World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2013

NIGERIA

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AFRO Library Cataloguing-in-Publication Data

Second Generation, WHO Country Cooperation Strategy, 2008-2013, Nigeria

1. Health Planning
2. Health Plan Implementation
3. Health Priorities
4. International Cooperation
5. World Health Organization

ISBN: 978 929 023 1363 (NLM Classification**:** WA 540 HN5)

Printed in India

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Map of Nigeria

ABBREVIATIONS

ADB	:	African Development Bank
AIDS	:	Acquired Immunodeficiency Syndrome
AOW	:	Area of Work
APOC	:	African Programme for Onchocerciasis Control
ARI	:	Acute Respiratory Infection
CBO	:	Community-based Organization
CCA	:	Common Country Assessment
CCS	:	Country Cooperation Strategy
CHEW	:	Community Health Extension Worker
CIDA	:	Canadian International Development Agency
CSM	:	Cerebrospinal Meningitis
DALE	:	Disability Adjusted Life Expectancy
DFID	:	Department for International Development
DOTS	:	Directly-Observed Treatment Short-Course
DPC	:	Disease Prevention and Control
EB	:	Extra-Budgetary
ECP	:	External Cooperation and Partnership
EDM	:	Essential Drugs and Medicines
ENV	:	Environmental Health
EPI	:	Expanded Programme on Immunization
EPR	:	Emergency Preparedness and Response
EU	:	European Union
FAO	:	Food and Agriculture Organization of the United Nations
FCT	:	Federal Capital Territory
FTC	:	Free Standing Technical Cooperation
FMOH	:	Federal Ministry of Health
GAVI	:	Global Alliance for Vaccine and Immunization
GDP	:	Gross Domestic Product
GFATM	:	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	:	Gross National Product
HHA	:	Harmonization for Health in Africa
HDI	:	Human Development Index
HEC	:	Health Economist
HEAP	:	HIV/AIDS Emergency Action Plan
HIV	:	Human Immunodeficiency Virus

HPR	:	Health Promotion
HRH	:	Human Resources for Health
HSR	:	Health Sector Reform
ICC	:	Interagency Coordinating Committee
IDSS	:	Integrated Disease Surveillance System
IHP	:	International Health Partnerships
IMCI	:	Integrated Management of Childhood Illnesses
IMD	:	Information Management and Dissemination
IMR	:	Infant Mortality Rate
IPRSP	:	Interim Poverty Reduction Strategy Paper
JICA	:	Japanese International Cooperation Agency
LGA	:	Local Government Area
MDAs	:	Ministries, Departments and Agencies
MDG	:	Millennium Development Goal
MICS	:	Multiple Indicator Cluster Survey
MMR	:	Maternal Mortality Rate
MNH	:	Mental Health
MOH	:	Ministry of Health
MTSP	:	Medium Term Strategic Plan (2008-2013) of WHO
NACA	:	National Agency for the Control of HIV/ AIDS
NAFDAC	:	National Agency for Food and Drug Administration and Control
NAPCA	:	National Action for Prevention and Control of AIDS
NAPEP	:	National Poverty Eradication Programme
NCD	:	Noncommunicable Disease
NEEDS	:	National Economic Empowerment and Development Strategy
NEPAD	:	New Partnership for Africa's Development
NGO	:	Nongovernmental Organization
NHMIS	:	National Health Management Information System
NHP	:	National Health Policy
NID	:	National Immunization Day
NIMR	:	Nigerian Institute for Medical Research
NPHCDA	:	National Primary Health Care Development Agency
NPI	:	National Programme on Immunization
NPC	:	National Planning Commission
NPO	:	National Professional Officer
NUT	:	Nutrition
PEI	:	Polio Eradication Initiative
PHC	:	Primary Health Care
POA	:	Plan of Action

PRSP	:	Poverty Reduction Strategy Paper
RBM	:	Roll Back Malaria
REDUCE	:	Maternal Mortality Reduction Strategy
RH	:	Reproductive Health
SAP	:	Structural Adjustment Programme
SCHEW	:	Senior Community Health Extension Worker
SEEDS	:	State Economic Empowerment and Development Strategy
SMOH	:	State Ministry of Health
SO	:	Strategic Objective (of MTSP, 2008-2013, WHO)
STI	:	Sexually Transmitted Infection
TB	:	Tuberculosis
UBE	:	Universal Basic Education
UN	:	United Nations
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNCT	:	United Nations Country Team
UNDAF	:	United Nations Development Assistance Framework
UNODCCP	:	United Nations Office for Drug Control and Crime Prevention
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
UNHCR	:	United Nations High Commissioner for Refugees
UNICEF	:	United Nations Children's Fund
UNIFEM	:	United Nations Fund for Women
USAID	:	United States Agency for International Development
WHO	:	World Health Organization
WTO	:	World Trade Organization

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

This second generation Country Cooperation Strategy for Nigeria is based on the WHO Eleventh General Programme of Work 2006-2015, the WHO Strategic Objectives of the Medium Term Strategic Plan (2008-2013), the WHO Director General's Six Point Agenda, and *Strategic orientations for WHO action in the Africa Region 2005-2009*, and aligned with national priorities such as are outlined in the National Development Plan which is based on the 7-Point Agenda of Nigeria. It is also harmonized with the work of the United Nations and other partners in Nigeria.

The Country Cooperation Strategy contributes to the Nigeria UNDAF II 2009-2012 that articulates the commitment of the UN Country Team to support the efforts of the Government of Nigeria towards attaining the goals contained in the National Economic Empowerment and Development Strategy (NEEDS2) 2008-2011 and provides the framework for the harmonization of the work of UN agencies in the country.

Reviewing the health and development challenges and the implementation of the WHO Strategic Agenda for Nigeria in the first CCS (2002-2007), the current WHO collaborative programmes and their comparative advantages, the work of development partners in the sector, UNDAF II and the last biennium's national reform agenda articulated for the health sector, the current CCS will focus on the following:

1. **Improving stewardship and governance.** In particular, the areas of focus are assisting ministries of health to develop enabling management tools, policies and legislation; developing medium term plans and expenditure frameworks; collaborating with other sectors; advocating to government; improving health security and the management of emergencies.

2. **Strengthening health systems within the context of Primary Health Care.** The WCO will advocate for the passing of the National Health Bill. It will support the FMOH in developing the National Strategic Health Development Plan (NSHDP); evaluate implementation of the National Health Policy and give technical support to important federal and state policy organs; assist in developing a health workforce management system; assist with strategies to improve the availability of essential medicines and health technologies; strengthen health information systems and research; assist with institutionalizing health accounts at national and state levels; support the implementation of national strategic health financing policy and the national health insurance scheme.

3. **Scaling up priority interventions.** The WCO will focus on interventions in polio eradication and routine immunization, malaria, TB, HIV/AIDS and on the implementation of integrated maternal newborn and child health strategies. WHO will support capacity-building to harmonize and expand the current IDSR system.

4. **Addressing the social determinants of health.** WHO will do this through providing support for Health Promotion and its integration into disease control programmes and support for the MOH in promotion of intersectoral collaboration. WHO will support the MOH in its promotion of healthy cities and villages, healthy workplace programmes and health promoting schools initiatives; WHO will support the strengthening of poverty reduction, human rights and gender-based priority health programmes.

5. **Coordinating partnerships and mobilizing resources.** WHO will carry out these strategic priorities in partnership with bilateral and multilateral organizations and donors, local and international NGOs, and the MOH; WHO will continue to play an active role in UNDAF II.

6. To support resource mobilization, WHO will work with other partners to continue to support the MOH in its advocacy for resource mobilization at all levels of government; work to facilitate access to funds from the various international health partnerships; work with relevant bodies at federal and state levels to generate evidence about the economic burden of diseases and assist in using this for advocacy; assist with monitoring the impact of health resources on development goals.

The choice of these strategic directions also reflects the "unfinished" agenda of the first CCS as well as the new challenges of the International Health Partnerships and Related Initiatives (IHP+) as well as Harmonization for Health in Africa.

The CCS is also linked to the third priority of UNDAF II (2009-2012): transforming social service delivery, that is, targeting policies, investments and institutional changes that can facilitate access to quality social services in health, education, water and environmental sanitation. It also includes HIV/AIDS prevention, treatment and care, emphasizing behavioural change in the achievement of better social outcomes. It also addresses policies, plans and institutions to prevent and manage cross-border threats (especially in connection with avian influenza and HIV/AIDS).

Finally, the CCS was developed through an extensive consultative process involving the Organization at all levels, the Federal Ministry of Health departments and agencies, private sector and civil society organizations, research institutions, development partners and other key stakeholders in health.

SECTION 1

INTRODUCTION

The Nigeria WHO Country Cooperation Strategy (CCS) is presented as an adaptable country-specific strategy that provides the framework of cooperation between WHO and the Federal Government of Nigeria. It reflects the values, principles and corporate directions of the Organization with a view to aligning them with other UN agencies and partners working in health and development within the country.

The current CCS (2008-2013) builds on the foundation established and implemented in the first CCS (2002-2007).[1] By identifying the current challenges of the Nigerian health system, it clarifies the role of WHO in supporting national health development.

The second Country Cooperation Strategy for Nigeria provides direction to the Organization in preparing subsequent biennial workplans. It is premised on the principles elaborated in the World Health Organization global health agenda defined in the Eleventh General Programme of Work (GPW) (2006-2013), the Medium Term Strategic Plan (MTSP) 2008-2013 and the Six Point Agenda of WHO. It has also identified the regional priorities as stated in the Regional Office document, *Strategic orientations for WHO action in the African Region 2005-2009*. It is consistent with broad national, subregional and regional organization orientations as well as the United Nations Millennium Declaration.

This CCS derives its focus from the third section of the results matrix (transforming social service delivery) of UNDAF II (2009-2012). It targets policies, investments and institutional changes that can facilitate access to quality social services in health, education, water and environmental sanitation, and HIV/AIDS prevention, treatment and care.

This CCS provides the platform for support to the government, especially the health goals in NEEDS II, the National Strategic Health Development and Investment Plan, State Health Plans and LGA health plans towards the achievement of the MDGs.

Nigeria has signed on to the International Health Partnerships and Related Initiatives (IHP+) and has applied to the Harmonization for Health in Africa (HHA) initiative for support towards the development of a compact in the spirit of the Paris Declaration. The CCS is aligned to support this.

The process of developing this CCS followed a wide consultation with FMOH stakeholders and other development partners. Internal and external consultations were held on the draft documents before finalization. Draft copies were shared with key stakeholders who provided useful feedback.

The document provides information on Nigeria's health and development challenges, development assistance, aid flow and partnerships for health development; current levels of WHO cooperation and support; and the WHO policy framework. It also outlines the WHO Strategic Agenda and Strategic Objectives that will be the focus of WHO work during the period 2008-2013; it further identifies their implications for the work of the WHO Secretariat at country, regional and HQ levels toward contributing to the achievement of better health for the people of Nigeria.

