



## **TECHNICAL COOPERATION FOR SUSTAINABLE DEVELOPMENT**

# **WHO Country Office Nigeria ANNUAL REPORT 2007**

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## List of Acronyms

ACT	Artemisinin based Combination Therapy
AFRO	WHO Regional Office for Africa
APOC	African Programme on Onchocerciasis Control
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral Medicines
ANC	Ante-Natal Clinics
BEOC	Basic Emergency Obstetric Care
BMI	Body Mass Index
BU	Buruli Ulcer
CBIS	Community Based Information System
CCS	Country Cooperation Strategy
CDTI	Community Directed Treatment with Ivermectin
CEOC	Comprehensive Emergency Obstetric Care
CHEWs	Community Health Extension Workers
CIDA	Canadian International Development Agency
CORPS	Community Resource Persons
CSM	Cerebro-Spinal Meningitis
CSO	Civil Society Organization
DALE	Disability Adjusted Life Expectancy
DFID	Department For International Development (UK)
DOTS	Directly Observed Treatment Short Course
EPI	Expanded Programme on Immunization
EU	European Union
FBO	Faith Based Organization
FCT	Federal Capital Territory
FCTC	Framework Convention on Tobacco Control
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global Drug Facility
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GSM	Global Management System
GWD	Guineaworm disease
HQ	World Health Organization Headquarters
HRH	Human Resources for Health

HAT	Human African Trypanosomiasis
HCT	HIV/AIDS Counselling & Testing
IDSR	Integrated Diseases Surveillance and Response
IHP++	International Health Partnerships + +
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPDs	Immunization Plus Days
ITNs	Insecticide Treated Nets
IILEP	International Federation of Anti-leprosy Associations
IHVN	Institute of Human Virology, Nigeria
IMAI	Integrated Management of Adolescent and Adult Illness
LGA	Local Government Area
MDGs	Millennium Development Goals
NAFDAC	National Agency for Food and Drug Administration and Control
NARHS Plus	National AIDS and Reproductive Health Survey
NTBLCP	National TB and Leprosy Control Programme
NCDs	Non-Communicable Diseases
NEEDS	National Economic Empowerment and Development Strategy
NEPAD	New Partnership for African Development
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NTBLCP	National Tuberculosis and Leprosy Control Program
NTD	Neglected Tropical Diseases
OPV	Oral Polio Vaccine
PATHS	Partnership for Transforming Health Systems
PHC	Primary Health Care
PLWHAs	People Living With HIV & AIDS
PMTCT	Prevention of Mother to Child Transmission
RBM	Roll Back Malaria
RH	Reproductive Health
TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCO	WHO Country Office
WHA	World Health Assembly
WHO	World Health Organization

## From the WHO Representative's desk



The year 2007 has been another successful one for the health sector in general and for the work of WHO with Government and partners in improving the health of Nigerians. The 51st National Council of Health held in November 2007 was rightly christened “creating wealth through health” and Government and partners continue to make efforts to actualize this slogan within the year. This report chronicles some of the efforts and achievements of WHO in supporting the country in 2007 in this regard.

### *Millennium Development Goals (MDGs)*

While progress towards achievement of the health-related MDGs is still constrained by the limited national health system capacity, the recent efforts of the government at removing these bottlenecks need to be appreciated. The Federal Government has played a key role in facilitating developments at state level, particularly through the policy dialogue that has taken place at the National Council on Health and through ministerial advocacy visits to the states. The commitment of the government at the highest level is demonstrated by the investiture of the First Lady Hajia Turai Yar'Adua as the National Goodwill Ambassador for Maternal, Newborn and Child Health. In order to fast track the achievement of MDGs 4 and 5 (to reduce child mortality and improve maternal health) and indirectly impact on MDGs 1, 6 and 7, (to eradicate extreme hunger and poverty, combat HIV/AIDS, malaria and other diseases, and ensure environmental sustainability) the Federal Ministry of Health is currently putting together a high profile initiative on Integrated Maternal Newborn and Child Health (IMNCH). This decision framework spells out the level of investment by all stakeholders including development partners and WHO is committed to providing technical support for this initiative.



### *Polio Eradication*

For immunization and polio eradication, Nigeria adopted a “home grown integrated approach”, the Immunization Plus Days (IPDs). During IPDs children are not only immunized against polio, but provided with other health interventions such as immunization against other childhood infections, de-worming and insecticide treated nets (ITNs). Monovalent Oral Polio Vaccine (mOPV) was also introduced in 2006 (mOPV1) and 2007 (mOPV3). These innovations have resulted in increased community participation, higher vaccination coverage rates and higher sero-conversion rates, resulting in close to 80% decline in confirmed polio cases in 2007 compared to 2006. The more extensive use of mOPV1 resulted in close to 90% decline in polio due to WPV1 in 2007 compared to 2006.

The factors that contributed to the improved coverage and quality of polio eradication activities in Nigeria are:

- Strong Government commitment at federal, state and local government levels;
- Renewed engagement and involvement of religious and traditional leaders;
- Partnerships with key stake-holders at community level including women groups, youth groups, religious instructors and community leaders;
- Strong partnerships between government ministries, agencies & departments (Health, Local Government, Religious Affairs), international agencies & NGOs (UN agencies, bilateral agencies, Rotary International) as well as national non-governmental, community-based, civil society and faith-based organisations.

The possibility of achieving interruption of the wild polio virus is greatest now as we are currently experiencing the lowest level of WPV transmission in the country. We believe Nigeria can do it and this is the time to do it!

### *Health Systems Strengthening*

The health system is the vehicle through which interventions can be delivered efficiently and effectively, and WHO Country Office in Nigeria places a premium on her support to government to strengthen the health system. Indeed, there is a growing demand from all stakeholders for WHO to provide more support in health systems strengthening and WHO is strategically positioned to do this.

Our strategy is to enable all stakeholders achieve a common understanding of what a health system is, and what activities are included in health systems strengthening. We wish to support the strengthening of all organizations, people and actions whose primary intent is to promote, restore or maintain health as these all make up the health system. We also wish to support efforts that influence the determinants of health as well as provide more direct health-improving activities. We will focus on the well understood pyramid of publicly-owned facilities that deliver personal health



services, whilst also giving due consideration to the less known aspects of the health system which include, for example, a mother caring for a sick child at home, private providers, behavioural change programmes, vector-control campaigns, health insurance organizations, occupational health and safety legislation. We will also promote inter-sectoral action by health staff, for example, encouraging the Ministries of Education at Federal & State levels to promote female education which is a well known determinant of better health. It is for these reasons that WHO is supporting the development of a Strategic Health Investment Plan to help Nigeria actualize her quest to be part of the IHP++. In this way, health systems strengthening will be made “**everybody's business**”.

### *United Nations in Nigeria*

Within the UN country team, WHO continues to support the United Nations Development Assistance Framework (UNDAF) II (2009-12) and the move towards harmonized UN support to Nigeria. The priority areas of support to Nigeria include: governance and accountability; productivity and employment; transforming service delivery and conflict and human insecurity. WHO will focus on the areas of transforming service delivery - Maternal, Newborn & Child Health Services/MNCHS (coverage, access, quality, demand), scaled-up national response towards universal access to prevention, treatment, care and support for people living with HIV and AIDS and mitigation of socio-economic impact, with special emphasis on gender and vulnerable/neglected groups. Also there will be intervention to increase access to safe water and sanitation (coverage, access, behavioural change) and Strengthen Health Systems within the primary health care framework.

### *WHO Country Office*

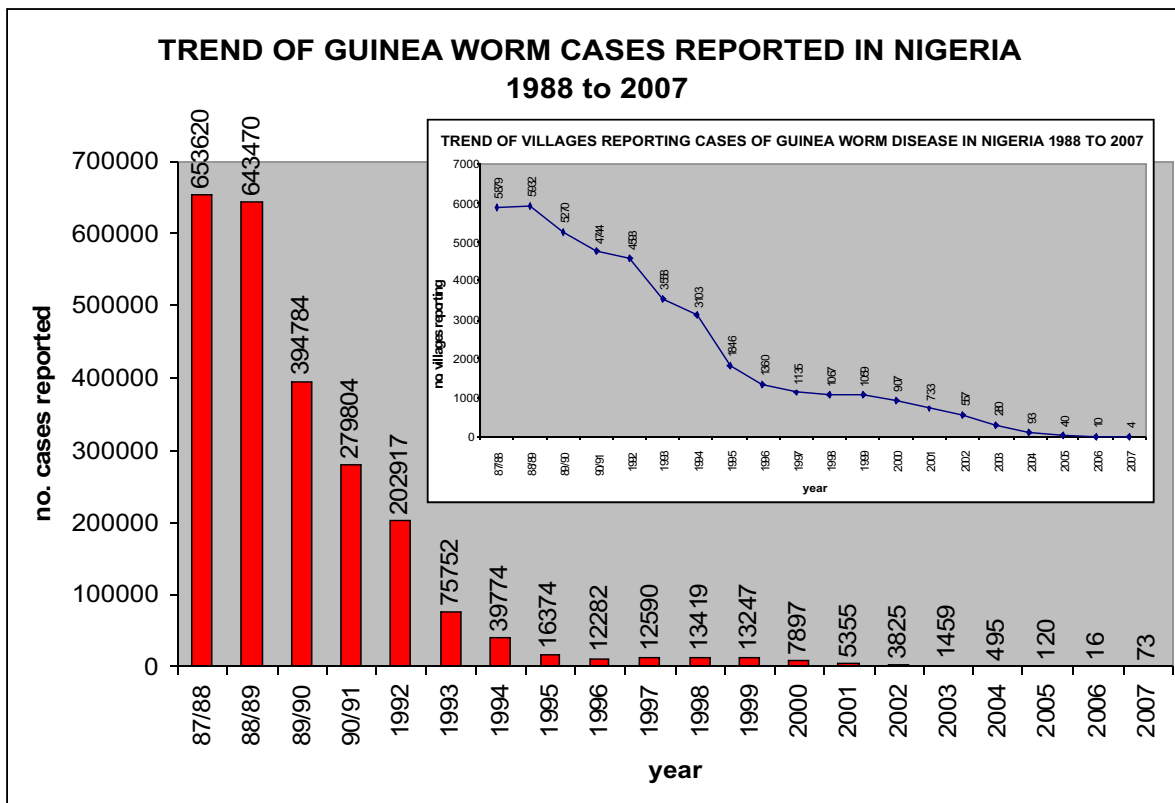
Finally, administratively, WHO Country Office Nigeria has evolved into a more robust structure with greater intellectual, technical and financial resources. This makes WHO the biggest partner in the country for health matters. The deliverables mentioned in this report were made possible by dedicated and responsive technical and administration staff members as well as financial support. The introduction of the Global Management System (GSM ) in 2008 promises to equip the office for prompt and improved service delivery.

## Communicable Diseases Prevention and Control

WHO has supported Nigeria in the prevention, control and eradication of communicable diseases over several years. WHO support under CPC has mainly been for Dracunculiasis (Guinea worm disease (GWD)), Human African Trypanosomiasis (HAT), Buruli Ulcer (BU), Lymphatic filariasis (LF), Onchocerciasis, Schistosomiasis and Leprosy. These are termed Neglected Tropical Diseases (NTDs), they are diseases almost exclusively of the rural poor in low-income countries. Although safe and cost-effective means of prevention and control are available, the NTDs continue to cause immense suffering and often life-long disabilities for the rural poor due to neglect.

### *Dracunculiasis*

The Nigeria Guinea worm disease eradication programme (NIGEP) has, as a result of commitment from various partners, made significant progress since its inception in 1988. With elimination in sight, the key issue in the eradication effort is intensification of pre-certification activities to meeting certification criteria. Precertification activities that were supported in 2007 include continually putting in place active surveillance in target villages, continuing collaboration with other disease programmes to maintain routine surveillance through the integrated disease surveillance and response (IDSR) system and advocacy for safe water provision to at-risk villages. Advocacy, partnership and coordination for GWD surveillance and safe water provision have been similarly strengthened.

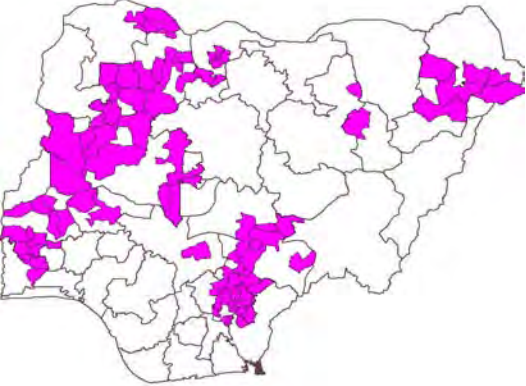


### *Human African Trypanosomiasis (HAT)*

Nigeria ranks amongst the highest in endemic countries for HAT. In 2007, WHO NIE, AFRO and HQ supported the country to conduct screening for HAT in Delta State where three sero-positive cases were identified and referred for treatment. The WHO also supported training for 25 health workers from the Federal Ministry of Health, Delta State Ministry of Health and the National Institute for Trypanosomiasis Research (NITR).

### NIGERIA GUINEA WORM DISEASE ERADICATION PROGRAMME (NIGEP)

**MAP OF NIGERIA SHOWING 88 LGAS CONTAINING 700 LINE LISTED VILLAGES SELECTED FOR ACTIVE GUINEA WORM DISEASE (GWD) SURVEILLANCE**



**ACHIEVEMENTS:**

- 1988 --- 653,000 reported cases from 6,000 villages.
- 2007 --- 73 reported cases from only 4 villages. Less than 150 cases yearly since 2005.

**KEY ISSUES:**

- Intensify interventions to stop transmission by 2009.
- Meet certification criteria by 2012 by establishing and maintaining certification standard surveillance.
- Provide adequate and regularly maintained safe water sources to all at-risk villages.


**WHO SUPPORT IN 2007:**

- Establishment and maintenance of verifiable active surveillance in 700 line listed villages. Currently about 60% monthly reporting.
- Collaboration with other disease programmes to maintain verifiable routine integrated disease surveillance using IDSR system. Currently about 80% of States/FCT reporting monthly.
- Promotion of partnership and advocacy for provision and maintenance of safe water sources to all at-risk villages. Currently 70% of 700 villages have at least one safe water source and 15% have adequate safe water sources.


### *Buruli Ulcer*

BU control programme is situated in the Tuberculosis and Leprosy (TBL) control programme to enhance integration and State TBL control officers now have responsibility for BU control. WHO supported screening for BU in Anambra, Cross-River, Ebonyi, Enugu and Rivers States. 15 of the 37 suspected cases were confirmed to be BU 9 of which were below 15 years old. These cases were referred to the TBL centres in their respective States and they all responded to treatment with streptomycin and rifampicin.

