 2010 as a result of the global financial crisis.

The external debt at the end of 2009 was about 2.2 percent of GDP, suggesting that debt sustainability may not be a major problem for the country. More importantly, a significant proportion of the debt service payments are made towards loans obtained for specific sector projects. For example, more than 77 percent of the loans currently outstanding against Nigeria are in health and social services, agriculture, education and training, transport and power. Because the country is committed to ensuring that debt does not become a burden, a Debt Sustainability Analysis (DSA) has been conducted every year since 2005. Apart from the Debt Management Office (DMO) that leads the process, other Ministries, Departments and Agencies (MDAs) involved include the Ministry of Finance, the Central Bank of Nigeria (CBN), the National Planning Commission (NPC), the Budget Office of the Federation and National Bureau of Statistics (NBS). The DSA involves various scenarios and stress tests (internal and external shocks), including various levels of drops in price and production of oil. In essence, the government is sensitive to the vulnerability of the economy as a result of the historical overdependence on oil revenue, and therefore is influenced to be conservative in its adoption of the threshold of 25 percent of the GDP. To this end, the government is embarking on aggressive Tax and Customs reforms to shore up revenue generation.

2.4.3 Poverty and social protection

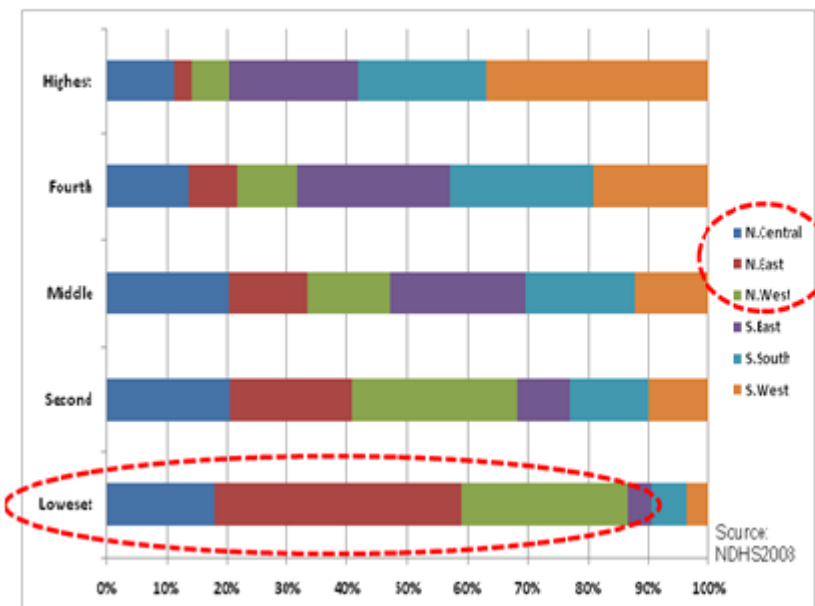
Over half of all Nigerians (54 percent) live below the poverty line. Both income poverty and food poverty is higher in rural areas. While 64 percent of the population lives below the income poverty line in rural areas, in urban areas the corresponding figure is 44 percent. Just over a quarter (27

percent) of the urban population is below the food poverty line. In rural areas this figure rises to 44 percent.

Urban poor are likely to have better access to services. For example, although an estimated 73 percent of urban dwellers have access to safe water, only 40 percent of rural residents have the same access. However, the depth of poverty is more acute in urban areas: the income gap of the poor in relation to the poverty line is 27 percent compared to 17 percent in rural areas.

Figure 2.4 Geo-political disparity in wealth quintiles

Nearly 90% of the lowest quintile concentrated in Northern 3 zones



Geographic location has a strong impact on consumption and poverty; people living in the northern regions fare considerably worse than those living in the rest of the country (Figure 2.4). The poverty incidence is highest in the North east zone (67.3 percent) and least in the South east zone (34.2 percent). More than half of Nigerians living in the northern and South-South zones are poor. Further, nearly 90 percent in the lowest income quintile live in the three northern zones.

Factors known to be sustaining poverty in these areas include illiteracy, low productivity, poor infrastructure, and unemployment. Additional factors in the South south zone include social instability, poor local governance, competition for economic resources, and environmental degradation.

Female-headed households on average have lower poverty levels. They tend to be smaller in size and their educational level is generally higher, both characteristics associated with higher expenditure levels. Female-headed households constitute about 16 percent of total households. Women in non-poor households have much more decision power than women in poor households for virtually all areas of spending. Women spend substantially more time than men on domestic tasks in both rural and urban areas. This difference starts quite young with girls aged 6-14 spending one-third more time on domestic tasks than boys the same age. Access to water and/or power has an important impact on time use for women in both urban and rural areas, substantially reducing the amount of time women spend on domestic tasks. Women and girls more than boys and men lack access to productive resources and opportunities. This is a challenge that requires more than the creation of employment opportunities or the provision of social services. Factors that impede women's access to available resources and opportunities in Nigeria are related to patriarchal norms.

These norms are often reinforced by the educational curricula and more covertly by legal and institutional frameworks and they shape individual and communal knowledge, attitudes and practices.

Vision 20:2020 recognises Nigeria's need to extend social security to all its citizens. However, the country's social protection system is primarily focused on the formal sector with attempts currently being made to extend safety nets to the poor and vulnerable. Citizens employed in the formal sector through the National Social Insurance Trust Fund, National Poverty Eradication Programme supported by Debt Relief Grants have extended cash transfers to the poor. Several states, including those assisted by UNICEF are trialling conditional cash transfers as incentive for education, especially for girls. The National Health Insurance Scheme has piloted a scheme to cover pregnant women and children under five in 12 states with plans to scale up to all states by 2011. There is almost no link between the weak child protection systems and the programmes extending cash transfers. Policy coordination on social protection issues remains weak, and the institutional responsibility for the sector is fragmented among different MDAs.

2.5 National economic development blueprint

Vision 20:2020 is Nigeria's current Economic Transformation Blueprint. It is a plan that aims at positioning Nigeria as one of the 20 largest economies in the world by the year 2020 with a Gross Domestic Product (GDP) of not less than \$900 billion and a per capita income of over \$4,000. It was approved by the Federal Executive Council in 2009. The blueprint lays out the path for rapid and sustainable growth of the country's economy. The Vision is for Nigeria to "have a large, strong, diversified, competitive and, technologically enabled economy that effectively harnesses the talents and energy of its people and responsibly exploits its natural endowments to guarantee a high standard of living and quality of life for its citizens".

The blueprint has five main chapters. Chapter one covers the macroeconomic framework including the propositions and projections designed to place the country on a robust double-digit growth trajectory from 2010 to 2020. Chapters 2 to 4 of the blueprint consist of three pillars on which the mainframe of the vision is constructed, namely: Guaranteeing the Well-being and Productivity of the people of Nigeria; Optimizing the Key sources of Economic Growth; and Fostering Sustainable Social and Economic Development. Among the core objectives of the Vision are guaranteeing affordable housing, access to finance, quality healthcare, potable water and sanitation, sustainable livelihood and an educational system that is functional, qualitative and employment inducing. The Vision identifies minerals and metals, agriculture, oil and gas, production of processed and manufactured goods for export, textiles and leather wares as the key sources of economic growth. The blueprint is also emphatic on policy measures to be put in place to achieve the objectives of optimizing the contributions of the different sectors to GDP. The blueprint emphasises the enthronement of an efficient, accountable, transparent and participatory governance system for the country.

In view of the nation's failure at implementing previous national development plans, the Vision 20:2020 blueprint includes the institutionalization of an effective, nation-wide Monitoring and Evaluation system that will hold successive governments accountable and responsible for results, while at the same time increasing their capacity for project implementation. Also, new legislation and the amendments of some existing laws bind successive governments to the implementation of the blueprint and ensure the delivery of Vision 20:2020.

2.6 Growth and economic indicators

2.6.1 Economic growth

Nigeria has been experiencing economic growth from 2005 to 2010. In fact in the first quarter of

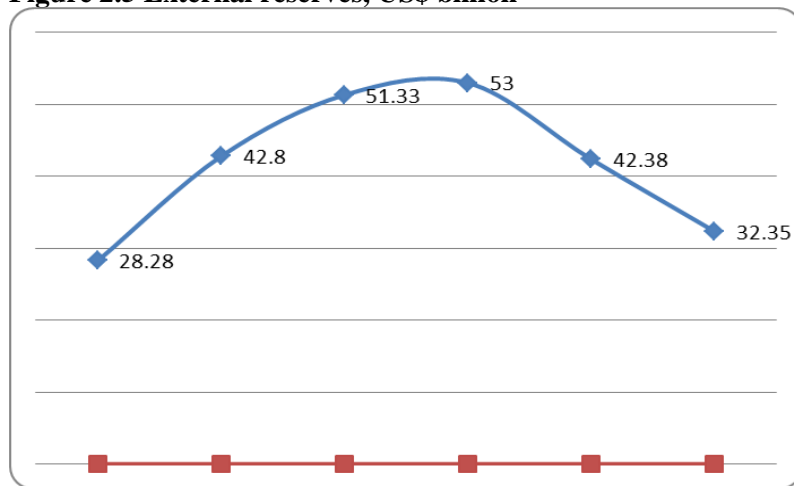
2010, the Nigerian economy grew by 7.2 percent compared to 4.5 percent growth in the same period in 2009 mainly due to increased oil production compared to the previous year. The increase in oil production came from a reduction in militant attacks and some movement in the peace and disarmament process. Another factor has been the improvement in the global economy after the global financial crisis of 2009. The major driver of growth during this period was agriculture, oil, wholesale and retail trade. Preliminary estimates by the World Bank however indicate that all things being equal, Nigeria would need 8 percent growth rate for the next 10 years to meet the MDG target of halving the prevalence of poverty by 2015 (World Bank, 2007). An implicit assumption in this calculation that a sustained 8 percent growth is necessary and sufficient to meet this MDG target is that there is a reduction in income inequality, estimated at 49 percent, as growth occurs, and that such growth is pro-poor and based on productivity gains and value-addition.

2.6.2 Exchange rate

The last six years have witnessed sustained high crude oil prices, higher than approved budget benchmarks in the preceding years. This has aided accumulation of both excess crude oil and other reserves. Nigeria’s gross official reserves stood at about US\$40 billion at the end of 2006. The foreign exchange market in 2009 experienced considerable demand pressure relative to the corresponding period of 2008, owing to the speculative activities triggered by the de-accumulation of external reserves in the aftermath of the global financial crisis in 2009.

In fact, due to the global financial crisis, the Central Bank of Nigeria injected funds into the banking system in August 2009 when five major banks that accounted for about a third of banking sector assets became financially distressed as a result of excessive lending to their customers and the crash in the stock market. The foreign exchange market was hit by speculative activities that were triggered by a fall in external reserve (Figure 2.5) in the wake of the global recession.

Figure 2.5 External reserves, US\$ billion



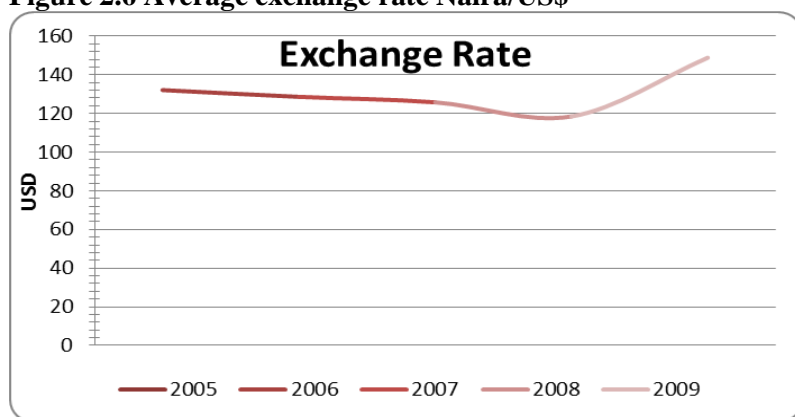
Source: CBN 2009, FGN Budget 2010.

The present level of reserves at about \$32.35 billion provides about 8 months of import cover for goods and services compared to international standards that prescribe 3 months of import cover. The reduction in the reserves level is attributed to the increased demand for foreign exchange in line with increased economic activities by the public and private sectors, including the outlays on the power sector by the three tiers of Government, and the seed money for the Sovereign Wealth Fund.

Consequently, foreign exchange demand by authorised dealers at the retail Dutch Auction System (rDAS) and Bureau de Change (BDC) segments of the markets rose substantially leading to the depreciation of the domestic currency. The average exchange rate of the Naira vis-à-vis the US dollar depreciated in 2009 by 20 and 29 percent in the rDAS and BDC segments of the market,

respectively, relative to the levels in the corresponding period of 2008. Furthermore, foreign exchange inflows into the economy contracted, reflecting the drop in Nigeria's crude oil earnings, while outflows increased owing to the increased funding of the rDAS segment of the foreign exchange market. Consequently, a net inflow of \$10.1 billion was recorded at the end of the first half of 2009, compared with \$37.7 billion in the corresponding period of 2008. Thus, the exchange rate depreciated from 119 Nigerian Naira (₦) to the US Dollar in 2008 to ₦150 in 2009 (Figure 2.6). However, the exchange rate has been relatively stable since. The Central Bank of Nigeria has been able to defend the Naira exchange rate within a specified band using the reserves in order to give confidence to the nation's international and local investors. Indeed the stable Naira policy was also critical in the aftermath of the capital market collapse as one of the measures taken to resolve threats to the stability of the banking sector. The CBN is conscious of the need to maintain a robust level of reserves by working with the fiscal authorities to ensure this.

Figure 2.6 Average exchange rate Naira/US\$

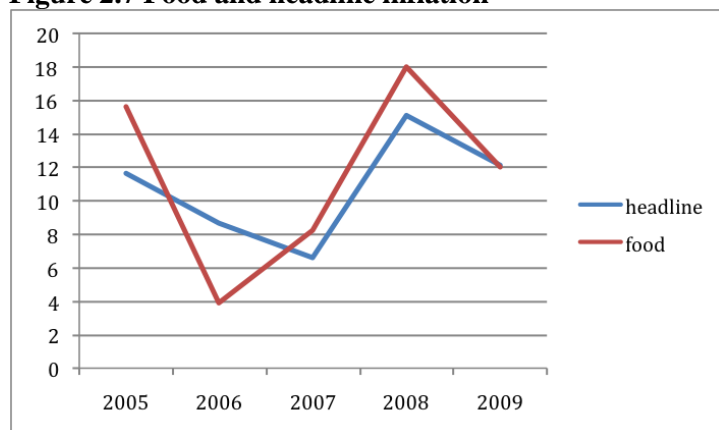


Source: CBN, 2009.

2.6.3 Inflation rate

Inflationary pressure declined as the headline (i.e. raw) inflation year-on-year dropped from 11.6 percent in 2005 through 8.6 percent in 2006 to 6.6 percent in 2007 (Figure 2.7). However, inflationary pressure rose sharply in 2008 to 15.1 percent before dropping to 12.1 percent in 2009.

Figure 2.7 Food and headline inflation



Source: CBN, 2009.

The food price inflation dropped from 15.6 percent in 2005 to 3.9 percent in 2006. However, it rose sharply to 8.2 percent in 2007 and 18 percent in 2008 and finally dropped to 12 percent in 2009. The farmer is also confronted with worsening domestic terms of trade such that a good harvest, which given the price inelasticity for food, lowers the prices of foodstuff but not the cost of production nor the prices of non-food items which he or she buys. While government has taken steps to curb inflation, the current situation is adversely affecting net consumers' purchasing power,

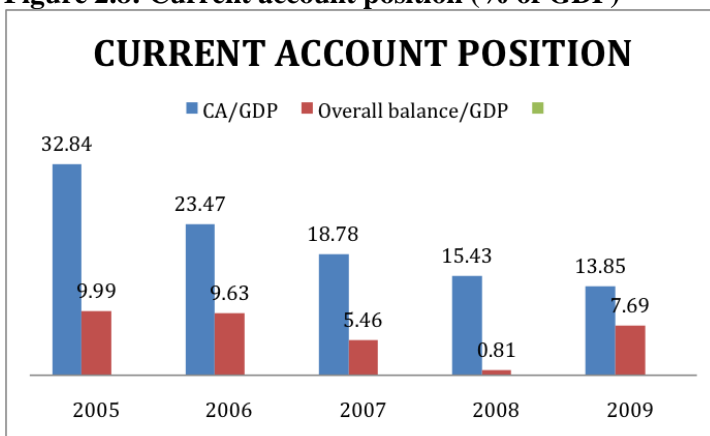
particularly the poor, restricting their access to food and non-food items. An assessment of the rising food prices in Nigeria conducted by the Food Security Theme Group supported by the Food and Agriculture Organisation (FAO), points out the negative impact on poor households of increased prices but also indicates that higher prices led to a growth spurt for some of the crops.

The steady decline of inflation rate recorded so far is expected to engender a favourable macroeconomic environment in the country. Thus, the real GDP growth rate is projected to improve. This is premised on the expected rise in agricultural output resulting from government initiatives, particularly the partial disbursement of the ₦200 billion commercial agriculture fund and favourable weather conditions across the country. The growth in industrial output is expected to remain unimpressive except the proposed Federal Government Investment in the power sector that yields positive results. Crude oil production is expected to be boosted following anticipated increase in global oil demand and the quick resolution of the Niger Delta crisis. The prospect of increased foreign exchange inflows would improve the overall balance of payment position and engender stability in the foreign exchange market.

2.6.4 Balance of payments

Though there were improvements in the country’s balance of payments (BOP) in 2002 rising steadily to 10 percent and 11 percent between 2004 and 2006, respectively, there has been pressure on Nigeria’s external sector since 2008. The pressure witnessed since the second half of 2008 persisted as the overall deficit in the balance of payments widened by 54.9 percent to ₦1,134 billion. The overall balance of payment to GDP ratio fell from 9.99 percent in 2005 through 9.63 percent in 2006 to 0.81 percent in 2008 and rose again to 7.69 percent in 2009. Current Account as a ratio of GDP fell from 32.8 percent in 2005 through 9.63 percent in 2006 to 0.81 percent in 2008 and rose again to 7.69 percent in 2009 (see Figure 2.8). This development reflected the unfavourable macroeconomic environment induced by the global financial crisis as well as the drop in the value of crude oil exports.

Figure 2.8: Current account position (% of GDP)



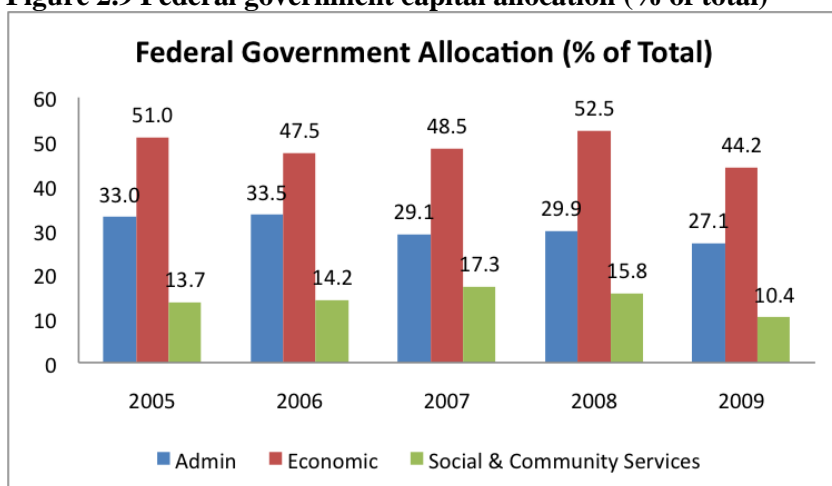
Source: CBN, 2009.

2.6.5 Budget and social services sector

The structure of planned expenditure of government at the federal level in the period 2005 to 2009 did not show evidence of priority status accorded social services as the budget share of the sector persistently lagged behind other sectors like administration and economic services. The share of social and community services spending rose from 13.7 percent of total capital spending in 2005 to 17.3 percent in 2007. However it declined to 10.4 percent in the first quarter of 2009 according to CBN reports. Also, another easily observable expenditure pattern over the period is the high variability in allocations to social services implied by the wide range. Both the relatively low allocation and the variability might delay the realization of the MDGs and poverty reduction in general (Figure 2.9).

Thus, although the social services sector has the greatest potential to contribute to the poverty reduction goal of Vision 20:2020 and attainment of the MDGs, the sector has not enjoyed priority attention in terms of public sector resource commitment at the federal level. Priority attention to social services, particularly education and health, is fundamental to the realisation of children’s rights. The lack of this, at least from the perspective of the budget, is alarming even though it is recognized that budgetary allocations alone are unable to solve all the problems faced by women and children. The provision of health and education facilities, which is a concurrent responsibility of all tiers of government, would normally require that the share of resources devoted to both increase as the population grows and changes in structure. The statistics above do not show such progression, and this is clearly detrimental to the realisation of the government’s goals of reducing poverty through improvements in health and education outcomes.

Figure 2.9 Federal government capital allocation (% of total)

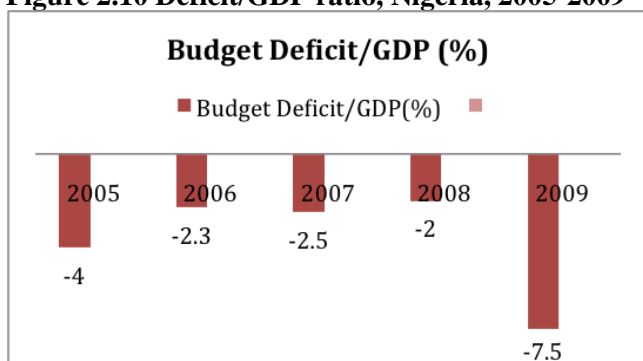


Source: CBN, 2009.

2.6.6 Budget deficit

The healthy trend in the macroeconomic indicators is also reflected in the decline in the Federal Government budget deficits. As Figure 2.10 shows, the deficit to GDP ratio that stood at 4 percent in 2005 declined to about 2 percent in 2008 before rising to about 7.5 percent in 2009. These improvements are the result of two main factors: the increase in the revenue from the oil sector and fiscal discipline, which is the hallmark of current budget process in Nigeria. Some of the key elements of the reform aimed at reducing wastage and corrupt leakage in the management of public resources are the establishment of the Budget Monitoring and Price Intelligence Unit, popularly known as Due Process Office, the monetisation of fringe benefits in the public service, the introduction of the medium term expenditure framework (MTEF) and the recently enacted Fiscal Responsibility law.

Figure 2.10 Deficit/GDP ratio, Nigeria, 2005-2009



Source: CBN, 2009.

3. Maternal and Child Survival

3.1 Introduction

This chapter focuses on maternal and child survival. It seeks to collate information and data at the national and sub-national levels, taking the issue of equity into account. Based on the concept of continuum of care, this chapter identifies areas of focus in child survival and maternal health where scaling up interventions in line with the national strategy is appropriate.

With five years to go until the 2015 deadline, maternal and under-five mortality rates are now significantly below the MDG targets in developed and many developing countries. The global maternal mortality rate is 22 deaths per 100,000 women, and 7 out of 1000 children die before the age of five (UNICEF, 2009). In Nigeria, the under-five mortality rate has been reduced from 187 to 157 deaths per 1,000 live births, and maternal deaths have been reduced from 800 to 545 deaths per 100,000 live births (NPC & ICF Macro, 2009). Despite this progress since the 2007 Situation Analysis, Nigeria, as this chapter will discuss, is still not on course to achieve all the MDG goals. The impediment to accelerated reduction of these deaths is not the lack of know-how and resources, as noted in the 2007 Situation Analysis, but structural and system wide weaknesses limiting access to services.

This chapter highlights the wide variation between zones, the impact of level of poverty on mortality and morbidity as well as on access to health services. An argument is made for the need to apply ‘an equity lens’ when planning and delivering services in order to fast track the achievement of the MDG targets.

3.2 Nigeria’s development planning, Human Development Index and life expectancy

Life expectancy in Nigeria is low, but increased slightly between 2000 and 2007. For males, life expectancy at birth increased from 46 years in 2000 to 48 years in 2007, while for females it increased from 48 years to 50 years within the same period. For both sexes combined, life expectancy increased from 47 years to 49 years between 2000 and 2007 (WHO, 2009). Nigeria’s current life expectancy level is lower than that of many of her less economically endowed neighbours, including Burkina Faso (52 years), Cameroun (50 years), Gabon (57 years), Gambia (59 years), Ghana (60 years), Guinea (56 years), and Senegal (63 years) (UNICEF, 2009).

Nigeria’s performance continues to be poor, remaining consistently in the low human development category. The “Human Development Index Trend, 1980 – 2010”, published in the 2010 UNDP Human Development Report shows that Nigeria has hardly made any progress in its human development score between 2005 and 2010 (UNDP, 2010). The human development score for 2005 was 0.402 while the value for 2009 and 2010 was 0.419 and 0.423 respectively. Nigeria’s 2010 HDI rank of 142 out of 169 countries is poorer than that of several developing countries. For example, the following West African neighbours, though less naturally endowed, ranked better than Nigeria: Ghana (ranked 130), Cameroun (ranked 131), Benin (ranked 134), and Togo (ranked 139).

Since the 2007 Situation Analysis, Nigeria’s long term development planning came together in the plan referred to as Vision 20:2020, which foresees Nigeria in “2020 among the 20 largest economies in the world” (National Planning Commission, 2009). The plan recognises the centrality of health and aims for a future where the country “supports and sustains a life expectancy of not less than 70 years and reduces the burden of infectious diseases”. Better economic performance between 2003 and 2009 have seen GDP grow by 236%, moving the country from a global ranking of 52 to 43, a change of about 17%. This would suggest that with focus, the framework objective is achievable.

The worrying trend is the limited impact this economic growth has in terms of the quality of life of the citizens. Life expectancy at birth actually decreased by 3 years in Nigeria in the 5-year period from 2003 until 2008, dropping from 51 years in to 48 years. Nigeria is often compared to the BRICS¹ countries, and among these the life expectancy in Brazil increased with 4 years from 68 in the same five-year period. It is against this background that President Goodluck Jonathan outlined the need for a more “equitable and broad based approach to achieving the MDG goals” in his statement at the 65th session of the UN (Jonathan, 2010).

3.3 Maternal, newborn and child mortality in Nigeria

There are a number of different estimates for maternal and child mortality in Nigeria (Table 3.1), but the consensus is that not enough progress is being made. Owing to its large population and high rates of mortality, Nigeria has the highest number of neonatal and maternal deaths of any country in Africa. Nigeria has the second highest number of neonatal deaths worldwide. About 8 percent of the world’s neonatal deaths and approximately 1 in every 9 maternal deaths worldwide are in Nigeria. There are wide variations in neonatal mortality rates between states, which mirror disparities in other health outcomes.

Table 3.1 Maternal, neonatal, and under-five mortality trends in Nigeria

	1990			1995			2000			2005			2008		
	NMR	U5MR	MMR	NMR	U5MR	MMR	NMR	U5MR	MMR	NMR	U5MR	MMR	NMR	U5MR	MMR
NDHS	42	192	-	-	-	-	37 (1999)	140 (1999)	-	48 (2003)	201 (2003)	-	40	157	545
UN	49	230	1100	49	230	1100	46	207	980	42	194	900	40	186	840
IHME	49	194	473	47	187	-	45	177	694	43	165	-	42	160	608

Source: NPC & ORC Macro, 2000; NPC & ORC Macro, 2004; NPC & ICF Macro, 2009, Ahman & Zupan, 2007; WHO UNICEF, UNFPA, & World Bank, 2010; Hogan et al., 2010; Rajaratnam et al., 2010.

3.3.1 Maternal mortality

A staggering 33,000 Nigerian women die each year giving birth, and for every maternal death at least seven newborns die and another four are stillborn (FMOH, 2011). Meeting MDG 5 for maternal survival will require a 75 percent reduction in the maternal mortality ratio (MMR) from an estimated 1,100 maternal deaths per 100,000 live births at baseline in 1990 to 275 per 100,000 live births by 2015. The UN-modelled MMR for 2008 is 840 deaths per 100,000 live births with uncertainty bounds of 460–1,500, which encompasses the other estimates from Institute for Health Metrics and Evaluation (IHME) and NDHS (Table 3.1). While some uncertainty surrounds the exact estimate, these figures are much too high compared with industrialized countries, where the average MMR is 8; the figure is as low as 4 in some countries. The most common causes of maternal mortality in Nigeria are post-partum haemorrhage (accounting for 23 percent), hypertensive disease of pregnancy (11 percent), malaria (11 percent), anaemia (11 percent), prolonged obstructed labour (11 percent), postpartum infection (puerperal sepsis) (11 percent), and unsafe abortion (11 percent). Other causes, including HIV and AIDS, contribute to about 5 percent of maternal mortality (FMOH 2007, 2011).

The gains recorded in reduced maternal mortality rate likely resulted from deploying and embedding the right strategies. However it is noteworthy that while the MMR has declined,

¹ BRICS refers to Brazil, Russia, India, China and South Africa – a group of emerging countries that Nigeria is often compared with in terms of economic growth trajectory.

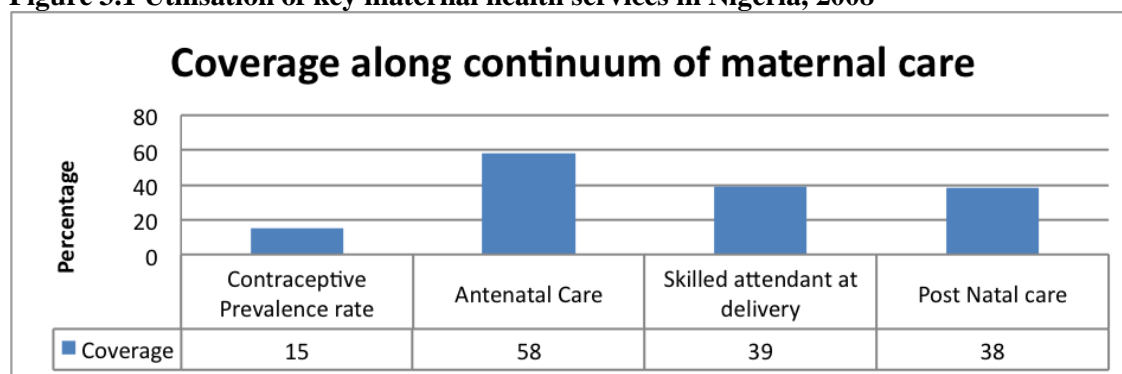
² Net Intake Rate (NIR) in Grade 1 is the number of new entrants in the first grade of primary education who are of official primary school entrance age. Expressed as a percentage of the corresponding age.

³ “Survival rate” to the last grade is the percentage of a cohort of pupils who enter the first grade of primary education

coverage along the continuum of care remains significantly low. This suggests that the reduction in MMR needs to be monitored until a sustainable trend emerges. Overall, the progress being made – with an annual rate of 1.5 percentage point reduction in MMR between 1990 and 2008 – is insufficient to meet the MDG target (WHO, 2010). Both the current figure for Nigeria as well as the rate of improvement is less than that of other BRICS countries such as Brazil and China, who have already achieved the MDG targets. In Africa, Ghana and Ethiopia both outperform Nigeria with MMRs of 350 and 470 deaths respectively per 100,000 live births (WHO, 2010).

Nigeria’s high MMR reflects the poor level of utilisation of important maternal care services, which function in a continuum and are capable of impacting maternal and newborn survival. These include family planning services (the contraceptive prevalence rate is 14.6 percent), antenatal care (58 percent of pregnant women received antenatal care from skilled personnel), skilled attendant at delivery (39 percent), and postnatal care (38 percent) (Figure 3.1). The inequity in the access to this important continuum of care, as will be discussed later in this chapter, suggests that inequity may also exist in maternal mortality figures by zone, rural-urban setting, educational achievement, and economic status.

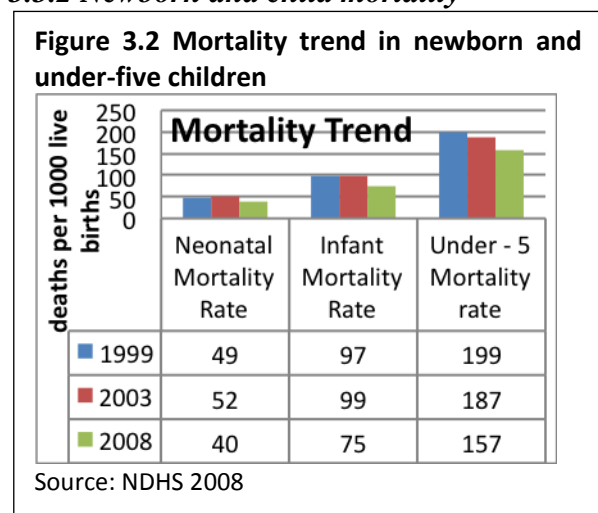
Figure 3.1 Utilisation of key maternal health services in Nigeria, 2008



Source: NPC & ICF Macro, 2009.

Supply and demand related causes have been identified as bottlenecks in expanding coverage of various life-saving maternal health services. On the demand side, the Integrated Maternal, Newborn and Child Health (IMNCH) strategy has identified delays in getting to the health facility and getting care within the facility as key bottlenecks to either attending antenatal service or delivering in a health facility (FMOH, 2007). Forty percent of the delays associated with maternal deaths in Nigeria are type 1 (delay in making decision to seek care), 20 percent are type 2 (difficulty reaching health facility) and 40 percent are type 3 (delay in receiving treatment at the health facility). Major causes of type 3 delays include health care costs, delays in seeing staff at health facility, delays due to lack of supplies and weakness in referral chain, non-availability of obstetric care, and sometimes non-availability of staff.

3.3.2 Newborn and child mortality



A comparison of the figures from the 2003 and 2008 NDHS shows a reduction in all childhood mortality rates (Figure 3.2) (NPC & ICF Macro, 2009). The neonatal mortality rate (NMR) decreased from 52 to 40 per 1,000 live births, while the infant mortality rate (IMR) decreased from 99 to 75 per 1,000 live births. The post-neonatal rate (PNR), derived as the difference between the infant and neonatal mortality rates, decreased from 47 to 35 per 1,000 live births. These statistics suggest that slightly more gain was made in reducing

deaths in the post-neonatal period than in the first 28 days of life. The trend between 2003 and 2008 is particularly encouraging considering the slight rise that was recorded for NMR and IMR between 1999 and 2003. Under-five mortality rate (U5MR) showed a consistent trend of decrease between 1999 and 2008. Between 1999 and 2003, U5MR decreased from 199 to 187 per 1,000 live births, and further decreased to 157 per 1,000 live births in 2008. Thus, between the period covered by the 2003 and 2008 NDHS, Nigeria recorded a decrease of 23 percent in NMR, 24 percent in IMR, and 16 percent in U5MR. Compared to the 1990 statistics, the 2008 figures show a 13.8 percent reduction in IMR (from 87 to 75 per 1,000 live births) and 18.2 percent reduction in U5MR (from 192 to 157 per 1,000 live births) in the 18 years period. The rate of reduction in childhood mortality rates in Nigeria is such that the country is unlikely to meet the MDG 4 target. The rate of reduction is also slower than that of countries such as Brazil and India where IMR and U5MR have been halved over a period of 20 years (UNICEF, 2009).

Considerable variations among the different zones in Nigeria exist with regard to all childhood mortality rates. Consistently, the North east has the highest rates and the South west the lowest (Figure 3.3). The IMR, for example, varies from 109 for the North east to 59 for the South west. The U5MR for the North east (222) and the North west (217) is more than double the figure for the South west (89). The variation in the NMR is considerably smaller than in the IMR and U5MR, with the rate ranging from 53 to 37 per 1,000 live births for the North east and South west respectively.

The 2010 situational analysis conducted in the context of the Integrated Maternal, Newborn and Child Health (IMNCH) Strategy by the Federal Ministry of Health (FMOH) in partnership with development partners, reports that neonatal causes accounted for 28 percent of under-five mortality, malaria for 20 percent, diarrhoea for 18 percent, and pneumonia for 15 percent. This pattern differs slightly from earlier data reported by FMOH in 2007 and quoted in the 2007 Situation Analysis. A comparison of the 2007 and 2010 figures (Figure 3.4) suggests that the proportion of under-five deaths caused by malaria (24 percent) and pneumonia (20 percent) has decreased, while the proportion due to neonatal causes (26 percent) and diarrhoeal diseases (16 percent), among others, has slightly increased. The reasons for these changes are not clear, and will need further exploration. More importantly, the preventive nature of the leading causes of under-five deaths in Nigeria should be of concern to all stakeholders, and highlights the need for upscaling and strengthening relevant interventions at household, community, health system, and macroeconomic levels.

Figure 3.3 Child mortality by geographic zones.

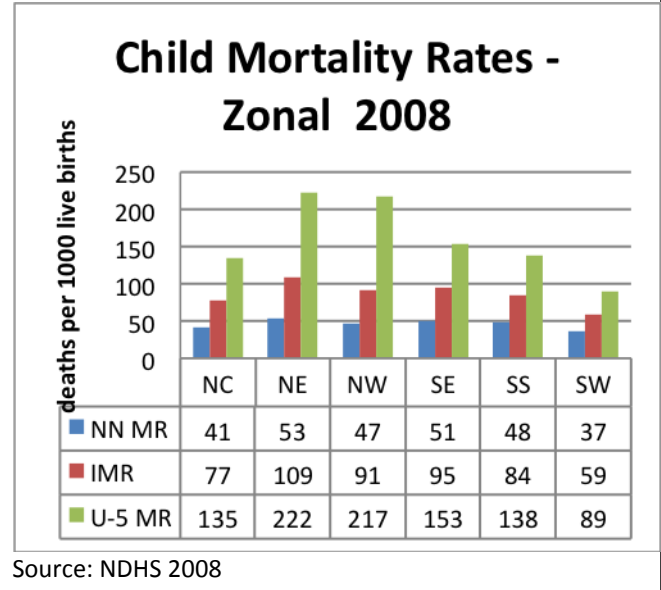
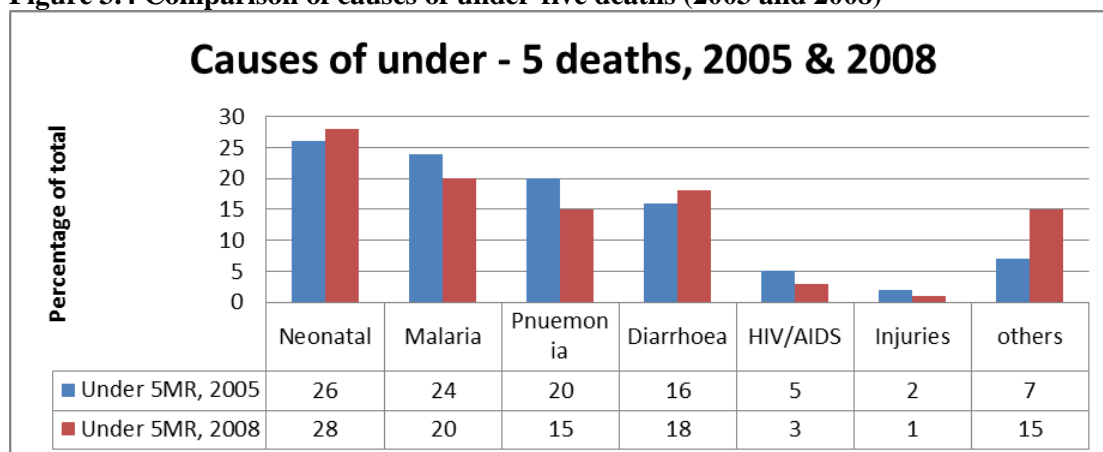


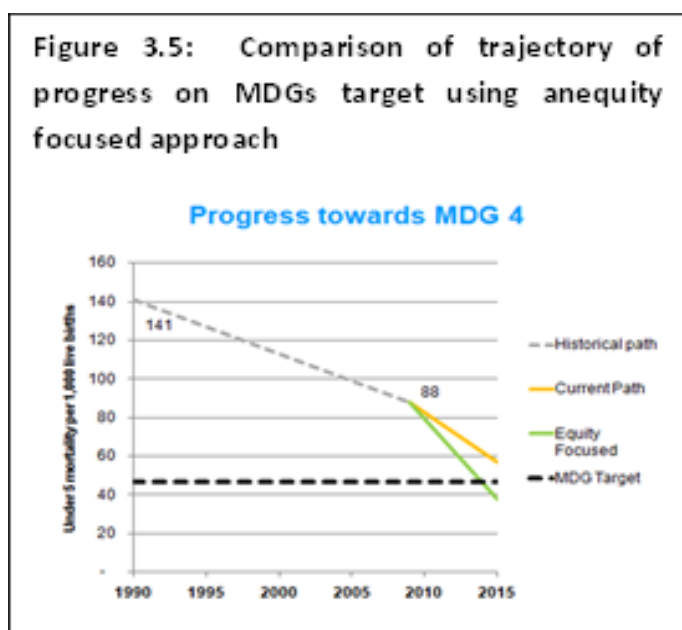
Figure 3.4 Comparison of causes of under-five deaths (2003 and 2008)



Source: UNICEF, 2010.

3.3.3 Equity, maternal and child survival in Nigeria

In reviewing the rates and dispersion of maternal and child mortality in Nigeria, it is clear that the impact of various disease conditions are unequally shared across population groups. Variables such as socioeconomic class, geography, and gender may impact on ability to access, use or get benefits from the health system. If Nigeria is to make rapid progress in further reducing the maternal and child mortality rates, it needs to use an equity lens in designing and implementing its strategies. WHO defines “equity in health to imply the ability of the system to provide a fair opportunity to everyone to attain their full health potential” (WHO, 2010b). UNICEF has extrapolated that an equity-based approach will reduce U5MR and promote progress toward MDG 4 faster than the existing trajectory in 15 countries including Nigeria (Figure 3.5)



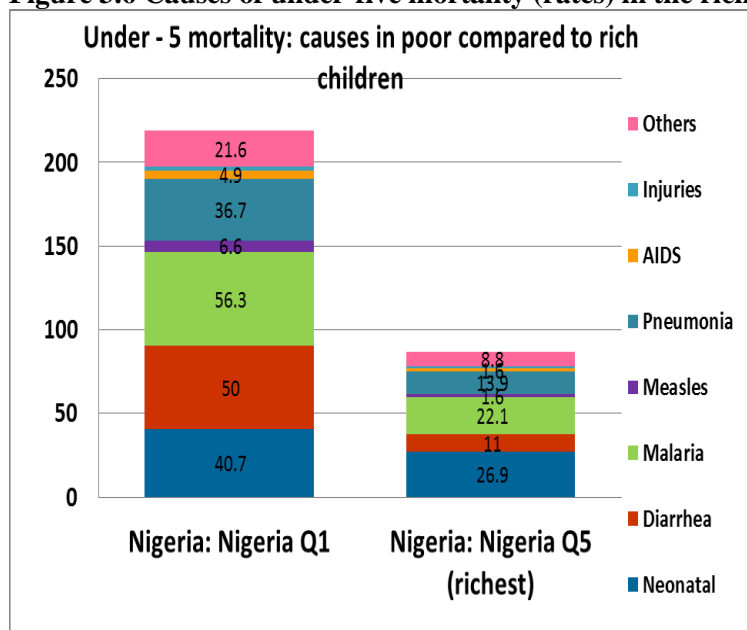
Source: UNICEF, 2010b

One approach to equity targeting is the use of the coverage deficit analysis, an un-weighted average of 7 indicators derived from: (i) MDG 1: percentage of under-5 children not stunted; (ii) MDG 2: primary net attendance rate; (iii) MDG 4: percentage of children 12-23 months who received DPT3; (iv) MDG 5: percentage of deliveries assisted by midwife or physician; (v) MDG6: knowledge of HIV/AIDS prevention (women); (vi) MDG 7: percentage of population using improved sanitation; (vii) MDG 8: birth registration. Analysing patterns of inequity in Nigeria using this measure and under-five mortality shows that 40 percent of the population (lowest and second quintiles) have

very high mortality, followed by middle and fourth quintiles with moderate mortality, and the highest wealth quintile with relatively low mortality (UNICEF, 2010). A review of the 36 states in Nigeria shows Zamfara and Jigawa states to have the highest health coverage deficit in the country with only 19 percent of children having access to life-saving and associated interventions. As expected considering the variations in U5MR across the different zones, the North west has a higher proportion of states with coverage above 30 percent: Kaduna at 39 percent and Kano at 38 percent are the two highest for that region, being slightly ahead in DPT 3 and skilled care at birth. Kaduna also has significantly higher net primary attendance, but low HIV prevention knowledge among women. Incidentally Katsina and Kano performed best in birth registration; Bayelsa from the South south zone is among the lowest 15 states nationally. Immunisation uptake and birth registration are particularly low in Bayelsa state, whereas the top three states – Anambra, Imo and Abia – are all from the South east zone. However Ebonyi state’s rate of 44 percent may have contributed to the overall zonal decline in U5MR rate of 153 compared to 103 in 2003 NDHS. Sanitation and DPT uptake is particularly poor in Ebonyi relative to other southern states, while the South west zone has coverages of 50–65 percent. The spread of these dimensions suggest the need for contextualisation of interventions.

Figure 3.6 presents an analysis of under-five mortality levels and causes for the rich and the poor using the 2008 NDHS wealth quintiles. The first quintile, that is the poorest group, suffers an under-five mortality rate of 220 per 1,000 births, whereas the richest quintile has an U5MR of 90 per 1,000 live births. There is a major difference not only in the level of under-five mortality but also in the causes of child mortality between the poor and the rich. An important finding is that the poor children in Nigeria mainly die of malaria, diarrhoea and pneumonia.

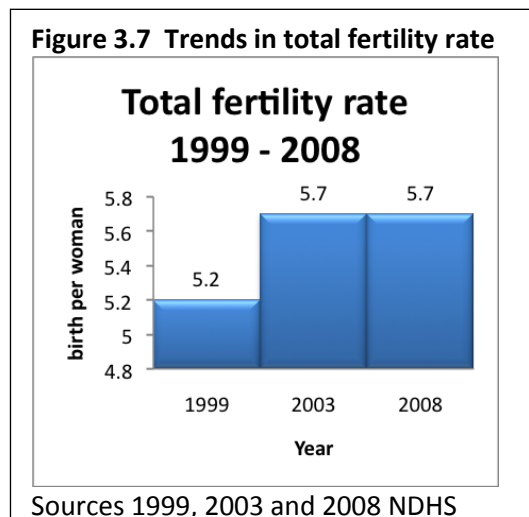
Figure 3.6 Causes of under-five mortality (rates) in the richest and poorest wealth quintile, 2008



Source: NPC & ICF Macro, 2009.

3.3.4 Conclusion

In conclusion, some progress has been made by Nigeria in improving maternal and child survival, however a lot more needs to be done if the country is to achieve its national and international benchmark targets. The under-five mortality rate has decreased to 157 per 1,000 live births from 199 per 1,000 live births in 1999. In the same vein maternal mortality has literally halved to 545 per 100,000 live births from 1,000 per 100,000 live births



ten years ago. This progress suggests that with concerted effort and political will, Nigeria could deliver on the MDG targets.

3.4 Improving sexual, reproductive and maternal health

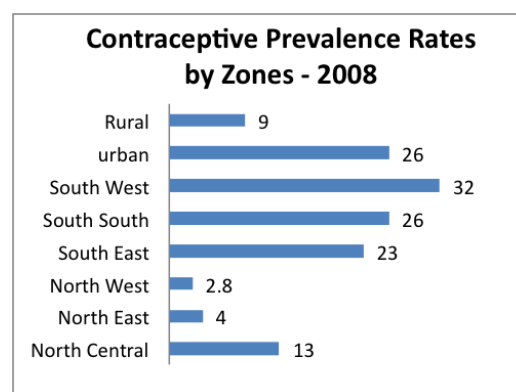
Sexual and reproductive health and rights (SRHR) contributes to Nigeria’s high maternal, neonatal, and child mortality. Nigeria accounts for an estimated 11 percent of the global incidence of maternal mortality (NPC & ICF Macro, 2009). Eleven percent of maternal deaths in Nigeria are caused by unsafe abortion (FMOH, 2007) and with a contraceptive prevalence rate at a mere 15 percent (NPC & ICF Macro, 2009), it is no wonder that the MMR continues to be high. Evidence has shown that family planning contribute to reducing MMR by reducing the number of births and thus exposure to the risk of mortality. It has been argued that family planning also lowers the risk per birth and therefore the MMR by preventing high-risk, high-parity births: some estimate that more than 1 million maternal deaths were averted worldwide between 1990 and 2005 because of the decline in fertility rate in developing countries (Stover and Ross 2009). In terms of morbidity, UNFPA estimates that two million women are affected by fistula worldwide, of which 40 percent or 800,000 women are Nigerians (NPC & ICF Macro, 2009). In one 2002 study focusing on unwanted pregnancy and induced abortion among women aged 15-49 years in 8 states, one in five pregnancies were unplanned (Bankole et al., 2006). HIV infection rates among young women (2.3 percent) is almost three times higher than among men (0.8 percent) (UNAIDS, 2008), reflecting the vulnerability and risk young women face.

3.4.1 Trends in fertility and use of sexual and reproductive health services

The total fertility rate (TFR) seems to be stabilising at 5.7 births per woman according to the 2008 and 2003 NDHS. Incidentally it was 5.2 births per woman at the time of the 1999 survey (Figure 3.7). The most recent TFR compares to that of Guinea, Benin Republic, and Burkina Faso but is higher than Ghana (4.0 births per woman). The North east (7.2) and North west (7.3) have the highest TFR with the South west having the lowest at 4.5 births per woman. Higher educational attainment correlates with lower TFR; women with post-secondary education have 2.9 births compared to 7.3 births for women with no education. Women in the highest wealth quintile have fewer children compared to women in the lowest quintiles. The fertility trend seems to be decreasing across all age groups albeit slowly. Nine percent of women in Nigeria would have given birth by 15 years of age and 47 percent by 20 years. Almost half of 15 – 19 years old in the North west (45 percent) and North east (40 percent) have had a child or were pregnant at the time of the 2008 NDHS. The teenage pregnancy rate is much lower at 8.1 percent in the South east and 8.8 percent in the South west. Many reasons underpin this high fertility rate including the preference for large families and limited uptake of family planning services.

While knowledge of modern contraceptive methods is very high with 72 percent of women and 90 percent of men knowing at least one method, uptake is much lower. Only 24 percent of women have ever used any modern method, with the male condom being the most used. Sexually active unmarried women tend to use contraceptives more than married women with 75 percent of the former having used contraceptives compared to 29 percent for the latter. On current use of contraceptives, the 2008 NDHS reports that the contraceptive prevalence rate (CPR) was only 15 percent with the highest use among women between 35-39 years of age and teenage use (15-19 years) at just 7 percent. Husbands and partners

Figure 3.8 Contraceptive prevalence rates by zones



Source 2008 NDHS

of three-quarters of the married women using contraceptives are aware of such use, suggesting spousal support. Contraceptive use is highest in the South west (32 percent) followed by the South south (26 percent). The North west zone has the lowest contraceptive use at 2.8 percent (Figure 3.8). The low CPR among women with no education (3.6 percent) compared to women with post-secondary education (37 percent), and the low CPR in the lowest wealth quintile (3.2 percent) compared to the highest quintile (35 percent) suggest that equity considerations are important factors in fertility reduction. Other factors such as rural-urban location – with contraceptive use at 9 percent in rural areas compared to 26 percent in urban areas – may also be key in fertility planning. The 2007 Situation Analysis rightly noted the “replacement motive” driven by a high child mortality as one explanation for higher fertility rates and lower use of contraceptives among rural woman and women in the North east and North west zones. Limited physical, financial, and social access to prenatal, antenatal and postnatal care as well as low immunisation rates, malnutrition and higher prevalence of childhood diseases in rural areas also contribute to the higher than average child mortality rates.

3.4.2 Integrating HIV/AIDS and sexual reproductive health in Nigeria

In the last 10 years HIV and AIDS programmes have taken a more vertical structure separate from the context of integrated sexual and reproductive health (SRH) programming. However, lately the need to ensure better integration of HIV and SRH programmes has been voiced as such integration has been demonstrated to improve health and service delivery outcomes for both. A systematic review of 58 peer-reviewed studies and promising practices, examining the evidence on effects of linking SRH and HIV services in 2009, showed improvements in indicators of health as well as in overall quality of services, providing further support for fast-tracking integration (WHO et al., 2009). Some of the benefits of better integration include the expansion of family planning towards reducing mother-to-child transmission of HIV with the potential to avert 12,000 unintended pregnancies to HIV-positive women in Nigeria each year and 533,000 globally (Reynolds et al, 2008). Another advantage of integration is the cost-effective benefit for the client and the health system. Providing family planning at HIV treatment centres has been estimated to save 25 percent of costs. Unfortunately there is very limited progress towards integration of HIV and SRH programming in Nigeria.

3.4.3 Gender-based violence

Gender-based violence is defined as any act of violence, whether occurring in the public or private space, that results in or is likely to result in physical, sexual, or psychological harm or suffering to women (UNGA, 1991). Twenty-eight percent of women interviewed during the 2008 NDHS reported having experienced physical violence at least once since they were 15 years old. Incidentally it seems physical violence is more common in urban (30 percent) compared to rural (26 percent) areas, and more common in the highest wealth quintile (34 percent) compared to the lowest (19 percent). In the area of sexual violence 7 percent reported having been sexually abused at some stage, and again the highest wealth quintile and most educated were reporting a higher frequency than other groups. Approximately one in 20 women (5.1 percent) also reported violence during pregnancy. It is instructive that more than 49 percent of perpetrators of sexual violence is either a husband, boyfriend or an acquaintance, which would suggest the need to programme around sexual debut for young people. More worrying is the fact that 22 percent of perpetrators are strangers, suggesting the prevalence of unreported rape. It is important that interventions are developed to look at these issues. The domestication of CEDAW by government would be a good start.

3.4.4 Antenatal care

Antenatal care (ANC) is central to the promotion of maternal and newborn health: the growth of the baby in the uterus and the mother’s health can be monitored to ensure that detectable complications are identified in time and managed in a systematic way and the woman can be adequately prepared for the delivery. The trend of ANC use is worrying as the latest 2008 NDHS reveals that only 57.7 percent of pregnant women received antenatal care from skilled health professionals (doctors,

nurse/midwife/auxiliary midwife), the level of use was the same in 2003 (58 percent). Similarly, the proportion of pregnant women reported by NDHS as receiving ANC from any source was similar for 2003 and 2008 – 63 percent and 63.3 percent respectively. There is a wide disparity in the use of antenatal care by zone, as the proportion of pregnant women who received ANC from skilled health professionals ranged from 31.1 percent in the North west and 43 percent in the North east to 87 percent in the South East and 87.1 percent in the South west.

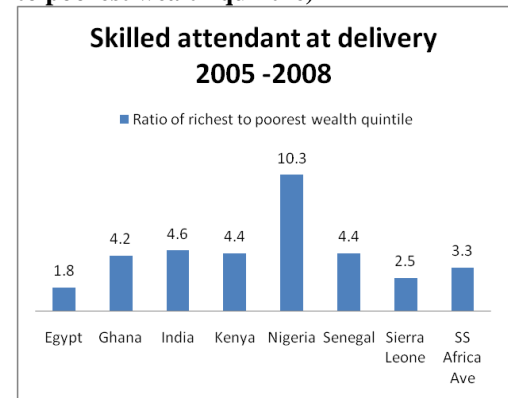
In terms of equity consideration, 43 percent of teenage mothers (under twenty years of age) received ANC from skilled professionals compared to 61.3 percent for pregnant women aged 20-34 years and 55.2 percent for those aged 35-49 years. In terms of educational level, almost all pregnant women with post-secondary education (97.4 percent) received ANC from a skilled health professional whereas less than a third (30.8 percent) of those with no education received ANC from skilled professionals. Similarly, 93.8 percent of pregnant women in the highest wealth quintile received ANC from skilled professionals compared to 23.5 percent of those in the lowest quintile.

The 2010 State of the World’s Children Report finds that antenatal coverage in Nigeria is low compared to some other developing countries such as Kenya, Ghana, South Africa, and Brazil - all of whom have over 90 percent ANC coverage. Globally, more than 85 percent of pregnant women received antenatal care from a skilled provider (UNICEF, 2010).

3.4.5 Place of delivery and assistance during delivery

Access to skilled attendants at delivery is central to maternal and newborn survival given that complications and emergencies that need professional care may arise. Only about a third of deliveries (35 percent) in 2008 took place in health facilities. This figure is just slightly higher than the 32.6 percent reported by the 2003 NDHS, indicating very little progress in the five-year intervening period. Considerable variation exists between geographic zones regarding delivery in health facility; ranging from 73.8 percent in the South east, 70 percent in the South west, 48.1 percent for the South south, 41 percent in the North central; 12.8 percent in the North east, to 8.4 percent for the North west (NPC & ICF Macro, 2009). In the same vein, the proportion of pregnant women belonging to the highest wealth quintile that delivered in health facilities in 2008 (79.6 percent) was more than ten times the proportion among women in the lowest wealth quintile (7.3 percent).

Figure 3.9 Comparison of likelihood of skilled attendant during delivery (richest to poorest wealth quintile)



Source: UNICEF SOWC 2008 – 2010

The term ‘skilled attendant’ refers to physicians and nursing professionals with midwifery skills to appropriately address emergency obstetric conditions. The classification used by NDHS, however, includes physician, nurse/midwife, and auxiliary nurse/midwife. Only about four in ten women (38.9 percent) were assisted by skilled personnel in 2008 (NPC & ICF Macro, 2009). This figure represents a marginal increase from the 2003 figure of 35.2 percent. As is the case with other maternal health indicators in Nigeria, there is a wide zonal variation. While only one in ten deliveries (9.8 percent) in the North west were assisted by skilled attendants, more than eight in ten deliveries in the South east (81.8 percent) received such assistance. The numbers for other zones are: North east (15.5 percent), North central (42.7 percent), South south (55.8 percent), and South west (76.5 percent). Nigeria’s figure compares poorly with that of South Africa and Brazil where more than 90 percent received skilled attendants, and is also lower than the sub-Saharan average of 46 percent.

Using an equity lens, women in the highest wealth quintile (85.7 percent) are much more likely to get skilled support at delivery compared to women from the lowest quintile (8.3 percent). Exploring the difference between women from the richest to the poorest wealth quintile in terms of likelihood to get skilled attendant at delivery, Nigeria has wider disparity level compared to the average for sub-Saharan Africa. Nigeria's disparity is also wider than that of developing countries such as Egypt, Ghana, India, Kenya, Senegal, and Sierra Leone (Figure 3.9). Among pregnant adolescents, a group known to be at high risk for obstetric complications, only a fifth (21.9 percent) delivered in health facilities while a quarter (24.6 percent) had skilled attendants at delivery. On the other hand, 38.5 percent of pregnant women aged 20-34 years delivered in health facilities while 42.7 percent of them had skilled attendants.

3.4.6 Postnatal care

A large percentage of Nigerian mothers do not receive post-natal care after delivery. As the 2008 NDHS reported, 56.3 percent did not receive postnatal check-up within the maximum period of 41 days after delivery. Only 38.3 percent of the mothers had received post-natal check-up within 48 hours of delivery (NPC & ICF Macro, 2009). These figures, despite being low, are a considerable improvement over the 2003 NDHS figures, which showed that 71.3 percent did not receive postnatal check-up and 23.2 percent received the check-up within 48 hours of delivery. Similar to the situation regarding access to other maternal health services, the northern zones lag considerably behind the southern zones. The proportion of mothers who did not receive any postnatal check-up ranged from 80.1 percent in the North west to 24.5 percent in the South west. In the North west, only 17.4 percent of mothers received postnatal check-up within 24 hours compared to 67.6 percent of mothers in the South west. Putting equity of access to the fore again, postnatal care coverage (within 48 hours of delivery) was lower in rural areas (29.7 percent) compared to urban areas (58.5 percent), and lower in the lowest wealth quintile (15 percent) compared to the highest wealth quintile (73.5 percent).

3.4.7 Scaling up service coverage and reducing bottlenecks

Supply and demand related causes have been identified as bottlenecks for the expansion of coverage of life saving maternal, newborn, and child health services. On the demand side, the integrated maternal, newborn, and child health (IMNCH) strategy has identified delays in getting to the health facility and getting care within the facility as key bottlenecks to either attending antenatal service or delivering in a health facility. Forty percent of these delays associated with maternal deaths in Nigeria are type 1 (delay in getting to hospital), 20 percent are type 2 (difficulty getting transport) and 40 percent are type 3 delay (delay in treatment at the hospital). Major causes of type 3 delays include health care costs, delays in seeing staff at health facility, delays due to lack of supplies and weakness in referral chain, non-availability of obstetric care, and sometimes non-availability of staff. It is noteworthy that 22 percent of deliveries are attended by traditional birth attendants who are not classified as skilled, 19 percent are attended by relatives or untrained persons and 19 percent are attended by no one (NPC & ICF Macro, 2009). There is an on-going debate including a concept note for discussion by the FMOH on exploring the possibility of including traditional birth attendants (TBA) within the care system. If this were the scenario when the 2008 NDHS took place 60 percent of deliveries would have been considered assisted. The concept of integration of TBAs into the care system presents an interesting opportunity to scale up access to antenatal and delivery care.

3.4.8 Conclusion

In conclusion, it is imperative that sexual reproductive health services including maternal and newborn care must be expanded and bottlenecks to accessing such services removed. There is broad consensus and an emerging wave of commitment backed by relevant strategies and approaches to increase the antenatal and skilled attendant coverage for pregnant women. However the same is not that clear for wider family planning and fertility reduction programmes which are often more politically difficult to manage. The continuum of sexual reproductive health and rights services

from family planning to pregnancy, delivery management, and postnatal care needs to be prioritised and kept high on the agenda.

3.5 Malaria situation and control

Malaria accounts for 20 percent of under-five deaths and 17 percent of maternal deaths in Nigeria annually (FMOH, 2009). It is estimated that more than half of the Nigerian population gets at least one malaria attack every year, a quarter of Africa's malaria burden. In 2009, an estimated 4.8 million cases of malaria were treated in public health facilities, excluding those treated at home, and this represents a doubling of the estimated 2.5 million cases treated in 1999 (FMOH, 2009). Malaria accounts for 50 percent of all outpatient visits. The National Malaria Control Programme (NMCP) estimates that malaria costs Nigeria about ₦132 billion annually in form of treatment costs, prevention, loss of work hours, and related costs. To effectively address malaria, NMCP in partnership with stakeholders have developed the National Malaria Strategic Plan (NMSP) 2009 – 2013. The objective of the plan is to reduce malaria related mortality by 50 percent.

3.5.1 Management of malaria using ACTs

The national guidelines on the management of malaria include improved early diagnosis, home management of malaria, recognition of complicated cases, referral and treatment at all levels of the healthcare system. The anti malaria treatment policy has approved artemisinin-combination therapy (ACT) as the first line of treatment for uncomplicated malaria both at home and in facilities. Considering the cost of ACTs prior to 2010, which was in the range of ₦1000 - ₦1500, this would have been a difficult strategy to implement. However with the Global Fund for AIDS, TB and Malaria (GFATM) Round 8 supporting the procurement and distribution of up to 80 percent of the needed ACT at socially marketed prices, it is likely that this strategy stands a chance of succeeding. The emergence of a strong public-private partnership should provide an incentive for the sustainability of the medicine supply chain. Rapid diagnostic kits (RDT) were procured with the intention to commence distribution by the last quarter of 2010. The NMCP is launching a media campaign to boost the use of ACT and increase the recognition of the signs and symptoms of malaria.

3.5.2 Intermittent preventive treatment for prevention of malaria in pregnancy

Malaria in pregnancy is dangerous to the mother and baby and could cause abortion, premature labour, and even intrauterine death of the foetus. Intermittent preventive treatment (IPT) is a key strategy for the prevention of malaria in pregnancy. IPT entails the administration of a full therapeutic course of antimalarial drugs to at-risk women at specified times regardless of whether they are infected or not. NMCP promotes the use of IPT with a 2013 target of all pregnant women attending ANC receiving at least two doses of IPT in addition to using insecticide-treated mosquito nets (ITNs) at home. Free tablets of sulphadoxine-pyrimethamine are given twice (in the 2nd and 3rd trimesters) to pregnant women attending antenatal care in all government-owned health facilities in Nigeria. As of 2008, as reported by the NDHS, only 5 percent of women attending ANC received the full dose of IPT. Utilisation of ITN varies by socioeconomic level: 11 percent of pregnant women from households in the highest wealth quintile used IPT compared to 4 percent of those in the lowest quintile. With a total of 18.3 million units of sulphadoxine-pyrimethamine currently available for free distribution, cost should no longer be a challenge and it is likely that Nigeria will make rapid progress in IPT coverage of pregnant women.

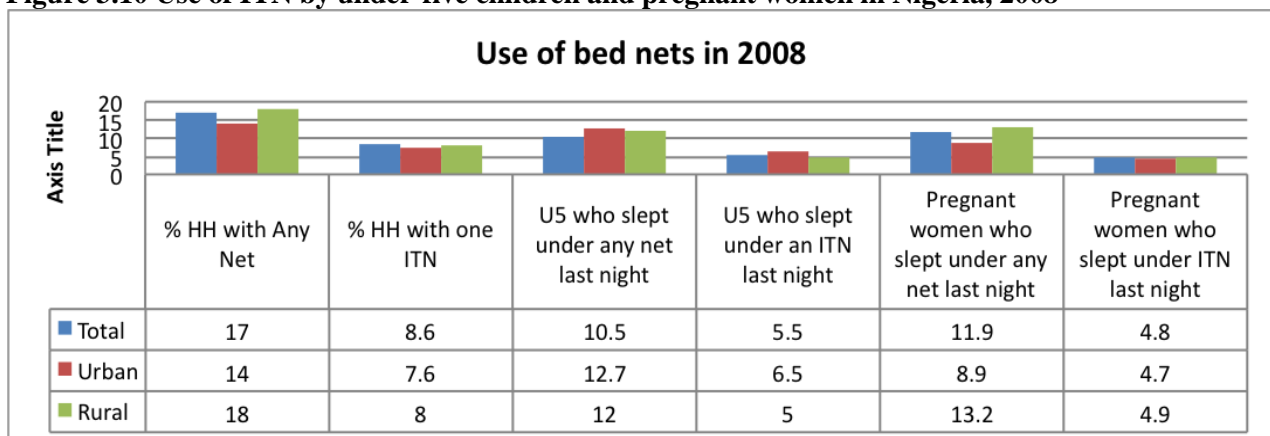
3.5.3 Scaling up integrated malaria prevention strategies

The use of long-lasting insecticidal nets (LLIN) is another key strategy for preventing malaria among pregnant women, children, as well as other population subgroups. As Figure 3.10 shows, household ownership and the use of LLIN among pregnant women and children in Nigeria is low, and varies between urban and rural locations. Only 17 percent of households own bed nets, while the proportion of pregnant women and under-five children who slept under any bed net the night

before was 12 percent for each of the two groups. The figure for insecticide-treated bed net (ITN) is lower, with only 8 percent of households owning one. In terms of zones, the South south and the South east had the highest proportion of households owning an ITN (10 percent), whereas the South west had the lowest ownership (6 percent). Approximately, one in 20 pregnant women (5 percent) and children (6 percent) slept under an ITN the night before they were surveyed in 2008 (NPC & ICF Macro, 2009). The good news, however, is that the use of ITN by under-five children was 50 percent in households that owned such nets, suggesting that when families own the nets, use may be high.

In response to this current situation, the Federal Ministry of Health has strengthened efforts to promote LLIN. Through its integrated vector management (IVM) approach, NMCP aims to distribute 63 million free LLINs to households with the support of development partners by December 2010, through stand-alone and integrated (with immunisation and antenatal care) campaigns. The objective is to achieve a minimum of 80 percent household coverage by 2013 and to ensure these nets are used by pregnant women and children. Free distribution is particularly likely to favour the use of LLIN among the poor and rural-based populations. However, while it is possible to achieve LLIN distribution targets, the real task lies in ensuring the sustained and correct use of bed nets. On-going LLIN distribution needs to be complemented by continuous community mobilisation, health education, and behaviour change communication. The current approach of integrating LLIN distribution and promotion into immunisation and maternal health programmes should also be sustained.

Figure 3.10 Use of ITN by under-five children and pregnant women in Nigeria, 2008



Source: NPC & ICF Macro, 2009.

In the context of the IVM approach, the promotion of LLIN is complemented by insecticide residual spraying (IRS) in a projected 2.5 million households across the country by the end of 2010, with the aim of covering 85 percent of eligible households. Based on the available budget, however, it seems likely that IRS will reach not more than a third of projected households.

3.5.4 Ways forward in malaria control in Nigeria

While the transformation of the malaria landscape in Nigeria is very commendable, it has been mainly centrally driven at the federal level. There is a need for greater commitment and participation in decision-making as well as implementation processes at sub-national levels. It will be an added value, in the light of programme sustainability, to explore mechanisms to decentralise some of the on-going processes to the state level. An example is decentralising the proposed mass media and community mobilisation campaigns to allow them to be driven by the states. This will increase state ownership. Promoting community involvement not only in the distribution of nets but also in raising awareness about their use would help in embedding the required health behaviour. Ultimately, as is generally the case with health technology, compliance and adherence are key pillars for achieving health impact. Thus, the strategic implementation of behaviour change

communication programmes and effective community mobilisation must be integral to all malaria intervention activities.

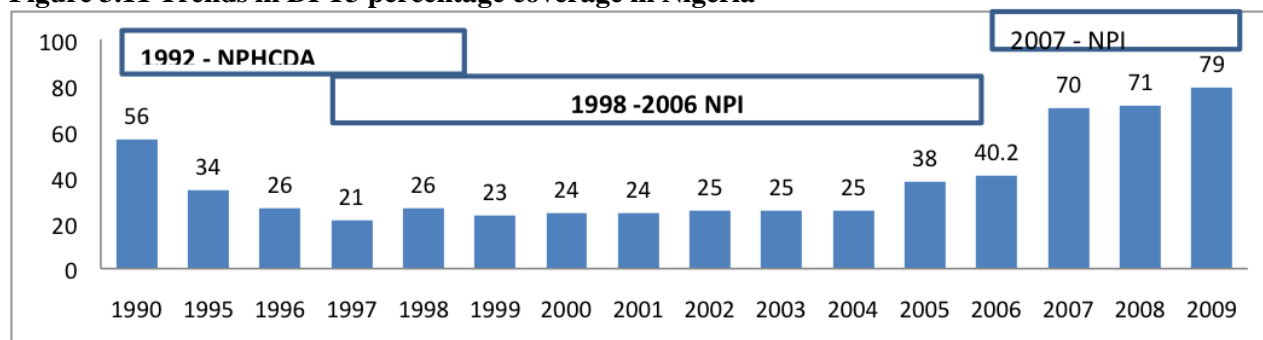
3.6 Improving immunisation in Nigeria

Immunisation is an effective strategy to address vaccine preventable diseases: significant reduction in childhood morbidity and mortality can be achieved from community immunity reducing disease transmission. Nigeria has started making progress in childhood immunisation after several years of poor performance, and this is starting to impact positively on child survival in the country. For example, the contribution of neonatal tetanus to infant deaths has declined to 3 percent in 2008 from 17 percent five years earlier. Recent gains in the area of polio eradication have also earned the country commendations internationally, and indicate that with adequate commitment, strategic focus, and well-directed efforts, Nigeria can improve its coverage of childhood immunisation significantly in a few years. Immunisation coverage data generally come from two different sources: the administrative data of the National Primary Health Care Development Agency (NPHCDA), and household-based surveys such as the Multiple Indicator Cluster Survey (MICS) and NDHS. These two sources have a different basis for their computation and may therefore produce different results in terms of absolute figures, but some similarities in trends are expected.

3.6.1 Trends in immunisation uptake

Figure 3.11 shows the trend in immunisation coverage in Nigeria based on administrative data, using DPT3 as a marker. A significant gain was made between 2006 and 2007, from 40.2 percent to 70 percent. The gain has been sustained since then and even improved. The administrative data show that the proportion of under-five children who received DPT3 increased from 71 percent in 2008 to 79 percent in 2009 (NPHCDA, 2010). There are variations in achievements by state. Whereas six states (Sokoto, Osun, Kwara, Nasarawa, Delta, and Gombe) and the Federal Capital Territory (FCT) had over 99 percent coverage of DPT3, the coverage was between 50 and 79 percent in most other states.

Figure 3.11 Trends in DPT3 percentage coverage in Nigeria



Source: NBS & UNICEF 2007; FMOH; NPHCDA, 2010.

This trend was also confirmed in the 2008 NDHS albeit at lower levels: the proportion of under-five children who had received DPT3 increased two-and-a-half times between 2003 and 2008, from 13 percent (NPC & ORC Macro, 2004) to 32 percent (NPC & ICF Macro, 2009). Also, 68 percent of under-one year children had received at least one vaccine in 2008 compared to 51 percent in 2003. The proportion of fully immunised children, however, only increased slightly – from 14 percent in 2003 to 19 percent in 2008 and 17 percent of under-five children had all the standard prescribed vaccines by the time they were one year. Immunisation coverage was positively associated with educational and economic status, and there is generally higher coverage in the southern part of the country compared to the north.

Nigeria has made great stride in the eradication of polio in the last three years, with a massive reduction in the number of reported wild poliovirus from 798 cases, representing 48 percent of the

global burden in 2008, to just 4 cases in the first 10 months of 2010 (Table 3.2) (Global Polio Eradication Initiative, 2010). Most states have achieved coverage levels above 70 percent, and only three states – Zamfara, Kano and Bayelsa – reported coverage of less than 50 percent. The 2008 NDHS data, on the other hand, puts the national coverage at 39 percent, with the North east (28.6 percent) and North west (24.3 percent) having rates below the national average. These zones contain the seven high-incidence states of Bauchi, Kaduna, Kano, Jigawa, Katsina, Yobe and Zamfara.

Table 3.2 Selected indicators on Nigeria’s progress with the interruption of the wild poliovirus

	2008	2009	Jan – October 2010
Number of wild poliovirus 1	798	388	4
Percentage of global total	48%	24%	Less than 1%
Number of infected LGA with WPV1	Not available	49	1
Number of states with DPT3 <50%	5	-	-

Source: Global Polio Eradication Initiative, 2010.

Sustaining the current trend of coverage and building on it will be crucial to sustain the polio eradication efforts. In addition, the polio eradication initiative has allowed better government-donor partnership, involvement of states and LGAs, as well as active engagement by traditional and religious leadership at various levels. It is important that this mechanism of engagement be continued and expanded. There is a need to maximise the potential of immunisation plus days (IPDs) and start using them to channel clients to routine immunisation services (more on this below). Securing continuous and adequate financial support from strategic stakeholders including bilateral and multilateral agencies, states and LGAs is also crucial.

3.6.2 Immunisation delivery services

The strategy to expand immunisation coverage in Nigeria combines routine immunisation and outreach. The Immunization Plus Days (IPDs) combine the use of routine and outreach approaches for delivery of multiple antigens as well as the distribution of other child survival commodities. The IPDs involve professional and lay health workers as well as community mobilisation and engagement. They were commenced in May 2006 and deliver the following commodities in addition to antigens – antihelminthics, Insecticide Treated Nets (ITNs), oral rehydration salts (ORS), Vitamin A, soap, and paracetamol. As the 2007 Situation Analysis posited, the IPDs are resulting in a strengthening of primary health care service delivery. For example, this approach improves skills and capacity of health workers to effectively engage in micro planning and delivery of Primary Healthcare (PHC) services, and it increases state, LGA, and community ownership of child survival programmes. In addition, IPDs strengthen inter-tier relationships and partnerships for the delivery of immunisation and other child survival services.

3.6.3 Ways forward for immunisation in Nigeria

Without any doubt, Nigeria has made substantial progress in the area of immunisation coverage in recent years. Sustaining this progress and further improving immunisation service delivery will contribute to improved child survival and health through meeting immunisation targets. The eradication of polio, for example, is within reach. The country should place more emphasis on the community engagement and social mobilisation structure as well as motivated leadership at the local level that has been strengthened in the recent years, particularly in the context of IPDs to promote routine immunisation of both children and pregnant women. The service delivery system, including commodity supply chain, equipment, and human resources, should continuously receive needed action and be maintained for maximised quality performance. There has been substantial progress in routine coverage in Nigeria, with immunisation services increasingly integrated into service delivery at state, local government and community level. In 2009, for example, more than 10 states had their health facilities conducting over 80 percent of their planned routine immunisation sessions and about 15 states achieved 50-80 percent of their planned sessions.

However, routine outreach services from health facilities are fewer as only health facilities in two states achieved 80 to 90 percent of their planned community outreach. Health facilities in over twenty states were only able to carry out less than 50 percent of their planned outreach services.

The NPHCDA and its associated institutional structure working in this area needs to be strengthened to embed many of the on-going processes, including better linkages and cooperation with state and local government. This is important considering that some of the on-going changes seem to be driven more by the existing leadership than by an institution-wide culture. Finally, monitoring and evaluation of service delivery processes and outcomes should continue to be of primary concern, and data on immunisation coverage should be mainstreamed and integrated into the National Health Management Information Systems (NHMIS).