SECTION 2

NIGERIA'S HEALTH AND DEVELOPMENT CHALLENGES

The Constitution of the Federal Republic of Nigeria (1999) establishes judicial, legislative and executive arms of government at federal and state levels.

The legislative arm of government comprises the Senate (upper house) and the House of Representatives (lower house) whose members are elected from state senatorial districts and constituencies, respectively. Each state has an elected executive governor, an executive council and a house of assembly with powers to make laws. Each local government area (LGA) is administered by an elected executive chairman and elected legislative council members from electoral wards. The 774 LGAs are divided into 9555 wards, which are the lowest political units.

The state governments have substantial autonomy and exercise considerable authority over the allocation and utilization of their resources. This arrangement constrains the leverage that the federal government has over state and local governments in terms of getting them to invest in social sectors, including health.

Most of the health and developmental challenges in Nigeria over the period of the first CCS (2002-2007) did not change significantly. Nigeria is on track toward achieving, in part or in whole, only three of the eight MDGs, namely those pertaining to universal primary education, HIV prevalence and sustainable development. With development partners, the government has initiated processes to address this situation. UNDAF II is the UN's response to these key shortfalls.

2.1 CHALLENGES IN ECONOMIC PERFORMANCE

Nigeria is the most populous nation in Africa. Within the period of the first CCS, the population grew from an estimated 118 million (2001) and an annual growth rate of about 2.8%, to 140 million (2006) with an annual growth rate of 3.2%.[2] Macroeconomic performance between 2000 and 2007 was remarkable (Table 1). GDP growth was positive through the entire period, attaining an annual average growth rate of 5.7%. Although oil continued to be the main driver of the economy, other sectors grew from 2.9% in 2001 to 9% in 2006.

Despite high income from crude oil sales and high external reserves, there is still a high incidence of poverty. The economic growth has not improved the welfare of the majority of the people; socioeconomic policies and programmes are therefore needed to reach the poor and most vulnerable groups in society.

Table 1: Macroeconomic indicators in Nigeria, 2000-2007

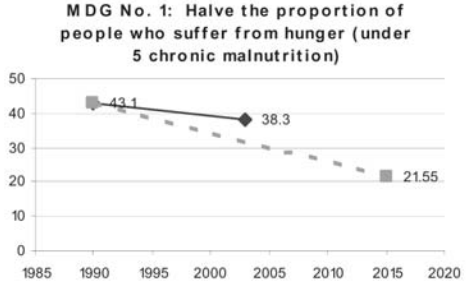
Economic Indicators									
	1990	2000	2001	2002	2003	2004	2005	2006	2007
GDP Growth (%)	8.2	5.4	4.6	3.5	9.6	6.6	5.8	5.3	5.7
Oil Sector Growth (%)	5.6	11.1	5.2	-5.2	23.9	3.3	-1.7	-3.7	-5.9
Non-oil Sector Growth (%)	8.6	4.4	2.9	4.5	5.2	7.8	8.4	9.5	9.2
Ext. Reserves (Months of Import cover)	Na	13.6	11.3	7.8	7.2	12.2	18.6	23.0	20.9
External Debt /GDP	106.5	64.9	57.3	72.1	61.1	84.5	69.2	7.4	4.0
Inflation Rate	7.5	6.9	18.9	12.9	22.2	14.7	16.2	13.6	5.9
Average Official Exch. Rate	7.9	101.7	111.9	121.0	127.8	132.8	132.9	128.5	127.4
Social Indicators									
Population (million)	88.5	108	118.8	122.4	125.6	129.2	133.8	140.0	140.0
Population Growth Rate (%)	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8	3.2
Life Expectancy (years)	Na	Na	54.0	54.0	54.0	54.0	54.0	54.0	54.0
Adult Literacy Rate (%)	na	57	57	57	57.0	62.0	57.0	64.2	64.5
Incidence of Poverty (%)	70.0	66.0	na	Na	Na	54.4	54.4	54.4	54.4

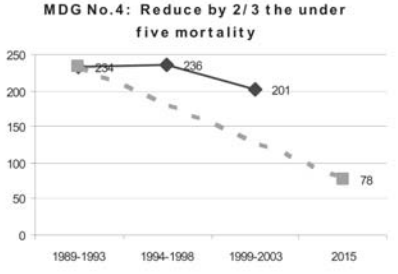
Sources: CBN Annual Reports and Statements of Accounts (various years).

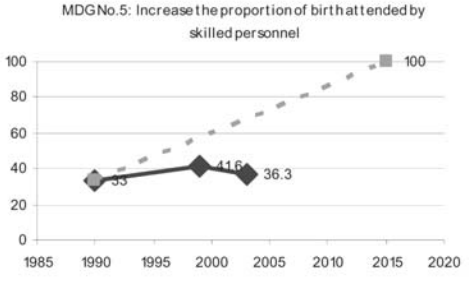
Nigeria's strategy for development is outlined in the latest version of the National Economic Empowerment and Development Strategy (NEEDS II) 2008–2011 which focuses on four major goals: poverty reduction, wealth creation, employment generation and value reorientation. The government's 7-Point Agenda has articulated the policy priorities as: (i) ensuring sustainable growth in the real sector of the economy; (ii) building physical infrastructure for power, energy and transportation; (iii) supporting agriculture; (iv) enhancing human capital development in education and health; (v) strengthening security, law and order; (vi) combating corruption; and (vii) developing the Niger Delta.

Figure 1: Progress towards the Millennium Development Goals in Nigeria

The four MDGs that are directly related to health are to: (i) eradicate extreme poverty and hunger; (ii) reduce child mortality; (iii) improve maternal health; and (iv) combat HIV/AIDS, malaria and other diseases.Sources: Federal Ministry of Health and World Bank, 2005; Nigeria Health, Nutrition, and Population Country Status Report; NDHS 1990, 1999, 2003.







Key targets are to achieve 10% annual average GDP growth, create 10 million jobs to lower the unemployment rate to below 5%, and reduce poverty by 30% by 2011. Others include achieving 11% annual growth in agricultural GDP; 6% annual increase in basic education enrolment; 50% increase in enrolment of girls in the six most disadvantaged states; reduction of infant, under-five and maternal mortality rates; provision of free health services to children under-five and pregnant women; and an increase in average life expectancy from 46.5 years to 60 years by 2011.

The Federal Government has earmarked about US$ 1 billion per annum of the gains from debt relief in a virtual poverty fund warehoused and dedicated to the MDGs; the fund is managed by the Senior Special Assistant to the President on the MDGs.

2.2 CHALLENGES IN HEALTH CARE

The major weaknesses that affect the delivery of health services include:

Inadequate decentralization of services: PHC facilities offer a limited package of services. Most health services can only be accessed at secondary and tertiary levels that are concentrated in urban areas, thus limiting access by rural populations.

Weak referral linkages: There are weak referral linkages between the levels of health care, limiting the provision of health services across a continuum of care.

Dilapidated health infrastructure: Dilapidated buildings and equipment are in need of repairs and maintenance or replacement to deliver even the basic services.

Weak institutional and capacity: Currently, there is no effective system for supervision of health services in the public and private sectors.

The National Health Bill, currently awaiting presidential assent, legislates that "all Nigerians shall be entitled to a guaranteed minimum package of services". In 2007, the Ward Minimum Health Care Package (WMHCP) was ratified by the National Council on Health as a minimum PHC standard. The Nigeria GAVI Health System Strengthening proposal (approved in early 2008) and other planned efforts will move Nigeria closer to the target of 50% of PHCs implementing the WMHCP by 2013. Currently, less than 15% of wards have at least one fully functioning PHC facility.

Nigeria continues to suffer from a double burden of both communicable and noncommunicable diseases (NCDs), with high levels of epidemic outbreaks and periodic occurrence of manmade and natural disasters and rising incidence of NCDs. Nigeria's health indices are weak (Table 2).

Table 2: Trends in basic health indices

Indicator	2000	2001	2002	2003	2004	2005	2006	*2007*
Infant Mortality Rate (per 1000 livebirths)	81.38	80.09	78.80	100.00	100.00	110.00	110.00	*86*
Under-five Mortality Rate (per 1000 livebirths)	183.75	189.50	195.25	201.00	197.00	201.00	201.00	*138*
Percentage of one-year-olds fully immunized against measles	32.80	41.10	61.80	31.40	50.00	60.00	60.00	*60.00*
Maternal mortality ratio (per 100 000)	704	704	704	800	800	800	800	*800*
Proportion of births attended by skilled health personnel (%)	42	42	37.3	36.3	36.3	36.3	36.3	*36.3*

Sources: MICS 1999, 2007; DHS 1999, 2003.

Maternal and child health

Less than 20% of health facilities provide emergency obstetric care (EOC) services, and only 36% of deliveries are attended by skilled personnel. Only about 60% of pregnant women have any antenatal care.

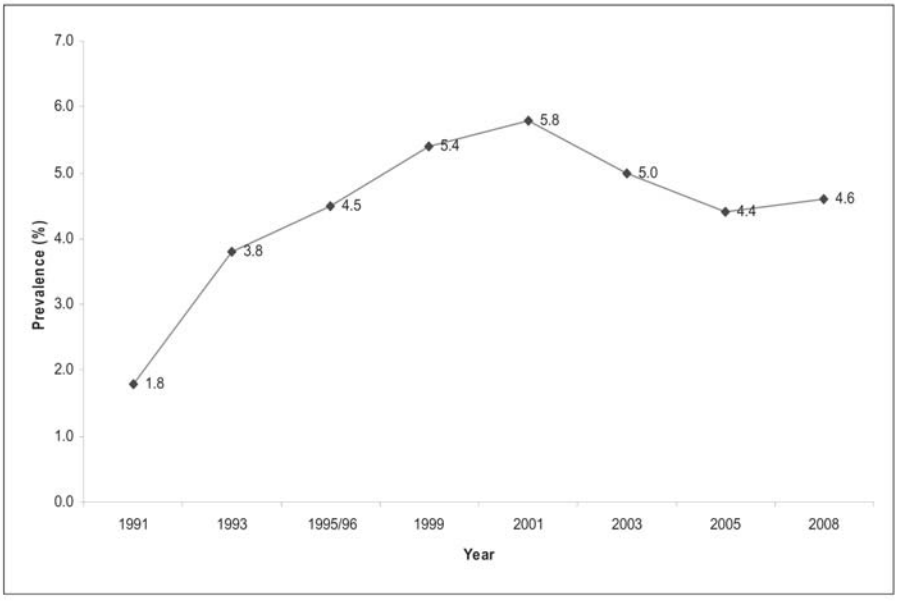
Most of the deaths among children are due to malaria (24%), pneumonia (20%), diarrhoea (16%), measles (6%) and HIV/AIDS (5%), with underlying malnutrition contributing to about 60% of the deaths. Newborn deaths account for 26% of under-five deaths; about 74% of these occur in the first week of life mainly due to pregnancy and delivery related complications. Many of these deaths occur at home.