**Anambra State: 6 years, female**



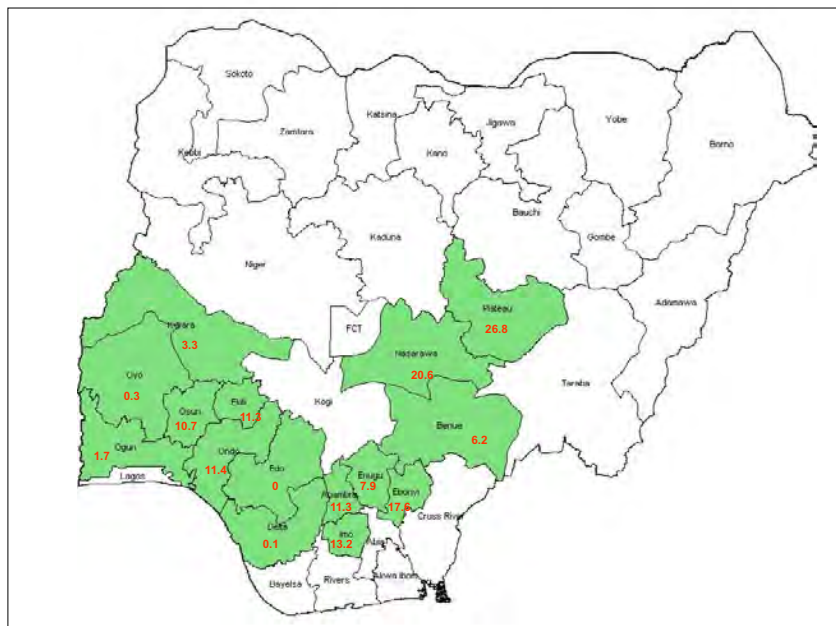
**Anambra State: 22 year old, female**



*Some cases of BU found during the preliminary assessment in Anambra State,*

### *Lymphatic Filariasis (LF)*

Lymphatic filariasis mapping by immuno-chromatographic test (ICT) method has been conducted in 15 States in Nigeria mostly with WHO support. Only Benue State was mapped in 2007 using ICT cards due to non-availability of the



*Map of Nigeria showing states mapped (ICT method) for lymphatic filariasis. Figures indicate average prevalence*

cards. Four other States were mapped in 2007 using examination of night blood but the results have been discountenanced due to the need for consistency in methodology. Mass drug administration for LF elimination is still limited to Plateau and Nasarawa States.

#### *Onchocerciasis*

30,000 communities in all 32 mesoendemic and hyperendemic States including the Federal Capital Territory have on-going Ivermectin distribution activities supported by WHO and other partners. Therapeutic coverage with Ivermectin increased from 77% in 2006 to 87% in 2007.

#### *Schistosomiasis*

Mass drug administration for Schistosomiasis control is limited to Plateau, Nasarawa and Delta States due to lack of the drug (praziquantel). WHO announced a donation of 1.5m tablets of praziquantel to the FMOH to improve on programme delivery in the three States.

#### *Leprosy*

Nigeria runs an integrated Tuberculosis and Leprosy (TBL) control programme and has attained elimination levels for Leprosy with less than 1 case per 10,000 population reported since 1998. WHO and ILEP partners supported the evaluation of the Leprosy programme and developed the 2007-2011 Leprosy Control Strategic Plan for Nigeria.

#### *Integration approaches*

WHO supported the country to establish a multisectoral Neglected Tropical Diseases (NTD) Steering Committee to advise the Ministry of Health on integrated approaches to the control of NTDs. Technical Guidelines for Integrated Disease Surveillance and Response (IDSR) were reviewed to incorporate some NTDs. The necessary integrated reporting forms were produced and health workers/data managers trained accordingly.

### Challenges in 2007

The challenges for the NTDs in 2007 included limited success at resource mobilisation, the existence of a rather weak health system, difficulties accessing drugs for mass drug administration, limited availability of diagnostic tools, difficulties in streamlining integrated approaches to service delivery and ensuring community participation for disease programmes where the communities do not view them as priority among their numerous poverty-inducing problems.

## Epidemic Alert and Response

Global Health Security (as referred to in resolution WHA54.14) is repeatedly threatened by the emergence of new or newly recognized pathogens, their possible deliberate or accidental release and the resurgence of known epidemic threats. Although biological weapons represent the most visible threat to security, emerging or epidemic-prone communicable diseases also threaten global health security because they frequently and unexpectedly challenge national health services and disrupt routine control programmes.

Epidemic-prone diseases in Nigeria include cerebro-spinal meningitis (CSM), measles, cholera, Lassa fever, yellow fever and avian influenza. In 2007, WHO helped to strengthen Nigeria's ability to react to threats to national, regional and global health insecurity arising from epidemic-prone and emerging infectious diseases. This was done by strengthening the Integrated Disease Surveillance and Response (IDSR), enhancing the capacity of federal, state and local governments for preparedness, early detection, investigation including laboratory and response to epidemics according to the guidelines of the International Health Regulations.

WHO supported the investigation of all rumoured and confirmed disease outbreaks, supported the Federal Ministry of Health in training health workers on IDSR and assisted with the supply of laboratory reagents and equipment.

### Epidemic prone disease occurrence in 2007

<i>Disease</i>	<i>No of Cases</i>	<i>No of deaths</i>	<i>Case fatality rate</i>	<i>Location</i>
Cholera	1660	48	2.9%	Bauchi, Bayelsa, Benue, Borno, Delta, Jigawa and Rivers States
Cerebrospinal Meningitis	2,764	242	8.8%	Sokoto, Kebbi, Zamfara, Katsina, Niger, Jigawa, Kano, Bauchi, Gombe, Adamawa, Taraba, Anambra, Enugu, Cross River States
Measles	6,158	196	3.2%	Health facilities across the country
Lassa Fever	21	8	38.1%	Edo, Taraba, Plateau States and FCT
Yellow fever	0	0	0%	Across the country
Avian Influenza	1	0	0%	

## HIV/AIDS

HIV/AIDS continues to be a public health concern for Nigeria despite HIV prevalence declining tendencies from 5.8% (2001) to 4.4% (2005). It is estimated that 2.86 million Nigerians were living with HIV in 2005, which is a high burden, second only to South Africa. About 500,000 people living with HIV/AIDS need treatment with anti-retroviral drugs, out of which approximately 166,000 were receiving treatment from a total of 215 sites supported by FMOH and partners. The major challenge during 2007 was to reduce the rate at which the infection was spreading while at the same time providing treatment, care and support services to all those in need using the existing health system.

WHO support to the national health sector response to the HIV/AIDS epidemic in 2006 and 2007 was in line with the strategies elaborated in the Country Office biennial plan. This includes facilitating access to normative guidance and technical tools, mobilizing partnerships at country level for financial and technical support to programmes, providing technical support for scaling up of the delivery of a package of health sector prevention, care and treatment interventions, providing support for strengthening the strategic information base for the national response to the pandemic, advocating and negotiating for increased resources for HIV/AIDS and mobilizing and supporting the private sector and communities to expand their involvement in HIV/AIDS prevention, care and treatment.

Good plans are critical for an effective national response to the HIV/AIDS epidemic. In recognition of this, WHO provided technical, material and financial support towards the elaboration of the HIV Prevention Plan and scale-up plans for HCT, PMTCT and Paediatric ART. As a follow up to the declaration of 2006 as a year of accelerating HIV Prevention efforts and the elaboration of the 2007 National HIV Prevention Plan, a plan for 2008-2009 was developed and launched during the World AIDS Day Commemoration on 1st December 2007.

WHO supported state ministries of health in organising consultations on universal access to HIV/AIDS services. They took place in Kaduna, Rivers, Enugu, and Ondo states during the year 2007. The meetings enabled states to identify bottlenecks, proffer solutions and develop roadmaps and scale up plans for achieving universal access to HIV/AIDS services by 2010.



*Launching of the National Prevention Plan 2007 to 2009*

### *The Integrated Management of Adolescent and Adult Illness (IMAI)*

The Integrated Management of Adolescent and Adult Illness (IMAI) approach which was introduced in Nigeria in 2005 continued to be used to rapidly scale up HIV/AIDS services. IMAI aims to develop the manpower needed to manage the increasing number of people needing treatment. Specialists need to be released to care for the more complex case and testing also needs to be scaled up. Many people live away from urban centres. Getting care to them will improve quality of care and adherence to treatment. Healthcare manpower can be increased if you delegate from doctor to nurse, nurse to community health worker, and further to PLAs and carers. WHO has developed a set of tools that can be used to train a facility to delegate in this way. In 2007, the IHVN used the IMAI in the training of health care workers from the sites they support, using the standard programme, manuals and the national core team of trainers.

The FMOH decided to phase the roll-out of the IMAI starting with one state. Rivers State managers were first trained in 2007 followed by 11 states implementing Global Fund (GFATM) Round 5 activities. Also in collaboration with the Federal Ministry of Health and other PEPFAR partners, another set of 11 states implementing the Round 5 GFATM grants were subsequently trained. More than 600 health providers were trained using the IMAI/IMCI package in 2007. The table below shows the break-down by health worker category trained.

#### *Health Provider Cadres Trained*

<i>Staff Cadre</i>	<i>Rivers</i>	<i>GFATM1</i>	<i>Ekiti</i>	<i>Bauchi</i>	<i>Edo</i>	<i>GFATM2</i>	<i>TOTAL</i>
Trainers	20	14	3	0	14	25	76
EPT	15	30	7	0	14	32	98
Doctors	17	42	8	15	19	38	139
Pharmacists	11	26	4	0	0	25	66
CHOs	4	26		0	0	28	28
Nurse Midwives	25	43	15	27	27	40	177
Nurse counselors	14	36	2	20	29	29	130
Comm. HEWs	3	0	15	0	0	0	18
Lab Assistants	0	0	3	0	0	0	3
Pharm. Technicians	5	1	1	0	0	8	15
Total number of people trained	114	218	58	62	103	225	780
Art sites / HIV care teams established	14	39	3	14	7	39	116

Along with training of the health workers, cultural adaptation of the IMAI patient and Community Education Materials, namely: Caregiver Booklet, flipchart for patient education, and ART adherence materials were adapted for use in Benue State.

The adapted patient/community education materials together with the TB/HIV co-management module are awaiting finalization and production. The other training manuals (Course Director/Facilitator Guide for Basic ART, Clinical & Acute Care Training Courses, Participant Manual for WHO Basic ART Clinical Training Course, and Facilitator's Guide for Basic ART Aide Training Course etc) are being reviewed and updated.

Specialist doctors now see the value of application of the IMAI package. The Nigerian HIV/AIDS Course for Doctors has been modified to start with the IMAI basic course for three days followed by the Advanced ART and Acute Care Course. Indeed, PLWHA are accepted as trainers of doctors. This is one of the aspects of the course most appreciated by clinicians, as it provides them with the kind of feed-back they rarely receive during traditional training. So that children are not marginalized in situations where there are no paediatricians, HIV/AIDS-IMCI supplementary course is used to impart the necessary skills and confidence to manage children to health workers immediately after the IMAI course is completed.

The integrated approach to training is a solution to the multiple courses a single health worker would otherwise have needed to attend before achieving competence to deliver ART services. Furthermore, the IMAI approach serves as a team building exercise, which is important in delivering chronic care. The IMAI approach has enabled tapping into the otherwise relegated human resource pool in the lower cadre of health and non-health personnel to bridge the gap of inadequate human resources for health.

### *Surveillance, Monitoring and Evaluation System*

Since 1991 Nigeria has conducted biennial HIV/Syphilis sentinel surveys among women attending ante-natal clinics (ANC) to estimate prevalence, define trends and make projections on the epidemics. The 2007 round of the survey had been rescheduled by government to allow data collection to take place during early 2008. However, with support from WHO, the FMOH implemented the critical pre-survey activities, including conducting advocacy meetings with the stakeholders to solicit their support. These advocacy meetings, conducted in November 2007 involved state authorities and development partners. During this time, the surveillance protocol was reviewed and guidelines were developed for the various health workers participating in the survey. The national ART programme started in 2002 involving 25 pilot sites mainly tertiary health facilities. By the end of 2007, a total of two hundred and ten (210) health facilities including tertiary and secondary ones were delivering ART services to a total of one hundred and sixty six thousand persons living with HIV/AIDS. Information and data on the level of development of resistance pattern to antiretroviral medicines in the country was needed in order to inform how best to continue with the scaling up of the services.

With support from WHO, and in collaboration with other stakeholders the FMOH embarked on the exercise that

resulted in the development/adaptation of the following protocols

- HIV Drug Resistance (HIVDR) early warning Indicators - to define national indicators and retrieve relevant data from ART sites in conformity with the NNRIMS
- HIVDR monitoring strategy for populations receiving ART;
- Evaluation of transmitted HIVDR using specimens from PMTCT sites (threshold survey).

The protocol development exercise took place at the National Institute of Medical Research, Yaba Lagos, from 6 to 9 November 2007 and involved 35 participants including some National ART Committee members, the National Technical Working Group on HIV Drug Resistance, some state AIDS programme managers, doctors, laboratory scientists, data managers, epidemiologists and ART site managers. Programme officers from partner organizations assisted the NASCP focal persons in facilitating the workshop.

During the year other surveillance activities that were undertaken included: data collection and analysis for the Integrated Bio-Behavioural Surveillance (IBBS) and the National AIDS and Reproductive Health Survey (NARHS Plus).

WHO and other partners assisted the Federal Ministry of Health in strengthening the national HIV/AIDS monitoring and evaluation plan using the generic Global Fund monitoring and evaluation system strengthening tool. A National Stakeholders' forum on monitoring and evaluation was organized by the National Action Committee on AIDS (NACA) at the Confluence Hotel Lokoja, Kogi State, on 6-9 February 2007. Principal and sub-recipients came together to respond to the questionnaire in the M&E system strengthening tool. By the second day the whole questionnaire had been administered, covering the National HIV/AIDS M&E Plan, PR capacity to manage data and provide oversight to lower entities, health facility and community services and systems and strengths and weaknesses were identified. Representatives from the Principal Recipients, Sub-recipients, NASCP and development partners proffered solutions for the identified weaknesses. The strengthening activities have since been included into work plans that are being implemented.

## Tuberculosis

### *World Stop Tuberculosis Day 2007*

The theme *TB Anywhere is TB Everywhere* was adopted for this year's celebration. The annual event was commemorated both at state and national levels from 19th to 26th March, 2007. At the national level a one week long activity was outlined by the national World TB day planning committee which included the following:

- Special prayers at churches and mosques.
- Airing of radio jingles and TV broadcasts increase awareness of early detection and treatment of TB
- Television discussion on the national network program *AM Express* in which WHO, USAID, and the national programme managers were the main discussants.
- Radio phone-in discussion programme on the national radio network, *Radio-Link* where the members of the public phoned in directly to a panel of discussants on various issues related to tuberculosis.

The high point of the celebration was the 5 kilometre walk on the 26th March, 2007 which ended with a rally at the old parade ground in Abuja. About 500 persons including federal and state government officials, some partners from WHO, USAID, CIDA, members of the armed forces, students and workers participated in the procession. They were all dressed in yellow T shirts and caps which had the inscription of *TB Anywhere is TB Everywhere*.

The WHO Country Representative, Dr Peter Eriki, in his goodwill message to the occasion reiterated WHO's commitment to continue to provide technical support to the National TB Control Programme in order to ensure accelerated progress towards the global targets. He urged all other stake holders to work closely together to in order to ensure effective control of Tuberculosis in the country and prevent Multi-Drug Resistant TB from developing.