3.7 Equity focused health system strengthening

Nigeria has a three-tiered health system, with the federal government, state, and local government levels having concurrent responsibility for health. The performance of the Federal Ministry of Health (FMOH), State Ministries of Health (SMOH), and the Local Government Health Departments and the relationships between these structures as well as with the people they serve are critical to the ability of the Nigerian health system to deliver services efficiently. The complexities of the institutional relationships entailed in the three-tiered system pose a challenge, particularly as responsibilities presently are not clearly defined and not grounded in law. In general and drawing from historical constitutional antecedents, FMOH has responsibility for tertiary health care and states have responsibility for secondary health care. The 774 LGAs are responsible for primary health care service delivery and operate through 9,555 health wards across the country. The overall performance of the Nigerian health system continues to be a challenge, and there is concern about poor health returns even at the level of investment per capita. Although 71 percent of Nigerians are said to have access to primary health care (PHC) facilities within a distance of 5 km, there are still considerable challenges in terms of access to care, quality of services and utilisation, as many government-owned services lack the required equipment, essential supplies, and qualified staff. However, in recent years there have been greater commitment and efforts aimed at revitalising PHC – the foundation of the country’s health system – particularly at the federal level.

A reform of the health system within the wider Nigeria Economic Empowerment and Development Strategy (NEEDS) framework was attempted between 2004 and 2007, combining political and technical approaches. Implementation of the health sector reform (HSR) was mixed; while a few components have been vigorously pursued, completed, and embedded within the system, others are at various stages of development and implementation. The strengthening of the National Programme on Immunisation, development of a National Health Bill, and improved National Health Insurance Scheme (NHIS) coverage are some of the gains from the HSR. A number of relevant policy documents focusing on improving service coverage were developed and disseminated among key holders. Some of the proposed actions such as the building of model PHC centres across the country by the federal government seem to have been completed, and the refurbishment of others are progressing fairly rapidly across the country funded with the Debt Relief Gains. On the other hand, there are several challenges including the proposed institutional reform within the FMOH, improved funding for the health system as a whole, and the stalling of the health bill at the National Assembly.

The HSR plan recognized that financing is central to improved service delivery and access to care that would lead to improved health outcome especially for the poor. Accordingly, the health bill clearly spells out the mechanism for health care financing at PHC level, where direct funding from the PHC Fund to State Primary Health Care Boards will be provided through performance based annual contracts. The availability of this Fund will serve to significantly reduce the burden on the PHC services from the political tug-of-war between the tiers of government and poor funding. One

of the areas of priority of the HSR plan is the health of mothers and children; this has led to the development of the Integrated Maternal Newborn and Child Health strategy in 2007. The HSR plan also provided the platform for the evolution of Nigeria's first National Strategic Health Development Plan (NSHDP) in 2010.

3.7.1 National Strategic Health Development Plan

The National Strategic Health Development Plan (NSHDP) is a unified and costed plan for the country as a whole that integrates federal and state plans. The plan, which was developed under the leadership of the Federal Ministry of Health, was adopted at the 53rd session of the National Council on Health. The plan builds on the health sector reform agenda carried out between 2004 and 2007 and the draft 10-year National health strategic plan. The development of the plan was participatory, with active involvement of a wide range of stakeholders including all tiers of government, development partners, civil society, professional organisations, and patient groups. The eight priority areas outlined in the NSHDP are: leadership and governance, health service delivery, human resources for health, health financing, National Health Information System, community participation and ownership, partnership for health, and research for health

The development of a plan is often the simpler task among the policy oversight and stewardship functions of the government in Nigeria. More difficult is linking the plans to the budgeting processes, implementing plans faithfully, and ensuring that implementers of the plans are accountable to the population. As is widely acknowledged, there are significant challenges related to planning, budget, implementation, review and accountability in Nigeria, and the Ministry of Health at federal or state level is no exception. It is therefore vital to provide structured support to strengthen these processes in the various states and ensure strict monitoring and evaluation of the implementation process. In addition, scenario planning, drawing from existing budgetary commitments, has been used to create a short-to medium-term investment plan for various levels. However the actual measure of success will be how these plans shape decision making at federal and state levels on allocations and the prioritisation of interventions and delivery routes that make the most impact on mothers and children. The NSHDP is unique in defining very explicit measureable goals and targets based on robust baseline data. It aligns with the MDG goals and incorporates targets outlined in the IMNCH strategy that preceded it.

Remaining mechanisms for the FMOH to hold the state accountable and vice versa are limited. Implicit accountability in the implementation of the plan is envisaged in the form of a Health Sector Joint Review. However, the form that the review would take is still unclear, and the potential impact it would have is difficult to predict. While there is no simple solution to address many of these issues, it is hoped that the National Health Bill, when passed into law, will at least provide some level of accountability in the management of PHC funds.

3.7.2 Integrated Maternal, Newborn and Child Health Strategy

The Integrated Maternal, Newborn and Child Health (IMNCH) strategy preceded the NSHDP and was developed in the context of the severe maternal and child mortality and morbidity realities resulting mainly from preventable diseases. The strategy recognised that if essential interventions reached 99 percent of women and their newborns, up to 72 percent of newborn deaths could be averted (FMOH, 2007). The strategy focused on the health conditions responsible for over 90 percent of maternal and child deaths. The integration of MNCH services involves the reorganization and reorientation of health systems to ensure the delivery of a set of essential interventions as part of the continuum of care for women, newborns, and children. Sixty-one globally recognised evidence-based interventions were selected for rapid scale up in the IMNCH strategy in three intervention areas: family-oriented community based; population-oriented outreach, and "individually-oriented clinical" services. It was envisaged that the strategy should guide financing and policy options of governments and development partners.

Implementation of the IMNCH Strategy has been limited so far. The institutional arrangements to oversee the embedment and implementation of the strategy have been configured in the FMOH under the Family Health Department. While a number of activities, including studies on the IMNCH situation in selected states, development of national reports on neonatal health, and advocacy at state levels, have taken place, it appears that the responsible department has not been able to position the IMNCH strategy adequately within the wider ministry and donor politics. States, with the exception of a few, have also not sufficiently prioritized IMNCH within their development agenda, and have not fully embraced the IMCH strategy. It also seems that the IMNCH does not have a sufficient number of committed advocates to push for its implementation, and therefore the unique policy, planning, and allocative functions of the strategy are not being maximized.

3.7.3 Improving health care service delivery

In the last 10 years Nigeria has expanded its programme response to meet health-related MDG targets and improve the survival and quality of life of its women and children. The actual measure of the performance of a national health system is the ability of citizens to access quality services at as minimal a cost as possible. In Nigeria, PHC is the appropriate level for the delivery of effective health services – both preventive and curative – to most mothers and children. Limited availability of and accessibility to PHC limit utilisation and impact of services at this level. Quality of services rendered also affect utilisation. For example, many of the existing PHC facilities are poorly equipped, and the service package offered is often poorly defined and delivered in a piece-meal fashion increasing the transaction cost for mothers and their children. Service delivery tends to ignore issues related to equity. Quality assurance systems, including monitoring of services, are often lacking. There is also a mismatch of human resources needed for this level of care, with many facilities lacking trained nurse/midwife and Community Health Extension Workers (CHEW); most qualified health personnel also tend to stay in urban areas to the detriment of rural areas where the majority of the population lives. Furthermore, community support for and involvement in PHC issues are weak.

Weak governance and management, paucity of funding and limited investment nationally on health promotion, continue to limit the effectiveness of the PHC system. Poor coordination within and between the tiers of care coupled with lack of shared vision and accountability, duplication of function, and role confusion, characterise service delivery in the PHC level to some extent. Weak referral systems lead to unnecessary delays, which compromises the health and well-being of clients as well as result in wastage of resources at higher levels of the system. Inadequate community and private sector participation in PHC service provision and poor monitoring of services weakens the ability of citizens to demand accountability and thus reduces the efficiency of the system. Finally the poor attitude of health workers, sometimes linked to poor remuneration practices, inadequate training and supervision, and poor technical skills as well as frustration resulting from lack of essential supplies and equipment, limits the utilisation of health services.

One of the key recent developments in IMNCH service delivery is the Midwives Service Scheme (MSS). The scheme, which is under NPHCDA, plans to recruit and deploy 2,500 skilled midwives to 652 designated health facilities in rural communities for one year. These midwives will provide skilled delivery services to pregnant women at the PHC level. The scheme, designed as an emergency measure, will help reduce the country's dismal performance on coverage of skilled attendants for women in labour. In total, 2,200 midwives have been deployed and 32 states have signed up for the scheme as of July 2010. Other ongoing initiatives include the Global Fund for AIDS, TB and Malaria (GFATM) Round 8 Health System Strengthening (HSS) Programme, which is supporting 925 PHCs in 185 LGAs (i.e. 5 PHCs per LGA) in all the 36 states and FCT. The support of the Global Alliance for Vaccines and Immunization (GAVI) for the development of the ward health system in 960 wards is another ongoing initiative: it is aimed at delivering better PHC

services based on the Minimum Health Care package.

3.7.4 Equity focused health financing and expanding access to care

The World Health Organisation in its health system report of 2000 remarked that 1.3 billion of the poor people in the world do not have access to effective care because of the weakness in the financing of health care. Poor utilization of modern health services is greatly influenced by cost of services including travel cost to the health facilities. Currently health care financing in Nigeria comes from a mixture of budgetary allocations, out of pocket expenditure, external development funding, and a small but growing social health insurance scheme. Some have argued that 65 percent of total health expenditure in Nigeria is out of pocket; this proportion is much higher than countries in Eastern and Southern Africa (Soyibo 2005). Out of pocket spending is the most regressive form of financing and the most likely to impede access to health care by the poor.

Government allocation to health is low with an average allocation of 5 percent between 2003 and 2008 (NPC & UNICEF, 2009). Out of Nigeria's ₦4,079 trillion 2010 budget, core health expenditure accounted for only ₦162 billion (4 percent) of the total budget (Federal Ministry of Finance, 2010). If the funds from the Office of the Special Assistant to the President on MDGs (OSSAP) are added, health sector allocation comes to about 7 percent of the budget, not including NACA's (National Agency for the Control of AIDS) budget, operational cost for the OSSAP office and others that are also impacting on health. Considering that revenue sharing between the tiers of government is roughly in the ratio of 53:47 in favour of the federal level (Babalola, 2008), the best-case scenario would be a health allocation of less than 10 percent. This defaults the Abuja Agreement of the governments of African nations, under the aegis of African Union, to allocate a minimum of 15 percent to health. A comparison of the 2010 health budget (roughly USD 1.5bn) with the annual costed budget for the NSHDP at (USD 4.4 billion) suggests that even with adjustment for states and LGA figures, available resources are still, at best, just about 50 percent of what is needed to implement the NSHDP. The use of approaches that will promote greater efficiency such as expanding the use of existing health training institutions for in-service training, incorporation of critical health issues in existing pre-service curriculum, the use of more integrated approaches (such as integrating hand washing into school health activities), joint programme implementation (for example, joint supervisory visits of various units) will make the available resources go further compared to present projections. The current structure of the budget needs to be redressed, as recurrent expenditure accounts for about 70 percent and tertiary care that serves a minority of the population receives high allocations compared with primary health care that is utilised by the greater majority.

The NHIS scheme in addition to the budgetary support to health is at the core of the government strategy to expand access to healthcare to all Nigerians. The Scheme established in 1999 has developed various insurance type schemes targeted at different segments of the society. These include the Formal Sector Social Health Insurance Programme, with variants covering the armed forces, police, and organised private sector groups. Coverage started with mainly federal employees and since 2006 has expanded to employees of two states. Beneficiaries pay a premium that is often based on income and entitles the insured person, spouse, and four children to service delivery through either a private or public health facility via NHIS accredited Health Maintenance Organisation (HMO). The formal scheme has often been criticised for operating like a private insurance provider, with no equity consideration. Universal coverage requires strategies to expand pooling and coverage beyond premium paying beneficiaries in order to cater to those who will never be able to pay premium.

The Maternal and Child Health Project (2008 –2014) is an example of an equity-focused scheme that the NHIS is piloting. The project objective is to reduce maternal and childhood mortality by creating a financing mechanism to provide free care to women and children. The project, which is

being funded by the national MDG office, is in two phases and has a ₦9 billion life of project (LOP) budget. The first phase is designed to provide free care annually to 600,000 women and children in three LGAs in six states, and the second phase which started in 2009 is expected to provide free care to an additional 600,000 women and children in another 6 LGAs in six other states. The service package includes PHC services for enrolled children and primary and secondary care (including caesarean sections) for all pregnant women. Children can join the scheme from birth until age five, while women may join from confirmation of pregnancy to six weeks after childbirth. Of the planned 600,000 to be covered during the first phase, only about 152,000 had been enrolled as of late 2009; the enrolment in southern states is slower than that of the northern states. Payment for services is based on capitation. An evaluation of the project showed the project to be contributing to reducing maternal and childhood deaths and associated morbidity with a 640 percent return on investment (Briscombe & McGreevey, 2010). The Health Policy Initiative estimates that approximately 590 women and 3,500 children would have died and some 12,000 women would have suffered serious pregnancy-related complications without the services offered by this project. The same evaluation also confirmed that an investment of ₦27 billion could provide nationwide coverage, which is doable if states contribute 50 percent of the cost at ₦370million per state.

In the last 10 years, donors' support to the Nigerian health system has expanded compared to the pre-democratic era. It is estimated that partners contributed about 2.2 and 2.8 percent of the total health expenditure in 2007 and 2008 respectively (WHO, 2010). About 45 million USD per annum was provided by bilateral and multilateral sources in the forms of marketing health products, technical assistance, and direct financial support. There also seems to be improved coordination amongst donors and between the donor community and government. An analysis of available funding shows an emphasis on programmes related to HIV and AIDS, immunisation, and lately malaria and other MCH-related conditions. The US government (including USAID) and the United Kingdom (DFID) are the main bilateral donors with others such as the Gates Foundation slowly advancing towards playing a larger role. The largest multilateral projects in the country include those funded by the World Bank (malaria booster project [USD 280 million] and Health Systems Development Programme 11 [USD 90 million]) and the Global Fund (malaria projects [about USD 350 million] and Health System Strengthening Round 8 [USD 55 million]). With purposeful leadership in the country and in the health sector, continued government commitment to health funding, and support of donors, Nigeria can make significant stride regarding maternal and child health.

3.7.5 Conclusion

Nigeria has, in the last 10 years, expanded its political, policy, and programme response to meet the MDG targets and improve the life expectancy of its women and children. The NSHDP, the IMNCH, the Roll Back Malaria strategy and other sectoral policies, strategies, plans, and ongoing schemes are not just responses to the weaknesses identified in the health system but also limit the fragmentation of the health system and promote service integration. The current 2010 review shows, in many ways, that some of the strategies adopted since 2007 are starting to bear fruits with improvements in selected areas, particularly immunisation and lately the ongoing scale up of malaria interventions. However, coverage of other vital life-saving MNCH services is still far too low to sustainably reduce MNC deaths. Geographic and socioeconomic barriers significantly shape service availability and who can access them. Scaling up coverage therefore requires a new way of doing things. This includes a recourse to improved equity focus for targeting and scaling up coverage, exploring new strategies to bridge gaps in financing to reduce out-of-pocket payments, and expanding access to skilled human resources particularly in rural areas, which is often one of the bottlenecks impeding service delivery and utilisation.

3.7.6 Ways forward in equity focused health strengthening, financing and expanding access to care

Advancing maternal and child health in Nigeria in a strategic way requires an equity approach with

emphasis on reaching hard to reach areas and the more vulnerable populations, and instituting mechanisms to strengthen systems and overcome barriers of access that the poor face. The critical question should be “who is benefiting and at what cost?” “Where are the most deprived women and children located and how do we access them?” This will ensure that those most vulnerable, who often need the services but cannot access them, get the strategic pull and push to benefit and improve their health outcomes. It is necessary to review some of the ways that UNICEF and other development organisations support its government partners, including influencing the construction of equity focused policies and services. This may include exploring different ways of delivering services such as developing and expanding innovative ways to reduce financial barriers for the poor and empowering communities as advocates for their health.

3.8 Policy and programmatic options for improving maternal and child survival in Nigeria

Some elements of the health reform agenda critical to bridging the coverage deficit gaps are still in various stages of finalisation and embedment - such as the National Health Bill. UNICEF and development partners are uniquely placed to deploy high-level advocacy for the bill to get adopted and passed into law. The bill will expand the financing envelopes available to states and LGAs, and support front line service delivery. It is instructive, for example, that the role of FMOH and NHIS (National Health Insurance System) is fairly equity blind in conducting their core mandate in the health system. The UNICEF-developed coverage deficit score is a powerful tool that needs to be shared with government as a policy and operational tool. UNICEF and other partners may explore how to support a shift in the government’s planning and financing frameworks towards prioritising the poorest quintile. Examples of this include influencing the integration of MNCH weeks into the annual state-level budget, and to continue to advocate for adequate budget allocation to the LGAs with the highest number of children who are not immunized against childhood diseases.

3.8.1 Advocate for MNCH implementation to spearhead implementation of the NSHDP

The IMNCH strategy and plan is not being implemented as envisaged. While the acceptance of the strategy is high both by government and development partners, the strategy is in dire need of advocates. This is a role that UNICEF and other development partners can take on; they can also support actual implementation of the plan technically and resource-wise. Cases in point include providing technical assistance for linking health system wide state operational plans to budgeting processes, and increasing knowledge and understanding of equity focused planning and targeting including marginal budgeting for bottlenecks (MBB).

3.8.2. Support equity focused health care financing

The MCH project of the NHIS is the first major attempt by the agency to use a pooling scheme to support equity based financing. The evaluation of the project shows the potential of making major impact on maternal, newborn, and child health in the country. Development partners in Nigeria, including UNICEF, may wish to use the experience of the project in defining priority interventions with NHIS and in taking the lesson from the MCH project to scale. This may include providing technical assistance to model the added benefit of including cash transfer, for example, in the MNCH scheme in the most deprived settings. Other mechanisms include testing other risk pooling insurance schemes and free provision of services to the poor in order to expand their access to services. Equally important is expanding service to incorporate the packages that will impact the most on maternal, neonatal, and child health mortality especially among the poor, and finally work with NHIS to develop an advocacy package to help secure additional funding and promote the model as a core element for achieving universal coverage. Furthermore, the NHIS needs support to explore how it may create coherence across the various financing schemes it presently administers, to create expanded pooling and risk sharing.

3.8.3 Strengthen strategic health knowledge management

The Nigeria Health Management Information System (HMIS) continues to struggle as most

government and donor programmes initiate and support parallel systems for their reporting. A positive development is that the NSHDP has prioritised information management within the health system, the experience however is that this is easier said than done. An advocate for HMIS is what is needed, akin to what happened with the HIV/AIDS Nigeria National Response Information Management System (NNRIMS). The government must actively partner with and encourage development partners to contribute to the strengthening of HMIS by ensuring that all service-related data, including those generated by donor-funded projects and agencies such as NPHCDA, come through that system. Efforts in this regard could include the provision of technical assistance to relevant federal as well as state ministries, departments, and agencies. The government and its partners may also need to take another look at the HMIS system and reporting formats in the context of the NSHDP, including reviewing the indicators sheet and definitions, after a consultation process to ensure development partners' reporting needs are fed into the process. The planned Joint Annual Reviews to monitor progress towards achieving the targets outlined in the National Results Matrix of the National Strategic Health Development Plan is a good area for specific development partners to provide technical assistance, not only to the process but to provide a particular focus on measuring the equity component of coverage. There is a shortage in translating available knowledge into policy briefs particularly at state level and in using them for advocacy. These briefs should be targeted at various segments of society including the religious, traditional, and legislative arm of government and citizens. The aim is to move some of the health policy discussions from the technical table to homes and places of worship. This can enable the transformation of norms needed in order for some of the MNCH issues to improve, and also generate adequate political will to ensure expanded domestic financing and public commitment to change.

3.8.4 Support strategic and equity focused approaches to service delivery

Frontline service delivery is where the battle to reduce Nigeria's MNC deaths will be lost and won. Strategic reflection is required on how to implement the service delivery needed to reflect a more equity driven approach. This would include discussions on geographical and population-based location of these interventions as well as strategies for reducing bottlenecks as they relate to specific groups. One such area is the strengthening of the capacity of households to be able to treat several childhood health problems. There is a great need to strengthen social mobilisation and behaviour change communication. Communication tools for social change should be used to complement mass media based strategies to promote health-seeking behaviour and institutionalise such behaviour as norms. There is also the need to expand access to critical services such as skilled health workers, and to strengthen human resources to meet the desired expanded services.

4. Education and Child Development

4.1 Introduction

The 1999 Constitution of the Federal Republic of Nigeria recognises the right of every Nigerian to quality education. Indeed, article 25 of the United Nations (UN) Universal Declaration of Human Rights from 1948, which predates Nigeria's 1999 Constitution, states that all children are "entitled to special care and assistance". It is in this vein that the UN Convention on the Rights of the Child (CRC), adopted by the UN General Assembly in 1990 and ratified by Nigeria in 1991, advocates the right of every child to survival, protection and development. This implies the right of all children to participate in quality education irrespective of their situation. The Nigeria Child Rights Act (2003) demonstrates Nigeria's commitment to domesticating the CRC. Though many of its constituent states have done likewise with varying amendments to reflect the realities of their situation, some states have been slow in domesticating the CRC and hence prohibiting the violation of children's right to education and development.

Nigeria has also ratified, in 1985, the UN Convention on the Elimination of all Forms Discrimination against Women (CEDAW) adopted by the UN General Assembly in 1979. However, even though Nigeria is yet to give a legal framework to a comprehensive implementation of CEDAW and many other UN and government-initiated standards on child rights, available evidence indicate a steadily increasing awareness of the importance of education for promoting the rights of its people (Box 4.1).

Strategic steps taken in this regard include the transformation of the education system by the 1977 National Policy on Education into a structured 6-3-3-4 system. This places emphasis on using education as an instrument for social and economic development of the country. This policy has been revised four times (in 1981, 1988, 2004 and 2007) in an effort to address some of the observed gaps and to accelerate access, retention, achievement and quality, and to reduce disparities in education. There is no doubt that appreciable progress has been made, especially in the area of enrolment. For example, there has been some increase in primary and secondary education enrolments since 1999. However, the goal of universal basic education (UBE) – "Achieving Universal Education for All" – is unlikely to be achieved by 2015 (Box 4.1).

The UBE programme was one of the landmark developments in the Nigerian basic education sector in the post military era. It was launched by former President Olusegun Obasanjo in 1999. The programme is aimed at combating low access and completion rates, large rural-urban, gender, and regional disparities, and poor quality of learning in basic education. The policy extended free and compulsory schooling from 6 to 9 years, and it now provides a legal framework for the federal government's intervention in the sector as well as the institutional arrangement for the management of UBE funds. The policy recommended disarticulation, which required that Junior Secondary Schools be separated from Senior Secondary level so as to properly align the secondary education

Box 4.1
Children's right to education remains unfulfilled despite much effort

The government of Nigeria has increasingly recognised the right of children to education and development. This became clearly evident in the constitution, progressive and child-friendly policies, international commitment, and activities from 1999 onwards when the country transited from military to democratic governance. However, owing to challenges related to enforcing the rights of the child, increased efforts have not necessarily translated into equitable advantage for the Nigerian child.

of

Box 4.2
Key education initiatives in Nigeria since 1999

1999 *Launch of UBE that extended free and compulsory schooling from 6 to 9 years*

2004 *Linkage of education, especially basic, with the National Economic Empowerment and Development Strategy [NEEDS]*

2004 *UBE Act that provides a legal framework for federal government's intervention*

2004 *Disarticulation policy that separates the junior secondary education from the senior secondary school level.*

2004 *Review of basic education curriculum*

2007 *Education is included in the federal government's 7-point Agenda and becomes a fundamental aspect of the Vision 20-2020.*

subsector with the national policy requirements. Other steps also taken to consolidate the government's efforts in accelerating the development of the education sector include: (a) the review of the basic education curriculum to improve its responsiveness to emerging global and technological demands; (b) the introduction and implementation of improved Salary Scale for Teachers (TSS) which, among other things, aims at restoring the stability of the academic calendar in most states which hitherto had suffered recurrent disruptions due to emoluments-related protests by the education sector workers; (c) increasing the premium placed on education by bringing it to the front row of the government's investment plan as evidenced by its inclusion in the 7-point Agenda and the Vision 20-2020 document (Box 4.2).

The mobilisation of Nigeria's human resource potential for sustainable development is essential for the country to achieve its aspiration to be among the 20 most developed world economies by the year 2020 (Vision 20-2020). As part of the government's commitment to the eradication of illiteracy and improvement of the quality of basic education, President Goodluck Jonathan in October 2010 presided over a stakeholders' summit to address the subsisting decay in the education system and improve quality across all subsectors. In addition, the federal government continues to leverage states to ensure adequacy of financial provisions by sustaining its contribution of 2 percent of consolidated revenue to basic education as stipulated in the UBE Act. Increased investments in basic education have resulted in gradual improvements in Nigerian children's access to basic education. More girls, as well as rural and other disadvantaged groups are increasingly benefiting from basic education.

Despite these efforts and others made by international development partners, Civil Society Organisations (CSOs), and other stakeholders in education, education service delivery in Nigeria is still less than optimum. Problems still existing include poor access, particularly in rural populations and households at lower socioeconomic levels, inadequate funding, gender disparity in favour of boys, unsatisfactory quality of teaching/learning, and inadequate human resources in the form of qualified and dedicated teachers and other education sector workers. This chapter analyses the trends in educational achievement in Nigeria, some of the key challenges being faced, and the ways forward.

4.2 Basic education: the bedrock of Nigeria's educational development

Before 1982, the structure of the education system in Nigeria can be described as 6-5-2-3: this meant six years of primary education (ages 6-11 years); five years of secondary education (ages 12-16 years) for those who obtained the first school leaving certificate and were able to pass the entrance examination to this second level of formal education; then two years of higher school education which was followed by at least three years of university education or other forms of

tertiary education, or by a minimum of four consecutive years of tertiary level education for those who did not go through the higher school education (ages 18-22 years). This transition to tertiary level education was dependent on successful completion of secondary school education with no less than five credit level passes in subjects related to the courses of study available at the tertiary education level.

Beginning from 1982, the structure of the Nigerian formal education system was changed to 6-3-3-4. This meant a six-year period of primary education (ages 6-11 years) followed by three years of junior secondary school (ages 12-14 years) for those who successfully completed primary education and obtained the first school-leaving certificate and passed the entrance examination to secondary school. This level of education was then followed by another three years of senior secondary school education (ages 15-17 years). Those who completed this level and earned at least five credits in subject areas relevant to the courses of study available at the next and final level of education (tertiary level education), would then be admitted for not less than four years of formal education at the end of which they obtained a bachelor's degree. Those who went through the Polytechnic or Monotechnic strands would study for two years for the National Diploma certificate, do one compulsory year of industrial attachment before spending another two years of study in either the Polytechnic or Monotechnic to obtain the Higher National Diploma Certificate. This is theoretically an equivalent of the Bachelor's degree obtained by those who went through the university strand of tertiary education.

The UBE programme was introduced first in 1999 and reviewed later in 2004 to remove uncertainties regarding how it should be operated, particularly with regard to the responsibilities of the three tiers of government (federal, states, and the Local Government Authorities [LGAs]) who had responsibilities for its successful implementation. According to its implementation blueprint, the UBE focuses on a compulsory nine-year programme embracing formal primary and junior secondary education levels. It is important to note that transition from primary school to JSS, under UBE, is expected to be automatic with no form of certification at the completion of primary education and no entrance examination before admission to JSS. Despite the fact that the UBE programme redefined basic education in Nigeria as a compulsory and free education programme given to Nigerians aged 14 years and below, the structure of the education system still remains 6-3-3-4. The stated reason for this is the government's desire to disarticulate the junior secondary school (JSS) segment from the senior secondary school (SSS) segment. The latter focuses more on academic development unlike JSS where a lot of attention is given to vocational education in addition to academic education. With this approach, it is expected that those who are not aspiring for more academic studies could, at the end of their JSS education, either transit into technical and vocational schools or graduate with a certificate that will make them suitable for various forms of work or apprenticeship. The additional important component is that it is expected that at the end of nine years of formal schooling, literacy, numeracy, and other relevant skills and knowledge would have been sufficiently acquired. Thus, the education received would be enough for the recipients to build on in the future even when they are not in formal schools.

It is pertinent to note that at the inception of the UBE programme, while primary, secondary, adult literacy and other non-formal education came essentially within the purview of government agencies, early childhood care and pre-primary education were predominantly a private enterprise (with the government providing policy guidelines aimed at standardizing curriculum and practice). However this situation has changed since the review of the National Policy on Education, which has now made early childhood development (ECD) an integral part of the UBE programme.

In a nutshell, the UBE is a comprehensive programme that attempts to ensure life-long education of which the formal and compulsory component is 9 years of schooling divided into primary education (6 years) and junior secondary education (3 years). The primary education stage is preceded by a

pre-school stage for children under 6 years of age.

4.3 Early childhood development and pre-primary education

Early childhood development (ECD) is the care, nurturing, stimulation, and healthcare that a child receives from birth to the age of five years. It is a period of rapid development in the life of a child. This stage is crucial in shaping the potential for a full and productive life in adulthood. When well nurtured and cared for in their early years, children are more likely to survive, grow in a healthy way, be less prone to diseases and illnesses, as well as develop critical thinking, language, emotional and social skills. ECD interventions aim to support effective and essential actions at each phase of the life cycle of the child, from pregnancy, through early childhood, school-going years, and adolescence. It assists parents, teachers, service providers, policy makers and other duty bearers to provide age-relevant support, care and protection for very young children in a holistic manner. ECD provides needed support for children's survival, growth, development, and learning through the health, nutrition, nurturing care and stimulation services provided to them. In most countries these services are usually supported by government through the joint operations of such social service sectors as education, health, and water and sanitation. Such services are aimed at either directly or indirectly giving support to parents and communities in properly caring for the development and early education through stimulation of the very young members of the community – either by direct intervention or by creating an enabling environment for their development and education, or by a combination of both approaches.

4.3.1 Policy development

In Nigeria the National Policy on Education (NPE) from 2004 recognises the right to pre-primary/nursery education (FGN, 2004). Section 2, Sub Sections 11 to 14 of the NPE states that early childhood care education (ECCE) or pre-primary education is to be provided to children aged 0-5 years prior to entry into primary school. The purpose is to promote smooth transition from home to school, prepare children for primary education as well as provide adequate care and supervision for children while their parents are at work. The state and local governments are encouraged to establish pre-primary sections in existing public schools. Earlier versions of the NPE show that the government had committed to a minimal role with regards to pre-primary education. Much of the responsibility for the provision of education was left to private providers while the government regulated standards.

However, with the UBE Act (FGN, 2004), and the National Policy for Integrated Early Childhood Development in Nigeria (FME, 2007), Nigeria's resolve to provide pre-primary education, particularly for children from marginalized and excluded groups, was strengthened. In addition, its effort to ensure attainment of the 2015 Education for All (EFA) targets further provided the impetus for government to play a more active role in expanding and improving early childcare and education so as to give all children a good start in their educational development. Implementation of the UBE policy requires all public primary schools to articulate and integrate a pre-primary section to boost the access of very young children to early childhood education in preparation for primary education. Its aim is to provide children with pre-academic skills to learn basic concepts, improve fine motor co-ordination, help children begin to master skills necessary for reading, writing, and numeracy, and develop social skills. Other government policies, including Vision 20-2020, FME Road Map for Nigeria's education sector and the One Year Education Strategy Plan (FME 2010), have continued to emphasise issues related to ECD, thereby fostering an enabling policy environment for implementation of the UBE policy.

The ECD policy is an expression of the government's intention and commitment to meeting the needs and fulfilling the rights of pre-school children. While the Child Rights Act (FGN, 2003), the UBE Act (FGN, 2004), the National Policy on Education (FGN, 2004), and some policies on nutrition and health make important contributions towards improving child welfare and survival in

Nigeria in their own right, the ECD Policy combines interventions from the various sectors to promote an integrated and holistic approach to child development. The policy aims to ensure a conducive environment for ECD implementation and advocates strong synergies between sectors for sustained and effective child development.

Guidelines to streamline the implementation of the ECD policy have been developed, though these are yet to be published and disseminated widely for use. Although the policy addresses ECD on a multi-sectoral basis, budgeting and implementation are virtually intrasectoral in structure. The inability to access funds at the right time, due to variations in ease of accessing funds in various sectors, hinders synchronisation in implementation of multi-sectoral activities. Factors such as low commitment to the enforcement of the ECD policy, non-domestication of national minimum standards, proliferation of sub-standard centres, dearth of basic facilities, inadequacy of qualified teachers and a large number of untrained care givers have contributed to low quality ECD delivery. The on-going support by UNICEF, UNESCO, DFID, World Bank and the Education Sector Support Initiative in Nigeria (ESSPIN) to states towards incorporating pre-primary education in Education Sector Plans is a welcome development which will hopefully ensure sustained funding for ECCE/pre-primary education by states. UNICEF has supported 18 states to develop their sector plans that included ECD as a thematic priority area, thereby ensuring sustained funding for ECD in these states. Enhanced status for ECD coordination at the national level was improved by the government's transfer of the inter-ministerial coordination point from a parastatal institution (National Educational Research and Development Council, or NERDC) to the Federal Ministry of Education, with the Honourable Minister as the Chair. This has forged more ministerial collaboration in support of ECD.

Box 4.3

Over half of all pre-school children are from poor households

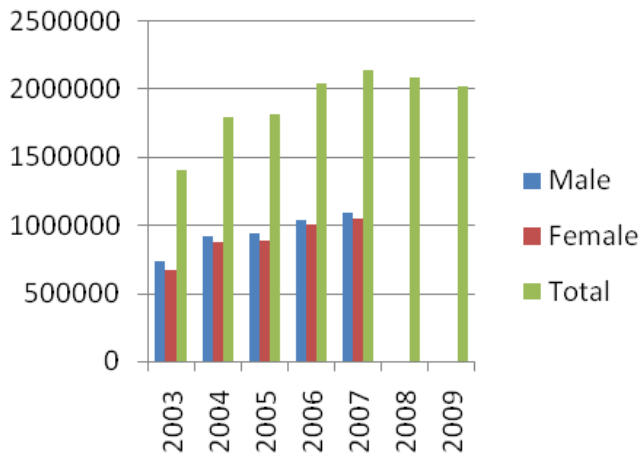
In Nigeria, 55 percent of 5,420,000 children aged below six come from poor households

EFA Global Monitoring Report, 2007.

4.3.2 Access and equity

Though implementation of the UBE policy across all primary schools has been slow, there has been consistent growth in children's enrolment in ECD programmes across the country since its inception. This increase corresponds to a period of expansion of ECD in public primary schools with an enrolment figure of 1,819,752 in 2010 representing a 33.1 percent increase over the 2005/2006 figure of 1,367,326 (NEMIS, 2010, p. 13. Of these, 49 percent (1,049,329) of the children enrolled were girls while 51 percent were boys (Figure 4.1). As observed by the 2007 Situation Analysis (NPC and UNICEF, 2007) the linkage policy, integrating pre-primary education into every public school to make it accessible to children, particularly those from low income families, accelerated the increase in the number of early childcare centres and engendered an upsurge in enrolment in primary schools, though without corresponding attempts to sustain quality. The increase in enrolment in each zone is probably an indication of the extent to which the policy on articulation of ECD to public primary schools had been implemented in each of the zones. It is however imperative that this increased accessibility should be carefully sustained and further improved through consistent advocacy and awareness creation (Box 4.3).

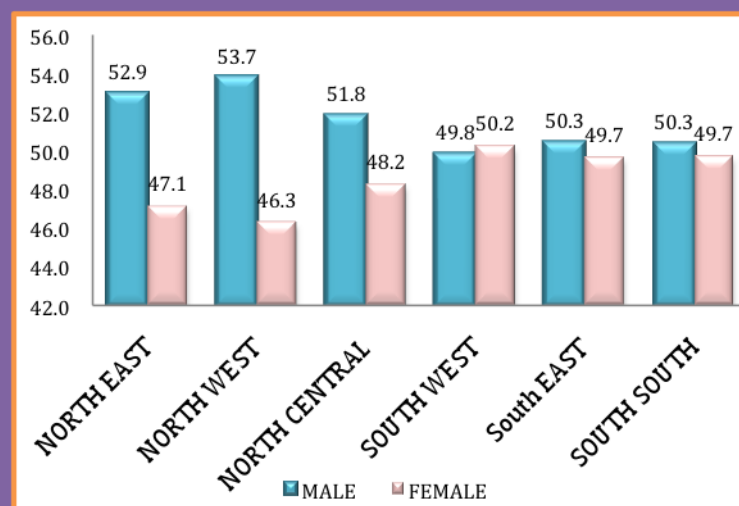
Figure 4.1 Pre-primary school enrolment 2003-2009.



Source: NEMIS 2010

Though progress has been made in enrolment over a few years, limited access for children is still a serious concern. The FME Road Map (2009) indicates that barely two million of the eligible pre-school aged children have access to ECD programmes nationwide. Data suggest wide gender disparities between the northern and southern states in enrolment at this level (Figure 4.2). In addition to inaccessibility of ECD services, studies have found that few children have access to play/learning materials at home, although there have been significant improvements. The percentage of under-five children living in households containing learning materials increased from 35 percent in 2005 to 51 percent in 2007 in urban areas, while the corresponding increase in the rural areas was from 20 percent to 29 percent (NBS & UNICEF, 2007).

Figure 4.2 Enrolment of children in ECD/pre-schools by geopolitical zones and sex, 2007



Source: FME (NEMIS, 2007)

As evident in Figure 4.2, gender disparity in enrolment in ECD is in favour of males in the northern zones while there is little gender difference in the southern states. The largest gender disparity in favour of males is recorded in the North west (54 percent for boys versus 46 percent for girls). In the southern zones there is near gender parity in enrolment with a gender gap of 0.4 percent. Data from the 2007 MICS reveal that the percentage of children 0-59 months old left in the care of other children under the age of 10 years is 29 percent for urban areas and 38 percent for rural areas (NBE &

UNICEF, 2007). These are quite high proportions; the number of children who have to care for younger children must be contributing significantly to the large number of out of school children at the primary level. Increasing enrolment in ECD centres can thus have a substantial and positive effect on older children's ability to go to school and exercise their right to education.

4.3.3 Quality

The progress made regarding access to pre-primary education in the last five years has not been matched by commensurate quality service, thereby compromising the efficiency and quality of the

outcomes. The common experience is to have young children in pre-school classes where they are learning very little because of unavailability of qualified teachers and caregivers and lack of teaching/learning materials. A recent study entitled “School Readiness Factors and Practices in Some Selected States of Nigeria” (FME/UNICEF, 2009) reveals very poor school readiness preparation for very young children at home, in the community, and at the school. This level of the basic education system continues to be embattled by inadequacy of qualified and well motivated ECCE teachers and caregivers, poor quality learning environment particularly in public owned facilities, low government financial resourcing and poor coordination among the line sectors to ensure holistic actions and support for providing quality service. Current efforts are ongoing by FME with the support of UNICEF and other international development partners to address many of these challenges.

The NERDC has articulated a Minimum Standard for ECD centres in Nigeria that streamlines various categories of facilities and operations. The guidelines specify minimum standards for, among other things, physical facilities, playground, furniture, and teacher qualification. However, the standards are not fully operational nationally due to weak quality assurance systems for monitoring compliance at state levels. Also, the National Integrated Early Care and Development curriculum for ages 0-5 years and other curriculum materials developed – using a rights-based and lifecycle approach making special provisions for orphans and vulnerable children and those living with HIV/AIDS – are not yet widely operational because they have not been mass produced to reach all schools. The curriculum materials include: (a) the National Care-Givers Manual for ages 0-5 (2006) where the roles and skills required for caring and stimulating children 0-3 and 3-5 years of age are fully articulated; (b) the National Manual for Local Toy Making (2007), to facilitate easy access and availability of local toys; (c) the Integrated Management of Childhood Illnesses (IMCI) Counselling Guide for Community Resource Persons and Care Givers; and (d) Child Stimulation Charts that have been translated into 13 local languages. It is hoped that that this challenge will soon be overcome when the state education sector and operational plans become fully institutionalized and inform budgeting.

The findings of a study on capacity of ECD in pre-service and in-service teacher education and development programmes revealed serious gaps in methodology, pattern of classroom interaction, and lack of depth in programming in ECD delivery (World Bank/UNICEF/FME, 2009). The findings are already being utilized by the National Commission of Colleges of Education (NCCE) and National Teachers’ Institute (NTI) to draft the frameworks for pre-service and in-service ECCE teacher capacity development. Furthermore, to ensure future supply of qualified ECCE teachers, the NCCE has mainstreamed ECCE into the pre-service teacher-training minimum standard and also instituted a special curriculum for specialization in ECCE with UNICEF’s support. The special course has been tested successfully in 21 Colleges of Education (CoEs), and is ready for wider implementation. Development of a critical mass of ECCE managers within the FME, State Ministries of Education (SMoEs), and NCCE and other partners is taking place through the training initiative of the Early Childhood Development Virtual University (ECDVU) and use of the UNICEF ECD Resource Kit. Twenty-seven ECD managers are currently in the ECDVU programme, in addition to five who graduated in 2009 while all ECD intersectoral partners at national and sub-national levels have acquired skills to apply the content of UNICEF ECD Resource Kit and the ECD Emergency Kit for quality programming. It is anticipated that all these catalytic actions will soon result in more visible progress and this process needs to be properly tracked. Development of a national standard for monitoring ECD progress is therefore imperative and should be accorded priority in subsequent interventions.

4.4 Primary education

Primary education remains the bedrock upon which the formal education system in Nigeria is built. It is the first stage of formal schooling for children, and their foundation in education is laid during

these six years of learning between the ages of 6 and 11.

Despite the existence of a plethora of policies that provide the operational framework for primary school development, the many international proclamations to which Nigeria is signatory, and the fact that funding is in relative terms slowly increasing, this sub-sector of education service provision is still grappling with challenges such as access, retention, internal efficiency, completion rates, quality, and low learning outcomes.

4.4.1 Access and equity

According to the Road Map on Nigerian Education Sector (FME, 2009), only 24.4 million children out of the expected primary education enrolment of 34.9 million were in school in 2009, indicating an out-of-school population of 10.5 million children (FME, 2009). The 2010 Education for All Global Monitoring Report also reported that 8.6 million children of primary school age in Nigeria are out of school (UNESCO, 2010). Data from national surveys indicate wide disparities in primary school enrolment indicators among states, geopolitical zones, socio-economic groups, urban and rural locations and gender (NBS/UNICEF, 2007, FME 'NEMIS', 2007). These disparities are related to socio-cultural, economic, religious, and attitudinal factors amongst others.

Absolute deprivation in education remains a major concern. A quarter of all children (25 percent) in the 7-16 years age group have no education; of these 49 percent are from the lowest wealth quintile. As many as 9 in 10 of these children with no education are found in the North west (46 percent) and North east geopolitical zones. They are also mostly found in the rural areas. Hausa girls from the northern part of the country face some of the world's most severe education deprivation. Just 12 percent of Hausa girls of primary school age attend primary school, and 97 percent of 17 to 22 year-olds have fewer than 2 years of education (UNESCO, 2010).

The 2007 NEMIS gives the net intake rate (NIR)² as 61 percent, (63 percent among boys, 60 percent among girls), with higher proportions in the urban areas than the rural areas. The difference between urban and rural areas may be attributed to the differences in economic conditions, parental awareness of the importance of primary education, availability of schools within reasonable distance, and access to facilities in more child-friendly environments that encourage enrolment. Unlike the situation in urban areas, there are limited social amenities in the rural areas to encourage the interest in education taken by children and their parents. In addition, girls especially in the rural areas are compelled to undertake household chores such as fetch water and firewood and take care of family members including younger siblings, the sick and the elderly, which may make them unable to attend school.

Gross enrolment in primary school has been increasing in recent years, though not consistently. While it increased from 17.9 million in 1999 to 25.7 million in 2003, it dropped significantly to 21.4 million in 2004 before increasing again to 27.1 million in 2005. Statistics from the 2006 National School Census (FME 2006, NSC) show an enrolment figure of 24,422,918 children. Of these, 13,302,269 are male (54.5 percent) and 11,120,649 female (45.5 percent), giving a gender parity of 83.6 percent. The inconsistencies in the enrolment level, despite the consistently increasing resource input and mobilization/awareness campaigns, could be attributed to three major reasons: (i) prolonged mass teachers strike in 2007, which might have induced boys and girls drop out as a result of lack of confidence in the system; (ii) withdrawal of the Home Grown School Feeding programme which de-motivated several enrolled children from continuing; and, (iii) failure of some private schools to return school census forms due to dissatisfaction with multiple taxation resulting in a drastic reduction in the aggregated enrolment for private schools in affected states in 2007.

² Net Intake Rate (NIR) in Grade 1 is the number of new entrants in the first grade of primary education who are of official primary school entrance age. Expressed as a percentage of the corresponding age.

Poverty is one of the key factors contributing to the high number of out of school children in Nigeria. Although basic education is said to be free and compulsory, there are some hidden costs that parents are required to meet. These include purchase of school uniform, transport costs, and in some cases, purchase of learning materials. Meeting these costs is a challenge for some parents, especially those from the lowest wealth quintiles, thereby making it difficult for children from these households to enrol and stay in school. Parents also consider the quality of education, and if it is perceived to be low, they may decide that it is not worth it to get their children or ward enrolled. In some cases, the elimination of official fees has led to deterioration in quality as the enrolment surged, increasing class sizes and straining the school infrastructure and quality of teaching and learning. Thus, abolition of school fees as a stand-alone strategy is often not successful in improving access and retention of children in school, and ought to be supported by other interventions including among others increased supply of teachers, classrooms, and learning materials.

Other factors associated with lacking enrolment, according to the 2004 household-based Nigeria Education Data Survey (NDES), include household need for labour (33.8 percent), consideration that the children are too young to attend school (20.2 percent), far distance to school (20.1 percent), preference for Qur'anic school (15.8 percent), poor school quality (13.8 percent), consideration that the children are too old to attend school (9.6 percent), and travel to school considered unsafe (8.9 percent). The same report outlines important age related variations in the reasons why pupils fail to attend school. For those aged 6 –7 years, the most important reason is “too young to go to school” (47.5 percent) followed by “school too far” (24 percent) and high monetary cost (19.4 percent). For those aged 8 –11 years the most important reasons include “labour needed” (35.4 percent), monetary cost (25.7 percent), school too far (21.9 percent), preference for Qur'anic school (18.4 percent), and poor quality of education (15.5 percent). For those aged 12-16 years the most important reasons for not attending school include “labour needed” (48.7 percent), monetary cost of schooling (23.1 percent), “too old to go to school” (21.5 percent), and preferences for Qur'anic education (20.3 percent).

In 2005, the net enrolment rate (NER) for primary school was 83.7 percent, 87 percent for males and 81.4 percent for females (FME, 2010). A different source however reported the NER in 2007 as 64 percent (males 68 percent, females 60 percent), with a gender parity index (GPI) of 0.88 percent (UNESCO, 2010). This suggests a considerable decrease in NER, which may be attributable to the different sources of information and hence different methodologies used for the data generation. The GPI, according to the 2007 NEMIS data, steadily increased from 0.84 in 2005, to 0.85 in 2006, and to 0.92 in 2007 (FME, 2010). While there are differences between these data and the UNESCO estimate reported above, they show a similar trend in terms of gradual but consistent progress towards gender parity.

When disaggregated by geopolitical zones, available data indicate that states in the South west, South east and South south zones have near attained gender parity, while the North east and North west zones have marked differences between boys and girls (Figure 4.3, p. 60). This is attributed to, among others, the economic conditions, distrust of western education by some northern communities, and early marriage and other gender-related discriminatory cultural practices and inhibitions like inadequacy or absence of qualified female teachers. Low commitment to the enforcement of the UBE Act is also a contributing factor.

The overall steady progress made in reducing gender disparities has been occasioned by numerous commitments and efforts made by the government and development partners such as UNICEF, DFID, World Bank, UNESCO, and USAID. Efforts aimed at mainstreaming gender in educational planning and implementation are particularly noteworthy in this respect. UNICEF and DFID have specifically supported implementation of the Girls' Education Project for the last six years in six

northern states (Borno, Katsina, Bauchi, Sokoto, Jigawa, and Niger) aiming at increasing participation of girls in education. Key interventions include ensuring that state education sector plans are gender sensitive, continuous advocacy with key education policy makers and decision makers on the need for gender mainstreaming, advocacy with traditional and religious leaders in support of education particularly for girls, promotion of gender sensitive school based development plans with community support, community participation in school management, training and recruitment of female teachers especially for remote rural areas to encourage girls' enrolment and attendance, and training of teachers in child friendly, gender sensitive teaching and learning methodologies. In addition to these interventions, the development of the National Policy on Gender in Basic Education has provided the legal framework for mainstreaming gender in educational programmes. The policy is now being implemented throughout the country.

Box 4.4
Internal efficiency in primary school level

In Nigeria, low primary school completion rate is reflected in declining internal efficiency from 82 percent in 2003/2004, to 69 percent in 2005, and 68 percent in 2006/2007.

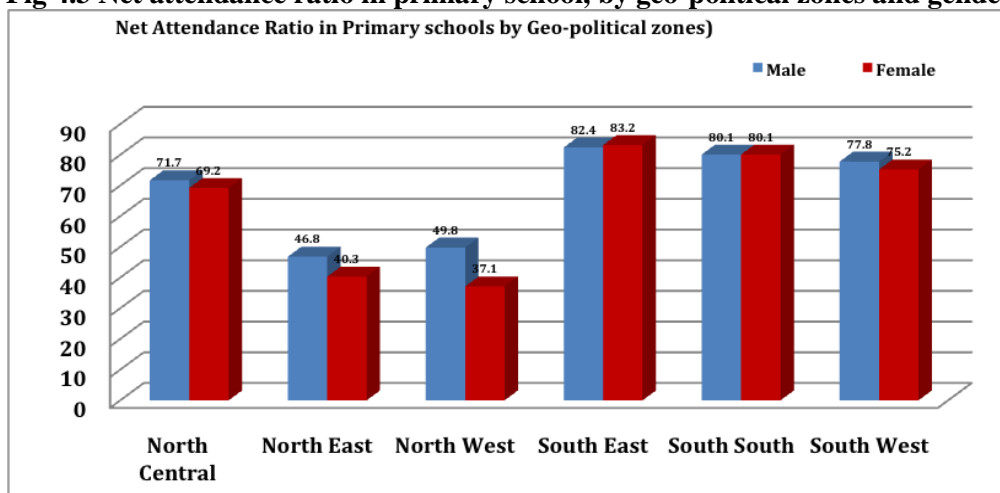
4.4.2 Internal efficiency and completion rate

The internal efficiency of a school system is calculated based on promotion, repetition, and drop out rates. The 2007 Situation Analysis (FGN/UNICEF 2007) reported that repetition rates were relatively low within the public school system. This is not necessarily a true reflection of the performance efficiency of the school system. Low repetition rates in Nigerian schools are a consequence of the seamless transition policy (smooth promotion) specified by the guidelines on the implementation of the UBE Act. Although this policy has become contentious in view of pupils' poor performance in external examinations, it is not without advantages. The issue lies with the poor implementation of the continuous assessment policy by teachers who are not adequately trained in the practice and process. It is possible that with appropriate training, teachers would be better equipped to track pupils' performance and provide remediation to improve success rates at completion.

As required by the 9-year compulsory schooling policy, pupils who enrol in grade 1 should complete 6 years of primary education. However, an appreciable proportion of pupils from privileged backgrounds transit from fifth or sometimes fourth grade to JSS 1 without completing the sixth grade in primary school. This practice tends to portray low primary school system efficiency. The direct movement from primary 4 or 5 to JSS 1 is a result of parents applying undue pressure to get their children into secondary schools earlier than allowed by policy. This practice ought to and should be discouraged because at such an early age, children do not easily conceptualize and understand complex concepts in science and technology. Internal efficiency has been on the decline since 2004 (Box 4.4). It has declined from 82 percent in 2003/2004, to 69 percent in 2005, to 68 percent in 2006/2007 – a reflection of low attendance rates, low transition by grade and low completion rates as will be discussed below.

Education statistics show that net attendance ratios (NAR) are relatively lower than net enrolment ratios (NER), implying that the number of children attending school is lower than the number of children who enrolled. The overall NAR and gross attendance ratio (GAR) for primary school in 2007 were 62 percent and 84 percent respectively (NPC & Macro ICF, 2008), with wide geographical and gender disparities. Attendance rates are higher in urban areas (NAR 74 percent and GAR 95 percent) than in rural areas (NAR 57 percent and GAR 79 percent).

Fig 4.3 Net attendance ratio in primary school, by geo-political zones and gender

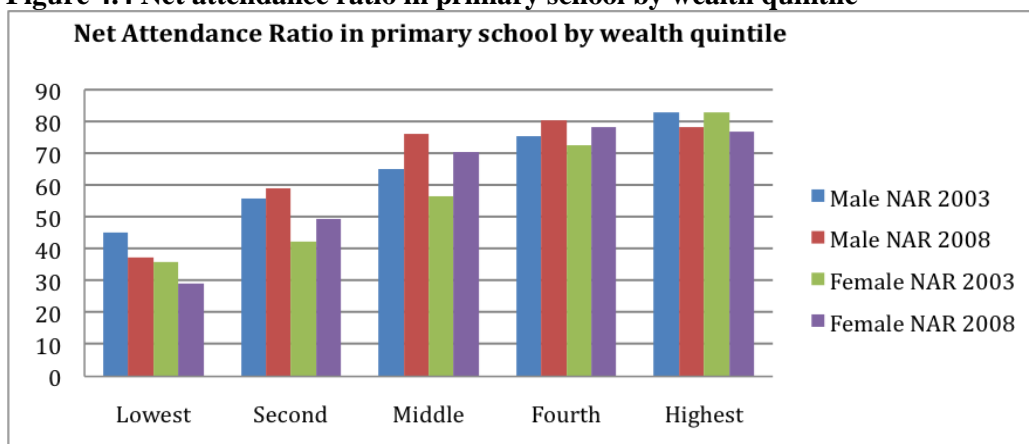


Source: NPC & ORC Macro, 2004; NPC & ICF Macro, 2009.

Wide variation is recorded between the geo-political zones with the proportion of girls attending school being lower than that of boys for all the three northern zones and the South west zone. In the South south and South east zones, girl attendance is slightly higher than that of boys. The primary school NAR is highest in the South east (83 percent), while that of North west is the lowest with 43 percent, in favour of boys (Figure 4.3). Dropout rates are higher for girls than boys towards the end of primary school, probably linked to early marriage and priority afforded to boys in terms of continued schooling in poverty-stricken families.

Analysis by wealth quintiles shows disparities between the poorest and richest when it comes to education: only a third of the children (33 percent) from the lowest quintile attend school compared to 79 percent from the fourth quintile. The same trend applies for the GAR, which is 105 percent for the fourth quintile and 48 percent for the lowest quintile. For both girls and boys, attendance increases with increasing household wealth in Nigeria. Overall, the NAR and GAR for boys (65 percent and 89 percent respectively) are higher than that of girls (59 percent and 80 percent respectively). The gender gap is reflected across all the wealth quintiles but the gap is smaller among the higher wealth quintiles.

Figure 4.4 Net attendance ratio in primary school by wealth quintile



Sources: NPC & ORC Macro, 2004; NPC & ICF Macro, 2009.

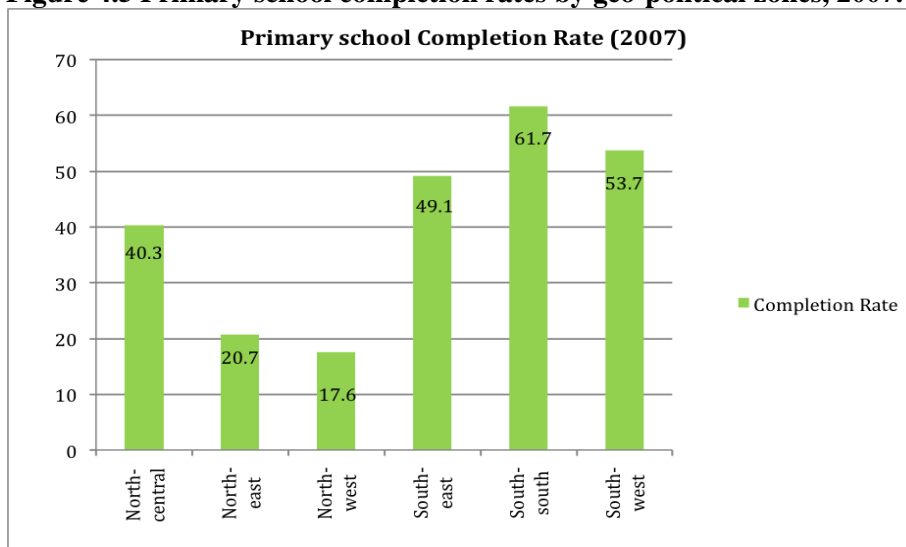
It is important to note that although the overall NAR is increasing, the net attendance of the already low NAR in the lowest quintile is actually decreasing (Figure 4.4). This clearly shows that school attendance by children from the poorest households has dropped between 2003 and 2008. This

further implies that fewer children from poor households attend school, while an increasing proportion of children from other quintiles do attend school. This is a major issue of concern, calling for further investigation and targeted interventions that can help keep these children from poor households in schools.

Further analysis of data on factors contributing to low attendance rates indicates that there are some differences in the reasons why urban- and rural- based pupils fail to attend school. While monetary cost affects both groups equally, need for labour, school being too far, poor school quality, and unsafe travel to school affect rural-based children more than their urban counterparts. On the other hand, preference for Qur’anic school, too young to attend school, lack of interest in schooling, and no good job for graduates affect urban-based children more than rural-based children.

Completion rates are still low, more so for the northern geo-political zones (Figure 4.5). In 2007 the completion rate was 17.6 percent for the North west and 20.7 percent for the North east zones compared to 61.7 percent for the South south zone. These low completion rates are a reflection of the low attendance rates and low transition rates by grade, especially in grade five.

Figure 4.5 Primary school completion rates by geo-political zones, 2007.



Source: NBS & UNICEF, 2007.

4.4.3 Learning outcomes

Data on the quality of learning outcomes are available from national assessments of the UBE programmes for 2001, 2003 and 2006. Among the targets of 2006 were pupils in primary school grade 6 who were then the first set of UBE pupils to get to this level. They were assessed in the four core subjects; English language, mathematics, primary science, and social studies/life skills. The findings of the national survey showed a mean percentage performance of 48.8 percent for English language, 42.9 percent for primary science and 49.8 percent for social studies, revealing low level performance in these core subjects. Compared to the 2003 Monitoring Learning Achievement (MLA), performances were only slightly better but similar in pattern of scores (below 50 percent in all subjects). In grade 4 the scores in the three areas were as follows: numeracy 33.7 percent, literacy 35.1 percent, and life skills 43.8 percent. In grade 6 the results showed essentially the same trends with the following scores: numeracy 35.3 percent, literacy 41.5 percent, and life skills 25.4 percent.

Disparities in learning achievement are influenced by the type of school children attend and sometimes their family background. Differences between schools play a critical role in the level of equity within education systems. Schools are often marked by large variations in class size, availability of books and teaching materials, quality of teachers, and school building standards. Improving school quality and narrowing differences between schools will reduce inequality in

student performance. School-based disparities do not operate in isolation, but interact with and reinforce wider disadvantage, including parental income, education, home language, and other factors that are strongly associated with learning achievement (UNESCO, 2010). In addition, poor performance could accrue from such factors as inadequacies of provisions at school level including poor teacher quality, non-coverage of syllabus, and lack of instructional materials or from challenges at macro level such as poor quality assurance practices and teacher support systems. Performances are also affected by issues related to the individual pupil as well as the family situation (FME/UNICEF MLA 1997, 2006). Targeted programmes should take into consideration all the associated factors of equity that may disadvantage children's performance.

4.5 Junior secondary education

Junior secondary school (JSS) is the second level of the 6-3-3-4 education system and targets children aged 12-14 years. JSS is to operate as a separate entity independent of senior secondary or primary schools (Box 4.5). The policy is based on (i) the realisation that a minimum of 9 years formal schooling is required for one to become permanently literate; (ii) the need to sustain the JSS identity as an avenue for introducing basic integrative skills and not allow it to be overshadowed by the character of primary or SSS levels; and, (iii) the need to protect the part of the federal government counterpart fund for basic education accruing to JSS.

4.5.1 Transition from primary to JSS

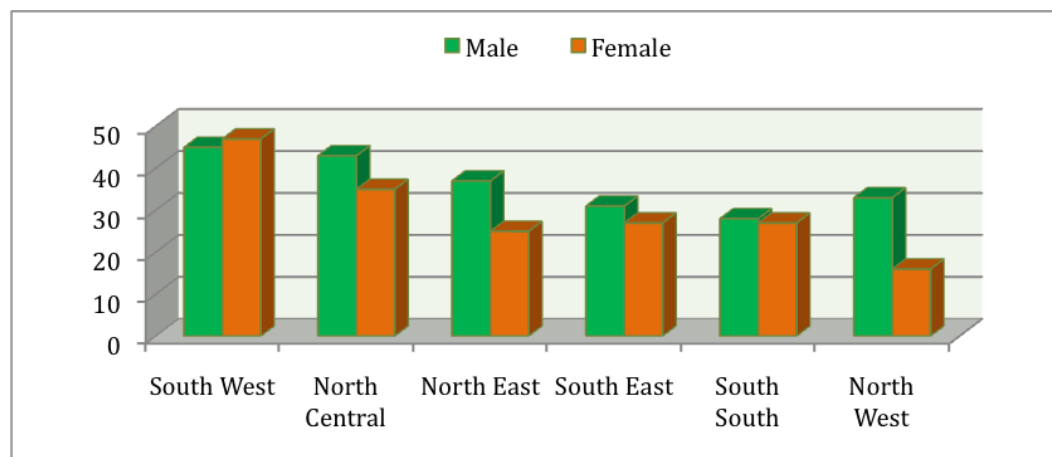
By the provisions of the 2004 UBE Act all pupils completing grade six of primary school should transit seamlessly to JSS I, implying 100 percent transition rate.

Out of a total of 10,844,998 children aged 12 to 14 years only 3,531,429 were enrolled in JSS in 2007, leaving 7,313,569 children out (FME, 2007b). The gross enrolment ratio (GER) for JSS in 2007 was 32.4 percent, a decline from 2006 when the GER was 36 percent. The EFA Global Monitoring report similarly reported the GER in 2007 at 35 percent (male 39 percent, female 32 percent) (UNESCO, 2010). Considering the intensification of activities aimed at ensuring a smooth transition to JSS, the decrease in GER may be related to the low returns of school census forms from private school proprietors, a major challenge that is still facing the country and distorting the education statistics.

Box 4.5

Separation between junior and senior levels of secondary education is in line with the National Policy on Education, for strategic development of the junior level free from overshadowing influence of the senior level. Complete disarticulation has been achieved in some states, while others have only achieved partial implementation.

Figure 4.6 Junior secondary school enrolment by geo-political zones, 2007.



Source: FME, 2007 (NEMIS)

According to the 2007 National Educational Management Information System (NEMIS), the highest GER was recorded in the South west (45.4 percent) and North central zones. The GER overall for boys (35.4 percent) was higher than that of girls (29.5 percent). Gender disparities in favour of boys are larger in the northern geo-political zones compared to the southern zones, and GER was actually higher for girls compared to boys in the South west zone (Figure 4.6). Girls in the South west zone (46.6 percent) had the highest GER while girls in the North west zone (16.4 percent) had the lowest GER. Overall, available data show a decrease in gender parity, with the GPI worsening from 0.87 percent in 2006 to 0.83 percent in 2007.

The NAR at the secondary school level is 49 percent, while the GAR is 73 percent. Both ratios are much higher in urban areas than in rural areas. Similar to the pattern seen in primary school education, the NAR is higher among males (52 percent) than among females (46 percent). The same is true for the GAR statistic, at 80 percent for males compared to 66 percent among females. The South east and South west zones have the highest NAR (both 69 percent) while the North east (27 percent) and North west (26 percent) zones have the lowest. Both NAR and GAR are highest in the highest wealth quintiles (74 percent and 106 percent respectively), while the figures for the lowest quintile are 15 percent and 25 percent respectively.

The transition from primary to junior secondary school is difficult for many children. Barriers at the primary level are often magnified at the secondary level, including cost, distance to school, perceived low returns on investment in education, labour demands, and – especially in the case of girls – deeply ingrained social, cultural and economic barriers. The likelihood of Nigeria achieving the Millennium Development Goal of 100 percent enrolment and completion of nine years basic education by 2015 is weakened by the fact that only 35 percent of the eligible children get to JSS level. Improving enrolment for children in the rural areas, especially girls, requires targeted interventions that will help them access and remain in school.

4.5.2 Completion rate

The JSS completion rate in 2006 (78.2 percent) was slightly lower than that of 2005 (80 percent), with slightly more females (78.4 percent) completing the basic education cycle than their male counterparts (78 percent). The reality of the male drop out syndrome in some areas combined with the intensification of activities to boost girl-child education, especially in the northern part of the country in recent years, could be responsible for the apparent advantage conferred on girls.

4.5.3 Learning outcomes

The 2006 assessment of the Universal Basic Education programme was carried out in primary grade six, JSS1, JSS2 and JSS3 classes. In addition to English language, mathematics, basic science and social studies, performance in introductory technology was assessed. The findings showed that the mean percent performance for all JSS classes were consistently lower than for primary grade six pupils. Although the assessment confirmed the superiority of the Basic Education Programme it also reiterated the low efficiency of the basic education subsystem as none of the classes scored over 50 percent in any of the subjects assessed. The lacking disaggregation of performance by gender, state, and related variables limits further analysis.

4.6 Adult and non-formal education

The National Policy on Education describes mass literacy, adult and non-formal education (NFE) as basic education given to adults, children, and youth of formal school age outside the formal school system. The aim, as specified in the policy, is to provide functional education for adults and youth who have never had the advantage of formal education or who left school too early (FME, 2009). Both federal and state governments have agencies under their respective Ministries of Education to coordinate adult and non-formal education delivery. The National Commission for Mass Literacy, Adult and Non-Formal Education (NMEC) and State Agencies for Mass Education (SAME)

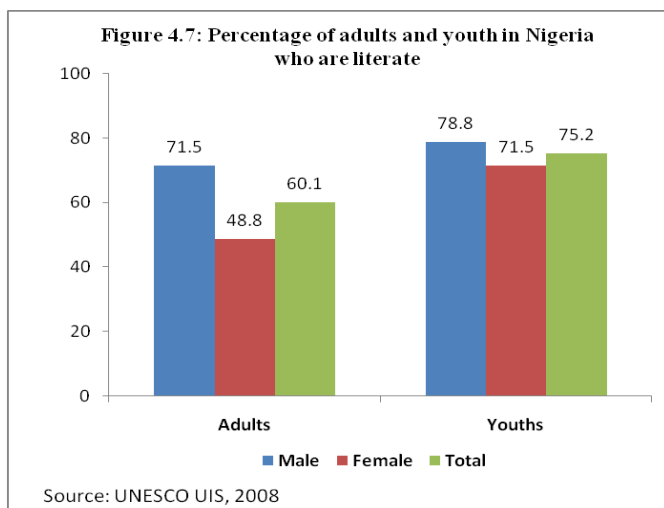
coordinate programmes in basic literacy, post-literacy, continuing education, and extra-mural studies. Their mandates include provision of alternative basic education to out-of-school children to empower and prepare them for the world of work. Achievements have remained hazy and inconclusive due to lack of well-organized data collection and monitoring systems. Progress in this sub-sector has generally been hampered over time by low government commitment and resourcing, lack of a properly structured facilitation/remuneration system for adult and non-formal education facilitators (teachers) and managers, lack of reliable data to facilitate results-based planning and monitoring, and weak systems and human capacity to plan and organize effective and efficient programmes.

Although the National Policy on Education (2004 Edition) properly articulated interventions for adult and non-formal education, low government priority and resourcing of this subsector has been a major factor inhibiting the promotion of a literate society in the country. UNICEF’s support to NMEC in 2006 to renew the edict establishing the Commission in line with democratic principles was truncated by the government-proposed reform to re-structure the Universal Basic Education Commission to include NMEC and the National Commission for Nomadic Education. In spite of this, NMEC was assisted to develop a National Blueprint and Action Plan to guide its work. The Blueprint and Action Plan have been approved by the National Council on Education and provide guides for the Commission’s interventions in recent times.

4.6.1 Access

The UNESCO Institute of Statistics 2008 Country Data Report on Nigeria reported an adult literacy rate of 60.1 percent, 71.5 percent among males and 48.8 percent among females. The youth literacy rate was higher at 75.2 percent, 78.8 percent among males and 71.5 percent among females (UNESCO UIS, 2008) (Figure 4.7). Progress on both adult and youth literacy has been somewhat slow over the years due to low government recognition and resourcing of this area within the education system.

Figure 4.7 Percentage of adults and youth in Nigeria who are literate.



Globally, an estimated seventy-three million children of primary school age are still out of school in 2007 (54 percent girls); sub-Saharan Africa accounts for 45 percent of the global out-of-school children (OOSC) figure in the same year. On the whole, a quarter (25 percent) of primary school age children in sub-Saharan African were out-of-school, and Nigeria accounts for the largest burden of this population with about 10.1million children not in school (UNICEF, 2012). If the OOSC who are of junior secondary school age are included, about 16 million children are then out of school in Nigeria. There are wide regional and gender disparities in the OOSC statistics across the country. This is a huge burden that calls for urgent and more

proactive action from the government.

Five major “zones of exclusion” have been identified with respect to available data. These are: (i) OOSC of pre-primary school age; (ii) OOSC of primary school age who have never been to school, who register very much later, who are attending NFE provisions or have dropped out; (iii) children in primary school but at risk of exclusion and dropping out; (iv) OOSC of lower secondary school age, including those who were never enrolled, those who have dropped out or are attending non-

formal education provisions; and (v) children in lower secondary school but at risk of exclusion and dropping out. The challenge for the country is to first ascertain the magnitude and spread of the population of OOSC, profile them according to their socio-economic characteristics including gender, and formulate a careful agenda for meeting their learning needs and equipping them for gainful life experiences through formal or alternative channels of education.

A 2010 national literacy survey conducted by the National Bureau of Statistics in collaboration with the National Commission for Mass Literacy, Adult and Non-Formal Education, reported the national youth literacy rate in the English language to be 76.3 percent (81.0 percent among males and 71.6 percent among females) and 85.6 percent in any language (89.4 percent among males and 81.6 percent among females) – with appreciable regional and gender disparities. The survey also reported that close to 3 million children aged 6-14 years have never attended any school, representing 8.1 percent of the population of children in that age group while another one million in the same age bracket have also dropped out of school, representing 3.2 percent of the population in that group.

The absence of reliable current statistics on enrolment in adult literacy and non-formal programmes precludes evidence-based analysis on enrolment and participation in this strand of educational service provision. Some on-going activities in adult and non-formal education receive technical support from UNESCO especially in the areas of policy development and planning. UNESCO has also participated actively in the conception, implementation, and monitoring of mass literacy programmes. A rapid assessment conducted in 2010 revealed wide human resource skill gaps in NMEC and the state agencies. NMEC, through collaboration with UNICEF and UNESCO as technical partners and the University of Ibadan as a capacity building expert, is empowering the middle level management to be more creative and innovative in responding to the needs of the subsector. A programme to revitalise youth and adult literacy in Nigeria under a four-year plan to be financed under the MDG Fund (as funds-in-trust to UNESCO) has been articulated and will soon become operational. The pilot phase of the Literacy by Radio Project for Improving Community Education and Literacy which ended in 12 states in 2006, has been scaled up to cover all the states in the country and the FCT. Primers in 21 local languages (Igbo, Kanuri, Hausa, Ibibio, Kolokuma, Tiv, Ejagham, Bekwara, Efik, Nupe, Ijaw, Edo, Yoruba, Ikwere, Kalabari, Khana, Abua, Obolo, Ekpeye, Igede and Idoma), facilitator's guides, and a publication on literacy by radio have been developed for this project.

A national survey conducted by NMEC in 2009 showed that adult literacy classes in Nigeria generally lack the basic facilities and infrastructure for effective teaching and learning. Facilities in learning centres vary according to providers; the lack of a policy on minimum standards for learning centres contributes to this situation. Annual budgetary allocations from the federal government, the MDG Funds and grants from donor agencies form the major funding sources for literacy and non-formal education. Funds from states, local and international development partners (UNESCO, UNICEF, DFID and JICA) are in the form of matching grants, counterpart funding, technical aids, and project specific assistance. The on-going Education Sector Development Plans for States in the federation potentially hold an answer to the question of poor funding of the subsector. Adult literacy and non-formal education have been integrated as a priority thematic component of the state plans that have been developed and should be well budgeted for and faithfully implemented.

4.6.2 Qur'anic education

The Qur'anic schools are numerous and highly patronized in Nigeria, especially in the north and in some states in the South west zone. For a high proportion of traditional Muslim parents, especially in northern Nigeria, Qur'anic schools are the only option for their children, especially for girls, as they believe that formal "Western" schools do not provide Islamic and moral training. Western

education is usually regarded by such parents as more expensive and exposing children to foreign values. It is estimated that there are more than 5 million children enrolled in Qur'anic schools in Nigeria. For most of these children, Qur'anic schools are their only hope of attaining any form of organized education.

There are many variants of Qur'anic education centres, starting from the privately owned centres that strictly focus on drilling children in how to read, write, memorise and recite the Qur'an to the more organised *Madrassa* for young adults. The *Madrassa* have classrooms for different levels and extend the depth of knowledge of the Qur'an to interpret it as well as acquire knowledge in other aspects of Islamic religious knowledge.

There have been a series of attempts by the government to integrate core subjects (English studies, arithmetic, social studies and basic science) into Qur'anic schools to ensure that children who only receive Qur'anic education would not be deficient in other skills that may be required for their full integration and participation in society. Many Qur'anic schools that have integrated core subjects have metamorphosed into 'Islamiyyah schools' that are similar to formal primary schools. The UBE Act (2004) makes provision for full integration of Qur'anic schools into the UBE programme, which is expected to enhance integration of core subjects in more schools.

Qur'anic schools integration is supported by UNICEF in ten pilot states in the north, namely Bauchi, Borno, Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto, Yobe and Zamfara. The UBEC with the support of UNICEF has adapted the primary school curriculum for use in Qur'anic schools that are willing to integrate the curriculum. In these states, a total of 14,014 Integrated Qur'anic Education (IQE) schools with an enrolment of 980,733 children including 276,608 females have been recorded (UBEC, 2007). The adapted curriculum has also been translated into two languages, Hausa and Kanuri, and primers developed for four subjects. Under a funding arrangement put in place by UBEC for this project each participating state receives a financial support of ₦6 million from the state's share of the Educational Imbalance Fund, which is 14 percent of the 2 percent of the Consolidated Federation Account. Reports from the Qur'anic Schools Integration pilot states show that with this financial support states have been able to improve quality of education given through construction and/or renovation of buildings, provision of instructional materials, undertaking baseline studies, as well as sensitisation programmes for stakeholders.

Reliable data on the full range of available Qur'anic education are just beginning to emerge, with the intervention of international development partners such as UNICEF, DFID, and USAID. A couple of illustrative figures demonstrate the popularity of Qur'anic education. In 2010, Niger State reported that it had a total of 2,452 Qur'anic centres of various categories with 56,357 learners (26,432 of them female) enrolled. In Sokoto State, there were 330 IQE centres with 37,070 learners enrolled in 2010. A survey conducted in the 2007/8 school year in Kano metropolis found that metropolitan Kano alone had a total of 3,703 *Tsangaya/Almajiri* schools, with a total of 1,560,611 learners spread across various levels in these schools. Till date, many IQE centres continue to face challenges in terms of quality of curriculum delivery, poor funding as well as structural challenges including coordination of the sector.

Islamiyyah schools, which also provide Islamic education, are distinctive entities in Nigeria. Unlike Qur'anic schools, which feature only religious education, *Islamiyyah* schools provide both religious and secular instruction. These schools enjoy support from parents and communities, and are increasingly seen as legitimate means to bolster the literacy and numeracy skills for children not attending government-funded schools.

Graduates of established *Nizamiyya/Islamiyya* primary schools transit to integrated secondary schools. In such schools, Islamic and other subjects (from the formal inclusive curriculum) are taught concurrently with both English and Arabic language used as medium of instruction. It is

noteworthy that in such primary and secondary schools where the integration system is being practiced the number of girls is higher than boys in most centres.

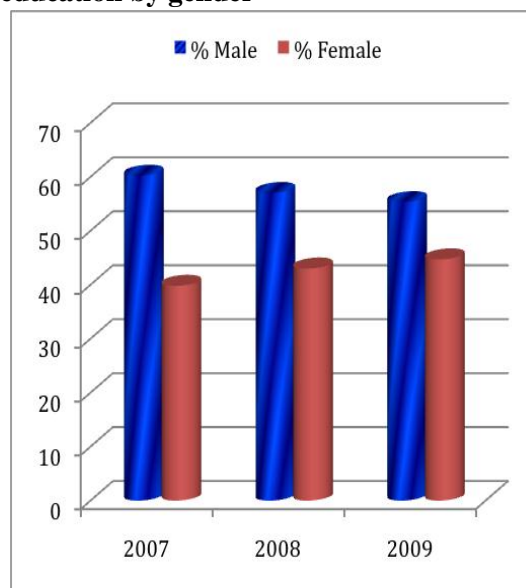
In early 2010, the FME set up a committee of experts with the directive to review the present situation of Qur’anic education in Nigeria. This committee has examined the challenges and submitted its report, which is yet to be made public by the FME. However, the report is expected to present a feasible roadmap to acceptable ways of integrating vital elements of formal basic education into the existing forms of education being provided in the many Qur’anic schools spread all over Nigeria, especially in the northern states that are predominantly populated by Muslims.