A number of interventions have been implemented, including Reaching Every Ward (REW), Integrated Management of Childhood Illness (IMCI), and, lately, Integrated Maternal, Neonatal and Child Health (IMNCH). However, these initiatives have not resulted in major changes in the indices, or significant impact on progress towards MDGs 4 and 5, possibly due to weak implementation frameworks and inadequacy of skilled personnel to ensure full coverage. Increasing poverty and cultural barriers are also problems. The former makes modern health technologies unaffordable to parents while often the latter makes them unacceptable.

HIV and TB

The HIV prevalence rate was 4.6% in 2008 (Figure 2). This, however, represents about 2.86 million people living with HIV/AIDS by 2007. The prevalence of HIV and STIs is quite high among the age group 15-24 years. The 2003 NDHS revealed that 18.3% of young people aged 15-24 correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission, while the 2005 NDHS indicated an increase to 25.9%. The 2005 NDHS revealed that 63.8% of young people aged 15-24 reported using condoms during sexual intercourse with a non-regular sexual partner (up from 43.9% in 2003). The number of children who have lost one or both parents to AIDS was estimated at 1 366 219 (2005 ANC Surveillance Estimates and Projections).

Figure 2: HIV prevalence, 1991-2008



The HIV epidemic has resulted in a resurgence of pulmonary tuberculosis (TB). Nigeria ranks fifth among the 22 high-burden countries for TB in the world. In 2005, 66 848 new cases were reported nationally from the DOTS sites; of these new cases, 35 048 (52%) were smear-positive. The HIV positive rate among TB cases was 27% in 2005 (WHO 2005). At the end of the third quarter 2006, there were DOTS services in 599 LGAs, 643 TB microscopy centres in 548 LGAs (1 per 230 000 population) and 2117 health facilities providing DOTS TB treatment (1 per 70 000 population).

Less than 500 of the 2117 DOTS centres were implementing TB/HIV collaborative activities. TB and HIV/AIDS programme staff have not been trained in infection control measures, and isoniazid prophylaxis among HIV positive individuals is still in pilot phase. With the approval of the TB Global Fund Round 5 proposal, which includes a 5-year budget of US$ 68 million, the rate of DOTS expansion is expected to increase.

Table 3: Malaria and TB indicators

Indicators	2000	2001	2002	2003	2004	2005	2006	2007
Malaria prevalence rate (per 100 000)	2024	1859	2203	1727	1157	1157	1157	1157
Death rates associated with malaria	0.23	0.19	0.15	0.19	0.16	0.16	0.16	0.16
Proportion of population in malaria risk areas using effective malaria prevention and treatment measures	15.74	12.01	12.57	21.75	7.07	7.07	7.07	7.07
Tuberculosis prevalence rate (per 100 000)	15.74	12.01	12.57	21.75	7.07	7.07	7.07	7.07
Death rates associated with tuberculosis	1.57	2.24	1.58	2.5	1.50	1.50	1.50	1.50

Source: Federal Ministry of Health

Malaria

Malaria is the most significant public health problem in Nigeria. It is responsible for high proportions of disease and deaths (30% under-five mortality and 11% maternal mortality). At least 50% of the population will have at least one episode of malaria annually while children under-five will have two to four attacks of malaria annually. It is a major cause of poor child development. The economic cost of malaria may be as high as 1.3% of economic growth per annum. Increasing drug resistance has added to the burden. The political will to roll back malaria is very strong. Nigeria has subscribed to recent global malaria programmes such as Scaling Up for Impact (SUFI) and is mobilizing resources to scale up cost-effective malaria control interventions for all populations at risk. A business plan has been developed and is receiving support from the Roll Back Malaria Partnership.

Integrated Disease Surveillance and Response

With support from WHO, the Government has developed guidelines for the intensification of Integrated Disease Surveillance and Response (IDSR). Five epidemic-prone diseases (cholera, CSM, measles, Lassa fever and yellow fever) are now being reported weekly, and 23 diseases are now on the notifiable diseases list. Completeness, timeliness and quality still remain challenges. The National Policy on IDSR requires that all communicable diseases be reported on IDSR forms on a weekly basis if they are epidemic prone; other diseases are to be reported monthly.

National Health Management Information System

Little attention has been given to health information generation and management or health systems research to build evidence for a response to emerging needs. Currently, there is little linkage between health research and health policy. Reliable data are lacking, there is often under-reporting, and data obtained from sources are often inaccurate or conflicting.

The need for improved basic infrastructure at all levels was recognized and an HMIS minimum package was prescribed in the revised NHMIS policy document. There are still problems of availability of forms, inadequate infrastructural support and lack of monitoring, support and budgetary provision for HMIS at state and local government levels. Data are rarely used at the level generated or for policy formulation, decision-making or management of programmes.

Government seeks to improve this situation and is receiving the help of partners such as the Health Metrics Network.

Human resources for health

Nigeria has one of the largest stocks of human resources for health in Africa, comparable only to Egypt and South Africa. There are about 39 210 doctors and 124 629 nurses registered in the country; this averages out to about 30 doctors and 100 nurses per 100 000 population. This compares to a sub-Saharan African average of 15 doctors and 72 nurses per 100 000 population (WHO 2006).

There are rural-urban disparities as well as state-state disparities in the distribution of health staff. Recruitment procedures are often cumbersome. Remuneration packages for health professionals vary between the federal and state level and also between states. The result is that health professionals tend to gravitate to the better-paying federal facilities and states. Private providers (except faith-based ones) mainly operate in urban settings where income levels are generally highest, resulting in reduced access to qualified and competent health professionals for people living in rural and deprived areas that bear a greater portion of the disease burden.

Health financing

The absence of institutionalized National Health Accounts has amplified the weak basis for assessment of health spending in Nigeria. This is particularly so as all levels of government have concurrent responsibility for funding the sector. Funding of the sector relies on a mixture of government budget, health insurance (social and private), external funding and private out-of-pocket spending. The level of spending on health is relatively low at less than 5% of gross domestic product (GDP). Household out-of-pocket expenditure as a proportion of total health expenditure averaged 64.5% between 1998 and 2002, which is very high. It is estimated that on average health care consumes more than half of total household expenditure in about 4% of cases and over a quarter in 12%.

The Federal Government and some state governments have substantially increased allocations to health care since 2003 (Table 4). The Federal Government has also tried to increase the resource allocation to PHC by other means, such as the National Health Bill which created a Primary Health Care Development Fund.

Table 4: Allocations to health (in Naira)

	2004	2005	2006	2007
Personnel costs	30 983 689 139	43 304 805 361	62 711 850 776	64 204 337 904
Overheads	2 393 687 372	3 589 580 000	5 030 358 565	7 182 496 670
Capital	26 410 000 000	31 671 999 123	39 122 800 001	52 536 005 425
TOTAL appropriations	**59 787 376 511**	**78 566 384 484**	**106 865 009 343**	**123 922 839 999**
Annual Federal budget		1,800 000 000 000	1 900 660 623 804	1 700 000 000 000
Health sector allocation as % of budget		4.4%	5.6%	7.28%
% increase in sector allocation		31.4%	36.0%	86.2%

Though Nigeria has made considerable progress in financing the health system, sustaining and improving on this performance will depend on the availability of equitable and efficient revenue generation mechanisms; pooling and managing financial risks; the extent to which vulnerable groups are protected; and the existence of efficient health-care purchasing arrangements.

2.3 HEALTH-CARE REFORM

The period 2003-2007 saw the development of a reform agenda[3] for the health sector which outlines government priorities. This has been considered in the development of the CCS and the linkages are shown in Section 6. Government priorities are:

- improving the stewardship role of Government,
- strengthening the national health system and its management,
- reducing the burden of disease,
- improving health resources and their management,
- improving access to quality health services,
- improving consumer awareness and community involvement,
- promoting effective partnership, collaboration and coordination.

Several additional policy initiatives in the health sector were developed (Table 5).

Table 5: Health sector policy initiatives

Revised National Health Policy
Framework for Achieving the Health-Related MDGs in Nigeria
National Health Bill
Revitalization of the National Council on Health
Report on "Repositioning of the Federal Ministry of Health"
National Health Insurance Scheme
Other frameworks and policies: Public-Private Partnerships; Human Resources for Health; Health Financing; HMIS; Ward Minimum Healthcare Package; Maternal, Neonatal, Child and Adolescent Health; Health; National Drug and Health Promotion policies; Health Sector Response to HIV/AIDS

A review of the challenges in the health sector indicates a weak system with disconnections and less than optimal function of the subsystems.

There is inadequate decentralization of services, weak referral linkages, dilapidated health infrastructure, and weak institutional capacity.

Information management is poor with poor implementation and utilization of the NHMIS with resultant lack of evidence-based planning and policy-making. Human resources are often poorly trained, inequitably distributed geographically and between disciplines. Health financing is suboptimal with little health accounting, inadequate government contributions and a nascent health insurance system.

This weak system has to cope with a rising population, a heavy burden of both communicable and noncommunicable diseases, and specific problems such as high maternal and child mortality.

The CCS proffers WHO support to national authorities in ameliorating these challenges. In particular, efforts will be made to support the scaling up of interventions that work while systematically strengthening the health system and achieving coherence in operations of the system.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

3.1 OVERALL TRENDS

With a rising foreign reserve profile, by all accounts, Nigeria is not an ODA- dependent country. Indeed, ODA constitutes about 1% of gross national income. Nigeria receives on average about US$ 2 per capita a year whereas the African average is about US$ 28. However, in an effort to fulfil its commitment to the implementation of the Paris Declaration, the Nigerian Government introduced in May 2007 its policy on Official Development Assistance.[4]

Available data from the National Planning Commission on the operations of development partners in Nigeria reveals that donors operate in a wide range of sectors of the national economy. The presence of some donors is widespread in many states of the Federation. Experiences have shown that while most donors carry out projects and programmes that reflect the priorities of government, these are not necessarily derived from the existing strategic frameworks. Some of the activities are derived from the country analytic studies individually undertaken by some donors (ADB, UNDP) or jointly undertaken by some donors (World Bank and DFID).

While the National Planning Commission (NPC) has the statutory responsibility of coordinating the use of external development assistance at all levels of government (federal, state, and local), coordination has not been as effective as it should at MDA levels and has been less so at state and local government levels where most of the programmes and projects are located. At the state levels, the ministries of finance, economic development or planning form the pivot for coordinating external assistance to the state and local government areas. The capacity to coordinate however varies greatly among the states.