### *Launching of the Strategic Plan for Tuberculosis Control in Nigeria*

The National strategic plan for Tuberculosis control in Nigeria, 2006-2010, was finalised and officially presented on the 26th March, 2007. The official launching of the document was done by the Honourable Minister of State for Health, Architect Halimat Tayo Alao. Present at the event were the WHO representative Dr Peter Eriki, and other representatives of the TB stakeholders, such as USAID, CIDA and ILEP organisations.

The 2006-2010 plan was developed with support from WHO and in collaboration with other TB technical partners (ILEP, CDC). It was largely based on the experience of implementing the 2001-2005 strategic plan as well as findings and recommendations of international monitoring missions.

The plan reviewed the progress made in tuberculosis control since the inauguration of the TB programme in 1991,



*Launching of the Strategic Plan for Tuberculosis Control in Nigeria*

progress made with the implementation of the 2001-2005 plan. The overall goal of the plan is to reduce significantly the burden, socio-economic impact, and transmission of TB in Nigeria. The plan outlines how expansion and enhancement of DOTs services will contribute towards reaching the 2015 global and MDG targets for TB control.

#### *Millennium Development Goals for TB control*

WHO continued to provide technical support to the Federal Government in implementing Tuberculosis control activities towards achievement of the MDG Goal 6, Target 8 and indicators 23 (reducing the prevalence and death rates associated with tuberculosis) and indicator 24 (increasing the proportion of tuberculosis cases detected and cured under DOTS)

In 2007, technical assistance was provided to the National Tuberculosis Programme in the development of a strategic framework and work plan that addressed the MDGs and which spelt out activities, costs and time frame that will ensure:

- Increased population access to effective TB services through expansion of DOTS TB services to more LGAs and facilities.
- Increased case detection rates of smear positive cases
- Increased cure rates and treatment success rates of the detected TB cases.

Achievements made towards the tuberculosis MDG targets in 2007 were as follows:

- The national case detection rate of smear positive cases gradually increased from 16% in 2002 to 35% at end of 2007 (global target is 70%);
- National treatment success rate of the smears positive cases remain high at 75% (global target is 85%) and
- Access to DOTS TB services at the LGA level increased as the LGA TB service coverage increase from 63% (494/774) in 2004 to 90.5%(701/774) at end of 2007.

### Resource Mobilisation

WHO also supported the National Tuberculosis Programme in resource mobilization to support the implementation of the strategic framework and workplan from organizations such as CIDA and USAID. The release of pledged annual grants from these organizations facilitated our support to the government in expanding DOTS tuberculosis control activities into more LGAs.

In 2007 an additional 2.7 million USD was received from USAID and CIDA as extra-budgetary funds for supporting the National TB and Leprosy Control Programme (NTBLCP) in implementing activities targeted towards expansion of DOTS services as well as promoting TB/HIV collaborative activities.



Specific activities implemented with these funds as outlined in the strategic work plan in 2007 included the following;

- Increasing the human resources capacity to deliver DOTS services at the peripheral health facility levels in 17 states (about 510 doctors, nurses and general health workers from 17 states were trained on DOTS in 2007);
- Expansion of the laboratory diagnostic network by establishing and strengthening LGA laboratory services to deliver DOTS diagnostic services (51 new microscopy centres were established in 2007 in 17 states);
- Empowering 102 PHC centres and general hospitals to deliver DOTS services in the 17 states.

## Malaria

### *Overview of main achievements:*

1. Development of National Malaria Control Monitoring and Evaluation (M&E) Framework 2007
2. Establishment of M&E Working Group.
3. Commencement of data entry for Nigeria using the WHO supported Global Malaria Program Database
4. Documentation of home management of malaria under the Community Directed Intervention
5. Scaling up of home management of malaria from Implementation Research.

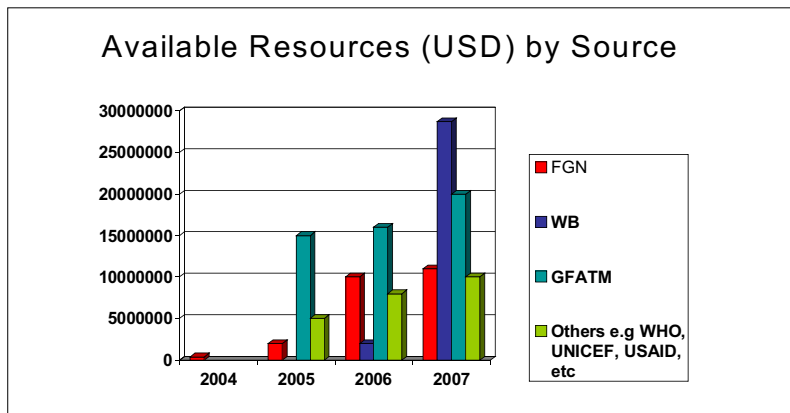
### *Africa Malaria Day (AMD) 2007*

The picture shows Health Minister, Professor EA Lambo, presenting LLIN to pregnant women in Bwari Community, Bwari Area Council, Federal Capital Territory, where the grand finale of the community oriented AMD 2007 commemoration was held. A football match between two area councils (Gwagwalada and Bwari) and road show were held to raise awareness and mobilise political and social support for the fight against malaria.



### *Effective Partnerships and Increased Country Level Resources.*

WHO supported the CCM in facilitating the successful recovery of USD61m Global Fund R2 and R4 MAL Grants into Phase 2 Combined Grant for Phase 2 Malaria component. The fund is now being judiciously and appropriately absorbed in 18 Global Fund States of Nigeria under a reprogrammed grant which encompasses comprehensive malaria control package utilizing public and private channels of implementation.

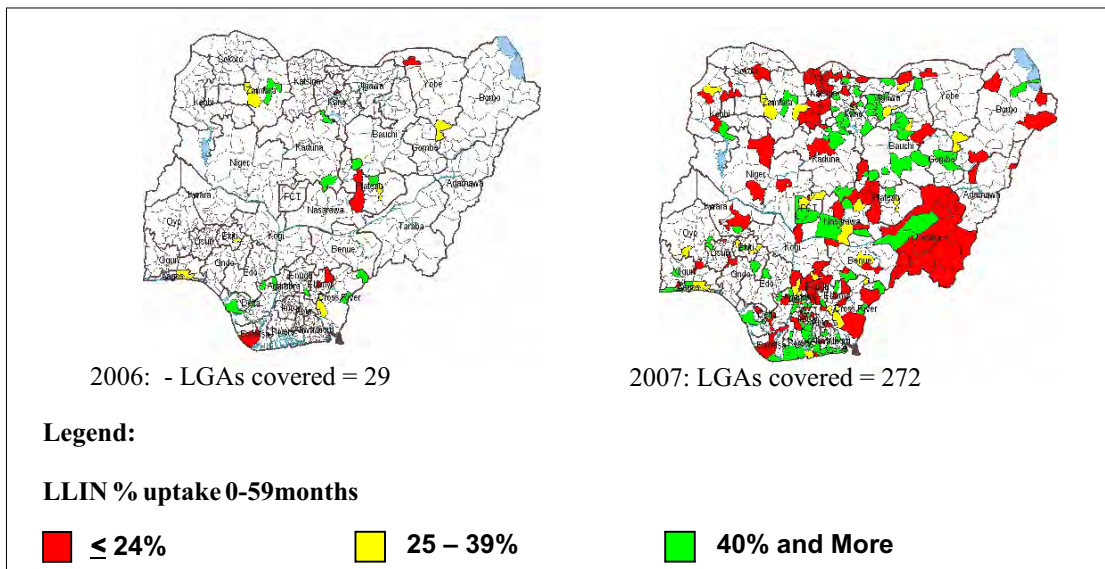


The team supported the development and submission of 2007 GF Round 1 MAL component proposal for 12 'orphan' States in Nigeria. Though proposal was adjudged technically sound, it was not considered successful for health systems and CCM capacity issues. WHO provided technical support to mobilise resources for partners e.g. World Bank's Malaria Booster's projects and Global Fund and monitor their performance as member of its Steering Committee and Country Coordination Mechanism (CCM) respectively.

WHO also conducted a gap analysis of Malaria Control Program in Nigeria May 2007 to show the needs met by commodities distributed by States in Nigeria.

**Immunisation Plus Days (IPDs)**

During the IPDs, WHO implemented the successful integrated mass LLIN distribution. This resulted in an increase in coverage from 29 LGAs in 2006 to 272 LGAs in 2007. WHO provided a technical support mission to evaluate the pilot Indoor Residual Spraying (IRS) Survey in 3 LGAs in Nigeria and supported the post-campaign household survey of LLIN use in Nigeria in 2007.



### *Community Directed Intervention (CDI)*

WHO provided support for the documentation of home management of malaria under the Community Directed Intervention (CDI) Project of the TDR/WHO to demonstrate linking of research outcomes with programme development and policy making. This was done in Garba Chede, near Jalingo in Taraba State and was the subject of a BBC World TV programme. A similar WHO/TDR Home Management of Malaria Project was successfully completed earlier in 2006 in Ibadan, Oyo State.

### *From Research into Program Implementation.*

WHO supported the scaling up of home management of malaria based on evidence from the TDR's supported Home Management of Malaria and Community Directed Intervention to scale up implementation of the HMM Strategy. There is evidence that integration is beneficial and can work if adequate support and favourable environment is available. Under the GFATM and World Bank Booster resources, among others, ACT implementation using Community Drug Distributors was shown feasible.

### *Facilitating Factors*

The purposeful leadership and increasing support of the WHO Country Representative and WHO Africa region team have been a major help in channelling more resources to this area. More financial and material resources, (for example LLINs) which have come from UNF and EXXONMOBIL have given the programmes a significant boost. Activities benefited from increased cooperation between WHO departments and collaboration with the NMCP and members of the RBM partnership. Additional posts have been created in WHO which have helped the programmes. For example a Medical Officer (MAL) is now in place and we anticipate recruitment of six more zonal officers.

### *Lessons Learned*

WHO's continued technical support to malaria programmes at country level is very much valued by Government and partners. The focus on coordination and integration of activities has enabled public health in Nigeria to benefit from significant added value from the achieved synergies.

The National MCP annual review and planning meeting supported by WHO and other partners, which is a forum for rewarding states' performance in malaria control, has created health and productive competition. The feedback should be used to attract political commitment at the highest level.

### *Constraining Factors*

The slow response to the call for RBM scaling-up from sub-national levels of government in Nigeria has been a problem in some cases. While remarkable response is being recorded in some states, not much progress is noticed at the LGA level.

### *Key Orientation for the Future*

- Nigeria and partners to strengthen technical capacity at all levels to provide appropriate guidance and technical leadership for malaria control in Nigeria.

- Nigerian government should focus on scaling up the proven interventions in the control of malaria.
- Nigerian government to strengthen its NMCP and related programs for the intensified implementation towards Scaling Up for Impact (SUFi).
- Nigerian government (at all tiers - Federal, State and LGA levels) should add their full weight to the anticipated partners' support in 2008 -2010.

### *Conclusion*

The scaling up experience demonstrates that capacity exists to intensify implementation and scale up for impact. With the commitment of government at Federal, State and Local Government levels, private and community stakeholders, and the support of Roll Back Malaria partners, the goal of ridding Nigeria of malaria can be achieved within the next three years. WHO, given the necessary resources, has the technical and managerial competence to provide the required support to the country leadership that will achieve the RBM goals

## Non-Communicable Diseases

Promotion of healthy lifestyles to reduce incidence of NCDs in Nigeria received a boost from WHO in the year 2007, with the production of a Draft Policy on NCDs and their risk factors. In the same vein, support was provided to the Nigerian Cardiac Society to establish a Heart Care Foundation to run Heart Care Centres in each of the six geopolitical zones of the country. In addition, technical support was provided to a Fulbright Scholar in collaboration with the Federal Ministry of Health for the collection of Cancer data in Nigeria.

WHO Framework Convention on Tobacco Control was launched and disseminated while a Multisectoral Committee on Tobacco was inaugurated and remains functional. The Global Youth Tobacco Survey report was published in one centre in Nigeria. Data was collected (on a small scale) on Road Traffic Injuries in Nigeria. WHO anchored the first UN Road Traffic Conference in Nigeria and supported the Road Traffic Strategy from the Federal Road Safety Commission (FRSC). The Oral Health Centre in Jos was evaluated and recommendations were made to assist it in achieving its aims to become more relevant to both national and international communities.

## Immunization and Vaccine Development

### *Strategic Direction in 2007*

The situation of immunization improved tremendously following intensified efforts to engage all major stakeholders. In 2006 Nigeria adopted and implemented the Immunization Plus Days (IPDs) strategy. The IPDs strategy resulted from an extensive consultative process aimed at enhancing community acceptance of polio eradication activities while at the same time improving routine immunization coverage as well as coverage of priority child survival interventions such as insecticide treated nets (ITNs), anthelmintics and Vitamin A supplementation amongst others. In an effort to strengthen routine immunization performance, Nigeria also adopted the WHO/AFRO recommended strategy of Reaching Every District (RED). The 4th administrative tier in the country is the ward therefore the programme was named the Reaching Every Ward (REW) Strategy.

By the end of 2006, Nigeria had made significant progress in improving routine immunization performance, reducing wild poliovirus incidence and accelerating control against other vaccine preventable diseases, particularly measles. This progress was, however, fragile as Nigeria remained the only polio-endemic country in the WHO African Region.

### *Advocacy and Political Mobilisation*

Strong political support for immunization activities in Nigeria was sustained through the political transition that the country went through in April 2007. His Excellency the President, Her Excellency the First Lady as well as the Honourable Minister of Health and other senior Government officials at federal level reaffirmed their commitment to immunization in general and polio eradication specifically. This same commitment and leadership was also observed at state level with several Executive Governors providing strong managerial and financial support for immunization.



*Her Excellency Hajiya Turai Yar'Adua, First Lady of the Federal Republic of Nigeria meeting with Dr Peter Eriki, WHO Representative to Nigeria in Kebbi, July 2007 on the side-lines of the national launch of the July 2007 IPDs.*

### *Reaching Every Ward Strategy*

WHO provided technical support to national authorities at federal, state, local government and ward level to strengthen the implementation of the Reaching Every Ward (REW) strategy. The Government of Nigeria signed a memorandum of understanding with WHO to conduct training on the strategy focusing on three operational components (micro-planning, monitoring for action and supportive supervision) for health workers at national, state, local government and ward levels. In the course of 2007, a total of 70 national level officers, 450 state level officers, 2,115 LGA officers and 56,633 officers from health facility level participated in this training.

### *Mid Level Management Training*

WHO experts from WCO as well as the Regional Office supported national authorities and partners in the preparation and implementation of a national Mid Level Management (MLM) training of trainers work-shop that benefited 63 participants from the Federal Ministry of Health, National Primary Health Care Development Agency (NPHCDA), health training institutions and partner agencies.