4.6.3 Nomadic Education Programme

The nomadic education programme in Nigeria caters to three major groups - pastoral nomads, migrant fishing families, and migrant farmers. The commitment to universal access to basic education heightened interest in the provision of quality basic education to nomadic and other educationally disadvantaged groups. The programme includes formal primary education for school-aged children as well as adult and non-formal education. Within the period under review, enrolment in nomadic primary schools increased steadily and consistently from 262,649 in 2007 to 457,913 in 2009. The increase was consistent for both males and females with the number of females enrolled rising by as much as 95.7 percent (from 104,590 in 2007 to 204,631 in 2009) (Figure 4.8).

Although no special provision is made for nomadic education within the UBE funds, the funding of activities under the programme has become more robust with consistent annual increase in capital allocation leveraged by provisions from the MDG Funds. This accounts for the recent achievements under the programme, including rising enrolment, survival³, and completion rates. The absence of population data on the scope of nomadic communities, however, precludes analysis on net and gross enrolments. While efforts are being made by the government to enable children from these communities to access education, the programme is faced with a number of challenges including lack of time on the part of many nomads to attend classes, persistent movement distracting them from benefiting fully from the educational interventions, lack of school in some areas of relocation, and the general low value placed on education in these communities.

Figure 4.8 Enrolment by year in nomadic education by gender



Source: NBS & UNICEF, 2007.

4.7 Quality education and quality assurance

Quality is at the heart of education, and what takes place in the classrooms and other learning environments is fundamentally important to the future well being of children, young people, and adults. It is only quality education that satisfies basic learning needs, and enriches the lives of learners and their overall experience of living. Successful education programmes require: (a) healthy, well nourished and motivated pupils; (b) well-trained teachers, using active learning techniques; (c) adequate facilities and learning materials; (d) a relevant curriculum that can be

³ “Survival rate” to the last grade is the percentage of a cohort of pupils who enter the first grade of primary education and who are expected to reach the last grade, regardless of repetition.

taught and learned easily and if feasible, in a local language, and builds upon the knowledge and experience of the teachers and learners; (e) an environment that not only encourages learning but is welcoming, gender-sensitive, healthy and safe; (g) a clear definition and accurate assessment of learning outcomes, including knowledge, skills, attitudes and values; (h) participatory governance and management; and (i) respect for and engagement with local communities and cultures (Dakar Framework of Action: 2000)⁴. Through support in the areas of teacher development, quality assurance, gender mainstreaming, promotion of child- and girl friendly schools, the FME has continued to make efforts to improve the quality of basic education in Nigeria.

4.7.1 Quality assurance systems

The existing systems for quality assurance are represented by the duties performed by the Federal Inspectorate Services (FIS) Department of the FME and the instruments and operational rules available to the FIS for the performance of this responsibility. There are no instruments or systems yet in place for institutionalised application of any standardised tests package at regular intervals to monitor the progress being made in the attainment of set national standards. Also, no form or organised codification of what constitutes a set of hitherto established standards for regulating the education processes has been established. Information indicates that these standards currently exists, however, it is difficult to ascertain whether clear indicators have been established for effective tracking of these standards.

The reform of the FIS, which is expected to institute a more vibrant and responsive system, is yet to be consolidated. The FME is said to be awaiting legal backing for the proposed National Quality Assurance Commission to take off. Capital appropriation for inspectorate activities has increased consistently in the past few years, in addition FIS has also received funding from the Debt Relief Gains (DRGs) to address some reform activities. However, the fact remains that the FME still maintains an elaborate structure, encompassing federal, zonal, and state inspectorate offices and this has continued to promote dissipation of scarce resources. The current extensive inspection structure, with little attempt to deconcentrate inspectorate functions, has reduced the achievement of the FIS to mere development of new Inspection Guidelines through the technical support provided by UNICEF and DFID/ESSPIN (Education Sector Support Programme in Nigeria).

As was observed in the 2007 Situation Analysis there is considerable overlap of functions and resource wastage in current quality assurance practices in view of the multiplicity of structures created by the FME, SMoEs, UBEB, SUBEBs, Local Government Education Authorities (LGEAs) and LGAs. The Federal Capital Territory and some states have replicated similar arrangements designating state and zonal inspectorates with minimal linkage to LEA inspectors who undertake supervisory roles in primary schools. There is also hardly any linkage with UBEC or SUBEBs or other state agencies with related mandate. This practice promotes multiple uncoordinated visits to schools in the name of quality assurance. Such multiple visits have not redressed the pervasive under-performance of public schools in national examinations. Also, in many states, there is apparently little success in regulation of proliferation of sub-standard private schools – some of which operate from makeshift structures and employ unqualified teachers. Attempts to impose sanctions have sometimes not been effective as the sanctions specified by the minimum standard ACT 16 of 1986 have become moribund and ineffective.

There are, however, some developments in inspectorate practice that are making a positive impact. The integration of global best practices such as Whole School Evaluation (WSE) that is more participatory is a progressive measure. The WSE is currently being integrated in some states including the FCT, the states being supported by UNICEF/DFID through the Girls' Education Project (Niger, Katsina, Bauchi and Sokoto), and other states receiving support from international development partners. Other forms of pedagogical support systems such as mentoring, school

⁴ See discussion in International Training Manual on Educational Governance, UNESCO, 2005, Module IV, p.3

cluster systems, and role modelling are also being gradually integrated in school support services. In addition, states such as Ondo, Jigawa, and the FCT are in the process of establishing semi-autonomous quality assurance agencies.

4.7.2 Quality of teachers

Effective service delivery of basic education in Nigeria hinges in part on the quality of teachers. Nevertheless, available data from the national Annual School Census (ASC) (FME, 2010) confirm that despite all efforts, teacher provisions in public primary schools do not generally comply with minimum standards. Specifically, the 2007 ASC data indicate a teacher to pupil ratio as high as 1:50 compared to the minimum standard of 1:30. In private schools, the average teacher to pupil ratio is 1:17. The qualified teacher to pupil ratio was even worse, with a figure of 1:121 in public schools compared to 1:55 in private schools. A rapid assessment in 2010 of 15 states and the FCT also found inequities in the deployment of teachers between urban and rural schools, with fewer female teachers in rural schools in many states (FME/UNICEF 2010b). The observed disparities were attributed primarily to refusal of rural posting particularly by married female teachers. There are also allegations of politicization of postings by local government authorities. Transfers and postings were allegedly employed as punitive measures against teachers with opposing views and political inclinations.

Specific measures aimed at improving the pupil to teacher ratio by the FME include the continuous support for the Federal Teachers Scheme coordinated by the UBEC. Although the programme is still operational, not all states have adequately accommodated or absorbed the teachers due to their inability to meet the local requirements of the programme such as provision of accommodation.

The National Teacher institute (NTI), the National Commission for Colleges of Education (NCCE) and the Teachers Registration Council of Nigeria are the agencies primarily responsible for ensuring teacher quality for basic education in Nigeria. The core mandate of NTI includes the certification of teachers (Nigeria Certificate in Education) through the distance learning programme (DLS), as well as regular and continuing teacher professional development. The NCCE regulates the operations of all Colleges of Education (CoEs) in Nigeria. Programmes and projects of the NTI and NCCE that have been specifically designed to ensure the realisation of basic education goals and conformity with the new policies and curricular demands include the Special Teacher Upgrading Programme (STUP), the Federal Teachers Scheme executed with UBEC, capacity building for teachers under the MDG Fund, and the Pivotal Teacher Training Programme organised in collaboration with state governments. The NCCE has developed guidelines for implementation of the new basic education curriculum and for institutional management of the CoEs. The NCCE has also developed a tool kit for institutional and programme assessment to be applied from 2011 onwards.

The Teachers Registration Council of Nigeria (TRCN) is yet to institute compulsory examinations for teachers who wish to renew their registration, as required by its mandate. Reward systems to adequately motivate good performance are generally non-existent or weak. Only a few states and the FME have instituted annual merit awards for teachers. However, the adoption and implementation of the new Teachers Salary Scale (TSS) by the federal and state governments has greatly reduced agitations and incidences of threat of strike actions.

A major attempt to redress inadequacies in teacher provisions was the development of a National Teacher Education Policy (NTEP) in 2009. The USAID through ENHANSE provided technical assistance for the development of NTEP. Despite the low enrolment in Bachelor of Education programmes and the increased cost to government for each person obtaining the degree, NTEPs critical quality provision poses its own challenges as it extended the duration of training for the award of a degree to five years and to four years for National Certificate of Education (NCE)

holders – without any commensurate incentives.

A USAID Teacher Education Initiative (TEI) is to support implementation of the NTEP. The project will review existing standards for conformity with the new policy and curricular demands. Preparatory activities have been completed, while the selection of the implementing contractor will be conducted prior to the take-off of the TEI project in January 2011.

The NTI has also coordinated a nationwide capacity building programme for teachers that is funded under the DRGs. However, such centralisation of training is expensive and not cost effective; the administrative costs are very high. It also does not reflect the globally emerging and preferable concept of in-school or cluster-based *in situ* strategies that have proved more impacting, cost saving, and sustainable. As confirmed by findings in the Child Friendly Schools evaluation and the 2010 Rapid Assessment, states have become more active in exposing teachers to capacity building opportunities particularly in core subject areas. State Education Resource Centres (ERCs) have been very useful in this regard and could be effective in coordinating training activities at the grassroots level. In addition, a scholarship scheme for young girls to train as teachers under the Girls Education Project (GEP) is addressing the inadequacy of female teachers in the remote rural areas. Finally, the FME in collaboration with JICA is implementing the “Strengthening Mathematics and Science Education” (SMASE) project, which aims at upgrading the teaching skills of primary school teachers in mathematics and science.

4.8 Curriculum development

The national policy on early childhood development (ECD) was produced to provide a national outlook on issues related to ECD in Nigeria. The curriculum developed for ECD in 2006 is based on the play way method of teaching, and is due for review by 2011. The minimum standard for setting up ECD programmes that have been in existence since 2007 will serve as a useful tool in this review.

A seventeen-subject curriculum for primary school and a 19-subject curriculum for junior secondary school were approved in 2006 by the National Council on Education (NCE) and published in 2007. These curricula have incorporated entrepreneurship education as well as the infusion of moral values including anti-corruption at these levels. One of the high points is the introduction of basic science and technology into the curriculum. This is to enable the pupils to understand the relationships between science and technology. To enable effective delivery of the new concepts in the curricula, a Teacher’s Handbook for the New Basic Education was developed each for the primary and junior secondary levels in 2009 to help teachers use the curriculum to improve the teaching/learning process to achieve better results. The handbooks provide teachers with best practices in the different subject areas in the school system.

Such instructional materials are a very important component of the new curriculum. As they will facilitate better understanding of concepts by pupils especially in science, technology, mathematics, and the humanities. The two handbooks - the Procurement, Production and the uses of Instructional Materials (2008), and Development of Instructional Materials from Local Resources (2009) - were articulated to improve teachers’ capacity in developing and improvising instructional materials to facilitate the teaching/learning process. Textbooks based on the new curriculum have been published under a public/private partnership arrangement between NERDC and commercial publishers, launched in April 2010 by the Honourable Minister of Education.

4.9 Governance and management for education system effectiveness and efficiency

The Federal Ministry of Education has responsibilities related to coordination of policy development, specification of standards, and quality assurance. The states, FCT, and the LGEA

administer, regulate, and control education within their domains. As indicated in the 2007 Situation Analysis, in some states there is still a predicament in the management of the existing structure for the UBE scheme. The conferral of authority to manage UBE resources on SUBEB completely cuts out SMOEs from UBE funds. This crisis threatens the success of the basic education programme.

School level management is constrained by low capacity of head teachers who most often have not received training or sufficient orientation on appointment before deployment to schools. This problem is being addressed by the National Institute for Educational Planning and Administration (NIEPA) in collaboration with UNICEF through its support to training members of the School-Based Management Committees on supporting school management and Whole School Development Planning and Management. In addition, in collaboration with the International Institute for Capacity Building in Africa (IICBA) a UNESCO institute, the NCCE undertook the training of head teachers across the country in 2008 and 2009. There has also been in-state training for teachers on effective classroom management

4.9.1 School based management committee and community participation

School level management is also being supported through the establishment of school based management committees (SBMCs). The SBMC is a structure representing all key stakeholders of the community who are willing and able to improve the management of the school to ensure improved teaching and learning for the children. They represent the participation of the community in school administration and have the potential to transform, sustain education, and promote school governance at the grassroots level. The SBMC involves the head teacher, teacher representatives, pupil representatives, representatives of the Parent Teacher Association (PTA), Old Pupils/Students Association, and other stakeholders from the community such as religious and traditional leaders and to ensure that all voices are heard in decision-making and school management issues. The concept of SBMC is built around partnership between government, parents, and the immediate community within which the school is situated to provide appropriate teaching and learning for children. The committees have been rallying points for collaborative action in supporting the school system. The involvement of the immediate community surrounding the school is resulting in the devolution of powers from government to the immediate beneficiaries of the school system. The community therefore sees the school's progress and survival as its responsibility.

Evidence from all over the developing world indicates that empowering communities to plan and manage the use of education resources can be a powerful transformational strategy to increase access to school and enhance the quality of service provision. It is to this end that the policy to establish SBMCs in all schools in Nigeria was promulgated at the NCE 54th plenary session in Ibadan in 2005. The concept note from which the policy derived ascribed the responsibility for its policy formulation to the FME, its implementation in schools to UBEC and SUBEBs within the implementation guidelines developed, the development of the capacities of its implementers in the performance of the responsibilities assigned to them was ascribed to NIEPA, and the monitoring of its implementation was assigned to FIS.

However, this study has found that apart from the promulgation of the SBMC as a policy and the development and publishing of its implementation guidelines, and development of modules for training members of the SBMCs in WSDP, not much has been done, especially with regard to ensuring that SBMCs are established and functioning in all schools as directed by the policy. Thus except for the Girls Education Project (GEP) states (where SBMCs have been established and empowered through provision of school grants to implement their whole school development plans) and a few other states supported by other development partners (World Bank, DFID, USAID), SBMC members have not been trained or adequately empowered to fulfil their mandates. There is also a threat to their sustainability in states where members expect some form of remuneration. Though SBMCs are expected to support school development planning and manage resources

available in the school, the management of school level resources are still centrally administered in most States. In 2008, NIEPA coordinated the development of a participatory SBMC training manual that was applied in the training of SBMCs in GEP states. DFID has also developed an SBMC training manual that reflects the particular needs of its various interventions under EPSSIN. A Community Management Voice and Accountability initiative has been established in states supported by DFID. This empowers local communities and the civil society to engage with government and demand accountability. The UBEC administered Community Self Help project also empowers communities with grants to support school development, further strengthening relations between schools and their surrounding community.

4.9.2 Institutional efficiency

The institutional assessment undertaken as part of the 2010 SESP/SESOP Rapid Assessment in 15 states and the FCT revealed low institutional efficiency due to human resource gaps and the absence of requisite technical capacities in supervisory institutions. This shortcoming was more prevalent in ICT and EMIS applications, strategic and operational planning, and in the application of data in policy decision making, particularly in states and LGEAs.

4.9.3 Development of Education Management Information System (EMIS) Development

The education management information system (EMIS) is still very weak in many states and hardly discernable in most LGEAs. A number of factors contribute to this situation, including low commitment of top management (sometimes based on low awareness on the importance of data), low demand for data, lack of evidence-based decision-making and planning. Poor funding for EMIS and related activities affects the regularity of the annual school census. Other factors that constrain sustainable EMIS include skills gap in data management, weak capacity of head teachers in completing school census forms, poor record keeping competencies among teachers, and lack of synergy among data collection agencies resulting in multiple data collection and release of inconsistent data by different agencies. A DFID and UNICEF initiative on Nigeria EMIS (NEMIS) development by way of technical support is currently assisting the FME and selected states on school census administration for sustainable EMIS development.

4.10 Children with special needs

Special education represents the specialized educational services offered to children and adults whose needs are not met by regular schools, class organization, and methods. The government's intention as articulated in the National Policy on Education is to provide adequate education for all categories of children and adults who require special education services. Special education was not specifically catered for within the UBE funding scheme, and data on special schools is not incorporated in the most recent available FME school census report from 2007. This is a major challenge, especially when considering the issue of equity in education. Children with special needs are more often invisible in the system; their needs are neglected as provisions to meet these needs receive the least resources.

Some positive developments, although minimal, have been recorded in this area. The Nigerian Educational Research and Development Council (NERDC) in compliance with government policy on inclusiveness, has adapted the 9-year basic education curriculum for the education of children with special needs. In 2008 the new basic education curriculum was adapted for the visually impaired. It has been brailled and is ready for mass production. A manual has been produced for the development of curricula for 'resource room' based subjects such as keyboarding, braille, reading and writing, orientation and mobility, and independent life skills. The resource room, if developed by schools, will enable the visually impaired to communicate and interact more effectively during the teaching/learning process.

4.11 Education in emergencies

Though emergency situations have been on the increase in the last few years arising from natural disasters and violent conflict, the Federal and State Ministries of Education are yet to put in place well-articulated plans, structures and procedures to enable them respond proactively to diverse emergency scenarios. Recent massive flooding experienced in Sokoto, Kebbi, Jigawa, Kano, Lagos and Ogun during this year left behind overwhelming devastation which disrupted children's schooling for many weeks due to the conversion of schools into temporary camps for internally displaced persons. UNICEF however has been engaging with the FME and the State Ministries of Education on the need to have a properly coordinated structure and plan within the education sector to ensure minimal disruption to teaching and learning during emergencies and to provide psychosocial care and support to traumatized and affected children. To ensure that the key education actors at national and sub-national levels have the required capacity to respond proactively and effectively to education in emergencies, a capacity building workshop was organized by FME with UNICEF's support and in active collaboration with the National Civil Defence Corps and the National Emergency Management Agency and its State Agencies. The workshop produced a framework for emergency preparedness and response that is currently in process to receive government approval. In addition, the Communiqué that emerged from the workshop recommended establishment of a Desk for Education in Emergencies at the Federal and State Ministries of Education to plan, implement, and coordinate all education activities in emergencies in collaboration with the NEMA/SEMA. The framework, when approved by the government, will guide the development of an Emergency Preparedness Response Plan by the Federal and State Ministries of Education. Each state's EPRP should also according to plan feed into the on-going sector plans being developed by states. Minimal emergency supplies have been prepositioned at federal and state levels to respond to emergency situations though the alarming scale of emergencies occurring during the past years is a signal for more actions by the government at federal and state levels.

4.12 Cross-cutting issues

4.12.1 School health

The health of students remains a critical area that affects key educational indicators such as attendance, retention, performance, and completion. It also affects the development of appropriate cognitive skills and the general well-being of students while they are in school. The National School Health Program is derived from the National School Health Policy published in 2007. Results from a situation analysis undertaken to ascertain the extent to which existing programmes at the schools aligned with policies revealed several gaps. This assessment was conducted under the Learning Plus Global Initiative, a key component of the Child Friendly Schools Initiative, in the 4 'Learning Plus' states (Jigawa, Lagos, Cross rivers and Benue, 2008) and published in 2008. The thrust of the Global Initiative is to use schools as centres for the provision of essential services for orphans, vulnerable children, and children affected and infected by HIV and AIDS through child-friendly adaptations of schools for children of all abilities. It is premised on three concepts; participation of students, inclusion of students, and gender equity. A school-based protocol was developed in 2009 to address the three concepts with emphasis on physical and psychosocial health, nutrition, safety and security, water and sanitation and nutrition services provision. Towards the mainstreaming of the concept of participation, a protocol for the establishment of School Health Clubs was developed in 2010, and is now available for use in schools. Through the effective use of these guidelines, concepts taught in the classroom are reinforced through further interaction within clubs in areas such as sanitation, violence prevention, young farmers, climate change awareness, and sports. Monitoring and evaluation tools for a comprehensive school health programme were developed in 2010 to provide a means for ensuring that the level of programme implementation in schools can be effectively tracked. This tool, which was piloted in 2010, is now ready for use.

Adequate nutrition is directly linked to improved health, attendance, and cognitive performance evidenced in improved learning outcomes. Following the suspension of the National Home Grown School Feeding programme, developments are focusing on capacity building of school feeding service implementers at the school level, such as the members of the SBMC and health teachers, who are involved in the supervision of food at the school level. A national training manual developed on different aspects of school feeding in 2009 has been applied in the training of micro-implementers comprising SBMCs, health education teachers, and school nurses. This manual presents a useful resource on establishment and maintenance of school farms and gardens, food procurement, logistics and storage, nutrition education, micro-nutrient fortification, deworming, food safety practices, safe water supply and other related aspects of school feeding.

Violence in schools challenges the establishment and maintenance of a healthy school environment and has direct implications on the key educational indicators and on absenteeism, safety, and security in the schools. Until quite recently this issue had failed to attract significant interest from policy makers. An assessment of the existence of violence in basic education in 2007 however revealed that perpetrators had more often than not escaped unpunished, encouraging others to exploit the apparent apathy to addressing the issue. There are currently five types of violence associated with basic education, namely physical, psychological, sexual, gender-based and health-related violence. A national strategic framework to mitigate violence in school was articulated in 2008. Guidelines are being developed detailing actions to be taken towards the building of systems at the prevention, response, and referral levels for mitigating the impact of violence in schools.

Towards building the capacity for the achievement of school health results, UNICEF has supported the FME under a collaborative arrangement with the Obafemi Awolowo University, Ife in Osun State, to develop three training packages for different key stakeholders in 2009. These are the School Health Programme course targeting teachers, the Counselling and Adolescent Health Development course for school counsellors, health education teachers, and nurses, and the Strategic Leadership and Management in School health course for College of Education provosts, educational planners and managers. The pilot tested and finalized course modules are currently available for dissemination to the Colleges of Education and other tertiary institutions.

4.12.2 Family life education and HIV/AIDS

This school health programme is in line with education component of HIV and AIDS which is addressed through the Family Life and HIV/AIDS curriculum introduced in 2003. An assessment of students' attitudes, knowledge and skills on HIV and AIDS in 2007 found that the scope of implementation of the 5-year HIV/AIDS curriculum Strategic Plan 2006-2010 was merely 22 percent.

A national monitoring and evaluation exercise in January 2010 revealed that implementation had risen to 41 percent. This has been made possible through interventions in various areas including capacity building of the teachers who teach at the Colleges of Education at the pre-service level to effectively deliver the Family Life and HIV/AIDS Education (FLHE) curriculum, development of instructional materials through UNICEF's support with the aim of complimenting the use of the Family Life and Emerging Health Issues (FLEHI) curriculum teacher's Guide developed by the National Commission of Colleges of Education in collaboration with Action Health Incorporated. Pilot testing of these instructional resource materials at the CoEs was carried out in 2010. In another collaborative arrangement UNICEF supported the National Institute for Educational Planning and Administration (NIEPA) and FME in the development of a management course for education planners and managers on the impact of HIV/AIDS on the education sector in 2009. The focus of this course is the increase in knowledge among this level of officers to enable better planning, financing, and administration of HIV/AIDS-related support provision. Challenges still face the implementation of the curriculum in some states, with some of them not funding the curriculum

implementation.

4.13 Key challenges

Despite the introduction of some progressive and child friendly policies by government, there are still factors indicating that children's right to education is not fully protected. These factors include poor access and participation in terms of school enrolment, low attendance, high dropout and repetition, low completion rates, poor quality of educational resources and service provision including infrastructural facilities and learning materials, weak relevance of curriculum, inadequate teacher supply as well as poor quality of children's learning outcomes (Box 4.6). The responsibility for ensuring adequacy, equity, and quality of provisions rests jointly on governments at federal, state, and local levels, communities, parents, teachers, and other key actors in the education process. The previous Situation Analyses from 2001, 2004 and 2007 document a number of barriers and

Box 4.6 Recurrent challenges

- Inadequate coverage and unsatisfactory level of access at all levels of basic education.
- Poor quality and relevance of education.
- Insufficient and poorly maintained infrastructure.
- Inefficient management and system.
- Unsustainable and inadequate funding.
- Negative impact of nutritional deficiencies and poor health on physical and cognitive development of children.

challenges that are inhibiting robust provision of basic education in Nigeria. A recent World Bank, DFID, and USAID Policy Note on education in Nigeria has recorded similar challenges and listed what it describes as the key enduring impediments to the actualisation of the right of women and children to education in Nigeria. According to this source, the following issues form part of the key challenges and they manifest at all levels of education and in all the states and

the FCT in varying degrees: (i) inequitable access; (ii) weak quality and relevance of learning and teaching; (iii) weak governance structures for management and planning, notably at the state and LGA levels; (iv) lack of effective monitoring and evaluation systems (EMIS) resulting in scarcity of data on the system's performance and finance; and (v) inefficient use and allocation of available resources. These major challenges are discussed below.

4.13.1 Equity and access to education

Despite significant efforts since the launch of the UBE programme in 1999, the prospect of achieving the education-related MDGs and EFA goals remains very dim. Nationwide, only 62 percent of school-age children attend primary school. At junior secondary school age, approximately one third of children currently receive three years of junior secondary education. There are large gender, income, and regional disparities in enrolment rates. A recent government report on the MDGs noted that universal basic education, especially in the northern states, is still a dream and unlikely to be achieved by 2015. Enrolment rates for girls in some northern states is still low. The cost of schooling, both the direct and indirect opportunity costs, remains a key reason for low enrolment and for dropping out of school. In addition, the poor quality also acts as a disincentive to enrol and remain in school, particularly for girls. It is instructive to examine a little bit further how girls are inhibited from going to schools, as the majority of children presently not in school in Nigeria are girls. The factors hindering girls' increased attendance, retention, and achievement in school have been summarized into two major groups: supply driven and demand driven group of inhibitions.

Some factors inhibiting educational development are listed below, both from the supply and demand side.

Supply driven factors inhibiting educational development:

Political and institutional factors

- Budget constraints
- Insufficient support for education for the poor
- Sustaining political will and adequate commitment to support proper implementation and enforcement of the UBE law, to ensure that a child's rights to enrol and participate meaningfully, is not respected and accorded at all levels of governance.
- Poor quality of educational facilities
- Ill-adaptation of educational programmes/systems to learning needs
- Poor implementation of strategies for women's and girls' education
- Low motivation among teachers
- Weak systems for tracking and mentoring children in school, especially girls
- Weak national coordination of education programmes
- Weak monitoring and evaluation mechanism
- Inadequate intersectoral collaboration
- Dearth of trained teachers at all levels

Factors linked to the school

- Limited study time due to frequent closure of schools as a result of trade union action
- Limited school and classroom spaces
- High school fees
- Paucity of qualified teachers
- Non-child-friendly schools;
- Teachers are not thoroughly sensitised on gender issues
- Gender stereotypes in curricula and text-books
- School curricula and organisation conflicts with traditional culture
- Violence and insecurity in school
- Lack of flexibility in school calendar
- Lack of separate toilet and sanitation facilities for girls
- Long distance of schools from pupils' home
- High pupil to teacher ratio
- Inadequate monitoring and supervision
- Limited opportunities for in-service training of teachers
- Inadequacy of female teachers and head teachers
- Exclusion of pregnant girls from school
- Limited study time for girls while at home

Demand driven factors inhibiting educational development

Cultural factors

- Gender stereotypes reinforcing the idea that a woman's place is in the kitchen
- Early marriage
- Western education perceived as incompatible with traditional cultural beliefs and practices
- Scepticism regarding the benefits of and outcomes from giving a girl western education
- Erroneous interpretation of some religious injunctions

Economic factors

- Hidden costs of education
- High demand for the girl-child's labour for household and agricultural work
- Poverty of parents or guardians
- Limited employment opportunities for those leaving school

- Lower employment opportunities and remuneration for girls
- High opportunity costs and perceived lower rates of return

4.13.2 Quality and relevance of education

About 70 percent of schools in the basic education system in Nigeria can be labelled quality deficient. Poor quality schools do not encourage attendance by pupils. For those children who manage to make it to school, poor quality stifles motivation and productive participation in school activities. Thus poor condition of teaching and learning environment is one of the main contributors to low learning outcomes. Such an environment is made up of poor conditions of physical facilities, shortage of textbooks and essential instructional materials, ineffective pre- and in-service teacher training, and outdated curricula. In such a situation basic education quality is insufficient to provide relevant knowledge and skills to develop one's full potential. According to government estimates, about 254,000 classrooms are currently available in basic education, with an additional 251,000 classrooms required. About 51 percent of available classrooms are considered to be in good condition. Only around 30 percent of primary schools have access to water and electricity and almost all schools have insufficient sanitation (toilets) for students, particularly for girls.

There is inadequate systematic and reliable information on students' learning outcomes. However, available surveys show that learning outcomes in primary schools are weak and vary considerably across states (FME MLA, 1996; 2003). Similarly, the DHS Education Data survey (FME 2004) noted that only 30 percent of boys and 26 percent of girls could read part of a simple sentence and just over 50 percent could add two digits totalling less than ten.

Furthermore, classroom observational studies in Nigeria have shown that both male and female teachers give the boys greater opportunities to ask and answer questions, to manipulate materials, and to lead groups (Situation and Policy Analysis (SAPA) of Basic Education in Nigeria, (1996). In the review of the studies on science classroom interactions in Nigerian primary and secondary schools it was found that girls are given less time on tasks than boys. Girls also have less opportunity to learn. These factors hinder the performance of the girl-child. Harsh and intimidating classroom interactions engender fear in pupils and hatred for school. Over 40 percent of pupils in grade four sampled in the MLA study in 2003 adduced their dislike for school to poor teaching methods and intimidation by the teacher, including caning. Untrained teachers operating in a resource poor school environment sometimes use inadequate lecture methods due to poor quality preparation of lessons. A high pupil to teacher ratio also stifles healthy classroom interaction. In many urban centres, classrooms especially in primary and secondary schools are overcrowded with as many as 100 pupils per classroom. In mixed schools, which are the norm in most primary and secondary schools, the girl-child often loses the struggle for space and has to cope with characteristic intimidation by boys in the class. Another cluster of factors that inhibit girls' education in Nigeria are economic factors largely associated with parental poverty. With about 70 percent of the population living below the poverty line the inclination is to have the girl child engage in income-generating activities rather than go to school. Thus, more school-aged girls than boys can be seen hawking in the streets or in markets selling wares. Such girls are exposed to all sorts of abuse including sexual abuse and the associated dangers of contracting HIV/AIDS and other sexually transmitted diseases.

Teacher qualification and deployment issues are critical to successful delivery of basic and secondary education. While there is an over-concentration of teachers in the urban areas, the most deprived, largely rural areas lack qualified teachers. This is particularly true for female teachers in the northern regions. For example the number of female teachers in Kano state is particularly low, with less than 15 percent of all teachers across the sub-sectors being female. In Kaduna about 34 percent of primary school teachers possess the required minimum qualifications.

4.13.3 Management and governance

The existing policymaking and planning capacity is inadequate and the governance structure is too complex and lacks accountability. There are two key issues related to policy making, management, planning, and monitoring capacity that are consistently relevant across states. First, there is an unclear division of responsibilities, overlapping functions, a multitude of parastatals, and poor working relationships among government and agencies resulting in a fragmented decision-making process that hampers implementation of a consistent and effective education policy. Second, there is inadequate strategic planning and management capacity to support tasks such as policy development and medium to long term planning.

At the federal level, the legal and regulatory framework for education is complicated by the existence and operation of the 21 education parastatals. Some of these have functions that overlap and duplicate those of the FME. The federal government had started the process of restructuring and realigning these parastatals, however that process has been abandoned due to political pressure. The draft Education Reform Bill, which was approved by the Federal Executive Council, and which among other things, had consolidated the 21 federal parastatals into 13 has not been fully implemented. At the state level, the complicated constitutional and legal framework of the educational system is hindering the delivery of universal basic education. This results in inefficient delivery, lack of accountability, and increased tension between the states and the FME.

Inadequate management and planning capacity, especially at state and local government levels impose further limitations for effective policy-making, management, and implementation.

4.13.4 Monitoring and evaluation

Weak management information systems have resulted in a scarcity of quality data for policy making and monitoring performance of the education system. Despite recent improvements in the development of the national EMIS, Nigeria still lacks readily available, accurate and reliable data by level of education and by field such as science, engineering, and social sciences. A recent study found that insufficient data monitoring and planning is observed at all levels (World Bank, 2006). These shortcomings impede a thorough assessment of performance of the education sector and analysis to inform evidence-based decision-making. Development partners are working with the government to address this challenge, especially in states where they are providing support for the development of Education Sector Strategic and Operational Plans.

4.13.5 Financing and Resource Allocation

Despite increase in public spending for education, the funding based on current trends is insufficient to achieve the education-related MDGs and to improve the quality and relevance of all levels of education in Nigeria.⁵ It is estimated that the federal government accounts for roughly 20 percent of total public education expenditure, with state and local governments accounting for the remainder, suggesting that state and local governments are the main financers of education. The few studies that have examined the financing of education in Nigeria suggest that public funding for education increased from 2.8 percent of GDP in 1999 to 6.2 percent in 2002, mainly as a result of sizeable salary increase for teaching staff (FME/UNESCO, 2007). Preliminary analysis indicates that the total cost of providing universal basic education (from grade 1 to 9) in Nigeria between 2005 and 2015 will be around US\$30 billion. However, there is considerable inefficiency in the use of resources.

4.14 Recommendations

To introduce specific actions that must be taken to address the challenges noted above and those

⁵ Attempts have been made recently to analyze public expenditures on education. However, the information base is inadequate to undertake a detailed assessment of the size, distribution, and impact of public expenditures across the three main levels of education and the three tiers of government.

that may be specific to the different sub-sectors of education, the following strategic steps need to be taken within the next two years of support to the educational development of Nigeria:

- a. Strengthening the capacity of the Ministry of Education and its relevant institutions for planning and management, including the restructuring of federal-level institutions (institutional strengthening, human resource development and strategic planning), and completing and implementing the federal 10 Year Education Sector Plan.
- b. Serious and continuous attention must be given to the reduction of pronounced disparities in the enrolment, attendance, transition and completion of basic education along variables such as gender, geographic area, rural or urban location, and wealth.
- c. Serious and urgent attention must be given to strategic institutional and human capacity building. This includes development of strategic and operational education sector plans, translating them into outcomes through results based desks operational tools at federal, state and LGA levels, effective results based budgeting and budget tracking, development of effective education quality assurance systems, development of modern curricula for functional and entrepreneurial education, and improving the quality of education at all levels.
- d. Innovative ways of expanding resources available for funding education need to be developed. There should be an introduction of means to make the process of education funds expenditure more transparent. There should also be an introduction of new mechanisms for doing more with less and improving cost efficiency in funds and other educational resources disbursement to considerably reduce the existing funding gaps.
- e. Management and governance of the education system require improvement to achieve more effective and efficient service delivery and accountability, emphasis should be given to the LGA and school level management.
- f. Addressing barriers to girls' education, especially in the northern regions, by means such as community mobilization and advocacy, recruitment and deployment of women teachers, and improvement of physical facilities. Similarly address barriers to ECD programmes, especially for the poor disadvantaged children from remote rural areas, and barriers to education for children from marginalized and hard to reach communities.
- g. Continued support to the national EMIS to further strengthen the availability and quality of data on the education sector for effective policy analysis and planning.
- h. Promote community participation in school management for empowerment, support to school management in decision-making, and improved education delivery.
- i. Promotion of an integrated approach to improved delivery of education through the child friendly schools initiative and inclusive education.
- j. Promotion of and support to quality alternative channels of education.

5. Maternal and child nutrition

5.1 Introduction

Hunger and malnutrition cause the most widespread human suffering in the world today. Whilst hunger cannot be measured directly, the extent and severity of malnutrition are fairly well known and measurable. With barely four years to the target date of 2015 for the attainment of the Millennium Development Goals (MDGs), under-nutrition is still a major cause of morbidity and mortality in women and young children. Reducing under-nutrition is part of MDG 1, which aims to eradicate extreme poverty and hunger. One of two targets of this goal is to halve, between 1990 and 2015, the proportion of people who suffer from hunger as measured by the percentage of children less than 5 years of age who are underweight. Achieving goals in primary education, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases depend crucially on nutrition. Under-nutrition leads to increased mortality and morbidity and hence reduces economic output and increases health care spending. Progress in goals 2, 4, 5 and 6 will be restricted without MDG 1 being achieved (Box 5.1).

Globally there is evidence of improvements in children's nutritional status. The percentage of underweight children is estimated to have declined from 25 percent in 1990 to 16 percent in 2010 (WHO, 2010). Stunting, or low height for age, in children less than 5 years of age decreased globally from 40 percent to 27 percent over the same period. Despite these overall gains, malnutrition still accounts for 3.5 million deaths, just over one-third of all deaths in children less than 5 years of age (Lancet, series 2008). Poor maternal nutrition is responsible for intra-uterine growth restriction and low birth weight as young children's nutrition depends critically on the nutritional status of their mothers during pregnancy and lactation. This is a very grave matter for national development and productivity in many developing countries as maternal under-nutrition has generational consequences. Micronutrient deficiency particularly vitamin A and zinc is estimated to be responsible for 0.6 and 0.4 million deaths respectively. Iron deficiency as a risk factor for maternal deaths adds to the fatality (Lancet series, 2008). Most micronutrient deficiencies are correlated with overall under-nutrition. For example, 31 percent of developing world households do not consume iodized salt and are therefore not protected from goitre. UNICEF estimates that 100 - 140 million children still suffer from vitamin A deficiency, and an estimated two billion people have too little iron in their diet. The combined effects on mortality, morbidity, and productivity are estimated to result in economic losses of billions of dollars.

Box 5.1 **Nutrition: a neglected issue**

“Nutrition is a desperately neglected aspect of maternal, newborn, and child health. The reasons for this neglect are understandable but not justifiable”.

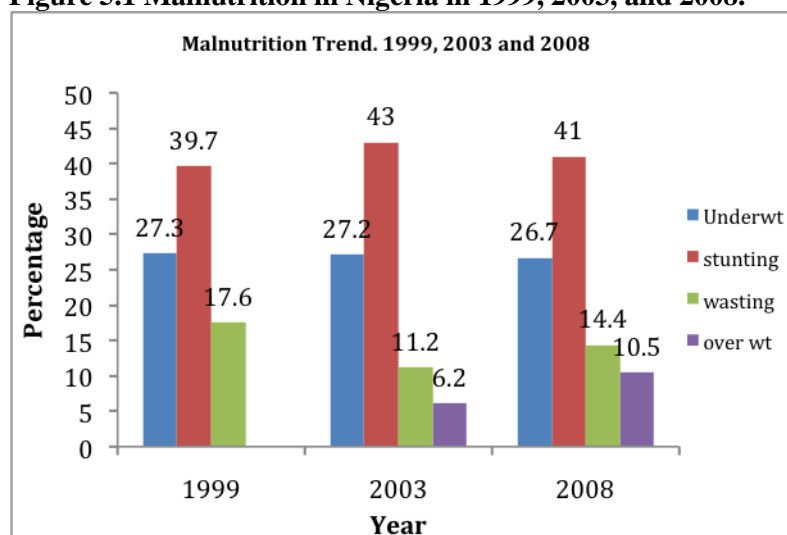
The Lancet Editor, Dr Richard Horton, 2008.

The Lancet series on maternal and child under-nutrition published in 2008 reported that 80 percent of undernourished children live in 20 countries located in Africa, Asia, the West Pacific and the Middle East, and Nigeria is one of the 20 countries. These series of five papers focused on the disease burden, the short and long-term cognitive and economic implications in adult life, and the need to implement interventions that have proven effective in reducing child and maternal malnutrition. These series also issued a wake-up call to countries and international communities to take urgent actions to support the scale-up of food and nutrition programmes nationally and globally.

Nigeria's childhood mortality level is unacceptably high, with malnutrition as an underlying condition for the leading childhood killer diseases such as malaria, pneumonia, diarrhoea, and vaccine preventable diseases. In addition there is a vicious cycle of poverty, disease and malnutrition, as malnutrition is one of the consequences of repeated episodes of these childhood diseases. The 2008 National Demographic Health Survey (NDHS) reported that 41 percent (almost 1 in 2) of children under five years of age were stunted and 23 percent (about 1 in 4) were severely stunted. Fourteen percent of children under five were wasted (low weight for height), and this is an increase from 11 percent in 2003. The results also show that the level of severe wasting increased to 7 percent, from 4.4 percent in 2003. This is an increase of over 50 percent. Twenty-three percent of children under five were underweight (low weight for age), with 9 percent severely underweight (Figure 5.1).

Stunting is a sign of chronic under-nutrition and exposure to repeated episodes of childhood infections. Wasting on the other hand is a sign of acute malnutrition and a silent killer as most mothers are not able to detect this until it is too late. A child who is underweight is suffering from a combination of acute and chronic malnutrition.

Figure 5.1 Malnutrition in Nigeria in 1999, 2003, and 2008.



Source: NPC & ICF Macro 1999, 2003, and 2008.

These results are similar to those of another household survey in 2007 that showed that 25 percent of children under five years of age were moderately underweight, 34 percent were moderately stunted, and 11 percent were moderately wasted. Severe nutrition prevalence figures were 8 percent severely underweight, 19 percent severely stunted, and 3 percent severely wasted (MICS 2007).

Nigeria is among the ten countries in the world with the largest numbers of underweight children with an estimated 6 million children under the age of 5 who are underweight. Fourteen percent of newborns have low birth weight due to poor intrauterine growth, which is usually a result of poor maternal nutrition and micronutrient deficiency especially iron and foliate. Table 5.1 shows the nutritional indices for the country. These indices underscore the need to take some urgent actions in order to reduce the suffering of women and children due to inadequate nutrition. However it is noteworthy that some progress has been made in the area of micronutrient activities in the country. The household iodised salt consumption rate is 97 percent, one of the highest in the world. The vitamin A supplementation coverage rate is also high, at 74 percent (UNICEF, 2008). In addition, 75 percent of infants aged 6-9 months are breastfed in addition to being given complementary foods.

Table 5.1 Nutrition indices, Nigeria

Percentage of infants with low birthweight 2003–2008*	Percentage of children (2003–2008*) who are:					
	Early initiation of breastfeeding	Exclusively breastfed (<6 months)	Breastfed with complementary food (6–9 months)	Still breastfeeding (20–23 months)		
14	32	13	75	32		
Percentage of children under five years of age (2003–2008*) suffering from:					Vitamin A supplementation coverage rate (6–59 months) 2008	Percentage of households consuming iodized salt 2003–2008*
Underweight (NCHS/WHO)	Underweight (WHO)	Wasting (WHO)	Stunting (WHO)	Stunting (WHO)	Full coverage (percentage)	
Moderate & severe	Moderate & severe	Severe	Moderate & severe	Moderate & severe		
27	23	9	14	41	74	97

Source: UNICEF (State of the World's Children), 2009.

Similar to the situation with children, many women in the country have poor nutritional status and micronutrient deficiency. The 2008 NDHS estimated that 3 percent of the women surveyed had short stature, two in three had normal body mass index (BMI), which decreased with age, and 4 percent were moderately thin. Micronutrient deficiency was high among women, especially during pregnancy (NDHS, 2008).

5.2 Policy environment and conceptual framework

Government efforts in the past include the establishment of the National Committee on Food and Nutrition that is placed within the National Planning Commission (NPLC) to coordinate a multi-sectoral approach to nutrition. This committee serves as the focal point for the coordination and harmonization of all nutrition related policies and programmes in the country. The Federal Ministries of Health, Agriculture, Education, Women Affairs and Social Development, and Industry and agencies like the National Agency for Food and Drug Administration and Control (NAFDAC), Standards Organisation of Nigeria (SON), and the Primary Health Care Development Agency (NPHCDA) are involved in national nutrition programmes.

5.2.1 Policy environment

A national food and nutrition policy is in existence. It was developed in 1995 and launched in 2002 (FMoH 2002). The policy has the overall goal of improving the nutritional status of Nigerians. This policy sets specific targets, which include reducing severe and moderate malnutrition in children under 5 years of age by 30 percent and reducing micronutrient deficiencies by 50 percent by 2010.

The following strategies were identified to fight malnutrition in the country:

- Improving food security through agricultural projects and poverty alleviation programmes to increase household income level.
- School feeding programme through the introduction of Home Grown School Farming programme, the thrust of this is to provide a balanced and adequate meal during the school day. The pilot phase has involved 12 states and the FCT.
- Improving health services to provide essential maternal and child care.
- Household salt iodisation programme to eliminate iodine deficiency.

- Controlling micronutrient deficiency through supplementation, staple foods fortification, and dietary diversity.
- Institutionalizing consumer protection measures to safeguard food quality and consumer health.
- Enhancing caregivers' capacity by promoting optimal infant feeding practices.

The national capacity and response in the country is weak in spite of the high burden of under-nutrition. Nutrition is poorly funded and it is not considered a priority by the policymakers at federal, state or local levels of government. One of the challenges is the lack of leadership as leadership and strategic capacity are essential ingredients for advancing the national nutrition agenda. Currently there is no effective multi-sectoral approach that delineates clear roles and responsibilities of each sector. Furthermore joint actions by the various sectors particularly at the user level are not integrated. At the state level, capacity is weak as trained nutrition officers are not available in most states. There are many sectors and agencies involved in nutrition as nutritional issues do not come under one single line ministry: this situation presents a challenge in terms of management. There has been a long debate about where its home should be. The last administration approved the establishment of the National Nutrition Council to serve as the coordinating and policy-making body for all nutrition programmes in the country. The council is supposed to be under the supervision of the presidency, unfortunately this council is yet to become fully operational after almost four years of its existence.

Table 5.2 shows the level of national commitment to nutrition programmes in the country. The government is currently not meeting the Abuja declaration of providing 15 percent budgetary allocation to health and the allocation to nutrition is even more negligible. The nutrition governance component of the PRSP strategy is weak. However, the period of maternity leave has just been increased from 12 to 16 weeks to ensure that working mothers have time to practice exclusive breastfeeding (EBF). This still falls short of the 6 months period recommended by ILO.

Malnutrition is a disease of poverty, and poverty in turn aggravates malnutrition. In Nigeria where the poverty level is as high as 70 percent it is not surprising that the rate of malnutrition in children and women in the country is one of the highest in the world especially among the poor, uneducated, and rural dwellers. Poverty reduction and economic transformation strategies including NEEDS and Vision 20:2020 indirectly address the issue of malnutrition. Nutrition is mentioned as one of the interventions for optimal health, and not seen in the larger context of development or as a strategy for poverty reduction. It is noteworthy that one of the goals of the Vision 20:2020 is to guarantee food security. The Ministry of Agriculture will be strengthened and empowered to meet the challenges of climate change, poor harvest resulting in high food prices, and national food insecurity.

Table 5.2 National commitment to nutrition

General government expenditure on health as percentage of total government expenditure	2007	6.5
Public expenditure on health (percentage of GDP)	2004	1.4
Per capita total expenditure on health (US\$)	2007	131
Nutrition component of the United Nations Development Assistance Framework (UNDAF)	2008	Weak
Nutrition component of poverty reduction strategy paper (PRSP)	2008	Weak
Nutrition governance	2008	Weak
Monitoring and enforcement of international code of marketing of breast milk substitutes	2007	No
Maternity leave	2009	16 weeks

Source: WB (2005), WHO (2010)

Although there are nutrition degree awarding institutions in the country and nutrition is taught in medical schools, there is evidence that nutrition officers' per capita is low (although hard data are not available to corroborate this). Table 5.3 shows the national capacity of the country with regard to nutrition programmes.

Table 5.3 Nutrition response capacity

Indicator	Year	Value
Degree training in nutrition exists (Yes/ No)		Yes
Nutrition part of medical curriculum (Yes/ No)		Yes
Number of trained nutrition professional by 100,000 population	No data	No data
Nursing and midwifery personnel density per 10,000 population	2008	16.1
GDP per capita (PPP US\$)	2007	2
Official Development Assistance (ODA) received (net disbursement) (percentage of GDP)	2007	6.7
Low income –deficit country (LIDFC)	2010	Yes

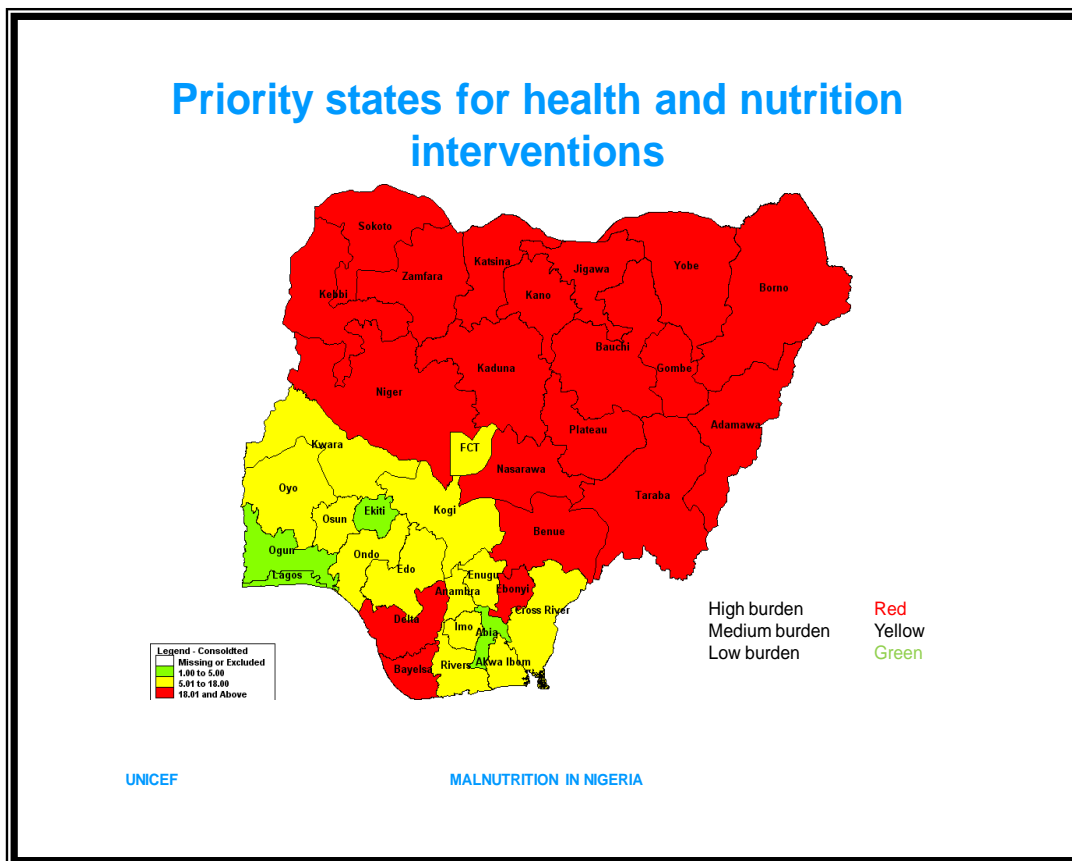
Source: WHO (2010)

UNICEF along with other development partners has been supporting nutrition projects in several areas including elimination of micronutrient deficiency and promoting an integrated approach to child development and growth involving the interplay among health, nutrition, sanitation and

education. UNICEF also supports improved nutrition practices and household care capacity through the promotion of key household practices for children under five years of age.

The burden of nutritional problems varies in the country, and as a result some states have been identified for priority action (Figure 5.2). Most of these states are in the northern part of the country with the exception of Delta, Bayelsa and Ebonyi states that are in the south. These states have low indices for child and maternal health and nutrition.

Figure 5.2 Map of Nigeria showing priority states for interventions



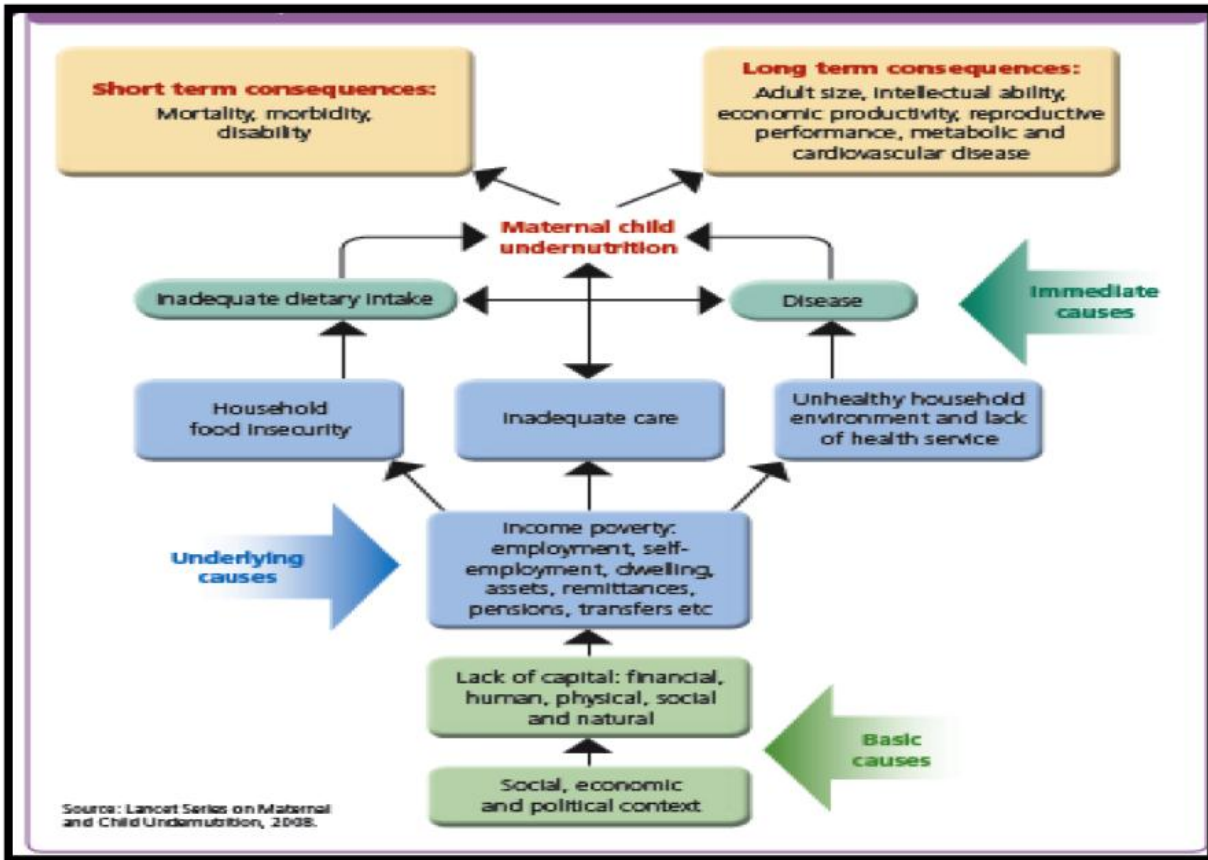
5.2.2 Conceptual framework

A framework depicting the relationship between poverty, food insecurity, and other underlying and immediate causes of maternal and child under-nutrition and its consequences is presented in Figure 5.3. It shows that the causes of malnutrition are complex, interactive, and multi-sectoral. In view of this a coordinated, integrated, and cross-sectoral approach must be adopted for an effective response to maternal and child malnutrition.

Immediate causes (individual level) of maternal and child under-nutrition

In Nigeria, child nutritional status is mainly affected by low exclusive breastfeeding practice, inadequate knowledge of the benefits of exclusive breastfeeding, poor complimentary feeding practices, and micronutrients deficiency. Other factors associated with the high level of under-nutrition include repeated episodes of childhood infections such as diarrhoea, pneumonia, malaria, and HIV infection. These diseases are usually the consequences of poor sanitation and hygiene, and lack of access to safe water supply. Maternal nutritional status before and during pregnancy is important for a healthy pregnancy outcome. Unfortunately mothers' nutrition status and health particularly during pregnancy is also poor in Nigeria.

Figure 5.3 Conceptual framework for the relationship between poverty, food security and other underlying and immediate causes of maternal and child under-nutrition



Underlying causes (household and community level)

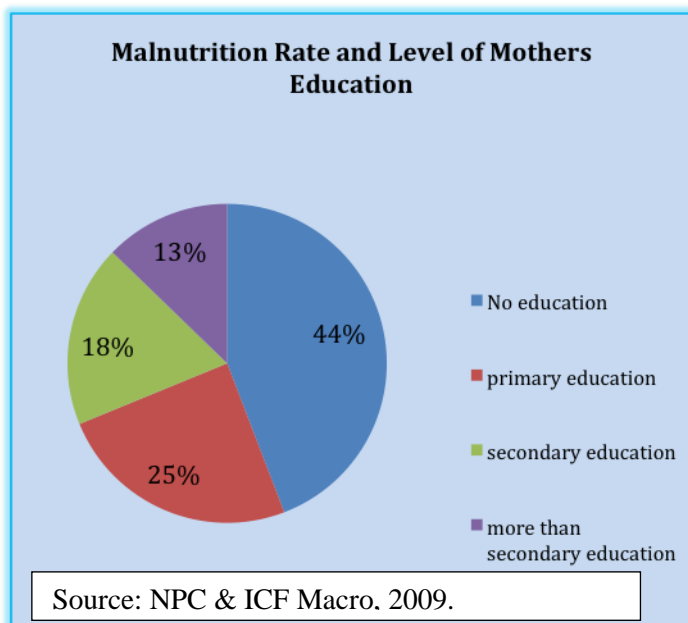
These causes are mainly due to household food insecurity, inadequate care for children and women, unhealthy household environment, and low access to health services. The poor, uneducated and rural dwellers lack access to effective health care because physical accessibility of health services is lower than for urban residents. The health system is weak with the primary care level being the weakest. There is also a low utilization rate of primary health care (PHC) services. Food security in the country is 68 percent (National Food Consumption and Nutrition Survey, 2003). This level is much lower in rural areas than in urban areas. The poor and uneducated mothers do not have access to an adequate amount of food of desired quality due to their low purchasing power particularly in the face of rising food prices. It is therefore not surprising that under-nutrition is higher in rural than urban areas. In addition, the environment is less healthy in the rural and poor households because of lack of basic facilities like potable water supply and improved sanitation.

Basic causes

These causes relate to the larger political, economic, and socio-cultural environment. In Nigeria there is low political commitment and poor understanding of nutrition by policy makers and the technical cadre. Poverty and gender issues, particularly with regard to the role of women, are also important factors regarding the poor nutritional status of children and mothers. Gender inequality is prevalent and women empowerment is low especially in the northern part of the country. This could explain the poor health and nutritional status of children in that part of the country. Gender empowerment is a key factor for health seeking practices, utilization of services, behaviour change, and ability to make decision within the household and ensuring the entitlement of the woman to adequate nutrition. Inequity is another major factor affecting nutritional status of children in the

country. Health and nutrition outcomes are worse in rural than urban areas. The 2008 NDHS reports that the malnutrition rate was higher in rural areas (13 percent) than urban areas (11 percent) in children under five years of age (NPC & ICF Macro, 2009).

Figure 5.4 Malnutrition rate and level of mother’s education

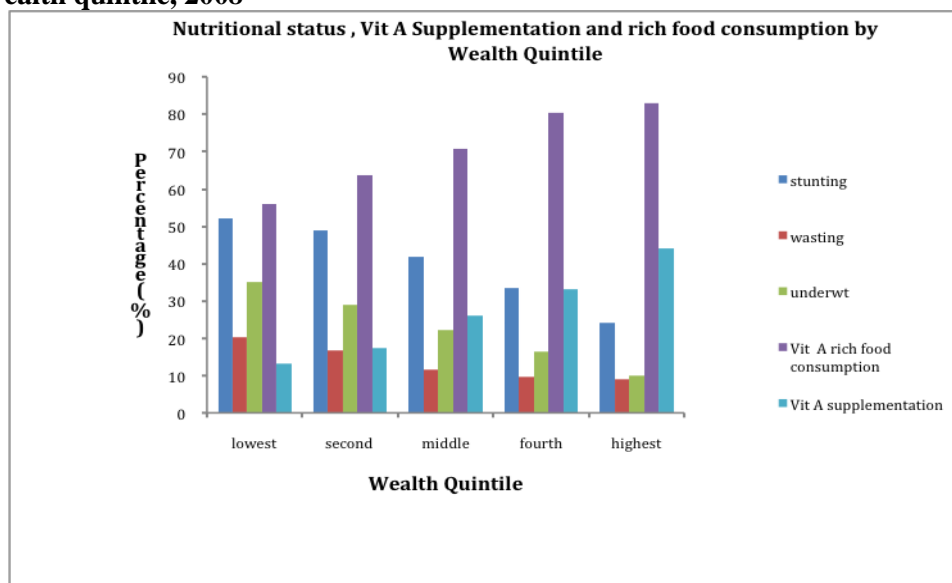


There is an association between the mother’s level of education and malnutrition rates among her children. According to the 2008 NDHS the malnutrition rate is highest in children whose mothers have no education (44 percent) and lowest in those whose mothers have secondary or higher education (18 percent and 13 percent respectively) (Figure 5.4). Ignorance and poverty are known to drive malnutrition because mothers who are educated have better economic power, better knowledge of infant feeding including micronutrients, and also better access to nutritious and safe food for their children. They have greater access to health

services and utilization is higher than their uneducated and poor counterparts. They are also less likely to be influenced by culture and traditional beliefs that are harmful. They are more likely to have access to safe water and adequate sanitation. Mothers who are educated and economically empowered are able to take decisions that will protect the health and well-being of their children. Overall, mothers’ level of education plays a major role in the development of a child. Malnutrition is known to be an intergenerational problem and long term investment in the role of a woman as an equal citizen through education, economic and social empowerment is the only way to deliver sustainable improvement in maternal and child nutrition and in the health of the mother and child in general. Poverty is associated with poor diet, unhealthy environment, and high fertility.

Poverty and malnutrition reinforce each other through a vicious cycle. Malnutrition in turn reduces immediate and future family income, thus perpetuating poverty. Poor malnourished women give birth to low-birth-weight babies, who will grow up with irreversible physical and cognitive impairment, which will limit their child bearing capability, educational attainment and possibility of having good employment thus perpetuating poverty in the subsequent generation. Data from NDHS 2008 also show an association between wealth level and nutritional behaviour (vitamin A supplementation and consumption of food rich in vitamin A) and status (malnutrition rates) (Figure 5.5). As income levels increase, so does the level of vitamin A supplementation and consumption, while malnutrition rates decrease.

Figure 5.5 Nutritional status, vitamin A supplementation and vitamin A rich food consumption by wealth quintile, 2008



Source: NPC & ICF Macro, 2009.

One of the underlying causes of malnutrition is unhealthy household environment. This is measured by access to improved drinking water supply and improved sanitation facilities in the home. According to the 2007 Multiple Indicator Cluster Survey (MICS), less than half of the population have access to improved water supply (49.1 percent) and sanitation (42.9 percent), and only 27.5 percent have access to both improved water supply and sanitation. There is considerable inequity with access to improved water supply and sanitation being highest in the upper income group (70.1 percent), among educated (47.0 percent) and urban dwellers (54.6 percent). There are also geo-political disparities, with the states in the northern zones having lower access to safe water and sanitation than the states in the southern zones.

5.3 Infant and young child feeding

Adequate infant and young child feeding practice is fundamental for optimal physical and intellectual development of a child, particularly in the first 2 years of life. It is well recognized that this period from birth to 2 years of age is a “critical window” for optimal growth, health, and cognitive development. The consequences of poor nutrition, in terms of foods, feeding practices and behaviour, during the first 2 years of life include repeated episodes of common diseases, delayed mental and physical development, under-nutrition and death. Under-nutrition is known to predispose infants to repeated occurrence of diarrhoeal diseases and acute respiratory tract infections (ARI), among other diseases. In the long term, these early nutritional deficits are linked to irreversible impairment in intellectual and work performance, with low productivity outcome. This situation also has an effect on overall health during adolescence and adulthood.

Appropriate infant and young child feeding (IYCF) practices include timely initiation of solid/semi-solid foods from age 6 months, feeding small amounts and increasing the amount of foods and the frequency of feeding as the child gets older, while maintaining breastfeeding. A 2008 survey shows that 25 percent of mothers of children aged 6-8 months, 30.1 percent between 9-11 months, 33.9 percent in the group 12-17 month and 28.8 percent of those 12-23 month were practicing appropriate IYCF (NDHS 2008).

In 2007, Nigeria adopted the National Strategic Plan of Action on Infant and Young Child Feeding (IYCF). The plan of action aims to revitalize attention towards feeding practices that have an impact on nutritional status, growth, development, health and thus the very survival of infants and young

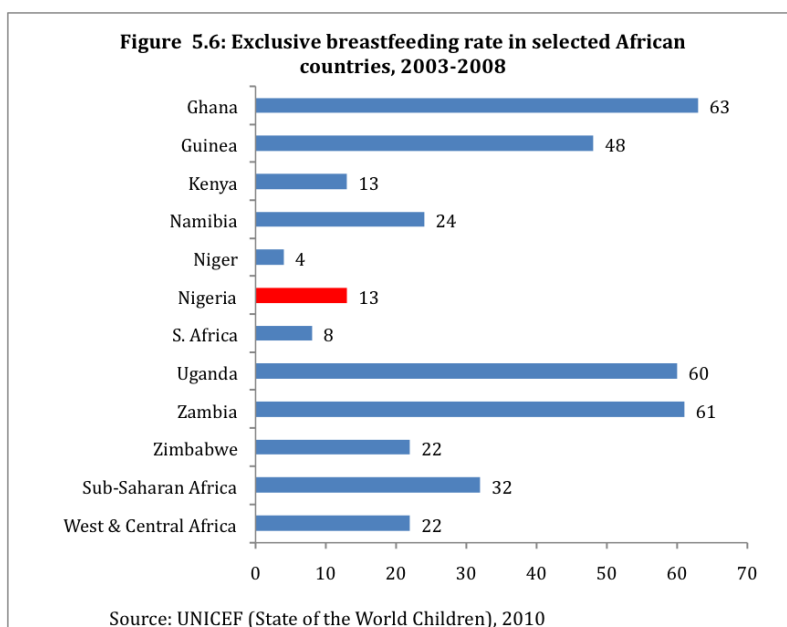
children. The strategy is a guide for action and provides the overarching framework that is necessary to protect, promote and support infant and young child feeding in the country. It identifies interventions with a proven positive impact, and identifies the roles and responsibilities of government, development partners, non-governmental organizations (NGO) and other major stakeholders. All the stakeholders are expected to work within this plan. The Nutrition division of the Federal Ministry of Health (FMOH) has developed a National Guideline for Infant and Young Child Feeding in Nigeria in 2005; this is being updated.

5.3.1 Exclusive Breastfeeding

Breast milk is the healthiest form of food for babies. Breastfeeding promotes health, helps to prevent disease, and reduces health care and feeding costs. It is beneficial to both mother and child, however, its benefits are more apparent if the child is exclusively breastfed. Exclusive breastfeeding (EBF) is breastfeeding with no other food or drink (including water) for the first six months of the child's life. It has been shown to be the single most effective high impact intervention for reducing infant mortality and morbidity (Lancet series, 2003). Sub-optimal breastfeeding, especially non-exclusive breast feeding in the first month of life, results in 1.4 million deaths and 10 percent of the disease burden in children under 5 years of age (Lancet series, 2008). Breastfeeding is also beneficial to the mother's health as it reduces post-partum bleeding by increasing the secretion of oxytocin, which causes the uterus to contract more quickly.

Breastfeeding is commonly practiced in the country, as almost all children less than 12 months of age are breastfed. However less than one fifth are exclusively breastfed, which makes Nigeria one of the countries with the lowest EBF rate in sub-Saharan Africa. The average rate for sub-Saharan Africa is 32 percent and 22 percent for the West and Central Africa sub-region. Nigeria with an EBF rate of 13 percent (NDHS, 2008) is lower than both averages (Figure 5.6).

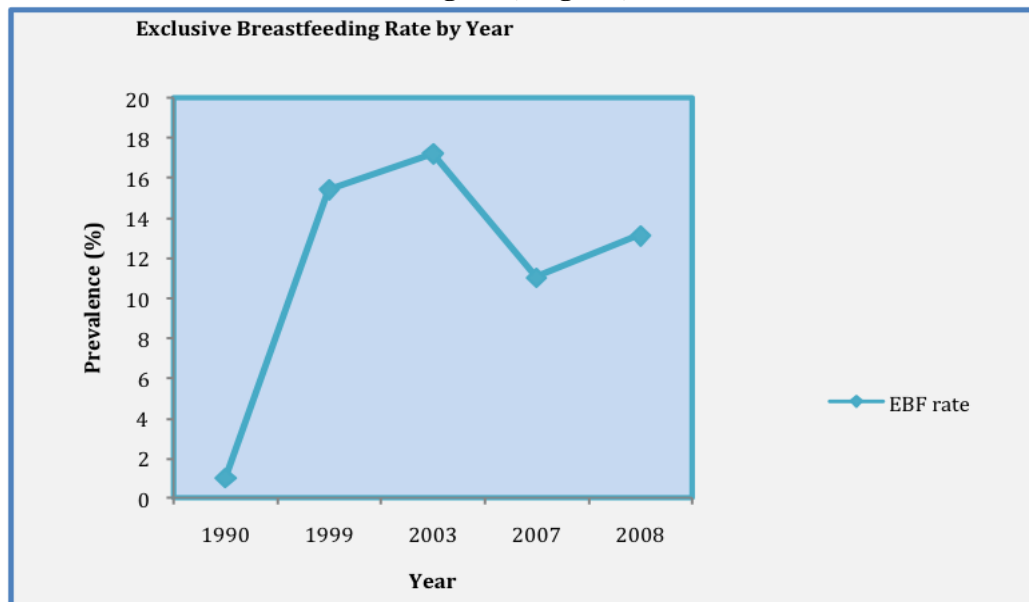
Figure 5.6 Exclusive breastfeeding of infants under 6 months of age in selected African countries 2003-2008, percentage



Nigeria's national policy and guidelines recommend exclusive breastfeeding for the first six months of life. The Baby Friendly Hospital Initiative (BFHI), which was initiated in 1992, made considerable changes in mothers' knowledge and practice of breastfeeding. There was a significant jump in EBF practice from 1 percent in 1990 to 15.4 percent in 1999 after the BFHI was introduced in 1992. Since then, there was a steady rise with the highest rate of 17.2 percent in 2003. However the EBF rate has been on the decline since 2003 with a rate of 13 percent in 2008. Figure 5.7 shows

the trend of EBF from 1990 to 2008. One of the factors contributing to the decline in EBF is a drastic reduction in the level of implementation of BFHI over the years. In addition, the initiative has not been mainstreamed into the health care delivery system of the country, and as a result those who live in rural areas with poor access to hospital services and where the needs are highest were not reached with this intervention.

Figure 5.7 Trend in exclusive breastfeeding rate, Nigeria, 1990 - 2008



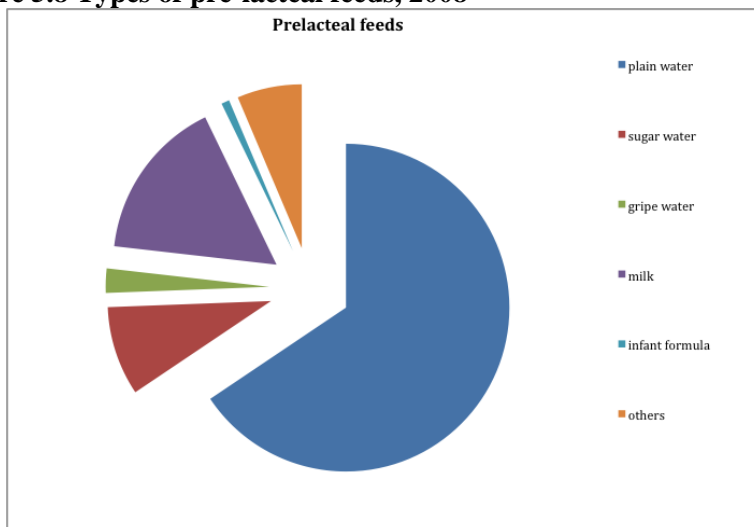
Source: NPC & ICF Macro, 2009.

The 2008 NDHS results show that younger infants are more likely to receive EBF as 20 percent of infants below two months are exclusively breastfed, compared with only 7 percent of infants aged 4-5 months. There is no marked geographical variation in the rate of EBF from northern to the southern states. The results also show that less than 50 percent of infants (38 percent) were put to the breast within one hour of birth and only 68 percent within the first 24 hours. These proportions are marginally higher than when they were measured five years earlier. At that time, 32 percent were breastfed within the first hour and 63 percent were breastfed within one day of birth (NDHS, 2003).

5.3.2 Pre-lacteal feeding

Pre-lacteal feeding, or foods given to newborns before breastfeeding is established, is widely practiced in Nigeria. NDHS 2008 results show that 56 percent of newborns received a pre-lacteal feed. There are no marked differences based on the gender of the newborn. However, there are substantial variations by residence, assistance at delivery, and place of delivery. Geographical variation in the practice of pre-lacteal feeding ranges from 31 percent in the South west to 79 percent in the North east. The level of education and economic status are inversely proportional to the practice of pre-lacteal feeding. Thirty-three percent of children whose mothers have more than secondary education are receive pre-lacteal feeds compared with children whose mothers have no education (68 percent). Thirty-nine percent of children born to mothers in the highest wealth quintile are less likely to receive a pre-lacteal feed than children born to mothers in the lowest wealth quintile (71 percent). Water is the most common pre-lacteal feed (82 percent of children were fed water). Milk other than breast milk was given to 20 percent of children and about 10 percent were given sugar or glucose water (Figure 5.8).

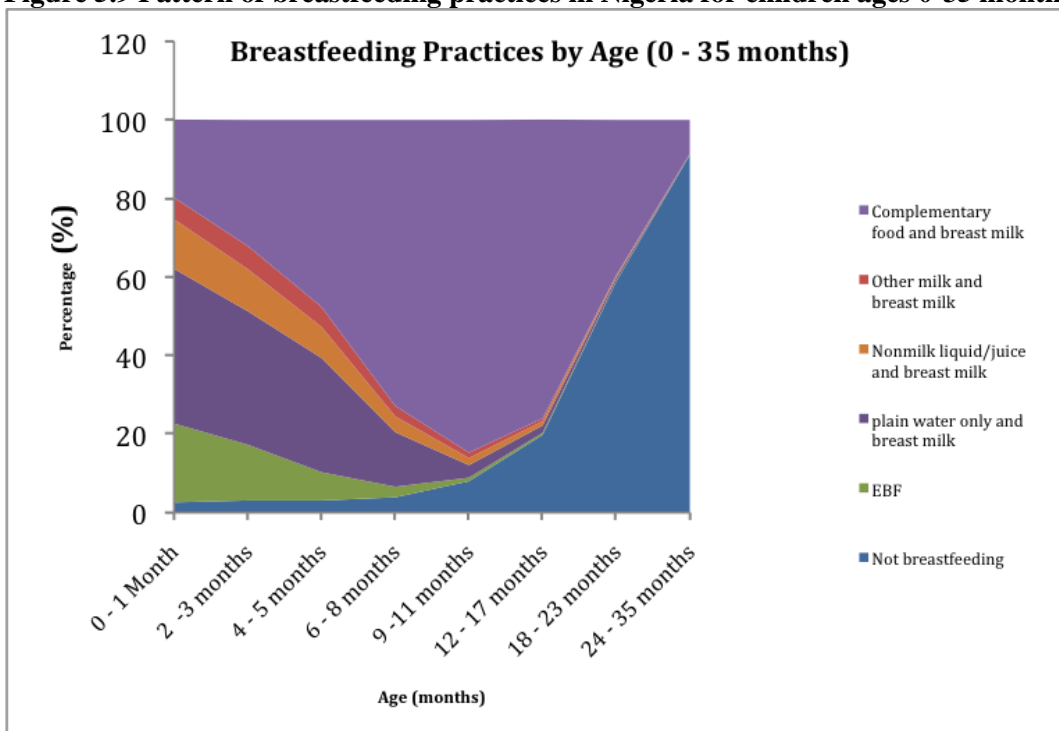
Figure 5.8 Types of pre-lacteal feeds, 2008



Source: NPC & ICF Macro, 2009.

Non-exclusive breastfeeding is common in Nigeria and infants are introduced to water, other liquids, and complementary foods as early as the first month of life (80 percent). After the age of six months, infants need to start receiving foods in order to meet all of their nutritional requirements. As shown in Figure 5.9, three-quarters of infants aged 6-8 months are breastfed and receive complementary foods. In the age group of 24 to 35 months, only 8.5 percent are receiving breast milk and complementary food compared with 39.5 percent of infants between 18 to 23 months.

Figure 5.9 Pattern of breastfeeding practices in Nigeria for children ages 0-35 months, 2008



Source: NPC & ICF Macro, 2009.