Tracking donor resource flow has been a challenge.[5] Available information revealed that from the drive towards MDGs, there has been more resource inflow for intervention programmes (HIV/AIDS, malaria and TB) and maternal mortality reduction.

At the level of coordination among donors, considerable progress has been made, although there remains much room for improvement. Coordination occurs at two levels: the political and the technical. At the political level, and depending on needs, government holds a general coordination meeting of the donors dealing with broad issues of general interest and eliciting responses from the donors and stakeholders. Such meetings are conducted at the highest level of participation, including ambassadors, high commissioners, and heads of donor agencies under the chairmanship of the NPC minister or the UN Resident Coordinator. The concept of “the three ones” (one plan, one coordinating body and one monitoring and evaluation system) at the highest level of government should be the basis for coordination. Consequently, within the principles of the Paris Declaration on Aid Effectiveness, Alignment and Harmonization, the Government of Nigeria is combining all the development frameworks (NEEDS, SEEDs, LEEDS, MTEF and the Seven Point Agenda). This will be the basis for donor

and partner alignment. Efforts are being made for development of the Joint Assistance Strategy (DFID and WB) and more coordination that may lead to SWAps in some states.

Within the United Nations development system, the United Nations Development Assistance Framework (UNDAF) is the basis for coordination. Currently UNDAF II responds to development challenges in Nigeria through a strategy that capitalizes on the particular ability of UN agencies, working as a team, to address key and linked aspects of governance at the federal or state level.

Reflecting this strategy, the UNDAF mission statement declares: "In the context of the country's international commitments, the UN Country Team will support Nigeria in its efforts to secure a policy and institutional environment within which all citizens are active agents of development that distributes benefits equitably to the present generation without jeopardizing gains for future generations." The mission statement and its underlying concepts are captured in four programme priorities: (i) governance and accountability that support transparent, equitable and effective use of resources; (ii) productivity and employment for wealth creation with a bias towards the poor and with the aim of contributing towards the growth of a vibrant, private sector-led non-oil sector; (iii) social service delivery to invest in Nigeria's human capital and contribute towards a democratic dividend that reaches most of the poor even as it boosts current and future potential for equitable growth; and (iv) reduction of the risk of crisis and conflict to help address the challenge in the Niger Delta while assisting with crisis prevention, management and mitigation in other parts of the country.

3.2 HEALTH SECTOR COORDINATION

The National Health Policy establishes the National Council on Health to advise the Government of the Federation, through the Minister, on: (i) the development of national guidelines for health; (ii) the development, implementation and administration of the National Health Policy; (iii) technical matters regarding the organization, delivery and distribution of health services; and (iv) any other matter assigned by the Minister. This is the Coordinating Framework for the health sector that binds the 36 States, FCT and FMOH in order to achieve coherence in service provision.

There are several partners operating in the health sector and in diverse areas of intervention and spread across various states (for details of donor intervention see Annex 1). Table 6 presents the interface between the donor interventions and the CCS priority areas.

Table 6: Donor interventions and CCS priority areas

DONOR AGENCY	CCS PRIORITY				
	Improving stewardship/ governance	Strengthening H\health systems within the context of PHC	Scaling up priority interventions to achieve the health MDGs	Addressing social determinants of health	Partnership coordination and resource mobilization
Africa Development Bank (AfDB)	XXX	XXX			
Canadian International Development Agency (CIDA)		XXX			
EC Delegation (health projects)		XXX	XXX		
Japan International Cooperation Agency (JICA)		XXX	XXX	XXX	
UNICEF			XXX	XXX	XXX
DFID	XXX	XXX	XXX		XXX
USAID					
World Bank (WB)	XXX	XXX	XXX		
GFATM		XXX	XXX		
UNFPA		XXX	XXX	XXX	XXX
Rotary International			XXX		

At the federal level, the Health Partners Coordinating Committee has also been the major coordination mechanism of activities in the sector. There are a variety of these coordination platforms such as ICC for polio eradication and routine immunization, and the Health Systems Forum; the most prominent is the CCM for Global Fund activities. The Global Fund Country Coordinating Mechanism is an independent body that is not aligned to any of the existing national coordination structures. Since its inception, CCM Nigeria has managed to secure grant approvals from the GFATM to total US$ 500 million. The current CCM Nigeria structure consists of three committees: the Executive, Oversight and Resource Mobilization Committees in all of which WHO provides technical support; in addition, the WHO Representative is the Chair of the Resource Mobilization Committee.

SECTION 4

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been and is still undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, and the achievement of the health-related MDGs. This organizational change process has, as its broad frame, the WHO Corporate Strategy.[6]

4.1 GOAL AND MISSION

The mission of WHO remains "the attainment by all peoples, of the highest possible level of health" (Article 1 of WHO Constitution). The corporate strategy, the Eleventh General Programme of Work 2006-2015[7] and the document *Strategic orientations for WHO action in the African Region 2005-2009*[8] outline key features through which WHO intends to make the greatest possible contributions to health. The Organization aims at strengthening its technical and policy leadership in health matters as well as its management capacity to address the needs of Member States, including the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions, which are based on its comparative advantage,[9] these are:

(a) Providing leadership in matters critical to health and engaging in partnership where joint action is needed;

(b) Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;

(c) Setting norms and standards, and promoting and monitoring their implementation;

(d) Articulating ethical and evidence-based policy options;

(e) Providing technical support, catalysing change, and building sustainable institutional capacity;

(f) Monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA

In order to address health related policy gaps in social justice, responsibility, implementation and knowledge, the global health agenda identifies seven priority areas; these include:

- Investing in health to reduce poverty;
- Building individual and global health security;

- Promoting universal coverage, gender equality and health-related human rights;
- Tackling the determinants of health;
- Strengthening health systems and equitable access;
- Harnessing knowledge, science and technology;
- Strengthening governance, leadership and accountability.

In addition, the Director-General of WHO has proposed a six-point agenda focusing on health development, health security, health systems, evidence for strategies, partnerships and improving the performance of WHO. In addition, the success of the Organization shall be measured in terms of results in women's health and the health of African people.

4.4 GLOBAL PRIORITY AREAS

Global priority areas have been outlined in the Eleventh General Programme of Work.[10] They include:

(a) Providng support to countries in moving to universal coverage with effective public health interventions;

(b) Strengthening global health security;

(c) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;

(d) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;

(e) Strengthening WHO leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The regional priorities have taken into account the global documents and resolutions of WHO governing bodies, the health Millennium Development Goals and the NEPAD health strategy, resolutions on health adopted by heads of state of the African Union and the organizational Strategic Objectives which are outlined in the Medium Term Strategic Plan (MTSP) 2008-2013.[11] These regional priorities have been expressed in *Strategic orientations for WHO action in the Africa Region 2005-2009*. They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy-making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructure.

In addition to the priorities mentioned above, the Region is committed to supporting countries to attain the health MDGs, and assisting in tackling the human resource challenges. In collaboration with other agencies, assisting countries to source financing for their national goals will be done with the leadership of countries. To meet these added challenges, one of the important priorities of the Region is that of decentralization and the installation of Intercountry Support Teams to further support countries in their own decentralization process so that communities may benefit maximally from the technical support availed to them.

To effectively address the priorities, the Region is guided by the following strategic orientations:

- Strengthening the WHO Country Offices;
- Improving and expanding partnerships for health;
- Supporting the planning and management of district health systems;
- Promoting the scaling up of essential health interventions related to priority health problems;
- Enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the WHO corporate strategy at country level will vary from country to country depending on country-specific contexts and health challenges. By building on the WHO mandate and its comparative advantage, the six core functions of the Organization, as outlined in Section 4.2, may be adjusted to suit individual country needs.

SECTION 5

CURRENT WHO COOPERATION

The first CCS 2002-2007 proposed a six-point strategic agenda for Nigeria focusing on resource mobilization for health; strengthening the health system; scaling up priority interventions; health promotion, sustainable development and healthy environment; and partnerships and coordination. The CCS was operational through three biennial workplans: 2002-2003 based on 23 areas of work; 2004-2005 with 16 areas of work; and 2006-2007 based on 15 areas of work. The reduction in the areas of work was an attempt to strengthen and refocus the plan of cooperation rather than spread interventions too thinly. However, each of the biennial plans amplified interventions in a successive manner to implement the strategic agenda.

5.1 RESOURCE MOBILIZATION

In resource mobilization, WHO facilitated development of several proposals submitted for funding major health interventions as part of the efforts to increase resources for the sector. Specifically, GFATM, GAVI, EC and the World Bank have all increased their funding portfolios in Nigeria. While developing the National Health Accounts, the government gathered evidence that indicated large out-of-pocket payments for health care; consequently, the government accelerated the launch of the National Health Insurance Scheme, not only to mitigate catastrophic health expenditure but also to provide a pool of funds for the health sector. WHO supported the development of policy on public-private partnerships to raise the profile of resource availability (especially from the private sector) for the health sector.

WHO advocacy and technical support facilitated effective partnership collaborations resulting in increased country level resources from government at all levels, local stakeholders and communities. This was done through WHO presence at state level as well as the use of evidence, advocacy tools and financial management procedures. The health budget portion of the total federal government budget has been increasing, while the special fund debt relief fund for MDG activities has also been made available to support health interventions. The WCO continues to improve its capacity for local resource mobilization as evidenced in the various funding MoUs with development partners, and within the CCS period a designated staff member was employed for resource mobilization. However, there is need to improve the negotiating skills of technical officers.

5.2 HEALTH SYSTEM STRENGTHENING

WHO has supported health system strengthening by engaging with government in a process of health sector reform. Within the period 2002–2007, various policies, plans and guidelines were reviewed and developed based on assessments and analyses supported by WHO.

In addition, WHO, through its TDR Programme and in collaboration with the Country Office and with support from the ministries of health, science and technology, has established

a research reference group on health systems and implementation research which will provide research evidence and synthesis for health system strengthening in the country.

Support was provided for the development of standard treatment guidelines (STGs) to support the rational prescribing and procurement of medicines in health facilities. WHO supported the traditional medicine programme to draft the Code of Conduct for practitioners and to develop the training curriculum. The medicine regulatory authority was helped to improve quality and safety of medicines by training health workers in integrated medicines supply management for all medicines including those for HIV, TB and malaria. WHO has supported the Federal Ministry of Health, the Medicine Regulatory Agency and the National Agency for Food and Drug Administration and Control (NAFDAC) to strengthen capacity to monitor fake and substandard drugs and deliver good quality, safe, effective and affordable medicines as well as promote their rational use. The National Drug Policy, which was first launched in 1990, was reviewed, while the medicines and medical supplies management information system at the Central Medical Stores was revitalized.