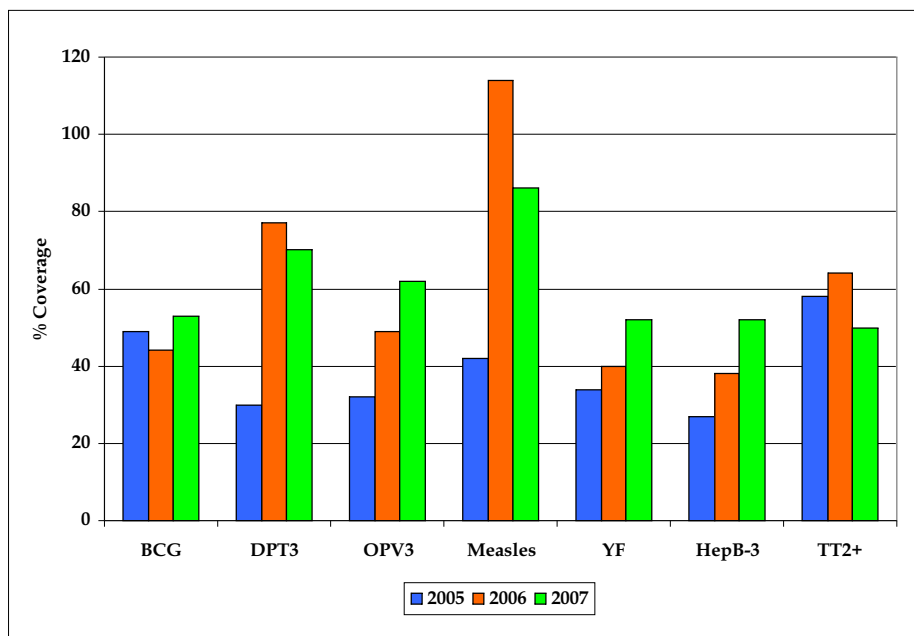
### *Routine Immunisation*

WHO provided technical and financial support for monthly routine immunization review meetings at state level. The objective of the monthly review meetings, attended by LGA Immunization Officers was to review monthly routine immunization data, identify progress and challenges and agree on priority areas for action. The monthly review meetings were also used to build capacity of LGA immunization officers.

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. The number of fixed immunization service delivery points increased by 21% between 2006 and 2007 i.e. from 15,089 to 18,357. The number of outreach immunization sites increased from 11,501 in 2006 to 13,080 in 2007, an increase of 14%.

### *Reported vaccine coverage for 2007*

<b>Antigen</b>	<b>Coverage</b>
BCG	53%
DPT3	70%
OPV3	62%
Measles	86%
Yellow fever	52%
Hepatitis	3-52%
TT2	50%



*Trends in Reported National Routine Immunization Coverage in Nigeria, 2005-7*  
 Source: Vaccination Data reported by states to NPHCDA

The increase in reported routine immunization coverage noted in 2006 was largely sustained in 2007. The greatest increase in coverage was noted for those antigens that were routinely included in the IPDs, particularly DPT and Measles. The proportion of all children aged under 1 year of age that received routine immunization during the IPDs is shown below:

*Proportion of all < 1 yr olds that received antigen during IPDs*

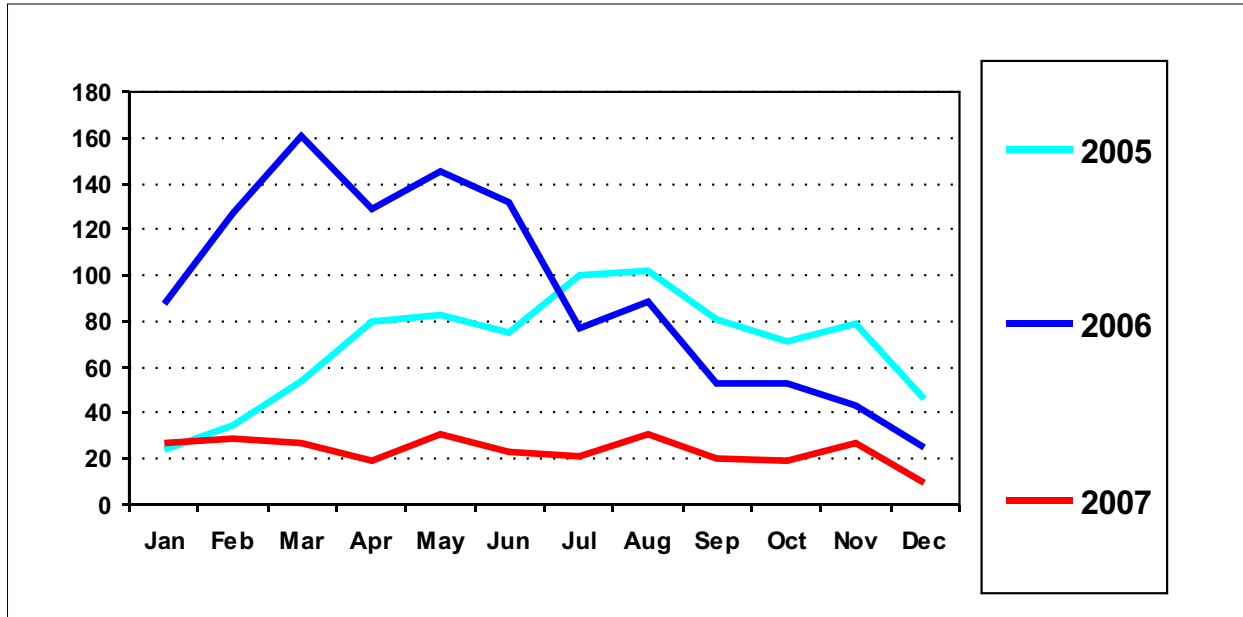
Year	Antigens			
	DPT3	Measles	Yellow Fever	Hep B3
2006	35%	54%	0%	0%
2007	37%	50%	29%	41%

BCG is not administered as part of IPDs while all doses of OPV administered during IPDs are considered supplementary and not routine doses.

High political commitment, continued involvement of traditional and religious leaders and provision of additional child survival interventions resulted in sustained community involvement and participation in polio eradication activities. The licensing and use of monovalent Oral Polio Vaccine Type 3 (mOPV3) further enhanced the efficiency of polio eradication immunization activities in Nigeria.

As a result of increased programme ownership and improved quality and coverage of polio immunization activities in 2007, there was close to 80% overall reduction in all confirmed polio cases in Nigeria in 2007 as compared to 2006 (286 cases in 2007 compared to 1,122 cases in 2006). This reduction was more dramatic for WPV1 where an 86% reduction was registered (843 polio cases due to WPV1 in 2006 compared to 117 WPV1 in 2007). A 39% reduction in polio cases due to WPV3 was registered in 2007 compared to 2006 (279 polio cases due to WPV3 in 2006 compared to 169 WPV1 in 2007).

*Trends of Wild Poliovirus cases by month in Nigeria, 2005- 2007*



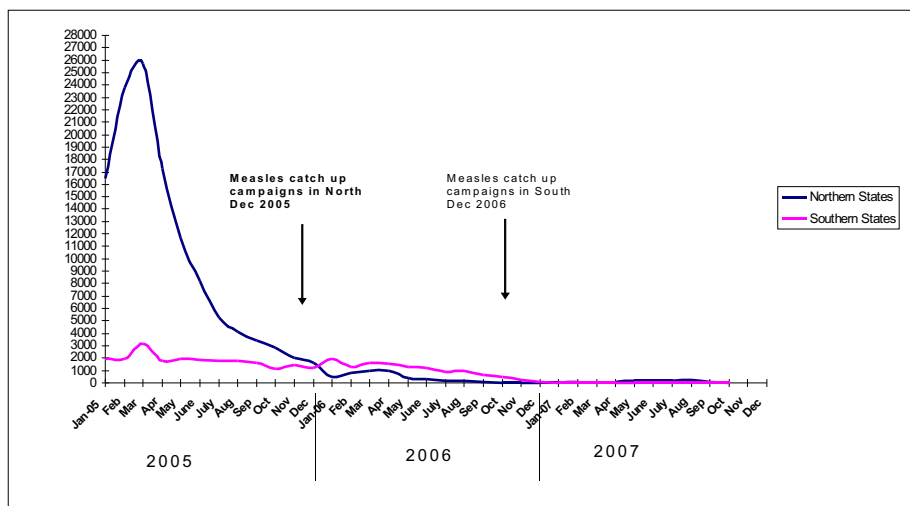
*Source: Polio Laboratory Network*

In 2007, Nigeria had a total of 68 circulating vaccine-derived poliovirus due to poliovirus type 2. Close to 70% of the LGAs with circulating vaccine derived poliovirus had confirmed wild poliovirus.

WHO supported the national authorities to implement recommended accelerated measles mortality reduction strategies. In 2007 the main focus was on strengthening routine immunization, improving the quality of case-based surveillance and measles case management. The significant reduction in measles morbidity registered following the measles catch up campaigns conducted in northern states in December 2005 and southern states in October 2006 was sustained in 2007.

During the second half of 2007, the accumulation of susceptible children due to gaps in routine immunization and increasing duration since the last campaigns resulted in measles outbreaks in several states, particularly the northern states that had conducted their campaigns earlier. Fewer children were affected by these outbreaks compared to the pre-catch-up campaign era.

### Trends in reported measles cases in Nigeria. 2005-2007



Source: Routine Surveillance Reports to FMOH

### Surveillance Activities

In 2007, WHO provided technical, material and financial support for surveillance for vaccine preventable diseases within the national policy framework of Integrated Disease Surveillance and Response (IDSR).

In 2007, routine surveillance reports of 22 diseases included in IDSR, including vaccine preventable diseases, were received regularly from 6,736 health facilities nation-wide (86 tertiary health facilities, 859 secondary health facilities and 5,791 primary health facilities). Active surveillance for acute flaccid paralysis, measles, neonatal tetanus, cerebrospinal meningitis and other diseases of epidemic potential including avian Influenza was conducted at 8,581 health facilities nation-wide (1,550 health facilities were designated high priority sites and were visited at least once weekly; 2,932 health facilities were medium priority sites and were visited once every fortnight while 4,099 health facilities were low priority sites and were visited once a month).

*All the 36 states in the Federation and the Federal Capital Territory (FCT) attained the two main acute flaccid paralysis (AFP) surveillance performance indicators (non-polio AFP rate of at least 2 per 100,000 population under 15 years; at least 80% stool adequacy rate). The proportion of LGAs meeting both AFP surveillance performance indicators increased from 67% in 2006 to 73% in 2007. Twenty six states plus the FCT achieved the two main measles case based surveillance performance targets i.e. detection rate of at least two suspected measles cases per 100,000 population and at least 80% of LGAs conducting investigation of at least 1 suspected measles case with the collection of blood specimen. Nigeria initiated Neonatal Tetanus (NNT) case-based surveillance in January 2007. During 2007, a total of 237 NNT cases from 26 states and 111 LGAs were investigated and documented on case-based forms. With regard to Cerebrospinal Meningitis (CSM), completeness of weekly reports from the 26 states in the CSM belt in 2007 was 97% while timeliness was 39%.*

WHO supported the two national polio laboratories in Ibadan and Maiduguri and both of these laboratories met or /sustained performance criteria for WHO accreditation. WHO also provided technical, material and financial support to four national measles laboratories in Lagos, Kaduna, FCT and Gombe.

### *Enabling Factors*

Enabling factors included strong political commitment, government ownership and oversight, strong partnership and coordination amongst development partners through the Inter-Agency Coordination Committee and increasing financial contribution to the programme from both domestic and international sources.

### *Constraints*

Service delivery gaps were due to inadequate health workers skills, poor attitudes and practices as well as frequent vaccine stock outs at service delivery points. Lack of regular supportive supervision from all levels has compounded the gaps in service delivery. Although there has been increase in completeness of monitoring data, the quality and reliability of the administrative data is sometimes in doubt as outbreaks of vaccine preventable diseases have occurred in some LGAs with high reported vaccination coverage.

Poor demand for immunisation, and in some cases outright rejection, continue to be experienced in some parts of the country, particularly those that continue to have the lowest vaccination coverage.

Health sector-wide challenges such as sub-optimal health infrastructure and logistics, lack of budget lines and funding for operational activities, poor health worker motivation, frequent health worker strikes, poor management and coordination capacity, particularly at the LGA level continue to affect service delivery.

With specific regard to polio eradication, a significant proportion of children in high-risk polio areas continue to be missed by both routine immunization as well as campaign activities.

### *Lessons Learned*

Strong government leadership and ownership at all tiers of government is crucial to the planning, coordination and delivery of high quality immunization services in Nigeria's Federal Governance structure.

Regular consultation and involvement of all key stake-holders, including health workers, representatives of civil society, community leaders and partner agencies in reviewing progress and challenges in immunization services and agreeing on priority areas for action is extremely important.

It is important to use evidence to guide areas to focus limited human, financial and material resources and the role of surveillance and programme monitoring data in guiding priority setting cannot be over-emphasized.

The experience in strengthening immunization services through improving inter-sectoral collaboration, community

participation, health worker capacity building and resource mobilization can be used for overall health systems strengthening and revitalization of primary health care.

### ***Key Orientation for 2008***

The main orientation for IVD programme in 2008 is guided by the national priorities as laid down in the cMYP 2006-2010 as well as the 2008-2009 WHO country office work-plan approved by the Honourable Minister of Health and WHO Regional Director. Main IVD programmatic thrusts in 2008 include (a) improving access to and utilization of immunization services including new and under-utilized vaccines, (b) enhancing the national capacity to achieve interruption of wild poliovirus transmission, (c) enhancing the capacity to sustain certification standard surveillance and (d) accelerating control of vaccine-preventable diseases including measles, maternal and neonatal tetanus and yellow fever .

## Child and Adolescent Health

### *Introduction*

About 1 million children under the age of 5 years die every year. These deaths continue to occur because known, simple and cost effective services/interventions are not being provided for majority of children who need them for survival. If this trend is allowed to continue, it will be difficult for Nigeria to attain the MDG4 (reducing child mortality by two thirds by 2015) and the related MDG5. In order to address the situation, WHO provided strong support for Nigeria in key areas that focused on developing the strategy and tools for effective interventions, building strategic alliances and partnership, building capacity for service delivery at facility and community levels, and institutionalizing proven tools and strategies for sustainability. The key achievements during the year are as described below.

### *Development of Integrated Maternal, Newborn and Child Health (IMNCH) strategy*

WHO in collaboration with other partners in the National Partnership for Maternal, Newborn and Child Health supported Nigeria to develop the IMNCH Strategy. The strategy comprises intervention packages that address the main causes of deaths in pregnant women, newborns and children under the age of five years. The strategy focuses on moving away from implementation of maternal and child health services in a fragmented and vertical manner to integration of the services to build synergy and enhance the impact of interventions. Its development is consistent with the World Health Assembly's Resolution WHA 58.31, which urges member-states to, among other things; accelerate actions to ensure universal coverage of maternal, newborn and child health interventions. All states of the federation through the National Council on Health (November 2007) have endorsed the accelerated implementation of the IMNCH strategy. In absolute terms, about 6 million Nigerian children and more than 200,000 mothers could be saved before 2015 if we faithfully implement the strategy.