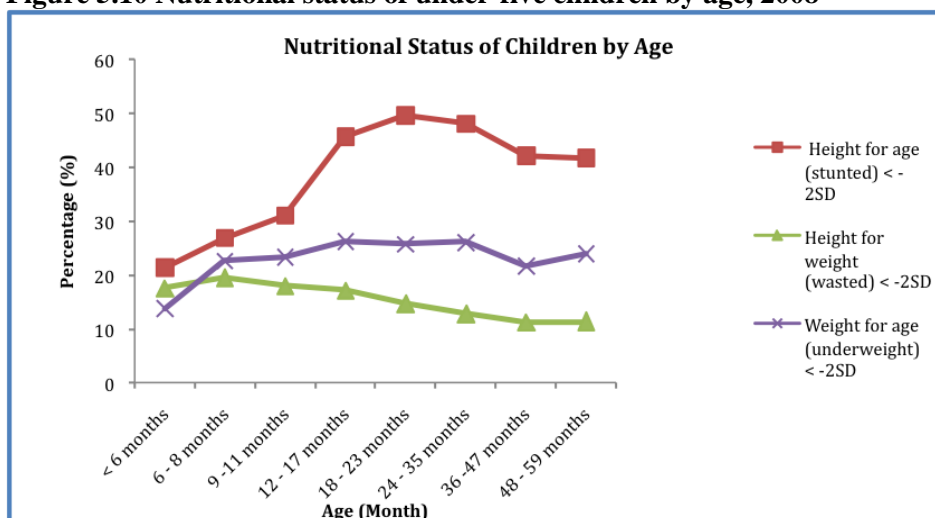
5.3.3 Complementary feeding

From the age of 6 months, breast milk is no longer adequate to meet the nutritional needs of the infant and complementary foods should be added to the diet of the child. The transition from exclusive breastfeeding to family foods is referred to as complementary feeding. It covers the period from 6 to 24 months of age. The goal of complementary feeding as determined by the UN standing committee on nutrition is that from 6 months to 23 months or longer, breastfeeding should continue to supply 350-500 calories per day and in addition 3-5 feedings of nutrient rich complementary food are needed (UNICEF/WHO: BFI 2009). WHO recommends that infants start receiving complementary foods at 6 months of age in addition to breast milk, initially 2-3 times a day between 6-8 months, increasing to 3-4 times daily between 9-11 months and 12-24 months with additional nutritious snacks offered 1-2 times per day, as desired. The NDHS (2008) shows that there has been an increase in the proportion of children aged 6-8 months who receive timely introduction of complementary foods, 75 percent (Figure 5.9). The FMOH has developed a guideline for infant and young child feeding (2005) in line with the WHO recommendations. This has also been incorporated into Integrated Management of Childhood Illness (IMCI) training materials.

5.3.4 Onset of malnutrition

The most damaging effects of under-nutrition take place during pregnancy and in the first 2 years of life (often referred to as 'the first 1,000 days'). Physical and cognitive damages associated with poor foetal growth and stunting are largely irreversible after the age of two years. Under-nutrition developed *in utero* may persist until adulthood as undernourished girls are more likely to become short women who are more likely to give birth to small babies. Under-nutrition is thus perpetuated across generations. Studies show that stunting is apparent even among children of less than 6 months of age (21 percent) as shown in Figure 5.10. There is a rapid increase of stunting through the first 2 years of life, from 27 percent in children of 6 – 8 months of age to 50 percent in children aged 18 – 23 months. The rate of stunting declines from the third year up to the fourth year. This unfortunate situation is due to the poor feeding practice of infants and newborn in the country.

Figure 5.10 Nutritional status of under-five children by age, 2008



Source: NPC & ICF Macro, 2009.

This is a very vulnerable period in the life of a young child. It is the time when malnutrition starts in many infants, contributing significantly to the high prevalence of malnutrition in children of less than five years of age. Even with optimum breastfeeding, children will become stunted if they do not receive an adequate quality, quantity and safe complementary feeding after 6 months of age. Stunting incidence is highest in the first 2 years of life when the demand for nutritional food is highest and this demand is not met. The situation is further worsened with the high rate and

repeated episodes of infections such as diarrhoea, pneumonia, malaria, and measles (Lancet series, 2008). This trend shows that the first two years of life offers a short window of opportunity for appropriate interventions to be instituted as any investment after this critical period is less likely to reverse any damage done.

5.3.5 Growth monitoring

The Federal Ministry of Health has adopted the new WHO growth standard. This is an opportunity to carry out anthropometric measurement of children and monitor their growth in order to detect early warning signs. Although growth monitoring is not a new intervention in the country, use of the new growth standard method is. The ministry is in the process of production of the new charts that will replace those currently in use. Currently growth monitoring is not being carried out by most health facilities due to lack of tools such as weighing scale and metre rule to measure weight and height, and mid-upper arm circumference measurement (MUAC) strip to carry out anthropometric measurements. Hence children that need nutritional interventions are often missed.

In 2008, FMOH with support from UNICEF and WHO adapted the new WHO child growth standards for Nigerian children. The adaptation included the use of measurements of weight for age and height for age as the minimum indicators to be measured at all levels. The target age group will be children 0 – 5 years of age and there will be separate growth charts for girls and boys. Due to increasing prevalence of acute malnutrition, further adaptation has taken place to address this problem. For instance, height for age is to be replaced with weight for length and weight for height, MUAC will also be included. These changes are to be incorporated into the existing child health card used in the infant welfare programme. FMOH has printed the new charts and plans for training of health workers are underway. This will be the precursor for the development of the much-needed national child health records.

5.3.6 Children in difficult situations

The most vulnerable victims of natural or human-induced emergencies are infants, young children, and pregnant and lactating women. The adverse situations that can affect these groups include droughts, floods, landslides, famine, and communal clashes with displacement of families. Other difficult situations are sick young infants, particularly those with persistent diarrhoea, low birth weight orphans, and children living with HIV and AIDS. There are nutrition guidelines in IMCI for management of the sick young infant both at community and health facility levels.

As the HIV epidemic progresses, more and more children are becoming orphaned and vulnerable because of AIDS. There are 9.7 million orphans and vulnerable children (OVC) in the country, an estimated 1.2 million are orphaned by AIDS. The consequence is that these children will end up in orphanages, streets, refugee camps, and remand homes. Children who are orphaned or in vulnerable households may be at increased risk of neglect or exploitation if the parents are not available to support them. A 2007 survey reported that 22 percent of OVC are underweight, 32 percent are stunted and 10 percent are wasted (MICS, 2007). Infants who are orphans are vulnerable to malnutrition because of lack of optimal breastfeeding and complementary food.

Several multi-sectoral interventions have been put in place by the government to address the needs of infants and young children and women living in difficult situations. These interventions have been supported by development partners through technical and financial assistance as well as supplies and capacity building. Other supportive services undertaken by NGOs, CBOs and faith-based organisations (FBOs) include running orphanages and centres for adolescent girls.

5.4 Acute malnutrition

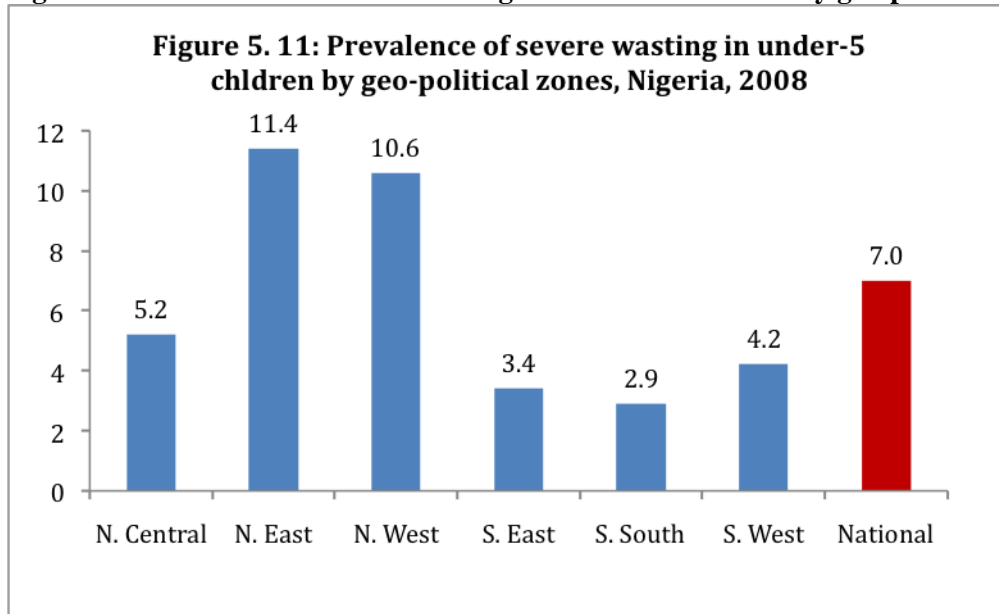
Acute malnutrition contributes to over 50 percent of the 10-11 million deaths from preventable diseases that occur annually in children under-five years worldwide. Severe malnutrition is a

leading cause of morbidity and mortality in children under-five years of age in developing countries.

5.4.1 Severe acute malnutrition

Wasting (middle upper arm circumference lower than 11.5 cm or weight for height of less than 3 standard deviation) with or without oedema in under-five children is classified as severe acute malnutrition. Many severely malnourished children die at home without care, and even when hospital care is provided, case fatality rates are very high, ranging between 30 and 50 percent. In Nigeria, the situation is such that severe wasting is on the increase, increasing from 4.4 percent in 2003 to 7 percent in 2008 (NDHS 2003, 2008). There are large regional differences, ranging from 2.9 percent in the South south zone to 11.4 percent in the North east zone (Figure 5.11).

Figure 5.11 Prevalence of severe wasting in children under five by geo-political zones, 2008



This inequity is also seen in the data for place of residence with people living in the rural area having a higher rate of severe acute malnutrition than those living in the urban area, 7.8 percent and 5.3 percent respectively. Educational and income inequity is apparent with the rates inversely proportional to the levels of education and income of the mother. The result of a screening exercise for malnutrition carried out among children under five years of age using the MUAC measurement during the May 2010 MNCH week, indicated a prevalence of 0.22 percent for severe acute malnutrition in the geographical area covered by UNICEF field office A. The prevalence of severe acute malnutrition in other areas is as follows: 0.14 percent for UNICEF field office B; 4.48 percent for UNICEF field office C; and, 4.72 percent in UNICEF field office D. The national average recorded was 1.35 percent.

5.4.2 Supplementary feeding programme

The treatment of severe acute malnutrition (SAM) is based on 3 phases, with phase 1 focusing on recovery of normal metabolic function and rehydration, phase 2 focuses on gaining weight with the right kind of therapeutic food, and phase 3 on rehabilitation, during which the child can be fed local foods such as supplementary foods at home or in a supplementary feeding centre. Most traditional mixed diets have lower energy content than milk-based diet F-100. They are also relatively deficient in minerals, particularly potassium and magnesium, and contain substances that inhibit the absorption of zinc, copper, and iron. Moreover, the diets are usually deficient in various vitamins. Thus, local foods should be fortified to increase their content of energy, minerals, and vitamins. Oil should be added to increase the energy content. The target groups for supplementary programs are moderately malnourished children less than five years of age, children discharged from outpatient

therapeutic centres, and pregnant and lactating women. There is no organized supplementary programme in the country for now. Many health institutions particularly the tertiary ones where there are trained personnel (dietitians and nutritionists) are using locally produced supplementation. UNICEF is supporting some institutions in research on appropriate and effective supplementary foods in the country.

In 2007, some national dailies and magazines reported that Nigerian children from states that border the Niger Republic were crossing the border to access therapeutic food from food camps in that country. The government with support from development partners carried out two rapid assessment surveys in four states located along the border. The states were Katsina and Jigawa in 2007, and Sokoto and Yobe in 2008. The results from these surveys pointed to an emerging emergency of severe acute malnutrition. In response to this emergency, UNICEF supported the training of health and nutrition personnel in in-patient management of acute malnutrition. Stabilization centres were established to manage cases of SAM with complications and children of less than 6 months of age. Cases without complication were managed in the communities in the outpatient therapeutic (OTP) centres with ready to use therapeutic food (RUTF). UNICEF in partnership with the Clinton Foundation, MSF, and Save the Children has been providing technical and financial support to the high-risk states and this intervention is being implemented in selected LGAs in Kebbi, Gombe, Sokoto, Katsina and Jigawa states. Between three and five high-risk local government areas in each state are currently implementing the programme. In the last 6 months, about 5,000 children were treated. Plans have been concluded to scale up to Borno, Zamfara and Yobe States.

Currently, there is no accurate database for SAM in the country as available records for cases and patient care are inadequate and are not capturing the real situation at both centres where in-patient cases are treated and the OTP sites for community-based management of acute malnutrition (CMAM). However, community management of severe acute malnutrition with ready-to-use therapeutic foods has been shown to induce weight gain in emergency settings and has been recommended by WHO, UNICEF, and the UN World Food Programme (Lancet, 2008). The overall case-fatality rate among severely malnourished children treated in community-based therapeutic care programmes in Malawi, Ethiopia, and Sudan between 2001 and 2005 was 4.1 percent, with a recovery rate of 79.4 percent and defaulting of 11.0 percent (Ashworth, 2006; Ciliberto et al. 2005). This compares favourably with case-fatality rates that are typically achieved with facility-based management, which is assumed to reduce deaths due to SAM by 55 percent (Lancet series, 2008).

5.5 Micronutrients

Micronutrient malnutrition is a term used to refer to diseases caused by a dietary deficiency of vitamins or minerals. More than 2 billion people in the world today may be affected by micronutrient malnutrition. Vitamin A, zinc, iron, and iodine are the major micronutrients that are of public health importance. Globally, deficiencies in vitamin A and zinc are estimated to be responsible for 0.6 million and 0.4 million deaths respectively, and iron deficiency as a risk factor for maternal mortality may cause up to an additional 115,000 deaths (Lancet series, 2008). The May 2004 Copenhagen consensus ranked provision of micronutrients as a top investment along with HIV and AIDS, malaria, water, sanitation and trade liberalization. There is a high level of micronutrient deficiency in children under five years of age in Nigeria.

5.5.1 Vitamin A

UNICEF estimates that 100-140 million children suffer from vitamin A deficiency. Some of the adverse effects of micronutrient deficiencies on health include decreased immune response, poor mental and physical development, visual impairments, complication in pregnancy and delivery and low birth weight. A recent household survey found that 69.3 percent of children aged 6-35 months living with their mothers consumed foods rich in vitamin A in the 24 hours preceding the interview. Children living in the urban area and southern part of the country are more likely to consume

vitamin A rich food than their rural and northern counterparts, and the proportion of children who consume vitamin A rich food is proportional to the level of education and the economic status of the mothers (NDHS, 2008).

5.5.2 Iron and foliate

Iron deficiency, especially iron deficiency anaemia, is one of the most important nutritional deficiencies in the world. Pre-school children and women of reproductive age are most at risk. Studies have shown that about 50 percent of pregnant women in developing countries are anaemic. Iron deficiency anaemia in pregnancy is associated with multiple adverse outcomes for both mother and infant that include sepsis, maternal mortality, perinatal mortality and low birth weight. Its long-term effects on the child include impairment of cognitive development and poor immune status resulting in increased morbidity.

The National Demographic Health Survey in 2008 found that 16 percent of children received iron supplements in the past week. One in four urban children had received iron supplements, compared with one in ten rural children. Children in southern zones (16 percent to 49 percent) were more likely to receive iron supplements than their northern counterparts (3 percent to 7 percent). The likelihood that a child received iron supplements in the past seven days increases with the mother's level of education and household wealth quintile. The overall consumption rate is 57.8 percent in children 6 – 59 months of age.

Folic acid (foliates) helps prevent neural tube defects that affect at least 225,000 children every year globally. Provision of folic acid to mothers during pregnancy will prevent about 75 percent of these defects. Folic acid deficiency causes anaemia in women of childbearing age and in pregnant women and can result in maternal mortality and infants with low birth weight.

5.5.3 Zinc

Zinc has been proven to reduce the severity and duration of diarrhoea. Its deficiency in children results in increased risk of diarrhoea, pneumonia, and malaria. Zinc has been included in the IMCI guidelines for the management of acute diarrhoea.

5.5.4 Iodine

Iodine deficiency is one of the major causes of preventable brain damage. Iodine deficiency has especially serious health implications for pregnant women and young children. During pregnancy, a mild deficiency can reduce brain development in the unborn child limiting its intellectual ability for life. The multiple consequences of iodine deficiency are: cognitive impairment, physical retardation known as cretinism (in children), and goitre. The international goal for addressing iodine deficiency is to achieve sustainable elimination of iodine deficiency by 2005. The indicator is the percentage of households consuming adequately iodised salt (>15 parts per million or more of iodine).

The federal government through NAFDAC has put in place a system to ensure the availability and consumption of cheap and adequately iodised salt. The results of a 2007 survey show that in 75 percent of the households salt was adequately iodized, while 21 percent of households had iodized salt with less than 15 ppm of iodine. In all, about 96 percent of households in Nigeria used iodised salt. The figures for adequately iodised salt in rural and urban areas are 73 percent and 80 percent respectively. There were pronounced zonal disparities; in the northern zones, between 59 percent and 76 percent of households used adequately iodized salt compared to between 81 percent and 86 percent of households in the southern zones. The use of adequately iodised salt increased with wealth status, it was lowest among households in the poorest wealth quintile and highest among those in the richest quintile (MICS, 2007).

5.5.5 Strategies for supplementation, fortification and dietary diversity

Supplementation

The 2008 NDHS reports a vitamin A supplementation rate of 25.8 percent (NPC & ICF Macro, 2009). This level is lower than 33.7 percent in 2003 NDHS. The report also shows that vitamin A supplementation was higher in the urban than in the rural areas. Mother's level of education was closely associated with children receiving vitamin A supplement; 14 percent of children of mothers with no education received vitamin A supplements in the past six months compared with 49 percent of children whose mothers had more than secondary education. Similarly, the proportion of children who received vitamin A supplements increased with household wealth status, from 13 percent among children in the lowest wealth quintile to 44 percent among children in the highest wealth quintile.

Vitamin A supplementation has been part of Immunization Plus Days (IPD) in the northern states and is also carried out during Child Health Week in the southern states. The National Council on Health early in 2010 passed a resolution for bi-annual implementation of Maternal, Newborn and Child Health (MNCH) week in May and November. Vitamin A supplementation is one of the main interventions that will be implemented during the programme. This is expected to boost vitamin A coverage. The results from the first round of MNCH week in May 2010 show that the national average for vitamin A supplementation was 92 percent. The following result was obtained for different geographical areas covered by UNICEF Field Offices: Field Office A 79 percent; Field Office B 72 percent, Field Office C 116 percent, and Field Office D 100 percent. The average figure obtained nationally was 92 percent. Mothers were not targeted for the supplementation intervention during the week.

Iron and foliate supplementation was carried out in the May 2010 MNCH week in all the implementing states. At the moment, there is no preventive zinc supplementation programme in the country and it was not part of the interventions provided during the MNCH week.

Fortification

Fortification is another way to increase micronutrient levels in the vulnerable groups. There has been an increase in fortification of food and beverages in the country with vitamin A and iron. The initiative to control and reduce micronutrient deficiency in Nigeria goes back to the 1990s. In 2002, the Ministry of Industry and the Standards Organization of Nigeria (SON) published mandatory standards for vitamin A fortification of flour, sugar and vegetable oils. By 2004, 70 percent of sugar, 100 percent of wheat flour and 55 percent of vegetable oil sold in the markets were fortified with vitamin A (UNICEF, 2006). In addition, there is fortification of wheat flour with iron to prevent anaemia. UNICEF and the Micronutrient Initiative along with the regulatory bodies (SON and NAFDAC) are supporting the country through partnership with the private sector food industries to ensure compliance.

Nigeria is almost attaining the target of the global recommendation of 100 percent salt iodisation. The household salt iodisation in the country, 97 percent, is one of the highest in the region (the average for West and Central African countries is 73 percent while that for sub-Saharan Africa is 60 percent) (UNICEF, 2010). Salt iodisation is low in the neighbouring Niger Republic. There is therefore a possibility that non-iodised salt can find its way into Nigeria particularly in the states bordering Niger Republic.

Dietary diversity

Dietary diversity refers to the number of different foods or food groups consumed over a given reference period. It is used as a proxy for measuring household food security. In Nigeria, the promotion of dietary diversity is yet to receive due attention. There is evidence that many families over the years have practised dietary diversity in the country but the number is on the decline due to economic hardship.

5.6 Nutrition and HIV and AIDS

HIV and AIDS are major challenges in Nigeria. The country has the third largest population of people living with HIV in the world after South Africa and India. Transmission of the virus through breast milk is responsible for a high proportion of children living with HIV, who have acquired the infection from their mothers. Malnutrition is linked to the growing HIV and AIDS pandemic, as it makes adults more susceptible to the virus and inadequate infant feeding increases the risk of mother-to-child transmission.

5.6.1 HIV and infant feeding and prevention of mother to child transmission

HIV counselling and testing (HCT) plays a major role in the prevention of mother-to-child transmission (PMTCT) and child nutrition practices, particularly breastfeeding. In addition, HCT is important, as knowledge of one's status is helpful. For instance, a mother's knowledge of her status will help her make an informed choice concerning breastfeeding of her child. Over the years, HIV has been a major challenge for exclusive breastfeeding (EBF), as EBF is being discouraged and breast milk substitute is being recommended for mothers who are HIV-positive. This is likely to have contributed to the gradual reduction of EBF rate in the country.

Special attention is however necessary to balance the well-known benefits of breastfeeding (and EBF) and the risk of HIV transmission through breast milk. This risk is nothing compared with the risk of mixed feeding which increases the risk of the young child dying from diarrhoea and pneumonia particularly in an environment with high levels of poverty and poor sanitation as the case is in Nigeria. Mothers who choose not to breastfeed are advised to make sure that in choosing any substitute they follow the principle of acceptability, feasibility, affordability, sustainability and safety (AFASS). This is hardly an alternative in Nigeria's resource poor setting. To address this challenge, the National AIDS and STD Programme (NASCP) and the Nutrition division of the FMOH in collaboration with development partners are updating the HIV and infant feeding guidelines in line with the recommendations of the "Rapid Advice On The Use of Anti-Retroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants", as well as "HIV and Infant Feeding: Revised Principles and Recommendations" (WHO 2010). They have come up with a policy of exclusive breastfeeding till 6 months of age. Details and modalities of the implementation of the policy are in the pipeline.

5.6.2 Nutrition care and support

There is a devastating interaction between malnutrition and HIV infection. People living with HIV (PLHIV) are exposed to an increased risk of food insecurity and malnutrition especially in poor settings that may aggravate their situation. This is especially true for sub-Saharan African countries where the HIV and AIDS burden is highest and malnutrition level in adults as well as in children is also high. Although adequate nutrition can neither prevent nor cure the infection, it is essential to maintain the immune system, sustain a healthy level of physical activity and support optimal quality of life. It also supports the efficacy of anti-retroviral therapy. To date, there is no coordinated nutritional care for PLHIV in the country. However some local NGOs have been involved in some forms of nutrition intervention, but this is barely enough. Malnutrition and HIV and AIDS reinforce each other and the success of HIV and AIDS programmes depend to some extent on paying more attention to nutrition. Nutrition and NASCP divisions of FMOH have developed dietary guidelines for PLHIV as part of national efforts to reduce the impact of HIV and AIDS on the nutritional status of PLHIV.

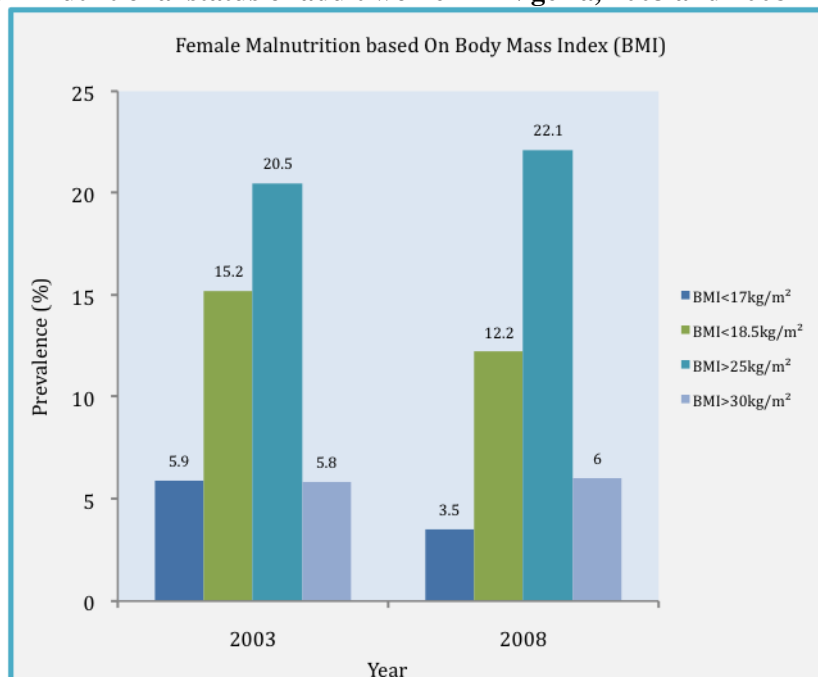
5.7 Maternal Nutrition

5.7.1 Body Mass Index

The 2008 NDHS shows that about 12.2 percent of adult women have a body mass index (BMI) lower than 18.5, which indicates chronic energy deficiency. Chronic poor nutritional status lowers a

woman's well being and reduces her productivity. Among pregnant women, poor nutrition results in birth complications and low birth weight in children and predisposes them to morbidity and mortality. The NDHS also shows regional, place of residence, income and educational disparities in nutritional status. The rich have a lower proportion of women with low BMI (6.7 percent) and obesity is more predominant amongst them (12.8 percent). A higher proportion of women in the northern states have lower BMI compared with their southern counterparts with a range of 20.7 percent in the North east to 6.8 percent in the South east. The rate of obesity is higher in the southern states than the northern states. Between 2003 and 2008, as NDHS results show, there was a decline in the level of malnutrition among females in the country. Unfortunately, there has also been an increase in the level of obesity (Figure 5.12).

Figure 5.12 Trend in nutritional status of adult women in Nigeria, 2003 and 2008



Source: NPC & ORC Macro, 2004; NPC & ICF Macro, 2009.

5.7.2 Birth weight

The weight of a baby at birth is a good indicator of a mother's health and nutritional status. In the developing world, low birth weight stems primarily from the mother's poor health and nutrition. Three factors have been found to predispose a newborn to be born with low birth weight: (i) the mother's poor nutritional status before conception, (ii) short stature (due mostly to poor nutrition and infections during her childhood), and (iii) poor nutrition during the pregnancy.

Babies who are undernourished in the womb face a greatly increased risk of dying during their early months and years. Those who survive often have impaired immune function and increased risk of disease. Therefore, they are likely to remain undernourished, with reduced muscle strength, throughout their lives, and suffer a higher incidence of diabetes and heart disease in later life.

5.7.3 Micronutrients

Another area of concern is the level of micronutrient deficiency among women. This can result in birth complications and serious health consequences for the children in future. A higher proportion of women in the highest wealth quintiles consume foods rich in vitamin A and ferrous compared with women in the lower wealth quintiles. They also use more household iodised salts in their homes. A nutrition survey (Maziya et al, 2004) found that 10 percent of pregnant women studied had vitamin A deficiency, about 20 percent suffered from iron deficiency and 4 percent had severe iodine deficiency. This situation is worrisome as iron deficiency among pregnant women can result

in maternal mortality, premature birth and low birth weight, stillbirth, brain damage and cretinism in the child.

The NDHS 2008 results reveal that 24.9 percent of women surveyed received post-partum vitamin A supplementation. Post-partum vitamin A supplementation was highest among urban women (43 percent), those with more than secondary education (56 percent), and those in the highest wealth quintile (57 percent). By zone, the proportion of women who received post-partum vitamin A supplementation ranged from 9 percent (North west) to 49 percent (South west). Mothers were not targets for vitamin A supplementation during IPDs and in the recently concluded MNCH week.

5.8 Nutrition, health and environment

5.8.1 Climate change

Climate change directly affects food security and nutrition and it is expected to increase the risk of hunger and malnutrition by an unprecedented scale within the next few decades. Under-nutrition is already the single largest contributor to the global burden of disease, killing 3.5 million people every year, almost all of them children in developing countries. Unless urgent action is taken, it will not be possible to ensure the food security of the growing world population under a changing climate. Sub-Saharan Africa will be more adversely affected than other regions in the world due to the lack of technology and resources to handle the situation. Up to 250 million people are expected to be affected by floods and drought from desert encroachment. All these will adversely affect food production and food security will be severely compromised. In this situation, the most vulnerable – children, women and the poor – will suffer earliest and will be most affected by climate change as it aggravates food insecurity and malnutrition. Northern Nigeria, particularly the states in the Sahel belt, is currently experiencing the effect of desert encroachment and food shortages. This can explain the rising incidence of wasting in young children. This is an emergency situation that the country has so far ignored.

A nutrition rapid assessment survey using the Standardised Monitoring and Assessment of Reliefs and Transitions (SMART) method to determine the extent of the problem has just been carried out in some high-risk states in the north with the support of UNICEF.

5.8.2 Food security

There are ongoing efforts to address food security in terms of food availability through interventions at the federal level such as provision of fertilisers at a subsidised price to boost food availability and establishment of silos. However, little or no attention is paid to household food insecurity especially among the low-income segment of the population. Food security is being threatened by the consequences of climate change, poverty, and social inequity in the country. With the global economic and food crises prices of food have increased, making food unavailable. When available, adequate and nutritious food is inaccessible to the vulnerable population. The National Food Consumption and Nutrition Survey (NFCNS, 2003) reports food security at 68 percent. Recently there is strong evidence that national food production has failed to keep pace with population growth and has been declining in per capita terms. One of the 7-point agenda of this government is to increase food and agriculture production. The food distribution system is also inefficient, due to inadequate storage technology, poor transportation and distribution systems in addition to food seasonality. Fluctuation in food prices is one of the fallouts, affecting most vulnerable populations such as the poor, women, and children.

5.8.3 Water, sanitation and hygiene

Diarrhoeal disease is among the leading causes of childhood deaths. The most affected are the populations in developing countries, those living in rural areas, and the poor. Some of the main factors responsible for this situation are lack of priority given to the sector, lack of sustainability of water supply and sanitation services, poor hygiene behaviours, and inadequate sanitation in public

places including hospitals, health centres, and schools. Providing access to sufficient quantities of safe water, facilities for a sanitary disposal of excreta, and introducing sound hygiene behaviours are important to reduce the incidence of diarrhoea and other sanitation-related diseases.

As discussed in the chapter on Water, Sanitation and Hygiene, Nigeria still has great challenges in terms of inadequate as well as inequitable access to improved water source and sanitation facility, with households in rural areas having lower access to these facilities than their urban counterparts. Lack of and poor access to safe water supply increases a child's vulnerability to infections and malnutrition, as unhealthy household environment is one of the underlying causes of malnutrition. Mothers living in rural areas also spend more time in search of safe drinking water thus affecting the amount of time they have to look after their children.

Good personal hygiene, particularly hand washing, is known to reduce the incidence of diarrhoeal disease. The message of hand washing is therefore being promoted, recommending hand washing before preparation of the young child's food, before and after eating, and after using the toilet. Hands must be washed with soap and water.

5.9 Recommendations

First and foremost, the government needs to place nutrition higher on the development agenda. The Nutrition Council must be reviewed and should take a coordinating and strong leadership role. There must be coherence and clear allocation of roles and responsibilities across the various sectors and stakeholders. To achieve sustainable impact in improving maternal and child nutrition, linkages are needed between the social sector (health and education), the productive sector (agriculture and commerce), and the private sector.

The Baby Friendly Hospital Initiative (BFHI) targets only mothers who deliver in health facilities, thus excluding mothers living in rural areas and who have no access to health facilities. BFHI should be mainstreamed into the health care delivery system and promoted at the primary health care level in order to address the low exclusive breastfeeding rate and declining implementation of the BFHI. A community-based approach should be adopted and community breastfeeding support groups established for grass root sensitization, campaigns, and messages on breastfeeding. The regulatory agency, NAFDAC, must continuously monitor and place surveillance on infant formula manufacturers to ensure that they adhere to the International Code of Marketing of Breast Milk Substitutes.

Given the high prevalence of malnutrition and limited resources, a decision must be taken on which intervention should be given the highest priority and ensure effective implementation and high coverage to achieve the greatest benefit. Priority should be given to interventions that are effective and have high impact on mortality reduction. These interventions must target vulnerable groups and be distributed equitably. Interventions that will promote household and community nutrition practices should be scaled up. These have been proven to be beneficial to the survival of women and children. Promotion of key household messages on EBF, complementary feeding, micronutrients, utilization of health services, water, and sanitation will bring about behaviour change in the community and the individual. UNICEF should support the government to implement this.

One of the challenges in the analysis of nutritional issues in Nigeria is the lack of reliable and essential data, particularly reliable routine data collection on several nutrition indices, which creates dependence largely on periodic national household surveys such as NDHS and MICS. The Health Management Information System of the Federal Ministry of Health collects and reports data from the states on children 0-6 months who are exclusively breastfed, number of children 0-6 months given vitamin A, and number of children 0-59 months weighed. The data are not complete as only

about 22 states out of the 36 states and FCT report regularly. The data are usually collected by untrained personnel. The records are incomplete and unreliable because case definitions used are not the standard definitions recommended by WHO and UNICEF. The Disease Surveillance unit in the ministry has added malnutrition to the list of notifiable diseases in the country for reporting. This is yet to be implemented. Given the paucity of effective data, strengthening monitoring and assessment of nutrition programmes is imperative. The establishment of a system for collecting routine, comprehensive and consistent data is recommended. This system should be integrated to include information on all key aspects of maternal and child nutrition generated by all actors in nutrition in the country. This should then be complemented by the regular large-scale surveys.

A National Food Consumption and Nutrition survey is long overdue as the last one was carried out in 2003, about eight years ago. UNICEF should strongly consider providing technical and financial support, partnering with relevant national agencies and development partners, towards making NFCNS a reality in the shortest possible time to strengthen the platform for evidence-based interventions.

Recording and record keeping is essential to the implementation of severe acute malnutrition (SAM) treatment and community-based management of acute malnutrition (CMAM). A database must be developed immediately to monitor patients and the programme, and the data linked to the existing data management system of government. The national protocols and guidelines for SAM and CMAM need to be finalised.

Micronutrient deficiency is one of the major causes of malnutrition. The Copenhagen Consensus (2004) concluded that investments in micronutrients were rated above those of trade liberalization, malaria, water and sanitation. Micronutrient activities must be scaled up in the country. Supplementation of micronutrients during the biannual MNCH week must be well organized, coordinated, and implemented throughout the country. With the shift from child health week to MNCH week, mothers must be targeted for Vitamin A supplementation along with iron and foliate. Zinc supplementation, which has not started yet, should be included among the interventions for the next MNCH week. Efforts at fortification of the various food items must be intensified. Social marketing must be aggressively pursued to sensitize the public. Continuous monitoring by relevant agencies must be carried out regularly, particularly in towns near the border with neighbouring countries.

UNICEF and other relevant international agencies should support the government to strengthen its capacity to detect early warning signs of acute malnutrition by resuscitating nutrition surveillance in the country. Private sector collaboration and support is also recommended. They should be encouraged through, among other things, involving them in local production of essential supplementary foods and ready to use therapeutic food (RUTF). They should partner with the public sector and development partners in food fortification and surveillance of the adherence to the International Code of Marketing of Breast Milk Substitutes.

5.10 Conclusion

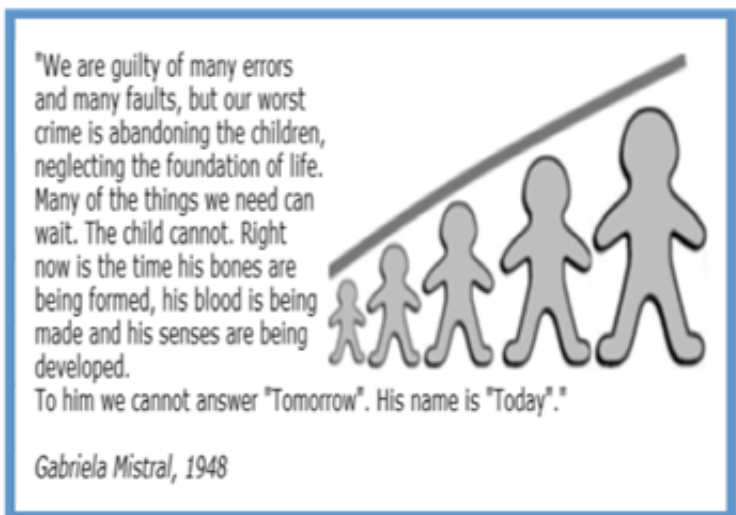
Nigeria has one of the highest rates of malnutrition in the world. It is one of the twenty countries where 80 percent of the world's undernourished children live. This unfortunate situation is a result of several factors including poverty, social inequity, weak health system, food shortages as a result of climate change, and low access to adequate, good quality, and safe food. Over the years, EBF practice has been on the decline, with fewer women practicing it. The environment is a challenge to the well-being of children as access to safe water and good sanitation is low. Repeated episodes of diarrhoea, malaria, pneumonia, and measles predispose the young child to stunting. This affects the future life and productivity of the child, as the condition causes irreversible damage to the brain and cognitive impairment, which has a generational effect in future. Micronutrient deficiency is another

major challenge to the optimal growth and development of the child. The country has taken significant steps to address this. With the bi-annual MNCH week for supplementation of vitamin A, de-worming, and foliate/iron for mothers, the rate of supplementation has increased considerably. The household salt iodisation rate is one of the highest in the world.

Equity plays a major role in the nutritional status of women and children in the country. A high proportion of people living in rural areas have limited access to good health services or health information sources that could impact considerably and positively on their health and health-related behaviour. They also have a lower level of education. In addition, the level of poverty is also higher in rural areas and their purchasing power to obtain high quality food is also more limited. Available data clearly indicate that children of uneducated mothers from poor homes are more likely to be malnourished than their peers of educated and less poor mothers. Malnutrition and poverty are interwoven and both have been found to slow down economic growth and development. To scale up nutrition programmes, nutrition must be mainstreamed into the National Poverty Reduction Programme.

The government needs to see nutrition not only as a social issue, but also as a development issue requiring a central position in the national development strategy. The government should also be ready to take ownership of and be committed to the reduction of malnutrition among children under five years of age. This must be backed by financial commitment. If this is not done, achieving MDGs 1,2,4,5 and 6 will not be possible.

Development partners should provide the necessary support to push the agenda of nutrition forward, working within the existing national structures in line with the Paris Declaration and Accra Agenda for Aid Effectiveness.



6. Child protection

6.1 Introduction

Child protection has become a central concern of sustainable human development and international human rights and humanitarian law. The extent to which the protection rights of the child are promoted and guaranteed in a given country is now key for assessing the state of human security and human development in that country. Driven by an increasing global movement seeing development as a universal objective, the universality of child protection issues, and the troubling fact that violations of children's protection rights are massive, under-recognised and underreported across the globe, the concern with child protection has led to the development of important international and regional legal instruments and collective mechanisms for combating violations against the right of the child to protection, including violence, abuse and exploitation.

The following are some of the most central and explicit of these instruments: the UN Convention against Torture and Other Cruel, Inhuman, and Degrading Treatment or Punishment (CAT), 1984; the UN Convention on the Rights of the Child (CRC), 1989; the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1981; ILO Convention on Minimum Age, 1973 and ILO Convention on Worst Forms of Forced Labour, 1999; UN Convention Against Transnational Organised Crime, 2003; and the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the UN Convention Against Transnational Organised Crime, 2003. Other key global initiatives include the Millennium Development Goals (MDGs) and the World Fit for Children (WFFC). In Africa, the major regional regimes on child protection include the African Charter on the Rights and Welfare of the Child (ACRWC), 1999 and the Libreville Platform of Action, 2000.

The centrality of child protection to human development can be viewed from two important standpoints. First, children constitute one of society's most vulnerable groups and their right to protection is integral to human development, given that children form a large segment of the population in many developing countries. Acts of violence, exploitation, and abuse against children are not only human rights violations, but constitute barriers to the survival and development of the child. Such children are at the risk of death, poor physical and mental health, HIV/AIDS, poor or no education, displacement, homelessness, and limited life opportunities. As forcefully argued by UNICEF (2008),

‘The protection of children from abuse, exploitation and neglect is integral to their survival, growth and development. The consequences of violation of a child's right to protection include reduced life expectancy, poor physical and mental health, reduced access to education and other services, homelessness, vagrancy, displacement and a sense of hopelessness. There is a strong link between child protection rights and all the other rights of the child. Often, the child experiencing abuse or exploitation is the same child experiencing late or no birth registration, malnutrition and illness, lack of early stimulation, and reduced learning opportunities.’

Second, the realisation (or lack thereof) of children's protection rights is a central determinant of the human development of future generations. Today's children are the adults of tomorrow. Guaranteeing the protection rights of children is a strategic and invaluable social investment in the much-needed human capital for future sustainable growth and development.

Even though the overall economic growth and social development indicators show that Nigeria has

been making some modest progress, considerable efforts are still required towards achieving key milestones in the area of child protection. With a human development index (HDI) score of 0.448 in 2005, Nigeria ranked 159 out of the 177 countries whose HDI performance was measured (UNDP 2007). This figure is lower than the average HDI for sub-Saharan Africa (SSA) and that of the least developed countries (LDCs), which stood at 0.472 and 0.464 respectively. These statistics are more disturbing when juxtaposed with those of other African countries that have performed better. Nigeria's 2005 HDI score was lower than that of the Democratic Republic of Congo (DRC), Ghana, Kenya and Sudan; these are countries with less economic endowment and slower growth rate, some of which have far less potential to perform well having gone through protracted periods of debilitating armed conflict, particularly the DRC and Sudan.

Yet, over the last decade, Nigeria has taken child protection very seriously and has taken some important steps towards promoting and protecting the rights of the child. One such step was the enactment of the Child Rights Act (CRA) No. 26 of 2003, which marked the domestication of the UN Convention on the Rights of the Child. The CRA represents a watershed in the country's legal jurisprudence as it articulates, inter alia, the protection rights of children, provides an implementation framework of key principles related to these rights, incorporates all existing laws pertaining to the rights of children (including the Children and Young Persons Act [CYPA]), and specifies the responsibilities and obligations of government, parents and other authorities, organisations and bodies in relation to these rights (UNICEF 2008). The CRA also set up the Family Court Division (with exclusive jurisdiction over children) and the Child Justice Administration (CJA). It also provides for the prohibition of capital punishment, imprisonment, and corporal punishment of children, and the use of scientific tests for deciding paternity cases (UNICEF 2008, 44). Further to this, other relevant security and law enforcement agencies in the country, such as the Nigeria Police (NPF) and the Nigeria Immigration Service (NIS) now have specialised units on child trafficking as provided for in the CRA.

Sections 58 to 64 of the Labour Decree (now Act) of 1974 also deal with child labour laws, which the CRA is empowered to enforce. Since the enactment of the CRA, 22 state governments have passed Child Right Laws, in line with the constitutional procedure of domesticating international law. Apart from the CRA, a number of states have other laws with crucial implications for child protection within their respective jurisdictions. These include: Ebonyi State Law No. 010 on the Abolition of Harmful Traditional Practices Against Children and Women, 2001; Edo State Female Genital Mutilation (Prohibition) Law, 2004; Enugu State Female Genital Mutilation (Prohibition) Law, 2002; Bayelsa State Female Genital Mutilation (Prohibition) Law, 2002; Edo State Criminal Code Amendment Law, 2000; the Anambra State Child Rights Law; Bauchi State Hawking by Children (Prohibition) Edict of 1985 CAP 58; and Cross River State Girl Child Marriages and Female Circumcision (Prohibition) Law, 2000. Other examples are the Sharia Penal Codes of Zamfara, Kano, Kebbi, Kaduna and Sokoto states of Nigeria, which protect children against various forms of physical and psychological violence (FMWA & SD, 2004: 4).

In addition to the CRA, the 2003 Trafficking in Persons (prohibition) Law Enforcement Administration Act (TIPPLEA) is a key piece of legislation for guaranteeing child protection rights in the country. TIPPLEA prohibits trafficking in human beings, particularly children (and women), and established the National Agency for the Prohibition of Traffic in Persons (NAPTIP) as a statutory agency for enforcing this law. There is now also a special office to the Special Adviser to the President on human trafficking.

Further still, a Social Protection Strategy (SPS) was developed by the federal government in 2004. The main goal of the SPS is 'to reduce poverty and protect vulnerable groups through effective and sustainable risk management mechanism thereby achieving sustainable social protection by the year 2015' (National Social Protection Committee, 2005). Designed to be integrated into Nigeria's

Poverty Reduction Strategy Paper (PRSP) known as the National Economic Empowerment Development Strategy (NEEDS), the SPS includes child protection as one of its four strategic directions. The SPS interventions focus on early child labour, child trafficking, withdrawal of girls from school for early marriage, and sexual exploitation. The strategy also assigns specific roles and responsibilities to all three tiers of government (federal, state and local), local communities, and civil society (NGOs, community-based organisations and faith-based organisations) for implementation, coordination and monitoring.

The developments above are very impressive steps in terms of establishing the necessary legal, policy, and strategy frameworks for child protection. Yet, in spite of these measures, little progress has been made on the level of actual protection of children in Nigeria from violence, abuse, and exploitation. Regrettably, the failure of child protection has continued to manifest through widespread occurrence of domestic violence and the cynicism of law enforcement agencies to it, the severity of the situation of children with disabilities, street children, children affected by communal conflict, drug abuse, trafficking and abduction, and the weaknesses in the juvenile justice system (UNICEF, 2008). It has been documented that the main factors that have undermined Nigeria's effort to fulfil its child protection obligations include harmful customary laws and traditional practices, lack of up to date data, inadequate resources, lack of political will, increased poverty, non-enforcement of laws and policies, inadequate public education and enlightenment on the rights of children (UNICEF, 2008).

The central objective of this chapter is to analyse the protective environment in Nigeria with emphasis on improving legal and social frameworks, building national systems, and strengthening social norms and values to prevent violence, abuse, and exploitation of children. UNICEF's child protection programmes are aimed at preventing and responding to such violence, abuse, and exploitation. The key issues that are addressed in this chapter are birth registration, child labour, child marriage, child trafficking, children in conflicts and emergencies, children and justice, children without parental care, female genital mutilation/cutting, sexual exploitation of children, and violence against children.

The key questions covered in this chapter include the following: what proportion of children in Nigeria experience violence, exploitation, and abuse? What are the circumstances of these rights violations? What are the implications of these violations for the rights, survival, and development of children in Nigeria? Which factors permit, drive, and sustain these violations? To what extent are these violations recognised and reported? What decisions need to be taken to prevent and respond to these violations? Answers to these questions are discussed separately for each of the major issues of concern below.

6.2 Present status and trends

The following section covers key issues in child protection in Nigeria today, and assesses their current status and trends based on available information. The following issues are covered: child labour, birth registration, harmful practices, children and justice, child trafficking and sexual exploitation of children, children in conflicts and emergencies, violence against children, and children without parental care.

6.2.1 Child labour

Child labour broadly entails children working in hazardous situations or conditions. This may involve working long hours in farms, quarries, private households, in commercial buses, on the streets, in mines, working with chemicals and pesticides in agriculture, or working with dangerous machinery. According to the International Labour Organisation (ILO) child labour is the engagement of children below 15 years of age in work or employment on a regular basis with the aim of earning a livelihood for themselves and their families. The ILO Convention 182 enumerates

the worst forms of child labour to include all forms of slavery or practices similar to slavery, such as sale and trafficking of children, debt bondage and forced labour, as well as use of children for prostitution and pornography. It includes the use of children in illicit activities, especially for production and trafficking of drugs, as well as children doing work that jeopardizes their health, safety, morals or development.

Working in such hazardous environments and under appalling conditions threatens the physical and moral development of children as it exposes them to violence, abuse, and exploitation. According to the ILO World of Work (2003), children can be made to work longer hours with little food, poor accommodation, and no benefits because they are generally easier to abuse, less assertive and less able to claim their rights. The ILO International Programme on the Elimination of Child Labour (IPEC) (2003) has showed that children most vulnerable to severe labour exploitation often come from disadvantaged, marginalized and socially excluded groups. These include orphans, children of single parent or child headed families, children of tribal or ethnic minorities, street children, migrant children and refugees.

Section 28 of the 2003 CRA provides for the protection of children in Nigeria from forced or exploitative labour and prescribes punishment for violations. A very crucial instrument at the state level is the Child Rights Law in Anambra State, which prohibits children from hawking during school hours (FMWA & SD 2004). In spite of this encouraging legislative development, child labour has remained a major problem of child protection in the country. According to an ILO study cited in UNICEF Nigeria Information Fact Sheet on Child Labour published in 2006, a shocking number of 15 million children are subjected to child labour across the country. Under the age of 14 years, most of these children work long hours in dangerous and unhealthy environments, carrying too much responsibility for their age, and with little food, small pay, no education and no medical care (UNICEF, 2006). It has been showed that child labour does not occur in the organised public sector of the economy because it is prohibited by the Labour Act of 1990. Rather, child labour is associated with the informal sector of the economy where the provisions of the Labour Act are not enforced (UNICEF, 2001).

According to a study conducted by UNICEF (1996, cited in UNICEF, 2006), the four major environments where child labour takes place in Nigeria are public places (e.g. streets and markets), semi-public places (e.g. cottage industries and mechanic workshops), private households (domestic servants mainly), and agricultural plantation and quarries (farm and quarry workers). Among children working in public places such as streets and markets, street vendors constitute 64 percent, beggars 13 percent, feet washers 8 percent, car washers/watchers 6 percent, scavengers 5 percent, and shoe shiners 4 percent. In semi-public settings, 24 percent are apprentice mechanics and vulcanisers, 18 percent are hairdressers/barbers, 17 percent are bus conductors, 14 percent are carpenters, 14 percent are tailors and weavers, 8 percent are caterers, and 6 percent are iron/metal workers (UNICEF, 1996). In spite of this picture, child labourers have not received prominent research attention. The areas that have been most neglected are young domestics workers, *Almajiri*, street children, children in agriculture, and children in construction work (UNICEF 2010).

The National Bureau of Statistics (NBS) conducted a study on child labour in 2006 and found that 29 percent of all children aged 5-14 years were engaged in child labour. One in five (21 percent) were engaged in family business while 9 percent were working outside the family unpaid (NBS 2006). The criteria used by NBS for measuring child labour were: doing at least 1 hour of economic work or 28 hours of domestic work per week at ages 5-11, and doing at least 14 hours of economic work or 28 hours of domestic work per week at ages 12-17.

The NBS study revealed important variations on the basis of sector, geopolitical zones, age, level of mother's education, and family wealth status. The sex of the child was not an important factor of

variation. Child labour was found to be more prevalent in rural areas (32 percent) than in urban areas (21 percent). The North central zone had a prevalence of 39 percent, followed by 38 percent in the South south, 27 percent in the North west, and 26 percent each in the South east and North east zones. Child labour is most common among children aged 5-11 years (34 percent), followed by children aged 15-17 years (19 percent), and children aged 12-14 (15 percent). Interestingly, prevalence is higher among children whose mothers had primary education (33 percent) than among children whose mothers had no education at all (30 percent). Children whose mothers had at least secondary education had the lowest prevalence of 22 percent. In terms of wealth status, child labour prevalence was 34 percent in the poorest households compared to 17 percent in the richest households.

Child labour has generally been found to impair the chances of early education of children as working children lack the necessary time, money, or energy for school attendance. UNICEF (2006) puts the figure of working children in Nigeria who do not attend school at all at about 6 million, while one million children are forced to drop out of school due to poverty or pressure to work in order to supplement the family income. The number of working children who are able to stay in school, at least partly, was put at over 8 million. However, these children still have to skip classes as a result of the high demand work places on their time and energy.

The NBS (2006) factsheet shows that 63 percent of child labourers were found to be attending school. Thirty-six percent of them (student labourers) were 5-11 years old while 14 percent were 12-14 years old. Again, child labourers (labourer students) likely to be in school were 32 percent among those whose mothers had no education, 34 percent for mothers with primary education, and 23 percent for mothers with at least secondary education. The likelihood of student labourers was 18 percent for children from the richest households and 40 percent for those from the poorest; while the highest prevalence of student labourers was in the North central and the South south zones (NBS, 2006). This study does not provide sex disaggregated data to enable gender analysis of school attendance among child labourers.

Rampant child labour in Nigeria has been strongly linked to poor economic conditions and instability in the family. In a recent baseline survey on child protection in Nigeria, 146 (46 percent) out of the 317 street children interviewed preferred to remain on the streets. Their reason was that the condition at home was more undesirable (UNICEF 2010). The same study shows that 80 percent of the street children claimed that they came from families with five or more children, 60 percent of them come from monogamous homes, 40 percent from polygamous homes, and 12 percent of them had lost at least one parent (UNICEF, 2010). Children working in agriculture in Nigeria are seriously under-studied with no recent data available. It is likely that a massive and growing number of children are involved in agriculture, and this is an area that needs to be researched to generate relevant data.

An important component of street children not captured in the NBS data above are the *Almajirai* (*Almajiri* for singular) in some Muslim communities, even though they are highly visible and a common sight in the streets. The *Almajirai* are young persons who leave for other towns solely to acquire religious (Islamic) knowledge. The system bellies serious child labour issues because it can turn children who are traditionally supposed to be Islamic pupils into perpetual beggars. They are made to work long hours (begging) each day to maintain the upkeep of their *Mallams* (Islamic teachers). This practice is prevalent in northern Nigeria, where children aged between 4 to 15 years leave their communities and families for Quranic knowledge under the tutelage of *Mallams* who are not necessarily resident in any particular town (UNICEF, 2010). As Imam (1998) argues, certain practices in the *Almajiri* system amount to child abuse. These practices include begging, denial of parental care (at the tender age of 4-11 years), poor learning conditions, denial of modern health care facilities, cruel/inhuman treatment, hawking and acting as porters in market places. The

UNICEF baseline survey provides the only existing in-depth analysis of the phenomenon of *Almajiri* in Nigeria, with disaggregated data, although the 2007 UNICEF Situation Analysis briefly discusses it. The *Almajiri* system is a male phenomenon with all the *Almajiris* studied being boys (UNICEF, 2010). The majority of them (77.6 percent) were between 14 and 17 years of age. Only 9.5 percent were between 5 and 9 years of age, and 12.9 percent were over 18 years old. The 2007 Situation Analysis provided specific figures for states where the phenomenon is most prevalent. For instance, in Adamawa and Kano the *Almajirai* were found to be all males and mostly 10-14 years old children who are denied formal education. In Kano state, 100 percent of them had never attended school, while 77.8 percent of them never attended school in Adamawa State, where also 22.2 percent dropped out of school as a result of poverty (UNICEF, 2007). While the situation in these two states represents the most affected areas, the phenomenon is visible in many parts of the north and south west of Nigeria. These children's occupation, welfare, and health status expose them to violence, abuse, and exploitation as clearly shown in the UNICEF baseline study.

The least visible category of child labourers is domestic servants. Unfortunately data on this category is seriously lacking, probably due to the lack of visibility. Yet, domestic servants in Nigeria are often victims of sexual violence, abuse, or harassment, particularly the girls – this is also likely linked to the lack of visibility. According to the UNICEF Information Sheet (2006), half the young domestic workers employed in Lagos said they knew of domestic servants who were sexually molested. Another important manifestation of child labour in Nigeria that is conspicuously missing in the literature is the use of children in the company of their parents (mostly mothers) for street begging. This is very common among the *Shua* Arab immigrants from the neighbouring Republic of Chad. This practice is very visible in almost all the major cities, yet it has not received any scholarly attention to generate relevant data for analysis and policy response.

6.2.2 Birth registration

Article 7(1) of the Convention on the Rights of the Child provides for registration of the child immediately after birth, and guarantees the right of the child to a name and to acquire nationality. Birth registration is the first legal acknowledgement of a child's existence, and it is fundamental to the realisation of a number of rights and practical needs:

- Providing access to healthcare.
- Providing access to immunisation.
- Ensuring that children enrol in school at the right age.
- Enforcing laws related to minimum age for employment, assisting efforts to prevent child labour.
- Effectively countering forced marriage of young girls before they are legally eligible.
- Protecting young people from under-age military service or conscription.
- Protecting children from harassment by police and other law enforcement officers.
- Securing the child's right to a nationality at the time of birth or at a later stage.
- Protecting children who are trafficked, including through repatriation and family reunion.
- Getting a passport, opening a bank account, obtaining credit, voting or finding employment.

The right to birth registration for every child in the country is provided for in Section 5(2) of the CRA of 2003 and is also provided for in the Birth, Death, etc (Compulsory Registration) Act, 1992. However, according to NBS (2008), only 23 percent of births among children under five years of age had been registered in 2007. This figure is far below the 35 percent coverage recorded by the National Population Commission (NPC) during its birth registration exercise from 1994 to 2007 (NPC, 2008). A breakdown of these figures shows variation according to age, sex, rural or urban setting, geo-political zone, level of mother's education, and wealth status of the household.

The NBS data found that birth registration was 20 percent among children aged under one year, about 23 percent for children aged 1-3 years, and 25 percent for children aged 3 to 5 years.

However, the NBS data were limited to children up to 5 years old. The NPC study covers a wider age range and found that birth registration was 37.6 percent among children under the age of one year, and 14.5 percent among children over 10 years of age (NPC, 2008). The difference between the NBS data and those of the NPC may not imply inconsistency, as the latter study is likely to have covered more recent births than much older ones.

The data also revealed that birth registration was slightly higher for boys (24 percent) than for girls (23 percent), and significantly higher for children in urban areas (43 percent) than for children in rural areas (15 percent). Birth registration was 13 percent for children whose mother had no education versus 43 percent for those whose mother had a minimum of secondary school; 9 percent for children in the poorest homes versus 51 percent for those from the richest households; 45 percent for the South west, 29 percent for the South east, 11 percent for North west and 18 percent for North central (NBS, 2006). These figures show that the chances of registration increase with the age of the child, the mother's level of education, and the wealth of the household. They also reveal a marked variation between the southern zones and the northern zones of the country, and between urban and rural areas, with rural areas and the northern zones lagging far behind. The overall picture from these figures is that the coverage of birth registration has been very low in Nigeria. However, according to the NPC (2008), a strategy document for 2008-2015 has been developed to remedy this policy and performance gap. The document is envisaged to expand coverage to target 60 percent by the year 2010 and 100 percent by 2015. The 2010 UNICEF Baseline Survey shows that the implementation of this NPC strategy is beginning to yield marked improvement in the level of birth registration. The survey shows the national average of birth registration to be 57.7 percent of births. The South west had the highest number of registered births with 81.1 percent while the North east had the lowest at 43 percent (UNICEF, 2010). The survey links this phenomenal increase to the national campaign on birth registration launched in July 2007 by the NPC.

6.2.3 Harmful practices

In this assessment, harmful practices form a broad category that covers child marriage as well as female genital mutilation or cutting (FGM/C). Child marriage is defined as marriage before the age of 18 years, which is considered a violation of the rights of the child. Although child marriage also affects boys, girls suffer far more in terms of incidence and impact. Girls are required to perform heavy domestic work, are under pressure to demonstrate fertility, and are responsible for raising children while still children (NBS, 2007). This compromises the development of girls, and often results in early pregnancy and social isolation, little education and poor vocational training, all of which reinforce the gendered nature of poverty. Married girls and child mothers also face constrained decision-making power and reduced life choices. Further still, married girls are more likely to experience domestic violence, to have more children than those who marry later in life, to suffer maternal mortality, and they are at a higher risk of HIV infection and are more likely to suffer vesicovaginal fistula.

Child marriage is currently a major constraint for the development of children in Nigeria. According to the NBS (2006), 15 percent of women aged between 15 and 49 years married before the age of 15 years. This trend is more rampant in the North west of Nigeria at 33 percent. The national figure for girls who married before the age of 18 is 40 percent, but 78 percent in the North west. Across the country 25 percent of women aged 15-19 years married before the age of 15. The figure is far lower in the South where it is less than 10 percent. Thirty-two percent of women aged 15-19 years are married or in union, but in the North west the figure stands at 58 percent (NBS, 2006). The more recent Nigeria Demographic and Health Survey (NDHS) also confirms that child marriage remains a current challenge in Nigeria. Among all females aged 20-49 years, 21.9 percent had been married by the age of 15 years and 46.1 percent had been married by the age of 18 years. More than a tenth (12.4 percent) of girls currently aged 15-19 years had already been married by the age of 15 years (NPC & ICF Macro, 2009).

The results of the 2006 NBS study also reveal important variations. The proportion of females aged 15-49 years who married before the age of 15 years is 19 percent in rural areas compared to 8 percent in urban areas. Similarly, the proportion of women aged 20-49 who married before the age of 18 years is 41 percent in rural areas and 23 percent in urban areas. Among girls aged 15-19 years 32 percent in rural areas are married or are in union, compared to 9 percent in urban areas (NBS, 2006). The probability of child marriage decreases with level of education and wealth: 26 percent of women aged 15-49 without education are likely to marry before age 15 as opposed to 4 percent for women with at least secondary education. Only five percent of girls from the richest households are likely to marry before 15 years as against 25 percent among the poorest quintile. While 58 percent of those aged 20-49 years without education marry before the age of 18, the corresponding figure is 16 percent for women with at least secondary education. Similarly, while 57 percent of those aged 20-49 in the poorest wealth quintile marry before the age of 18, the corresponding figure is 18 percent for women in the richest wealth quintile. Also, 68 percent of women between ages 15-19 years were found to be likely to marry or be in union before age 15; while the figure is 6 percent for women with at least secondary education; 6 percent for the richest women; 56 percent for the poorest quintile.

Another striking observation about child marriage is the age gap between couples. The NBS data show that 45 percent of females aged 15-19 currently married or in union are at least 10 years younger than their spouses. The proportion is far less for women aged 20-24 years (15 percent). Thirty-four percent of girls aged 15-19 years currently married or in union were 5-9 years younger than their spouses (2 percent for women aged 20-24 years), while 18 percent are less than 5 years younger (4 percent for ages 20-24). The data also show the age disparity between spouses to be wider in rural areas than in urban areas, similarly it is also wider among the poorly educated than the better educated, and among the poorest than the richest households.

FGM/C constitutes another major type of harmful practice against the girl child. FGM/C violates the rights to equal opportunities, health, freedom from violence, injury, abuse, torture and cruel or inhuman and degrading treatment, protection from harmful traditional practices, and to make decisions concerning reproduction. The most commonly identified consequences in the literature (FMOH, 2008; Toubia, 1995; UNICEF, 2008) include death, severe infection and septicaemia, trauma, failure to heal, abscess formation, cyst, excess growth of scar tissue, urinary tract infection, painful sexual intercourse, increased susceptibility to HIV/AIDS and hepatitis, reproductive tract infection, painful menstruation, obstructed labour, increased risk of bleeding and infection during childbirth, and prolonged labour in future births.

FGM/C is a deeply entrenched tradition in many parts of the country, though earlier analysis has indicated that it is on the decline owing to various policies, legislations and programmes (UNICEF, 2007). While the NBS (2006) figures put the prevalence at 32.6 percent, the figure for 2007 reflects a decrease to 26 percent (NBS/UNICEF 2007). As mentioned above in the background section, apart from the CRA, 11 states of the federation have passed important legislations prohibiting FGM/C. These states include Bayelsa, Cross Rivers, Delta, Ebonyi, Edo, Ekiti, Ogun, Ondo, Osun, Oyo, and Rivers. However, as put in the previous Situation Analysis, there is still a deficiency in the actual implementation of these legislations (UNICEF, 2007). In addition a National Policy and Plan of Action on the Elimination of FGM (FMOH, 2002) is also in existence. This policy stipulates the eradication of FGM by government at all levels in collaboration with traditional rulers, women leaders, community and religious leaders, traditional birth attendants, and NGOs working on the subject.

According to the NBS figures, 26 percent of women aged 15-49 years had at least one form of FGM/C in 2006. However, the figure for 2008 based on the NDHS is 30 percent (NPC & ICF

Macro, 2009); this supports the observation that the practice is on the decline in the country. The NDHS also shows that the likelihood of circumcision is 38 percent among women aged 45-49 years compared to 22 percent among women aged 15-19 years. This trend is strengthened further by the fact that FGM occurs mostly during infancy as 82 percent of those who have had the experience did so before their first birthday, with only 2 percent having the experience between ages 1 and 4, and 13 percent from age 5 and above (NPC & ICF Macro 2009). The NDHS shows that most acts of female circumcision (64 percent) are performed by people who are not health professionals, particularly by traditional circumcisers. Only about 9 percent of the cases are performed by trained nurses, midwives and doctors. Reporting is also abysmally low. The NDHS shows that women with more than secondary school education and those in the highest wealth quintile are more likely than others to report that a doctor performed the circumcision (NPC & ICF Macro, 2009).

There are significant variations across the country in terms of FGM/C. The lowest prevalence is in the North east with just 2 percent, and the highest prevalence is in the South east with 53 percent followed by the South west with 51 percent (NBS, 2006). The figure reported by the NDHS is slightly different: 58 percent among the *Yorubas* and 51 percent among the *Igbos* (NPC & ICF, 2009). The NBS figures show that the practice is more prevalent in urban than in rural areas (37 percent and 21 percent respectively). Wealth status and education also support a similar pattern. While the prevalence of FGM/C is 7 percent in the poorest quintiles, it is as high as 36 percent among the richest. FGM/C has been experienced by 10 percent of women with no education compared to 37 percent of women with education. Furthermore, its prevalence is 20 percent among women aged 15-19 and 40 percent for ages 45-49. These trends are corroborated by the NDHS figures.

6.2.4 Children and justice

Children in contact with the law constitute one of the most important issues of child protection. This is so for two main reasons. The first is that law enforcement in the security and justice sector agencies paradoxically are the statutory institutions with the sole mandate to enforce child protection. The second reason is that because these agencies are legally authorised to bear arms, they can potentially misuse their powers and abuse the vulnerable segments of the society, particularly children, if they are not effectively regulated and supervised to ensure that they operate within the framework of democratic governance, rule of law and human rights.

Children are prone to suffer severe rights violations when they come in contact with the formal criminal justice system, including the police, the courts, and the prisons. This is particularly so in countries where the promotion and protection of human rights are not well advanced, where there has been a persistent cycle of armed conflict and/or rampant violent criminality, and where there is a generally weak political culture of accountability and transparency of public institutions. Under such conditions, the culture of impunity is likely to pervade and law enforcement as well as security and justice actors and institutions are more likely to violate than protect human rights. The protection rights of children, being one of the most vulnerable groups in society, often suffer considerably under such circumstances. Some of the violations commonly suffered by children at the hand of security and justice agencies are arbitrary and illegal arrest, unlawful detention, improper and unfair sentencing, deplorable conditions, abuse, and torture in prison.

The CRA (Section 204) provides for an exclusive child justice administration (CJA) which replaced the juvenile justice administration as the only process for trying child offenders, and that no child shall be subjected to the criminal justice process or to criminal sanctions. The CRA provides that detention must be the last resort, and must only be in a secure accommodation or community home, and not in prison or police cell. The only exception to this is when the offence is violence or sexual and the child is over 15 years of age. The CRA (Section 149) also established the Family Court for the trial of child offenders for each state and the FCT, and gives the Family Court unlimited

jurisdiction to hear and determine civil and criminal proceedings in respect of a child or the interest of a child (Section 150). As rightly argued in the UNICEF Situation Analysis (UNICEF, 2007), the CRA regime offers an opportunity to the justice system to rehabilitate rather than condemn the child offender.

Yet, children conflicting with the law are a major child protection challenge in Nigeria. According to the Nigerian Country Report to the African Union in 2006, about 6,000 children who conflicted with the law were in various prisons and detention centres across the country (UNICEF, 2007). Less than 10 percent of these children were girls, and these girls were victims rather than perpetrators, mainly of gender-based sexual violence (GBSV) and child trafficking. According to the same report, the bulk of the children involved were ‘beyond parental control’ (34.5 percent), followed by children held for robbery (26.3 percent). Other alleged offences included public demonstration and/or rioting, drug pushing, murder, manslaughter, rape, burglary, stealing, receiving stolen property, assault and conspiracy. Only 4.7 percent were held for caring and protective custody.

An assessment of child justice in the 2007 UNICEF Situation Analysis concludes that the system is vindictive rather than rehabilitative and suffers from the lack of social welfare in the country (UNICEF, 2007). Based on the figures published in the 2006 Nigeria Country Report to the African Union, the analysis observes that a rather large number of children beyond parental control were lumped unfairly with child offenders in the prisons and detention centres. It also noted that of the total number of child offenders held, about 50 percent were outside the violent crime category. These observations indicate that the juvenile justice administration is also harsh and severe in the way in which it punishes mere economic crimes, even when dealing with first offenders. Furthermore, and although exact figures are not provided, the analysis also reported the prevalence of corporal punishment such as flogging, whipping, stoning, and amputation of limbs under the sharia justice system in the northern parts of the country to be a contravention of the provisions of the CRA and international instruments to which Nigeria is a signatory.

The 2006 Nigeria Country Report to the African Union shows that remand homes were the most frequently used custodial institutions in the country (68.5 percent) for child offenders (UNICEF, 2007). However, while the remand homes were meant for the rehabilitation and protection of children in conflict with the law, the UNICEF assessment mentioned above revealed huge challenges with the homes, including lack of motivation of caregivers, lack of skills, neglect, under-funding, government corruption, and the lack of policies. These observations were also shared with other institutional care centres across the country. An earlier UNICEF assessment found that the homes across the country were too few to serve the growing number of children in need of care, and generally suffered from lack of funding, inadequate facilities, lack of specialised staff, poor information management, inadequate number of activities relevant to the centres’ objectives, and low level of motivation among staff (UNICEF, 2005).

A more recent UNICEF assessment found that a whopping 71.3 percent of children in all the remand homes surveyed were serving pre-trial terms while the remaining 28.7 percent had been processed through the formal court systems and remanded by court orders (UNICEF, 2009). This large number of pre-trial detention is a violation of the spirit of Section 212 (1) of the CRA, which stipulates that pre-trial detention shall be used only as a measure of last resort and for the shortest possible period of time. The assessment found a host of other contradictions within the remand system, including: (i) many of the children in pre-trial detention were found to have been rescued from the street for protective custody, pending court orders for remand, family reunion or reintegration, and there were therefore no reasons for detaining them before tracing their parents or committing to remand; (ii) some of the pre-trial detainees were held for up to 6 months (which is the statutory length of custodial sentences) and above, revealing that pre-trial detention was being used as punishment instead of correction and rehabilitation; (iii) investigations were not being

conducted into cases of death in remand homes, reasons for those deaths were not offered and some parents of the victims were not even informed; (iv) no child had any access to a formal pre-trial diversion mechanism of resolving cases through alternative means other than recourse to hearing in the formal justice system; (v) the majority of children detained in police stations were mixed with adults, thus exposing them to violence, abuse and exploitation, while knowledge of the complaint system and what it stands for was very weak among the children; (vi) there was nonchalance towards advocating redress for children that had filed complaints among caregivers, who in some cases were some of the perpetrators and thus an impediment to full redress or reparation; (vii) access to children detainees was frequently denied by employees during inspection visits; (viii) access to educational, medical, recreational, life skills and vocational facilities, and safe water were grossly inadequate; and (ix) there was no provision for balanced diet or any reintegration and rehabilitation facilities. On the basis of these findings, the assessment concluded that the renamed child justice administration was no different from the formal criminal justice system in terms of its abysmal rehabilitation and reintegration processes.

In general, the criminal justice system in Nigeria is fraught with a number of challenges that hamper the protection of the rights of accused persons as well as convicts. A prominent challenge is the prevalence of corruption in the system. This is witnessed in all the chains of events, from arrest, police bail, arraignment, trial, sentencing and treatment of convicts and prisoners. In many cases where a criminal offence is reported, the police usually expect to be bribed before launching investigation and arrest. Where the complainant fails to offer money, the police would usually cite the lack of necessary logistics and abandon the case. Corruption is also rampant at the stage of bailing an accused detainee from the police station. Even though police bail is officially free (with notices at the police charge room boldly stating that 'bail is free'), the police demand for various amounts of money (depending on the gravity of the alleged offence) before granting bail to detained suspects. Where the relatives of the detained fail to give money, the police deploy various explanations for keeping the suspect for so many days that relatives are pressured into paying up (Access to Justice, 2005; FRN, 2006 and 2007; HRW, 2005; Odinkalu, 2008; Isima, 2010). The Nigerian police not only fail to protect the rights of children, but have also been directly involved in the violation of the protection rights of the child in many reported instances. A recent case is the well-publicised abduction and rape of a 16-year old girl by one Police Inspector and two Police Constables in Kano in December 2010. This was not just a one-off occurrence but rather reflects a general pattern of an often undisciplined force.

It is even more problematic when the accused has to be bailed from the court after arraignment. Court clerks usually sell bail forms that are meant to be free, and those who cannot afford to pay immediately would remain in detention until they are able to buy the form. After paying for the form, it is common practice that the accused would also be forced to pay a so-called bail fee before the magistrate approves his or her release. Linked to this is the challenge of long delays in the trial process, with so many cases lasting between 10 and 15 years. A major factor for these delays is that the courts are notorious for granting frivolous applications for adjournment, in many cases as a result of deliberate manipulation of judges by wealthy parties (Aguda, 1988). It has been observed that while the Supreme Court has started to show impressive signs of growing independence, the lower courts in the states and the local judiciary still suffer from significant political interference, corruption, and inefficiency (U.S. Department of State, 2004). Other endemic problems in the criminal justice system include the use of extra-legal force and planting of criminal evidence by the police, arbitrary arrest and detention, extraction of confession through torture, paucity of legal counsel, cruel and inhuman sentencing, lack of integrity on the part of some judicial personnel, inadequate funding and lack of infrastructure, the abuse of discretionary powers by judges, political interference, too little attention to correctional policies concerning juvenile offenders, corruption, and poor socio-economic conditions in prisons including overcrowding, poor ventilation, poor sanitation, lighting, and medical care (Amnesty International, 2008; U.S. Department of State,

2004).

6.2.5 Child trafficking, children on the move, and sexual exploitation of children

Under this sub-section, child trafficking is grouped together with the exposure of children to violence and abuse as a result of internal migration and with sexual exploitation of children because the issues are closely interlinked. Children who are trafficked within the boundaries of a country often face the same risks of exploitation as children who are constantly on the move within the country as a result of internal migration. Sexual exploitation and violence are significant common risks that both trafficked children and children on the move are constantly exposed to.

Children are particularly vulnerable to trafficking. As a result of their very weak capacity to assess risk, express their concerns, and to take care of themselves, children are virtually dependent on adults for most needs and this dependency makes them vulnerable to trafficking. Child trafficking is one of the world's fastest growing criminal industries, thriving as a clandestine organised crime and surviving largely through corruption of state agencies responsible for law enforcement (UNODC, 2006). Child trafficking has been intricately linked with child labour, driven by an unmet demand for cheap and malleable labour as well as the demand for young girls and boys in the fast growing commercial sex sector (UNICEF Baseline, 2010). It is also found to expose children to a range of dangers, particularly violence, sexual abuse and other forms of exploitation. Orhant (2002) points out some of the various forms of exploitation, including eating only once a day, and being compelled to perform some specified assignment at the end of the day. Much of the existing literature on child trafficking has put the emphasis on cross border flows and has therefore tended to focus on immigration controls. However, Mike Dottridge has argued that crossing international boundaries is not what matters most in child trafficking. In a study of child trafficking, Dottridge (2004) found that the central concern of victims is the *social frontier* across which they move when taken away from the relative protection of their family and friends, making it easier to exploit them and difficult for them to escape. This underlines the critical importance of child trafficking within national borders to child protection.

Yet in spite of the serious threat of child trafficking to child protection, data on the pattern and trends of the phenomenon in Nigeria is seriously lacking, just as on human trafficking globally. According to the previous Situation Analysis the absence of any reliable estimate of the number of trafficked children is largely due to the clandestine nature of the phenomenon (UNICEF, 2007). Worse still, the meagre existing data on human trafficking are not disaggregated and lump together children and adults. In spite of these limitations, available information shows that child trafficking in Nigeria occurs on a large scale and has been going on for quite some time.

A UNICEF study in 2004 made the startling revelation that child trafficking is more endemic than trafficking in women and men in the country (UNICEF, 2004). The Nigerian Police Force recorded 157 cases of child trafficking as early as 1987, 240 cases in 1988, 95 in 1989, 204 in 1990 and 174 in 1991. In Calabar, in Cross River state, the police reported 13 cases of child stealing and 8 cases of kidnapping between 1997 and 1999 (UNICEF, 2010). The ILO (2001) gave a figure of some 4,000 children trafficked from Cross River state to various parts of the country and to other countries in 1996. The same ILO study showed that children were being kidnapped and sold for between 50,000 and 100,000 Naira for the purpose of child labour and ritual sex (including homosexual abuse) in Sokoto state. By 2003, it was found that about 15 million children were engaged in child labour in Nigeria with 40 percent of them at risk of being trafficked both internally and externally for domestic and forced labour (UNICEF, 2007b). In a 2004 study conducted by NAPTIP and UNICEF on the phenomenon in southern Nigeria, it was found that children formed a large part of the total repatriated victims of external trafficking from Nigeria, representing 46 percent (NAPTIP/UNICEF 2004). Among these children, the female to male ratio was 7:3, and they had mainly been exploited through prostitution (46 percent), domestic labour (21 percent), forced

labour (15 percent), and entertainment (8 percent). The study also showed that internal trafficking of children is mostly for the purpose of forced labour (32 percent), domestic labour (31 percent), and prostitution (30 percent).

The West African sub-region also provides a booming market for child trafficking, with a high frequency of traffic between Nigeria and its neighbours. The victims are increasingly being trafficked for sexual exploitation and to work in shops, though they are used mainly for domestic work (UNICEF, 1998 and 2010a). On the international scene, Nigeria is a leading source of trafficked children in Europe. The US Department of State (2000) has showed that Nigeria and Albania supplied most of the minors who work as street prostitutes in Italy: 1,500-2,300 minors out of a total of 1,880-2,500. In 1999, about 200 of these victims from Nigeria and Albania were reported killed while attempting to get off the streets and out of organized prostitution (Douglas, 2001). Faris (2002) had also reported that teenage girls from Nigeria constituted the largest proportion of trafficked sex workers in Italy.