5.3 SCALING UP PRIORITY INTERVENTIONS

IDSR received greater impetus from the states and zonal offices of WHO. The mechanism established for polio surveillance was invaluable during the outbreak of avian influenza. All 36 states and the Federal Capital Territory attained the two main acute flaccid paralysis (AFP) surveillance performance indicators (non-polio AFP rate of at least two per 100 000 population under 15 years; at least 80% stool adequacy rate). WHO supported the initiation of neonatal tetanus case-based surveillance. WHO supported the strengthening of diagnostic and laboratory services as a backbone of health services delivery. The polio reference laboratories have continued to be strengthened with support to other laboratories for measles and yellow fever.

WHO has supported the strengthening of early warning systems and laboratory capacity for diagnosis of H5N1. In addition, WHO has helped the health ministry to reduce the risk of human HPAI infection through the establishment of rapid response teams at federal and state levels, and the training of clinicians in its diagnosis and management, and through the supply of PPE kits.

WHO actively supported the antimalaria drug efficacy trials in 2002 which tested chloroquine and sulphadoxine-pyrimethamine, and those in 2004 which tested artemether-lumefantrine and artesunate-amodiaquine. This helped to generate evidence that led to the review of the antimalaria treatment policy and guidelines in 2005.

Between 2002 and 2007, WHO supported the scaling up of priority interventions in Nigeria through individual health worker and institutional capacity development. Support was provided for development of the strategy for maternal, newborn and child health; implementation of the global strategy on infant and young child feeding; increasing capacity for scaling up the integrated approach to management of sick children in Primary Health Care facilities, and promotion of key household practices; strengthening capacity in the zones to improve paediatric care at referral facilities; improving newborn care; developing institutional capacity for the teaching the Integrated Management of Childhood Illness strategy in basic health institutions.

Also, support was provided for developing, implementing and documenting the success stories of the Home Management of Malaria and Community-directed Interventions strategies. Other catalytic efforts included a pilot initiative on Making Pregnancy Safer, including building capacity for emergency obstetric care through life-saving skills training for midwives and NYSC doctors.

Support was provided to scale up access to TB diagnostics and DOTS and also to integrate all DOTS services into the PHC system. A framework was established for TB/HIV collaborative activities. DOTS expanded from 59% state coverage in 2002 to 100% (37) by 2005, increasing the case detection rate from 16% (2002) to 30% (2006). WHO provided support for reviewing the Strategic Plan (2006-2010); developing guidelines for a public-private mix for DOTS; initiating the process for establishing an effective national management system for multidrug-resistant TB; promoting effective collaboration among all TB partners and stakeholders through joint partnership meetings and monitoring. The national ART programme which started in 2002 involving 25 pilot sites (mainly tertiary health facilities) was expanded to 210 health facilities delivering ART services to 166 000 persons living with HIV by the end of 2007.

Also with support from WHO and in collaboration with other stakeholders, the FMOH embarked on the exercise that resulted in the development and adaptation of the following protocols:

1. HIV Drug Resistance Early Warning Indicators to define national indicators and retrieve relevant data from ART sites in conformity with the NNRIMS;
2. HIV Drug Resistance Monitoring Strategy for populations receiving ART;
3. evaluation of transmitted HIVDR using specimens from PMTCT sites (threshold survey).

The Patient Management Monitoring System and training of health-care providers were harmonized. The IMAI strategy and the training of the national core team of trainers and expert client trainers were implemented. WHO provided support to the Reaching Every Ward strategy; Immunization Plus Days: the integrated measles control approach; activities for sustaining high-quality disease surveillance.

Interventions such as antihelminthics, insecticide-treated bednets and oral rehydration salts were included in the immunization drive and led to increased immunization coverage. The support provided by WHO for routine immunization strengthening contributed to the efforts of national authorities and other partners and resulted in improved access to and coverage of routine immunization services.

Health promotion, sustainable development and healthy environment as strategic agenda items received modest attention. Institutional capacity was built for health promotion with support to competency-based training in health promotion organized by the Department of Health Promotion and Education, University of Ibadan. WHO facilitated the development of a nutrition partnership. Generation of evidence on health and poverty was carried out and this is being used to influence intervention programmes and resource allocation. Very little has been achieved in the area of mainstreaming health into the plans and activities of other MDAs.

5.4 PARTNERSHIP AND COORDINATION

With active participation and support from WHO, a few coordination platforms have been developed and strengthened. The ICC, CCM, Health Systems Forum, Malaria Partnership and IMNCH partnership are examples. These platforms (especially the CCM) have moved ahead to develop a system based on the "three ones" for HIV/AIDS as the basis for support to implementation of activities. In some states, partners (including DFID, CIDA, UN agencies, USAID and the World Bank) are working under state government leadership to what might eventually be a health sectorwide approach.

As part of the intensified efforts to achieve interruption of wild poliovirus transmission in Nigeria, WHO has supported the directive of the National Primary Health Care Development Agency (NPHCDA) to all states to establish or strengthen high-level intersectoral coordination committees at state level with oversight of planning and implementation of priority polio eradication activities. These committees exist as state task forces or interagency groups for polio eradication or immunization and bring together ministries of health, local government, information, women's affairs, education; health partner agencies; and community representatives, including traditional and religious leaders. Several states are already using these committees to support planning, implementation and monitoring of other health priority activities such as outbreak detection and response.

5.5 OFFICE ENVIRONMENT

With the decentralization of technical cooperation in Nigeria, WHO presence at state level has enhanced close monitoring of WHO-supported state and LGA-based programmes as well as ensured increased interaction with partners in the states. The opening of imprest accounts for state offices has increased facilitation of the flow of funds to projects and activities. The direct disbursement mechanism was introduced to support polio eradication and this has enabled more than 95% of allocated funds to be disbursed for operational activities and payment of vaccinators. In addition, a few other partners and the Government have utilized the mechanism for disbursement of their funds.

Within the CCS period 2002-2007, the Country Office fully relocated from Lagos to Abuja, within the UN premises housing other UN agencies. There is now better interaction with other UN agencies and with Federal Ministry of Health staff. Furthermore, housing all programmes within one building facilitated the supervision and coordination of all programmes and activities by the WHO Country Representative.

The GPN was installed and it has facilitated communication with the Regional Office, other Country Offices and HQ. It has equally facilitated networking with other regions of the Organization.

5.6 STAFFING SITUATION

In full support of the implementation of the CCS in Nigeria, HQ, the Regional Office and the Intercountry Support Team for West Africa continued to respond positively to all requests for support emanating from the WCO. Staff numbers increased from 350 in 2003 to 478 in 2005; however, with the current contract reform, the numbers decreased to 439 by the end of 2007. While the majority of staff members are on the Expanded Programme on Immunization (92%), other programmes for TB, HIV/AIDS, guinea-worm, and family and reproductive health also benefited from additional staff for scaling up interventions.

Organizational restructuring and staff reprofiling have been undertaken to ensure that the office is well-led, well-staffed and well-equipped to effectively coordinate and deliver the WHO response to national health development in Nigeria. Finally, programme coordination and working across areas of work have improved tremendously. There is now more effective and efficient delivery of WHO technical programmes and improved visibility of the Organization in Nigeria.

Drawing from technical and financial backstopping from HQ, the Regional Office and ISTs, the Country Office was able to achieve these successes within the CCS period.

SECTION 6

STRATEGIC AGENDA

The choice of these strategic directions also reflects the "unfinished agenda" of the first CCS as well as the new challenges of the International Health Partnerships and Related Initiatives (IHP+) and Harmonization for Health in Africa.

This Country Cooperation Strategy is firmly based on WHO policies and strategies, the six core functions of WHO, and the Strategic Objectives of the Medium Term Strategic Plan 2008-2013 (MTSP) which form the current planning and implementation framework for WHO work at country level. It is aligned with national priorities and is harmonized with the work of United Nations (UNDAF II) agencies and other partners in Nigeria.

The current CCS will focus on the following strategic agenda:

1. improving stewardship and governance,
2. strengthening health systems within the context of Primary Health Care,
3. scaling up priority interventions to achieve the health MDGs,
4. addressing the social determinants of health,
5. partnership coordination and resource mobilization.

The Strategic Objectives are aligned (Table 7) to the reform agenda articulated for the health sector which aims at (i) improving the stewardship role of Government; (ii) strengthening the national health system and its management; (iii) reducing the burden of disease; (iv) improving health resources and their management; (v) improving access to quality health services; (vi) improving consumer awareness and community involvement, and (vii) promoting effective partnership, collaboration and coordination.

Table 7: Linkages between Federal Ministry of Health priorities and CCS Strategic Objectives

FMOH priorities	CCS priority areas				
	(1) Stewardship and governance	(2) Strengthen health systems within the context of PHC	(3) Scaling up priority interventions	(4) Addressing the social determinants of health	(5) Partnership coordination and resource mobilization
1 Improving the stewardship role of Government	+++	+++	+++	+++	+++
2 Strengthening the national health system and its management	+++	++ +	+++	++	++
3 Reducing the burden of disease	++	+++	+++	++ +	+++
4 Improving health resources and their management	+++	++	+++	++	+++
5 Improving access to quality health services	++	++ +	+++	++	+++
6 Improving consumer awareness and community involvement	++	+++	++	+++	++
7 Promoting effective partnership, collaboration and coordination	+++	+++	+++	++	+++

Key: *+++= Very strong linkage; + += Strong linkage; += Some linkage*

The synergy that will result from working with other agencies active in the health sector is recognized. UNDAF captures the linkages with development partners and the UN system (UNICEF, UNFPA, UNDP, UNAIDS) in particular. UNDAF II provides a unique opportunity for the UN system in Nigeria to work together to "deliver as one" in six states and the FCT. Delivering as one connotes joint responsibility and accountability of the UN system for specific outcomes. While UNDAF results are to be achieved from efforts in all states, the UN will be delivering as one in Adamawa, Akwa-Ibom, Benue, Imo, Kaduna, Lagos and FCT.

This CCS is linked to the third priority of UNDAF II (2009-2012), that is transforming social service delivery, which consists of three UNDAF outcomes. The first UNDAF outcome targets policies, investments and institutional changes that can facilitate access to quality social services in health, education, water and environmental sanitation, and HIV/AIDS prevention, treatment and care. Contributions to this result will come from agency outcomes that enable preparation of evidence-based policies and plans as well as expansion of service delivery. The second UNDAF outcome emphasizes behavioural change in the achievement of better social outcomes. The related agency outcome seeks to boost public demand for and participation in social service delivery. The third UNDAF outcome is based on policies, plans and institutions to prevent and manage cross-border threats (from avian influenza and HIV/AIDS, for example). The relevant agency outcome targets the implementation of agreed international norms and conventions for the prevention and management of such threats. The linkages between the CCS Strategic Agenda and the UNDAF Outcomes are further elaborated in Table 8.