### *Promoting Partnership for Maternal, Newborn and Child health*

In March 2007, partnership for accelerating implementation of IMNCH interventions received a boost as WHO supported government in hosting a national conference. Three WHO staff from headquarters in Geneva and the regional office in Brazzaville led by ADG for Family and Community Health, Dr Elizabeth Mason, attended this high profile advocacy meeting. At the forum, the National Partnership for MNCH was inaugurated. This broad based partnership includes key development partners working on maternal, newborn and child health in the country.

WHO facilitated the visit of the Country Support Working Group of the Global Partnership on MNCH to Nigeria. Advocacy visits were paid to the Speaker of the House of Representatives of the National Assembly, the Governor of Niger State (who is the current Chairman of the Northern Governors' Forum), the House Committee on Health, the Chairman of the Senate Committee on Health and the Senior Special Assistant to Mr. President on MDGs.

### *Improving Integrated Management of Childhood Illnesses*

WHO assisted in developing tools for strengthening capacity for service delivery to improve neonatal and child survival. The existing 6-day training package for first level health workers on integrated management of childhood



*Global Partnership for MNCH briefs the Minister of Health*



*MNCH focal person presents IMNCH strategy to the Governor of Niger State*

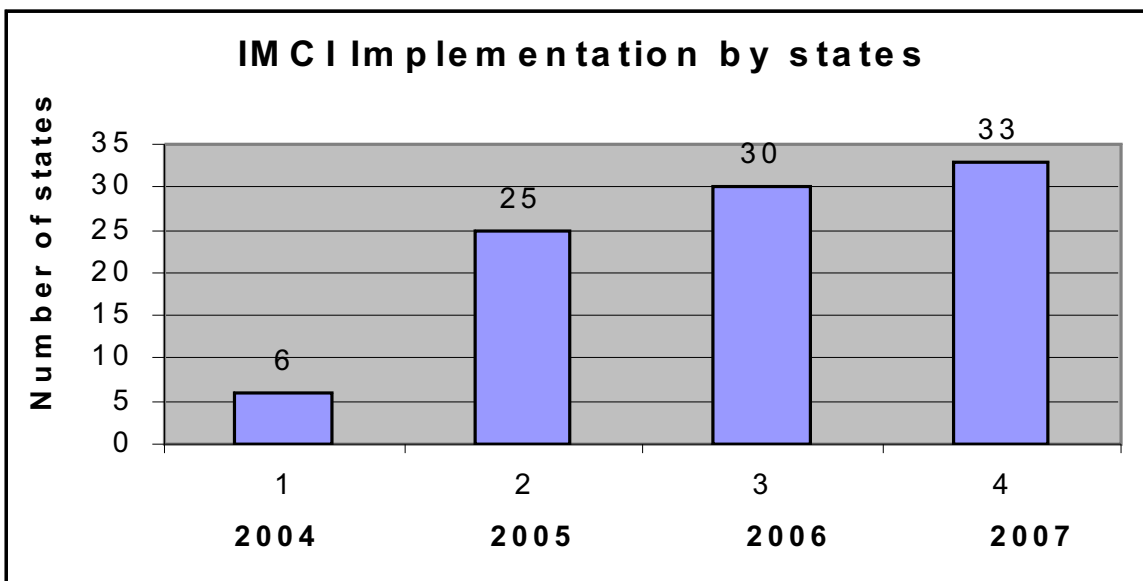
illness strategy was adapted to include care of the newborn, WHO/UNICEF guidelines on zinc and low osmolarity ORS for management of diarrhoea, HIV/AIDS and other technical updates in the treatment of common childhood illnesses.

*Increasing Human Resource Capacity for Service Delivery*

The Integrated Management of Childhood Illness (IMCI) strategy has been adopted as a main thrust for neonatal and child survival. As part of the capacity building efforts for scaling up IMCI implementation to all primary health care facilities, WHO has provided support to build capacity in three additional states in the year. This increased the total number of IMCI implementing states to 33 out of 36 states and the FCT though the coverage within the states is limited.

*Scaling Up of ART Services for Children*

In 2006, it was estimated that 2.86 million persons were living with HIV/AIDS. Only 95,910 of these were on ART. Of these, 4200, representing 4.8%, were children. The situation not only revealed a poor access to ARV, it also showed that ART Services were skewed in favour of the adult population. One of the reasons for this is inadequate skills of health



workers in identifying and managing children infected with HIV. WHO in response, supported six courses (HIV Complementary Course for Integrated Management of Childhood Illness) run back to back with Integrated Management of Adult (HIV) Illness in the year. About 400 doctors, nurses and community health officers were trained in skills needed to diagnose and manage sick children with HIV infection among the many presenting with signs and symptoms of common childhood illnesses. These participants were from selected Anti Retroviral Treatment sites in 26 states of the federation.

### *Supporting Community Interventions for Neonatal and Child Survival*

Household and community practices have great influence on the health and development of children and their mothers. WHO and UNICEF in collaboration with other partners have examined evidence and identified key household and community practices that need to be adopted by households and communities to improve health.



WHO supported the review and adaptation of the generic materials to train community resource persons (CORPS) who will promote the key practices. These materials referred to as community-IMCI materials, include training manuals, trainers guide and pictorial guide for counselling caregivers and mothers. These materials were also revised in the year to accommodate maternal and newborn care by including, birth preparedness, complication readiness, and essential community newborn care interventions. In addition, WHO has assisted in developing community based information system (CBIS) in some communities. This entailed developing community data gathering forms (on common childhood illnesses, births and deaths, etc, and training CORPS and CORPS supervisors on their use. The CBIS has a great potential for improving the data on the overall health picture of the areas since data on community which hitherto were not collected, can now be generated and added to the health facility data. The Federal Ministry of Health in collaboration with WHO and other partners has harmonized the CBIS data collection forms with the National Health Management Information System (NHMIS). The draft document is now waiting for stakeholder review for consensus building and field testing in 2008.

As part of efforts to enhance capacity for promoting the key community maternal, newborn and child health practices, WHO supported the FMOH to train over 100 CORPS in four states during the year. Rapid baseline surveys were conducted in selected communities (in three new states) and action plans for improving family and community practices were developed with the community after sharing the results of the survey. In one state, the community action plans were incorporated into the budget of the Local Government for funding in 2008.

### *Institutionalizing IMCI*

The Integrated Management of Childhood Illness (IMCI) strategy has been recognised as a potent delivery vehicle for some of the high impact interventions for neonatal and child survival. To ensure a wide coverage of the trained personnel and reduce the overall cost of capacity building for integrated management of childhood illnesses in the country, Nigeria has introduced IMCI teaching into its basic health training institutions including the schools of nursing.

By the end of 2006, despite the fact that IMCI had been included in the curriculum of the nursing schools, only 8 Nursing schools were teaching it. Part of the problem was inadequate capacity for teaching in the schools. WHO in 2007, through the Federal Ministry of Health, collaborated with Nursing and Midwifery Council to build capacity in an additional 14 schools of nursing. In addition to training two tutors from each school, each of the 14 schools developed an institutional work plan for IMCI teaching in their schools.

### *Evidence of Child Health Activities Generated*

Availability of data on Integrated Management of Childhood Illness and other related child health activities improved substantially in the year. To achieve this, WHO assisted in developing a tool which was used to collect data on IMCI and related activities. The data is currently being checked for validity and consistency. In addition, the regional IMCI monitoring tool was adapted and is now being modified to capture data on maternal and newborn care activities as well. These tools are invaluable in generating data on activities and through indicator tracking, the progress made towards attaining MDGs 4 and 5 in the country.

In collaboration with national and state governments, three states were supported in the conduct of rapid baseline surveys on key household and community practices. Data was collected on health facility support for introducing community IMCI in the context of promoting MNCH at community level. This generated baseline data on the key household and community practices such as health care seeking, infant feeding, immunization and sanitation practices.

## Reproductive Health

### *Strategic Direction in 2007*

Addressing the high burden of maternal morbidity and mortality in Nigeria requires multi-sectoral evidence-based approaches applied in a concerted manner. To address this need, WHO is leading technical support to the Federal Ministry of Health in collaboration with other partners assisting governments at Federal, States and LGA levels.

Although some progress has been reported by the National HIV/AIDS & Reproductive Health Survey (NARHS) 2005 and a few more recent surveys, reproductive health indices are still far below expectations for achieving MDGs 4 and 5 by 2015. WHO has provided technical and financial support to address key interlinked elements required to build the continuum of care. One of these is human resources development for maternal and neonatal health care. WHO has helped to build pre-service capacity for improving midwifery education and supported implementation of the Road Map for accelerating maternal and newborn mortality reduction. This aims to provide accessible, high quality, maternal and neonatal health (M&NH) care services by helping individuals, families and communities increase their control over maternal and neonatal health and by integration of other primary healthcare programmes with M&NH services.

### *Training National Youth Service Corp (NYSC) Doctors*

About 45 National Youth Service Corp (NYSC) doctors were trained on Emergency Obstetric and Neonatal Care (EmONC) in eight states across the geopolitical zones in Nigeria. NYSC doctors are post interns undergoing the compulsory one year national service and they are usually the cadre of medical personnel available in the rural areas.



*Some NYSC doctors during the EmONC training*

The Federal Ministry of Health in collaboration with the NYSC management and WHO planned the pilot project which is for a year (Nov 2007-August 2008). With the support of distinguished experienced medical experts (obstetricians, paediatricians, anaesthesiologists and laboratory Scientists) five doctors from each of Akwa Ibom, Benue, Cross River, Kano, Katsina, Lagos, Ogun, and Taraba States were trained for three weeks at the onset of their service on elements and practice of EmONC. Thereafter they were linked with mentors who are senior consultant obstetricians in their states of

service for the year. Efforts were made to ensure that these doctors were posted to serve in rural areas. Support by continuous telephone communication was provided to ensure interaction between the NYSC doctors and their mentors.

Training them to proficiency in EmONC is expected to contribute significantly to the reduction of maternal and neonatal mortality among the underserved and rural communities in Nigeria. This pilot was implemented as a demonstration of how existing, poorly tapped human resource can be maximized as a strategy and the project is expected to be scaled-up nationally.

### *Training Midwifery Graduates*

Cancer of the cervix is the second most common cancer among women globally. If not detected early, cervical cancer is a fatal disease. Most cases of cancer of the cervix occurring in Africa are detected very late mainly due to lack of awareness and poor access to screening facilities.

To address this, technical support was provided from 21-24 August 2006 for basic midwifery graduates to acquire additional skills in visual inspection with acetic acid (VIA) prior to commencement of the compulsory one year rural posting. The first batch has since commenced service with encouraging reports from the states.

In September 2007, WHO supported the training of about 30 core trainers from schools of nursing & midwifery and Nursing and Midwifery Council of Nigeria on syndromic management of STIs to ensure effective teaching of comprehensive STI case management is integrated into the curricula of training institutions for nurses and midwives in Nigeria.

*Christiana Musa is a midwife on mandatory post-qualification community service in Chibok LGA, Borno State. She was described by her supervisor as hardworking, dedicated to duty and generally effective. The doctor in her clinic will always want her to be around anytime he is managing a complicated delivery. She initiated home visits, counselling and provision of family planning information and services to grand-multiparous women and their husbands. The women in this area often suffered serious obstetric complications. She is involved in a school health programme during which she provides monthly counselling and health education sessions to students of a school with a high teenage pregnancy rate.*

*Christiana has now become a household name in the community she's serving in. When women are in labour even in the nights they go to her for assistance which she is ever willing to give. Although the demand on her is sometimes great, she's above all, happy with what she's doing. Her acceptance by the community and the confidence they have in her is propelling her to do more.*

*Report by Mrs Hajaratu Shetima Principal School of Midwifery Maiduguri 9<sup>th</sup> August 2007. This is part of the positive impact that WHO interventions bring to services delivery.*



*Core trainers from schools of Nursing and Midwifery during TOT for Syndromic Management of STI in Minna*

### *VIA & Cryotherapy training*

In 2007, the WHO Country Office Nigeria supported government in the national scale-up of VIA & Cryotherapy and integration into other RH services. About 55 obstetricians & midwives from secondary and tertiary institutions and 55 basic midwife graduates were trained on VIA and cryotherapy for screening and management of pre-cancer of the cervix in August 2007 at one of the Reproductive Health Research centres enjoying WHO support. It is expected that when a nurse/midwife detects a positive case, she will refer to the gynaecologist, who confirms and treats with cryotherapy, thus, fulfilling the “see & treat” approach..



*VIA & Cryotherapy training at WHO collaboration Centre, CRHR Sagamu*

### *Making Pregnancy Safer*

In 2007, WHO addressed some of the weaknesses identified during the 2006 assessment of the progress with the Making Pregnancy Safer initiative in the focus LGA. 90 Midwives had refresher training on the use of partographs for monitoring/managing labour and infection control/decontamination process.

### *Sexual and Reproductive Health Dialogue*

A dialogue between providers and consumers of sexual and reproductive health services took place in December 2007 in Abuja. The meeting aimed to address issues about health workers' attitude which were identified as one of the major reasons for the poor utilization of sexual and reproductive health (SRH) services by adolescents and adults in Nigeria. The forum was a collaborative effort between WHO, the FMOH, the Nursing and Midwifery Council and the National Council of Women Societies.

About 250 people comprising urban and rural women, men, nurse-midwives, principals of schools of nursing and midwifery, nursing and midwifery council members, officials of state and federal ministries of health and development partners participated in the dialogue. At the end participants were able to arrive at a consensus on the way forward for an improved relationship that will ensure greater access to and use of SRH services in Nigeria. Proceedings from the interactive meeting were compiled in a documentary format for mass dissemination to create more awareness and promote client-oriented sexual and reproductive health services.



*Cross section of participants during the Sexual and Reproductive Health Consumer-Provider Dialogue in Abuja.*

### *Strategic Partnership Programme*

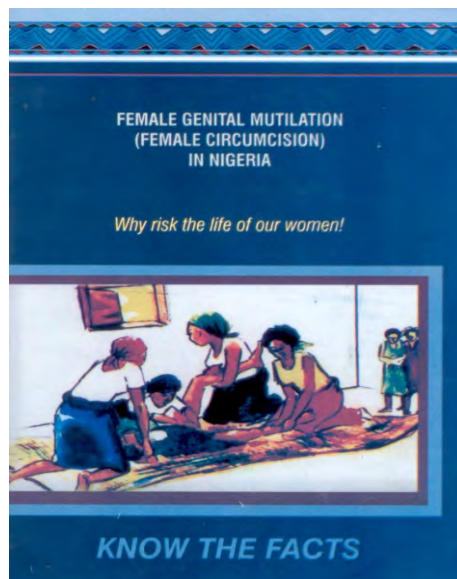
The focus of the Strategic Partnership Programme (SPP) in Nigeria during 2007 was to support the integration of national guidelines and tools for sexually transmitted infection and family planning - updated in 2006 - into the Standing Order of Practice (SOP) of the Primary Health Care system in Nigeria. The newly revised National Guidelines on the Syndromic Management of STI and the updated National Family Planning /Reproductive Health service protocol were used to update and revise standing orders for Community Health Extension Workers (CHEWs) and Junior-CHEWs. Other areas of concern in the SOP earlier raised by the National Board of CHEWs were addressed to ensure acceptability of the revised SOP to all. The final SOP incorporating syndromic management and other updates was deliberated upon and ratified by stakeholders during a consensus meeting. This ratification was followed by orientation of PHC master trainers from six states from each of the geopolitical zones of the federation. Participants were from Sokoto, Oyo, Benue, Kogi, Delta and Enugu states.