Child trafficking in Nigeria is mostly internal and a significant proportion of the victims are girls. In 2000, UNICEF conducted a study among school children and children living in the streets of Port Harcourt, Owerri, Calabar, Lagos, Sokoto, Maiduguri and Kano. It was found that 19 percent of the school-aged children were trafficked and 98 percent of them were Nigerians (UNICEF, 2000). A study conducted by NAPTIP in 2004 showed that 80 percent of victims of trafficking were female, and that about 46 percent of the victims traced were children. Evidence from other studies indicates that the phenomenon of child prostitution is now common in most towns across the country (Adedoyin and Adegoke, 1995; MWASDRS/UNICEF, 1999; and Oloko, 1999). In this regard, trafficking is increasingly seen as a crucial manifestation of the 'growing feminisation of poverty' which now poses broader challenges to women and girls in a world of gender discrimination (GENPROM, 2002).

A significant number of victims of child trafficking in Nigeria have been subjected to sexual abuse. In the limited studies that exist it has been showed that victims of child trafficking, particularly girls, are sexually molested. One study carried out among child street hawkers in Benin City in 2001 found that 9.9 percent of respondents had suffered sexual abuse (Isah and Okojie, cited in UNICEF, 2010 Baseline). Bearing in mind that trafficked children are used mainly as domestic servants, a UNODC (2004) report indicates that a fair proportion of victims of child trafficking who serve as domestic servants in households are sexually abused, resulting in teenage pregnancies. Thus, no matter the ultimate objective, child trafficking puts children in a social context that removes their immediate protection and exposes them to sexual and other forms of exploitation.

More fundamentally, trafficking in children has been linked to migration. The study by Dottridge (2004) indicates that child trafficking is a negative consequence of a much larger phenomenon of people constantly on the move from place to place in search of a better life in the context of poverty, globalisation and restrictions on migration, lack of education, discrimination, cultural norms, domestic violence, and natural or man-made crisis. While conceding that only a few of migrant children are trafficked the conventional way (kidnapped or sold), the study advances the concept of *soft trafficking* which involves children leaving home deliberately as a result of decisions made by their parents.

With a high rate of urbanization, Nigeria is a country where soft trafficking is a crucial child protection issue that requires attention. The International Organisation for Migration (IOM, 2009) puts the urbanisation rate in Nigeria at 5.8 percent in 2008. UNDP (2008 & 2009) has showed that the urban population in the country almost doubled from 1975 to 2009, having grown steadily from 23.4 percent in 1975 to 48.2 percent in 2005 and 49.8 percent in 2009. In spite of this general urbanisation trend, the IOM study however did not give any figure on the link between internal

migration and child trafficking in the country.

Unfortunately, existing studies on migration in Nigeria have focused on movement across international borders (emigration and immigration), to the neglect of internal migration. Even the few existing studies on internal migration such as the Post Enumeration Census (PES) of 1991 and the 1993 report of the Network of Surveys on Migration and Urbanisation in West Africa (NESMUWA) are seriously out of date. Besides, the studies are not disaggregated to show data on children on the move or on internal trafficking of children, nor are children of nomadic groups who are constantly on the move given any significant attention in the literature. There is therefore a crucial need to undertake a focused study on internal migration in order to understand the situation of children who are constantly on the move.

Immigration into Nigeria is, however, an important element for assessing the plight of children on the move. The immigrant population in Nigeria has increased steadily since independence, rising from 101,450 in 1963 to 477,135 in 1991, 751,126 in 2000, 972,126 in 2005, and projected at 1.1 million in 2010 (NPC, 1998, UNDP, 2009). In addition, NAPTIP has published data on rescued victims of human trafficking that show figures for foreigners in the country. However, all these figures suffer from a common lack of disaggregation by age, and this limitation makes any analysis of the trafficking of children on the move very difficult.

Sexual exploitation of children is another element that is intertwined with child trafficking and exploitation of migrant children as the foregoing analysis demonstrates. The CRA of 2003 prohibits child prostitution, unlawful sexual intercourse, and other forms of sexual abuse of children. Apart from the CRA, the criminal law in Nigeria also has several provisions protecting children from abuse and sexual exploitation. The criminal code applicable in southern Nigeria prohibits trade in prostitution or transport of human beings within or outside Nigeria, while the penal code applicable in northern Nigeria prohibits the buying and selling of minors for immoral purposes, buying or disposing of slaves, and unlawful compulsory labour.

Purposeful study on sexual exploitation of children is conspicuously lacking. The major reason for this is the clandestine nature of the practice, the pervasive culture of silence around the issue of sexual exploitation in Nigeria and the consequent difficulty of obtaining data (UNICEF, 2010a). The major issues of child sexual exploitation in Nigeria include child prostitution, exposure of children to pornography (both as producers and consumers of materials), and rape. While child prostitution is discussed briefly above as a common experience of trafficked children, the limited literature indicate that a high percentage of young girls and boys, predominantly from the South west and North central zones of the country, have been exposed to pornographic materials. Equally evident is the pervasiveness of rape as a serious national problem, and this is discussed more extensively in the section on violence against children. According to the National Survey of Sexual Exploitation of Children in Nigeria (FMWA, 2001), the major perpetrators of sexual exploitation of young girls are parents, teachers, seniors in schools, strangers, neighbours, senior government officials, 'sex barons' and pimps.

According to the 2007 UNICEF Situation Analysis, sexual abuse of children in Nigeria occurs behind closed doors and goes unreported and undetected. A UNICEF study of child trafficking in Nigeria shows that 14 percent of surveyed street children had suffered sexual molestation (UNICEF Baseline, 2010), while Isah and Okojie reported that 9.9 percent of female street hawkers surveyed in 2001 in Benin, Edo State, had been sexually abused (cited in UNICEF, 2010a). Also Ogundipe and Obinna (2007) warn that the absence of data on sexual exploitation of children in Nigeria does not negate the existence of the problem. Rather, the context of rapid urbanization, especially in such major cities as Lagos and Abuja, and the consequent proliferation of children living on the street without care and protection suggest a high incidence of sexual exploitation of children. What this

calls for is an in-depth study to unveil its prevalence and trends across the country.

6.2.6 Children in conflicts and emergencies

Child rights are most severely violated in situations of armed conflict and emergencies. During periods of violent armed conflict, there is a general breakdown of law and order that permits large-scale atrocities and violations by a variety of actors, including state and non-state armed groups. Often, there is impunity for these atrocities and violations owing to societal breakdown and the difficulty or near impossibility of enforcing the law. This impunity, in turn, reinforces further violations and acts of opportunistic violent crimes by elements who take advantage of disorder, thus leading to a cycle of violence and insecurity.

Children, and particularly girls, are exceptionally vulnerable to sexual and gender-based violence (SGBV) and suffer serious consequences such as abduction, sexual abuse, and rape during armed conflict and emergency situations, which may result in unwanted pregnancy and HIV infection. This is particularly acute where girls have been internally displaced or have become refugees in another country as a result of armed conflict. In its field guide for displaced settings, the Reproductive Health Response in Crises (RHRC) Consortium/Gender Based Violence (GBV) Global Technical Support Project identifies the following violations as commonly faced by young girls as refugees (RHRC Consortium/GBV Global Technical Support Project):

- Abuse that existed in society previous to the conflict;
- Domestic violence that often increase: in many displaced settings, women are separated from family, community members, or other support systems that may formerly have offered a certain amount of protection from abusive partners;
- Exploitation and abuse from people with power, even those who control and distribute humanitarian aid.

The field guide also identifies the main factors that contribute to gender-based violence in conflict situations to include:

- A general breakdown in law and order, with an increase in all forms of violence;
- Erosion in the social structures and the normal mores of society that control acceptable behaviour in the community;
- The perception by perpetrators that they will not be brought to justice;
- The polarization of gender roles during armed conflict with the development of an aggressive ideal of masculinity and the idealization of women as bearers of the cultural identity;
- The goal of ethnic cleansing: rape, forced pregnancy, and other forms of GBV can be weapons of ethnic cleansing and tend to destroy individuals mentally and the social bonds within a group.

Nigeria is neither a war-torn nor a post-conflict society with a large-scale humanitarian emergency, and all of the conditions identified above may not be present. Nevertheless, as a conflict-prone country, Nigeria has been home to a cycle of localised but deadly communal armed conflict and political violence in different parts of the country since the end of the Civil War in 1970. Of utmost concern has been the period since the transition to democracy in 1999, which has witnessed the highest level of deadly conflict since the Civil War, both in the frequency of occurrence and the casualty level. The protracted environmental and resource (oil) conflicts in the Niger Delta, the recurrent communal conflicts in Jos, the religious riots in Kano and Kaduna, the extremist violence in the North East, the violent land dispute in the South East, the virulent election-related violence in the South West, and the high-handed operations of the military in civilian communities during episodes of violent disorder are some of the manifestations of political fragility and instability that characterise the current democratic dispensation in Nigerian. Children are also especially vulnerable in situations of emergency due to man-made or natural disasters. In addition to conflict, flooding

and fire outbreaks are some of the common emergency incidents in Nigeria.

In all these episodes of deadly conflicts, many children lost their lives, lost their parents/guardians, were left disabled or were internally displaced as a direct result of the violence. According to IPU & UNICEF (2004), the same child who suffers directly from conflict and humanitarian crises is prone to malnutrition and illness, deprived of early stimulation, out of school and more likely to be abused and exploited. Other indirect fallouts of such violence include closure of schools and hospitals. There is no reliable data on child casualties of communal conflicts in the country. However, Alemika et al. (2005) show that many children, including school children, were killed during various conflicts in the country – with some of the killings done by armed personnel who shot and burnt children and adults, operating more like invasion forces in conflict situations. These atrocities were most evident during the military invasion of Odi, Bayelsa state, in late 1999 to avenge the killing of 7 policemen by some elements in the community. News reports also revealed that children and women were killed in reprisal attacks in the recent Jos conflict (EIN News, 2010a). Alemika et al. (2005) also show that most of the people arrested by the security forces after the religious violence of 2000 in Kaduna were children. The children were allegedly detained in extremely poor hygienic conditions and many of them suffered different forms of ill treatment.

The corollary of child victimisation during conflict and emergencies is the abuse of children through forceful recruitment as combatants in armed conflict. The Inter-Agency Standing Committee (IASC) argues that the same children who serve as child soldiers during armed conflict become street children and children who are separated from their families in peace time (IASC, 2002). Children's unique vulnerability to military recruitment and manipulation into violence is seen as a consequence of the fact that they are innocent and impressionable. It is crucial that child soldiers are engaged in the promotion and protection of the rights of children during and after armed conflict and emergencies. As the IASC suggests, such engagement may be the inclusion of children in participatory planning and implementation of programmes (such as enrolling in schools and teacher training) to meet the psycho-social needs of internally displaced persons (IDPs) who are children and building capacity among them. In addition, it can also include disarmament, demobilisation and reintegration (DDR) of child soldiers by separating them from other soldiers, addressing the indoctrination of children, reintegrating schooling, family tracing, and reconciliation (as well as reconciliation and acceptance in the receiving communities); reunification of unaccompanied children with their families; involvement of street children as researchers to prevent violations and exploitation against them.

Although data on the phenomenon of child soldiers in Nigeria is virtually non-existent, anecdotal evidence points to a large presence of child combatants in some of the more recent episodes of violent conflict in the country. Some of the most recent examples that require close examination in an empirical study of the phenomenon of child soldiers include the conflicts in the Niger Delta and in Jos. It is likely that these conflicts have exposed an untold number of children to violence, abuse, and exploitation both as victims and perpetrators. It is therefore probable that conflict and emergency situations represent a new crucial and compelling area of challenge for child protection in Nigeria, where the quest for a protective environment for children must urgently begin.

Apart from armed conflicts, disasters (natural and man-made) also affect many children in the country. The most common disasters in Nigeria are drought, flood, epidemics, and road accidents. These disasters increase children's vulnerability to avoidable death, displacement and violence, including SGBV. Again, data on disasters and their impact on children in Nigeria are non-existent, even though disaster management is an important area of concern for the country. This concern is driven by the increasing occurrence of disasters, including large-scale flooding in diverse parts of the country almost on a yearly basis, drought in the northernmost states, as well as road accidents.

6.2.7 Violence against children

Violence against children may be rampant in Nigeria and an important issue of child protection in the country, though it is largely under-reported and under-studied. According to the Africa Child Policy Forum (ACPF), violence against children in Africa generally is justified on cultural grounds as a way of instilling discipline. This makes children reluctant to speak about their experience of violence and hence there is a dearth of data and knowledge about the nature, incidence, magnitude and consequences of violence against children (ACPF, 2010).

The CRA provides for the protection of children against harmful practices including violence. Section 22 (1) particularly prohibits the imposition of corporal or capital punishment or imprisonment on any person below the age of 18 years. In spite of this broad legal framework, violence against children remains a serious national problem. Rape is one of the most common forms of violence against children in Nigeria, according to the limited available data. UNICEF (2010a) reports that about one in every 200 girls is subjected to rape attack; only 1 out of 6 cases are reported to the police.

Basic education institutions constitute a notorious environment where violence against children occurs. It has been observed that violence against children in school is likely to compromise learning as it increases fear, anxiety, and absenteeism as well as dropping out of school (Hart et al., 2005). According to an assessment of violence against children in basic education in Nigeria, 85 percent of children reported experience of physical violence, 50 percent reported psychological violence, 5 percent reported gender-based violence, 4 percent reported sexual violence and 1 percent reported health-related violence (UNICEF, 2007). These figures show that physical and psychological violence are the most common forms of violence against children in the country.

The same data also show a higher prevalence of violence against children in basic education institutions in the south of Nigeria than in the north, with the exception of sexual violence (UNICEF, 2007). While physical violence was reported by 90 percent in the south, it was reported by 79 percent in northern Nigeria. For psychological violence, the reported figures were 61 percent and 38 percent respectively for the south and the north. However for sexual violence, 3.2 percent of school children in the south reported experience while 4.7 percent reported experience in the north. The perpetrators of violence at this level include teachers who represent 26 percent, followed by senior students (9 percent), classmates (8 percent) and head teachers (6 percent). Other studies reveal the importance of gender in the type and level of violence. Chege (2001) and Chege & Mati (1998) reported that teachers were more likely to use physical violence such as canings, beatings, and whippings on boys, while girls were more likely to receive verbal abuse and psychological humiliation.

The prevailing culture of silence regarding violence against children makes it difficult to obtain reliable data on rape among school children. However, UNICEF, (2010a) reports that about 5 percent of girls are subjected to rape attacks, even though it is hardly ever reported to the police. Another study (UNICEF, 2007) reported that 5.4 percent of male students and 7.2 percent of their female counterparts were aware of students that had been raped. The report also showed important variations among different subgroups of the population. While 9.6 percent of students in urban areas knew of students who had been raped, in rural areas this was reported by 3.9 percent of students. The percentage is higher (9.3 percent) in junior secondary school compared to primary school (3.1 percent); it is also higher in southern Nigeria (9.4 percent) than in northern Nigeria (3.1 percent). It should be kept in mind that the culture of silence and the reluctance to report rape by school children may have masked a much higher level of prevalence.

The observed impact of physical violence in school, according to the UNICEF study, has mostly been school absenteeism. The data reveals 6 percent absenteeism – 7 percent of girls and 5 percent

of boys – due to physical violence witnessed in schools. In the south of Nigeria school absenteeism was 9 percent and in the north it was 3 percent. The likelihood of absenteeism from school due to physical violence was higher among children in junior secondary school (9 percent) than children in primary school (3 percent). Psychological violence had less impact on school attendance with 4 percent absenteeism, while sexual and gender-based violence accounted for 1.8 percent of absenteeism (UNICEF, 2007).

Outside the school setting data on violence against children are generally lacking, including for environments such as streets, work place, and home. However, existing limited data on domestic violence offer an additional insight regarding violence against girls. According to UNICEF (2007) data, many girls suffer sexual violence in home settings before the age of 15 years. While 28 percent of them reported that the perpetrator was a stranger, 12 percent reported it was a friend or acquaintance, 11 percent reported that he was a relative, while 7 percent reported that he was a family friend. Unfortunately, the low level of reported cases of general violence against children masks the actual figure of prevalence, which could be considerably higher. According to the UNICEF study cited above, the reporting of violence against children in basic education is low among pupils. Most pupils knew who to report cases of violence to, yet the proportion of them who actually report was 4 percent for sexual violence and about 40 percent for physical violence (UNICEF, 2007). Actual prevalence is therefore likely to be under-reported.

Emerging categories of violence against children in Nigeria that are yet to receive any policy and scholarly attention include kidnapping, ritual killing, and witchcraft persecution. These are serious violations of the protection rights of the child as provided for in Section 27 of the CRA. Kidnapping first emerged as a security problem associated with the escalation of violence in the Niger Delta conflict from 2006 onwards. Kidnapping of foreign oil expatriates in the region was initially used by militant armed groups as a powerful weapon for extracting military and political concessions from the Nigerian state. However, as the conflict intensified, kidnapping became a highly lucrative business for criminal elements who had infiltrated the original political struggle for local control of petroleum resources. Under the general climate of insecurity, kidnap syndicates operated under the guise of militants and made hundreds of millions of naira from ransoms. Kidnapping soon became a brazen day-to-day criminal business outside the immediate scene of the conflict, particularly in the city of Port Harcourt. Though hardly documented in any systematic way, many children were kidnapped in the Niger Delta at the height of the conflict between 2006 and 2009, reported in various daily newspapers as commonplace occurrence. With the de-escalation of the Niger Delta conflict as a fallout of the Federal Government Amnesty Programme of late 2009, kidnapping as a criminal enterprise has shifted focus from the core Niger Delta to the neighbouring zone of the South east. Kidnapping as a violent crime has become rampant in the South east over the last year, and a great number of the victims are children, according to news reports. Currently, child kidnapping is most notorious in Abia state where the police seem to be unable to effectively combat the heinous crime in the last few months. As reported by Azeez (2010) on a recent incident in Abia where 15 school children were kidnapped, it took a joint operation of the military and police to safely rescue all the children.

Anecdotal evidence also reveals that child kidnapping has been going on quietly behind the scene in other parts of the country, much of which has been linked to the ritual killing of children by political elites for the purpose of enhancing their political power, and to the lucrative profit associated with the practice. This is a phenomenon that has not been studied and there are no available data on the number of children that are missing on a daily basis. The lack of data and analysis on ritual killing of children hampers reliable assessment for the purpose of policy development.

The expression ‘ritual killing’ is used in Nigeria to refer to the use of human body parts to acquire

supernatural or spiritual powers. Like other forms of violence against children, available data on ritual killing are hard to come by mainly because it is under-studied. However, a study conducted on the subject by Stephen Roblin in 2009 provides some tentative insight (Roblin). The study found that trade in human body parts is believed to be a lucrative business in Nigeria, involving many suppliers and buyers who are believed to be connected to the quest for political and economic power in the country. Many of the victims of ritual killing are said to be children since they are the most vulnerable.

Another story published by Jason Clarke in 2009 shows that abduction and killing of children for ritual purposes has been on the rise in the city of Kano in northwest Nigeria, where body parts from toddlers and young children (2-5 years old) are preferred for voodoo. Though figures are non-existent, the Nigeria's Freedom Radio was cited as quoting an average of 50 parents per week who placed announcements on their station for missing children.⁶ The Suleija area of Niger state is another place where residents fear child ritual killing. Cases of child ritual killing date back in history; one of the most infamous cases was the killing of a young boy by a ritualist syndicate in Owerri, Imo state, in 1996. Many other isolated cases across the country have been reported, including from Calabar, Cross River state, where two men plucked out the eyes of a young lady for a money-making ritual. In Ifo, Ogun state, a businessman inflicted the same harm on his younger sister. In Ibadan, Oyo state, a taxi driver was arrested by the police for using his fourteen-month old baby for rituals. In Onitsha, Anambra state, two young men seized a boy and cut off his sexual organ with the intention of delivering it to another man, who allegedly offered to pay 1.5 million naira. In Warri, Delta state, a woman was caught in a bush decapitating a 4 year-old boy for ritual purposes (Igwe, 2004). Because ritual killing is shrouded in so much superstition, these isolated cases are not likely to be representative of the events and a deliberate study focusing on the issue is needed.

A third important element of the new types of violence against children in Nigeria is the phenomenon of child witch-hunting. Most prevalent in the South south, particularly Akwa Ibom state, this practice involves allegations of witchcraft against children from whom confessions are extracted under duress (EIN News, 2010b; UNICEF, 2010a). According to Indibe (2010), thousands of children (including infants) are beaten, burned, maimed and killed on grounds of unproven accusation of practising witchcraft. Others are poisoned, slashed, chained to trees, buried alive or simply beaten and chased off into the bush (McVeigh, 2007). This practice is driven mostly by church pastors who claim to detect witches through visions and dreams, and then conduct 'deliverance services' – exorcisms – for children they accuse of witchcraft, which they blame for parents' or families' miseries such as divorce, disease, accidents, or job losses. It is on record that the more children the pastor declares witches, the more famous he or she gets and the more money he or she can make. The parents are asked for so much money that they would pay in instalments or perhaps sell their property to pay for the deliverance service (McVeigh, 2007). These pastors are alleged to charge fees anywhere from \$300 to \$2,000 for the deliverance service (The Genius 2010). This heinous practice may have been going on for a long time, but it was brought into light in late 2008 when Channel 4 released the shocking documentary: 'Saving Africa's Witch Children' (Channel4, 2008). Since then, more gruesome facts have emerged about the deeply entrenched nature and wide religious acceptance of this practise in many communities in the state. The fanaticism around child witch-hunting inhibits any tendency to speak out against this new form of violation of the right of the child in the local communities affected.

Apart from the communities not willing to speak out about this inhumane practice, even the state government that has the obligation to promote and protect the rights of the child has allegedly put its weight behind the practice. As reported by Indibe (2010), the parents of victims of child witch-

⁶ For more of this story, see <http://www.themorningstarr.co.uk/2009/07/05/ritual-killings-on-the-rise-in-nigeria/>

hunting who make up the natural first line of child protection not only join the community but also initiate the steps of inviting the community to mete out these extreme persecutions to their own children. The phenomenon has not been studied directly apart from the few peripheral references in the literature. There is therefore no reliable data on the prevalence, present status, and trend. According to McVeigh (2007), there were about 5,000 children who have been abandoned in certain areas of the state between 1998 and 2007, while many bodies had turned up in the rivers or in the forest and many more were never found.

Child witch-hunting in Akwa Ibom state has also been closely linked to other serious violations of the protection rights of children, including child trafficking, child prostitution, and child labour exploitation. According Stepping Stones Nigeria (SSN), there are frequent 'disappearances' of abandoned street children and widespread killings of suspected child witches (with a particular case involving 14 children being murdered by having hot pokers forced inside them) in Oron local government area, where the belief in child witches is especially deeply held. This has turned the coastal area into a hotbed for child prostitution, with many boats travelling along the Gulf of Guinea using the area as a stopping off point. Many of the victims of child witch-hunting are shipped to Gabon and Equatorial Guinea to work on plantations (SSN, 2007). All the information above suggests that child witch-hunting is not only prevalent in many parts of the country, but feeds other forms of child rights violations. This means that measures taken to fight child trafficking and child labour must address child witch-hunting as well.

6.2.8 Children without parental care

Children without parental care is the term used to cover all children not living with their parents, for whatever reason and in whatever circumstances. Such children are particularly exposed to violence, abuse, and exploitation at home, in schools, orphanages and other residential care centres, on the street, in work places and in prisons. Studies have shown that the children who are most vulnerable to severe labour exploitation often come from disadvantaged, marginalized, and socially excluded groups, including orphans, children of single parents or child-headed families (ILO IPEC, 2003). Another important finding from studies is that it is usually the same children who are separated from families (including orphans, unaccompanied children, single-parent families and child-headed households) who serve as child soldiers during armed conflict (IASC, 2002). This unique vulnerability is due to children without parental care being removed from the immediate protective environment of their primary caregivers.

Orphans and vulnerable children (OVC) represent the most significant category of children without parental care in Nigeria on which some appreciable data currently exist. While all orphans fall within the category of children without parental care, not all vulnerable children do. However, vulnerable children whose parents are ill for a long period of time and/or are extremely poor, or children who live in households where other adults suffer from chronic illness can experience significant hardships which may considerably limit the resources available to meet their basic needs, including feeding, clothing, shelter, health care and education. This shows that most non-orphans, including street children, who are classified as vulnerable may either be living without their parents or are not able to enjoy minimum parental care, hence the emphasis on OVC.

Up-to-date, reliable, and comprehensive data on children without parental care are very limited, and it is therefore difficult to capture the nature and trends of the problem. According to the National Guidelines and Standards on Orphans and Vulnerable Children published by the Federal Ministry of Women and Social Development (FMWA & SD, 2007), the estimated number of orphans in Nigeria from all causes was 7.8 million children in 2007 and this was projected to increase to 8.2 million orphans by the year 2010. The NDHS found that 12 percent of children under the age of 18 years were not living with a biological father, while 6 percent were orphaned (one or both parents dead) (NPC & ICF Macro, 2009). The same survey defined 5 percent of children under the age of

18 years as vulnerable; living in a household in which at least one adult was chronically ill for 3 months during the past 12 months, or having a parent who had experienced chronic illness in the past year. In total, 11 percent of children under the age of 18 years were considered orphans and/or vulnerable (NPC & ICF Macro, 2009). The NDHS data also identified important variations among different subpopulations. Among children under the age of 5 years only 2 percent were orphans, while 14 percent were orphans among children aged 15-17 years. The North west and North east zones had the lowest proportion (4 percent) of orphans and the South east had the highest proportion (11 percent). From 2003 to 2008, the proportion of children under the age of 15 years who were not living with either parent decreased from 11 percent to 9 percent, while the proportion of orphans among children under the age of 15 decreased from 6.2 percent to 5.2 percent (NPC & ICF Macro, 2009).

Other variables considered by NDHS regarding OVC included impact on schooling, ability to meet three basic material needs (a pair of shoes, 2 sets of clothes, and a blanket), orphans living with siblings, nutritional status, exposure to sex before the age of 15 years, succession planning, and external support for household (NPC & ICF Macro, 2009). Whereas the survey surprisingly showed that OVC were more likely to attend school than non-OVC (80 percent versus 73 percent respectively), OVC were slightly less likely than non-OVC to possess the three basic needs. Rural-based OVC were less likely than their urban counterparts to have all three basic needs met (61 percent as against 77 percent respectively). Fifty-four percent of orphans were not living with all their siblings, the highest proportion was in the South west (69 percent) and the lowest in the North west (43 percent). In terms of nutrition, the survey found that among OVC and non-OVC 28 percent and 27 percent, respectively, were underweight. While it is feared that teenage OVC may be at a higher risk of early sexual activity due to lack of parental guidance and supervision, the survey found that at age 15-17 years non-OVC had a slightly higher likelihood of early sexual activity than OVC: 6 percent and 5 percent, respectively, for boys versus 15 percent and 14 percent, respectively, for girls.

Succession planning is another essential measure for ensuring that children will receive appropriate care and support in the event of the death of a parent or primary caregiver. A quarter (25 percent) of primary caregivers sampled made arrangements for care to be provided to a child in the event of their inability to provide care due to illness or death. This leaves out 75 percent of potential OVC without a care succession plan. In addition, a very high proportion (95 percent) of OVC lived in households that did not receive any type of support, while 6 percent received at least one type of support, and the support was most likely to be emotional in nature (3 percent). All these figures, apart from school attendance and exposure to early sexual activity, reveal a bleak scenario of child protection for children living without parental care. Furthermore, the NDHS data are limited and represents a minimum estimate of the extent and circumstances of OVC in Nigeria in that it only captures OVC living in households. It does not cover the vast number of OVC living in institutional homes and other non-household environments, including children living on the street, *Almajarai*, and children in conflict and emergency situations.

Yet, even where OVC are taken to government or private care centres or homes, their situation is not any better. An assessment of institutional child care centres in Nigeria published by UNICEF in 2005, as highlighted earlier, concluded that the homes were in a dismal state and that the children in the homes were in dire need of rehabilitation. Their actual performance came far short of the public policy on institutional care. The assessment focused on nutrition, clothing, accommodation, recreation, medical care and education. A key revelation was that the growing number of children in need of care was far in excess of the capacity of the very few homes existing across the country. In addition, the homes were found to suffer capacity deficiencies, including poor funding, inadequate facilities, lack of specialised staff, poor information management, inadequate number of activities relevant to the objectives of the centres, low level of motivation among staff, and total absence of

government monitoring of the activities within privately owned homes or the quality of care and facilities (UNICEF, 2005).

As discussed above, the political landscape of Nigeria has been boldly marked by irregular and low-intensity communal conflicts in various locations, particularly since the dawn of democratic rule in 1999. The limited existing data have showed that children are increasingly abused as child militants in the various recent communal conflicts and episodes of mass violence across the country. This includes the use of the *Almajirai* and young but radicalised religious fundamentalists (e.g., the Taliban) in the north, child militias in the Niger Delta, “Area Boys” in the Lagos area, and young political thugs mostly evident during elections and related violence across the country (UNICEF, 2007).

It has been documented that the vast majority of street children and the *Almajirai* do not receive parental care at all. In a UNICEF survey of street children in 2005, it was found that 33.3 percent of street children in Adamawa state lived under bridges, with another 33.3 percent living in motor parks or with *Mallams*. In the city of Lagos, the study found that half of the street children lived under bridges, while others lived in market stalls (UNICEF, 2005). In both states, the majority of the children were 10-14 years old. This lack of parental care among street children and *Almajirai* is corroborated by the 2007 UNICEF Situation Analysis, which reported that an alarming 95 percent of *Almajirai* surveyed in Kano state were staying with Mallams. This figure stands at 90 percent in Adamawa State. Across the country, a high 73.6 percent and 72.5 percent of *Almajirai* surveyed in 2010 did not live with their fathers and mothers, respectively (UNICEF, 2010). Some of the most common risk factors associated with street children, and by extension *Almajirai*, are vulnerability to illness, drug abuse, crime, high rate of school absenteeism or drop-out, accidents, arbitrary arrest and harassment by law enforcement agents, malnourishment, the risk of being trafficked and the risk of being recruited as child soldiers during armed conflict (UNICEF, 2007). Even though there is a dearth of data on street children and *Almajirai*, as well as the risk factors associated with them, the two studies referred to above reveal the enormity and gravity of the challenge faced by children without parental care in Nigeria.

6.3 Causality analyses of child protection issues

For most of the violence, abuse and exploitation suffered by children in Nigeria, the causes have generally been identified in the literature to include poverty, parental negligence, culture, tradition, religion, and governance failure. However, the causes assume specific dimensions when the trends in each of the child protection issues discussed above are examined. In this section, the causes of each of these trends are presented based on findings in the existing literature.

6.3.1 Child labour

Some of the literature discussed earlier associate child labour exploitation mainly with poverty, marginalisation, and social exclusion. Universally, children most vulnerable to severe labour exploitation are often orphans, children of single parents or child-headed families, children of tribal or ethnic minorities, street children, migrant children, and refugees ILO IPEC (2003). In the specific case of Nigeria, the limited literature has clearly linked child labour to poverty and family instability, even though many important manifestations of child labour exploitation have not been studied. The UNICEF (2010) baseline survey on child protection in Nigeria, for instance, shows that 146 out of 317 children interviewed (46.1 percent) preferred to remain on the streets because they felt that the economic condition at home was more undesirable. The same study shows that 80 percent of the street children came from large families, while 12 percent of them had lost at least one parent.

On the specific phenomenon of *Almajiri* children, the causes appear to be a combination of poverty, marginalisation, religion, and parental neglect. The UNICEF (2010) baseline report revealed that

Almajiri is a tradition practiced among some Muslim communities. In the same report, 59.5 percent of surveyed *Almajirai* reported leaving home for the purpose of acquiring Qur'anic education, 16.4 percent reported leaving due to the religious beliefs of their parents, 16 percent reported leaving due to hardship at home, and 20 percent reported leaving for various other reasons including orphanhood and lack of parental care. Parents of the *Almajiri* have been found to come from a poor socio-economic background, 40 percent are farmers, 40 percent are traders, and 10 percent are *Mallams*.

6.3.2 Birth registration

A major trend in birth registration of children as discussed above is that the coverage is very low in Nigeria. While only 23 percent of births of children under 5 years of age had been registered in 2006, the overall figure for all registration between 1994 and 2007 is 35 percent (NBS, 2006; NPC, 2008). The figures show variation in coverage among different subsectors of the population. Data from the National Population Commission (NPC, 2008) show that birth registration coverage was highest among children under the age of 1 year (37.6 percent) and lowest among children over 10 years old (14.5 percent). In other words, recent births are more frequently registered than what was the case for births a decade ago. The likelihood of registration also increases with the level of education of the mother and the wealth status of the household. There is a marked difference between the southern zones and the northern zones of the country, and between urban and rural areas – with the rural sector and northern zones lagging far behind (NBS, 2006; NPC, 2008). Grinding poverty is far more endemic in northern Nigeria than in southern Nigeria, the formal education level is far lower in northern Nigeria than in southern Nigeria, and rural areas generally are far poorer than urban centres (UNDP, 2009) – all these facts illustrate the prominence of poverty and low education level as major factors of low birth registration.

However, in spite of the significance of poverty and low level of education, perhaps the most important explanation for the low level of birth registration in the country is the lack of strong government commitment, at least until very recently. In areas where the government is absolutely committed, if studies into the pattern and trends in birth registration had been commissioned much earlier and groups with very low coverage would have been deliberately targeted in a vigorous birth registration campaign. Fortunately the government appears to recently have awoken to its responsibilities and has developed a strategy to expand birth registration of children to 100 percent by the year 2015.

6.3.3 Harmful practices

The main forms of harmful practices considered in this assessment are child marriage and female genital mutilation/cutting (FGM/C). Child marriage is common in Nigeria, and poses a significant threat to the development of children in the country. As discussed above, the phenomenon is most prevalent in the northern parts of the country, in the rural areas, among women without education, and among those from the poorest families. The data clearly show that poverty and low level of education and awareness are the major factors that support and/or sustain the practice of child marriage. The data also show that where these factors are present, the age gap between the girl and her older spouse appears to be much wider.

FGM/C is equally prevalent and is a deeply entrenched tradition in many parts of the country, though UNICEF (2007) has showed that the practice has been declining. It is most prevalent among the Yoruba and Ibo speaking peoples of south western and south eastern Nigeria (NPC & ICF Macro, 2009). Interestingly, MICS figures (NBS, 2007) show that the practice is more prevalent in urban (37 percent) than in rural (21 percent) areas, and it is also directly linked to wealth and education. While the prevalence of FGM/C is only 7 percent among women from the poorest wealth quintile, it is as high as 36 percent among women from the richest wealth quintile. FGM/C is reported by 10 percent of women with no education and 37 percent of women with education. Furthermore, the prevalence is 20 percent among women aged 15-19 and 40 percent for ages 45-49 (NBS, 2007). These trends are corroborated by the results of the NDHS. What these data show is

that poverty, low level of formal education and awareness, and issues of underdevelopment are not the causes of FGM/C at all. Rather, they suggest other powerful factors such as religion, culture, traditions, and beliefs. According to the NDHS, most women who support FGM/C believe that the practice is important for preventing pre-marital sex, improving marriage prospects and social acceptance, improving cleanliness and hygiene, enhancing sexual pleasure for future spouse, and religious approval. The same reasons were given by men who support the practice.

6.3.4 Children and justice

The criminal justice system in Nigeria has been a source of abuse and violations of the protection rights of the child through arbitrary arrest, detention, torture, and harsh punishment at the hands of the police and the judicial and penal institutions. There is no existing study on child victimization by law enforcement agencies in Nigeria, however many reported incidents reveal a high rate of harassment, arbitrary arrest and detention, and torture of children by the Nigeria Police Force (NPF) for the purpose of financial extortion (Amnesty International, 2008 Human Rights Watch, 2010; OSJI & NOPRIN, 2010; UNICEF 2009). Some of these cases have led to extra-judicial killings and unexplained, un-investigated and unpunished disappearances of child victims (OSJI & NOPRIN, 2010; HRW, 2010). The major causes of this kind of conflict with the law have been identified as pervasive corruption, lack of resources, poor training, poor working conditions, and the total lack of political oversight and accountability over law enforcement agencies (Amnesty International, 2009; HRW, 2010).

The child justice administration is another key area where children in conflict with the law may suffer abuse and exploitation. Existing data on children in conflict with the justice system are scarce, apart from the UNICEF (2009) study on remand homes. According to that study, most of the violations suffered by children in the child justice administration include sexual exploitation, prolonged pre-trial detention, and inadequate access to educational, medical, recreational, life skills and vocational facilities, safe water, balanced diet, and any reintegration and rehabilitation facilities. The UNICEF study does not provide any explanation for these rights violations.

However, according to another report from UNICEF (2007), the most prominent factors that account for children conflicting with the law are poverty, social inequality, failed educational system, family instability, peer pressure, and armed conflicts in which children are used as combatants. It would seem that other major causes are lack of strong government commitment in terms of funding and political oversight of the child justice administration. More studies are needed to generate policy relevant data.

6.3.5 Child trafficking, children on the move, and sexual exploitation of children

Child trafficking, children on the move and sexual exploitation of children form important areas of child protection in Nigeria. Data are largely lacking, though the limited information available confirm that they constitute significant issues, some related to illicit industries profiting on the exploitation of children. The major reasons for the difficulty in generating reliable estimates on these issues are their clandestine nature as well as the fact that sexual exploitation of children in Nigeria occurs behind closed doors and goes unreported and undetected. The causes behind trafficking indicated in the limited literature on the topic is the unmet demand for cheap and malleable labour as well as the demand for young people in the fast growing commercial sex sector. The NAP TIP/UNICEF (2004) study shows that child victims of human trafficking are primarily exploited for prostitution and production of pornographic materials, followed by domestic and forced labour.

In the context of rapid urbanisation and increasing movement of families within the country, children of migrant families also become more exposed to child trafficking and sexual exploitation. Again, analysis on internal migration in Nigeria is virtually non-existent; as is its link with child trafficking and sexual exploitation. Dottridge (2004) offers some explanations of the global migration trends. The causes identified include poverty, globalisation and restrictions on migration,

lack of education, discrimination, cultural norms, domestic violence, and natural or man-made crisis. While sexual exploitation of children is intricately connected to child trafficking and migrant children, the dearth of analysis and the clandestine nature of this practice have so far inhibited the identification of causal factors. However, the National Study of Sexual Exploitation of Children in Nigeria (FMWA, 2001) indicated that the factors associated with violence against children and child sexual exploitation include illiteracy and ignorance, unhealthy quest for material gains, severe economic depression, poverty, peer group pressure, lack of sex education from parents and bad examples set by parents on sexual behaviour.

6.3.6 Children in conflicts and emergencies

There are no existing studies dedicated to the analysis of children in conflicts and emergency situations in Nigeria, even though global studies have showed that children are exposed to the worst forms of violence, abuse, and exploitation during periods of armed conflict and emergency. The need for such data is critical given the fact that Nigeria is a conflict-prone country where localised violent conflict is rife. In these episodes of conflict, many children lost their lives, lost their parents or guardians, were left disabled or were internally displaced as a direct result of violence. The limited evidence available show that many children, including school children, were killed during various conflicts in the country, sometimes the perpetrators were personnel of military and police forces (Alemika et al., 2005; EIN News, 2010a). In addition to children being victims of direct violence, UNICEF (2010) makes reference to how street children have been used as foot soldiers in some of the recent communal conflicts in the country.

While there is no existing causal analysis, it can be inferred from the above that children's exposure to violence and abuse during conflict in Nigeria can be traced to the activities of state security and military forces as well as non-state armed groups. It has been documented that military and security forces in Nigeria are brutal and use excessive force in their interaction with the wider civilian society, even during peacetime. This becomes more severe in situations of armed conflict when they operate under emergency orders. It is likely that factors responsible for this include inadequate training on human rights and rules of engagement combined with weak public accountability and political oversight of security and armed forces, reinforced by a culture of impunity. However, these are theoretical conjectures that need to be tested through a deliberate study on the situation of children in conflicts and emergencies in the country.

6.3.7 Violence against children

Traditionally, violence against children in Nigeria manifests mainly through physical violence, psychological violence, and sexual and gender-based violence (SGBV). In most African societies, physical and psychological violence against children is justified on cultural grounds as a way of instilling discipline (ACPF, 2010). This cultural underpinning makes children reluctant to speak about their experience of violence and contributes to the dearth of data and knowledge about the nature, incidence, magnitude, and consequence of violence against children.

The only reliable source of data is an assessment of violence against children in schools in Nigeria conducted by UNICEF in 2007. The report of that assessment shows that physical and psychological violence are the most prevalent forms of violence against children in schools, though SGBV was also common. In addition, existing limited data on domestic violence offer some insight on violence particularly affecting girls. According to the UNICEF (2007) data, many women suffer sexual violence in the home setting before the age of 15 years. Outside the school and domestic settings, there are no reliable data on violence against children in other environments where it is likely to occur, including in the streets and work place.

Other important forms of violence against children that have not received any policy or scholarly attention include kidnapping, ritual killing, and witchcraft persecution. These forms of violence are shrouded in so much superstition and socio-cultural beliefs that understanding them is likely to

generate controversy unless a deliberate study is conducted across the country. While many cases of kidnapping are perpetrated by criminal syndicates for the purpose of extorting large ransoms from parents of victims, other cases of kidnapping and all ritual killing of children have been explained by the quest for political and economic power. It can be added that parental neglect also contributes considerably to the exposure of children, particularly street children, to the risks of kidnapping and ritual killing.

Child witch-hunting is a unique form of violence against children in the sense that it thrives on the force of religious mobilisation by which whole communities, including even parents of the victims, openly undertake violent campaigns against suspected child witches. The anecdotal evidence shows that this heinous practice is driven by church leaders who prey upon and profit from the ignorance of those who suffer the most due to the dire economic conditions in the region. It appears that some of these poor people who suffer miseries that they are unable to explain are so desperate for answers that they are even willing to turn their backs on their own children, and offer whatever fees the pastors charge.

6.3.8 Children without parental care

The bulk of children without parental care are orphans and vulnerable children (OVC), and they are given prominent attention in this assessment. The most significant causes behind children becoming orphans in Nigeria include accident (42 percent), communal armed conflict (22 percent), maternal mortality (17 percent), and HIV/AIDS (11 percent) (WHO survey cited in UNICEF, 2007). However, orphans form a subgroup in the much larger group of children without parental care and many other causal factors have been associated with other categories of OVC, particularly street children, trafficked children, unaccompanied children, and children in child-headed homes. UNICEF (2007) identifies large family size, poverty, paternal neglect and family instability as some of the major causal factors. *Almajirai* children are also without parental care. The literature does not explicitly state the causes of the *Almajiri* system, except that it is closely associated with Islam, and mainly practiced in northern Nigeria. The UNICEF (2010) baseline report revealed that 59.5 percent of surveyed *Almajirai* reported leaving home for the purpose of acquiring Qur'anic education, 16.4 percent due to the religious belief of their parents, 16 percent due to hardship at home, and 20 percent for various other reasons including orphanhood and lack of parental care (UNICEF, 2010). What is obvious from the above is that poverty, religious beliefs, and the absence of a primary caregiver are the most prominent drivers of the *Almajiri* system.

6.4 Capacity Gap Analysis

The following section analyses gaps in the capacity of various stakeholders to promote and fulfil the protection rights of children.

6.4.1 Government commitment to fulfil children's right to protection

The commitment of the government to fulfil the protection rights of children in Nigeria has not been impressive in all the areas discussed above, though a few important steps have been taken on some issues. These steps include the ratification of the United Nations Convention on the Rights of the Child (CRC), the African Union (AU) Charter on the Rights and Welfare of the Child and other relevant international instruments. On the policy front, the government has demonstrated a strong commitment to fighting FGM/C through the development of the National Policy and Plan of Action on the Elimination of FGM in Nigeria in 2002. This policy defines FGM as a form of violence against the girl child and an infringement on children's right to life, health, human dignity and integrity (FMWA & SD, 2004). Other crucial policies are the National Guidelines and Standard Practice on OVC, and the 5-year National Plan of Action 2006-2010 (FMWA & SD, 2006 and 2007).

Institutional development is an area where the government appears to have demonstrated the

highest level of commitment. This commitment is evident in the creation of an OVC unit in the FMWA & SD in 2004, and the establishment of a National Steering Committee on OVC in 2005 (FMWA & SD, 2007). The major objective of the Committee is to serve as the highest decision-making body on the subject and to take responsibility for policy development, capacity building, and planning at all levels. The work of the Committee led to the development of the 5-year National Plan of Action (2006-2010) as well as the development of the National Guidelines and Standard Practice on OVC. The main objectives of the guidelines are to guide the development and implementation of interventions, to provide minimum standards for quality of services and activities, to provide a clear understanding of the guiding principles and define roles and responsibilities for all stakeholders, and to enhance collaboration and strategic partnership through effective referral and coordination (FMWA & SD, 2007).

Other critical institutions set up or facilitated by the government include the National and State Child Rights Implementation Committees, the Child Development Departments in the Federal and State Ministries of Women Affairs, the National Council of Child Rights Advocates of Nigeria (NACCRA) as the umbrella NGO involved in child rights advocacy, the Nigerian Children's Parliament, and the National Agency for the Prohibiting of Traffic in Persons. In addition, desk offices have been set up at the Ministries of Women Affairs (federal and state levels), the Police, Immigration and Customs Services for monitoring child protection issues and for ensuring compliance with the laws and policies dealing with violence against children (FMWA & SD 2004). The establishment of the Child Trafficking Unit in the Nigeria Police Force and the Nigeria Immigration Services also demonstrate the government's commitment to combating violence against children.

Furthermore, the formation of the Association of OVC Organisations of Nigeria (AOON) in 2006 as a network of NGOs working on the subject is another key development. This is crucial for factoring civil society input into the national response to the OVC challenge. Other key initiatives include the establishment of the Child Rights Implementation and Monitoring Committees (CRIMC) at national and sub-national levels with CSOs as active members, the undertaking of studies on sexual exploitation of children in collaboration with partners, the setting up of the Presidential Committee on Human Trafficking, the creation of drop-in centres for rehabilitation of sexually abused children, and the translation into three major Nigerian languages (Yoruba, Igbo and Hausa) and distribution of the Convention on the Rights of the Child (FMWA & SD, 2004).

Training or capacity building is another important area where the government has demonstrated some level of commitment, particularly on the issue of child justice administration. The FMWA & SD (2004) reports that, with respect to violence against children, the government provided training on prevention, protection, redress, and rehabilitation to social workers and psychologists, teachers and other educators, court officials, the police, and prison officials from the late 1990s up to the time of the study. The report also shows that some staff of the National Human Rights Commission, prison officers, court officials and judges, and social workers received government-sponsored training on juvenile justice administration between 2002 and 2003. While this commitment is encouraging, there are no recent data to show if these training programmes have continued to date.

Another important area of support for the child justice system has been the creation of the office of the Public Defender by the Lagos State Ministry of Justice in 1999. The office provides *pro bono* legal aid for children at the state level. According to UNICEF (2007), this initiative is gradually being emulated by other states and the federal government. The Nigerian Bar Association (NBA) has also taken up the initiative and has begun to provide *pro bono* services to children in conflict with the law and children in need of care and protection through its branches across the country. However, it has earlier been pointed out that the *pro bono* service has been grossly inadequate and only benefitting a few children in the state capitals (UNICEF, 2007).

Yet, while the measures discussed above are commendable, the lack of strong government commitment has been evident in many vital areas. To start with, there is no comprehensive policy on violence against children in the country. The Ministry of Women Affairs, which has overall policy responsibility for children without parental care, is under-funded and thus lacks the capacity to fulfil its mandate of effectively supporting the national OVC response (UNICEF 2007). This under-funding is visible in institutional care centres for children across the country, to such an extent that the 2007 UNICEF Situation Analysis describes the level of neglect in the institutional care centres as ‘despicable’. This assessment supports findings from an earlier UNICEF study of institutional care centres in Nigeria. The earlier study (UNICEF 2005) indicated that both government-owned and private homes across the country were too few to serve the growing number of children in need of care, and that they all suffer from lack of specific budgetary provisions, inadequate facilities, lack of specialised staff, poor information management, inadequate number of activities necessary for realizing their objectives, and low level of motivation of their staff. The total absence of government monitoring of the activities within privately owned care centres was also identified as a major element of this neglect. All the above show that unless a greater commitment is demonstrated by the government at various levels, the existence of good policies alone will not promote or even protect the rights of children without parental care.

Another glaring manifestation of this shortfall in governmental commitment is the lack of data on financial and human resource allocation to address the problems of child protection. According to the Ministry of Women Affairs, which is responsible for child protection, there was no available information on specific financial allocation or human resources to activities aimed at addressing violence against children (FMWA & SD, 2004). The only exception has been the powers granted under the Anti-Trafficking Act to the national anti-trafficking agency (NAPTIP) to seek budgetary allocation and approval from the National Assembly, to accept gifts of land, money, and other property, and to borrow money from banks to carry out its activities.

So far, even the response to the OVC challenge discussed above has come mostly from the civil society. According to the National Guidelines and Standards on Orphans and Vulnerable Children (FMWA & SD, 2007), these responses have essentially involved the provision of an initial safety net to affected children outside their immediate families by NGOs. Yet, as cited in the guidelines, these responses are still very limited in scope and size, and there are still gaps in the quality and consistency of care provided. To date, there is no evidence of serious government commitment to address the situation of children in hard-to-reach populations, such as nomadic communities, children whose parents are in prison, and children affected by armed conflict (child militias, abducted, refugees, IDPs, and orphans). This means that much more still needs to be done, particularly in terms of proactive government programmes.

6.4.2 Legislation and enforcement

At the international level, Nigeria is signatory to the UN CRC and has ratified the convention. At the domestic level, apart from the 1999 Constitution that provides for the protection of all citizens (including children) as a directive principle of government, the enactment of the CRA (2003) and the Trafficking in Persons (Prohibition) Law Enforcement and Administration Act (2003) provide a solid legal foundation focused on child protection issues in the country. In addition to the CRA, the passing of Child Rights Law in 22 states of the federation has provided a solid legal foundation for protecting and promoting the rights of the child at lower levels of government in those states. Various states in Nigeria have also enacted legislations prohibiting FGM and other harmful practices that constitute violence against children (FMWA & SD, 2004).

Yet, as discussed earlier, the CRA has not been passed in 40 percent of the states (15 states). The implication is that there is no legal foundation for evolving robust policies and programmes in

relation to the rights of children in a large number of states. Furthermore, while the CRA is comprehensive and ambitious, it still conflicts with some areas of the Nigerian legal system and the sharia law in existence in some northern parts of the country, requiring more work on revision and harmonisation. For instance, while Section 221 of the CRA explicitly prohibits the imposition of corporal or capital punishment or imprisonment on any person below the age of 18 years, the FMWA & SD (2004) notes that there is no specific provision for the punishment of those who administer corporal punishment to children under the Nigerian legal system. Rather, the existing penal and criminal codes operating in both northern and southern Nigeria provide for capital punishment and corporal punishment as sentences for crimes committed by any person in the country if it is based on the order of a competent court of law. The existing legal system including the criminal and penal codes and the sharia system therefore needs to be reviewed and brought into consistency with the CRA.

Furthermore, other relevant international legal regimes crucial to child protection have not been ratified and domesticated in the country. Examples are the Optional Protocol on Children in Armed Conflict, the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, and the African Charter on the Rights and Welfare of the Child. According to Alemika et al. (2005), Nigeria has signed these instruments but has not ratified them. There is no evidence to show that these instruments have finally been ratified and domesticated.

Where the legal foundation exists, enforcement becomes yet another challenge. For instance, sections 50-52 of the CRA specifically provide for the enforcement of the rights of children without parental care and empowers:

'(...) a child development or police officer or any other authorized person to bring a child in need of care and protection before a court for a corrective order, if he has reasonable grounds for believing that the child is an orphan or is deserted by his relatives, neglected, ill-treated or battered by his parent or guardian or custodian, or found destitute, wandering, homeless or surviving parent undergoing imprisonment, mentally disordered, or otherwise severally handicapped; or found begging for alms, or in company of a reputed/or common thief or prostitute, or otherwise beyond parental control or exposed to moral or physical danger.'

There are no existing data on the extent of enforcement of these provisions in the states that have adopted the CRA. Nevertheless, studies cited earlier show that a great number of children without parental care are daily confronted with physical and moral danger without being taken to the family court for corrective order as provided for in the CRA above. Street children, *Almajarai*, and child victims of armed conflict and emergencies are a frequent sight in most towns and cities in Nigeria, and it is common knowledge that they live in austere and high-risk conditions without parental care. The fact that they are so visible show that the provisions of the CRA are not taken seriously by the authorised law enforcement agencies, let alone enforced. Significantly, it appears that enforcement of child protection legislation occurs only when there is a groundswell of pressure on and support to law enforcement agencies. For instance, in 2003 UNICEF collaborated with the police, immigration, and NGOs to rescue and repatriate about 300 children from quarries in Ogun state back to their home country, Benin Republic (UNICEF, 2006). Such supportive efforts from international development partners and the local civil society are likely to have exerted pressure on law enforcement agencies to act.

Contrary to effective enforcement of child protection legislation, existing literature shows that the activities of law enforcement agencies in relation to children in need of special protection have

rather brought these children into conflict with the law. While there is no existing study focusing deliberately on child victimization by law enforcement agencies in Nigeria, Amnesty International (2008), UNICEF (2009), Human Rights Watch (2010), and OSJI & NOPRIN (2010) have documented many instances where children (particularly street children) have been targeted victims of commonplace and routine harassment, arbitrary arrest and detention, and torture by the Nigeria Police Force (NPF) for the purpose of financial extortion. Some of these cases have actually led to extra-judicial killings and disappearances of vulnerable children who do not have the protection of wealthy and powerful parents or guardians.

6.4.3 Attitudes, traditions, customs, behaviour and practices

There are generally few studies on the attitudes, traditions, customs, behaviours and practices relating to child protection in Nigeria. For example, the only recent in-depth national analysis on attitudes towards child protection issues in the country specifically relating to the issue of FGM/C is the 2008 NDHS. The study shows that in spite of the high prevalence of FGM/C in various parts of the country, the attitude is changing and most of the surveyed women (62 percent) wanted the practise discontinued. A higher proportion of urban women (66 percent) compared to rural women (59 percent) support its abolition. The majority of men (64 percent) were equally opposed to the practice and wanted it discontinued. Very importantly, the survey found that education plays a prominent role in this changing attitude as support for the practice decreases with increasing level of education.

It has also been observed that a pervasive culture of silence in Nigeria in relation to child protection issues is likely to inhibit society's response to the violation of the rights of the child (UNICEF, 2007). This culture involves a widespread reluctance to speak out on entrenched practices and situations that amount to abuse, exploitation, or violence against children. In addition, the predominance of the *Almajiri* system in Muslim communities suggests a linkage between religion (Islam) and deliberate removal of children from parental care, though this presumption needs to be thoroughly explored through focused studies on the practice. Although available data are seriously limited and grossly inadequate, they do show that all the *Almajirai* are boys (UNICEF, 2010), indicating a gender preference that requires further study and exploration in societies where the practice is predominant.

The African Child Policy Forum (ACPF) argues that the social belief that women are fundamentally of less value than men in African societies results in deeply entrenched gender inequalities and institutionalised social customs, norms, and attitudes to the detriment of the girl child (ACPF, 2010). These beliefs, customs, norms and attitudes are said to be at the roots of the pervasive inequality between men and women and the overall subordination of women and girls in society at large, which in turn supports and perpetuates violence against girls.

6.4.4 Open discussion and engagement with other actors on child protection issues

Data on open discussion, including the engagement of civil society and the media, on issues of children without parental care are very sparse and out of date. However, the process leading to the enactment of the CRA in 2003 involved the active participation and engagement of a wide spectrum of state and non-state actors. The process brought about the formation of a lobby group comprising the mass media, CSOs, child rights activists, legislators, judicial/law enforcement officers, academics, and government officials, which pushed for the passage of the CRA by the National Assembly and its eventual promulgation into law. Following the enactment of the CRA the group was advocating for the adoption of the CRA as state law in all 36 states of the country (FMWA & SD, 2004). Further evidence of open discussion and engagement include the national OVC conference in 2004, the zonal consultation workshop in 2005 that was convened to develop the National OVC Plan of Action (2006-2010), and the costing workshop for the National OVC Plan of Action in 2006 (FMWA & SD, 2007).

In addition, radio and television media were reported to be actively involved in awareness-raising and prevention of violence against children in the time preceding the FMWA & SD study in 2004. Some of the notable programmes included the “Izozo” weekly TV drama on human trafficking, the “I need to know” TV programme on the reproductive health and rights of adolescents, the “It is my life” radio magazine programme on reproductive health, and the “Society and Child” TV campaign on discrimination against the girl child (FMWA & SD, 2004). However, these data are out of date, and the paucity of more recent data on the role of civil society and media in generating national debate and creating public awareness on the problem may be a reflection of a declining level of their engagement since the passage of the CRA or a dearth of analysis on their engagement.

Also, a growing number of local and regional NGOs have begun to take up child protection as a priority. The literature shows that a significant number of them are working together to provide technical expertise for policy formulation and assimilation into mainstream governmental plans through networking, sensitisation, data generation, and advocacy to influence legislative reforms and resource allocation. The most prominent of these NGO coalitions include the Nigerian Chapter of the African Network for the Protection against Prevention of all Forms of Child Abuse (ANPPCAN) and the National Council of Child Rights Advocate of Nigeria (NACCRAN). The ANPPCAN, for instance, conducted research on child trafficking in Nigeria in 2000 for ILO that now serves as a baseline reference. Local NGOs whose activities have been documented include the Women Trafficking and Child Labour Eradication Foundation (WOTCLEF), which is identified as the foremost local NGO in the areas of child trafficking, child labour, and sexual exploitation of children. It runs a shelter and an apprenticeship training school for the rehabilitation of trafficked girls, has organised several national and international conferences, and called the attention of stakeholders including government to the problem of trafficking of children into labour and prostitution. There are several other notable NGOs, including: Heartland Child Care Foundation which uses advocacy strategies to fight child trafficking by dissuading parents from collaborating with trafficking agents; Idia Renaissance which works to combat drug abuse, drug trafficking, cultism on campuses and prostitution; Child Life-Line, Women’s Consortium of Nigeria, and Children’s Rights Advocacy Group of Nigeria (CRAGON) all of which specialize in data collection, advocacy, campaigns, mobilisation, rehabilitation, treatment and provision of services to victims of violence against children (FMWA & SD, 2004). However, in spite of this encouraging development, it appears that the activities of these NGOs are localized and lack national coverage, particularly in the mobilisation of communities and the wider society to break the silence and speak out against violence against children, child abuse, and exploitation across the entire country.

6.4.5 Children’s life skills, knowledge and participation

The inauguration of the Nigerian Children’s Parliament in 2002 marked the highest point of investing in children’s life skills, knowledge, and participation to address the issues of their own protection. Since inauguration, the Children’s Parliament has been involved in a modest number of conferences and advocacy events on child abuse and neglect, juvenile justice administration, and passage and enforcement of relevant legislation (FMWA & SD, 2004). Another notable participatory programme that involved children is the 2009 National Baseline Survey on Child Protection Issues conducted by UNICEF. This participatory research relied on a national sample of children and youth at risk living in regular households, institutions, and on the streets. The study population was children between the ages of 5 to 17 years, while the scope of the survey covered three thematic areas: child trafficking, sexual exploitation and prostitution; child domestic work, child labour in construction industry and agriculture, *almajiri*, and area boys’ syndrome; and youth violence, youth crime and drugs, and militancy.

Other than the Children’s Parliament and the UNICEF participatory survey, there are no available data on involvement of or consulting with children in designing, implementing and monitoring programmes and policies on issues that concern them. Similarly, there are no data available on

efforts to improve the life skills, knowledge, and participation of children in preventing or responding to violations of their rights. Such efforts would involve the inclusion of children in the planning and implementation of participatory programmes, such as enrolling in schools and training of teachers to meet the special needs of children recovered from the street, conflict, or from high-risk environments, and involving child victims in research to prevent violations against them. The lack of data on such programmes may suggest that they do not exist.

6.4.6 Capacity of those in contact with children

People in regular contact with children include parents, teachers and staff of basic education institutions, social workers, caregivers in child institutional care centres and remand homes, law enforcement officials, and staff of the child justice system. Their capacity needs to be enhanced to create an effective environment for child protection.

The literature is however patchy on capacity building of these groups of people in close contact with children. The FMWA & SD (2004) reports that the government had provided training on prevention, protection, redress, and rehabilitation to social workers and psychologists, teachers and other educators, court officials, the police, and prison officials from the late 1990s up to the time of the study. The report also shows that some staff of the National Human Rights Commission, prison officers, court officials and judges, and social workers received training on juvenile justice administration between 2002 and 2003.

Schools have also received some level of capacity building support to address child protection issues. In a joint study by the Ministry of Education (FME) and UNICEF, it was found that primary schools and junior secondary schools across the country had received some form of awareness-creation support towards preventing violence against children in schools, including seminars and distribution of information materials (FME & UNICEF, 2007). The study shows that about a third of the pupils and head teachers had attended violence prevention seminars in their school within the year preceding the study. Yet, in spite of these efforts, the study revealed that about 71 percent of schools across the country do not have established counselling services. Even where counselling services were provided, only 16 percent of teachers had attended the violence prevention seminars (FME & UNICEF, 2007). Other deficiencies in the literature include lack of evidence of any form of capacity building support for other critical categories of people in contact with children such as the police, social workers, families, and health workers with regard to violence against children.

6.4.7 Basic services for recovery and reintegration

Data is also lacking on recovery and reintegration of children who have been separated from parental care. This is particularly crucial with children affected by armed conflict, such as child militias (for example, the *egbesu* boys in the Niger Delta conflict and the *Almajarai* in some of the conflicts in northern parts of the country), abducted children, refugees, internally displaced children and orphans. Their special needs must be addressed consciously through programmes enabling social reintegration into civil society. As recommended by IASC (2002), such programmes would involve separating children from other combatants, addressing the indoctrination of children, reintegrating schooling, and reconciliation with the wider community. Other parallel programmes may involve reunification of unaccompanied children with their families, and meeting the psychosocial needs of internally displaced children and building capacity among them. Child victims of armed conflict or violence need psychological, post-traumatic and humanitarian assistance from government, NGOs and international humanitarian aid agencies. However, at the time of this analysis, there were no available data on such children who had received physical and psychological treatment during the sporadic armed conflicts that have erupted in various parts of the country.

The child justice administration provides another key avenue for the recovery and reintegration of children from hazardous environments back to normal life in the society and in their family settings.

Yet, the audit of the literature above on the child justice administration reveals a system that is fraught with such a plethora of distortions that it is counter-productive and operates in conflict with the protection rights of children. The assessment in the 2007 UNICEF Situation Analysis noted that, rather than rehabilitative, the system was vindictive, unfair, harsh, severe, and suffered from lack of social welfare structures in the country. On the basis of these serious dysfunctions, the assessment concluded that the re-christened child justice administration was no different from the formal criminal justice system in terms of rehabilitation and reintegration processes (UNICEF, 2007).

6.4.8 Monitoring and reporting

Admittedly the emerging regime (legal and institutional frameworks) for child protection in Nigeria is innovative and provides for monitoring and reporting of child protection abuse to inform appropriate responses. Of crucial importance is the Office of the Special Adviser and Special Presidential Committee on Human Trafficking, Child Labour and Slavery in the Presidency. These offices oversee the overall coordination and monitoring of all issues of and responses to violence against children. Other vital developments are the child rights implementation and monitoring committees at national and sub-national levels with CSOs as active members. Also desks officers at the Ministries of Women Affairs (federal and state levels), the Police, Immigration, and Customs Services are required to monitor child protection issues and ensure compliance with the laws and policies dealing with violence against children. In addition, the National Human Rights Commission (NHRC) has the mandate to receive and follow up complaints on all forms of violence against children. Its Special Rapporteur on Children, in particular, has the responsibility for monitoring, investigating, conducting research, and providing legal assistance to child victims of violence and human rights abuse. However, whether these mechanisms are actually performing their responsibilities of monitoring effectively is an important issue on which there are no existing current data.

Nevertheless, the literature indicates that actual monitoring and reporting have lagged behind the establishment of the mechanisms above. With regard to a legal 2003 framework, the FMWA identified the major weaknesses as the absence of mechanisms to assess the impact of the new child protection legislations and their enforcement. A year after their enactment, there was no system for formal enquires into all child deaths arising from violence, for example, nor were there regularly published reports of known or suspected violent deaths investigated by the government. One important reporting system is the annual Police Report, which contains information on crime rates and trends, including information on violent deaths among children. Yet the information provided in this report does not include relevant data on the number of reported cases of violence against children, the number of convictions, or reported cases for various categories of crimes of violence against children over several years (FMWA & SD, 2004).

6.5 Conclusion and recommendations for the next country programme

The analysis above clearly shows that much is still required to be done in order to ensure a protective environment for children in Nigeria. Admittedly, the passage of the CRA at the national level and in the majority of states, as well as the ratification of the major relevant international legal instruments, signal a consolidation of the requisite legislative environment for promoting child protection. However, the shortfall in the actual implementation of the key provisions of these legislations, as discussed above, has left the protection rights of children largely violated. The analysis reveals that attempts to improve the protective environment for the child have continued to face a range of key challenges. These challenges include a serious lack of current data on most existing and all emerging child protection issues, inadequate political commitment, growing incidence of poverty, low level of public awareness, pervasive lack of public accountability, and a weak culture of law enforcement.

On the basis of the foregoing analysis the following pages list actions recommended for strategic

intervention regarding child protection. Most of the recommended actions focus essentially on research, training, campaigns and public awareness raising, capacity building, and lobbying and policy advocacy to address the challenges identified above.

6.5.1 Child trafficking

- Commission a comprehensive nation-wide study on child trafficking. The study should include internal trafficking, internal migration and urbanisation, with disaggregated data to yield understanding of the nature, pattern, and scale of child trafficking.
- As a preventive strategy, launch awareness campaigns in schools, communities, nomadic populations, and religious institutions on the risks of child trafficking.
- Advocate for the ratification and domestication of the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography; and the African Charter on the Rights and Welfare of the Child

6.5.2 Children and justice

- Commission research on child victimisation by the criminal justice system (the police, the justice system and the prisons) in Nigeria.
- UNICEF should work with relevant civil society organisations to monitor the operation of the child justice administration (CJA) and to report on lapses in order to mount pressure for improvement and positive change
- Strong advocacy for increased government funding for and more attention towards remand homes and institutional care centres. The advocacy should be directed at creating enabling policies for improved childcare in remand homes, adequate funding, and establishment of many more homes.
- In addition, the training of staff and care givers in remand homes and institutional care centres should be supported to enhance their capacity to defend and promote the protection rights of the child in their custody.
- Undertake advocacy for the creation of the Lagos-type Office of the Public Defender in all states to provide *pro bono* legal aid for children from poor backgrounds in conflict with the law.
- Launch a campaign to create popular awareness of the CJA, particularly the Family Court, and educate the population on its operation.
- Lobby for the establishment of a specialised Juvenile Unit in all police stations and headquarters to deal with child cases.
- Mount an intensive and sustained campaign working with CSOs and lobbying directly for national government and parliament to institutionalise effective supervision and oversight of the CJA (the police, judiciary and prisons).
- Conduct training for the police on human rights, particularly the rights of the child. This training may be targeted at police personnel in a juvenile unit at the initial stage, and increasingly extended to the rest of the personnel who are most likely to be posted to the unit.
- Capacity building training for parliamentarians, particularly members of relevant committees on child protection, to enhance performance of their oversight functions in relation to the law enforcement agencies and the CJA.

6.5.3 Birth registration

- Mobilise communities through awareness campaigns for childbirth registration, along with

CSOs and community-based organisations (CBOs). This campaign should concentrate on rural areas, poor settlements, and northern Nigeria, where the rate of birth registration has been very low.

- Support the ongoing implementation of the NPC strategy of expanding childbirth registration to 100 percent by 2015 through close monitoring and reporting on progress.

6.5.4 Violence and harmful practices against children

- Conduct purposeful empirical research on the prevalence and trends of SGBV against children.
- Conduct empirical research on child kidnapping, ritual killing, and child witch victimisation to determine the scale, main drivers, and pattern of these practices.
- Launch a nationwide campaign to raise public awareness regarding child kidnapping, ritual killing, and child witch victimisation, using English and local languages to target parents, religious leaders, and community and political leaders.
- Support the implementation of the various laws against FGM/C, SGBV, corporal punishment and other forms of violence against children at national and state levels. This should include technical assistance to translate the legislations into policies, strategies, and action plans.
- Mount vigorous campaigns targeted at schools and in homes to generate or increase awareness of children and duty bearers on the right of the child to not be subjected to any form of violence. Such a campaign would also help in weakening the culture of silence that condones violence against children
- Systems for reporting violence against children should be strengthened by supporting the watchdog role of the civil society, including monitoring and reporting
- Lobby relevant state governments to bring sharia law as well as the criminal and penal codes into harmony with the CRA on the subject of corporal punishment.
- Launch a national campaign against child marriage, with particular focus on the rural sector, poor communities, and northern Nigeria.
- Support school enrolment campaigns and efforts especially targeted at rural areas, poor communities, and northern Nigeria. Enrolment up to secondary school education is crucial for reducing and halting child marriage as it enhances the child's awareness of the dangers of the phenomenon and provides empowerment against the social pressure to marry too early. Furthermore, children in school today will become the educated and aware parents of tomorrow who will fight against child marriage.

6.5.5 Children in armed conflict and emergencies

- Commission a study on children in situations of armed conflict and emergencies to show the pattern, trends, and scale of children both as victims and perpetrators of armed conflict. The study should be used to inform children-focused interventions in peace-building programmes.
- Launch a public awareness campaign against the use of children in armed conflict. The campaign should start from conflict areas in the Niger Delta and North Central states and create awareness on international humanitarian law (IHL) that deals with the rights of the child in armed conflict. UNICEF should particularly work with the Federal Government Amnesty Programme and conduct training for ex-militants (including former child combatants) on IHL.
- Conduct training for military, police, and security agencies on human rights, IHL, and the rules of engagement in relation to children during crisis management or counter-insurgency

operations.

- Strengthen advocacy for effective investigation of atrocities committed against children during armed conflict.
- Advocate for the ratification and domestication of the Optional Protocol on Children in Armed Conflict.
- Engage political parties through workshops to campaign against the use of children in election related violence.

6.5.6 Child labour

- Convene a regional conference of all the northern states' Governors, traditional and religious leaders on the reform of the *Almajiri* system towards eradicating child labour and promoting formal basic education.
- Work closely with UNESCO and other development agencies to promote formal basic education in northern Nigeria as a way of reducing child labour.
- Implement a sustained campaign in rural and poor communities on planned parenthood and parental care for children.
- Conduct more research to generate disaggregated data on the nature, scale, and trends of child labour occurring in different environments, mainly groups such as young domestic workers, the *Almajarai*, street children, and children in the agricultural sector and in construction.

6.5.7 Children without parental care

- Commission a comprehensive study on OVC, including those living in institutional centres and other non-family environments.
- Support the capacity of CSOs to monitor and report on the situation of institutional care centres.
- Lobby the federal government for increased budget allocation to the Ministry of Women Affairs and Social Development for an effective national OVC response.

6.5.8 Attitudes, traditions, and customs

- Commission research on prevailing attitudes, traditions, and customs that impede or facilitate violence, abuse, and exploitation against children in Nigeria.

6.5.9 Monitoring and evaluation

- Support and strengthen the capacity for monitoring and evaluation in the various child protection units in government ministries, departments, and agencies

6.5.10 Social welfare system

- Lobby the federal government to create a social welfare system that caters to the specific rights of the child.
- Conduct research on the proportion and pattern of government budgetary allocation for child protection programmes.

7. HIV and AIDS

7.1 Introduction

There are indications that the HIV epidemic in Nigeria has ‘stabilized,’ however HIV remains a significant public health concern. Nigeria is estimated to have the second largest HIV epidemic worldwide. Approximately 2.87 million people were estimated to be living with HIV in Nigeria at the end of 2008, rising to 2.95 million by mid-2009 with 1.72 million of them (58.3 percent) female (FMOH, 2009a). In 2008 alone, 271,151 new adult and 68,864 new childhood HIV infections and 280,000 AIDS-related deaths were estimated to have occurred (FMOH, 2009a). Cumulatively, 2.99 million AIDS-related deaths, among them 1.72 million female, are estimated to have occurred in Nigeria till date (FMOH, 2009a).

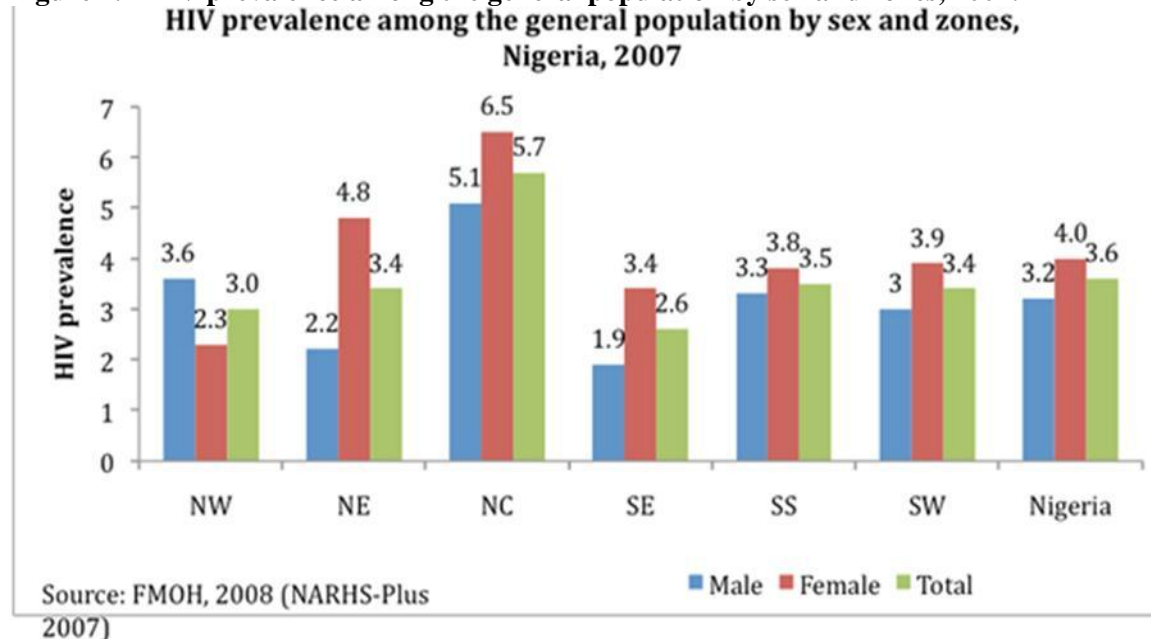
The HIV epidemic in Nigeria is tracked through three HIV-specific statutory national surveys, and normative national population and health surveys. Since 1991, Nigeria has been conducting HIV seroprevalence sentinel surveys among women receiving antenatal care (ANC) on a two-year basis to monitor the trend of the infection. A behavioural surveillance survey targeting key populations at higher risks for HIV was also conducted nationally in 2005, and included groups such as men who have sex with men (MSM), intravenous drug users (IDU), and female sex workers (FSW). The National HIV/AIDS and Reproductive Health Survey (NARHS) and the Nigeria Demographic and Health Survey (NDHS), unarguably the two leading nation-wide household surveys, provide some information regarding HIV-related knowledge, attitude, and sexual behaviour among the Nigerian population. The Multiple Indicator Cluster Survey (MICS) is another population-based survey with some relevant HIV-related data. The inclusion of HIV testing in the 2007 NARHS (otherwise known as NARHS-Plus) affords Nigeria the opportunity to determine HIV seroprevalence among the general population for the first time. The Integrated Biological and Behavioural Surveillance Survey (IBBSS) conducted in 2007 also included HIV testing, and thereby provided information of HIV seroprevalence among key populations at higher risks for HIV. In general these surveys show that Nigeria is experiencing varied epidemics across geopolitical zones, states, localities, and population groups. Disaggregated data confirm characteristics of a generalized epidemic with pockets of concentration in some key target populations. New data on the HIV epidemic is expected mid-2011, from the 2010 ANC sentinel survey, IBBSS and NARHS.