Table 8: Linkages between CCS Strategic Objectives and UNDAF II2 Outcomes

UNDAF II Outcomes	CCS priority areas				
	(1) Stewardship and governance	(2) Strengthen health systems within the context of PHC	(3) Scaling up priority interventions	(4) Addressing the social determinants of health	(5) Partnership coordination and resource mobilization
1 Agency Outcome C.1.1: Federal Government and states able to utilize evidence-based approaches to formulate policies and develop plans for improved social service delivery with clear and costed targets as well as feasible and transparent financial plans	+++	+++	+++	+++	+
2 Agency Outcome C.1.2States provide quality and affordable social services in Y% of facilities		++ +	+++	+++	++++
3 Agency Outcome C.2.1 Groups and/or alliances of organizations stimulate public demand for and community participation in social service delivery in X states, with particular attention to the role of the poor and disadvantaged	+	+++	+++	++ +	+++
4 Agency Outcome C.3.1 Federal Government and selected states able to implement agreed international norms and conventions for the prevention and management of cross-border threats	++++				++++

6.1 STRATEGIC OBJECTIVE 1: IMPROVE STEWARDSHIP AND GOVERNANCE FOR HEALTH AT ALL LEVELS

To strengthen health system capacity for equitable and efficient service delivery through improved governance (stewardship), resource development and investment and fair financing, WHO will work within the context of UNDAF to support strengthening of governance and accountability of the health sector by ensuring that more resources are mobilized and channeled effectively in support of national development priorities, including the MDGs.

The main areas of focus are to support:

(a) the ministries of health with proper definition of the roles and responsibilities of key actors in the sector by developing the requisite enabling management and stewardship

tools, policies, operational health sector strategic development framework and legislation. This will include strategies for managing financial, human and physical resources.

(b) the FMOH and the state ministries of health to focus on medium term plans and expenditure frameworks and access to timely and reliable data on health development through capacity-building.

(c) the health sector to achieve coherence with other health-related sectors (stewardship for health) by building partnerships, generating evidence that situates health within development and using policy and advocacy briefs with the executive, legislative and judicial arms of government.

(d) the MOH to ensure health security and challenges of emergency situations.

These will be done while strengthening WHO presence in Nigeria through adequate administrative and managerial support backed by information technology and systems that facilitate the use of resources across the entire Organization to implement the CCS.

6.2 STRATEGIC OBJECTIVE 2: STRENGTHEN HEALTH SYSTEMS WITHIN THE CONTEXT OF PRIMARY HEALTH CARE

Based on the six building blocks and the priority areas of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the WCO will advocate for the passing of the National Health Bill and support revitalizing PHC, including referral systems as the backbone for strengthening the health system.

The main focus will be to support:

(a) the FMOH to coordinate the development of a national strategic health investment plan called the National Strategic Health Development Plan (NSHDP) with Primary Health Care as its foundation; to monitor and evaluate the implementation of the National Health Policy and give technical support to the functioning of various organs such as the National Council on Health, State Health Advisory Committees and Local Government Health Committees to focus on the development of Primary Health Care systems.

(b) the health sector-led diagnosis of health system constraints and strengthening of the policy and planning processes to improve health system performance. WHO will promote an integrated approach to health programmes within the health system through joint planning, implementation and evaluation of activities.

(c) the MOH and relevant agencies to develop a health workforce management system aimed at better planning, management, motivation and retention; and strengthening of the capacity of health training institutions.

(d) the federal and state health authorities in setting up sustainable mechanisms for increasing availability, affordability and accessibility of essential medicines, commodities, supplies, appropriate technologies and infrastructure through provision of adequate resources, technology transfer, the use of community-directed approaches and African traditional medicines; including strengthening the capacities of regulatory institutions including NAFDAC to improve the quality control of both orthodox and traditional medicines.

(e) strengthening of health information and surveillance systems, linkage to community-based information systems and dissemination of health information; facilitate the

strengthening of health sector databases and their linkages with other national databases for the purposes of monitoring the MDGs.

(f) the health sector to strengthen health systems and implementation research and to improve access to, and application of, research evidence through knowledge management systems and platforms.

(g) generation of evidence on health financing through institutionalization of national and subnational level and intervention-specific health accounts; support the implementation of the national strategic health financing policy and plan, and facilitate their integration into the overall national development framework for protecting the poor and vulnerable.

(h) continuing efforts of implementing the national health insurance scheme, especially community-based schemes.

6.3 STRATEGIC OBJECTIVE 3: SCALE UP PRIORITY INTERVENTIONS TO IMPROVE HEALTH

It is recognized that tools and strategies have already been developed for most of the priority interventions; however, the challenge is to adapt these tools and adopt strategies to deliver the interventions to those who need them most. This will be done by supporting strategies for scaling up towards universal access, including coordination with civil society and the private sector.

The main areas of focus of WHO will be to support:

(a) and sustain the current focus on polio eradication and routine immunization, malaria control, DOTS services, and HIV and AIDS treatment care and support as well as implementation of Integrated Maternal, Newborn and Child Health (IMNCH) and adolescent health strategies.

(b) the strengthening of Integrated Disease Surveillance and Response (for communicable and noncommunicable diseases) and strengthening capacity of public health laboratories for disease control and eradication efforts; specifically, WHO will support capacity-building to harmonize and expand current surveillance systems; strengthening national systems for major risk factor surveillance (by developing, validating and disseminating frameworks, tools and operating procedures to combat increasing burdens of death and disability attributable to the major risk factors).

(c) scaling up of interventions for neglected tropical diseases (NTDs).

6.4 STRATEGIC OBJECTIVE 4: ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

In addressing the social determinants of health, the WCO will advocate for the passage of a national health bill that is pro poor. The WHO Commission on Social Determinants of Health has called for "closing the gap" and resolving health inequities between different groups. The burden of disease resides with the poor, most of whom live on less than one dollar per day. WHO would advocate for provisions that would facilitate universal access to basic health-care packages that are within the national health bill, among others.

The main focuses of the WCO in addressing the social determinants of health are to support:

(a) the MOH to promote healthy lifestyles and healthy living, as well as the implementation of regional and country strategies in health promotion; and facilitate the integration of health promotion into disease control and community health programmes.

(b) the MOH in its promotion of intersectoral collaboration, public-private partnership, including civil society and communities with a view to improving the use of health services; taking appropriate action on the economic, social, demographic, nutritional, cultural and environmental determinants of health, including climate change.

(c) intersectoral actions, working with other partners such as FAO and UNICEF, to implement requisite food safety and food security interventions, including adequate nutrition; and monitor progress and impact.

(d) the MOH in its promotion of healthy cities, healthy villages, healthy workplace programmes and health-promoting schools initiatives.

(e) strengthening of the poverty reduction, rights-based and gender dimensions of priority health programmes; the FMOH to adopt organization-wide gender equality policy and gender mainstreaming strategies; the MOH in advocacy for mainstreaming health and gender into the plans and activities of other ministries and agencies whose activities impact on health such that good health can be seen as an input for development as well as a result of development.

6.5 STRATEGIC OBJECTIVE 5: IMPROVE PARTNERSHIP COORDINATION AND RESOURCE MOBILIZATION FOR HEALTH

To improve partnership coordination, WHO will focus on these strategic priorities in partnership with bilateral and multilateral organizations and donors, and local and international NGOs. This will necessitate building partnerships as well as fortifying existing ones. Using its comparative advantage as an international agency with a global mandate on health, and relying on its convening powers, the main focus in promoting and coordinating partnerships for health will be to:

(a) engage partners in dialogue on implementation of regional and global strategies, and resolutions of the WHO governing bodies; WHO will encourage linkages with other sectors by advocating for the mainstreaming of health into their activities and stress the fact that investments in these sectors do have a lasting impact on health and that adequate investments should be made in such sectors.

(b) work with MOH to broaden partnerships with NGOs and CBOs as vehicles to be used for scaling up implementation of priority interventions; in addition, WHO will advocate for the establishment of and strengthening of Interagency Coordination Committees (ICCs) for health at all levels.

(c) continue to play an active role in UNDAF II and the UN Country Team as well as supporting the Ministry of Health to coordinate partners in the health sector.

(d) increase the current level of per capita expenditure will require substantial efforts in resource mobilization using the opportunities created by increased donor interests in health.

Funding from domestic sources, that is, all government levels as well as the private sector, will need to be harnessed for rational utilization and sustainability. The main focus in resource mobilization will be to work with:

(a) other partners to continue to support the MOH in its advocacy for resource mobilization at all levels of government (federal, state and local) and from the private sector in order to ensure that additional resources are allocated to the health sector; this is necessary for the health budget to meet the per capita requirement of US$ 34–40 recommended by the Commission on Macroeconomics and Health.

(b) bilateral and multilateral partners and government to facilitate access to funds from the various international health partnerships (such as GFATM and GAVI) and ensure aid effectiveness.

(c) ministries of health, finance and planning as well as other relevant bodies at federal and state levels to generate evidence about the economic burden of diseases and utilize such evidence as advocacy tools.

(d) ministries of health and finance and various offices of statistics to ensure auditing of resources to the health sector and monitoring the impact of health resources on developmental goals.

Table 9: Linkages between the Nigeria CCS Strategic Agenda and WHO Strategic Objectives

WHO Strategic Objectives	CCS Nigeria Strategic Agenda				
	Improving stewardship and governance	Strengthening health systems within the context of PHC	Scaling up priority interventions to achieve the health MDGs	Addressing the social determinants of health	Partnership coordination and resource mobilization
SO1: To reduce the health, social and economic burden of communicable diseases	X	XX	XXX	X	X
SO2: To combat HIV/AIDS, malaria and tuberculosis	x	XXX	XXX	x	x
SO3: Prevent and reduce disease, disability and premature death fromchronic non-communicable conditions, mental disorders, violence and injuries	XXX	XXX	XXX	xxx	x
SO4: To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps	x	XXX	XXX	XXX	xx
SO5: Reduce the health consequences of emergencies, disasters, crises and conflicts, and	x	x	XXX	XXX	XXX

minimize their social and economic impact					
SO6: Promote health and sustainable development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex	XXX	XXX	XXX	x	XXX
SO7: Address the underlying social and economic determinants of health through policies and programmes that strengthen health equity and integrate pro-poor, gender-responsive and human rights-based approaches	xx	xxx	xxx	x	xx
SO8: Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	XXX	x	x	x	xxx
SO9: To improve nutrition, food safety and food security throughout the life-course, and in support of public health and sustainable development	x	x	xx	xxx	xx
SO10:To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research	xxx	XXX	XXX	XXX	XXX
SO11:To ensure improved access, quality and use of medical products and technologies	x	x	XXX	x	x
SO12: To provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work	xxx	x	x	xxx	xxx
SO13:To develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively	x	x	x	x	xxx