### *Health Promoting Schools (HPS) Initiative*

In furtherance of the technical assistance for development of a National Strategic Framework on the health and development of adolescents & young persons in Nigeria, WHO, early in 2007, supported the printing of a policy for dissemination to stakeholders. The Health Promoting Schools (HPS) initiative was extended to three new states in 2007. In Bayelsa State, four schools benefited from WHO's support for the training of 38 students/pupils, 18 teachers and two environmental health officers. Thirteen food handlers were trained to promote comprehensive school-based health, hygiene and nutrition programmes as effective means to improve student health and thereby, educational outcomes. In 2007 WHO engaged government and communities in Jigawa and Osun states to identify schools where the HPS initiative can be implemented in 2008.

### *Gender Based Violence*

During the year, WHO supported finalization of the national guidelines on prevention and response to gender-based violence in Nigeria. WHO also supported the printing of about 20,000 copies of IEC materials on “Facts about Female Genital Mutilation in Nigeria”. (The document can be downloaded from the WHO Nigeria website - [www.who.int/countries/nga](http://www.who.int/countries/nga)).



## Essential Medicines

### *Monitoring Medicine Prices*

In the 2006-7 biennium, there was evidence that medicine prices in Nigeria were very high both in public and private sectors. In response to this WHO, in collaboration with the Federal Ministry of Health, selected sentinel sites in 12 states of the country to monitor medicine prices on a quarterly basis. Comparison was made between the public and private sectors, and with international reference prices. Summary tables of the results were made and published in three national dailies.

The publication elicited several reactions. There were articles in the national and international media focusing on the problem of medicine prices in Nigeria. Individual facilities reported that they became aware of the wide variability in prices between states, facilities and sectors. Armed with this information, they were able to negotiate for better prices with vendors. Some state governments demanded explanations from their pharmaceutical services why prices were high and initiated mechanisms to make changes.

Interventions to improve pricing are still not satisfactory. Greater advocacy, wider publication and specific policy changes need to be put in place to ensure price reductions. Such interventions will include the involvement of the government at both the federal and state levels in bulk procurement of key essential medicines, adoption of a pricing policy and better regulation of procurement in both public and private sectors. These interventions will be the focus of EDM support to the government of Nigeria in the years ahead.

### *Determining Access to Essential Medicines*

The percentage of Nigerians who have access to medicines has never been objectively measured. WHO has developed a tool to assess the use of medicines in the population. The tool was tested in Brazil, Gambia and Nigeria with the objective of assessing its effectiveness and refining it for wide adoption in all member countries as a monitoring tool.

The results show that there is good accessibility to health facilities as fewer than 2% have to travel more than one hour to get to any health facility in the public and private sectors. Public facilities and drug sellers were the most accessible. Affordability was shown to be a barrier to access to medicines. The majority of chronically ill patients did not have up to a 30-day supply of medicines and one out of three did not take medicines because they could not afford them. Health insurance coverage was quite low with only 5% coverage of surveyed households. Only half of medicines found in households were adequately labelled.

The study continues to underscore that cost of medicines is a key barrier to access to essential medicines in Nigeria. Radical measures such as greater insurance coverage, rational procurement practices by the government need to be put in place to improve access to medicines.

### *Mapping Supply Management of Medicines*

Since the return of Nigeria to democracy, there has been greater involvement of bilateral and multilateral agencies in the procurement of medicines for a variety of programmes. It is not known if resources committed to improving access to medicines are very optimally deployed and to answer these questions, the supply management of medicines in the country was mapped.

The results confirmed that the system used in the country is uncoordinated, duplicated and expensive. This often results in huge caused by expired medicines, parallel systems for distribution, and poor accountability for the huge resources committed to procurement and supply management. The burden on the managers of the parallel systems is heavy in terms of reporting to the various actors. Procurement prices when compared to international prices are high and savings of up to 75% of the current cost of procurement could be made if rational procurement was undertaken.

A coordinated, harmonised system will be of benefit to the country and a clear cut procurement policy is necessary to ensure that Nigeria develops a sustainable procurement and supply management system.

### *Supporting Good Procurement Practices*

The Christian Health Association of Nigeria (CHAN) which has more than 2000 member institutions has been a key player in ensuring access to medicines in Nigeria. Our studies showed that their procurement prices compared favourably with procurement agencies in other countries. In order to assume greater responsibility in the procurement of good quality and affordable essential medicines, CHAN decided to embark on contract manufacturing of its medicines for Nigeria in other countries.

WHO supported CHAN in 2007 to prequalify some manufacturing companies in India to embark on procurement of key essential medicines. The negotiated prices with compliant companies was an about a third of international prices. This underscores the value of pooled procurement in the reduction of prices for essential medicines in Nigeria. CHAN intends to commence importation of medicines in 2008 and they are expected to be accessible to both public and private facilities.

### *Standard Treatment Guidelines*

Most countries support health professionals in promoting the rational use of medicines through the publication of clinical guidelines for the management the most prevalent diseases. While efforts have been made by some priority programs (tuberculosis, sexually transmitted infections, HIV/AIDS, malaria etc.) there is very little guidance for the clinician in Nigeria to support the management of the most prevalent illnesses in the country. Thus, there is poor availability of medicines in health facilities, wastage of scarce resources through irrational prescribing and absence of consensus between providers.

Nigeria has embarked upon the development of Standard Treatment Guidelines (STG) to support the rational prescribing and procurement of medicines in health facilities. In 2007, several meetings were organized for some key facilities to obtain their endorsement of the draft document and to elicit their commitment. Some secondary and tertiary

facilities from the northern and southern zones of the country were invited to meet, discuss and start using the document. The stakeholders welcomed the concept and committed its to the use and dissemination in their respective facilities. The finalised document will be printed in 2008 and distributed for wider use in the country. It is hoped that it will improve the rational use of medicines in the country.

### *Drugs and Therapeutics Committee (DTC) set up in UNTH Enugu*

The University of Nigeria Teaching Hospital Enugu requested the support of WHO in improving medicines use and management in the facility in 2006. An assessment was undertaken using WHO monitoring indicators. The results showed poor medicines management, poor accountability and irrational use of medicines. The factors together created a barrier to access to medicines in the facility. In order to improve the use of medicines it was agreed that WHO should support the facility to set up a DTC. The Committee is intended to facilitate communication between departments, develop and monitor the use of Essential Medicines List and continuously monitor the rational use of medicines in the facility.

WHO supported the facility to develop an Operational Policy and Guidelines to run the DTC by adapting the guidelines developed by WHO & Management Sciences for Health (MSH) *Drugs and Therapeutic Committees - A practical Guide*. The terms of reference and membership for the relevant subcommittees were developed. Using the draft Standard Treatment Guidelines for the country, an Essential Medicines List was adapted for the facility to guide procurement and prescribing in the facility. WHO also supported the facility to procure two computers with relevant accessories to support record keeping and the Drug Information Centre. Three other tertiary facilities will be supported in 2008 to set up their DTCs in 2008.

### *Improving Medicine Regulations In Nigeria*

From December 2006 to February 2007, WHO in partnership with DFID (PATHS and HCP) conducted an assessment of the medicine regulatory authority NAFDAC to determine areas requiring support in their laboratory, regulatory and surveillance systems. The objective of this evaluation was to determine support which the agency would require in order to attain WHO certification for the laboratory. The regulatory and surveillance functions were assessed to improve their ability to better achieve the regulation of medicines in Nigeria. The activity culminated into a strategic plan for strengthening the agency in 2008 and 2009.

### *Promoting Traditional Medicines*

To build the capacity of traditional medicine practitioners in the country and ensure their adherence to ethical standards of practice, WHO supported the traditional medicine program to draft the Code of Conduct for practitioners and develop the curriculum for training. The stakeholders met and endorsed the documents. These will be printed and disseminated in 2008.

## Health Systems and Service Delivery

### *Enhancing the Stewardship Role of Government*

The determination of Government to improve the weak health system and thus give better health to the people received a boost as WHO and partners facilitated the development of a Strategic Health Investment Plan (SHIP) for the country. This is a documentary framework that harnesses the evidence generated to identify and cost key integrated actions required for addressing the disease burden of the country including services, systems, and modalities needed to implement and evaluate them.

The process of developing a strategic health investment plan was kick started by a retreat involving the Honourable Minister of Health and top government officials and development partners. This was followed by a presentation at the National Council on Health (NCH) in November 2007 where the Minister of Health and all State Commissioners of Health reviewed the process. WHO provided technical facilitation for the retreat and the NCH.

The principles have also been introduced to some states which are being supported to develop state level plans. In particular, WHO provided support to Kwara and Kogi States to develop their state plans for 2008-2011 and to carry forward the State Economic Empowerment and Development Strategy II (SEEDS).

### *Cost Implications of the Response to HIV/AIDS in Nigeria*

In 2007 the study on: Universal Access to Treatment Care and Support; and Innovative Financing Mechanism for HIV/AIDS was concluded. The study revealed that the national response is becoming more coordinated with improved contributions and participation by the private sector, civil society organizations, bilateral and multilateral organizations and PLWA. In particular, there has been an increased flow of resources from the Nigerian government, Global Fund to fight AIDS, Tuberculosis and Malaria, the US government (through PEPFAR) and the World Bank, through the Multi-country HIV/AIDS programme, (MAP).

While estimates indicate the total resources that have been put into fighting HIV/AIDS in Nigeria in 2004 and 2005 were \$41.335 million and \$99.612 million respectively, this study's estimate for the period 2006-2012 shows that about N54.042 billion (\$425.5 million) would be required in 2006 to provide this comprehensive package of prevention, treatment and care. The corresponding figure for 2007 is about N83.433 billion (\$457.0 million) and the amount required for the 7-year period of 2006-2012 is about N1007.47 billion (\$7932.8 million).

### *Cost of providing a core package*

To provide a core package under the assumption that ART is scaled up to attain 60% coverage by 2010 and sustained at that rate until 2012, the cost is about N60.161 billion (\$473.7 million) for 2007 and the amount required for the 7-year period of 2006-2012 is about N731.611 billion (\$5760.7 million), (see table).

Providing this same core package under the assumption that ART coverage of 85 per cent would be attained by 2010 and sustained until 2012, costs will increase from \$2,999 to \$3,546 while the costs of No-ART obviously will decrease given that fewer people would be in need of the service. In total about N35.364 billion (\$278.5 million) will be required in 2006

### Estimated Cost of Providing Core Package of Care for People Living with HIV/AIDS in Nigeria (60%) coverage

Millions of US\$									
	2006	2007	2008	2009	2010	2011	2012	2006-2012	% total cost
<b>Prevention</b>	<b>68.9</b>	<b>86.3</b>	<b>106.3</b>	<b>128.8</b>	<b>154.2</b>	<b>182.7</b>	<b>214.3</b>	<b>941.5</b>	<b>16%</b>
PMTCT	68.9	86.3	106.3	128.8	154.2	182.7	214.3	941.5	16%
<b>Care and treatment services</b>	<b>182.0</b>	<b>340.4</b>	<b>411.5</b>	<b>523.2</b>	<b>702.1</b>	<b>925.4</b>	<b>1,163.7</b>	<b>4,248.3</b>	<b>74%</b>
ARV	25.0	52.3	103.7	188.0	283.9	383.9	504.4	1,541.2	27%
Laboratory Tests	15.4	26.1	53.5	103.8	168.8	234.3	296.5	898.4	16%
Services	10.4	13.3	28.7	56.9	100.7	150.7	199.7	560.4	10%
<b>Total ART</b>	<b>50.8</b>	<b>91.7</b>	<b>185.9</b>	<b>348.7</b>	<b>553.3</b>	<b>768.9</b>	<b>1,000.6</b>	<b>2,999.9</b>	<b>52%</b>
<b>Care in the absence of ART</b>	<b>131.2</b>	<b>248.7</b>	<b>225.7</b>	<b>174.5</b>	<b>148.8</b>	<b>156.5</b>	<b>163.0</b>	<b>1,248.4</b>	<b>22%</b>
<b>Subtotal</b>	<b>250.9</b>	<b>426.8</b>	<b>517.8</b>	<b>652.0</b>	<b>856.4</b>	<b>1,108.1</b>	<b>1,378.0</b>	<b>5,189.8</b>	<b>90%</b>
Policy, advocacy, administration and research	27.6	46.9	57.0	71.7	94.2	121.9	151.6	570.9	10%
<b>TOTAL Millions of Naira</b>	<b>35,364</b>	<b>60,160</b>	<b>72,992</b>	<b>91,912</b>	<b>120,720</b>	<b>156,209</b>	<b>194,253</b>	<b>731,611</b>	
<b>TOTAL Millions of US\$</b>	<b>278.5</b>	<b>473.7</b>	<b>574.7</b>	<b>723.7</b>	<b>950.6</b>	<b>1,230.0</b>	<b>1,529.5</b>	<b>5,760.7</b>	<b>100%</b>

to provide this package of care. The corresponding figure for 2007 is about N60.161 billion (\$473.7 million) and the amount required for the 7-year period of 2006-2012 is about N767.391 billion (\$6042.4 million). This is far beyond the actual current spending level which was put at about \$99.6 million in 2005.

#### *Costs of Tuberculosis in Nigeria*

In Nigeria, only about 26.8 per cent of TB patients were discovered to have TB following a routine medical check up. This has been revealed in another study on the cost of Tuberculosis in Nigeria supported by WHO. Similarly, the study indicated 39 per cent of patients had to stop work for at least one day during ailment and about 83 percent of patients suffer productivity losses in form of either loss in hours of work or total stoppage of work.

While TB drugs are free, on average, a patient incurs private direct cost of treatment of about N17, 000 with transport cost accounting for the lion's share (about N14, 500). Furthermore, the average cost of time lost by patients while seeking and obtaining care is about N2, 370 per patient; the bulk of which is associated with time lost at the treatment centre which the patient visits on the average 85 times. On the whole, the study revealed that the average cost of TB illness in Nigeria is about N179, 500 per patient cured, with about 82.4 per cent of it being institutional (public) cost while about 17.6 per cent of it is private cost. Given an average daily income of about N247.50 and average age of about 34 years for TB patients in Nigeria, it can be shown that the benefit from mortality averted is about N1.4 million per patient assuming a life expectancy at birth of about 50 years. Therefore, the benefits of DOTS far outweigh its costs.