7.2 Analysis of the current HIV situation and trends

7.2.1 HIV situation among the general population

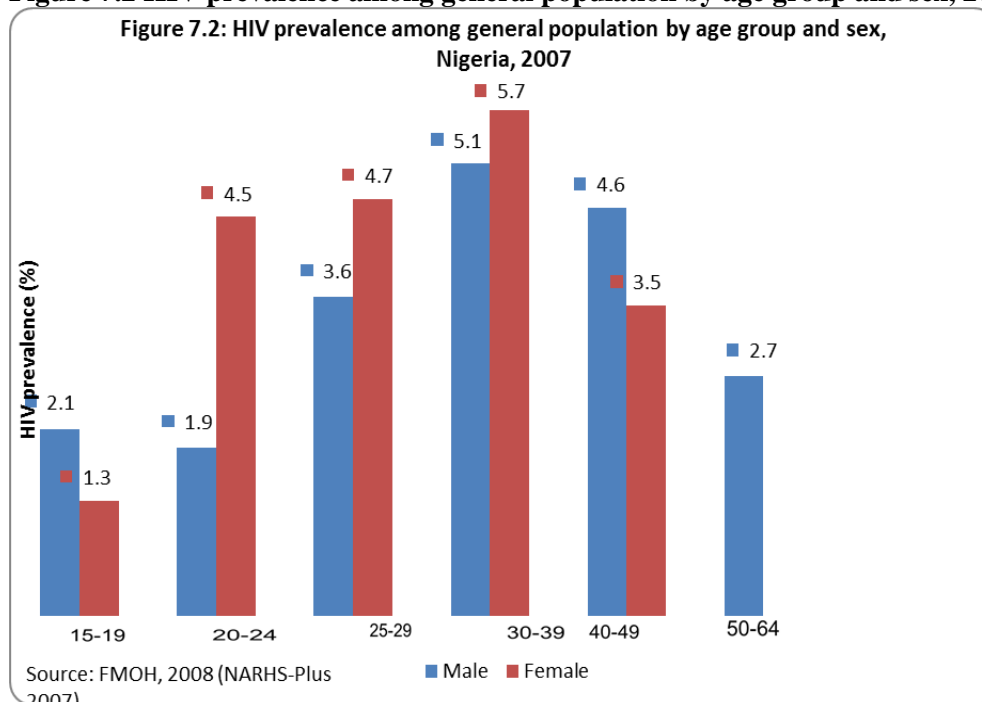
The 2007 NARHS, which covered women aged 15-49 years and men aged 15-64 years, reported a national prevalence of 3.6 percent (FMOH, 2008). The prevalence was higher among females compared to males in each of the geo-political zones with the exception of the North west zone (Figure 7.1).

Figure 7.1 HIV prevalence among the general population by sex and zones, 2007.



The age-disaggregated data from the 2007 NARHS show that females have higher HIV seroprevalence at all ages except in the youngest and oldest age groups (15-19 and 45-49 years) (Figure 7.2). The highest HIV prevalence among the general population for both sexes is in the fourth decade of life (age 30-39 years): 5.7 percent for females and 5.1 percent for males. Among females, the next highest level is in the age group of 25-29 years (4.7 percent).

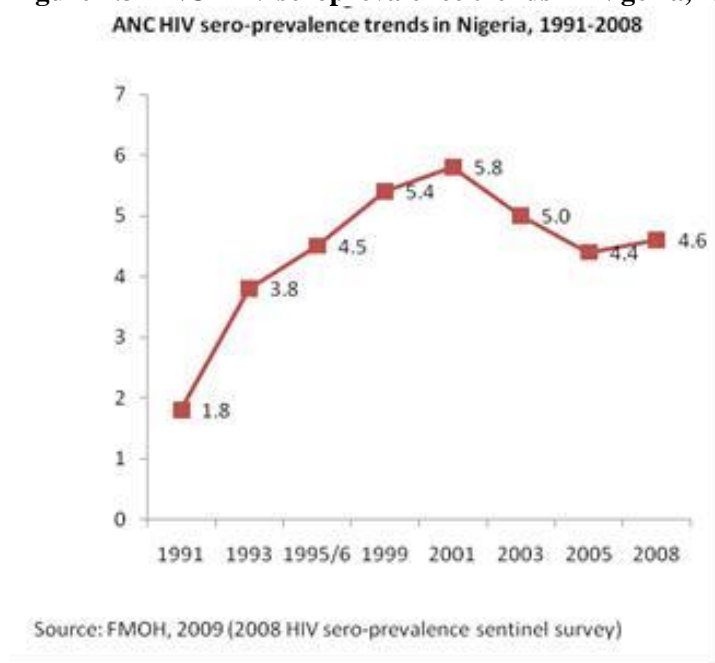
Figure 7.2 HIV prevalence among general population by age group and sex, 2007.



7.2.2 HIV trends among pregnant women

The results of the ANC serosurveillance surveys showed an increase from 1.8 percent in 1991 to 5.8 percent in 2001, followed by a decline to 5.0 percent in 2003 and to 4.4 percent in 2005 (Figure 7.3). The 2008 survey showed a slight increase to 4.6 percent (FMOH, 2008).

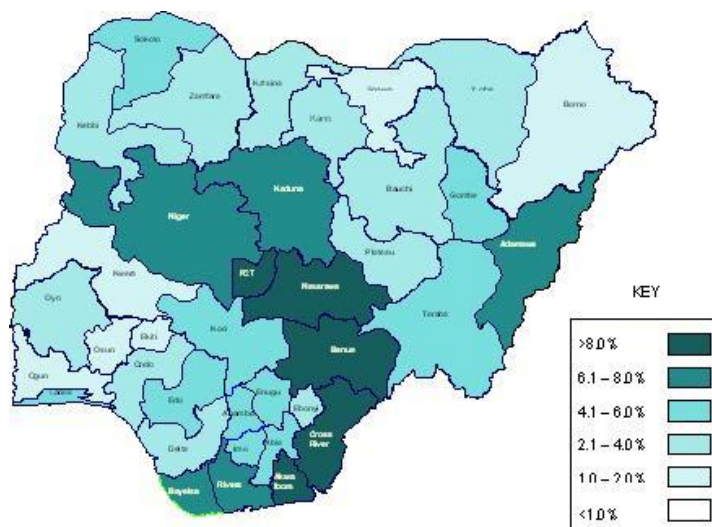
Figure 7.3 ANC HIV seroprevalence trends in Nigeria, 1991-2008.



Analysis of the 2008 ANC seroprevalence survey showed geographical clustering of HIV prevalence (Figure 7.4). The South south (7.0 percent) and North central (5.4 percent) geo-political zones have the highest median ANC HIV seroprevalence level in the country. The seroprevalence level for the other zones, in descending order, is as follows: North east 4.0 percent, South east 3.7 percent, North west 2.4 percent, and South west 2.0 percent.

HIV seroprevalence levels are higher in urban than in rural areas in almost three quarters of the states in Nigeria. On the other hand, the rural prevalence is higher in the FCT and nine states (Akwa Ibom, Borno, Ebonyi, Enugu, Kebbi, Kwara, Ogun, Oyo, and Sokoto), while the figures for urban and rural areas were the same for Delta state (FMOH, 2009a).

Figure 7.4 HIV prevalence among pregnant women receiving ANC by states, 2008.



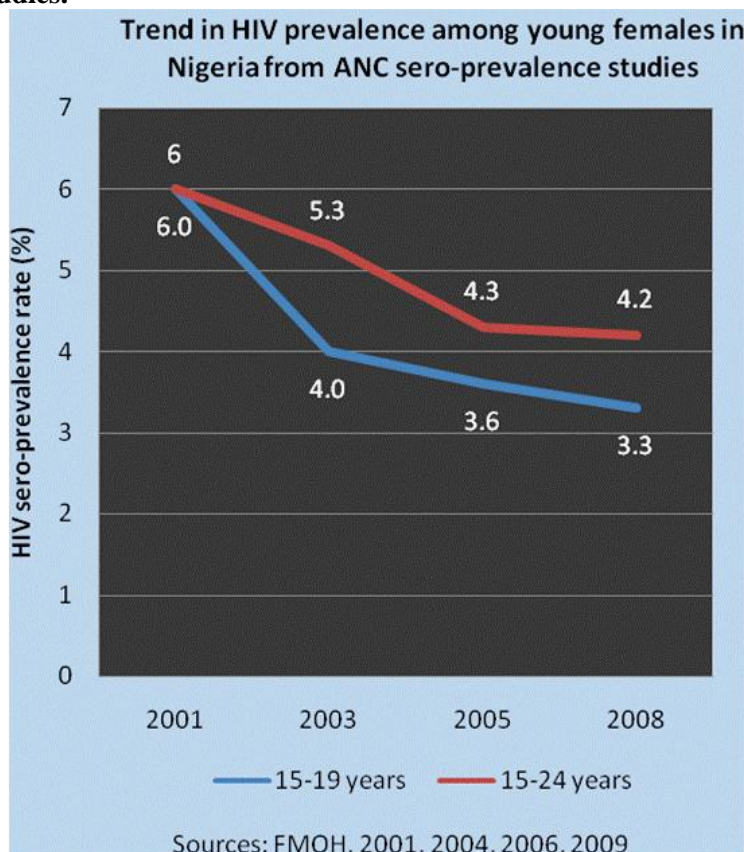
Source: FMOH 2009a

7.2.3 HIV situation and trends among young people

HIV prevalence among 15 to 24-year-old pregnant women is one of the indicators for the sixth Millennium Development Goal. The 2008 ANC serosurveillance survey reported a prevalence of 4.2 percent for the age group 15-24 years, 3.3 percent for the age group 15-19 years, and 4.6 percent for age group 20-24 years (FMOH, 2009a). HIV prevalence among young pregnant women aged between 15 to 24 years in 2008 varied from 0.4 percent in Osun state (South west zone) to 12.0 percent in Ebonyi state (South east zone). Urban pregnant young women (aged 15-24 years) recorded higher prevalence rates than their rural counterparts in 28 of the 36 states. Urban and rural-based pregnant young women in Kwara state recorded the same prevalence, while the FCT and seven other states (Akwa Ibom, Anambra, Benue, Borno, Ekiti, Ogun, and Sokoto) recorded comparatively higher prevalence among rural than urban youth.

The trend in the national prevalence of HIV among youth (aged 15-24 years) is commonly used as an index of new infections. The results of ANC serosurveillance show that the HIV seroprevalence steadily declined among pregnant young women (aged 15-24 years) from 6.0 percent in 2001 to 5.3 percent in 2003, 4.3 percent in 2005, and 4.2 percent in 2008 (FMOH, 2009a) (Figure 7.5).

Figure 7.5 Trend in HIV prevalence among young females in Nigeria from ANC seroprevalence studies.



The steady decline in HIV prevalence among pregnant girls aged 15-19, with an overall reduction from 6.0 percent in 2001 to 3.3 percent in 2008, supports the inference that the HIV incidence rate is decreasing in Nigeria, indicating significant progress in Nigeria's HIV control efforts.

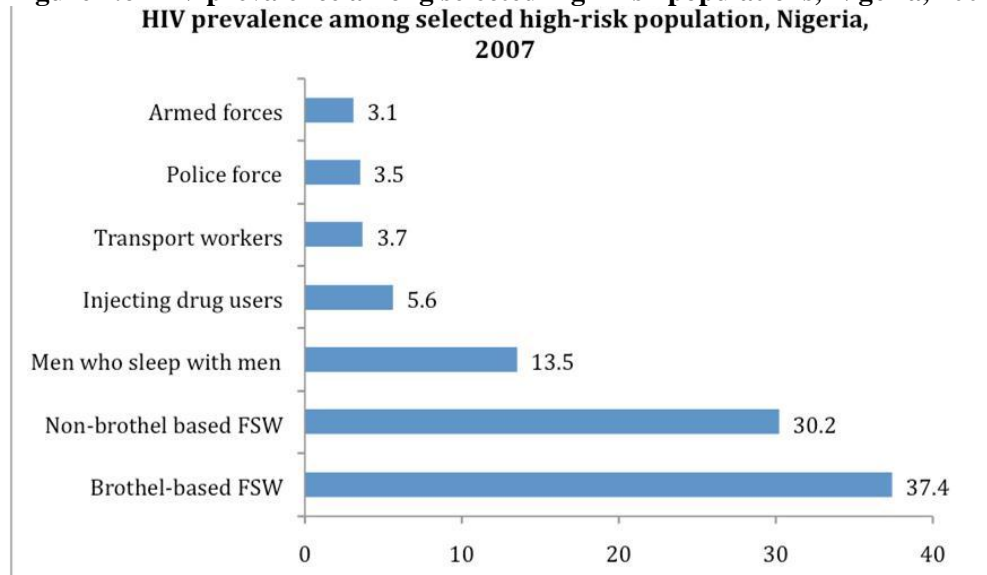
Increased adoption of safer sexual behaviour is likely to explain the observed trend of declining HIV infection rates among young people. A comparison of the results of the 2003 and 2007 NARHS (FMOH, 2004a, 2008), for example, shows a decrease in the proportion of adolescents (aged 15-19 years) who ever engaged in sexual intercourse from 26.8 percent to 22.2 percent for males and from 46.5 percent to 42.9 percent for females.

7.3 HIV transmission and associated factors

7.3.1 HIV transmission routes

The results of the mode of HIV transmission (MoT) modelling undertaken by NACA, UNAIDS and the World Bank (2009) provide evidence on where new HIV infections are coming from and drivers of the HIV epidemic in Nigeria. Approximately two-fifths (42.3 percent) of all HIV infections occur among individuals classified as engaging in ‘low-risk’ sex (Figure 7.6). This finding indicates a need for intensified HIV prevention programming for the general population. On the other hand, the MoT modelling also shows that a disproportionately high share of infections are contributed by key populations at higher risk for HIV. In Nigeria, IDUs, FSWs and MSM who constitute about 1 percent of the adult population, but account for as much as 23 percent of new HIV infections. With their partners, these groups account for 32 percent or one third of new infections – a significant and important finding. On the whole, ‘over a third of new HIV infections are attributable to these high-risk groups and their partners who constitute only about 3.4 percent of the adult population’ (p. 2). Indeed, the result of IBBSS, which reported a prevalence level of 5.6 percent for IDUs, 13.5 percent for MSM, 30.2 percent for non-brothel-based FSW, and 37.4 percent for brothel-based FSW, confirmed the high HIV risk status of these groups. The results of the MoT modelling indicate the need to target key groups at higher risk of infection with effective interventions.

Figure 7.6 HIV prevalence among selected high-risk populations, Nigeria, 2007.



Source: NACA, UNAIDS and WB (2009).

Some states have conducted sub-national MoT analyses, which confirm the different epidemics across the states. In Kaduna for instance the ‘low-risk’ heterosexual transmission accounts for over 70 percent of new infections, and new infections from key target populations constitute a significantly smaller proportion (Kaduna State AIDS Control Agency, 2010).

7.3.2 Drivers of the HIV epidemic in Nigeria

Poverty is a major factor in HIV-related behaviour in Nigeria. Women in the lowest socioeconomic class, for example, are more likely to be engaged in sexual behaviours that make them vulnerable to HIV than those in the upper socioeconomic group (NPC & ICF Macro, 2009). The median age at first marriage for women aged 25-49 years, for example, is 15.4 years for women in the lowest wealth quintile compared to 23.1 years for those in the highest quintile. Among women aged 15-24 years (both married and unmarried) 30.0 percent of those in the lowest wealth quintile are likely to have engaged in sex before the age of 15 years compared to 4.5 percent of those in the highest quintile. Among women aged 18-24 years (both married and unmarried), 73.5 percent of those in the lowest wealth quintile are likely to have engaged in sex before the age of 18 years compared to

25.4 percent of those in the highest quintile.

A number of gender-related socio-cultural practices such as early marriage, polygamy, wife inheritance, cleansing rituals for widows, female genital cutting, and wife hospitality⁷ are also drivers of the epidemic in Nigeria (NBS & UNICEF, 2007). As the 2008 NDHS reports, 12.4 percent of girls aged 15-19 were already married. By age 18, 39.4 percent of females aged 20-24 years had been married (the national median age at marriage for that age group is 19.8 years). The median age at first marriage among women aged 25-49 years is as low as 15.2 years in the North west and 15.6 years in the North east, whereas it is above 20 years in the southern geo-political zones (20.9 years in the South south, 21.8 years in the South west, and 22.8 years in the South east). Recent evidence however suggests that the prevalence of many gender-related practices and human rights violations are decreasing as a result of appropriate interventions (NBS, 2007; NBS & UNICEF, 2007; NPC & ICF Macro, 2008).

Low HIV risk perception is another factor reported to influence the HIV epidemic in Nigeria. The result of the 2007 NARHS shows that only 2.5 percent of females and 2.2 percent of males perceive themselves as being at high risk for HIV (FMOH, 2008). Other factors that have been reported as drivers of Nigeria's HIV epidemic include: multiple concurrent partners, informal transactional and inter-generational sex, lack of established services for sexually transmitted infections – particularly for key groups at high risk of HIV infection, stigma and discrimination, and inadequate health services (NACA, 2008).

7.4 National response to HIV and AIDS in Nigeria

7.4.1 Institutional framework

Nigeria's response to HIV and AIDS has grown over time, moving from a health-sector response to a multi-sectoral response in 1999 with the National Committee for HIV/AIDS (NACA) as the coordinating body at the national level. State Action Committee on AIDS (SACA) and the Local Government Action Committee on AIDS (LACA) are the coordinating bodies at the state and local government levels respectively. NACA transformed into a full-fledged agency under the presidency – the National Agency for the Control of AIDS – in 2007, and many SACAs have similarly transformed into agencies with a strengthened structure and capacity for more effective response coordination.

7.4.2 Policy environment

In 2009 NACA developed a revised national policy as well as a national strategic framework (NSF) with a strong focus on prevention. The policy recognizes prevention as the 'most important strategy as well as the most feasible approach for reversing the HIV epidemic' (FGN, 2009a) and the strategic framework aims 'to reposition prevention of new HIV infections as the centrepiece of the national HIV and AIDS response' (FGN, 2009b). In line with the new policy and NSF, the National HIV/AIDS Prevention Plan (NPP) has recently been revised for the 2010-2012 period. The revised plan builds on the 2007-2009 prevention plan, which recommends the use of 'combination prevention' – as does the National HIV/AIDS Behaviour Change Communication Strategy (2009-2014). The 2007-2009 prevention plan also recommends a 'minimum prevention package' (MPP), based on the principle of combination prevention. The position of the NPP is well grounded in behaviour change theories and aligns with the current emphasis of the HIV prevention field globally on 'combination prevention' (Coates et al, 2008; van Griensven & van Wijngaarden, 2010). The recommendation for minimum prevention package aims to address the challenge of low effectiveness and efficiency resulting from the use of varying dosages and intensity of interventions by service provider. However, poor dissemination and inadequate human capacity and material and

⁷ Wife hospitality refers to the practice whereby wives are required to engage in sexual intercourse with males who are visiting the family. This practice occurs in some parts of the North west zone.

financial resources have limited the implementation of the comprehensive approach advocated for by the 2007-2009 plan (NACA, 2010a).

The revised NPP highlights and re-emphasises ‘comprehensive programming, involving an appropriate mix of ranges of policy and programmatic interventions known to be effective, with emphasis on “combination prevention” to address vulnerability and risk factors at different levels at which behaviour is influenced – individual, community and socio-cultural/socio-economic milieu – and the delivery of a minimum prevention package of interventions’. The minimum package underscores adequate dosage and intensity of interventions; it stipulates the use of activities from three different intervention prongs to reach each target. The defined prongs are community outreach, HIV counselling and testing, peer education model, school-based approaches, peer education plus models, workplace interventions, infection control interventions in clinical settings, STI management, specific population awareness interventions (targeting population at higher risk for HIV and vulnerable populations), and vulnerability-centred approach (such as income generating activities, microfinance, alternative livelihood source, skill acquisition, essential life skills training, gender, and improving male support). A tracking tool for prevention intervention – an electronic management information system – has been developed to track, validate, store, and analyse captured data based on the minimum package of prevention interventions. The tracking tool was launched in December 2009, and it is too early to assess its acceptability, utilization, and impact.

Several useful implementation guidelines including national plans, standard of practice, and protocols have also been developed to address other HIV-related prevention interventions, including blood safety and PMTCT as well as overarching issues such as management information systems and programme management.

7.4.3 Programme issues

The review of the implementation of the 2003 National HIV/AIDS Policy and the first National Strategic Framework (2005-2009) that took place in 2009, clearly documented increased efforts and expenditure on the HIV issue between 2005 and 2009 (NACA, 2009b and 2009c). The review noted that ‘Nigeria has been steadfast in its commitments to strengthen its response to the HIV and AIDS epidemic during the National Strategic Framework 2005-2009 period through the implementation of multi-sectoral comprehensive intervention programs broadly clustered around complementary thematic areas of Promotion of Behaviour Change and Prevention of New HIV Infections; Treatment of HIV/AIDS and Related Health Conditions; Support and Care for people living with and affected by HIV/AIDS; Policy, Advocacy, Human Rights and Legal Issues; Institutional Arrangements and Resource Mobilization and Application for the national response; and Monitoring and Evaluation Systems including research and knowledge management’.

The review also highlighted a number of challenges and gaps in the national response. Among others, it noted that the HIV-related expenditure, and probably efforts, between 2005 and 2009 was largely skewed towards treatment rather prevention. This was corroborated by NASA: “whereas 45.1 percent and 47.1 percent of national expenditure for HIV and AIDS was for care and treatment activities in 2007 and 2008 respectively, the proportion utilised for prevention activities was 12.6 percent in 2007 and 14.7 percent in 2008 while 1.9 percent and 2.5 percent was used for OVC activities in 2007 and 2008 respectively’ (FRN, 2010). Only 14.6 percent and 7.6 percent of the national HIV-related expenditure in 2007 and 2008 respectively was from government resources, while the corresponding proportion from external sources was 85.4 percent and 92.3 percent respectively (FRN, 2010). This situation may reflect the focus and contribution of some major international development partners in the largely donor-financed HIV response environment. For example, the United States government, which was a key player and major funder of response activities through the President’s Emergency Plan for AIDS Relief (PEPFAR) initiative, largely

focused on treatment during the period. On the other hand, the large gap between national expenditure on treatment versus prevention activities also probably reflects the fact that the unit cost of providing treatment services including drugs and laboratory services is far greater than that for HIV prevention services.

The review also noted that capacity for programme coordination and implementation was considerably weaker at the sub-national level compared to the national level, and a coordinating structure was absent in many LGAs. With the multiplicity of partners in the national response, including growing numbers of civil society organizations (CSOs), the review drew attention to the challenge of coordination and sustainability in a climate of global financial crisis where programmes are largely donor-dependent and donor driven.

7.5 Primary prevention of HIV among adolescents and young people

Young people are at the centre of the HIV epidemic, and the need to prioritise actions to reduce HIV infection among young people has now been globally recognized. The political declaration on HIV/AIDS, which resulted from a UN-convened high level meeting in 2006, agreed on the need ‘to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence and skills-based youth specific HIV education, mass media interventions, and the provision of youth friendly health services’ (UNGASS, 2006).

The UNAIDS 2009-2011 outcome framework addressing young people calls on programmes to ‘empower young people to protect themselves from HIV’ by putting young people’s leadership at the centre of national responses, providing rights-based sexual and reproductive health education and services, and empowering young people to prevent sexual and other transmission of HIV infection among their peers. Young people are already leading the prevention revolution in many countries. Evidence shows that new HIV infections among young people in the 15 countries most affected by HIV have dropped by as much as 25 percent as young people embrace safer sexual behaviours (UNAIDS, 2010).

7.5.1 Causality and capacity analysis of problems

HIV transmission among young people in Nigeria is rooted largely in their risky sexual behaviour. Broadly, HIV and other health-related outcomes and interventions among young groups are influenced and clustered around three main foci: safe and supportive environment, knowledge and skills, and health-related services (WHO, 1997, Lule et al., 2006).

Safe and supportive environment

Policy and legal instruments are major approaches to fostering an environment promoting adolescent health development and reduction in risky behaviours such as those relating to HIV. New efforts in this direction between 2007 and 2009 included the development of the following policy documents: National HIV/AIDS Policy and strategic framework; National Prevention Plan for HIV/AIDS; National Policy on the Health and Development of Adolescents and Young People (FMOH, 2007); and the National Youth Policy (FMYD, 2009). The National Action Plan (2010–2012) for Advancing Young People’s Health and Development in Nigeria, which was developed to re-energise the implementation of the youth and adolescent health policies, is also quite strategic in this realm as it provides a common frame and multi-sectoral pathways to address HIV and other health challenges of young people.

HIV knowledge and prevention skills

Level of awareness and knowledge

The level of HIV and AIDS awareness among young people (aged 15-24 years) in Nigeria is high:

it increased from 84.9 percent among females in 2003 to 87.1 percent in 2008, but decreased among males from 95.3 percent to 91.4 percent in the same period (NPC & ORC Macro, 2004; NPC & ICF Macro, 2009). HIV-related comprehensive correct knowledge⁸ is however quite poor, and lower among females compared to males. In 2008, according to the NDHS, only 22.2 percent of females and 32.6 percent of males aged 15-24 years had comprehensive knowledge about HIV (NPC & ICF Macro, 2009). HIV knowledge is also lower among youth in the younger group (aged 15-19 years) compared to the older group (aged 20-24 years): among females the proportion that had comprehensive HIV knowledge was 19.7 percent for the 15-19 years age group and 24.8 percent for the 20-24 years age group, while it was 28.2 percent and 37.2 percent respectively among males. Young people with lower education, rural-based, living in the northern geo-political zones, and those from poorer socio-economic background had lower HIV knowledge compared to their peers (NPC & ICF Macro, 2009).

Factors likely to be associated with the low HIV knowledge among young people include cultural and child rearing practices which inhibit parent to child communication around reproductive health issues, and inadequate youth-friendly services and thus inadequate access to relevant information, education and communication (IEC) interventions. Inequity in the target and reach of adolescent or youth-focused IEC may also play a role. Many IEC programmes, for example, are skewed towards secondary school students in urban areas, with younger adolescents, out-of-school young people (especially adolescent girls out of school) in rural areas hardly or very poorly covered. Programmes have also largely neglected young people in tertiary institutions.

Analysis of interventions

Programmes aimed at improving knowledge among young people in Nigeria include the school-based Family Life and HIV Education (FLHE) programme, community-based programmes, and media-based interventions. Though approved nationally since 2001, the implementation of school-based FLHE remains limited till date (FME & UNICEF, 2006); instructional materials are not adequate in terms of numbers and the commitment of state governments is not optimal. Recent developments in the use of electronic approaches, including development of e-curriculum and delivery of FLHE through interactive computer-based programmes, though likely to enhance FLHE coverage have at the moment very limited coverage (pilot scale). The National Youth Service Corps' Peer Education Programme, which is being implemented with the support of UNICEF, has given great impetus to FLHE activities in schools. An evaluation showed that the programme has succeeded in training thousands of volunteer corps members as peer education trainers (PETs) since its commencement in 2002. The PETs, in turn, have trained several thousands of peer educators at school level, who are reaching out to their peers, thereby possibly reaching millions of young people in secondary schools all over the nation yearly with HIV and AIDS education. The programme has, however, been documented to be weak with regards to life skills (Osagbemi et al., 2009).

Community-based programmes are platforms that can be used to reach both in-school and out-of-school youth. In Nigeria, programmes targeting out-of-school youth include those delivered in the context of youth serving facilities such as youth centres; community-based outreach such as those targeted at artisan groups, youth 'hot spots', and youth-attracting events such as festivals and sporting activities; and interventions in faith-based settings. Many of these are also capable of reaching in-school youth simultaneously, but some have been designed specifically or primarily to target out-of-school youth. Many of the out-of-school targeted information programmes are implemented by civil society organisations. Unfortunately, very few of such activities have been rigorously evaluated even when funded by international development partners (GH Tech, 2010).

⁸ Comprehensive knowledge, as defined by UNAIDS, comprise the following: (i) knowing that consistent use of condoms during sexual intercourse and having just one HIV-negative and faithful partner can reduce the chances of getting HIV; (ii) knowing that a healthy-looking person can have HIV; and, (iii) rejecting two common misconceptions about AIDS transmission and prevention.

There is increasing interest in the use of sports for promotion of HIV-related prevention, particularly among young people who constitute a high proportion of both athletes and spectators. Opportunities for mainstreaming HIV issues into sports events include training of peer educators and counsellors among sports personnel at all levels, provision of male and female condoms in sports camps, use of billboards in sports centres, information dissemination and use of enter-educative approaches during sports breaks to reach spectators as well as television and radio audiences, and the use of sports heroes to propagate or advocate HIV-protective behaviours. The National Sports Commission in 2010 was supported to develop an operational plan for the use of sports as an entry point for HIV prevention among young people. Its organizational structure and geographical reach presents an opportunity for targeting young people through the medium of sports.

Enter-educative approaches are powerful in reaching young people with information and influencing their attitudes and behaviours. While they are relatively expensive, their reach can be very wide. The multi-media campaign 'Zip-up!' implemented by the Society for Family Health with the support of the United States Agency for International Development (USAID), is perhaps the country's flagship adolescent and youth-focused media programme in recent years. Rigorous scientific study shows that it has succeeded in increasing abstinence-related communication among young people (Fatusi et al, 2007/8). Another programme to be noted is the '*Ku Saurara!*' ('Listen up!') – an entertainment-education program implemented in some parts of northern Nigeria. This program provided reproductive health information and links to quality health and counselling services through relationships with community-based youth-serving organizations and youth-friendly health clinics.

Safer sex practices and access to relevant health services

Among adolescents (aged 15-19 years), 15.3 percent of the girls and 6.2 percent of the boys have engaged in sex as early as the age of 15 years. Among never married young people aged 18 to 24 years, 23.9 percent of females and 23.3 percent of males had initiated sex before the age of 18 years (NPC & ICF Macro, 2009). Many sexually active young people still do not have access to friendly health services and essential health commodities such as condoms. Only 36.6 percent of females aged 15-24 years know a condom source compared to 68.0 percent of males (NPC & ICF Macro, 2009). The proportion of young people (15-24 years) who know where an HIV test could be undertaken is 45.4 percent for females and 59.3 percent for males, while less than a tenth of the age group have ever been tested for HIV and received the result (9.2 percent of females and 7.4 percent of males) (NPC & ICF Macro, 2009). On the other hand, there is still considerable opposition to the use of condoms by young people among Nigerian stakeholders. For example, only 32.1 percent of women aged 18-49 years and 46.8 percent of men aged 18-59 years, agree that children aged 12-14 years should be taught about using a condom to avoid HIV infection (NPC & ICF Macro, 2009).

Many young people lack access to youth-friendly health services, as relevant facilities are few in Nigeria, particularly in public health facilities (FMOH & AHI, 2009). Also, many of the available youth-friendly health facilities are poorly utilized. Many facilities face challenges in terms of skilled service providers due largely to lack of standardized and institutionalized training on adolescent health. The school health programme (SHP) constitutes a potential cost-effective approach for reaching young people in schools with HIV-related information, counselling, and referrals, and also contributes to creating a safe and supportive environment for adolescent health development. Unfortunately, SHP has suffered significant neglect over the years in Nigeria, and the implementation of school health services is known to be weak in most parts of the country. The UNICEF-supported Learning plus Initiative is an emerging opportunity regarding school-based interventions, and an approach that builds on the school health platform. The initiative aims to strengthen schools as centres not only for learning, but also to provide social services and relevant

psycho-social support for the holistic development of young people particularly in the face of the challenge of HIV and AIDS. The programme needs to be expanded and implementation at school level rolled out as quickly as possible.

In conclusion there is some understanding of the HIV epidemic in Nigeria, critical for tailoring a robust evidence-based response. However, there is still a knowledge gap on the specific factors placing young people at risk that will require further disaggregation in MoT data and other national surveys. Over the last few years there is increasing emphasis on evidence-based ‘combination prevention’ interventions in national guidelines. What remains to be done is to urgently scale up evidence-based interventions starting with the already ongoing prevention projects. For current prevention initiatives, it is critical to address the quality of interventions, and sustain the quality of services over time, linked to other health and HIV services at health facilities and in the community. A robust evaluation would be a good starting point to inform necessary improvements.

7.6 Prevention of mother-to-child transmission of HIV (PMTCT)

Pregnant women living with HIV are at high risk of transmitting HIV to their infants during pregnancy, during birth, or through breastfeeding. However, the risk of mother-to-child-transmission of HIV (PMTCT) can be reduced to less than two percent by a package of evidence-based interventions including potent anti-retroviral (ARV) drugs, elective caesarean section, and safe replacement feeding (UNAIDS, 2009). Use of combination ARV regimens can reduce MTCT rates to less than 5 percent even in breastfeeding populations (Luo, 2010).

The UN General Assembly has set a target for 80 percent of pregnant women and their children to have access to essential prevention, treatment, and care by 2010 to reduce the proportion of infants with HIV by 50 percent. In 2009, UNAIDS made the call for virtual elimination of mother-to-child HIV transmission by 2015. UNAIDS defines ‘virtual elimination’ as MTCT rates of less than 5 percent. Four strategic programme elements are needed to achieve these goals: (i) preventing primary HIV infection in women of reproductive age, (ii) preventing unintended pregnancies among women living with HIV, (iii) preventing HIV transmission from a woman living with HIV to her infant, and (iv) providing appropriate treatment, care, and support to mothers living with HIV and their children and families.

Since the UNAIDS call to action there has been unprecedented political commitment for elimination of MTCT within a framework of support for the MDGs (4, 5, 6 and 3) by 2015. There is clear commitment across broad constituencies beyond the UN, including the community of CSOs such as PLHIV, GFATM, USG’s PEPFAR, implementing partners, and broader international HIV community. The GFATM, for instance, has prioritized reprogramming of AIDS funds for use for PMTCT – an opportunity that Nigeria has already taken advantage of for Rounds 5, 8 and 9 funding. The USG’s PEPFAR has also committed resources over current HIV commitments, specifically for PMTCT.

7.6.1 Analysis of current situation and challenges

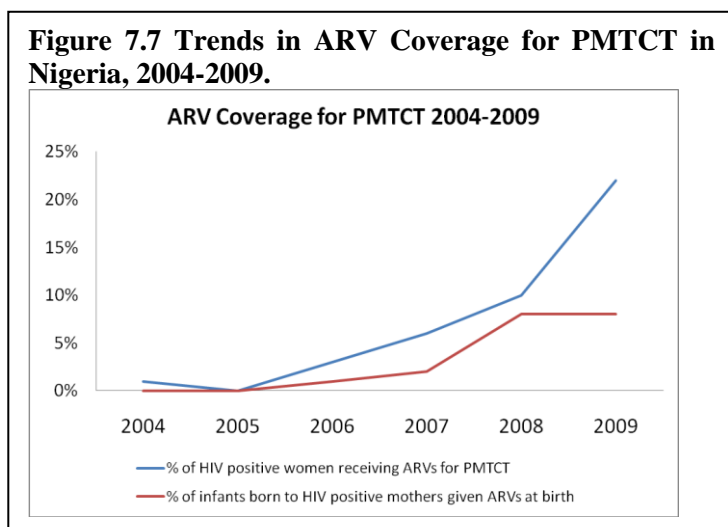
Nigeria and South Africa share the highest burden of HIV disease among pregnant women and children worldwide. Nigeria contributes about 32 percent of the global gap in PMTCT coverage (FMOH, 2010a). Currently, an estimated 1.72 million women are living with HIV in Nigeria and approximately 56,681 HIV-positive births are recorded annually (FMOH, 2009).

Uptake and coverage of PMTCT services

HIV counselling and testing (HCT) is the entry point into PMTCT, but the proportion of pregnant women who have undertaken HCT in Nigeria is low. According to the 2008 NDHS, only 15 percent of all women had ever been tested and the proportion tested within 12 months before the survey was 7 percent (NPC & ICF Macro, 2009). Compared to 11 percent in 2008, 13 percent of pregnant

women received HIV testing and counselling services (FGN/UN, 2010). Also, the PMTCT maternal ARV coverage was 22 percent at the end of 2009, up from 10 percent in 2008 (Figure 7.7). While the reported increase is a positive development, it generally falls far short of the objectives of the national PMTCT programme.

Figure 7.7 Trends in ARV Coverage for PMTCT in Nigeria, 2004-2009.



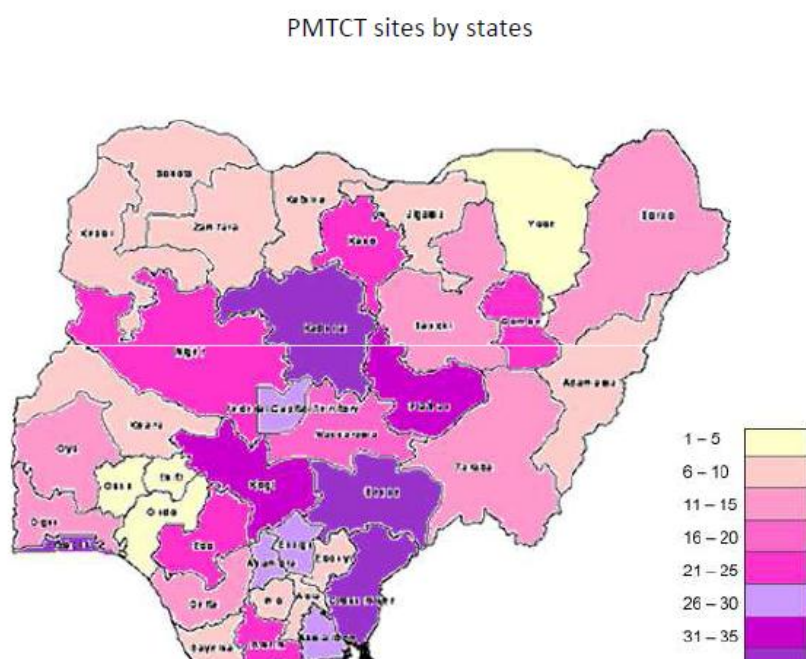
Individual and household factors contribute to this poor coverage alongside factors related to the health services. At the individual and household level, poor knowledge of PMTCT, poor HIV perception, and fear of HIV stigmatisation may all play a part. According to the 2008 NDHS, only 25.9 percent of women aged 15-49 years and 32.7 percent of men aged 15-59 years knew that HIV could be transmitted by breastfeeding, and that the risk of MTCT could be reduced by the mother taking special drugs during pregnancy (NPC & ICF Macro, 2009). The low utilisation of

orthodox maternal health care services by pregnant women is also a challenging issue as exemplified by the low proportion of pregnant women using key maternal health services in 2008: 58 percent received antenatal care (at least 1 visit) in health facilities, 39 percent delivered under the supervision of skilled attendants, and 35 percent delivered in health facilities. The wide gap between ANC coverage and availability of PMTCT services in ANC on the one hand, and between skilled attendance at delivery and maternal ARVs on the other hand also indicate that missed opportunities contribute to the MTCT challenge in Nigeria. Fertility-related behaviours such as high fertility rate (5.7 children per woman in 2008), low contraceptive prevalence rate (10 percent among married women and 42 percent among sexually active, unmarried women), and unmet family planning need (20 percent) contribute to the MTCT burden. The 2008 NDHS reported that 97.3 percent of children born in the past five years had been breastfed, hence the proportion of HIV-positive mothers breastfeeding must be high (NPC & ICF Macro, 2009).

In terms of the health services factor, a major challenge is the limited number of PMTCT facilities and the inequity in their distribution. The 2010-2015 PMTCT Scale Up Plan reports that only 63 tertiary, 482 secondary, and 473 primary health facilities, totalling up to 1018 facilities and representing 4.5 percent of the 22,726 health facilities in the formal health sector, provide PMTCT or HCT services (FMOH, 2010). A national survey of health facilities offering PMTCT services has reported that whereas all tertiary-level PMTCT units offer ARV prophylaxis to HIV-exposed newborns, about three-quarters of secondary-level PMTCT units offer such services, but only a tenth of primary-level PMTCT units offer such a service (Amanyeiwe et al, 2008). According to data submitted by the federal government in close collaboration with the UN as part of the global universal access health sector reporting, there was a modest increase from 2009 to 2010 in the number of facilities offering PMTCT services; from 533 to 670 facilities.

The distribution of health facilities offering PMTCT is highly skewed in favour of urban areas despite the fact that only about one-third of the Nigerian population live in the urban areas. PMTCT services are also mostly available in tertiary and secondary facilities, whereas the primary health care facilities are the nearest to the people. The services are also relatively lacking in the private sector, which accounts for about 38 percent of orthodox health facilities and provides about 60 percent of health care in the country (FMOH 2005, 2009). The distribution of the services across the country is also uneven (Figure 7.8).

Figure 7.8 Distribution of PMTCT sites, 2008



Source: FMOH, 2010a.

Policy issues regarding PMTCT

The policy environment is important to promoting PMTCT on a nationwide basis. Nigeria’s policy frameworks reflect that the HIV control programme in the country has continuously considered PMTCT as a critical intervention. The prioritisation of PMTCT is also evident in recent national submissions to the GFATM. In addition to submissions for reprogrammed Rounds 5, 8 and 9 for PMTCT, the programmatic focus for the entire R10 proposal, although unsuccessful, was PMTCT. National policies that are of relevance to PMTCT include the National Policy on Infant and Young Child Feeding in Nigeria (2005) and the Child Health Policy (2005). The Federal Ministry of Health also has a Health Sector Strategic Plan for HIV and AIDS (2005 – 2009) that focuses on the health sector specific responses to HIV and AIDS. One of the outputs specified in the plan is ‘delivery of sustainable, comprehensive, quality prevention, treatment, care and support services in both public and private sector facilities’, including PMTCT.

One of the objectives of the 2003 National Policy on HIV/AIDS is to reduce MTCT by 50 percent by the year 2010. The revised National Strategic Framework (NSF) and Plan (NSP) for HIV/AIDS (2010-2015) also have PMTCT as one of the main focus areas of its prevention strategy. The NSP aims to reach 50 percent of pregnant women with HCT by 2010-2011 and to increase the coverage to 80 percent by 2015 (Table 7.1).

Table 7.1 The PMTCT-related target of the 2010-2015 National Strategic Plan

Time frame	Projected number (and proportion) of pregnant women to be reached with HCT	Projected number (and proportion) of pregnant women to be reached with ARV prophylaxis
2010-2011	3,165,166 (50 percent)	55,575 (25 percent)
2012-2013	5,102,535 (80 percent)	118,065 (50 percent)
2014-2015	5,113,830 (80 percent)	197,900 (80 percent)

Source: NACA, 2009

In response to the revised NSF, a new national scale-up plan has been developed with the overall goal of contributing to ‘improved maternal health and child survival through accelerated provision of comprehensive PMTCT services’ (FMOH, 2010a). The plan is costed at US\$ 1.75 billion (US\$1,745,598,817). The targets are to ensure the following by 2015: at least 90 percent of all pregnant women have access to quality HIV counselling and testing; at least 90 percent of all HIV positive pregnant women access more efficacious ARV prophylaxis; at least 90 percent of HIV exposed infants access more efficacious ARV prophylaxis; at least 90 percent of HIV positive pregnant women have access to quality infant feeding counselling; and at least 90 percent of all HIV exposed infants have access to early infant diagnosis services. These targets, which are higher than the targets specified in the NSP, are a result of the national push for results that are ambitious enough to deliver on elimination of MTCT. Strategies specified to achieve these targets are: creation of community demand for PMTCT services; capacity building and facility strengthening; primary prevention of HIV in the context of PMTCT; prevention of unintended pregnancies among HIV positive women; prevention of HIV transmission from HIV-infected women to their infants; treatment, care and support for HIV positive mothers, their children, and families; and ensuring increased resources for the National PMTCT programme.

Nigeria has also developed a number of national documents related to PMTCT programme implementation with a view to supporting the expansion and delivery of quality –facility-based PMTCT services. These include national guidelines, scale-up plan, training curriculum, and standard of practice. Many of these have been updated at various times. Specifically, the PMTCT guidelines have been updated in 2005 and 2007 in line with the new WHO guidelines for better programme effectiveness. The major changes include that of moving from single dose nevirapine to more potent ARV formula and also the introduction of the opt-out provider-initiated HCT to replace the opt-in method previously used.

In response to WHO’s recent Rapid Advice on ‘Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants’ (WHO, 2009a) and on ‘HIV and infant feeding’ (WHO, 2009b), and subsequently the generic guidelines 2010, FMOH has completed the process of reviewing and updating the following guidelines: the National Guidelines on PMTCT and Training Manuals (2007); the National Guidelines on Paediatrics HIV Treatment and Care (2008); Training Manuals and SOPs; and Guidelines on Infant and Young Children’s Feeding in Nigeria. The new WHO release advocates initiation of antiretrovirals (ARV) prophylaxis for PMTCT earlier during pregnancy (from 14 weeks), and also involves the use of newer regimen and extended ARV prophylaxis to mothers and infants for the duration of breastfeeding. Progress in adaptation of revised guidelines has been unprecedented. Within one year of release of the guidelines, Nigeria has moved swiftly to adopt the guidelines and to instruct implementation of these guidelines nationally. Guidelines on the integration of reproductive health/family planning and HIV have also been developed.

Programme implementation issues

Nigeria’s national PMTCT programme took off with six tertiary health facilities spread through all the six geopolitical zones. The programme is implemented under the auspices of the then National AIDS and Sexually Transmitted Disease Control Programme (now, HIV and AIDS Division) of the Public Health Department of FMOH. The initial support for the programme was from UNICEF. Subsequently, the Harvard School of Public Health/AIDS Prevention Initiative in Nigeria (APIN) began supporting two additional sites and the Centre for Disease Control and Prevention (CDC) began supporting three sites, bringing the number to 11 by the end of 2003. Expansion from tertiary to secondary facilities with support from the US President’s Emergency Plan for AIDS Relief (PEPFAR) and Global Fund for AIDS, Tuberculosis and Malaria Round 5 contributed substantially to the increase recorded in the HCT coverage of pregnant women. Efforts at the primary health care level supported by some international development partners have shown the positive impact of

community-directed PMTCT and are contributing to expanding access at the grassroots level.

A multi-disciplinary National Task Team on PMTCT was established in 2001 with a mandate to provide technical guidance and support the policy formulation of the FMOH. The team holds quarterly annual review meetings, and was restructured in January 2010 to enhance its effectiveness towards the scaling up of PMTCT services. Following a national symposium on PMTCT as part of the 2009 World AIDS Day celebrations, NACA constituted a National PMTCT Core Working Group with members including FMOH, UN agencies, the United States Agency for International Development (USAID), the Centre for Disease Control and Prevention (CDC) and ICAP. The overall purpose of the working group is to invigorate high political commitment on PMTCT, facilitate development of an accelerated PMTCT operational plan, and to mobilize additional resources.

While the PMTCT programme in the country is four-pronged in principle, in practice it is skewed towards the third element – preventing HIV transmission from a woman living with HIV to her infant – with considerable focus on the use of effective antiretroviral drugs and appropriate obstetrics practice. Specific PMTCT interventions, as stated in the national guidelines are HIV testing and counselling, HIV infant feeding counselling, modification of obstetric practices, administration of ARV prophylaxis to the mother-child pair, and care and support for HIV positive women and their families (PMTCT plus) (FMOH, 2007). These, essentially, are the main elements of the PMTCT activities that have attracted the attention of most HIV actors in the country. A major reason accounting for this development may be that the first two prongs are more preventive in nature, and the accountability for services offered is mostly out of the direct control of the PMTCT team. Such a situation demands strong linkage between the clinically focussed PMTCT team in health facilities and other units such as family planning and other reproductive health services. Unfortunately, such a linkage is either absent or very weak in most places where it seems to exist, and although a framework for integration of reproductive health and HIV has been developed, it is yet to be fully and effectively operationalised.

The result of the national PMTCT programme gap analysis indicates that accelerating scale-up is achievable through integration and decentralization of services from tertiary and secondary facilities to primary health care facilities, increasing access to early infant diagnosis (EID) and ensuring the operationalisation of all the four components of PMTCT programmes. However, the poor state of many of the health facilities is a serious constraint in this respect, and is further complicated by the weak state of the health system. Lacking trained human resources is central in the consideration of the health services factor as it is critical to expansion of services as well as to quality assurance in service delivery. The situation with regards to human resources for health is quite poor and makes quality service delivery at that level a crucial issue. The fact that some of the available PMTCT service protocols designed primarily for secondary and tertiary level of care have not been adapted for primary health care level also poses challenges with regard to the quality of PMTCT services that the primary care level may offer. Limited programming for community-based initiatives, low involvement of the private sector, and weak public-private partnership also limit access to PMTCT services delivery.

Effective community and male involvement in PMTCT are also critical to improving demand generation and support for pregnant women living with HIV. These demands include effective communication, community engagement, and social mobilisation strategy and interventions. Unfortunately, the PMTCT programme has paid very little attention to the issue of community mobilisation and communication, despite the fact that the country has developed a national communication and community engagement strategy in support of PMTCT, which was developed with the support of UNICEF. To address such gaps and improve the access to PMTCT services further, the integrated cluster model is now the advocated approach within the Nigerian PMTCT

programme arena; it involves linkages between a number of PHCs and a comprehensive treatment centre, use of community-support structures such as support groups, and the integration of a number of HIV-related services. The broader national PHC strengthening efforts anchored by NPHCDA, which are already underway, and the integration frameworks already articulated will give a huge boost to efforts to expand PMTCT if the necessary collaboration and linkages are effected.

A PMTCT Management Information System has been developed and has standardized tools while FMOH maintains the central database and provides technical assistance to the PMTCT sites for monitoring and evaluation of the PMTCT activities. However, some international development partners (IDPs) are not using these national reporting formats or report their data to the designated authorities. Monitoring and evaluation is generally rather weak, and a high proportion of sites/facilities do not submit service data to the statutory authority at state and national levels on a regular basis. The PMTCT programme is also experiencing some challenges in terms of quality as some partners plan and undertake their PMTCT activities without recourse to the national plans, protocol, guidelines, or tools. Coordination of donors' support has improved over time, with several coordination forums in operation, but some challenges still exist in that respect particularly at the sub-national level.

Nigeria's PMTCT programme is heavily dependent on external funding with the United States Government's PEPFAR, the Global Fund for AIDS, Tuberculosis and Malaria, and United Nations agencies as some of the leading funding bodies. It is reasonable to expect that the recent global economic crises will impact external aid for Nigeria's HIV programming. For instance, there is already significant 'flatlining' of the USG's support for national HIV programming. Although in the short term the financial support for PMTCT programmes has actually increased, funding shortfalls for HTC and for treatment directly impact PMTCT. Many sites that are supported by funding from the US government are not taking any new clients, but are rather maintaining the existing ones. To address the gaps that are emerging from these developments and at the same time pursue its ambitious target of universal access (80 percent coverage), Nigeria needs to substantially increase its domestic funding for HIV and AIDS programmes even as it continues to build partnerships with various IDPs and strengthen the coordination mechanism for donors' support. Public-private partnership is also critical so as to mobilise significant resources from the private sector.

A number of new opportunities for expanding access to PMTCT are emerging in Nigeria. These include opportunities to reprogramme some funds under the Global Fund to support PMTCT, and initiatives to strengthen the health system through the Health System Strengthening Component of Global Fund Round 8 and the National Strategic Health Development Plan. The Round 9 of the Global Fund will extend PMTCT to 925 PHC facilities. The recently initiated Midwives Service Scheme (MSS) presents also an opportunity for PMTCT expansion. The scheme, anchored by the National Primary Health Care Development Agency at the PHC level, involves deployment of four midwives per PHC in 652 PHCs across Nigeria for two years (2010 to 2011), and offers the potential for expanding PMTCT to PHCs more aggressively and improving quality of service delivery. The MSS is funded by the Millennium Development Goals (MDGs)/Debt Relief Funds, as part of the efforts to accelerate the achievement of MDGs 4 and 5 in Nigeria.

7.7 Paediatric HIV and AIDS in Nigeria

Nigeria has the largest burden of paediatric HIV infections in the world (FMOH, 2007). It is estimated that 90 percent of HIV infections and AIDS-related deaths in children occur in sub-Saharan Africa; Nigeria accounts for about 14 percent of the total sub-Saharan Africa burden. Modelling using Spectrum suggests that 29.1 percent of children born to mothers living with HIV are HIV-infected, while data from the FMOH programme put the figure at 13.1 percent (NACA, 2010c). Estimates from UNAIDS put the number of children living with HIV in Nigeria at 150,000 in 2001 and 200,000 in 2007 (UNAIDS, 2008). FMOH, in 2008, estimated the number of children

(under the age of 15 years) living with HIV to be 278,000 and indicated that 103,080 children need ARV therapy (FMOH, 2009b). Without effective treatment, about 50 percent of HIV-infected children will die before their second birthday and 75 percent before their fifth birthday (Ejembi & Oshin, 2006). Providing effective treatment to children with HIV and AIDS is critical not only for their survival but also for their quality of life.

7.7.1 Analysis of current situation and challenges

There are several challenges and actions faced in terms of policies regarding paediatric HIV and AIDS, and programme implementation issues, as is highlighted below

Policies regarding paediatric HIV and AIDS

Nigeria's policy focus on paediatric HIV and AIDS intervention has been considerably strengthened over time. The revised National HIV/AIDS Policy (2009-2015) and the National Strategic Framework (2009-2015) have far stronger focus on paediatric HIV care than their predecessors. The new policy for example, states that 'To ensure quality in HIV treatment services, government shall ensure the availability of adequate infrastructure, skilled health workers, and effective logistic system to support care and treatment services and ensure uninterrupted supply of drugs and commodities including appropriate formulations for young children at all levels'. The revised strategic framework specifies that 'at least 80 percent of eligible adults (women and men) and 80 percent of children (boys and girls) are receiving ART based on national guidelines by 2015'. NSF projects the proportion of infants who are born to HIV infected mothers to be offered ARV prophylaxis and early infant diagnosis (EID) services to be 25 percent (an estimated 55,575 infants) in 2010-2011, 50 percent (118,065 infants) in 2012-2013, and 80 percent (197,900 infants) in 2014-2015.

Programme implementation issues

The federal government of Nigeria rolled out its ART treatment plan in 2002, with a target of 10,000 adults and 5,000 children. Unfortunately, while the adult treatment component took off then, the paediatric HIV treatment did not commence until October 2005. The number of paediatric ART sites increased to 74 in 2008 (Ejembi and Oshin, 2008). The proportion of ART sites providing paediatric ARV services increased from 20.6 percent in 2007 (NBS & UNICEF, 2007) to about 29.5 percent by 2009. Most of the sites providing paediatric ARV services are in tertiary facilities and donor-supported.

Ten percent of children in need are receiving ART to prevent AIDS and HIV related mortality, a figure not directly comparable to the 2008 baseline (12 percent), due to changes in criteria for treatment affecting the total number and proportion of children in need of treatment. Data on cotrimoxazole prophylaxis and early infant diagnosis are less consistent, and no data exist on infant feeding practice at 3 months. Some states now have some baseline facility and service data, but in the absence of sub national HIV estimates, have not been able to compute population-based coverage baselines.

Nigeria's first draft of National Guidelines for the Management of Paediatric HIV and AIDS was developed in 2003 by FMOH with the assistance of UNICEF. While the final print version of that document was not produced, it provided the template for the inclusion of paediatric HIV and AIDS management in the 2005 guidelines for the use of antiretroviral drugs in Nigeria. The provisions of the guidelines, though a good starting point, were considered inadequate with regards to many aspects of paediatric treatment.

The establishment of a Technical Working Group for Paediatric HIV and AIDS in September 2006 was pivotal in the evolution of paediatric HIV and AIDS treatment in the country. The committee spearheaded the development of the National Paediatric HIV and AIDS Treatment Guidelines in

2007. The content of the document reflects current scientific knowledge and evidence-based practices in consonance with the then available scientific knowledge. It also stipulates the resource requirement and range of services to be provided at the different levels of the health care system. In addition, the guidelines emphasise the need to establish linkages with pre-existing programmes to ensure efficient use of resources. Such programmes include PMTCT, ART, HIV counselling and testing (HCT), home-based care (HBC) for HIV-infected persons, orphans and vulnerable children (OVC), integrated maternal, newborn and child health, and school health. Other important documents that have been developed in support of paediatric HIV care include training curriculum and manuals for different cadres of health workers, and standard operating procedures. The process of developing the paediatric ART scale-up plan was initiated in May 2007.

One of the major challenges with increasing access to paediatric care is the fact that the services are provided mainly by tertiary and secondary facilities in the public health sector. The PHC facilities, which constitute about 85 percent of public sector health facilities in Nigeria, have hardly been involved in paediatric HIV issues, even in the provision of prophylaxis to HIV-exposed babies. This has implications for access to the services, particularly among the poor and in rural areas where secondary and tertiary facilities are usually not available.

Infrastructural challenge is another issue, as paediatric care often requires equipment specific for the age, which are lacking in many health facilities. There are also some challenges with regard to the availability of a good network for sample referral and a results management system that will facilitate appropriate utilization of existing HIV DNA PCR facilities. In general, experience with EID is still limited in the country, and there are challenges regarding the availability of skilled laboratory personnel. Also, laboratory tests for paediatric HIV care are comparatively more expensive than those of adults. Availability of fixed dose combination drugs for paediatric HIV care remains a challenge, although the situation has improved considerably over the years. However, as the report of an interactive forum on national paediatric antiretroviral therapy held in November 2010 indicates, there are also challenges with utilization of paediatric HIV drugs, including the fixed drug combinations, due to poor capacity on the part of health workers to use them. The forum also noted that some success have been recorded in terms of using a 'clinical mentorship' strategy to overcome identified capacity deficits.

Availability of appropriately skilled healthcare workers has also been a challenge with paediatric care, although the use of complementary Integrated Management of Childhood Illnesses (IMCI) attached to the Integrated Management of Adolescent Illnesses (IMAI) training has helped in increasing human resources. With funds from the Round 5 of the Global Fund, Nigeria has been able to train more health care providers of different cadres, including medical officers, nurses, pharmacists, and laboratory workers. Increase in the number of PHC facilities with midwives consequent upon the introduction of the MSS offers the potential to increase the number of service delivery points for paediatric care. The continuous interest of NACA in decentralising programmes and taking them nearer the grassroots level as well as efforts to strengthen the health system as a whole are positive factors that could improve the availability, access to, and quality of paediatric services. Increasing interest in task shifting in the Nigerian health sector also improves the likelihood of expanding services, by involving other cadres of workers such as community health officers and extension workers. Task shifting, if adopted and supported, could prove an important structural element to drive a decentralized scaling up of services. The community component of Integrated Management of Childhood Illnesses (IMCI) and the Integrated Mother, Newborn, and Child Health programme pursued by the federal Ministry of Health also offer opportunities for linkages to improve the community reach of paediatrics care.

7.8 Cross-cutting programming challenges

Gaps in service coverage constitute a key challenge as discussed under each area of focus, i.e.

primary prevention of HIV among young people, PMTCT, and paediatric HIV care. It is important to highlight that most of the existing bottlenecks in HIV interventions in Nigeria are amplified by the need to programme for a very large population size across several tiers of governance, MDAs, and development and implementing partners. The challenges in this respect include:

- The weakness of systems particularly LGAs for stewardship and oversight, PHC infrastructure and health systems, and community systems are constraining geographical expansion and scale of all HIV services – primary prevention, PMTCT and paediatric HIV treatment;
- Where services exist, there are challenges with fragmentation and inadequate integration/linking of facility and community based services – HIV (prevention, HTC, PMTCT, ART) with Maternal, Newborn, and Child Health (MNCH) & SRH services limit uptake and directly impact the quality for women children young people and families served by these services. The government has advanced integration and decentralization as the prioritised strategies for scaling up services;
- National standards exist for all services, however systems for support and oversight of implementation and adherence to these standards are outstripped by demand;
- Effective planning, budgeting and resourcing, and advocacy are hampered by a lack of sub-national HIV estimates, as well as weak data recording, reporting, monitoring and evaluation systems, and data use at all levels.

7.9 Conclusions

Nigeria has made some progress between 2007 and 2009 in the areas of primary prevention of HIV among young people, PMTCT and paediatric HIV and AIDS. However, progress in many areas, while encouraging, fall short of various national targets. The development of a new national policy and strategic framework, which emphasise prevention as a priority approach, provide a platform for greater progress in the future if they are faithfully implemented.

Analysis of the current situation, as presented above, shows that:

- There is broad understanding of the HIV epidemic in Nigeria at national and state levels including the MoT and drivers of the epidemic, and most at risk populations. There is less of an understanding regarding service coverage beyond the general acknowledgement that services are for the most part concentrated in urban areas and at tertiary and secondary levels. Understanding the coverage at sub-national and local levels will require disaggregated data at local levels – both of the population in need as well as of service delivery.
- There is appropriate focus on evidence-based interventions for primary prevention, PMTCT, and paediatric treatment, with recently revised guidelines on PMTCT, HIV and infant feeding, and paediatric treatment, and endorsement of ‘combination prevention’ and national minimum prevention package.
- There is cohesion among the articulated strategies across key policy, planning, and programmatic national instruments, the most important strategy being integration and decentralization. Important work has already started that could fast track implementation of these strategies.
- To attain national targets, implementation needs to urgently go to scale with standard of care as articulated in the national guidelines sustained over time.
- The national HIV response relies heavily on external funds (84 percent), and sustained external aid in the short term as well as dramatically higher domestic financing will be needed to sustain the response and deliver on the national goals for 2011 to 2015.

7.10 Recommendations

Nigeria has several policy documents that provide a clear roadmap for advancing primary prevention of HIV among young people, PMTCT, and paediatric HIV and AIDS services. The NSP, National Health Strategic Development Plan, and National Health Sector Strategic Plan for HIV are especially important in this respect. The NSP has set the targets for the achievement of universal access in Nigeria, and highlights the key activities and specifies the financial resources needed to achieve the targets. The national PMTCT scale-up plan and the national prevention plan, which build on the NSP have further elaborated on mechanisms to achieve set targets and operationalise the scale-up agenda, highlighting key strategies and costing broad groups of activities. Thus, the most important task for the country is to implement the NSP and the related plans faithfully. One of the fundamental issues in this respect is to be able to mobilise the needed resources and invest appropriately in priority activities, track the use of the resources, monitor programme implementation to ensure optimal effectiveness, and strengthen coordination. As such, the efforts of UNICEF and other development partners must be geared toward supporting the realisation of NSP priorities.

The following important issues, among others, deserve attention:

- For all prevention programmes, programming at scale remains an overarching priority. The primary strategies articulated for this are decentralization to local levels and integration. Underpinning successful decentralization and integration is the strengthening of LGA capacities to plan, implement, and monitor programmes at the level closest to communities and the people most in need of services, and ensure accountability and equity in service delivery.
- The opportunity of a well-articulated family life and HIV education programme must be grasped, and the programme taken to scale. Financial and technical resources need to be mobilized to ensure 100 percent implementation of the curriculum; while the complementarity of extracurricular interventions like the NYSC RH/HIV peer education project should be evaluated for possible replication and expansion.
- Planning at the local level will be enhanced by the availability of relevant disaggregated data; the capacity to manage and use disaggregated local data for decision-making and programming is key to effective planning and intervention at the local level. Thus, increased attention must be paid to data generation and utilization issues, and capacity must be appropriately build at the local level in this direction.
- Programming at scale must be complemented by adherence to standards of care (MPP for primary prevention and implementation of new WHO guidelines for PMTCT, HIV and infant feeding, and ART). This adherence should be supported as a priority.
- Paediatric treatment is at a very low baseline relative to other gains in programming in the area of HIV. Exceptional efforts are needed to urgently bridge the gap between coverage of adult and paediatric diagnosis and treatment.
- Strengthening collaboration between different levels and systems, and enhancing the coordination of activities are critical to achieve success in Nigeria's diverse administrative landscape. Effective government leadership and stewardship of HIV and AIDS programmes are required in this respect, with the cooperation and support of all partners. In order to ensure the success of any coordination framework put in place

8. Water, sanitation and hygiene

8.1 Introduction

Nigeria had a population of 140,431,790 in 2006 and with an annual growth rate of about 3.2 percent (NPoPC, 2007a), the population is estimated to be over 159 million in 2010. The country has a total land area of over 923,768 square kilometres with a coastline of approximately 850 kilometres, stretching from Badagry in the west to the Rio del Rey in the east. The climate is humid tropical, characterized by high temperatures and humidity with marked wet and dry seasons, though there are variations between the south and the north. Total rainfall decreases from the coast northwards: the south has an annual rainfall ranging between 1,500 and 4,000 millimetres (mm) occurring mainly between March/April and October/November, and the extreme north has an annual rainfall ranging between 500 and 1,000 mm, occurring mainly between April/May and September/October.

The major rivers in the country are Niger, Benue, Anambra, Cross, Imo, Kwa Iboe, Osun and Ogun which together with many other tributaries drain half the land area in Nigeria. The country has a total surface area of water bodies excluding deltas, estuaries, and wetlands of approximately 14,887,500 hectares or 148,875 km², constituting about 16 percent of the total surface area.

8.2 Water supply in Nigeria

Nigeria is drained by two river systems named the Niger-Benue and the Chad. The Niger-Benue system discharges into the Atlantic Ocean via an extensive delta region. With the exception of a few rivers that empty directly into the Atlantic Ocean (that is, west and east of the Niger Delta), all other flowing rivers and streams drain into the Chad basin or the Niger-Benue system. The two river systems are separated by a primary watershed extending northeast and northwest from the Bauchi Plateau, which is the main source of their principal tributaries. Thus, Nigeria is blessed with a vast expanse of inland freshwater and brackish ecosystems, spreading all over the country from the coastal region to the arid zone of the Lake Chad basin. The country has an estimated surface water resource potential of 267.3 billion cubic metres and an estimated ground water potential of 51.9 billion cubic metres.

About 60 percent of the country is underlain by crystalline rocks of the basement complex, 20 percent is underlain by consolidated sedimentary materials, and 20 percent by unconsolidated sedimentary materials. Static water levels in wells range from zero in parts of the coastal alluvium to 200 meters in the inland sedimentary areas. The ground water quality in the country is generally good, as only about 20 percent of the country is underlain by highly corrosive ground water (pH < 6.5). Cases of high levels of fluoride, nitrate, iron, manganese, and arsenic in ground water are few. There is however the problem of saline intrusions in the coastal areas of the country.

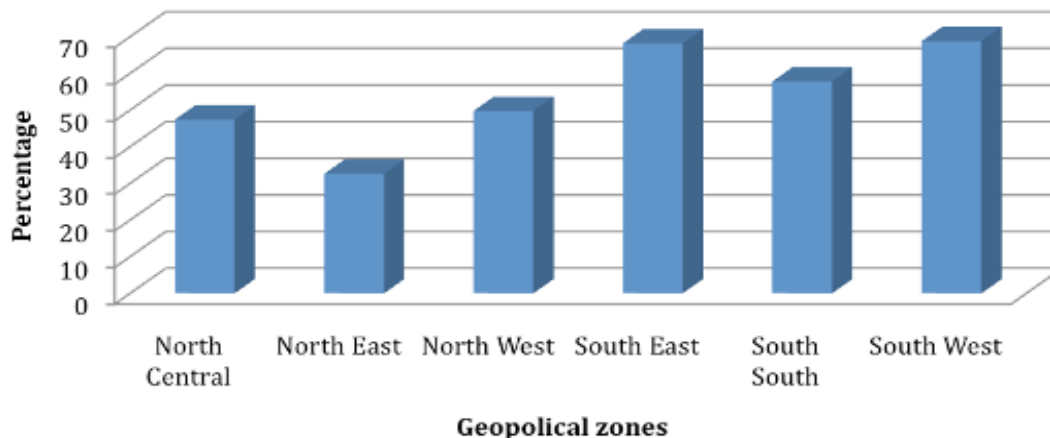
All surface waters except springs require some treatment before use. The cost of developing a surface water source is at least twice the cost of developing a ground water source. Consequently, where there is little capital available, there is a preference for a ground water source. The main sources of water for domestic activities such as drinking, cooking, bathing, and washing are pipe-borne water, borehole, well (protected and not protected), water tanker, rainwater, rivers/streams, and springs.

8.2.1 Access to safe water

In line with the definition used in the National Water Supply and Sanitation Policy (2000), access to water supply is defined in this report as the availability of at least 30 litres of improved, safe water per person per day within 250 metres of the user's dwelling. Sources of such water include pipe,

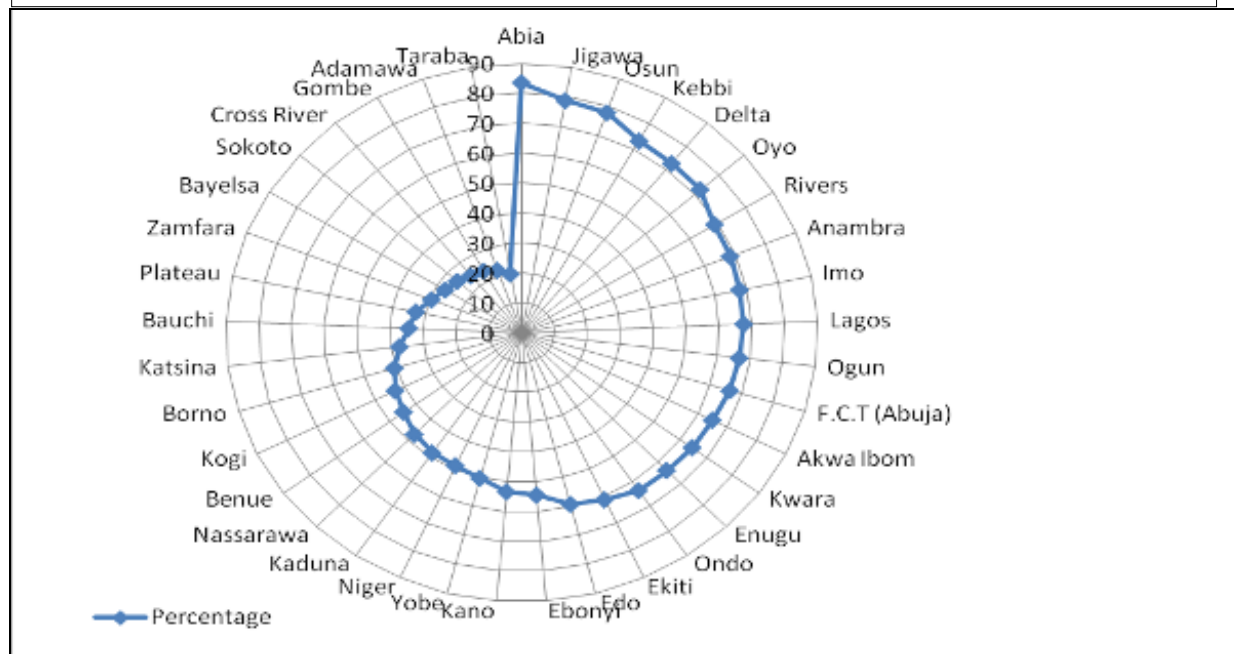
borehole, rainwater harvesting, protected well, and protected spring. Safe water also refers to water that is free of any significant risk to health over the lifetime of consumption. According to the 2008 NDHS (NPC & ICF Macro, 2009), 75.4 percent of the urban population and 43.6 percent of the rural population had access to improved drinking water. The national average was 54.2 percent. There was a regional variation regarding access to improved water sources with the North east geopolitical zone having the lowest access (32.6 percent) and the South west having the highest access (68.8 percent) (Figure 8.1). Similarly, the population with access to improved sources of water varied from 19.9 percent in Taraba state to 83.6 percent in Abia state (Figure 8.2).

Figure 8.1 Access to improved source of drinking water by geopolitical zones



Source: NPC & ICF Macro, 2009.

Figure 8.2 Access to improved water source by state

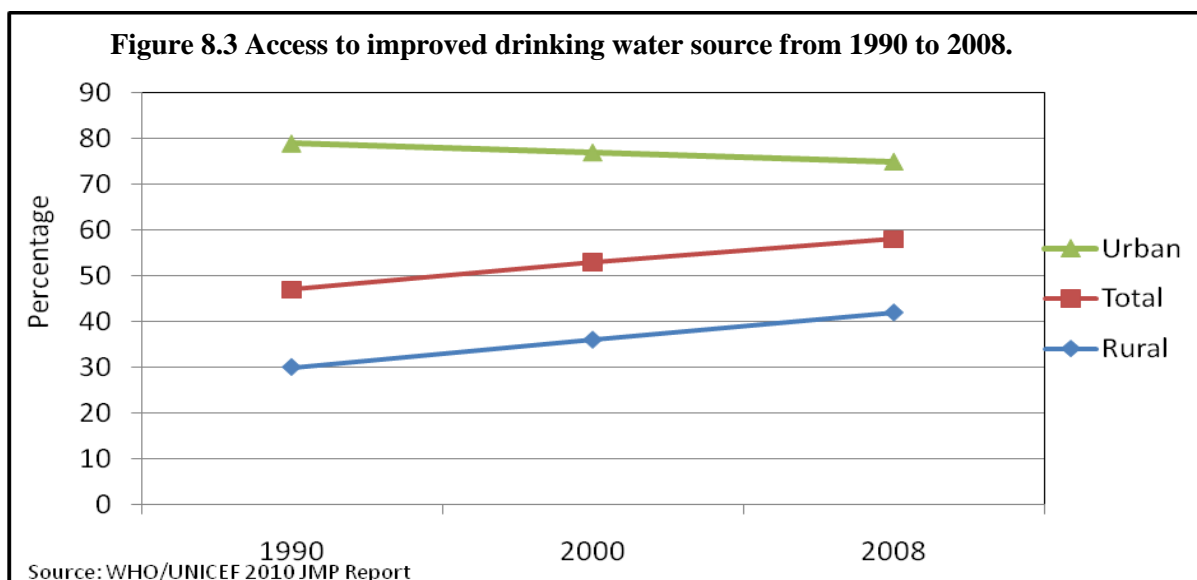


Source: NPC & ICF Macro, 2009

Other sources of data also show a trend in access to improved water sources similar to the findings of the 2008 NDHS. The 2006 Core Welfare Indicator Questionnaire (CWIQ) report found that 65.4 percent of people in urban areas and 41.7 percent of people in the rural areas had access to safe

water (NBS, 2006). The CWIQ report the following year showed that 49.1 percent of the population were using improved sources of drinking water; 75.7 percent of the urban population and 37.4 percent of the rural population (NBS, 2007b).

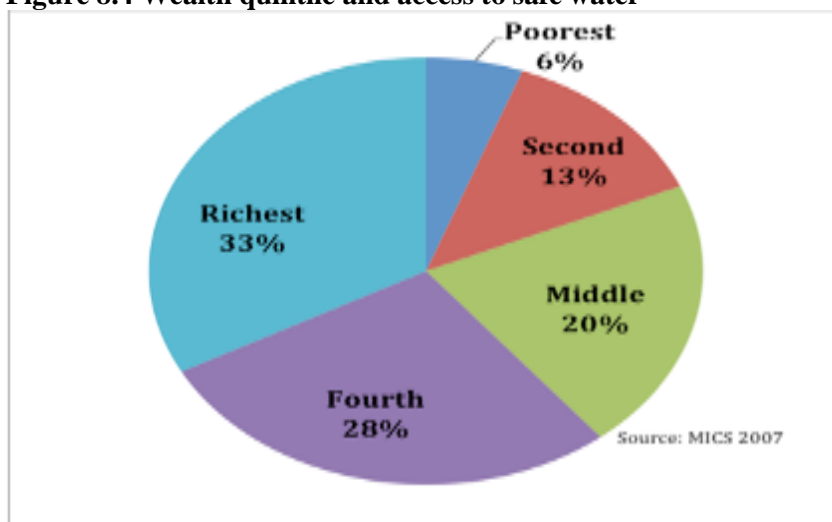
The report of the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP) for 2010 (using 2008 data) estimated that 58 percent of Nigerians had access to improved water sources; the proportion with access was higher in urban areas (75 percent) than in rural areas (42 percent) (WHO/UNICEF, 2010). Compared to the figures reported in previous surveys, figures from both the 2008 NDHS and 2010 JMP reports indicate that there was some progress in access to improved water sources nationally between 1990 and 2008. However, there was a decline in access in urban areas from 79 percent in 1990 to 75 percent in 2008, while access in rural areas increased during the same time period (Figure 8.3). The present level of access in Nigeria is lower than the sub-Saharan average of 60 percent. About 70 percent of those without access to safe water are in rural areas, and in absolute terms there were more people (64 million) without access in 2008 compared to in 1990 (51 million). About one out of five people who use unimproved drinking water in sub-Saharan Africa lives in Nigeria (WHO/UNICEF, 2010).



Some major factors worth noting in the analysis of accessibility to water sources are time spent to obtain the water and burden on who collects water for the households. According to the 2008 NDHS, just less than half (48.8 percent) of the population spent less than 30 minutes (round trip) to obtain drinking water while 25.8 percent had water sources within their premises. Only 23.7 percent of the population spent more than 30 minutes to obtain drinking water. The burden of fetching water for household consumption and other domestic purposes fell disproportionately on female members of the family. About 23.3 percent of adult females compared to 16.1 percent of adult males were usually responsible for collecting the drinking water. Similarly, 4.9 percent of female children compared to 4.2 percent of male children were often saddled with the responsibilities of fetching water for the household (NPC & IFC Macro, 2009).

Access to safe drinking water was disproportionately skewed towards the rich as only 6 percent of people in the poorest wealth quintile had access compared to 33 percent of people in the richest wealth quintile (Figure 8.4) (NBS & UNICEF 2007).

Figure 8.4 Wealth quintile and access to safe water



8.2.2 Drinking water quality

Generally, drinking water fetched from safe sources is often contaminated during transportation and storage, and there is no guarantee that the water will remain safe up to the point of consumption. Hence, household water treatment and storage become very important in improving the quality of drinking water. The 2008 NDHS reported that 85 percent of the households did not treat their water and just about 10.8 percent of the population used appropriate methods including boiling, bleaching, straining, filtering, and solar disinfecting (NPC & ICF Macro, 2009).

The Nigerian Standard for Drinking Water Quality (NSDWQ) was developed in 2007 to replace the World Health Organisation's guidelines and applies to all drinking water in Nigeria with the exception of mineral and packaged water, which are controlled by the National Agency for Food and Drug Administration and Control (NAFDAC) and Standard Organization of Nigeria (SON). Thus all water sources intended for human consumption should comply with the parameters and maximum allowable limits as contained in the Nigerian Standard for Drinking Water Quality. According to the standard, the simple parameter indicators of quality of drinking water that should be controlled on a regular basis through periodic monitoring are: taste, odour, colour, turbidity, pH, conductivity, iron, nitrates, aluminium (for water treated with aluminium compound), residual chlorine (for water treated with chlorine compound), *E.coli* (with 95 percent compliance over a one-year period), and fluoride (SON, 2007).