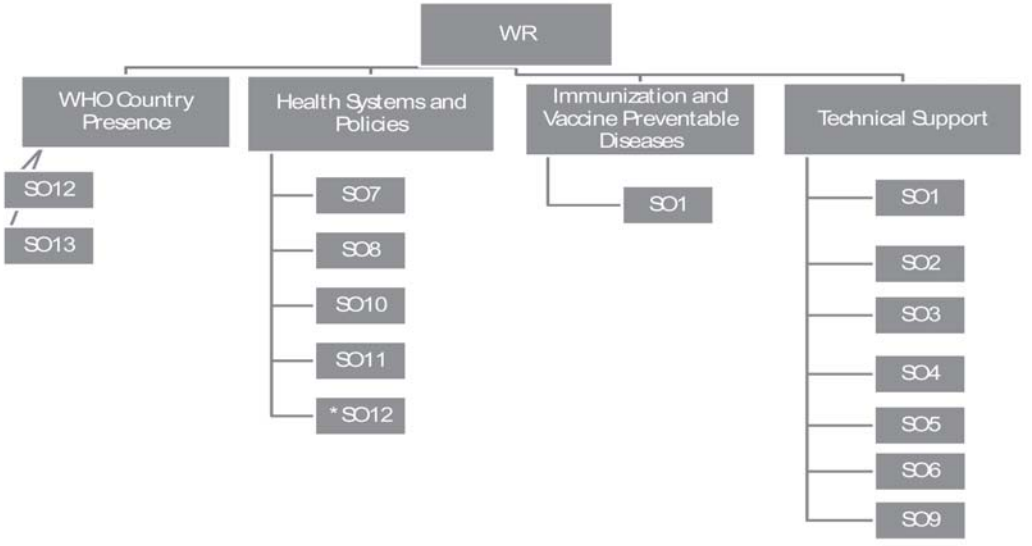
SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

7.1 COUNTRY OFFICE

It is recognized that implementation of this second generation CCS will require more active engagement of the WCO with health partners in policy dialogue and guidance, partnerships, advocacy for health, and strengthening of health systems.

Figure 3: Organization of the Nigeria Country Office



For better implementation of the CCS and delivery on the strategic agenda, the Country Office has been reorganized, under the guidance of the Country Representative, into four clusters. The WHO Country Presence Cluster will execute Strategic Objective(s) (SO) 12 and 13 and will be under the direct supervision of the WR. The Health Systems and Policies Cluster will deliver on SO7 to SO11 and will be supervised by a health systems advisor. The Technical Support Cluster will focus mainly on SO1 through SO6 and SO9 and is supervised by the HIV/AIDS Technical Advisor.

Because of the poliomyelitis problem in Nigeria, the desire to improve routine immunization and the plan to use immunization as an entry point in strengthening Primary Health Care, the Immunization and Vaccine Preventable Diseases Cluster has been carved out of the Technical Support Cluster to focus mainly on delivering SO1 and is supervised by the EPI Team Leader.

As stated earlier, implementing the first CCS, facilitated by the massive deployment for polio eradication, led to the restructuring of the WCO and deployment of intervention support at six national zonal offices, one liaison office and 36 state offices.

Given the high level of capacity built at state level, the effort will be to strengthen state offices to work (after the certification of polio eradication) towards strengthening health systems with PHC as the basis and ensure that zonal offices provide mobile support and supervision to the states. Programmatically, the Country Office will shift its operations from discrete processes to a broad sectoral results-based approach by ensuring an integrated package of interventions which can be deployed from zone to state level.

The highly consultative process of this CCS involved a better analysis of challenges and opportunities at the country level; it resulted in more selective items for the Strategic Agenda, taking health systems as the basis for analysis and paying particular attention to the values and principles of human rights, gender and the social determinants of health. This has helped to establish the strategic directions for WHO work in the country and has also defined the competencies needed for this work. With the changing profile of health partnerships, stronger advocacy and brokerage skills will be developed within the WCO. Positions for policy dialogue and health system strengthening will have to be consolidated and strengthened to support the government as indicated in the Strategic Agenda.

Working across Strategic Objectives in planning WHO support to Nigeria, the staff in the Country Office will be profiled to better support CCS implementation. The array of epidemiologists deployed to the states that are already supporting polio eradication and immunization will be reprofiled to support a full range of implementation of the minimum package of health based on the PHC approach.

Institutionally, with the introduction of the GSM, the Country Office will upgrade the ICT infrastructure. Staff capacity will be built for maximum operation.

Sustaining support, especially while reprofiling the array of epidemiologists necessary for the full range of implementation of the minimum package based on PHC, will require massive funding. Thus, emphasis will be placed on resource mobilization. In addition, financing the implementation of the CCS will be done through the biennial plans that will be developed. Active resource mobilization will be engaged especially with in-country donor partners.

7.2 REGIONAL OFFICE

Implementing this CCS will require the leveraging of technical backstop and resource inputs from Intercountry Support Teams, the Regional Office and HQ.

With the further delegation of authority to the WHO Representative and Country Office, the sufficient flexibility that exists for country-level implementation, especially in a decentralized scenario, will further facilitate achievement of the goals of the CCS.

7.3 HEADQUARTERS

In line with the principle of "One WHO", Headquarters will work with the Regional Office to provide technical support and mobilize resources for the implementation of the Nigerian CCS, and to document lessons learnt from the CCS process and its impact on WHO work. WHO headquarters will continue providing up-to-date technical information to WCO Nigeria through the Regional Office.

SECTION 8

MONITORING AND EVALUATION

The CCS outlines the broad Strategic Agenda and Strategic Objectives for the Country Office in the medium term. The workplans of the various clusters of the WCO will be aligned with the Strategic Agenda and its specific objectives. Monitoring WCO performance will be done biannually through routine monitoring of achievements of the indicators contained in the workplans of the various units. This will then serve as the basis for monitoring the progress of the CCS Strategic Agenda.

The CCS has established, through a highly consultative process, the strategic directions for WHO work in the country and has also helped define the competencies needed for this work. WHO's contribution to the national health developmental agenda and the country's input to the global health agenda will have to be assessed both qualitatively and quantitatively at specific times during the duration of this CCS and harmonized with government and partner schedules and agendas.

Both mid term and end-of-term evaluations will involve the main national counterparts, United Nations agencies and other developmental partners.

Tools for the evaluations will evolve over time. Data to be used for evaluation will come from existing systems and are complemented by mostly qualitative information, including the perceptions of major national and other stakeholders.

In line with the commitment to "deliver as one" within the UN system, evaluation of the CCS will report on the following UNDAF II indicators:

- availability of robust and functional databases highlighting gender, structural and other differentials in social conditions;
- number of key officials in MDAs with enhanced knowledge and skills for policy formulation and planning using rights-based approaches;
- proportion of facilities in providing quality and affordable services;
- number of MDAs with capacity for providing quality and affordable social services;
- proportion of facilities and institutions with management structures, systems, skills, equipment and supplies for gender-sensitive service delivery and social mobilization;
- proportion of individuals and households with improvement in behaviour and practice regarding uptake of specific social sector services;
- type of conventions and other international instruments ratified by the country to prevent and manage cross-border threats.

SECTION 9

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ANNEXES

ANNEX 1: DONOR INTERVENTIONS IN NIGERIA

Name of Partnership	Type of Partnership	Principal Area of Intervention	Location	Funding
Africa Development Bank (AfDB)	Multilateral	Capacity Strengthening of State Ministries of Health, Support to Primary Health Care and Capacity for Federal Ministry of Health. (Project Ends December 2008)	12 States namely: Abia, Imo, Edo, Akwa-Ibom, Lagos, Oyo, Niger, Benue, Kaduna, Katsina, Yobe and Bauchi	US 34 074 000
Canadian International Development Agency (CIDA)	Bilateral	Technical and physical upgrading of the Schools of Health Technology and health facilities at its practicum sites. Dates: 2003 to 29/07/2011	Bauchi & Cross River States	US 19 648 000
		Nigeria AIDS Responsive Fund	National	US 4 715 520
		Support to comprehensive health sector reform and strengthening evidence-based primary health care system in Bauchi and Cross River states. Dates: Planning Phase (2005 to 31/10/2007) Proposed Implementation 2008 – 2011	Bauchi & Cross River States	Planning:US 589440; Proposed Implementation: US 19 135 765.01
		Support to stop poliovirus transmission in Nigeria, as part of the effort to eradicate polio gobally, and to improve the quality of routine immunization services in Nigeria. Dates: 2007-31/03/2010	National	US 14 736 000
		Supports the procurement of contraceptive commodities for the period and ensure contraceptive security for the country from 2005-2008. It also seeks to provide safe delivery kits, caesarean section packs and antenatal packs in 6 pilot States. DATES: 2005 to 30/09/2009	UNFPA-Assisted States	US 11 364 772
EC Delegation (Health Projects)	Multilateral	Support to Polio Eradication	National	€53 340 000
		Support to Routine Immunization and the NPI (now NPHCDA). (June 03 – June 09)	Abia, Cross River, Gombe, Kebbi, Osun, and Plateau with possibility of extending up to 17 additional states	€ 44 060 000
		Support to Kano State to reduce the incidence of vaccine preventable diseases through the delivery of safe and quality routine immunization (Mar 02 - July 10)	Kano	€ 15 460 000
		Integrated Sexual and Reproductive Health and Service Delivery in Northern Nigeria	Kano, Bauchi, Jigawa, Katsina, Kaduna, Kebbi, Gombe, Sokoto, Benue and Zamfara	€ 1 800 000
Japan International Cooperation Agency (JICA)	Bilateral	Support for Infectious Diseases Prevention for Children (through UNICEF)	UNICEF/National	47 250 million yen
		A technical assistance to the Lagos State Government on Health Reform matters. (August 2005-August 2008)	Lagos State	55.6 million yen