For more information on the study contact Dr. Amos Petu; WHO office in Nigeria

### *Community Based Health Insurance Scheme*

Concerned with the high cost of health care much of which is out of pocket expenditure, in 2007, WHO further provided support to generate evidence about community health insurance scheme. The study revealed that more than 90% of the respondents were willing to enrol in CBHI scheme. Also, more than 90% of the respondents were willing to enrol their other household members. However, less than 30% of the respondents were willing to pay up to 500 Naira per month as premium.

One high point of the study is the solidarity that respondents showed when it came to health care. Many respondents were willing to contribute so that the poor and indigent people would benefit from CBHI (altruistic WTP).

## Administration and Finance

The Nigeria Country Office, in 2007, had a staff complement of over 400. This total staff count includes national immunization staff holding Special Services Agreements (SSAs) and a mix of Short Professional and General Service Staff. This makes the country office the largest WHO office in the African Region, and only second to India in WHO worldwide.

### WHO Country Office Nigeria - Staff Designation by Contract Type

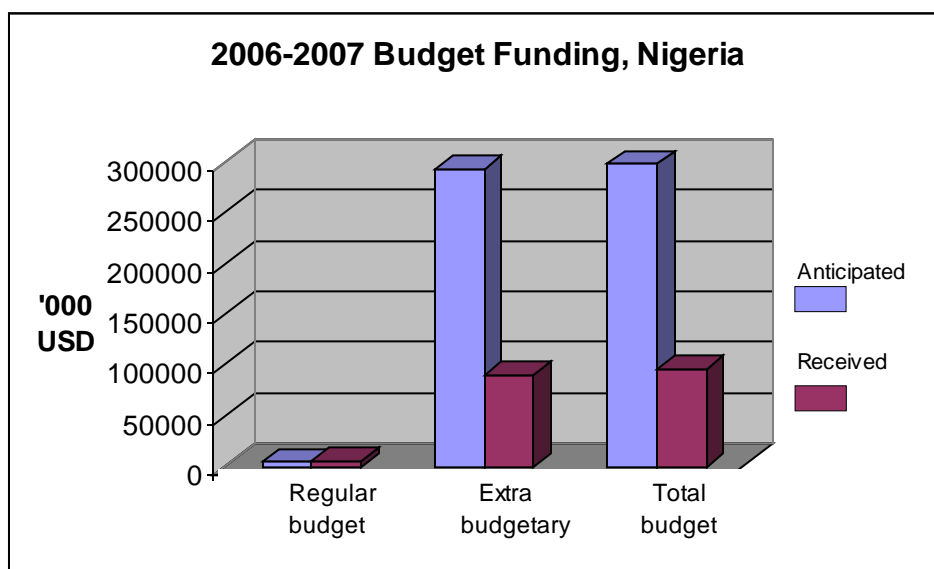
Designation	SSA	ST	FT	TOTAL
Internationally Recruited Staff members	-	27	8	35
Routine Immunization Officers	2	-	-	2
National Logistics Officer	1	-	-	1
National Social Mob. Officer	1	-	-	1
Surveillance Officers	68	-	-	68
National Immunization Officers	42	-	-	42
Admin. Clerks/Messengers/Cleaner/Gardener	-	11	2	13
Polio Labs. Support Staff	15	-	-	15
HIV/AIDS	-	5	1	6
Roll Back Malaria	-	1	1	2
Prevention Communicable Diseases [incl. GWM & IDSR-AI]	-	2	1	3
FHP	-	1	1	2
Health Systems	-	-	1	1
Integrated Management of Childhood Illness	-	-	2	2
TB & Joint HIV/AIDS	-	5	1	6
Essential Drugs & Medicines	-	-	1	1
Health Promotion	-	-	1	1
Personal Assistants & Secretaries	-	7	4	11
Administrative Assistants	-	35	5	40
Programme Assistants	-	1	1	2
Senior HR Assistant	-	-	1	1
Personnel Assistants	-	2	1	3
Finance Assistants	-	2	2	4
Transport and Vehicle Maintenance Assistants	-	4	-	4
ICT Assistants	-	1	1	2
Finance Clerk	-	-	1	1
Equipment Operator	-	-	1	1
Registry Clerk, Receptionist & Typist	-	-	3	3
Zonal Logistics Assistants and Store Keeper	-	8	-	8
Data Managers	-	2	-	2
Data Clerk	-	1	-	1
Radio Operators and Technicians	-	13	-	13
Zonal Data Assistants	-	6	-	6
Drivers	-	124	12	136
<b>TOTAL</b>	<b>129</b>	<b>258</b>	<b>52</b>	<b>439</b>

The presence of an effective administrative support team is, therefore, critical to support the implementation of technical programmes. Cognisant of this, HQ, AFRO and ICST-West had continued to respond positively to all requests for support emanating from the country office.

The Polio Eradication Initiative, with scaled up efforts to interrupt wild polio virus transmission, had continued to mobilise the greater part of the financial and human resources of the country office. Greater administrative support that is also closer home is, therefore, needed to support programme implementation. To further strengthen administrative support, the Regional Director approved the deployment of professional human resources and budget & finance officers both of whom assumed duties in June 2007.

A strong and active administrative unit of dedicated and responsive staff, therefore, continued to be the hallmark of the numerous achievements mentioned in this report.

A major part of 2006-2007 biennial funding was utilized in 2006 and the balance of funds brought forward in 2007 was further stretched by unanticipated rising staff costs and this affected regular budget funds the most. The release of the 3% RB funds withheld by the DG/RD went a long way in closing up the shortfalls. The RD further allocated about USD315,000 RB funds to Nigeria to further close the funding gaps by offsetting negative salary allotments in RB. This made it possible to implement additional planned activities.



*The graph shows the total of funds that were anticipated compared to the amount actually received during the period*

Although the office continued to receive great support from all tiers of the organization both administratively and financially, there were still significant funding gaps in extra-budgetary resources planned in 2006-2007 which in turned hindered the full scale implementation of planned activities for the period.

The main administrative achievements worthy of mention in this report include:

- The successful implementation of HR reforms policies including recruitment and contracts administration
- The successful installation of support systems for budget and finance, regional office administration and financial information (ROAFI) data base and also human resources administration, PAYTEMP. Although a

read-only version of ROAFI was installed, this was found quite useful in monitoring budgets and expenditures.

- The overhauling of the GPN connectivity to increase the number of functional GPN extensions in the Country Office including further enhancements in the radio linkage between the main office in the UN House and the annex office located in Asokoro.

To conclude, the country office was able to efficiently manage available funds through prudent financial management involving rational allocation of the limited financial resources and sound planning which to great extents mitigated the adverse effects of the funding constraints.

In 2007, the Country office played host to a number of missions from AFRO and HQ to provide support to the programming efforts in Nigeria. The tables at the end of this report provide details of these missions.

## WHO Nigeria Country Office Retreat

### *Objectives*

As part of the traditional WHO way of always searching for better ways of working and charting the way forward for enhancing WHO's work in Nigeria, staff members of the World Health Organization (WHO) Nigeria, led by the Country Representative, Dr. Peter Eriki left the confines of their offices for a 4 day retreat in Kaduna from 18 to 21 July 2007.

The objectives of the meeting were to ensure that staff members are well apprised of the planning paradigms within WHO; develop draft 2008-2009 Work Plan and also jointly review the operational modalities and implementation of the 2006-2007 Work Plan. Others were to discuss and agree on: the modalities and road-map leading to the development of the second generation of the Country Cooperation Strategy (CCS) which will involve Government and partners; the re-profiling paradigm for the Country Office and the next steps as well as to finalize the human resources Plan for the Nigeria Country Office.

### *Welcoming remarks WR Dr. Peter Eriki*

Dr. Peter Eriki in his welcome address, urged the participants to work in order to maintain WHO's leadership role in public health. He noted that it is crucial to constantly adopt innovative ways of service delivery and constructive engagement of stakeholders in order to work in the increasing complex and dynamic landscape. He noted that the six point agenda, the Regional Director's 5-point strategic orientation, the organization's 11<sup>th</sup> Global Program of Work and the strategic objectives of the work plan were the yardstick for the measurement of WHO's work in the years ahead. He further informed participants that the work plan for the country office must be situated within the context of the UN reforms. He then requested the country office to look for opportunities to work with the new government to advocate for and manage resources in order to achieve its health agenda.



*Dr. Peter Eriki : WHO Representative giving his orientation at the staff retreat*

During the four-day Retreat, participants brainstormed on issues such as the WHO Global Programme of Work, the Medium-Term Strategic Plan 2008-2013, the programme budget 2008-2009 and the Country Work Plan for the coming biennium. They also worked on the office's human resources plan, re-profiling, the second generation Country Cooperation Strategy (CCS) and discussed a number of administrative issues that would improve the management of the office. The retreat served to facilitate work by staff within and across strategic objectives, which greatly facilitated the drafting of the 2008-2009 Work plan for the WCO/Nigeria.

A number of decisions were reached at the end of the Retreat. They include the setting up of an in-house Committee to kick-start work on the second generation CCS, the finalization of the 2008-2009 Country Work Plan and Human Resources Plan as well as the development of an organogram for the office, based on the Clustering option, for functional operations. This would be in five clusters: Disease Prevention and Control; Maternal and Child Health; HIV/AIDS, Tuberculosis and Malaria; Immunization and Vaccine Preventable Diseases and Health Systems.



*Participants engaged in discussion during the retreat*

## Missions to WCO Nigeria in 2007

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
<b>REPRODUCTIVE HEALTH</b>				
28-29 March	Family and Community Health Cluster WHO/HQ	Dr Elizabeth Mason (ADG.a.i Family and Community Health), Dr Samira Aboubakar (Team leader Country Support for CAH) Dr Diallo Mamadou WHO HQ Dr. Andrew Mbewe, CAH/AFRO	To participate in National Conference on Partnership for Scaling Up high impact maternal, newborn and child health interventions (and presentation of integrated strategy on MNCH)	High level participation by WHO at the National Conference  Technical inputs to the draft Integrated MNCH strategy
17-27 Sept.	Country Support Group of Global Partnership on MNCH	Dr Al Bartlet (USAID) Dr Diallo Mamadou WHO HQ	To boost advocacy for maternal, newborn and child health in Nigeria	Met National Assembly Committees on Health  Held Meeting with NGOs working in MNCH field  Assisted the National Partnership on MNCH to review government draft proposal for the GPMNCH  Identification of other areas of collaboration with the global partnership.
14-24 Oct 2007	HIV Division, WHO/HQ	Dr. Siobhan Crowley, Pediatric ART focal person, Dr. Chika Hayashi, focal person for M&E HIV/WHO/HQ Dr. Abdulhamid Alisalad, focal person M&E for HIV/WHO/AFRO, Dr. Louise Mapleh-WHO /AFRO inter-country team, Dr. Chewe Luo - Senior Programme Adviser, HIV and Health, Health Section, UNICEF NYHQ, Dr. Rene Ekpini - Senior Advisor, PMTCT and Pediatric Care and Treatment, UNICEF NYHQ Dr. Anirban Chatterjee - Project Officer, HIV and Nutrition, UNICEF NYHQ, Dr. Omotayo Bolu - Medical Officer, PMTCT Care and Treatment Branch, Global AIDS Program/CDC ,	To examine the current status of the PMTCT and Paediatric HIV/AIDS treatment Programmes in Nigeria in terms of coverage, quality of service delivery, integration and impact.  To examine the data & information management system, focusing on successes, challenges and opportunities.  To examine existing management and coordination of national PMTCT and paediatric HIV programmes and their effectiveness in facilitating integrated service delivery.	Identified gap+E13s in the implementation of PMTCT and Pediatric HIV/AIDS treatment programmes  Made recommendations on the way forward to improve the implementation of PMTCT, Pediatric HIV/AIDS treatment and care programs and Infant Feeding activities including the development of a consolidated and costed State level PMTCT/Pediatric Care & treatment scale up plans
28-29 <sup>th</sup> March 2007		Dr Elizabeth Mason, ADG a.i FCH, HQ Dr Samua Aboubakar, Coordinator CAH, HQ. Dr Mamadou Diallo, PMNCH Senior Adviser.	Support the National conference on promoting Partnership for Maternal Newborn and Child Health in Nigeria	Nigeria Partnership for MNCH launched
6 <sup>th</sup> -8 <sup>th</sup> , 27 <sup>th</sup> -29 <sup>th</sup> Aug. 2007		Dr Nii Hammond University of Zimbabwe ,College of Health Sciences Medical School Department of O&G	Support VIA and Cryotherapy National Scale-up training workshop.	110 health care providers trained to screen for cancer of cervix using VIA and treatment with Cryotherapy

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
17- 20th Sept. 2007		Dr Al Barton Dr Mamadou Diallo, PMNCH Senior Adviser.	Support Nigeria PMNCH by the Country Support working group of the Global Partnership for Maternal Newborn and child Health	Advocacy visits to policy makers and partners
15 <sup>th</sup> -24th Oct. 2007		Dr Chika Hayashi, M&E HIV/SIR, HQ Dr Alisalad ME, Dr Francis Onyago-AFRO Mrs Louise Mapleh ICST/WA	Inter Agency Task Team visit on PMTCT/Paediatric ART	Recommendations for improved national PMTCT programme and acceleration of scale-up plan
15 <sup>th</sup> -26th Jan. 2007	USAID	Dr Maarten van Cleeff Ms Ineke Huitema Mr Bill Coggin Ms Susan Bacheller USAID/ W	To assess the status and impact of USAID support for the TB control in Nigeria and to recommend strategies to maximize the effectiveness of USAID funds  To assess the status and impact of USAID and USG support for TB/HIV-AIDS collaborative activities and to recommend strategies for strengthening this program	Status and impact of USAID support for the TB control in Nigeria assessed and recommendation made on the way forward.
7th 18th Jan. 2008	TB CAP	Dr. Sangeta Mookherji Dr. Jan Voskens	To collect basic information in all aspect of PPM in Nigeria.	Report of National Situation of PPM available
10th 17th May 2007	TB CAP	Sara Massaut	To support development of the work plan for TB CAP	Draft Work plan for TB CAP developed.
9th 21st July 2007	WHO, USAID	Dr. Daniel Kibuga Dr. Daniella Cirriello Ben Lozare Dr. Krishnan Ineke Huitema	To assess progress in programme development & implementation of Previous mission recommendations  To provide technical support to PR and various SRs in the various areas of the TB control interventions including TB Prevalence survey and MDR management etc.	Progress on the implementation of the TUB round 5 of GFATM obtained.  Technical support provided to the TUB PR and SRs  Technical support provided on the TB prevalence survey  Technical support provided on the MDR survey and operation of the National and zonal reference laboratories.
3rd 9 <sup>th</sup> May 2007	TB CAP	Dr. Gilbert Makombe	To build the capacity of core National trainer on Management and Leadership skill  To learn the basic practices of leading and managing so that managers are capable of leading their workgroups to face challenges and achieve results.	Capacity of core National trainer of on Management and Leadership skill developed.
29th Oct 2nd Nov. 2007	WHO AFRO	Dr. Daniel Kibuga	To provide technical support on the way forward for increase case detection rate.	Challenges facing TB Control programme in Nigeria identified and solution proffered.  Way forward to increase TB case detection rate identified.