8.2.3 Analysis

Available information indicates that although access to improved and or safe water supply in both urban and rural areas has been improving over the years, the situation is not yet satisfactory in all parts of Nigeria. The factors responsible for this situation include poor funding, lack of adequate equipment for provision of water facilities, limited managerial capacity, insufficient capacity for operation and maintenance, and the fact that well-developed policies at the federal and state levels are not reflected at the local government and community levels. Governments in Nigeria do not consider adequate supply of potable water as a right, especially for children and women who are mainly responsible for fetching water for household use. Lack of adequate supply of potable water is associated with a high prevalence of water-borne diseases such as gastroenteritis, schistosomiasis, onchocerciasis, diarrhoea, and cholera. The girl-child and mother suffer most as, in addition to higher level of exposure to infection, they often have to take care of the sick members of the family; the girl's attendance and good performance at school may thereby be compromised.

If this situation persists, the MDG targets will not be achieved since the populace will continue to suffer from poor health, limited education, poverty, as well as loss of productive time and high morbidity and mortality. Moreover, lack of attention to local capacity building for sustaining water

supply services, weak planning, poor spare parts supply chain, poor coordination at all levels, and lack of accountability and transparency in the sector are among the other factors militating against the attainment of MDG targets.

In order to address the current situation, it is crucial for decision-makers at all levels to recognise access to safe water as a fundamental human right for all citizens, and in particular for children and women who are often saddled with the responsibility of fetching water for the household and are the most vulnerable to become sick and possibly die from unsafe water. The decision-makers are in a position to provide adequate funds on a sustainable basis for water supply development in addition to approving and implementing key policy documents that are already finalised. There is a need to be more transparent and accountable, set up a functional monitoring and evaluation system for water supply development and ensure the involvement of all key stakeholders from the conception of projects to execution. Moreover, there should be capacity building for CSOs and CBOs, and evidence-based advocacy and sensitization of all stakeholders, and better coordination between line ministries, departments and agencies.

8.3 Sanitation situation in Nigeria

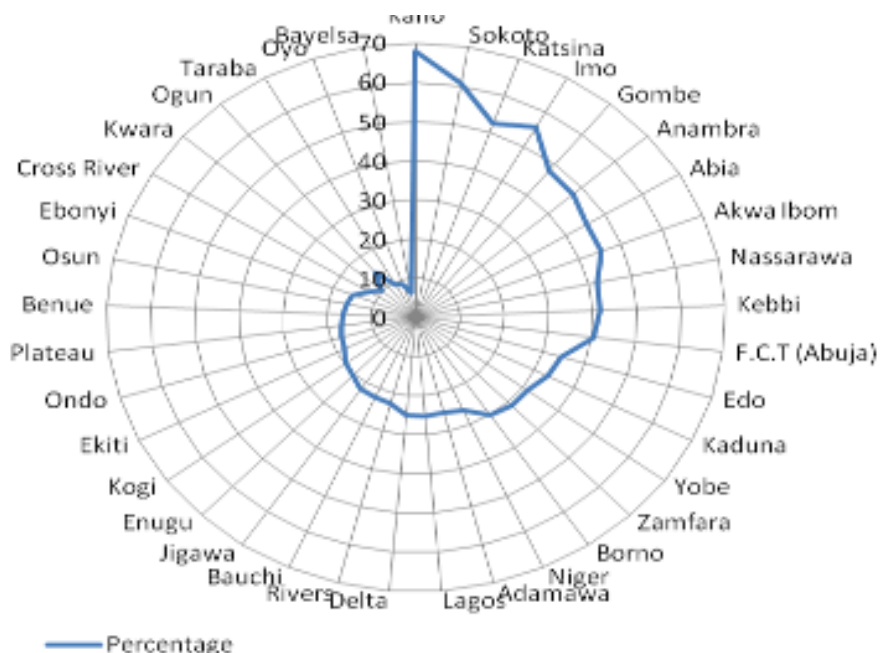
Access to sanitation refers to the availability of facilities for disposal of human wastes that can effectively prevent human, animal, and insect contact with the human wastes. Access to adequate sanitation implies the availability of hygienic facilities at convenient distances for users. Access to safe sanitation means safe disposal of human waste or excreta. Improved sanitation technologies include connection to a public sewer, connection to septic system, pour-flush latrine (water closets), ventilated improved pit latrine (VIP), and sanplat.

Access to sanitation is very important for the woman and girl child who are at risk of being exposed to physical attack or molestation if they have to travel long distances at night or in deserted places to use toilet facilities. Some cases show that poor school attendance of the girl-child especially during menstrual period is attributed to the absence of adequate sanitation facilities in school, and these include situations where girls have to share the same toilets with boys.

8.3.1 Access to safe sanitation

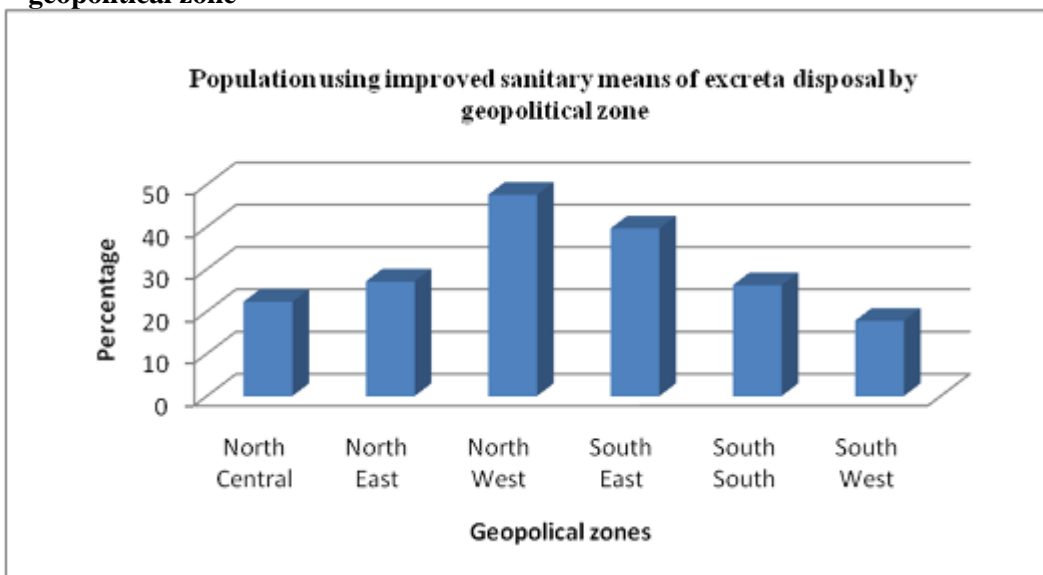
The level of sanitation and hygiene coverage in Nigeria is generally poor. The 2008 NDHS estimated that just about a third (31.2 percent) of the population used improved sanitation facilities with access slightly better in urban areas (37.5 percent) than rural (28.1 percent) (NPC & ICF Macro, 2009). There were also regional and state variations in access to improved sanitation, from as low as 6.4 percent in Bayelsa state up to 67.9 percent in Kano state (Figure 8.5). On a regional basis, the South west geo-political zone had the lowest access to improved sanitation (17.8 percent) while the North west had the highest level of access (47.6 percent) (Figure 8.6). In almost three-fifths of all the states in the country under 30 percent of the population had access to improved sanitation (Figure 8.5).

Figure 8.5 Access to improved sanitation facilities by state



Source: NPC & ICF Macro, 2009

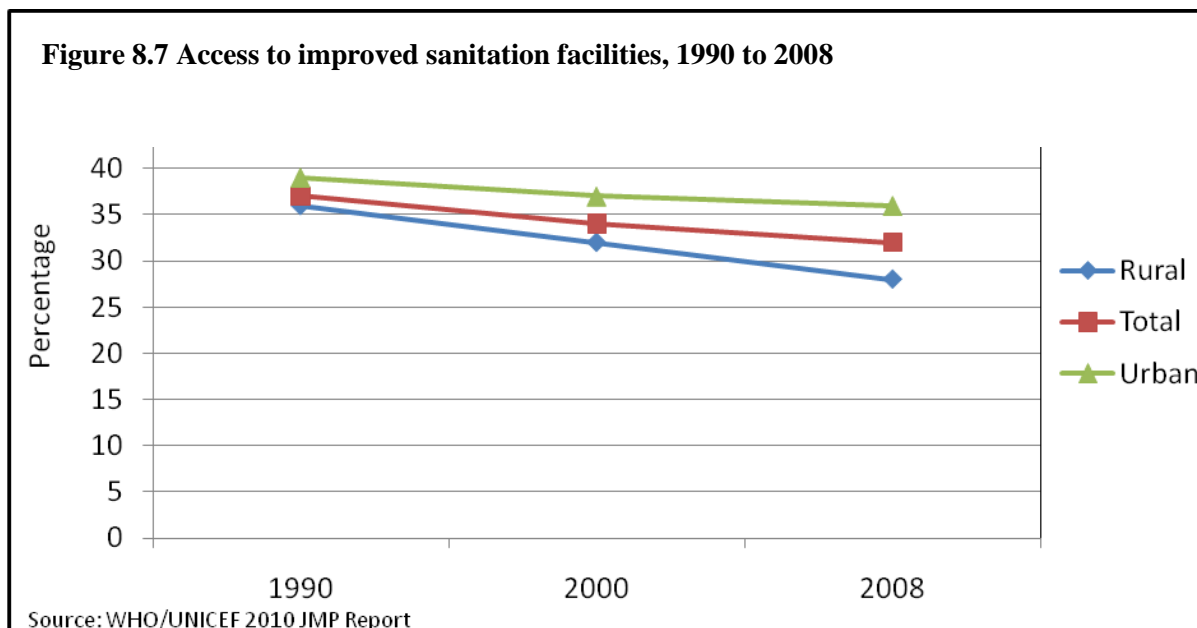
Figure 8.6 Population using improved sanitary means of excreta disposal by geopolitical zone



Source: NPC & ICF Macro, 2009.

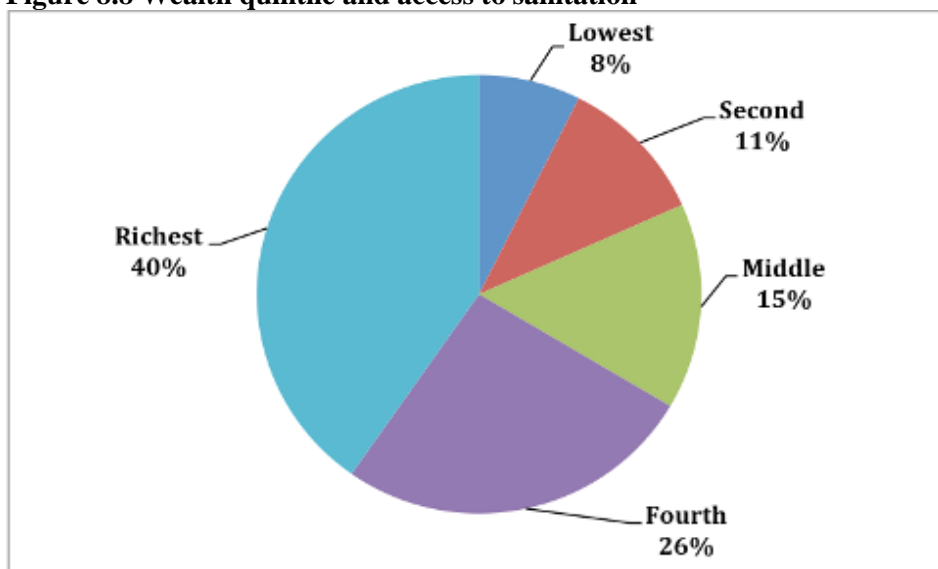
The 2010 JMP report (using 2008 data) estimated the proportion of the population with access to improved sanitation to be 32 percent. Access in urban areas was 36 percent compared to 28 percent in rural areas. About 22 percent of the population practiced open defecation with the majority of those that practiced open defecation being in rural areas. The JMP report indicated a decline in access to improved sanitation from 37 percent in 1990 to 32 percent in 2008 (Figure 8.7). At the current level of access, over 100 million people in Nigeria are without access to sanitation and 33 million people are defecating in the open. Although the sanitation access in Nigeria is low, it is slightly above the sub-Saharan Africa average of 31 percent. One out of five people who use

unimproved sanitation facilities in sub-Saharan Africa reside in Nigeria (WHO/UNICEF 2010).



Apart from geographical disparity in access to sanitation, there is also disparity by socioeconomic class: rich people tend to have more access than the poor. The 2007 MICS reported that the lowest and second lowest wealth quintiles accounted for only 20 percent of access to improved sanitation while the richest quintile accounted for 40 percent (Figure 8.8).

Figure 8.8 Wealth quintile and access to sanitation



Source: NBS & UNICEF, 2007.

There is a need for increased evidence-based advocacy, awareness creation, mobilisation as well as health and hygiene education on the importance of safe sanitation at all levels as this will contribute to the achievement of MDG targets and lead to increased productivity and longevity for the citizenry. The standard practice of the Town Planning Authorities not approving building plans if they do not have provision for adequate sanitary facilities should be resuscitated and strictly adhered to. Specifically, rural dwellers should also be sensitised to desist from using unimproved pit latrines, the bush, or worst of all direct defecation into water courses.

8.3.2 Analysis

The present low coverage of sanitation facilities as presented above is due to a number of factors. Firstly, the traditional attitude to sanitation still subsists, especially in rural areas, which views access to sanitation facilities primarily as a private household affair in which no outsider should interfere. Secondly, many people particularly in rural areas do not always relate poor sanitation to their health. The diseases that result from poor sanitation contribute to poor health, loss of productive time and, in some cases, death. Here again, the girl child is particularly vulnerable, especially in schools where adequate sanitary facilities are not provided. Post-pubertal girls are known to stay away from school during their menstrual period where there are no gender sensitive sanitary facilities, or where the girls are expected to share toilet facilities with boys. Some girls drop out of school completely for these reasons. Invariably, this affects the educational attainment and socio-economic status of girls. In cases where the toilet is far away from the house or does not exist, the citizens, especially women and girls may be exposed to the danger of physical molestation or attack by animals.

It is noteworthy that as a result of advocacy, especially by UNICEF and some other development partners and NGOs, the Federal Ministry of Water Resources (FMWR) has introduced a budget line for sanitation, primarily intended to raise awareness and promote education on sanitation. This is a welcome development that must be sustained by the federal government and adopted by the states and local governments as well as all other stakeholders in the water, sanitation and hygiene (WASH) sector.

Failure to improve sanitation undermines efforts that are made in the provision of water supply. Thus, the provision of safe water supply should be accompanied by adequate provision for sanitation and increased hygiene awareness; otherwise the water will get contaminated as a result of poor sanitation practices. For institutions such as schools and markets, it should be mandatory that no approval should be given for the construction of new buildings if adequate provision is not made for the availability of sanitary facilities. The minimum standard should be one toilet for 40 pupils. For the existing buildings and other structures without adequate sanitary facilities, an ultimatum should be given to concerned individuals or groups on deadlines for meeting the minimum standard.

Another constraint is the weak planning and coordination of sanitation programmes at all levels. The national MDG targets articulated at the federal level are often not translated to implementation at the state, local government or community level. Emphasis should therefore be placed on achieving the MDG targets also at these levels. There is a need for strong advocacy to drive home the importance of good sanitation at all levels and particularly for children of school age. Moreover, addressing the inequality in rural and urban coverage and among different wealth quintiles, as well as the geo-political disparities will have a major impact on several of the MDGs. There should also be the political will to mobilize the required resources to stop open defecation, which represents the greatest sanitation-related threat to human health.

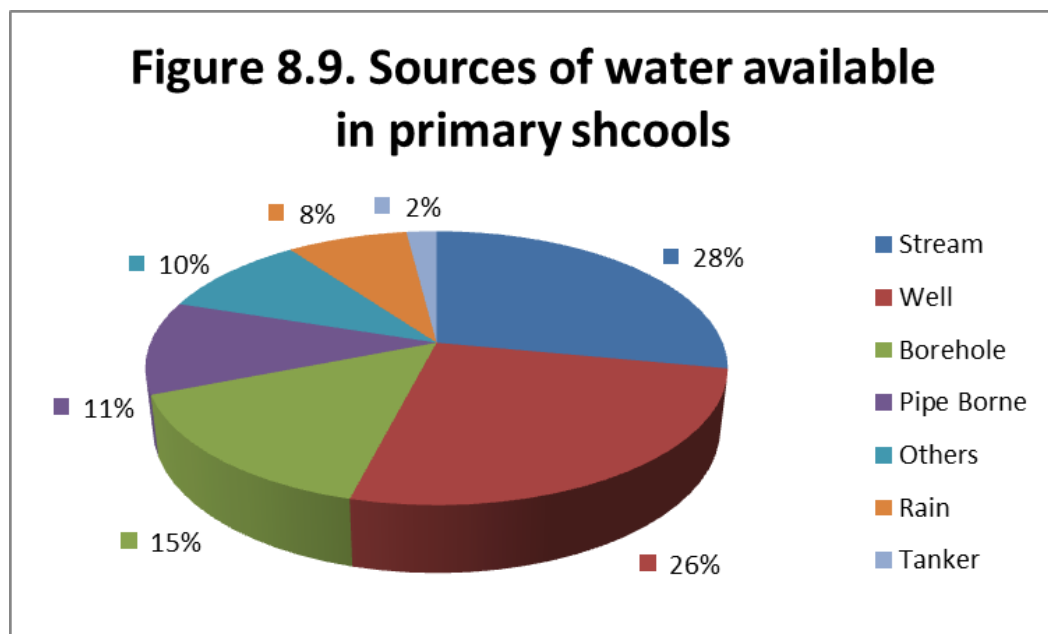
Efforts should be made to scale up successful models such as the Community-led Total Sanitation (CLTS) towards achievement of both national and global targets. The CLTS approach focuses mainly on achieving sustained behaviour change through motivation and mobilization of communities to understand the risks associated with open defecation and take collective actions towards solving the problems. The approach, which is presently being implemented in 30 out of the 36 states, has the potential of contributing significantly to sustained sanitation development in Nigeria. As of June 2010, there were 2,654 CLTS communities and 425 open defecation free (ODF) communities in the country.

8.4 Institutional coverage of water supply and sanitation in schools

8.4.1 Coverage of water supply in schools

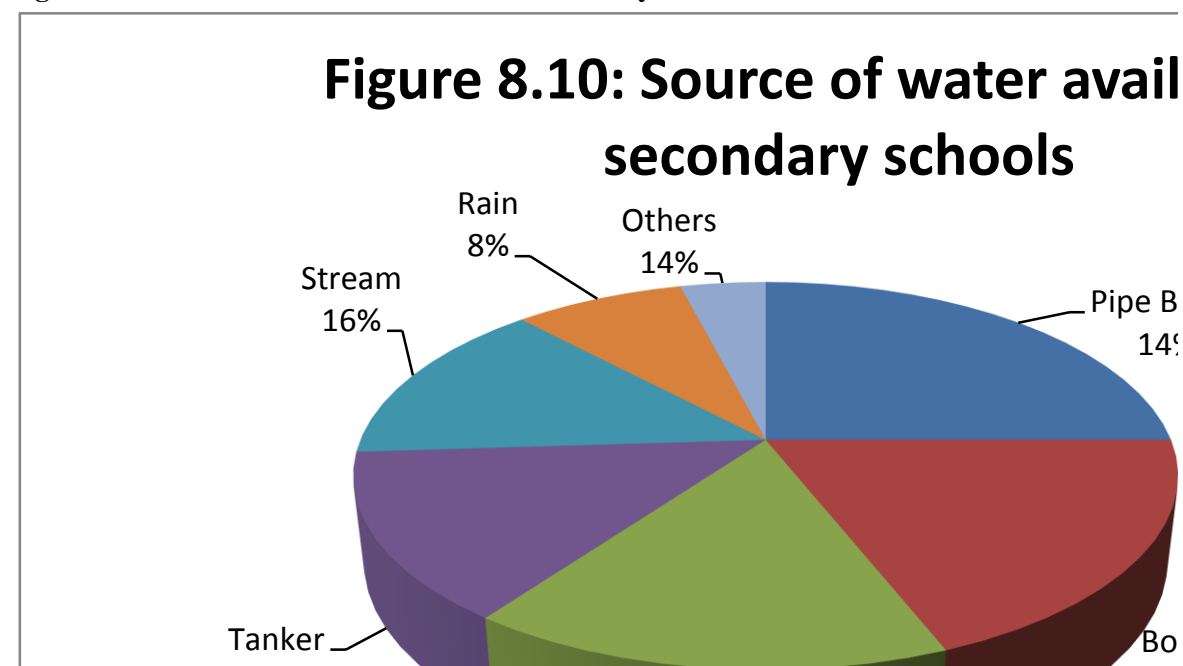
Access to water in Nigerian schools is low. The Basic and Secondary Education Statistics in Nigeria (FME, 2006) reported that about 71.4 percent of primary schools and 60.8 percent of secondary schools had access to water. The main sources of water in the schools included pipe-borne, borehole, well, water tankers, stream, and rain (Figures 8.9 and 8.10).

Figure 8.9 Sources of water available in primary schools



Source: FME, 2006

Figure 8.10 Sources of water available in secondary schools

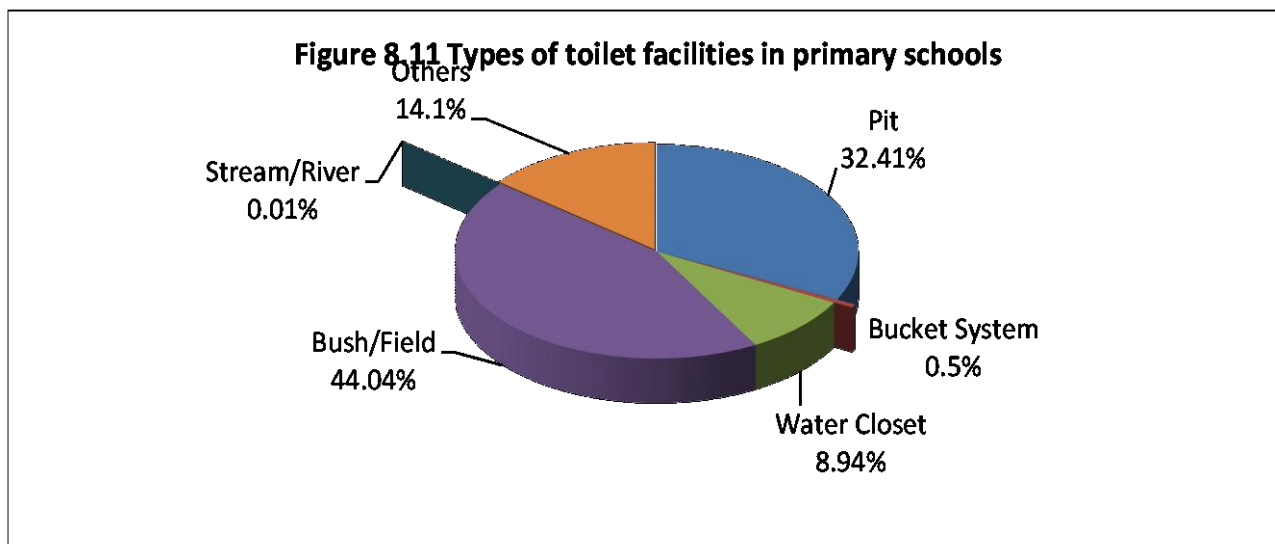


Source: FME, 2006

8.4.2 Coverage of sanitation in schools

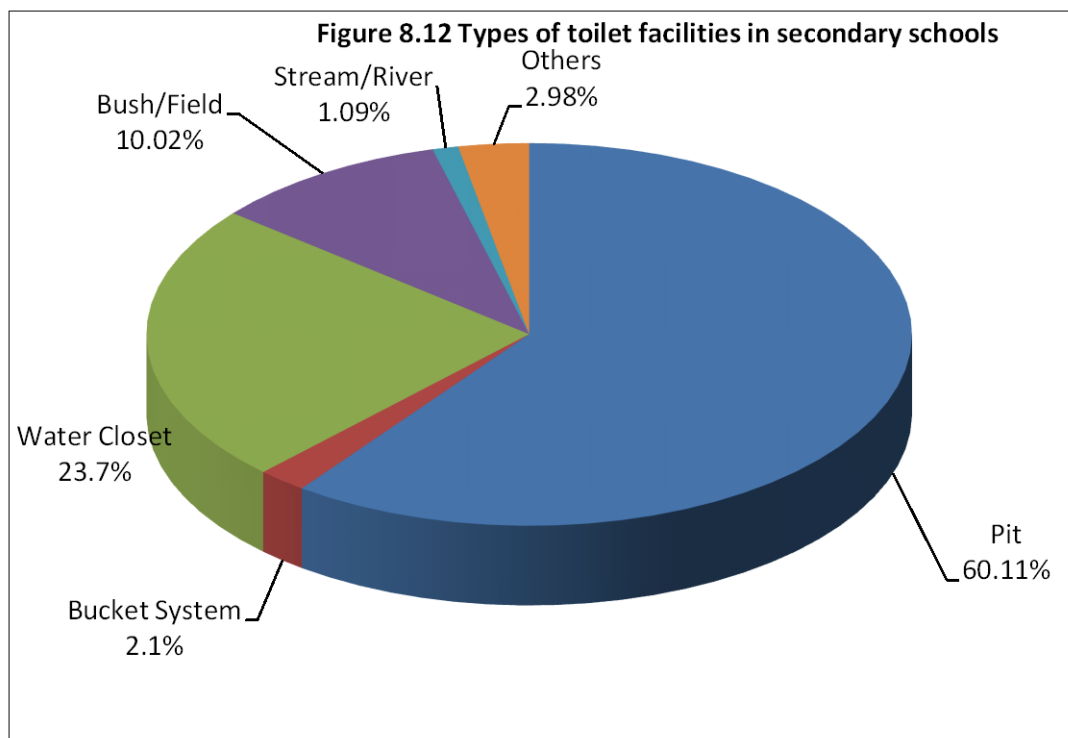
The sanitation situation in schools is presently unsatisfactory. The Basic and Secondary Education Statistics in Nigeria (FME, 2006), from its survey of about 60,000 primary schools across the country, reported that 41.4 percent of primary school pupils had access to sanitation. The technical guide for construction of school sanitation facilities in Nigeria (2009) puts the current toilet to pupil ratio at 1:600 for primary schools and 1:172 for secondary schools. This is very low compared to the standard of 1:30 stipulated in the 2006 School Health Policy developed by the Federal Ministry of Education (FME, 2006). The current figures are also poor compared to the standard specified in the 2009 Technical Guide for Construction of School Sanitation Facilities, which is 1 latrine/toilet cubicle/compartment for 40 pupils (1:40) and 2-user urinals per 1 latrine/toilet compartment (UNICEF, 2010). Moreover, a school should have at least 2 units (1 for boys and 1 for girls).

Figures 8.11 and 8.12 show the types of toilet facilities available in Nigerian public schools (both primary and secondary): 44.0 percent of public primary schools and 10.0 percent of public secondary schools have the bush or field as their 'toilet' facilities. Indiscriminate defecation (in the bush and streams) could be seen as the root cause of faeco-oral transmission of diseases, which significantly affects the health and well being of pupils and teachers. Thus, reduction in open space defecation rates could result in the prevention of diarrhoeal diseases, stunting, and malnutrition, thereby reducing child deaths and morbidity.



Source: FME, 2006

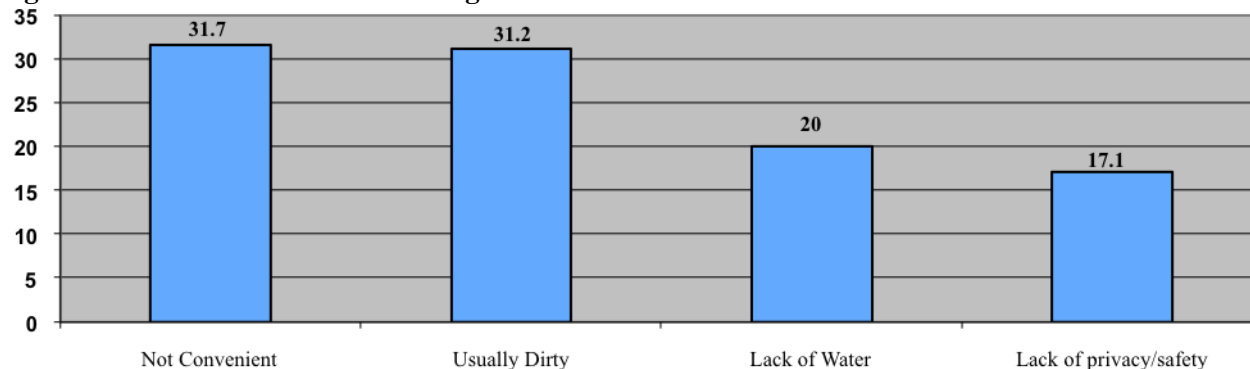
Figure 8.12 Types of toilet facilities in secondary schools



Source: FME, 2006.

The girl child has been found to be the most affected by lack of safe water and sanitation facilities in school, with students trekking up to 2-3 kilometres to collect water for personal hygiene and for the school kitchen (CASSAD, 2003). This invariably affected the time that was spent on actual studies as food was prepared with water fetched by students before classes commenced. In many cases these girls arrived in school after nine o'clock in the morning, after classes might have started. Moreover, when there is not enough water for personal hygiene, the girl child may be forced to go to class without cleaning up. This can make her uncomfortable leading to loss of concentration especially during her menstrual period. In a study among girls in primary and secondary schools, the reasons given for not using school toilet facilities include: not convenient (31.7 percent), usually dirty (31.2 percent), lack of water (20 percent) and lack of privacy/safety (17.1 percent) (Figure 8.13).

Figure 8.13 Girls reasons for not using school toilet facilities



Source: CASSAD, 2003.

The Technical Guide for Construction of School Sanitation Facilities in Nigeria (UNICEF, 2010) reported that availability of safe drinking water, sanitation and good hygiene positively influences attendance and learning outcome in schools. The absence of these facilities has contributed significantly to low enrolment, attendance, and retention in schools in Nigeria, especially among

girls. Promotion of hygiene and sanitation in schools is also essential because schools offer an important point of entry for raising the profile of hygiene and sanitation, as well as improving the environmental health conditions in the communities, since schools are integral parts of their communities. Moreover, children could be effective change agents for hygienic practices, such as washing of hands, using latrines, and maintaining hygienic environments generally in the communities. Moreover, children who adopt good hygiene practices at a young age may not only be able to work as peer advocates but also grow up to be health conscious adults, while transferring the knowledge, skills, and practices to the rest of their peers, families, communities, and the nation at large.

8.5 Health and hygiene status

Recent studies have shown that the health status of the individual will be much improved if good hygiene practices such as hand washing after defecation and before eating are adopted.

8.5.1 Hygiene promotion and education

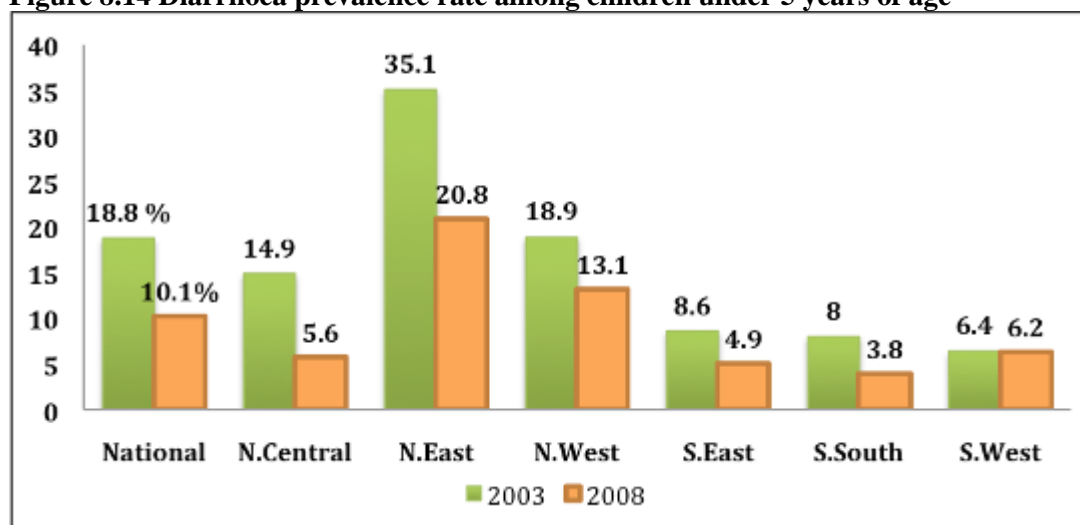
Effective health promotion and education lead to improved public health and personal well-being as well as reduction in diseases such as diarrhoea, guineaworm, onchocerciasis, schistosomiasis, malaria, typhoid, and gastroenteritis. This consequently leads to a reduction in cost of curative health care and improvement in productivity of school children and family members as less time is wasted in seeking health services for treatment of sanitation-related diseases.

Diarrhoea

Diarrhoea is a major cause of morbidity and mortality among young children. Exposure to diarrhoea-causing agents is frequently related to the use of contaminated water and unhygienic practices in food preparation and disposal and handling of children's excreta. Diarrhoea with blood in the stool is indicative of dysenteries or other diseases that need to be treated differently from diarrhoea in which there is no blood in the stool.

The 2008 NDHS reported a diarrhoea prevalence rate of 10.1 percent, which is an improvement over the 2003 figure of 18.8 percent. The rate varies from 3.8 percent in the South south geopolitical zone to 20.8 percent in the North east (Figure 8.14). An estimated 3.84 million diarrhoea cases were reported in 2003 among children under 5 years of age, while 2.59 million cases were reported in 2008.

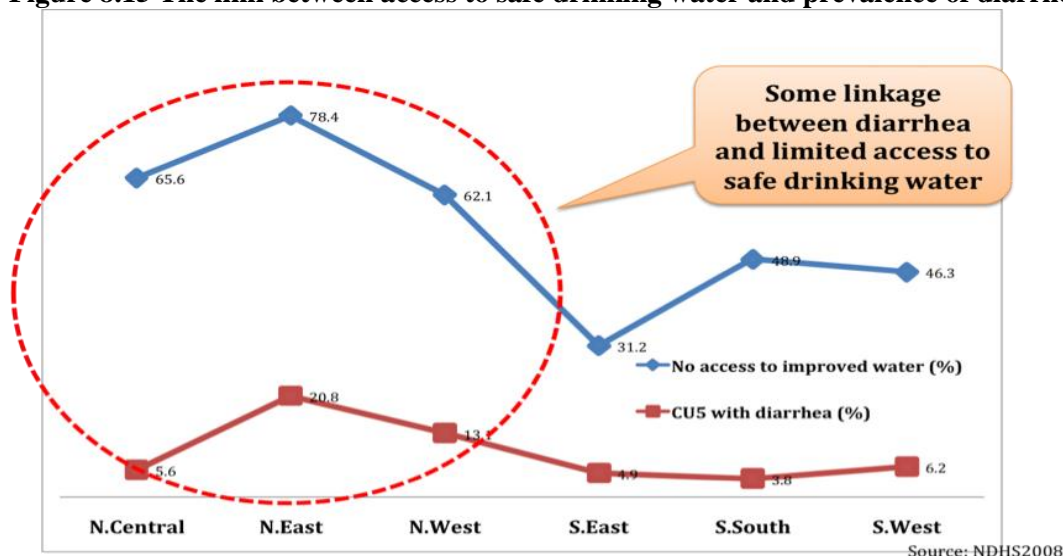
Figure 8.14 Diarrhoea prevalence rate among children under 5 years of age



Source: NPC & ORC Macro, 2004; NPC & ICF Macro, 2009.

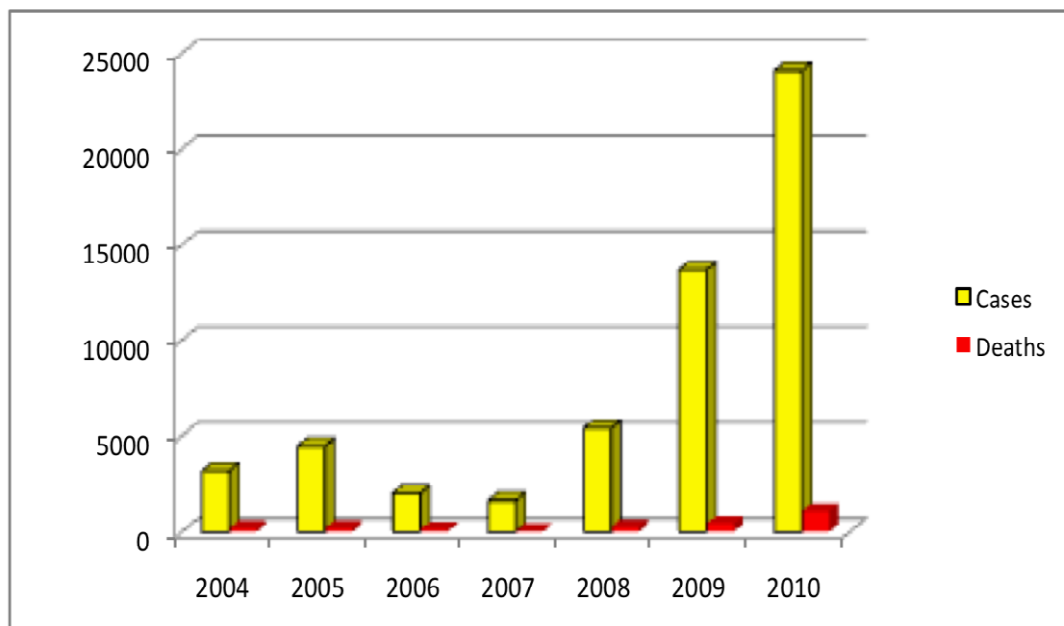
Using the figures from the 2008 NDHS, a link can be established between diarrhoea prevalence rates and access to improved water sources as shown in Figure 8.15. Places with low access to safe water sources tend to have more cases of diarrhoea among children under five years old.

Figure 8.15 The link between access to safe drinking water and prevalence of diarrhoea



There was also an increase in cholera incidence in Nigeria between 2004 and 2010 primarily due to poor sanitation and hygiene practices and inadequate access to safe water sources (Figure 8.16).

Figure 8.16 Cholera in Nigeria



Source: FMOH

Guinea worm (dracunculiasis)

The Nigerian Guinea Worm Eradication Programme started in 1987 with a nationwide active case search. The programme was being pursued at five closely interrelated levels, namely the national, zonal, state, local government area, and the village/community level. Between 1987 and 2005, considerable progress was made towards the eradication of guinea worm in Nigeria, with the disease endemic in only six of the 36 states of the country. The total number of reported cases was 120 in 2005, down from 653,620 cases in over 3,000 villages spread across all the geopolitical

zones of the country in 1987/88. In 2006, the number of reported cases dropped further to 17 cases (Nigeria Guinea Worm Eradication Programme, 2007).

However, in 2007 there was a sharp increase in the number of reported cases of guinea worm infection to 73 cases, which the Guinea Worm Eradication Unit of FMOH attributed to the relocation of people from a prominent guinea worm endemic area to non-endemic areas. Other reasons for the resurgence of the disease include the lack of safe drinking water in endemic communities, who depend on unsafe surface water such as ponds and streams for drinking. In 2008, however, there were only 38 cases reported in five villages. Since November 2008, Nigeria has not recorded any case of guinea worm, a fact corroborated by a specific monitoring mission. Thus, Nigeria is well on the way to be certified guinea worm free. Nevertheless, there is a need to sustain efforts towards the provision of safe water and sanitation facilities as well as the promotion of good hygiene practices to eradicate it completely.

Some of the major agencies that actively support the eradication of guinea worm disease in Nigeria include the Federal Ministry of Health, The Carter Center (Global 2000), Yakubu Gowon Center, WHO, UNICEF, JICA, UNDP/World Bank, CIDA, Canadian Volunteer Agency (CUSO), DFID, and the European Union (EU).

River blindness (onchocerciasis)

This is a water-related disease caused by the filarial parasite *Onchocerca volvulus* and transmitted to humans by species of the black flies (*Simulium*) which breed in river courses. It is a leading cause of blindness globally.

The WHO Progress Report of 2005-2006 indicated that 50 percent of persons treated for onchocerciasis in Africa were Nigerians, where it was hyper- or meso-endemic in 32 states and the Federal Capital Territory. It was estimated that 7-10 million persons were infected including 1-3 million children. The 2008 Nigerian Demographic and Health Survey noted that Nigeria accounted for 40 percent of the 40 million people infected with onchocerciasis worldwide, while more than 32 million were estimated to be at risk of the disease (NPC & OFC Macro, 2009). Thus, these figures made Nigeria the most endemic country in the world.

The FMOH through the National Onchocerciasis Control Programme (NOCP) has been spearheading the control of the disease in Nigeria with the support of UNICEF and a coalition of partners including several NGOs. Under the aegis of the African Programme for the Control of Onchocerciasis (APOC), the NOCP aims to achieve effective control and possibly elimination of onchocerciasis as a disease of public health importance in the country. The major strategy adopted for the control of the disease is the community directed treatment with Ivermectin (CDTI), which entails mass treatment of all eligible persons in endemic communities and seeks to create community ownership of the programme. UNICEF's support for onchocerciasis in Nigeria started in 1991 in four states but has now been extended to cover ten states (Bauchi, Benue, Cross River, Ekiti, Gombe, Niger, Ondo, Osun, Ogun and Oyo). It is estimated that UNICEF support covers a population of 15,115,694 people living in 13,617 endemic communities in the ten states.

The major problem of the onchocerciasis programme in Nigeria is poor and inadequate government funding. Approved budgets are hardly released for effective and timely implementation of relevant interventions. Other problems associated with the programme include inadequate training and re-training of personnel, poor record keeping, insufficient provision of logistics and equipment, weak and ineffective monitoring and evaluation, poor advocacy and mobilisation, and negligible community participation at the implementation stage. There is definitely a need for more funds to be provided for the National Onchocerciasis Control Programme in Nigeria, and the affected communities should be assisted to develop a sense of ownership of the programme for long-term

sustainability.

Schistosomiasis (Bilharziasis)

Schistosomiasis, also referred to as Bilharziasis, is a water-related disease with a relatively low mortality but a high morbidity rate and a severe debilitating effect on victims, especially children of school age. The disease is prevalent in 74 developing countries with more than 80 percent of the infected people living in sub-Saharan Africa. In Nigeria, the mean prevalence for infections with schistosomiasis and soil transmitted helminthiasis ranges from 13 percent to 100 percent across the country (NPC & OFC Macro, 2009).

There is an on-going schistosomiasis control programme in the country and this is managed by FMOH, working through state ministries of health, affected local government councils, and communities. A major way of controlling schistosomiasis is through the administration of praziquantel for treatment of affected persons, accompanied by the creation of relevant awareness on the disease transmission and prevention, mass mobilization, training and retraining, monitoring and evaluation of the affected communities. Some support is provided by some development partners and NGOs, but funding for the programme is still rather low. In 2006, FMOH budgeted only ₦10 million for the programme and only about 10 percent of that amount was eventually released. So far only Global 2000 is actively supporting the schistosomiasis control programme in Plateau and Nasarawa states, involving provision of improved water supply, good sanitation facilities, and effective hygiene education in the affected communities as important control measures.

8.5.2 Analysis

Together, the water, sanitation, and hygiene related diseases constitute a tremendous burden in Nigeria, but can be treated collectively through large-scale integrated programmes that not only use safe and effective drugs and/or management but also focus on preventive methods and interventions. Safe and cost-effective control of these diseases would include provision of safe water, sanitation facilities, and hygiene. Other strategies that could be adopted include creating adequate public awareness to promote enhanced early detection and reporting, containment of cases, treatment of unsafe water sources with the appropriate chemical (temephos), distribution of appropriate water filters to endemic communities (for prevention of guinea worm), and provision of safe water sources and safe sanitation facilities in the endemic villages and villages at risk.

It is an established fact that provision of water supply and sanitation facilities does not automatically and directly translate to appropriate use, absence of diseases, good health, and the well-being of the citizenry. Unhygienic social and unhealthy behavioural practices such as not washing hands after the use of toilet or before eating predisposes people to high risk of contracting water and sanitation-related diseases such as diarrhoea which may eventually lead to death. Good hygiene practice is therefore key to attaining good health and attaining the MDGs. The attainment of the MDGs must be reflected at the community level, with a clear target set in the area of provision of safe drinking water and sanitation facilities as well as hygiene education and promotion. Vulnerable groups like children, girls and women should be made to understand and imbibe the culture of good hygiene practice. The activities supported by UNICEF and other development partners in promoting hygiene, including advocacy and sensitisation as well as provision of relevant facilities, should be sustained particularly at the community and local government levels. To achieve this goal, it will require sustained funding and capacity building through the training of requisite human resources.

The external support agencies (ESA) assisting in guinea worm eradication should not relax their effort after the country has sustained zero-case status for several months; rather, sustained education and monitoring of programme activities should be maintained for at least three years before such

areas can be certified free of guinea worm. Similarly, alternative safe water sources should be provided in communities at risk for transmission of the infection so as to prevent them from having to depend on the use of water from unwholesome sources for drinking.

There is a need for more external support towards the control of onchocerciasis, one of the world's leading causes of blindness. As noted earlier, in onchocerciasis endemic areas the child's right to good health may be compromised in either of two ways: (i) directly as a consequence of blindness, which results from infection to which they are exposed when they go to blackfly riddled rivers to fetch water for domestic use, or (ii) indirectly by poor and irregular attendance at school when they have to stay at home to look after blind members of the family. Definitely, children's schooling abilities and educational development would be compromised when they lose their sight, or when kept away from schooling in order to take care of their blind parents, more so where facilities to take care of the blind are few and far apart.

Children of school age are the most susceptible to schistosomiasis infection because of substantial exposure to surface water through activities such as swimming in infested ponds or streams. Poor sanitation compounds health risk since the agents of infection – the different species of schistosomes – are voided from the urine or excreta of the infected person into bodies of water containing suitable intermediate hosts for the transmission cycle to be sustained. Strong evidence-based advocacy and effective hygiene education and behaviour change communication are needed in the affected communities. Of equal importance is the provision of safe water supply and sanitation facilities. There is a strong need for support from federal, state, and local governments and development partners in the creation of needed awareness and provision of safe water sources. Whereas appropriate hygiene education can bring about the willingness to change hygiene behaviour, for most hygiene behaviours appropriate water and sanitation facilities are needed to enable people to transform intention into positive action.

8.6 Policy issues and reform

8.6.1 Policies, laws and strategic framework

There was no clear-cut policy on water supply and sanitation in Nigeria until the year 2000 when the federal government approved the National Water Supply and Sanitation Policy. There are noticeable shortcomings in the policy, mainly in the area of sanitation as it failed to address some important issues such as health and hygiene education, operational research, efficient and affordable sanitation systems, roles of government and all other stakeholders including funding arrangement, and relevant legislation. Regrettably, the review of the policy has not been finalised by the Federal Ministry of Water Resources (FMWR). Indeed, the new National Water Resources Policy as well as the National Water Resources Bill being put together by the Federal Ministry of Water Resources since 2004 is still at the draft stage. Furthermore, the Water Resources Decree 101 of 1993, the Federal Ministry of Environment (FMENV) Policy and Implementation Guidelines (2005), the Federal Ministry of Education (FME) Nigeria National School Health Policy and Implementation Guidelines (2006) among others, have never really been relied upon by practitioners because of the many contradictions therein.

Similarly, the FMWR in collaboration with the 36 states and FCT, the National Water Resources Institute (NWRI), UNICEF, EU, and the World Bank developed in 2004 the draft National Rural Water and Sanitation Programme Strategic Framework, which is yet to be approved by the Federal Executive Council. However, the FMENV has championed and obtained approval for the 2005 National Environmental Sanitation Policy, which contains broad statements on environmental matters and problems as well as recommendations on how to handle various issues relating to environmental degradation.

Also, the EU supported Water Supply and Sanitation Sector Reform Programme (WSSSRP)

contributed to the drafting of the National Water Resources Bill, with the aim of establishing a new institutional framework for the nation's water resources, defining functions and powers of the institutions, licensing water users, regulating construction and safety of dams, monitoring compliance, and providing dispute resolution procedures. The draft water bill once enacted is expected to replace Decree 101 of 1993/Act 100 of 1999 and other related laws. The EU is also funding WSSRP support to state line ministries to draft state WASH policies.

UNICEF supported FMWR through the National Task Group on Sanitation in 2007 to develop a strategy for scaling up sanitation and hygiene to meet the Millennium Development Goals in Nigeria. The strategy is aimed at streamlining sanitation and hygiene into a common sector-wide approach within the broader national development framework and to promote greater harmonization and effective coordination in programme delivery for maximum benefit and efficiency.

The above-mentioned draft policies aim at addressing strategies for the provision of sustainable water and sanitation to the citizenry. Very often the communities that are directly involved are not part of the development of these policies. Even the few national NGOs that purportedly represent the communities often are not able to express or represent fully the desires and preferences of the various local communities. This explains why many projects that are conceived at the federal and state levels are not sustainable because the communities do not own them. There will be a need to approve and adapt some of the existing policies for easy assimilation and implementation by the communities. Issues such as cost sharing formula and demand-driven approach in delivering water and sanitation services, among others, should be presented in a way that the eventual beneficiaries and the communities appreciate, understand, accept, and willingly implement.

8.6.2 Vision 20:2020

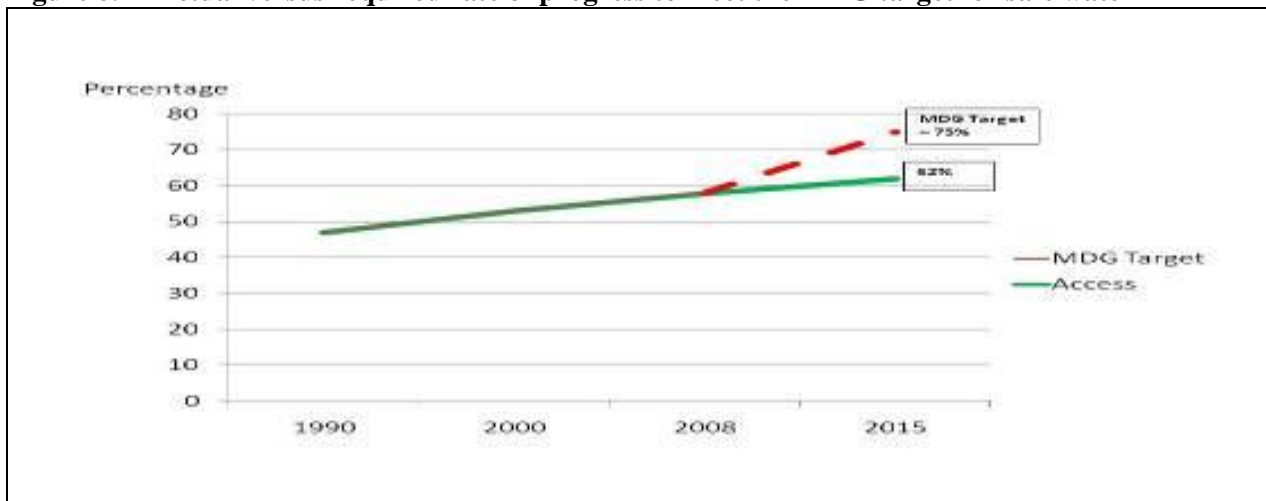
The newly prepared Vision 20:2020 strategy document includes water supply and sanitation among the major thematic areas to be focussed on for Nigeria to be one of the 20 largest economies by the year 2020. This inclusion in the national development agenda would serve as a boost to the sector and could assist the country in achieving MDG targets, while positioning Nigeria among the world's largest economies by the year 2020.

8.6.3 Millennium Development Goals

The Millennium Development Goals (MDGs) represent a renewed commitment to overcome poverty and to address many of the most enduring failures of human development. The MDGs as agreed by the international community in year 2000 comprise of 8 goals, 18 targets, and 48 indicators. Water is interconnected with all the eight MDGs and basic sanitation was added to the list at the 2002 World Summit on Sustainable Development in Johannesburg. Goal 7 of the MDGs is to halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. The MDG targets for improved water sources and basic sanitation for Nigeria is that by 2015, 75 percent of the population will use an improved drinking water source and 63 percent of the population will use an improved sanitation facility. It has been widely recognized that the improvement of water supply and sanitation is a core element for poverty reduction.

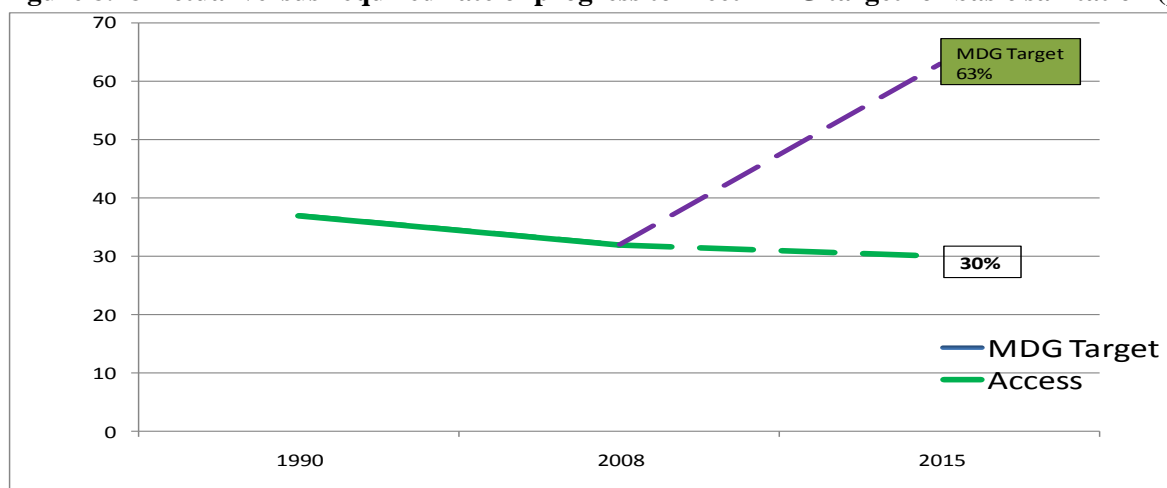
However, the challenge now is whether Nigeria will be able to meet these MDG targets by 2015, giving the low level of funding in the sub-sector and increasing population. Really, going by the coverage data from the latest WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, (published in March 2010), Nigeria is not likely to meet the MDG targets for water supply and sanitation if things continue at the current rate. Nigeria is not on track to meet the MDG target on safe water and if the present trend is maintained, only 62 percent of the population (compared to the MDG target of 75 percent) will have access to improved water sources by 2015 (Figure 8.17). On basic sanitation coverage, the report shows that at the current rate, only 30 percent of the population (compared to the MDG target of 63 percent) will have access to improved sanitation facilities by 2015 (Figure 8.18).

Figure 8.17 Actual versus required rate of progress to meet the MDG target for safe water



Source: WHO & UNICEF 2010

Figure 8.18 Actual versus required rate of progress to meet MDG target for basic sanitation (percent)



Source: WHO & UNICEF 2010

Thus failure to make major strides means that millions of Nigerians in urban and rural areas will continue to be denied their right to access to safe water and sanitation facilities. This negative trend must, therefore, be reversed quickly for the MDG targets to be met. Also, special efforts need to be made including injecting more funds into the sub-sector, effective utilisation of funds allocated to the sector, effective and efficient coordination, as well as greater demonstration of political will on the part of all key decision makers at all levels to ensure increased access of the population to safe drinking water, improved sanitation facilities, and hygiene education. The implication of Nigeria not meeting the MDG targets is that Africa may not also meet her MDG targets, given Nigeria's size and population vis-à-vis the rest of Africa.

8.6.4 Challenges in the water and sanitation sector

The National Policy on Water Supply and Sanitation (2000) clearly advocates the active involvement of the private sector, not only in design and construction of water and sanitation schemes but also in the funding and day-to-day running of these schemes especially for urban areas. So far the progress in this area is rather slow. It is also noteworthy that the document describes water as an economic good, compared to the earlier notion of water as a social service. These are commendable steps, but a lot more needs to be done to translate these innovations into reality.

Another important challenge for the various local communities is to develop an acceptable, simple, and practical system that provides key stakeholders and other actors with the necessary information to make informed decisions. The state and local governments also lack political will and policy reform efforts as well as transparency and accountability in the channeling of financial resources. The coordination, planning, monitoring, and evaluation of WASH activities are poor – for the following reasons: WASH institutions have overlapping mandates, most Local Government Area authorities do not have institutions for WASH service delivery, lack of regulatory framework, presence of political interference in the operations of WASH institutions, weak management capacity, poor technical skills of WASH institutions, and lack of transparency and accountability.

8.6.5 Analysis

Poor access to improved water supply, sanitation facilities, and hygiene in Nigeria could be blamed on poor implementation of health, education, housing and other related policies, low level of awareness about issues concerning environmental sustainability, and the general underdevelopment of the rural areas. This is what the MDGs (among other initiatives) seek to address. Some of the poorly implemented policies include: the 1989 National Policy on Environment; the 1993 Water Resources Decree no. 101; the 2000 Rural Water Supply and Sanitation Policy; the 2000 National Water Supply and Sanitation Policy; the 2007 Draft Nigeria Water Act; and the 2008 National Water Resources Bill. The challenge of these policies is the urgent need for harmonization, coordination, and consistency of policy.

There is a need for strong political commitment at all levels to allocate sufficient resources for the provision of safe water, basic sanitation, and hygiene education. A workable mechanism ought to be developed to ensure that value is obtained for whatever money is allocated for water supply and sanitation projects in Nigeria. Sufficient and persistent emphasis should be placed on the reform in the water supply and sanitation sub-sector.

Under favourable conditions, the development of a ground water source could be cheaper than developing a surface water source. However, there is still the challenge of drilling boreholes in some parts of the country. The challenges include the cost of borehole drilling, local manufacture of equipment and spare parts, local manufacture of drilling chemicals, borehole design, drilling conditions, and good knowledge of the hydrogeology of the area where the borehole would be located. Where available and properly harnessed, groundwater will complement the surface sources and increase access to improved water supply.

8.7 Institutional framework

On the 28th of July 2010, the United Nations General Assembly declared that safe and clean drinking water and sanitation is a human right essential to the full enjoyment of life and all other human rights. The resolution expressed deep concern that an estimated 884 million people worldwide lacked access to safe drinking water and a total of more than 2.6 billion people did not have access to basic sanitation. Studies have also indicated that about 1.5 million children under the age of five die each year and 443 million school days are lost because of water and sanitation related diseases. The Nigerian situation is more precarious, as elucidated in this report. Regrettably, this precarious situation is exacerbated by a weak institutional framework and lack of value and respect for human rights.

8.7.1 Federal level

Under the Nigerian Constitution, water supply and sanitation are responsibilities shared by the three tiers of government. The Federal Ministry of Water Resources is responsible for policy formulation, coordination, planning, and capital investment. The ministry also liaises with all the states of the federation for meaningful progress to be made in the sector. The National Water Resources Institute is responsible for training and research, while the River Basin Development Authorities are

responsible, among others, for planning and developing of water resources facilities for irrigation and water supply. The Federal Ministries of Health and Environment play similar roles in their respective sectors, especially in the areas of sanitation and hygiene promotion. More importantly, there are regular coordination meetings between and among the Federal Ministries of Water Resources, Health and Environment, and the development partners in the WASH sector in order to share experiences and strategise for the future. The recent de-merging of Federal Ministry of Agriculture and Water Resources and re-creation of the Federal Ministry of Water Resources in 2010 have the potential of refocusing attention and attracting more investments for improved service delivery in the sector.

However, the coordination between the federal, state, local government, NGOs, and CBOs is rather weak. As a result, many of the policies and legislative frameworks developed at the federal level are not well assimilated at the state and local governments levels. And perhaps to make matters worse, many of the policies and laws in the sub-sectors are still in draft form, thereby limiting the effective implementation of such laws and policies. Thus there is a need to improve the planning and implementation of the Water, Sanitation and Hygiene Programme at the three tiers of government in Nigeria, while the scaling up of successful pilot programmes should not be constrained by poor funding and frequent change of focus by stakeholders.

8.7.2 State level

Most states have a ministry of water resources, while in some the responsibility for water resources is combined with rural development or the environment. Water supply service delivery for urban and semi-urban areas is the responsibility of state water corporations or boards. State rural water supply and sanitation agencies (RWSSA) are charged with the responsibilities of defining policies and providing safe water, sanitation, and hygiene in the rural areas. There are still some states without RWSSAs established by law who therefore cannot be given budget recognition and regular funding.

Also, most states have poverty reduction agencies through which they fund water supply activities. But in some of the states there are no well-defined agencies that are responsible for sanitation related to waste water. Only Abuja and parts of Lagos enjoy functional sewage plants.

8.7.3 Local government level

The 2000 National Water Supply and Sanitation Policy gave the local government areas (LGAs) the responsibility for establishment, operation, and maintenance of rural water supply schemes in conjunction with the benefiting communities. They also have the duty of establishing and maintaining public conveniences and refuse management. However, in reality the responsibility is split between the Department of Works (water supply) and the Health Department (sanitation) in most cases.

Each local government is expected to have a WASH department or unit to handle water supply, sanitation, and hygiene issues at that level. In most cases those in charge of such units are junior in rank, and are therefore not in a position to exert enough pressure to push through meaningful proposals for the implementation of water and sanitation programmes in their areas of jurisdiction. Apart from non-provision of sufficient funds for their activities, available information indicates that a substantial number of the LGAs have established WASH departments, headed by directors. However, the staffing situation and capacities of these LGA WASH departments are varied.

Also, it has been observed that there is a high turnover rate of trained personnel as many of them, soon after gaining some competence, resign from their positions to set up businesses in the private sector. Some of the trained personnel later on come to the same council to vie for jobs as contractors. One way of reducing the high turnover could be by making the trainees sign a bond to work with the government agency that trained them for a certain number of years before resigning

from their appointment. In the meantime, effort should be made to step up capacity building in the water and sanitation sector so as to have enough trained human resources.

8.7.4 Community level

At the community level, members of the community are encouraged to partake and hold voluntary offices in Water, Sanitation and Hygiene Committees (WASHCOM), which are responsible for management of community WASH facilities. Under the Small Town Water Supply and Sanitation Programme, this approach has been piloted and found to be successful in some states. So far UNICEF has trained a substantial number of personnel on water, sanitation, and hygiene as well as community management to support activities of WASHCOMs in Nigeria.

8.7.5 Private sector

The private sector is still leading in the area of consultancy and construction in the water and sanitation sub-sector. The recent initiatives in Lagos and Calabar have resulted in partnerships between the government and private firms. The lessons learnt from such initiatives can assist in fashioning similar projects in other urban and semi-urban areas of the country.

Also, there is an informal private sector activity involving tanker drivers, pushcart operators, and private borehole owners who sell their water on a commercial basis. In many parts of the country, there are private individuals who remove solid waste from houses using either wheelbarrow or truck and charge their clients on a monthly basis. Also, commercial sanitary facilities are becoming popular in Nigerian motor parks. Very often the activities of informal private sector operators or Small Scale Independent Providers (SSIP) are threatened by state government agencies through imposition of expensive licenses or outright stoppage. Some state government agencies see SSIP as competitors with state government agencies who are supposed to provide similar services. The situation needs to be carefully reviewed.

8.7.6 Civil society organisations/non-governmental organisations (CSOs/NGOs)

Water Aid and Tulsi Chanrai Foundation (TCF) are two of the active international NGOs in the sector, while the national CSOs and NGOs are yet to make significant impact in addressing the issue. There is also Concern Universal NGO operating in Cross River and Ebonyi states. There is a National Civil Society Network on Water and Sanitation (NEWSAN), but so far NGOs' participation in the sector is still very limited and the few of them that are engaged are of limited capacity.

Moreover, the NGOs have no access to relevant data needed for engaging citizens to demand for their rights. Realising the weakness in the capacity of CSOs/NGOs, development partners are building the capacity of these organisations on various aspects of WASH. Currently, the NGOs are being empowered and encouraged to track WASH sector spending and, in turn, empower individuals and communities to demand their rights to safe water and basic sanitation through citizens' action and advocacy. It should be noted, however, that while some of the NGOs focus primarily on water and sanitation, others have water and sanitation only as part of their operating structure.

There is a definite need for strong, active, and credible national NGOs in the sub-sector to support the good work of international NGOs such as Water Aid and TCF. Networks of NGOs working in the sector need support in the area of capacity building, provision of basic office and other operational equipment to facilitate their effective advocacy role in WASH, as well as monitoring WASH programmes executed by different levels of government in their zones.

8.7.7 Community-based organisations (CBOs)

Most communities in Nigeria have community-based associations such as Mothers' Club and others that cater for community needs such as building of churches and mosques, provision of electricity,

provision of scholarships for pupils, road maintenance, and water projects. Existing CBOs need to be educated to see the problems associated with lack of water, sanitation, and hygiene, the effect on the health and time usage of children and women, and indeed the overall effect on the health of the entire community.

8.7.8 External support agencies or development partners

The major development partners who are very active in the sector include those discussed below.

World Bank

The activities of the World Bank in Nigeria are mainly concentrated in urban and semi-urban areas. The Bank, through the Local Empowerment and Environmental Management Project (LEEMP), collaborates with state governments on the development of rural areas in selected states in Nigeria. Water supply and sanitation facilities are among the environmentally sustainable and socially inclusive development priorities being packaged as baskets of projects funded by the bank under LEEMP.

European Union (EU)

The European Union is a major donor in the water supply and sanitation sub-sector in Nigeria. The Small Towns Water Supply and Sanitation Programme in Adamawa, Ekiti, and Delta, had a grant of €15 million (₦2.6 billion) for the period 2003-2008. Under the programme, it is expected that about 500,000 residents of 24 small towns in the three states would be provided with adequate water supply and sanitation. The benefiting communities have to pay at least 5 percent of the construction cost as a sign of commitment.

Also, the EU is supporting the Water Supply and Sanitation Sector Reform Programme (WSSSRP) being carried out in six focal states (Anambra, Cross River, Jigawa, Kano, Osun, and Yobe). The WSSSRP takes into consideration critical legal, policy, and institutional issues in the selected states. It is hoped that if the programme succeeds in the selected states, it will be straightforward to replicate the success in the remaining 30 states and the Federal Capital Territory.

The programme is jointly funded by the EU, the federal government of Nigeria, the six focal states, and the benefiting LGAs and communities. The total value of the programme is €119.63 million, out of which the EU will provide €87 million (approximately N14.4 billion), the three tiers of government and beneficiary communities will contribute €31.43 million, and UNICEF €1.2 million. The programme implementation was from 2005 until end July 2011. The overall objective of the EU-assisted WSSSRP is to contribute to poverty reduction, sustainable development, and to achieve Millennium Development Goals (MDGs) in the six focal states of the programme. More specifically, the purpose of the WSSSRP is to increase access to safe, adequate, and sustainable water supply and sanitation services in the six focal states. Part of the EU support for WSSSRP is implemented through UNICEF to the tune of €29.955 million for the implementation of the programme in the rural areas of the six states. Furthermore, the programme aims at ensuring a balance between water supply, hygiene promotion, and sanitation. Although the take-off of the project was delayed and the pace of implementation reportedly slow, the programme is persisting with reforms in order for all stakeholders to accept and internalise reforms in the areas of water supply, sanitation, and hygiene.

The EU also supported WaterAid with a grant of €899,463 to empower civil society and local authorities for pro-poor and inclusive water and sanitation governance in Bauchi and Plateau states. Furthermore, the EU provided a grant of €2,925,000 to WaterAid to enable the NGO to partner with the governments of Enugu and Jigawa states in 12 small towns. The states and affected LGAs contributed the equivalent of €975,000 according to an agreed cost sharing ratio. At the end of the project 400,000 people are expected to have access to improved water supply while 10,000 persons

should have access to improved sanitation. The EU continues to support water and sanitation through the micro projects in the Niger Delta/oil producing states (MPP3, MPP6 and MPP9).

Concern Universal, another NGO, received a EU grant of €712,276 in Cross River state. The project targeted 80 communities in Bekwara, Ikom, Obudu, and Obanliku LGAs and aimed at construction and rehabilitation of 148 boreholes and 12 spring-water points. Under the programme, WESCOMs/WASHCOMs were formed and trained, sanitation centres were established, 320 demonstration sanplat latrines were constructed, and 200,000 people were exposed to better environmental health and sanitation.

Under the Integrated Rural Water Supply and Sanitation Project (2006 – 2009), the EU provided a grant of €491,583 (over N80 million) to Concern Universal for the construction and rehabilitation of water points in 80 communities in Cross River and Ebonyi states. The project aimed at improved hygiene and sanitation practices for 144,000 people. In addition, the project developed the communities' organisational capacity for management of rural water and sanitation systems through establishment and strengthening of WESCOMs/WASHCOMs.

Another grant of €864,611 was provided to Concern Universal for a sustainable WASH project in 4 LGAs in Ebonyi and Cross River states (2009-2012). Fifty rural communities with about 80,000 beneficiaries were targeted. The specific objective is to increase access to safe water and improved sanitation, and to increase improved hygiene practices in 50 communities in Yala and Ogoja LGAs (Cross River state) and Izzi and Ikwo LGAs (Ebonyi state).

United Nations Children's Fund (UNICEF)

UNICEF is a major player in the WASH sector in Nigeria with a total budget of \$89.7 million for the period 2009-2012. UNICEF is currently active in all the 36 states of the Federation and FCT working in partnership with states, local governments, communities, NGOs, and CBOs. The water, sanitation and hygiene programme, under the FGN and UNICEF Country Programme Action Plan (2009-2012), aims to increase access to safe water sources, hygienic practices and improved sanitation especially in the rural areas and among vulnerable populations. The programme has three components: policy and institutional environment, water supply, and sanitation. The key targets of the programme are: (i) an increase of 5 percent in the proportion of the population in focal states with access and use of improved water sources (based on the 2007 baseline); (ii) an increase of 3.5 percent in the proportion of the population with access to and use of improved sanitary and hygiene facilities (also based on 2007 the baseline); (iii) that an additional 800 schools have safe water sources and sanitation facilities; (iv) adoption of sustained behaviours for water, hygiene, and sanitation in 2000 communities; and (v) that Nigeria becomes certified dracunculiasis-free. Moreover, community management of water and sanitation programmes will emphasize greater participation of women, while capacity development for emergency management agencies will be undertaken to ensure rapid access to safe water for internally displaced persons and all victims of emergencies.

UNICEF is collaborating with the Government of Nigeria, bilateral and multilateral partners, and other United Nations agencies. Such partners include the EU, Rotary International, the Government of Japan, the Red Cross, USAID, WHO, the Canadian International Development Agency (CIDA), the World Bank, the Government of Netherlands, and the Swedish International Developmental Agency (SIDA). The country programme is also being implemented by line ministries, departments, and agencies (MDAs) and other national and local partners.

Department for International Development (DFID)

DFID is a major development partner supporting WASH programmes in Nigeria. DFID is presently supporting the £20 million Sanitation, Hygiene and Water in Nigeria (SHAWN) project being

implemented by UNICEF in four states (Bauchi, Jigawa, Katsina, and Benue). SHAWN focuses on accelerating access to safe excreta disposal in targeted rural communities in 12 LGAs across the four states, while simultaneously promoting hand washing practices and ensuring access to safe water. Success of the project is expected to lead to LGA-wide approach being adopted for accelerating access to WASH services in other LGAs and states. The five-year project, which commenced in March 2010, will end in March 2015. It is anticipated that not less than 1.9 million people (480,000 in each of the four states) in the rural areas will be direct beneficiaries of the project. DFID has earlier supported UNICEF with £19.4 million to implement WASH projects in Ebonyi, Enugu, Benue, Ekiti, Kwara, Jigawa, Zamfara, and Borno states from 2002 to 2009. WaterAid also received support of £240,000 from DFID for its WASH activities in Nigeria up to year 2008.

Japanese International Cooperation Agency (JICA)

JICA's support is primarily aimed at providing water to rural communities in selected states. The strategy is to provide drilling rig, drilling materials, and hand pumps for the drilling and installation of productive boreholes along with technical training to staff of Rural Water and Sanitation Agency (RUWASA), LGA WASH Unit, and WASHCOM. JICA partners with RUWASA in the three states of Oyo, Kano, and Yobe. The Oyo project that started in 2002 covered eradication of guinea worm and water supply and is now completed with the drilling of 100 boreholes. JICA provided two drilling rigs in addition to drilling materials and hand pumps together with technical training to RUWASA at a total cost of ₦700 million. In addition, JICA supported human resources capacity building to target LGAs and communities. The Kano project started in 2006 and included water supply and sanitation, human resources capacity building, provision of a drilling rig, drilling materials, and hand pumps for drilling of 240 boreholes fitted with hand pumps. The budgeted cost of the Kano Project was ₦380 million. In-country training was conducted in the 2007 – 2009 period. The Yobe project started in 2008 and had similar components as that of Kano state, with a total budget of ₦253 million. It had a target of drilling 89 boreholes. Additionally, JICA was supporting in-country training for about 500 people including RUWASA staff, LGAs' WASH units, and WASHCOMs with the total budget of ₦17 million for the year 2008 – 2010. Beyond these three states, JICA is also providing resources for implementation of WASH activities in Katsina and Bauchi states to the tune of ₦755 million, and for enhancing the function of the Rural Water Supply and Sanitation Centre for capacity development in the National Water Resources Institute, Kaduna (₦830 million for 2010-2013 activities).

African Development Bank (AfDB)

AfDB has contributed substantially to rural and urban water supply and sanitation development in Nigeria. Some years past, the Bank was the leading contributor to urban water supply, though with little attention to sanitation. Today it has on-going programmes on rural and urban water supply and sanitation whose overall objectives are to increase access to safe water supply and sustainable sanitation, thereby contributing to the achievement of the national target of 75 percent access by 2015 and 100 percent access by 2020.

AfDB in 2007 provided Unites of Account (UA) 51 million (or approximately US\$77 million) for rural water supply and sanitation in Yobe and Osun states. The programme has three main components:

- Infrastructure provision including construction and rehabilitation of water and sanitation facilities. This will affect selected schools, health centres, markets, and public places.
- Community development, including moving communities to participate in design and construction as well as strengthening their capacity to operate and manage the installed water and sanitation facilities. The programme also involves the development of a comprehensive action plan, training and promotion of good hygiene behaviour, and at the federal level

popularisation and advocacy of the sector policy on Rural Water Supply and Sanitation (RWSS). Finally, institutional support is provided at various levels to ensure long-term sustainability of the sector, also for the private sector and NGOs through the provision of operational equipment and training of staff.

- Programme management provision to ensure smooth implementation through technical assistance, project supervision, and consultancy services. This to prepare baseline studies, operating costs, audit, impact assessment studies and research on appropriate strategies, tools and technologies, monitoring and evaluation as well as human resource development and participatory assessment of institutions' capacity, role and mandate especially in the area of public-private partnership (PPP) for hygiene promotion.

Ultimately, the programme will improve the quality of life of the rural poor and reduce the incidence of water and sanitation related diseases by accelerating the provision of safe water supply and adequate sanitation facilities.

AfDB has also provided a loan for Urban Water Supply and Sanitation (UWSS) for Oyo and Taraba states, with focus on three main components: (a) infrastructure provision (b) institutional reform and capacity building, and (c) project management. Relevant activities also focus on selected schools, health centres, markets and public places. The programme includes water resources and climate change studies. The AfDB loan for this programme is UA50.0 million (or \$77.0 million) to Oyo and Taraba states (with Oyo providing \$9.93 million and Taraba \$3.65 million) to improve access to safe water supply and hygienic sanitation services in the cities of Ibadan and Jalingo. The objective is to raise the level of safe water supply from about 30 percent in Jalingo and 25 percent in Ibadan to 80 percent by 2014, through rehabilitation and extension of the existing infrastructure. It will also improve sector management, overall performance, and long-term financial viability of urban water supply agencies in the two states through institutional reform and capacity building. The project was expected to start in September 2010.

In the recent past, AfDB has provided loans in excess of \$200 million for water supply to Akwa Ibom, Cross River and Oyo states, and to the FGN for the construction and equipment of six Reference and Regional Water Quality Monitoring Laboratories in each of the six geo-political zones of Nigeria. AfDB also provided, in the not too distant past, loans for water supply to Bauchi state township, Anambra, Niger, Plateau, Edo, and Delta states in excess of \$500 million.

WaterAid Nigeria (WANG)

WANG works in six focal states (Bauchi, Benue, Ekiti, Enugu, Jigawa, and Plateau) to promote increased and equitable access to water sanitation and hygiene. WANG works through partners to deliver its projects at the local and community levels. These partners include LGAs and civil society partners who are the direct implementers of service delivery. There are currently 46 projects being implemented by WANG partners across 22 LGAs at state and community levels.

WANG is currently in partnership with the National Water Resources Institute (NWRI) to spearhead and promote rope pump technology for rural water supply. This is currently piloted in Bauchi and Plateau states. Small town water supply schemes are implemented by WaterAid in six selected small towns each in Enugu and Jigawa states with support from the EU Water Facility Action.

WaterAid is one of the pioneering promoters of community-led total sanitation (CLTS) in Nigeria as the most viable option for achieving large-scale rural sanitation in communities across the country. The approach has been introduced in all local governments that WANG works with through locally based facilitators and community 'natural' leaders. WANG is also supporting partners to lead in the designing and piloting of community-based hygiene promotion techniques.