		Lagos States Environmental Saniation and Malaria Control	LGAs of Surulere, Mushin and Ajeromi-Ifeledon	68.3 million yen
		Support to improve hospital management, the work environment and quality of service through the introduction of Total Quality Management (TQM), Continuous Quality Improvement (CQI) and 5S-Kaizen Activities (March 2007- October 2008)	Lagos State MoH,	4 million yen
		Support to improve service delivery of maternal and child health at the Primary Health Centers (PHCs) in targeted six (6) LGAs of Lagos State and also at the Lagos Island Maternity Hospital (LIMH) (2008-2011, provisional)	Support to improve service delivery of maternal and child health at the Primary Health Centers (PHCs) in targeted six (6) LGAs of Lagos State and also at the Lagos Island Maternity Hospital (LIMH) (2008-2011, provisional)	Support to improve service delivery of maternal and child health at the Primary Health Centers (PHCs) in targeted six (6) LGAs of Lagos State and also at the Lagos Island Maternity Hospital (LIMH) (2008-2011, provisional)
		ART centres for the scaling up of ART services in Nigeria. The Country-focussed Training on Prevention of HIV Transmission in Nigeria was held yearly in Japan from 2001-2007.	Ebonyi, Benue & Osun	15 million yen
		Support to training programmes of health professionals in public sector. It covers such areas as HIV/AIDS, MCH, Immunization, Hospital Pharmacy, Nursing, Dentistry, Health Promotion, and Health Management. The average duration of the courses is from 6 weeks to 3 months.	FMOH, Tertiary and Secondary Hospitals in Nigeria.	30 million yen
UNICEF	Multilateral	Integrated Maternal, Newborn and Child Health (IMNCH)/ Accelerated Child Survival & Development (ACSD)The Accelerated Child Survival and Development (ACSD) was initiated by UNICEF in 2006 has been used systematically to build service delivery capacity of the 111 focus LGAs level through bottleneck analysis and followed by micro planning, and by mid 2007 all the 36 States and FCT had been supported and were implementing the Accelerated Child Survival and Development (ACSD) process. The ACSD gave birth to Integrated Maternal, Newborn and Child Health (IMNCH) strategy at the request of Government by inviting UNICEF to use the MBB Tool for analysis and costing to include both maternal and child health and thus MDGS 4 and 5. The thrust for the 2009-2012: Support to reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period as well as malaria prevention & control (RBM) and Integrated Management of Childhood Illness from 2009- 2012	National/Zonal The IMNCH roll out will be supported in Kaduna, Sokoto, Gombe, Adamawa, Ebonyi and Edo states	US$ 15,000,000
		Malaria Control (through universal LLINs coverage)Support malaria control activities including technical support for GFATM	National/Zonal	US$ 50,000,000

		proposal development. Five states supported in the promotion of ITNs/LLINs and home care management of malaria by care givers from 2002 -2008. A new focus 2009-2012 is on universal coverage of LLINs in Kaduna, Sokoto, Kebbi and Adamawa with 6.5 million through UNITAID.		
		Immunization services including Polio eradicationSupport to polio eradication and measles control and strengthening routine immunization. Support to capacity building for emergency/ epidemic preparedness and response as well as pre-positioning of supplies to ensure rapid response to emergencies from 2009- 2012	National/Zonal	US$ 90,000,000
		Nutrition including severe acute malnutrition (SAM) and micronutrientsSupport for management of severe and acute malnutrition, improve food safety and food security throughout the life cycle, household and community care & child stinulation as well as micronutrient deficiency control	National/Zonal	US$ 16,700,000
		HIV/AIDS Prevention (PMTCT) Support to Prevention of Mother To Child Transmission (PMTCT) of HIV, care and support for infected infants	National/Zonal	US$ 4,000,000
DFID	Bilateral	Partnership for Transforming Health Systems (PATHS)	Federal, Enugu, Kano, Kaduna, Jigawa	US$ 112,000,000
		health Commodities and Equipment Procurement (Mar 05 - Mar 09)	Federal, Enugu, Kano, Kaduna, Jigawa,	US$ 60,000,000
		Partnership for Reviving Routine Immunization in Northern Nigeria (PRRINN)(Oct 06 - Oct 11)	Federal, Jigawa, Katsina, Yobe and Zamfara	US$ 40,000,000
		Support to HERFON a Nigerian NGO building a critical mass of influential change agents to take forward Health Sector Reform through advocacy, study tours, networking and small "Know-How Fund" projects. (Jan 05 - Jan 09)	National	US$ 7,000,000
		HIV/AIDS prevention, care and support at the LGA level. (Jun 06 - Jun 10)	Niger State	US$ 7,200,000
		Support for national and sub-national level institutions; as well as expanded support for marketing and distribution of malaria control commodities (Nov 07 - Oct 12)	Federal, up to 8 States (actual States to be determined)	US$ 100,000,000
		The health component of DFID's support for the Lead States after PATHS and HCP. (Tentative June 08 – May 13)	Federal, up to 6 States	US$ 300,000,000
		Promoting Sexual and Reproductive Health for HIV/AIDS Reduction (PSRHH) is a national behaviour change and condom social marketing programme, the goal of which is to improve sexual reproductive health among poor and vulnerable populations in Nigeria. (Jan 02 – Dec 08)	National	US$ 105,600,000

		BBC World Service Trust (BBC WST). The project is an accountable grant which supports public awareness-raising on HIV/AIDS through the media, and is designed to complement PSRHH (April 05 - March 08)	National	US$ 10,000,000
		Strengthening Nigeria's Response to HIV/AIDS. The project provides support for an effective and coordinated multisectoral, evidence and rights-based response in 6 high prevalence states through SACA capacity development (Sept 04 – July 09)	Cross River, Kaduna, Enugu, Benue, Nasarawa and FCT	US$ 50,000,000
		Support for reinforcing the structural response to HIV/AIDS in Nigeria with specific reference to NACA, the Global Fund CCM, and the World Bank. (Nov 06 - March 08)	Federal	US$ 1,320,000
		Enhancing Nigeria's Response to HIV/AIDS (Under design). This programme will leverage systemic change that strengthens government and partners' abilities to strategically prioritise, and scale up activities that deliver HIV/AIDS interventions (2008 to 2013)	To be determined	To be determined
USAID	Bilateral	NetMark seeks to increase the availability and use of insecticide-treated nets (ITNs) and long-lasting insecticidal nets (LLINs) to prevent malaria, targeting pregnant women and children under five and supports technology transfer of long lasting net to Nigeria, five-year (2004-2009	Abia, Akwa-Ibom, Cross-River, Abuja FCT, Lagos, National	US$ 5,392,124
		Improved Reproductive Health In Nigeria (IRHIN) project improves the understanding of, access to, and correct use of contraceptives to reduce unintended or mistimed pregnancies through the social marketing of contraceptive commodities. 5 years project 2005-2010	National and 3 clinical States (Abia, Cross River and Kaduna)	US$ 13,500,000
		COMPASS carries out integrated health and education activities. The program includes child spacing, safe motherhood, child health interventions and basic education. Five-year (2004-2009)	Lagos, Bauchi, Kano, Nassarawa and FCT	US$ 95,000,000
		COMPASS carries out Polio eradication activities by improving the quality and coverage of Supplementary Immunization Activities, working with local indigenous organizations to increase acceptance of immunization	8 States in the North- Kebbi, Katsina, Zamfara , Kaduna, Sokoto, Bauchi, Jigawa, Kano	US$ 4,500,000
		Integration of family planning services into HIV prevention, care and treatment services for the general population including the uniformed services, five-year (2004-2009)	Lagos, FCT & Cross River	US$ 1,000,000
		Distribution and social marketing of pre-packaged anti malarial treatment	National	US$ 4,290,730
		The PEPFAR Nigeria programme supports a comprehensive, evidence-based prevention programme, targeting interventions based on the epidemiology of HIV infection in Nigeria.	National except Ekiti State.	US$ 37,660,062 US$ 83,946,227

		HIV-related palliative care	National except Ekiti State.	US$ 29,903,403 US$ 63,712,243 US$ 33,529,470
		HIV treatment and reporting in PEPFAR focuses on ART treatment	National except Ekiti State.	US$ 318,987,577
The World Bank (WB)	Multilateral	support improvements in the delivery of primary health care services with a particular focus on maternal and child health and reproductive health services; and Approved 06/06/02, Closing: 07/01/08	Covers 36 States, excluding Kano but including FCT as a well as a Federal component	US$ 127,000,000
		Polio Eradication Project	National	US$ 80,400,000
		Malaria Control Booster Project: well-defined set of Malaria Plus Package of interventions (MPP); Approved: 12/12/06Closing: 03/31/12.	National	US$ 180,000,000
		HIV multisectoral response and laying the foundation for scaling up HIV/AIDS prevention, care and treatment services at the Federal, State and Local Levels.Approved: 07/06/01 Closing: 06/30/09.	Covers 18 States: Akwa Ibom, Benue, Ebonyi, Kaduna, Lagos, Taraba, Adamawa, Cross River, Imo, Plateau, Nasarawa, Anambra, Borno, Edo FCT, Oyo, Katsina, Sokoto Zamfara, Kebbi, Kogi, Kwara, Ogun Ondo, Osun, Ekiti, Baylesa, Delta, Abia Enugu, Bauchi, Gombe, Yobe, Jigawa, Rivers and Federal	US$ 112,582,570 $50 million Additional Financing
		Avian Influenza Control And Human Pandemic Preparedness And Response Project Managed by World Bank Agriculture Team – involves both human and animal health aspects	Covers all 36 States	US$ 50,000,000
World Health organization (WHO)	Multilateral	Support to reduce the health, social and economic burden of communicable diseases, (2008 and 2009)	National	US$ 59,480,000
		Support to Combat HIV/AIDS, tuberculosis and malaria (2008 and 2009)	National	US$ 23,887,000
		Support to prevent and reduce diseases, disability, and premature death from non communicable conditions, mental disorders, violence and injuries and disabilities (2008 and 2009)	National	US$ 1,246,000
		Support to reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals. (2008 and 2009)	National	US$ 7,927,000
		Support to reduce the health consequences of emergencies, disaster, crisis, and conflicts and minimise their social and economic impact. (2008 and 2009)	National	US$ 7,815,000

		Support to promote health and development, prevent and reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances. (2008 and 2009)	National	US$ 1,376,000
		Support to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender responsiveness and human right based approach. (2008 and 2009)	National	US$ 376,000
		Support to promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address root causes of environmental threats to health. (2008 and 2009)	National	US$ 1,066,000
		Support to improve nutrition, food safety and food security throughout the life course and in support of public health and sustainable development. (2008 and 2009)	National	US$ 2,664,000
		Support to improve health services through better governance, financing, staffing, and management informed by reliable and accessible evidence and research. (2008 and 2009)	National	US$ 12,601,000
		Support to improve access, quality and use of medical products and technologies. (2008 and 2009)	National	US$ 1,802,000
Global Fund to Fight AIDS, TB and Malaria (GFATM)	Multilateral	HIV	National	US$ 60,000,000 (phase 1)
		TB	National	US$ 25,570,061 (Phase 1)
		Malaria	National	US$ 40,700,000 (Phase 1)
UNFPA	Multilateral	Support to RHCS and Supply of FP Commodities (2003-2008)	National	US$ 7,000,000
		Support to Reproductive Health -Maternal health and Obstetric Fistula. Support capacity building activities (institutional and human resource development) for the delivery of quality safe motherhood with focus on EmOC services in 15 states), including the provision of essential EOC supplies. (2003-2008)	15 States. States with high prevalence of obstetric fistula	US$ 15,000,000
		Support to strengthen Systems and mechanisms for implementation of syndromic management of STIs/RTIs (2003 - 2008)	National level and 15 States	US$ 2,600,000
		Improving the access of young people to gender-sensitive SRH and HIV prevention (2003-2008)	National level and 15 States	US$ 5,500,000
Rotary International	International NGO	Polio Eradiation	National	US$ 51,470,655