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
20th 30th November	GDF	Elizabeth Ominde-Ogaja Tushar Kanti Ray	To assess the adherence to GDF terms and conditions of support.  To assess drug needs for next year of GDF support.  To assess the issues raised by GDF technical Review Committee (TRC) or during previous GDF country visit or monitoring.	Adherence of the FMOH to GDF terms and conditions of support assessed.  Emergency drug needs for next year of GDF support computed
26th 29th Nov. 2007	TB CAP	Katherine Foley	To assess the status and impact of CIDA support for the TB control in Nigeria and to recommend strategies for the way forward.	Update on CIDA obtained and area of further support identified.  Plan for additional \$700,000 identified
3rd 8th Dec. 2007	WHO AFRO	Dr Maarten van Cleeff Sara Massaut	To introduce TB CAP to FMOH.	TB CAP introduced to FMOH and partners.
10th Dec. 2007	GDF	Dr. Gargioni Guilliano	To update the NTBLCP and partners on the new Global Guidelines and plan for CBTC To finalize the road map to introductory process on CBTC in the country.  To finalize the plan for inter-country exchange of NTBLCP focal person for CTBC to countries with best practices in CBTC	NTBLCP and partners updated on the new Global Guidelines and plan for CBTC Road map to introductory process on CBTC in the country finalized
<b>GUINEA WORK ERADICATION PROGRAM</b>				
17th to 28th Sept. 2007.	External Assessment Of The Status Of Nigeria Guinea Worm Eradication (NIGEP) Field Activities	Dr. Alhousseini Maiga, WHO/AFR Dr. Paul Cantey CDC Atlanta Dr. Scott Laney CDC Atlanta Dr. Jean- Claude Mubakama UNICEF Mauritania Mr. Evans Liyosi WHO Kenya	To assess the status of the NIGEP field activities including data reporting and management.  To provide recommendations on the way forward in order to rapidly meet the requirements for certification by WHO.	Mission report including 14-point recommendations.
<b>EPI</b>				
15 Jan. to 5 Feb.	EMRO Consultants	Dr Amer Mohamed Elkholy Dr Abdel Samee Al Halwany Dr Monir Abdalla Mohammed Dr Mohamed Sibak Dr Gamal Abdalla Dr Ibrahim Mahmoud Attia Dr Ahmed Younes Dr Hassan Abdel Rahim Yassin Dr Mohamed Rabeia Kassab Dr Abdel Halim Abdou Behiry Dr Ahmed Mohamed Khedr	Technical Assistance to Polio Eradication (Nigeria) - January IPDs	

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
February to April, 2007	STOP TEAM 24 mission	Subadhra Rai (feed-back bulletin) Francis Gershon Abotsi (logistics) Abida Raza Mohammed (MLM training)	To provide support for strengthening Routine Immunization, Polio Eradication and Accelerated Measles Control	
24 Feb. 2007 to 4 June 2007	CDC mission	Mr Phil Smith	To provide support for strengthening Routine Immunization, Polio Eradication and Accelerated Measles Control	
15 February to 10 April, 2007	EMRO Consultants	Dr Amer Mohamed Mahmoud Elkholy Dr Abdel Samie Ahmed El Sayed El Halwany Dr Ibrahim Mahmoud Attia Salem Dr Ahmed Kamal Ahmed Younis Dr Mohamed Rabeie Mohamed Kassab Dr Abdel Halim Abdou Attia Behiry Dr Ahmed Mohamed Ahmed Khedr Dr Mohamed Ahmed Ahmed Abou Soliman Dr Mostafa Abdel Salam Mitwaly Elwan Dr Mohamed Salama Salama ElBltagy Dr Maher El Said Mohamed Darwish Dr Wagdy Mohamed Abdel Moezz Habib Dr Abdel Hamid Youssef Ali Youssef Dr Badr Mohamed Badr Awad Dr Yehia Mahmoud Mohamed El Sayed Dr Abdel Wahed Kamel Dr Moharam Abdel Rahman Ahmed Abdel Rahman Dr Mamdouh Abouel Fetouh Metwally Selim Dr Abdel Raouf Farahat	To provide technical support for March and late March IPDs	
6 - 16 March 2007	External Polio Administrative Review in Nigeria	Ms Jennifer Linkins POL/HQ, Mr Alhagie Corr ICST/Zimbabwe (representing BFO) Ms Helena O'Malley AO/VPD, Mr Durao, RPO/AFRO, Dr Nshimirimana, VPD/AFRO Mr Maher POL/HQ	To enhance the administrative efficiency of the WHO Country Office to implement IVD priorities in the context of on-going organizational reforms and funding shortfalls.  To strengthen administrative and managerial capacity of the WHO/Nigeria EPI Team with respect to budget and finance, personnel, operations and supplies including inventory management.  To align structure, resource management, administrative procedures and practices with achievement of strategic objectives	

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
20 - 29 March, 2007	WHO/HQ mission	Dr Naveed Sadozai	To work with national authorities, WHO colleagues involved in soc mob and partners also involved in soc mob (UNICEF, COMPASS, EU-Prime) to follow up on a number of social mobilization/communication priorities	
25 Jan. - 22 March 2007	CDC	Ms Sue Gerber	To provide support for strengthening Routine Immunization, Polio Eradication and Accelerated Measles Control	
3 - 4 May 2007	ERC	Dr Samuel Okiror Mr Chris Maher Dr Bruce Aylward Dr Kaushik banerjee	To participate in the Expert Review Committee (ERC) meeting on strengthening immunization in Nigeria	
21 - 27 May 2007	Polio Laboratory accreditation	Dr Francis Kasolo Dr. E. da Goverville	Annual Accreditation of WHO Polio laboratory Ibadan, Nigeria	
24 May - 3 June 2007	HQ	Dr S. Naveed	Work with National Social Mobilization Group	
7 June - 30 July, 2007	CDC	Ms Sue Gerber	To provide support for strengthening Routine Immunization, Polio Eradication and Accelerated Measles Control	
4 June - 8 Aug. 2007	EMRO Consultants	Dr. Monir Abdalla Mohammed Dr. Mohammed Sibak Dr. Gamal Abdalla Dr. Mohamed Ahmed Naguib Dr. Ibrahim Al Dessouki Mohamed Mostafa Dr. Hazem Abdalla Salama Dr. Essam El Sayed Elsayed Sherif Dr. Ahmed Khedr Dr. Abdel Halim Abdou Attia Dr. Ibrahim Mahmoud Atia Dr. Abdel Aziz Ahmed Abdel Mawgood Dr. Ahmed Abdel Baki Ahmed Hussein Dr. Magdi Mahmoud Hozyen Dr. Kamal Zaghloul Mohamed Dr. Mohsen Abdel Monim Kheriaba Dr. Hassan Abdel Rahim Yassin Mashour Dr. Tarek Fekry Mohamed Khamis Dr. Mohamed Salama Abdel Rahman Dr. Essam Othman Ismail Dr. Mohamed Al Hassan Al Shami	Technical Assistance to Polio Eradication (Nigeria) - June/July IPDs	

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
21 May to 30 June, 2007	Short Term consultancy	Dr Tagodoe	To provide technical support for EPI and Polio Eradication activities including supplementary Immunization with OPV, Vitamin A and Acute Flaccid Paralysis Surveillance	
18 - 21 June, 2007	AFRO Regional Virologist mission	Dr Francis Kasolo	To conduct interview for fixed term positions for National Polio staff	
22 June, 2007	WHO/HQ Polio Support mission	Oliver Rosenbauer	Monitor June IPDs and participate in communication TAG.	
13 July - 4 Aug. 2007	WHO/AFRO/CDC	Dr A.J. Williams Dr. S. Daniluk Mr Paul Chenoweth	To provide technical support to the National Polio Laboratories (Ibadan and Maiduguri), Nigeria	
27 July - 03 Aug. 2007	WHO/HQ	Dr S. Naveed	To provide support for July IPDs in 12 high risk States	
07 - 09 Aug. 2007	WHO/HQ mission	Ms Linda Muller, External Relations Officer	To provide support to WCO in resource mobilization	
20 - 24 Aug., 2007	ICST support mission	Ms. Avokey Fenella	To discuss with National authorities the progress and plans for strengthening surveillance for the disease for early detection of outbreak, for monitoring the impact of preventive action and also to discuss the implementation of initiatives to rapidly increase the immunity of susceptible populations through vaccination.	
10-22 Sept., 2007	Mid-level Management Course	Dr Rose Macaulay, Dr Dicko Modibo, Dr. Evariate Mutabaruka	To provide a clear framework for public health managers, specifically those in the immunization programme, to conduct their day-to-day managerial activities and resolve problems that arise in the implementation of National EPI plans, especially in the implementation of the RED/REW strategy.	
15 Sept. - 15 Oct. 2007	CDC	Ms Jennifer Mann	To provide support for strengthening Routine Immunization, Polio Eradication and Accelerated Measles Control	
22 Sept. - 16 Dec.	CDC Stop Team 26	Milijana Petrusic Dos Santos, Jumanne Magoma, Somesh Kumar, Zenube Abdurahman, Leocrencia Chivundu	To provide support for strengthening Routine Immunization, Polio Eradication and Accelerated Measles Control	
24-28 Sept.	WHO HQ and AFRO mission	Mr Chris Maher, Dr Sam Okiror	To review PEI programmatic issues, evolving epidemiology of wild polio virus in Nigeria and propose priority actions that needs to be implemented towards interruption of WPV transmission.	

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
16 - 23 Oct., 2007	WHO/HQ mission	Dr Naveed Sadozai	To follow up on the process of arranging for reciprocal visits by Egyptian and possibly other religious, community, and medical leaders to Nigeria (following the visit by Nigerian leaders to Egypt earlier in 2007).	
16 - 23 Oct., 2007	Communication Expert	Mr Thomas Moran	To develop an effective communication strategy that will lead to the eventual interruption of both wild poliovirus and circulating vaccine derived polio virus	
23 - 31 Oct., 2007	CDC mission	Ms Sue Gerber	To provide support for strengthening Routine Immunization, Polio Eradication and Accelerated Measles Control	
25 Oct. - 10 Dec., 2007	EMRO Consultants	Dr Abdel Samee Al Halwany Dr Mohamed Sibak Dr Basem Abdel Hay Sadek Dr Hisham Bastawy Hashem Dr Alaa Eldin El Sayed Mohamed Dr Mohamed El Sayed Ali Dr Alaa Eldin Mohamed Kamal Dr Alaa Eldin Hussein Labib Dr Lotfy Hassan Ismail Dr Mostafa Abdel Salam Mitwaly Alwan Dr Mohamed Lachin Dr Ibrahim El Dessouki Dr Abdel Hamid Yousef Dr Ahmed Mohamed Ahmed Khedr Dr Sayed Abdel amid Abu Ferikha Dr Serag Abdel Halim Selim Dr Magdy Hozaien Dr Mohamed Rabei Kassab Dr Ahmed Younis	Technical Assistance to Polio Eradication (Nigeria) - October - December IPDs	
8-9 Nov., 2007	WHO HQ/AFRO mission	Dr Bruce Alyward, Mr. Chris Maher and Dr Sam Okiror	To participate in the Expert Review Committee (ERC)	
18 - 23 Nov., 2007	Polio Laboratory accreditation	Dr Esther De Gourville/Dr Francis Kasolo	To conduct accreditation in Maiduguri Laboratory	
15 - 23 Nov., 2007	Measles labs accreditation	Dr Annick Dosseh	Annual accreditation of national measles laboratories	
13- 27 Nov., 2007	WHO/HQ mission	Dr Naveed Sadozai	To follow up on the process of arranging for reciprocal visits by Egyptian and possibly other religious, community, and medical leaders to Nigeria (following the visit by Nigerian leaders to Egypt earlier in 2007).	
24 Nov. - 1 Dec. 2007	CDC mission	Dr Rolle Italia	To provide support on estimation of the frequency of epidemics in Nigeria	

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
2-7 Dec., 2007	HQ mission	Ms Linda Muller, External Relations Officer	To discuss with national authorities as well as in-country partners and donor agencies, the prospects and opportunities for international funding for priority 2008 Polio Eradication activities in Nigeria	
<b>HIV/AIDS</b>				
15 May-7 June 2007	HIV/AIDS Global Fund Round 7 Proposal for Nigeria	Dr Kenyanta Sunkutu	To support the elaboration of HIV/AIDS Global Fund Round 7 Proposal for Nigeria	Draft Global Fund HIV/AIDS Proposal for Nigeria
15 May-21 May 2007	As Above	Dr Seniat Kebede	As Above	As Above
5-9 Feb. 2007	Global Fund National M&E systems strengthening tools in Nigeria		To facilitate the administration of Global Fund National M&E systems strengthening tools in Nigeria	Revised national M&E Plan
16-21 Oct. 2007	The Joint Technical on PMTCT Scale up and paediatric care	Dr Abdul Kamil Alisalad	To participate in the Joint Technical Mission to support PMTCT Scale up and paediatric care	Mission Report
<b>ESSENTIAL MEDICINES</b>				
11-14 July 2007	Mapping and Assessment of Medicines Procurement and Distribution Systems	Mrs Helen Tata	To Support the Mapping and Assessment of Medicines Procurement and Distribution Systems	Mission report
<b>MALARIA</b>				
June 13-29, 2007	Evaluation of Pilot Indoor Residual Spraying (IRS) in Nigeria	Dr. Magaran M. Bagayoko VBC-WHO/ICST, Central Africa)		
18-Oct-07	RBM Partnership Executive Director's visit to the new Health Minister, Prof. Adenike Grange.	Dr Thomas Tauscher (RBM HQ)		
Aug. 16-29, 2007	Mission to monitor and document TDR supported Home Management of Malaria (HMM) Research Project in Taraba State	Dr. Hans Remmy Prof. O. O Kale Ms. Jaime Guth and BBC Crew		

DATE	MISSION	MEMBERS	OBJECTIVES	OUTCOMES
December 10-12, 2007	Support to the Annual State Malaria Control Programme Managers' meeting	Dr. J. J. Banda (RBM Secretariat, Geneva) Dr. Claude Rwagacondo (RBM West Africa)		
December 12-15, 2007	Signing merged GFATM RDS 2 & 4, Phase 2 grant for malaria	Mark Willis (Fund Portfolio Manager for Nigeria and Liberia)		
<b>HEALTH SYSTEMS</b>				
1-5 Sept. 2007		Dr. Anthony Saddoh	To support Nigeria to elaborate Strategic Health Investment Plan.	
19-23 Nov. 2007		Dr. Anthony Saddoh	To support Nigeria to elaborate Strategic Health Investment Plan.	
9-15 December 2007	TDR	Prof Ayodele Oduola Dr Zingales Dr Philip Lo Verde Dr Ikram Guilani Dr Worachart Sirawaraporn Prof Sara Melville Dr Mariano Jorge Levin Dr Christine Clayton Dr Rodrigo Correa-Oliveira Prof Isabella Akyinbah Quakyi	To develop future strategy and support for South-South Initiative for Tropical diseases Research.	