WaterAid is a member of the National Task Group on Sanitation together with relevant government ministries, departments and agencies, media, civil society, and UNICEF. The task group presently functions as a coordinating body for the promotion and streamlining of sanitation interventions in the country.

A fundamental component of WANG's governance programme is working with civil society organizations at state and community levels, and through networks to inform local people about their rights to water, sanitation, and hygiene education, and empower them to have a voice and engage effectively with duty bearers at local and state level. At a higher level, WANG seeks to identify, grasp, and create opportunities for partnership and collaboration to best amplify the people's voice. This includes working with the media and other sector stakeholders. WANG desires to influence sector practice and policy towards ensuring equitable and increased access to water, sanitation, and hygiene for all. WaterAid's innovative approach known as Localizing the MDGs Initiative (LMDGI) is the primary tool for delivering improved accountability and good sector governance. It is premised upon two factors; local development plans and citizen's engagement. Local development plans include LGA profiles of existing WASH and other relevant facilities as well as cost projections over 5 years. This is a comprehensive planning document to guide resource allocations and target interventions in a demand driven and equitable manner. Citizen's engagement refers to a participatory and inclusive interface between community members and duty bearers for mutual accountability and performance assessment.

In its programme delivery, WANG adopts a modelling approach to research, and develop and deliver projects based on a few selected features. The projects are expected to be replicated and taken to scale by government and other actors for wider access for the population. Key concerns for WANG are that programmes should be:

- Equitable and inclusive: access for all, including the poorest and most vulnerable groups.
- Sustainable: promoting durable structures as well as community participation and ownership at all stages from conceptualization to decision making, design, planning, implementation, monitoring and evaluation.
- Cost effective and affordable: interventions are to be based on low cost and the most appropriate technology options that are locally resourced.
- Replicable and applicable to a wide range of local contexts.

In order to effectively and efficiently achieve this, WaterAid supports the development of sector capacity through direct training and capacity building of partners and member organizations and by researching, documenting, and sharing learning and best practice. This also involves working with and through sector institutions and structures to develop and strengthen systems for effective service delivery and sector governance.

WaterAid delivers its programmes in Nigeria through local implementing partners that are fully representative of the areas in which they work. In a bid to deepen this engagement and further position the organization more strategically, WANG recently closed down their state programme offices through a restructuring process. Partnership agreements were entered into with key CSO networks in the partner states who would not only implement activities but also represent WaterAid at the state level linking closely with the country office in Abuja. This approach is to further increase capacity of these networks as well as to reduce administrative and overhead costs of programme management and increase overall programme efficiency.

Tulsi Chanrai Foundation (TCF)

Tulsi Chanrai Foundation is partnering with UNICEF, government, and other agencies to establish systems for Village Level Operation and Maintenance of Hand-pumps (VLOM) in Nigeria. The

NGO had earlier partnered with UNICEF in establishing systems for and rehabilitation of hand pumps in 11 states of the country. This also involved developing the capacity of WASHCOMs, training of local area mechanics, and establishment of spare-parts supply chain. Apart from UNICEF, TCF also partners with other organizations such as TY Danjuma Foundation. TCF's Water Program rehabilitated 1,200 hand-pumps in 11 states, providing safe water to over half a million people and reducing the burden on women and children formerly tasked with fetching unclean water at the expense of education and other work. The communities own and maintain these hand-pumps with the help of local mechanics trained under TCF's programme and who are linked to a supply chain for spare parts and tools.

8.7.9 Analysis

Development partners have encountered a number of challenges in executing WASH programmes, including lack of security; weak infrastructural development such as telephones, power supply, and public water supply; lack of a reliable national database; unclear policy framework; and limited consultancy capacity.

Also, the participation of CSOs and NGOs in the sector has remained limited as most of these organisations have weak capacity. The constraints include lack of technical knowledge on WASH, participation, inclusion, and equity principles. Another challenge is the inaccessibility of public sector WASH officials (especially at the local government level) and decision makers, and weak political commitment that manifest in, among other things, low financial commitment in terms of counterpart funding.

Other challenges include ineffective monitoring and evaluation of projects, insufficient funds or non-release of counterpart funds by the LGAs, inadequate coordination between stakeholders and problems in scaling up of projects to new areas. In general, the funds budgeted and released for water supply and sanitation by the three tiers of government are not sufficient to meet the current challenges in the sub-sector, let alone achieve the MDGs. There is also lack of reliable management information for accurate planning in the water and sanitation sub-sector.

Although the Nigerian constitution provides for the local governments to handle water supply and sanitation in their areas of jurisdiction, they are often hindered because of the Joint Account System (JAS) operated by the LGAs and their state governments through which funds meant for the former are controlled by the latter. Consequently, the LGAs are not in a position to fund their WASH programmes as expected. The local government should be the focal point for achieving the MDGs, especially Goal 7.

In addressing some of the challenges, the roles and responsibilities of all stakeholders in the sub-sector should be very clear. Participation of the private sector at community and local government levels should be encouraged. For instance, the activities of small-scale independent providers (SSIP) should not be suppressed with expensive licenses or outright stoppage of their activities by government. Government agencies responsible for monitoring their activities should encourage them by guiding them on provision of safe water and sanitation, rather than stifling them with heavy penalties or demanding huge sums of money for registration. Also, both the government and the external support agencies should support the local NGOs in the sub-sector so as to enable them to complement the good work being done by the development partners and international NGOs.

Broadly, the main lessons learned include: (i) project results are better where there is good awareness, mobilisation, and capacity building, (ii) good coordination with the government and other stakeholders increases the potential for success in project execution, and (iii) coordination meetings between and among development partners is good for sharing experiences and avoiding duplication of efforts.

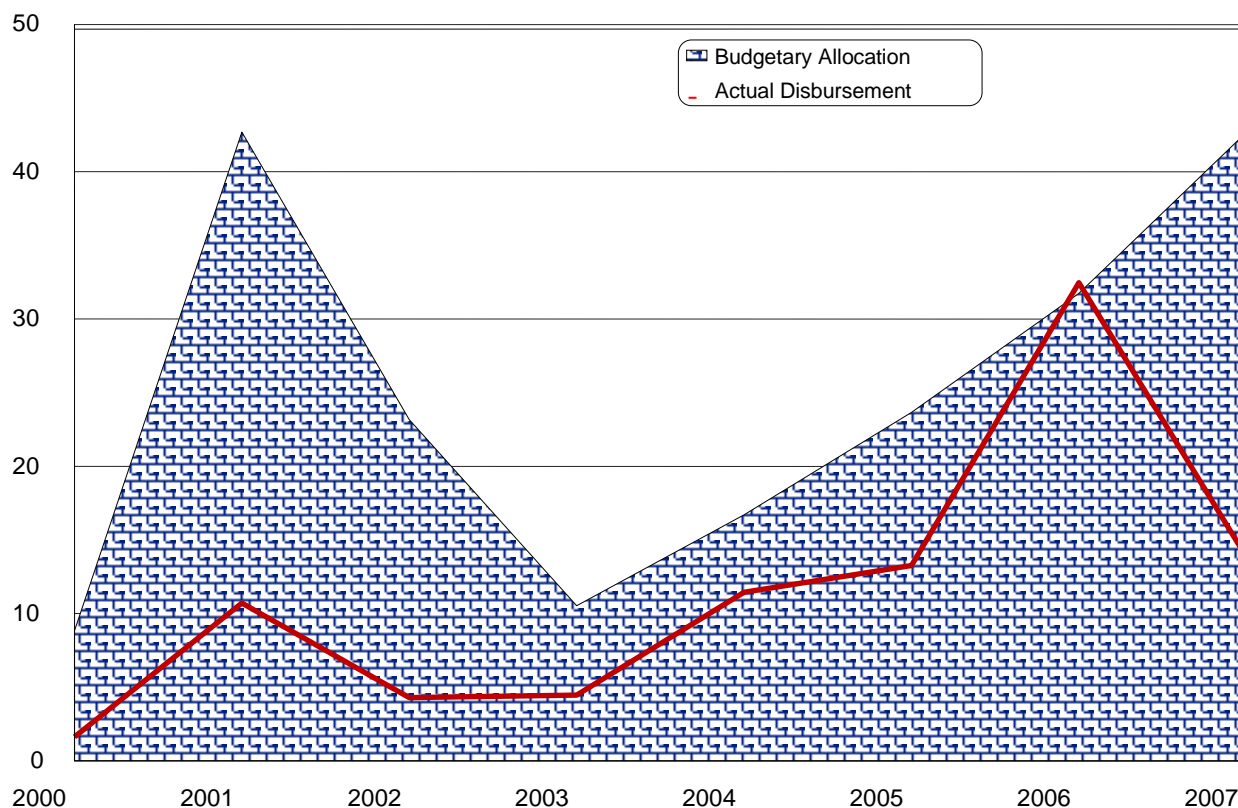
8.8 Funding

Access to safe drinking water and improved sanitation is as important as any other health or development issue at national, regional, and local levels. Adequate investments in water supply and sanitation can therefore be expected to yield economic benefit, since the reductions in adverse health effects and health care costs would outweigh the costs of undertaking the interventions. Experience has also shown that interventions in improving access to safe water and sanitation can be an effective poverty alleviation strategy. Water supply and sanitation is funded by several stakeholders including the federal government, state governments, local governments, the private sector, and development partners. However, the actual budgeted amount for WASH development at all levels of government is not released in full to the affected executing agencies in any fiscal year.

8.8.1 Federal government

The Sector Investment Profile Study on water supply and sanitation between 2000 and 2007 as reported by the Nigeria Water and Sanitation Monitoring Platform (2009) shows that the federal government allocation increased from ₦8.8 billion in 2000 to over ₦42 billion in 2007. The allocation peaked in 2002 with about ₦42.7 billion but declined in 2003, before picking up again to reach a second peak in 2007. The cumulative allocation to the sector between 2000 and 2007 was ₦200 billion and this gave an average yearly budgetary allocation of ₦25 billion. The MDG Projects are likely responsible for the sharp increase in allocation to the sector between 2006 and 2007, having received a total of ₦41 billion (Figure 8.19). Overall, the funds allocated to the water and sanitation sector, including the special MDG funding arising from the gains of debt relief for Nigeria, are not sufficient to meet the current demands, let alone meet the MDG targets.

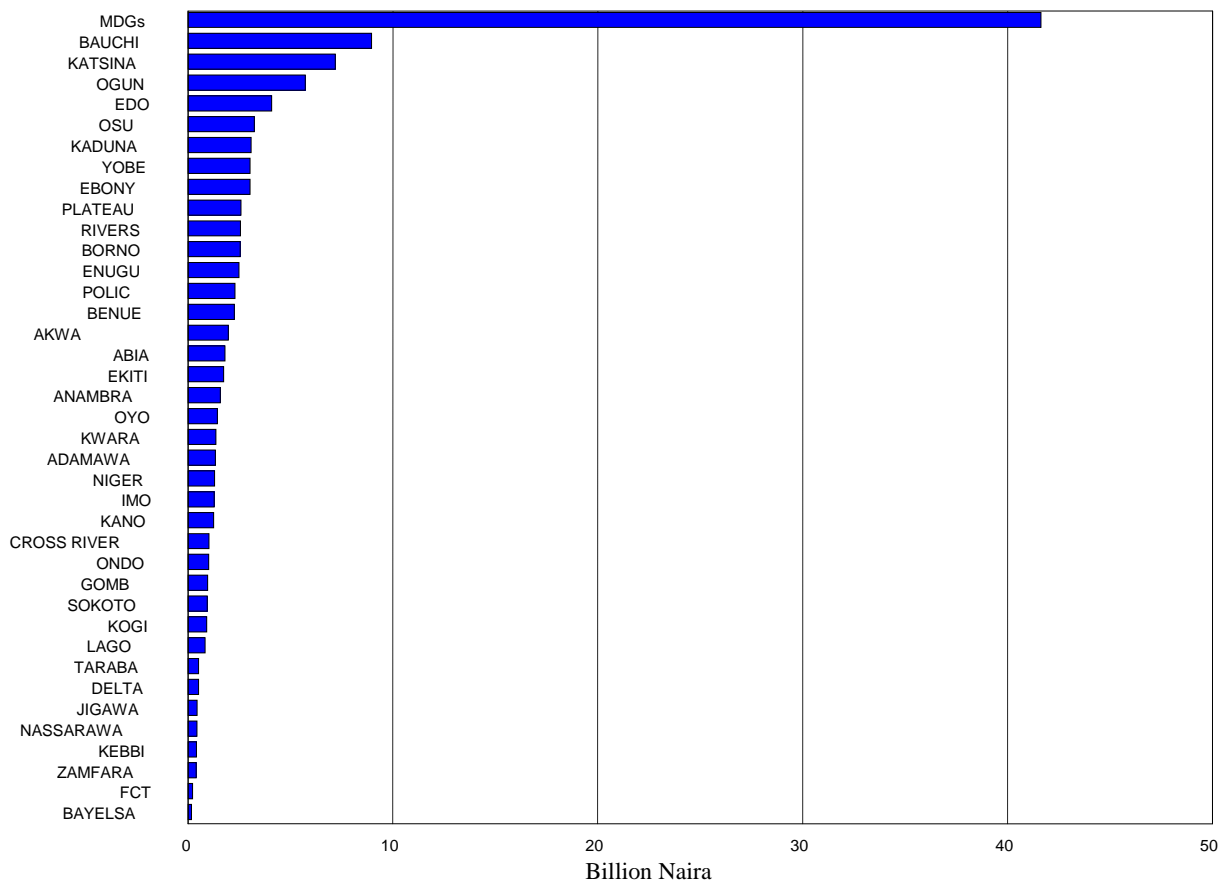
Figure 8.19 Federal government budgetary allocation and actual disbursement to water supply and sanitation (2000-2007), billion Naira.



Source: MSWP, 2009

Regrettably, not all the amounts budgeted were released: less than 50 percent (₦92 billion) of the ₦200 billion budgeted was actually released to the sector during the period. The rate of release, however, increased from 42 percent in 2003 to 68 percent in 2004 before declining again (Figure 8.19). The improvements recorded in 2004 and 2006 were probably due to the emphasis on achieving MDG targets. Another issue is the effective use of the funds released to deliver services to the targeted communities by the responsible agencies as well as the contractors engaged in the sector.

Figure 8.20 Federal government budgetary allocation to water supply and sanitation in states (2000-2007)



Source: WSMP, 2009

8.8.2 State governments

The 36 states and the Federal Capital Territory annually approve budgets for water supply and (to a very limited extent) sanitation. However, budgeted funds are never released in full and on time. This also explains why so many water projects are not completed and the completed ones not functional. Table 8.1 shows that for the time period 2000-2007, the percentage of the state budget allocated to water supply in selected states ranged from 4.83 percent in Cross River state to 9.99 percent in Kogi state. Similarly, the percentage average budget to sanitation in relation to the annual budget for the period of 2000-2007 ranged from 0.72 percent for Kogi State to 3.07 percent for Jigawa State.

8.8.3 Local governments

Although the 1999 Constitution of Nigeria stipulates that water supply and sanitation are the responsibilities of LGAs, the reality in all the 36 states is that LGAs appear not to pay enough attention to this responsibility. The Sector Investment Profile Study on water supply and sanitation between 2000 and 2007 conducted by the Nigeria Water and Sanitation Monitoring Platform

(WSMP) shows that in the eight states studied, the total budget of the 28 LGAs covered was about ₦102.415 billion. Out of this amount, ₦2.855 billion (2.78 percent) was allocated to water supply, out of which ₦1.50 billion was released. The released amount was 52.7 percent of what was budgeted and 1.5 percent of the entire budget appropriation. The gross budget on sanitation was ₦1.66 billion, while the released fund was ₦2.597 billion (156 percent of the budgeted amount and 2.54 percent of the total budget appropriation for sanitation (MSWP, 2009).

8.8.4 Development partners

Investments of the various external support agencies working in Nigeria for the period 2000-2009 are as shown in Table 8.2. The total budget was released. Although the contribution from these agencies was rather small compared to the total requirements in the sector, it was more than double that of the Federal Government of Nigeria. There is an urgent need for the government to increase the annual budgetary provision for water supply and sanitation, and more importantly to make sure that the amount of funds budgeted is always released and judiciously used so as to obtain appropriate value for money.

Table 8.1 Summary of total annual budgets, allocation, and actual disbursement to water and sanitation by selected states, 2000-2007 average

State	Total annual budget (2000 - 2007) [million ₦]	Water Supply					Sanitation				
		Total annual budget on water supply (2000 - 2007) [million ₦]	Total actual disbursement on water supply (2000 - 2007) [million ₦]	Actual disbursement as percentage of budget (2000-2007)		Expenditure on water supply (2000-2007 average) (col. d/b *100)	Annual budget on sanitation (2000 - 2007) [million ₦]	Actual disbursement on sanitation (2000 - 2007) [million ₦]	Percent average actual disbursement to sanitation budget (2000-2007) (col. i/h *100)	% Average budget on sanitation to annual budget (2000-2007) (col. h/b *100)	% Average effective expenditure on sanitation (2000-2007) (col. i/b *100)
				(col. d/c *100)	(col. c/b *100)						
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)
Adamawa	190,705	12,891	7,441	57.73	6.76	3.90	1,501	1,183	78.78	0.79	0.62
Gombe*	183,331	17,956	6,419	35.75	9.79	3.50	2,855	731	25.62	1.56	0.40
Jigawa**	134,874	9,351	6,120	65.45	6.93	4.54	4,144	1,890	45.62	3.07	1.40
Katsina	143,218	9,776	5,486	56.12	6.83	3.83	2,257	1,579	69.97	1.58	1.10
Kogi	222,909	22,276	2,850	12.80	9.99	1.28	1,613	293	18.14	0.72	0.13
Kwara	198,831	10,780	3,892	36.11	5.42	1.96	2,309	480	20.78	1.16	0.24
Enugu	148,243	11,696	2,644	22.61	7.89	1.78	4,356	277	6.37	2.94	0.19
Cross River	239,827	11,572	10,852	93.78	4.83	4.53	3,990	1,960	49.12	1.66	0.82

* Full information available from 2004
Source: WSMP, 2009.

** Full information available from 2003

Table 8.2 Investments in water supply and sanitation by development partners (2000-2009).

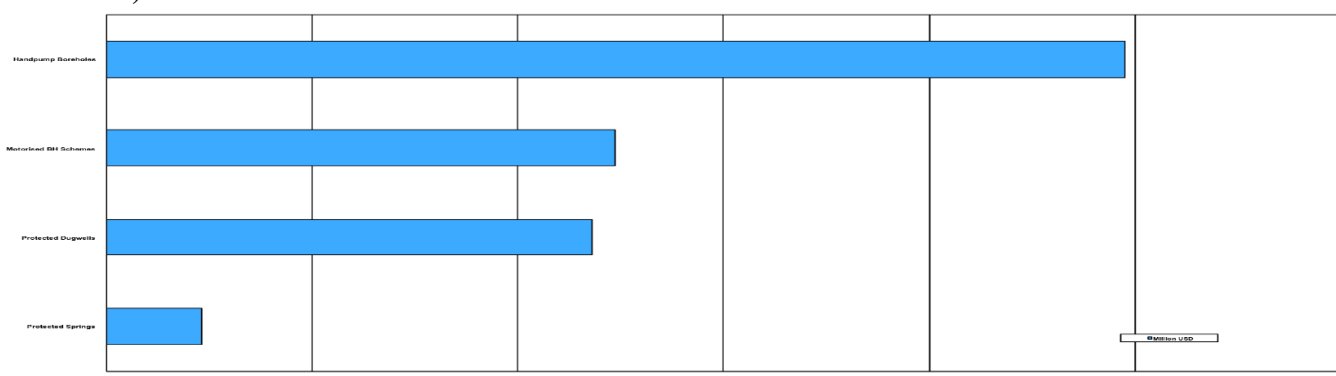
	Name of donor	Amount budgeted	
		Original currency	₦ billion
✓	EU (through WSSSRP)		14.167
✓	EU (through Small towns)	€15 million	2.600
✓	EU (through UNICEF)	€33.28M	5.769
✓	UNICEF	\$37.66M and €91.4M	22.080
✓	DFID	GBP 17.8M	4.541
✓	World Bank	\$850M	112.380
✓	GOV & COMM	€45.14M	6.858
✓	AfDB	\$352M	46.500
✓	JICA	1258m JPY	7.430
✓	WATER AID	€2700.28	14.167
✓	WATER AID (through UNICEF)	\$747,565	0.092
	GRAND TOTAL		236.584

8.8.5 Investment plan

Water Supply

The National Rural Water Supply and Sanitation Programme Strategic Framework (FMAWR, 2004) projected a gross National Rural Water Supply Investment Plan for safe water supply in rural areas of Nigeria between 2003 and 2015 to be \$1.05 billion (Figure 8.21). The estimated required investment for improved sanitation facilities are shown in Figure 8.22. The projection was based on the assumption of 40 percent safe water access and 35 percent sanitation access in the beginning year as well as the major technology options shown in Tables 8.3 and 8.4.

Figure 8.21 National RWSS Programme - gross investment plan (2003-2015) for safe water supply (\$US million).



Source: FMAWR, 2004.

Table 8.3 Major technology options for rural water supply and per capita costs.

Technology options	Per capita cost \$	Population served / facility	Technology proportion (percent)
Motorized / solar scheme	20	3,000	20
Hand pump boreholes	20	300	40
Hand pump dug wells	15	100	10
Protected hand-dug wells	10	100	20
Protected spring	15	3,000	10

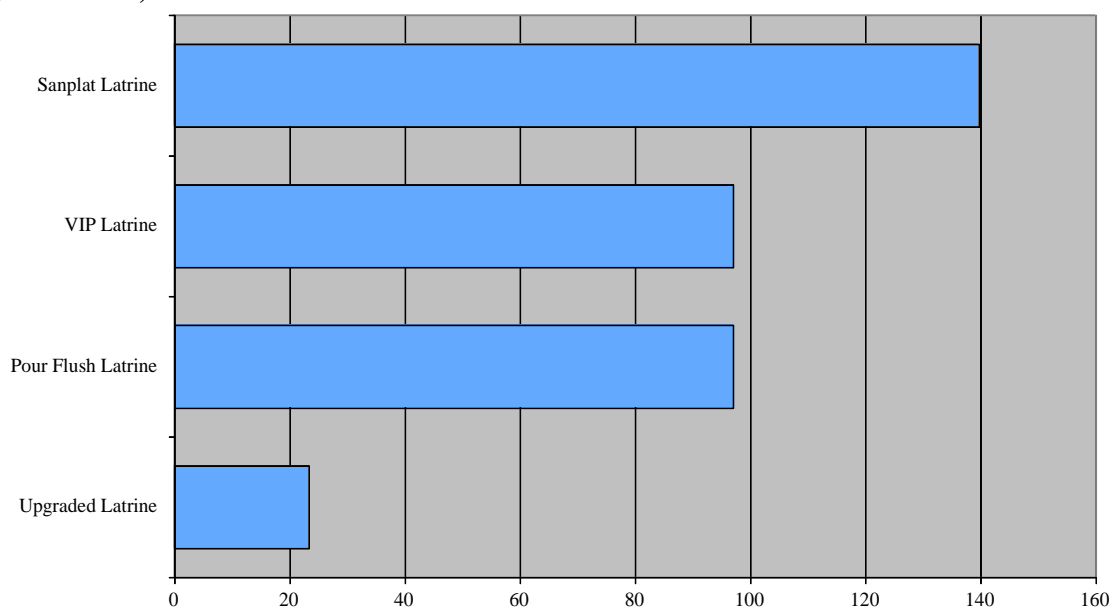
Source: FMAWR, 2004.

Table 8.4 Major technology options for rural sanitation and per capita costs.

Technology options	Per capita cost (\$)	Proportion (percent)
VIP latrine	25	5
Pour flush (PFL)	25	5
Sanplat	3	60
Upgraded pit latrine (UPL)	1	30

Source: FMAWR, 2004.

Figure 8.22 National RWSS Programme – gross investment plan (2003-2015) for improved sanitation (\$US million).



Source: FMAWR, 2004.

The investment required for the national RWSS programme to achieve 100 percent access to safe water and improved sanitation is to be secured mainly from the budgets of federal, state and local governments, communities, external support agencies, the private sector, and NGOs. Individual households are also expected to make a substantial contribution (about 70 percent), because the provision of facilities such as household latrine or toilet is the main responsibility of the different households.

8.8.6 Analysis

Achieving adequate safe water and improved sanitation coverage in Nigeria is possible if government and other stakeholders are more proactive and alert to their responsibilities by supporting households and communities in the provision of safe water and improved sanitation. The three tiers of government should help in financing the required infrastructure and programmes.

The monitoring and evaluation structure is weak, but with good funding and adequate planning effective monitoring of all activities in the sector will be achieved. There is also a need for better coordination between the federal government agencies, state governments, local governments, communities, external support agencies, and the private sector to articulate the contribution from each stakeholder in order to meet the funding gap required to achieve the MDGs in water and sanitation.

Although provision of water and other social services is the responsibility of the government at all levels, they have limited budgets and human resources capacity for the implementation of the sector's activities. The Water Investment and Resource Mobilization and Implementation Guidelines (WIMAG) developed by the Federal Ministry of Water Resources that had the potential of improving resource allocation from federal to state and local government levels should be resuscitated.

8.9 Recommendations

Based on the analysis undertaken in this chapter, the following specific recommendations are made:

Strengthening of operation in rural areas

Since the coverage of safe water and improved sanitation is in favour of the urban areas, there is a need to step up efforts to improve coverage in rural areas. The recommended technology options for rural water supply include: motorised/solar scheme, hand pump borehole, hand pump dug well, protected hand-dug well, and protected spring. So far, UNICEF and other agencies tend to favour the use of hand pumps, probably due to the notion that the operation and maintenance cost of hand pumps is low compared to motorised pumps. It is also believed that the technology involved in hand pumps is such that women and local technicians can handle it. However, as the population increases it could be more cost effective to use motorised pumps provided there is a well-trained community association that is prepared to bear the running costs of such a system. For rural areas, the recommended technology options for improved sanitation include ventilated improved pit (VIP) latrine, pour flush, sanplat, upgraded pit latrine, and septic tank/soakaway (where there is ample running water).

Promotion of community-led total sanitation (CLTS) approach

The on-going promotion of the CLTS approach by development partners should be sustained and extended to unreached communities in order to facilitate and enhance community knowledge and understanding of the risks associated with open defecation. The CLTS approach aims at empowering the community to analyze the extent and risks of environmental pollution caused by open defecation and to construct and use toilets without any form of subsidies. It is a collective community action to stop open defecation and promote the use of acceptable home made improved toilets. Although the approach is based on the use of latrines and a complete end to open defecation, it is also an integrated approach to sanitation development that is not limited to latrine construction but also includes hygiene promotion, community management of solid and liquid waste, and community empowerment.

The most important factor is to eradicate open defecation, and with sustained mobilization people will adopt sanitation technology best suited for them in terms of affordability and appropriateness (sanitation ladder). Adoption of this approach could lead to the communities achieving the status of open defecation free (ODF) communities.

Promotion of appropriate community view on disposal of human waste

The problem with sanitation is that it is usually considered a household affair with each household responsible for disposal of its human waste. There is a need to change this viewpoint, because any household in a community that does not dispose of its human waste appropriately invariably endangers the health of others. Consequently, all stakeholders should be enabled to see sanitation as an issue not restricted to households to handle the way they deem fit. Awareness creation and community mobilisation activities are important to enable members of the community to gain this understanding, which would further galvanise appropriate community-based actions to deal with sanitation issues.

Sustaining reform processes and institutional capacity building at various levels

Reform is a major part of providing safe water supply and sanitation in Nigeria. It is necessary to put more resources into programmes (software component of project) to achieve the necessary effect of the installation of water and sanitation facilities. There is a need for sustained reform programmes starting from the federal level through the states and local governments all the way to the communities. Very often policies developed at the federal level are not well understood and owned by people at the local government or community level. In addition there is a strong need for capacity building of personnel at all levels of government on delivery of safe water supply, improved sanitation, and hygiene promotion. Regular monitoring and evaluation of achievements are also important. In this regard, it is important to clearly and adequately define coverage – not in terms of installed water and sanitation facilities, but rather in terms of functional safe water supply and improved sanitation facilities.

Enhancing synergy in programmatic approach

UNICEF programmes that support the government are aimed at ensuring the realisation of children's and women's rights in the areas of water supply and sanitation, so as to enhance the health and well-being of these vulnerable and large population sub-groups. More synergy is required between the agencies responsible for water supply and sanitation and health institutions at all levels. It must be emphasised that funding water supply and sanitation programmes without putting sufficient emphasis on hygiene will turn out to be counter-productive in the long run. Consequently, the support UNICEF gives hygiene education and promotion must be stepped up and maintained as well as adapted by government agencies.

Advocating for improved legal and regulatory framework

The legal and regulatory framework for water and sanitation programmes that impact directly on the situation of women and children is far from perfect. Many legal and regulatory framework policies in the sub-sector are yet to be approved. There is a need to intensify advocacy at the highest level to ensure that these documents receive the necessary approval. Besides, they have to be adapted to community levels such that ensuing projects can be owned and managed effectively by members of the community.

Emphasising adequate school water supply and sanitation facilities

There is clearly a weakness with regards to the availability of adequate numbers of toilets in schools for pupils and staff. Authorities responsible for registration of schools must ensure adequate student-toilet ratios before approval is given for the commencement of the schools. In the case of existing schools that fall short of the recommended standards, appropriate measures should be taken to achieve the set target. Furthermore, all stakeholders in the school system should be further enlightened on the dangers inherent in the non-provision of safe water supply and sanitation. The school health policy should be promoted and implemented in all existing schools, and the WASH requirements in the policy should be made important conditions for approval of new schools.

Enhancing inter-sectoral and intra-sectoral partnership

Water supply, sanitation, and hygiene are crosscutting issues that affect many other sectors including health, education, environment, and housing. This calls for a strong and enduring partnership between the operators or stakeholders in the different sectors so as to achieve maximum and enduring results in water supply and sanitation delivery. Similarly, there is a need for an equally strong intra-sectoral partnership by all agencies whose primary responsibility is the provision of water supply and sanitation for the different segments of the Nigerian society. In this regard, the three tiers of government will need to strengthen their existing partnership arrangements with UNICEF and other international/development partners with particular focus on safe water supply, improved sanitation, and hygiene-related issues. In addition, governments on their part must develop strong political will, backed by adequate financial responsibility, to provide WASH

facilities as a basic right for the country's growing population. Areas of partnership and networking between various actors include provision of training, resources and technical assistance, and expertise required to improve the deplorable WASH situation in the country. The advantages of such partnerships include, among others, sharing of knowledge and experience, avoidance of duplication in development of facilities, and wise use of limited resources.

Fostering sustainability of water supply and sanitation facilities

A major weakness in the sub-sector is the frequent breakdown and in some cases total abandonment of installed water and sanitation facilities in many parts of the country. One reason for such waste of resources is failure to involve the ultimate beneficiaries of the facilities at the conception, planning, implementation, and monitoring and evaluation stages of the projects, which in turn makes it difficult for them to own and sustain the projects. Other reasons include lack of emphasis on operation and maintenance of facilities by promoters and lack of clear-cut strategies and training for long-term sustainability of constructed or installed facilities. Community-level operation and maintenance should be integrated into water supply and sanitation contracts by establishing Water, Sanitation and Hygiene Committees (WASHCOMs) and providing community-level training for operation and maintenance of water supply and sanitation facilities. The potential for generating funds locally in support of the continued operations of such equipment and facilities also needs to be explored. Moreover, the use of appropriate technology for water supply, sanitation, and hygiene (e.g. VLOM and CLTS) should be strengthened and scaled up in the country to support sustainability of such current projects.

Promotion of a sector wide approach (SWAP) in programme management

The sector wide approach (SWAP) entails donor agencies joining a common programme with key partners such as the government, NGOs and CBOs with a basket funding mechanism to jointly participate in WASH sector reform. This could provide the opportunity of leveraging resources, including funds generated locally, in support of the continued operations of water supply, sanitation facilities, and hygiene. Within the SWAP framework, donors provide financial resources with the understanding that they will be used for specific and agreed purposes, while progress is monitored closely by a joint government, donor, and CSO committee.

8.10 Conclusion

Safe water, sanitation, and hygiene are essential to sustain life. Access to adequate, safe supply of water and sanitation facilities therefore constitutes a basic right of all citizens, particularly for children and women who are the most vulnerable members of the community. This means that the three tiers of government in Nigeria should place high priority on the development of and equitable access to safe and adequate water supply and sanitation services as a key component of good governance. One way of doing this is to synergize it with the strategies for fighting poverty and accelerating socio-economic development as envisaged in the Vision 20:2020 and other key national development policy documents. The need to prioritize WASH-related actions in the national development scheme is quite urgent in view of the current low level of access to safe water and sanitation across the country, and the negative impact this has on the health and well-being of the population, particularly women, children, and the poor. Without doubt, improving access to safe water, sanitation, and hygiene will result in tangible benefits to health and development. Hence, every effort should be made to accelerate the rate of progress towards achieving universal access to safe water and sanitation.

9. Communication for Development

9.1 Introduction

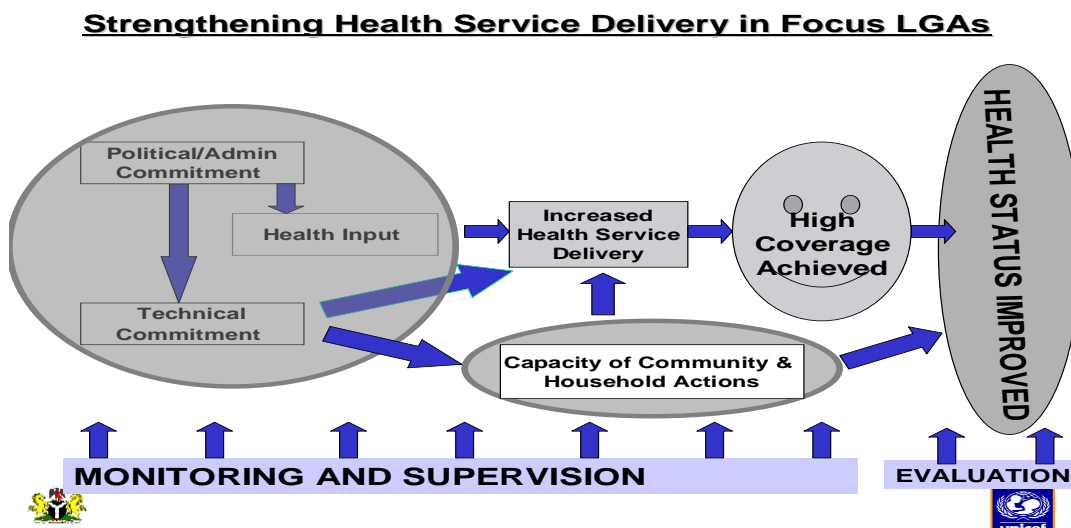
Communication for behaviour and social change (CBSC) has, in the last few years, gained increased attention from governments as well as national and international partners as a veritable and inevitable complement to development programmes across sectors. This increase in interest is linked to the failures and frustrations tied to restricting communication support to information sharing, dissemination, and management. The global rediscovery of the practice of placing people at the heart of their own development and at the core of energising processes of community discussion, including consensus building, action, monitoring and evaluation, is in itself a success story.

A key objective of development communication is the development of appropriate communication messages and packages to facilitate behaviour change at the individual, household, and community levels. This chapter of the situation analysis assesses how communication is working or has worked in Nigeria; provides an overview of the prevailing programme communication landscape; analyses existing policies, socio-cultural and service conditions across Nigeria; and reviews the partnerships and alliances formed as a means of creating an enabling environment for close monitoring of commitments to the rights of children and women. The chapter ends with the key lessons learned and suggests some direction and vision for improved programme communication by government, UNICEF, and other partners in Nigeria.

9.2 Behaviour and social change communication for appropriate child survival, development, protection, and participation practices

The 2009-2012 Country Programme of UNICEF recognised that unnecessary childhood illnesses and deaths can be prevented if parents and communities have relevant life-saving knowledge and skills at individual, household, and community levels. Such knowledge and skills have implications for the achievement of the MDGs relating to child health. During the programme cycle under review, there have been some shifts in strategies and approaches in the communication sector. A number of approaches have characterised messaging and community engagement – with varying levels of reach, continuity and impact. The primary paradigm shift is from the information, education, and communication (IEC) (top-down) model to increasing emphasis on the human rights perspectives of improved participation, dialogue, collective responsibility, and ownership of projects by communities. This is complemented with a shift from emphasis on IEC materials and products to dialogue, and from anecdotal feedback on usefulness of materials to evidence-based assessment of the contribution of communication approaches to programme results. According to Onabajo (2005), this shift has resulted in improved participation, dialogue, and ownership of several communication projects. This holistic and inclusive approach, as illustrated in Figure 9.1, underscores the significance of engaging communities for any development effort as applied in Local Government Areas (LGAs).

Figure 9.1 Strengthening health service delivery in focus LGAs



Source: UNICEF

According to the 2008 National Demographic and Health Survey (NDHS), the current level of knowledge at the community and household level that addresses basic preventable diseases is low (NPC & IFC Macro, 2009). Health seeking behaviour is poor and there are still practices that increase vulnerabilities of children. The knowledge, attitude, and practice (KAP) indicators between 2001 and 2006 suggest that behavioural challenges still abound. For instance, 78 percent of mothers and caretakers could not state two danger signs of pneumonia in children, only two out of every 10 mothers could correctly state the number of times a child needs to be taken to the clinic for immunisation, and barely 22 percent could state the required number of doses an infant needs (NBS & UNICEF, 2007).

Low knowledge is accompanied by widespread prevalence of negative attitudes. For example, 33 percent of residents in the North west zone perceived early marriage as normal (NBS & UNICEF, 2007). Focus group discussions conducted in 2006 showed that the majority of parents still believed that children should not take food and fluids during diarrhoeal episodes, and that if one does not wash hands after changing a baby there is no problem, as a baby's stool is not harmful.

The combination of negative attitudes, low knowledge, traditional myths, and norms translates into practices that often have very harmful effects on the survival and development of children. For instance, according to the 2007 MICS, 82.7 percent of mothers did not increase food and water intake nor give oral rehydration salts (ORS) to children during bouts of diarrhoea, thereby increasing the risk of diarrhoea-related childhood death. Only 14 percent of mothers breastfed exclusively up to three months and 41 percent were giving milk and water at 3 months. Barely 3.5 percent of children aged under five slept under insecticide treated bed nets and only 23.3 percent of children were registered at birth. In addition, female genital mutilation/cutting (FGM/C) was still practiced in parts of the country and millions of women had suffered various forms of violence (NBS, 2007).

The negative attitudes, knowledge gap, and harmful practices all result in inadequate utilisation of services, high child morbidity and mortality levels, new patterns of abuse and exploitation of children, and a vicious cycle of harmful practices and poor health status.

Some immediate causes of such low knowledge of basic 'facts for life' include the inadequate knowledge and skills on the part of health workers to effectively counsel parents and community members for uptake of services; the absence or very limited exposure to health education messages;

and the very limited participation and ownership of social development services by communities. At the structural level, one notes that development communication or behaviour change policies and strategies are not available in several government agencies; hence the complementary human and financial resources to deliver effective interpersonal communication services are lacking.

Nigeria, like so many countries in Africa, has a history of campaign-oriented communication programmes. These include on-going campaigns for polio eradication, HIV and AIDS, measles, Roll Back Malaria, vitamin A, anti-child trafficking, FGM/C prevention, and promotion of girls' education and sanitation. These tend to indicate that the campaign mode of addressing knowledge gaps and promoting new child survival behaviours has become entrenched globally and in Nigeria. In part, these campaigns reflect donor priorities over time and are linked to funding for such exercises. Oftentimes the 'urgency in meeting eradication targets has forced heavy reliance on top-down dissemination of information – or at best – horizontal dissemination of information in which a neighbour or peer, paid by the government, tells her neighbours what to do. Real dialogue (about polio), however, seems to take place among health workers, social mobilization teams, district and LGA officials, national staff, and the global health community about what Nigerians are thinking and doing' (CFSC, 2005). The use of participatory hygiene and sanitation transformation (PHAST) tools has proved to be effective in communities where interventions have been well supported.

In the face of the low KAP indicators, the increase in access to vitamin A and vitamin A fortified foods, as well as the current results in polio eradication are all clear signs that some positive results have been achieved in projects where communication has made primary inputs. If however the goal, as stipulated in the 2001 and 2007 UNICEF Situation Analyses, is to nurture a culture in which the well-being of children and families becomes the responsibility of parents and communities, the need to go to scale in an integrated manner with flagship initiatives so as to achieve a critical mass of measurable results is urgent, in order to achieve the MDGs.

The example of the current UNICEF programme communication plan is inspiring: it is underpinned by human rights based programming, gender-sensitivity, and is data-driven while also laying emphasis on dialogue and participation as a way of ensuring inclusiveness and self-determination of households and communities. Specifically, data-driven communication planning has proved to be more useful in achieving measurable results. Such effective programming approaches need to be more widely disseminated and replicated across the intervention landscape in Nigeria to impact positively on the health and development of the child.

The Nigerian society is known for its very rich culture of communication processes involving traditional musicians and poets who grace local events, town 'criers' or announcers who pass on information from traditional institutions, entrenched and vibrant religious institutions, dialogue among age and gender groups, professional bodies, and several variants of civil society groups. During the programme period starting in 2009, access to information increased exponentially. Local radio stations have sprouted in all states and the Federal Capital Territory (FCT). Community radio stations are expected to commence soon with the empowerment of the National Broadcasting Commission by the Presidency to commence provision of licences for community radio. Mobile phones and home videos have penetrated the grassroots. These are complemented by tens of daily newspapers and magazines, internet in urban areas, and a wide array of billboards, posters, flyers, leaflets, brochures, T-shirts and all kinds of campaign materials that flow through the society.

9.3 Strategic thrusts

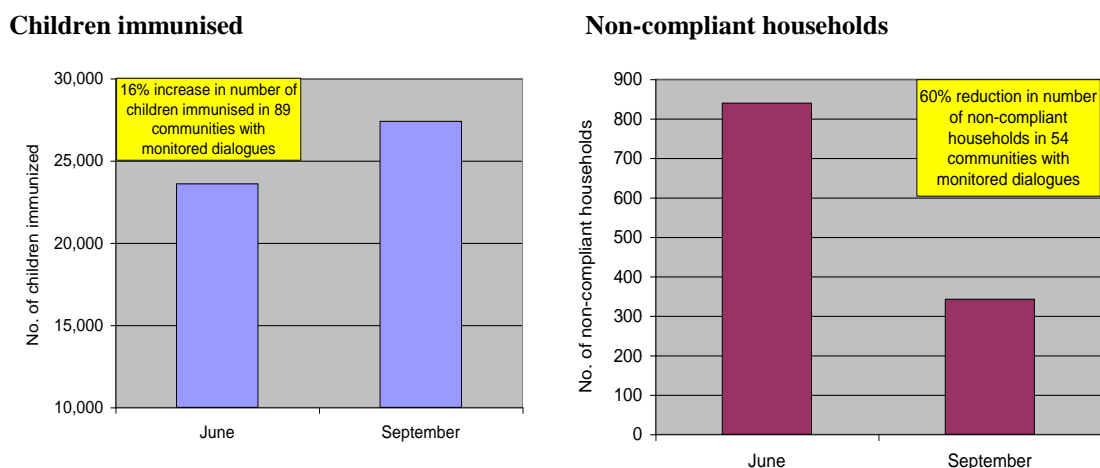
9.3.1 Inter-personal and community-oriented approaches

Community dialogue is the most popular strategic approach used. Its use increased during the polio controversy that necessitated dialogue with religious and traditional leaders, civil society groups, and media associations. This approach has also been used in other projects on issues such as girl's

education, sanitation, and hygiene promotion and avian influenza. Community dialogue, as a strategic communication for development programme platform, was initially introduced to Nigeria in 2002 to support the HIV and AIDS programme, with technical support from UNICEF headquarters in New York, USA. Dialogues have provided opportunities for clarification and consensus on community problems, the actions to take to resolve the problems, and assignment of responsibilities for implementation.

An independent community dialogue audit sponsored by UNICEF in six states (Kano, Kaduna, Katsina, Jigawa, Bauchi and Zamfara) from June to September 2007 showed a positive impact of community dialogue as a communication approach. The audit showed that community dialogues for polio eradication were moderated/facilitated by ward heads (50 percent), imams (10 percent), or ward focal persons (24 percent). The audit further showed that the community dialogues were preceded by pre-dialogue planning meetings between the service providers and the community leaders, and that prayers were conducted at the start and end of the dialogues to set the moral tone of the dialogue. It was noted, on the other hand, that most (98 percent) of the dialogues were attended by men who were not the primary caregivers in the home. Over 95 percent of the participants reported to be satisfied with the dialogues and felt that they were better ‘enlightened’ and in a position to counsel their neighbours to accept and have their children immunised against polio. There was a 60 percent reduction in non-compliance for polio vaccination in 54 communities within the 3-month period of June to September 2007. The dialogues have increased participation and self-determination among families and communities. Furthermore, they have resulted in the availability of a pool of community resource persons who facilitate these sessions of dialogue and who now have the required knowledge and skills. Figure 9.2 shows the impact of community dialogue on uptake of immunisation services in some states of northern Nigeria.

Figure 9.2 Impact of community dialogues linked to the Immunisation Plus Campaign



The audit recommended that for dialogues to have the desired impact in motivating the adoption of sustained behaviours, UNICEF and partners should:

- Strengthen the capacity of the social mobilization teams at the various levels of government to organize and conduct community dialogue through well-programmed workshops and seminars.
- Establish a broad-based local Community Dialogue Committee under the leadership of the ward head to work with the social mobilization team on all matters regarding community dialogue. This should be made up of representatives of relevant stakeholders’ groups, including religious institutions, politicians, community-based organisations (CBOs), traditional birth attendants (TBAs), and teachers. The committee and social mobilisation team should take up such issues as community sensitization, information dissemination, and mobilization on relevant health and

development issues.

- Use evidence-based successes recorded by the programme in the communities since inception to commit the respective state governments, through the state ministries of information and health, to accord official recognition to community dialogue as a state event and possibly adopt it.
- Employ the services of social mobilization and media experts to effectively communicate messages that respond to specific issues or reasons raised as barriers to uptake of services.

Similarly, the Technical Advisory Group evaluation of the polio eradication initiative/routine immunisation (PEI/RI) campaign in June 2007 recommended that community dialogues should be improved upon and strengthened through greater methodological coherence and focus on local community leadership, agenda setting, and facilitation. Specifically, this should include expanded and more intensive training of appropriate local facilitators directly, especially members of the Ward Health and Community Development Committees; continued support and expansion of 'peer' dialogues for women, religious leaders, and other segments of the community; and the integration of community dialogues with local radio. The challenge of scaling-up resources, cost and time if adequately addressed, will impact on the foundations to increase knowledge, change attitudes and practices in favour of accelerating progress towards achieving MDGs in Nigeria.

Community theatre for development (TfD) is another indigenous interpersonal approach that has enjoyed much acceptance and acclaim, and it has been a useful tool for stimulating discussion in communities on the issues of child survival and development (University of Ibadan/UNICEF, 2005). The involvement of community members in the planning, implementation, and evaluation of this process has made it an exciting and inexpensive way of first imitating current attitudes and practices and then presenting models of behaviours and practices to promote and also address common barriers to ideal behaviours. It has been an invaluable approach in addressing immunisation, breastfeeding, hygiene, and sanitation issues (Osofisan, 2003).

Each of the four UNICEF operational zones in Nigeria has an average of 10-15 LGA Mobile Theatre Groups that have received some forms of support from the agency (NACA). They were initially conceived as an arm of the LGA structure, assuming that once they were seen to be relevant, local communities would provide the necessary funding for their survival and utilisation. Unfortunately, several of these groups receive no support from their LGAs and are seen as an external agency project.

The approach used by many of the groups for transmitting information in the context of TfD was highly monological and non-participatory. Each group carried out some preliminary research in the community, identifying gaps in the basic practices of children, women, and families. The community's problems were re-portrayed in dramatic sketches, using key messages already outlined in UNICEF's 'Facts for Life' booklet. Very few attempts (for example, the Aro community in Benin City) had been made to use theatre for development approaches that required participatory research, collective problem identification, scenario and playmaking rehearsal, performance, discussion, and community action as a part of the process. The brief period in each community also did not allow for any sustained follow-up action and linkage with village-based development workers in each rural or peri-urban setting.

A critical review of the use of LGA Mobile Theatre Groups indicated the urgent need to: (i) re-orient LGA Mobile Theatre Groups so as to emphasise more community-based participatory action; (ii) develop information and communication approaches that advocate for the transmission of basic 'Theatre for Development' skills and techniques to local communities; (iii) institute mechanisms to reduce dependence on external funding for mobile theatre groups as a means of disseminating child

survival and development (CSD) information; (iv) create a direct link between the LGA village-based community workers and community members, encouraging the latter to readily re-portray their reality through drama/theatre arts independently; and (v) institutionalise CSD/CRC information delivery through an established Department of Theatre Arts of a Nigerian university so as to generate a new breed of professionally trained theatre practitioners committed to CRC/CSD issues and trained on the process of Theatre for Development techniques for community application. This approach has stimulated partnership with outside institutions such as Ibadan, Jos, Benin and Ahmadu Bello universities, it has resulted in the publication of training manuals, guidelines, and workbooks, and finally it has engendered increased capacity development for facilitators (University of Ibadan/UNICEF, 2005).

Community viewing and listening centres have been a part of the messaging processes in communities. While the listening centres are in more locations than the viewing centres, enhancing youth participation, life skills acquisition, discussion and the provision of correct and complete information through group listening and viewing is a common feature in most communities. A major challenge has been the irregular availability of electricity for viewing, costs of operating generators, updating the messages viewed or listened to, and poor maintenance of the facilities (UNICEF, 2005). However, viewing and listening centres continue to be a strategic inclusion in approaches for reaching communities, especially young people.

The Community Information Board is a flagship initiative begun as a result of extensive discussion among several stakeholders including government, community institutions, traditional and religious leaders, civil society, universities, and development partners. UNICEF provided technical and financial support from the beginning. The board serves as a tool to generate basic information on child survival, development, protection, and participation within the community, ultimately feeding into the agenda of community dialogue sessions. It is operated solely by members of the community. The key added value is that it catalyses discussion, decision making, and action, and facilitates the participation of all segments of society in the development process. It mirrors the community in a way that is credible and sustainable since the data, processes, and volunteer data gatherers and recorders are local to the community. The information board has been translated into the Hausa language.

9.3.2 The mass media

In spite of some limitations on the reach of mass media owing to economic and literacy factors, mass media remain the channel with the highest reach. Radio usage is higher compared to access to television and newspapers. The print media are a key information channel for opinion leaders and policy makers. However, radio has been used extensively to reach groups in communities with special programmes promoting the rights of children. Commercialisation still remains a challenge, as news and programmes relating to the rights of children are not considered to be of much commercial value and tend to suffer neglect. Continuous advocacy to mass media managers and superintending political officials has continued to yield additional airtime and newspaper space for promoting child survival and development. Emerging opportunities exist in the increase in Nigeria's GSM teledensity, as its usage is widespread both in urban and rural areas and text messages have been used to reach millions of people during information campaigns. The number of GSM lines in Nigeria increased from zero in 2001 to about 25 million in 2009.

With the formation of State Social Mobilisation Technical Committees (SOMTECS), chaired by the Directors of the State Ministries of Information, the mass media partners have benefited from a series of training courses, consultations, funding for established work plans and even funding for the production of radio and television programmes. UNICEF and some other IDPs such as USAID have continued to partner with the media in the bid to improve their effectiveness regarding health-related communication, particularly related to mothers and children. One such partnership is the

provision of information kits on a range of child health issues as well as equipment and supplies to media organisations to support their work. Such investments have generated free airtime by radio stations and reduced prices negotiated, for example, through the Broadcasting Organisations of Nigeria (BON) for all HIV and AIDS programmes on private radio. The monthly media matrix tracked by UNICEF indicates clearly the level of interest maintained by journalists involved in writing about the child survival, development and protection programmes.

Many media partners still use jingles, public service announcements, sports, and some interactive programmes as the primary format for providing social development messages. In the area of HIV and AIDS programming, the primary source of information for adolescents and youths is radio. This channel is complemented by television and popular magazines. The mass media have been contributors to massive awareness campaign activities, and provide opinion leaders and sometimes household heads with information and knowledge on appropriate practices that trickle down to individuals within the family and facilitate the adoption of positive behaviours. The growth of interactive radio broadcasting is encouraging the strengthening of message content clarification through its feedback process. A major challenge in this remains the limited access to telephones by rural communities.

Key examples of effective media use include the series of radio jingles by NAFDAC against the illegal sale and use of vitamin A; the intensive information campaign following the onset of avian influenza in Nigeria; the on-going HIV and AIDS campaigns in almost all national and FM radio stations; and the local dialect broadcasting by radio stations in Enugu on several harmful traditional practices. The careful documentation of these jingles and public service announcements (PSAs) can be improved. There is a need to develop a strategy to sustain mass media interest in issues concerning children; reporting on incremental gains and sharing human-interest stories on positive changes in the lives of individuals and in communities as a result of improved health behaviour, including appropriate use of health services.

Building alliances with health editors in the various national and regional mass media organizations is another strategic approach. Such alliances have been successfully used by UNICEF in its previous country programme and efforts to revive them are ongoing. The Journalists Alliance for PMTCT (JAP), the umbrella body for media personnel working on PMTCT, has organised skills-building meetings reaching hundreds of health editors. JAP has also facilitated a service to regularly share information through two national newspaper columns and six radio/TV weekly/daily programmes. Several jingles are being aired nationwide, and two full-length radio dramas and a 10-minute TV drama in Hausa language are being produced with support from media organisations. A key shift in alliances with mass media personnel is to work towards integrating all sectoral issues in the partnership to prevent sector-based alliances and an unnecessary multiplicity of mass media partners.

The mass media are a strategic partner in social marketing; they continue to contribute to the increasing success of social marketing of appropriate child survival behaviours. Vitamin A, insecticide-treated bed nets, and exclusive breastfeeding are examples of child health issues that have received mass media support in this regard. A working partnership between BBC World Service Trust and other development partners is expanding the social marketing frontier. Apart from the primary provision of information to households and caregivers on infant and child feeding practices in the languages that they understand, capacity development activities for mass media personnel, civil society organisations, and community animators have formed part of the package of interventions. The concept of using Media Dark Kits for discussion in communities is an innovative inclusion. The kits are available in Hausa and pidgin English.

9.3.3 IEC print materials

The production and dissemination of IEC materials (communication products) continue to be the frontline channel to pass on messages concerning the basic 'Facts for Life' promoted by UNICEF, government and non-government partners to create awareness and facilitate behaviour change. In 2006, guidelines and checklists for preparing IEC materials and a pre-testing manual and checklist were introduced. These have contributed to better standardisation of the quality of materials being developed and ensured pre-testing before production. The perceived value of IEC materials is based on the belief that even in families where both parents are illiterate, there is often a literate person in the compound, neighbourhood church/mosque, or within the community who can explain the text. Hence, IEC materials have proved useful in complementing inter-personal communication activities.

9.4 Audience analysis

The major audiences for communication for development have continued to be parents and caregivers, traditional and religious leaders, heads of households, and other family members (e.g. uncles, grandmothers and children). More specific audiences include females, youth, children, and some vulnerable groups (such as widows, orphans, physically challenged, and out-of-school youth). To become effective partners for the promotion of the realisation of the rights of children and women, these audiences constantly require accurate and adequate information and capacity strengthening on the different issues related to child survival and development. Religious leaders, among others, occupy a significant position in the socio-cultural environment and enjoy wide acceptance, respect, and moral and spiritual influence among all strata of the society, particularly in the north. They continue to be participant audiences in messaging for behaviour change. However, challenges remain in terms of the strong adherence of some traditional leaders to harmful practices that violate or impede the realisation of children's rights.

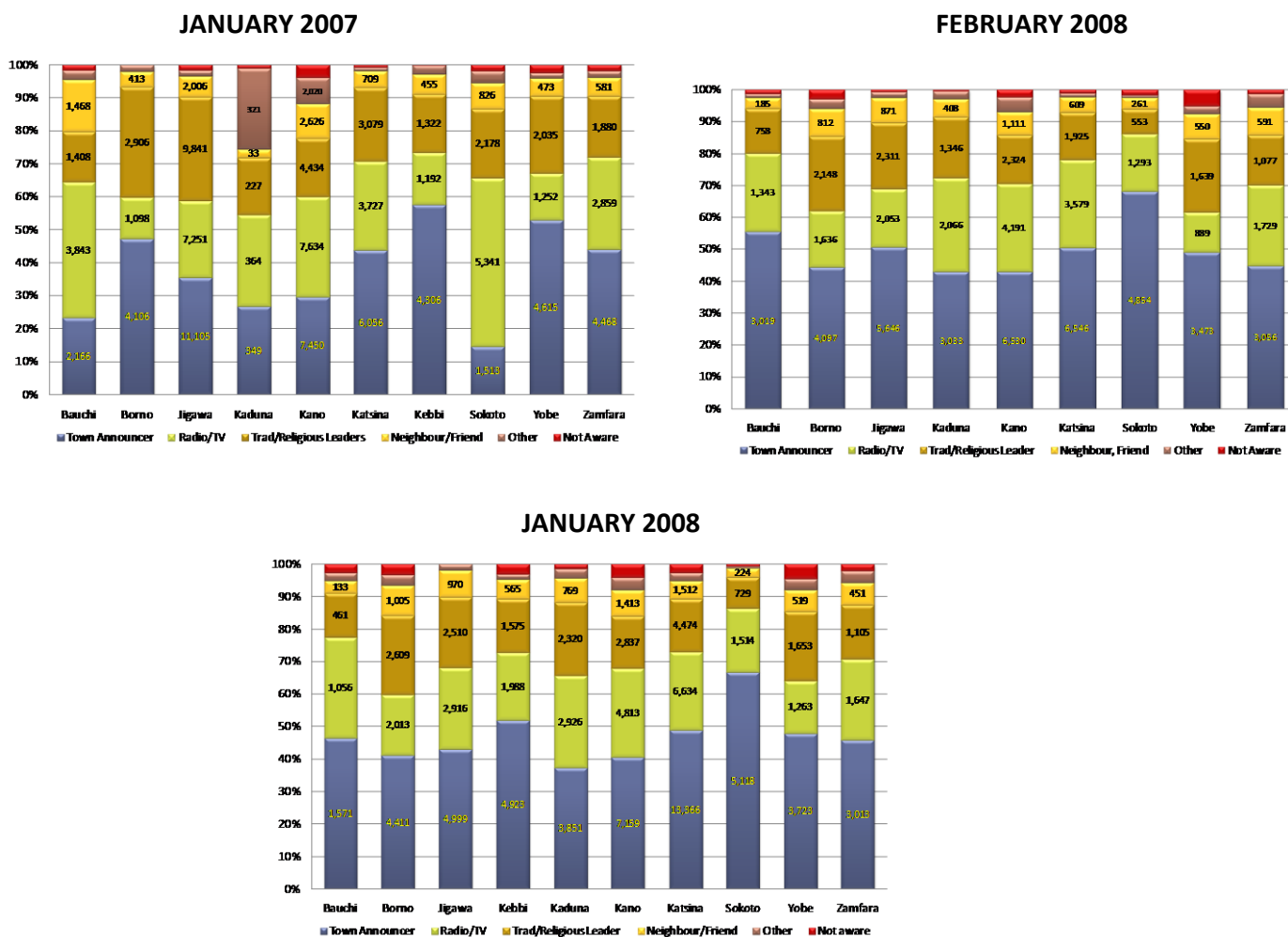
9.5 Channel analysis

In most communities, gatekeepers define what is appropriate and acceptable and what is not, especially on matters of social and cultural norms and values. They stand out as a primary channel for engaging communities in Nigeria. These institutions include traditional rulers, other community leaders, and executives of community administrative structures such as the Community, Village, or Ward Development Committees. Religious leaders complement traditional leaders as primary means of contacting community members. It is in realisation of the importance of religious leaders that the federal government established the Nigeria Inter-Religious Council (NIREC) as a formal structure for engaging this group of leaders. The Forum of Traditional and Religious Leaders and the Media on Immunisation and Child Survival was also formally inaugurated by Nigeria's former President, Chief Olusegun Obasanjo in August 2005. This body has been active in promoting appropriate knowledge and practices in the areas of immunisation and HIV/AIDS prevention, and several of its members actually monitor implementation of exercises.

Community-based networks have also been the focal points for community mobilisation and participation in projects. The most popular kinds of community networks are men's groups, age groups, women's groups, youth groups, and community coordinating committees such as the Water and Environmental Sanitation Committees that have become credible sources of information on water, sanitation, and hygiene activities. Health Committees and School-Based Management Committees (SBMC) also exist. The Federation of Muslim Women's Associations of Nigeria (FOMWAN) is an example of an active NGO with extensive network at grassroots level that is engaged in house to house counselling for immunisation, line-listing of all children eligible for polio immunisation, and in 'defaulter tracing' for immunisation. Their work goes beyond support for immunisation services.

Town announcers are agents of the traditional leadership structure, and enjoy credibility and acceptance from community members. As part of programming, however, incentives like cash and bicycles and tools such as megaphones have proved invaluable in motivating and sustaining their engagement in the immunisation campaign. Figure 9.3 presents evidence of the critical role of town announcers in information dissemination at community level as a source of information among the surveyed population.

Figure 9.3 Sources of information linked to Immunisation Plus Campaign in selected states



Source: Independent monitoring data.

9.6 Enabling and constraining factors

Communication for development involves a strategic shift from conventional programme communication paradigms, addressing not only the ‘what’ but also the ‘how’ of interfacing with the core group of participants in programming (in policies, practice, and capacity development). This means incorporating the voices and needs of children, women, and communities, focusing on the *whole* child and addressing not just survival and physical development but also social, emotional and cognitive development. It also includes addressing complex social norms, underlying cultural and equity issues; scaling up community-led communication interventions; harnessing the vast potential of new communication technologies; communicating better with children; and defining and demonstrating measurable (communication) results. The focus for the Government of Nigeria (GON)/UNICEF Country Programme for 2009-2012, for example, has been defined as realising child-friendly governance and child-friendly social values, making social transformations and change vital contributors.

The culture of respect for leadership has often meant that most community members accept the opinions and direction of their leaders on matters of community well-being, including the survival and development of their children. In addition, community networks have a wide membership, meet regularly, and are often centres for information-dissemination and sharing, as well as consensus building among members. During the last GON/UNICEF Country Programme, these networks were active as participants and facilitators in the promotion of key household practices, including breastfeeding, improvement in household nutrition, use of insecticide-treated bed nets, utilisation of immunisation services, safe excreta disposal, hand-washing, antenatal care attendance and men's participation in child care in communities. Girl-child education, enrolment, retention, and completion of basic education by boys and girls and birth registration also benefited from the efforts of the traditional leadership structure and activities of community-based networks.

In spite of these support systems for communication programming, some cultural practices that impede the realisation of the rights of women and children still persist. For instance, MICS 2007 reported that 19.3 percent of females still supported FGM/C as a cultural practice (NBS & UNICEF, 2007). Early marriage was still perceived as normal in some parts of the country, particularly in the northern geopolitical zones. For example, the survey reported that 33.3 percent of respondents in the North west geopolitical zone were of such opinion. Widows were still subjected to dehumanising rites, and the abuse and trafficking of children violated some of their most basic rights.

9.7 Government structure and policy environment

The existence of three tiers of government – federal, state, and LGA – creates an opportunity for the necessary interface and linkages that can facilitate development-related interventions. The three levels of government are further complemented by units and departments involved primarily in information management and dissemination, messaging, and behaviour development and change. These units include the SOMTECs, the National Orientation Agency, the National Primary Health Care and Development Agency, the National Youth Service Corps, Public Enlightenment Committees, the Child Rights Information Bureau, Federal Information Centres, the National Task Group on Sanitation, State Information Offices, Health Promotion Officers at all levels of government, and state and LGA Social Mobilisation Committees for Immunisation. It should be noted, however, that the weak capacity of government (especially at the LGA level) for interactive media and interpersonal communication on national and state-wide initiatives to address concerns of families and communities pertaining to child survival and development is a factor partly responsible even for extreme child rights violations such as child trafficking.

9.8 Programming with children and youth

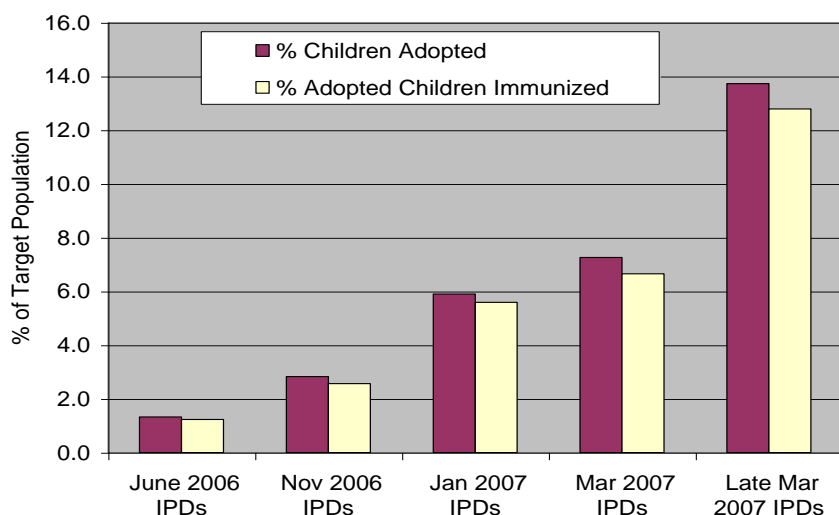
Nigeria's large population with an estimated 63 million children and youth aged under 15 years presents a mixed bag of programming challenges and opportunities. This group offers a huge potential for the emergence of households knowledgeable on key child survival practices, and for building bridges towards making adults see alternatives to negative behaviours. In fact, programming with young people and child parliamentarians resulted in a draft bill to make immunisation of children aged under five years mandatory.

Peer dialogue and mentoring has led to a significant increase in knowledge of reproductive health, life building skills, and HIV/AIDS, and also engendered a positive attitude towards persons living with HIV and AIDS among students in secondary schools (UNICEF, 2006). The emerging thinking that the existing National Youth Service Corps (NYSC) Reproductive Health and HIV Project would keep the community component in focus holds even greater prospects of expanding the frontiers for behaviour development among young people.

The child-to-child immunisation strategy is another example of successful programming with children. The strategy was initially piloted in May 2006 in Bakori LGA, Katsina state, in one primary school and with 40 pupils. Teachers were oriented on how to train pupils to implement the activities. Each pupil chose five children under five years of age in their community and observed those children for evidence of immunisation. If the chosen children did not have the mark indicating immunisation, the pupils talked to the parents and escorted the child to the nearest fixed immunisation post. The pupils recorded their results, with the help of the teachers, on the supplied forms. At the end of the exercise, 100 percent of the adopted children were fully immunised.

Based on this success, the strategy was adopted in more LGAs in Katsina State. By March 2007, 490 schools from 30 LGAs had participated in the exercise and 105,116 children were immunised, representing 91.9 percent coverage. In each of the exercises, results showed that more than 90 percent of adopted children were immunised. Figure 9.4 shows a gradual increase in the number of adopted and immunised children from June 2006 to late March 2007.

Figure 9.4 Child-to-child participation linked to the Immunisation Plus Campaign



This strategy was designed to mobilise youth in peer-to-peer initiatives to develop sustainable and integrated campaigns that engage the community at all levels. Peer influence and community involvement are key elements that have been documented in health advocacy campaigns, and so were utilised to try to ensure that the greatest number of children were educated regarding polio and routine immunisation and that a maximum number of children were immunised. The children involved in the programme know their communities and, by extension, can know how many children aged under five years are living in the community. They have a high level of access to households and can therefore effectively monitor the vaccination status of their ‘adopted’ children.

However, the strategy has not been employed in a systematic way since March 2007 due to competing school interests, lack of earmarked funding, and insufficient ownership at the state and LGA level. Designated leadership and implementation procedures would help ensure that the strategy is reinforced and introduced in other states. Advocacy visits to the Ministry of Education is crucial to sustain the Ministry’s commitment to programming with youth. This commitment will need to be formalised with national and all LGA level partners, and orientation exercises conducted to prepare for state-wide implementation of the strategy for immunisation and other programmes. While these re-orientation efforts are important components of the strategy, it is still a fairly inexpensive technique for educating and reaching a high number of children. As such, sustainable mechanisms are achievable. Key lessons from previous experience should also be addressed in

future training activities, for example better preparation for teachers particularly in rural schools regarding completing line lists. These lessons have highlighted the need for periodic re-orientation to ensure that all teachers have knowledge and skills regarding the process to ensure accurate data collection.

9.9 Partnerships

Alliances with universities resulted in several of them initiating internal processes to mainstream issues related to children's and women's rights into their curricula, as noted earlier. UNICEF's Situation Assessment and Analysis publication has been used as an advocacy tool to mobilise academicians and students, and to mainstream child rights issues into relevant tertiary academic curricula. Out of 40 tertiary institutions involved in 2005, 25 carried out seminars and workshops in various faculties, and ten universities initiated internal processes to mainstream children's and women's rights issues into their curricula. The University of Jos established a Child Rights Centre, while the Benue State University in Makurdi established a postgraduate Centre for Gender Studies. An academic Chair on Child Rights was also established at the University of Lagos. Over 30 universities, polytechnics, and colleges involved in communication for development, mass communication and/or theatre, worked on course outlines on the rights of children and women.

Between 2005 and 2010, several alliances also emerged with the private sector, non-governmental and community-based organisations to drive forward the child rights agenda in Nigeria. These alliances have created a heavy demand for building the knowledge and skills of partners. Private sector collaboration also increased slightly, with businesses like Coca-Cola, V-Mobile, Binatone, DHL, Sheraton Hotels, and British Airways contributing to national projects. Unquestionably however, the most outstanding partnerships have been with religious and traditional leaders. Public pronouncements on child survival and development by the Sultan and *khutba* (mosque orators) were initially occasioned by the need to address the polio crisis, but eventually evolved into a more comprehensive approach to promote child survival and development.

The mass media continue to be key partners for information dissemination and programme communication. In 2005 alone, over 40 government and commercial radio outlets were conveying messages to individuals and families through drama series in Yoruba, Hausa, Pidgin, Fulfude, Kanuri and Igbo languages on key household practices, the use of insecticide-treated bed nets, and the use of vitamin A enriched foods. Through this partnership, millions around the country were reached with child survival and development messages.

New strategic alliances were also established with Governors and local government officials, professional bodies, academics, women and youth groups as well as other civil society organisations. State Action Committees of the Nigerian Movement for Children (NMC) were established in at least fifteen states in addition to one zonal committee. These committees sensitised non-governmental and community-based organizations and youth groups on child rights, in support of a Nigerian Movement for Children. The participation of Governors, local government officials and First Ladies in campaign activities has helped to mobilize communities for child well-being. The linkages that have been established at different levels and with different groups need to be sustained for effective impact.

The introduction of the World Café approach to consultations, idea-generation and brainstorming is helping the expansion of frontiers in partnerships. A World Café on partnerships brought together a wide variety of partners from all over Nigeria to discuss mechanisms for initiating, maintaining, and sustaining partnerships that promote respect, transparency, and equity. This is being followed up in terms of laying good structures for partnerships and ensuring that partnerships go beyond conventional definitions. There is also a clear need to partner better with children and young people.

9.10 Lessons learned

1. Social marketing alone is insufficient to ensure the adoption of positive behaviours and practices. It has to be complemented by inter-personal communication activities and social mobilisation processes designed to move from awareness creation to real understanding.
2. Short-term and incomplete cycles of engagement are likely to be underlying reasons for why knowledge of several initiatives is still so low. There is a need to strengthen and scale up proven and effective approaches. Initiatives that are homegrown and emanating from communities deserve more attention.
3. Data driven communication is sine qua non for effective planning as data analysis can point to high-risk areas that require priority attention. It also supports well-targeted advocacy and provides an effective basis for determining the level of intervention required.
4. Documentation facilitates information sharing, and is useful for feedback to various stakeholders as this sustains their interest and engagement in communication activities.
5. Investments in capacity building for mass media personnel generate free airtime and print space.
6. Partnerships increase gains, mileage, and achievements both in scale and quality, and engagement with communities strengthens sustainability frameworks.

9.11 Conclusions

This section uses the SWOT approach to capture the strengths, weaknesses, emerging opportunities, and remaining threats to communication for development during and at the end of the programme cycle. The conclusions are drawn from the preceding analysis and evaluations cited, and include the outcome of consultations among several stakeholders.

Strengths

- a. Programmes are increasingly focusing on addressing behaviours as opposed to message dissemination and awareness-creation through IEC materials.
- b. Data-driven programme communication, planning, and implementation are already evident but largely limited to the PEI/RI programme due to inadequate data and funding; the approach of initial baselines and end-of-cycle evaluations is more common to other programmes.
- c. Increased focus on community-level intervention and provision of support for communication activities at that level.
- d. Early engagement and participation of communities is key to the success and sustainability of any development goal.
- e. Community dialogue facilitates understanding and animates communities for action and ownership.
- f. The Community Information Board is acting as convener for more structured community discussion and response.
- g. Expanded partnership with several stakeholders in development has increased. This is evident through the formation of State Social Mobilization and Technical Committees, State Social Mobilization Committees, and State Action Committees on HIV/AIDS.
- h. More interactive radio programming is making room for individual and general public concerns to be addressed.
- i. Community viewing and listening centres are stimulating dialogue and bridging knowledge

gaps in remote rural areas. The BBC World Service Trust project has increased interest in this.

- j. Theatre for Development is a viable approach to mirroring harmful practices and engaging communities to take action in promoting healthy behaviours for child survival and development.

Weaknesses

- a. Going to scale has been a challenge in every communication for development initiative.
- b. Monitoring and evaluation have not been fully mainstreamed in communication efforts.
- c. Documentation has not received adequate attention, resulting in low visibility and credit for the contribution of communication for development to overall programme results.
- d. Funding has been very insufficient, time bound, and donor-driven, focusing on vertical approaches – hence the limits on depth and intensity of several initiatives.
- e. The short time frame for communication for development initiatives makes it difficult to demonstrate changes in knowledge, attitudes, and practices.
- f. The capacity of service providers and social mobilisers at the LGA and community levels is limited and would require substantial strengthening to deliver programme communication at scale.
- g. The high demand for IEC materials and products makes participatory communication difficult. Less attention and support is given to participatory communication.
- h. Knowledge and skills related to communication for development and its key approaches/platforms are still limited among counterparts and partners.

Opportunities

- a. The move towards strengthening integration in primary health care (encompassing immunisation) paves the way for more holistic communication around the well-being of children, women, and the entire family.
- b. New awareness of communication for development within the Federal Ministry of Information and Communication is already filtering down through the Federal Information Officers in the states and staff of the National Orientation Agency.
- c. New partnership opportunities especially with the private sector are emerging, such as V-mobile sending text messages to customers on polio immunisation and HIV/AIDS prevention, and private radio stations donating additional free airtime or reducing costs for social development programmes.
- d. The opening of new radio stations (FM) in states and universities, which often include broadcasting in local dialects, will increase the reach of media to communities.
- e. Licenses for community radio will open new channels for community engagement.
- f. The willingness of religious and traditional leaders to get involved in community dialogue, social mapping, and monitoring of implementation of services and programmes will open doors for more integrated programming at community level.
- g. The key government strategic plans recognize the role and contribution of communities to overall development.
- h. A more active participation of marginalised groups such as women and children offers additional opportunities for more sustainable healthy practices at the household and community levels.

Threats

- a. Commercialisation of mass media (especially with the FM radio) is a barrier to large-scale

development programming.

- b. Monetisation of the polio communication campaign has undermined volunteerism at all levels and in other sectors and contributed to the lack of social development programmes.

9.12 Recommendations

1. Engaging communities provides a platform to address challenging attitudes and practices and paves the way for a more integrated and holistic programming around child survival, development, protection, and participation.
2. A common strategy, set of tools, communication language, and approaches will facilitate going to scale with behaviour change communication through the networks and alliances formed by the various campaigns (such as Roll Back Malaria, polio eradication, routine immunisation, vitamin A, HIV/AIDS, girl's education, sanitation, community management of malnutrition, and birth registration).
3. Adherence to the guiding principles of rights and evidence-based programming will ensure that in all communication for development efforts, community structures/institutions are respected, local culture is appreciated, and space is created for all groups to have their voices heard.
4. Evidence-based approaches will facilitate improved documentation of the impact of communication for development efforts. Communication planning guided by regular monitoring, and generation and use of data and evidence through systematic documentation will provide more insight into the contribution of communication to programme results.
5. Intensity and continuity over time is critical for ensuring the understanding of key messages by the people (which goes beyond mere awareness) as well as for facilitating change in attitudes and practices and sustaining the adopted health behaviours resulting in changes in the morbidity and mortality patterns for children and women and the social change results of development programmes.
6. Building the capacity of a wide range of civil society partners (especially umbrella partners with networks down to the grassroots levels), will better position the government to deliver development programmes on a large scale and accelerate efforts towards the achievement of the Millennium Development Goals.
7. Working at establishing sustainable frameworks for partnerships will help in scaling up interventions and leveraging the comparative advantages of various partners to achieve greater impact.

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