

## **DRAFT REPORT**

# **Strategic Assessment of Social Sector Activities in Northern Nigeria**

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## 1.0 The Northern Context of Social Sector Programming

The scope of this assessment applies to the 10 States of the core North east and west as well as the 9 States of the North Central region. The zone shares borders with Niger and Chad Republics to the North, Cameroon to the east and Benin Republic to the West. To the south, it is bounded by the South West, South East and South South zones. An estimated 53% of the 130, 000,000 people in Nigeria are from the Northern zone of the country. Of the 774 LGAs in the country, 419 are located in the North.

A total of 75.9% of the landmass of the country is in the North which has a lower population density compared to the South of the country. The lowest population density of 32.8 people per square kilometer is found in Borno State. The mean zonal population densities are 51, 83 and 213 people per square kilometer in the North East, North Central and North West zones respectively. The figures for the Southern zones are 584.6 , 483.2 and 207 for South West, South East and South South zones respectively. The North is therefore much less populated than the South, with the lake Chad Basin in the North East zone, the Niger River valley in the North Central zone, the Sahel savannah grass plains and the semi desert areas of the extreme northern area of the North East and North West zones being very sparsely populated. The topography of the zone varies widely from the semi desert plains of the Chad Basin formation in Yobe and Borno States to the mountainous Mambilla plateau of Taraba and Plateau States, with the highest point in Nigeria found in Plateau State.

While significant religious, cultural, gender relations and language differences exist between the North east and west and the North Central region, there are key factors which bind these regions together making them more closely connected to each other than to any other region in the country. Binding factors include the prevalence of the Islamic religion, the dominance of Hausa as the language of communication, agriculture as the mainstay of economic activity, low population density, the communal nature of civil society organizations and the preponderance of rural settlements within a wider context of rural poverty.

The Northern zone is comprised of a more homogenous Hausa/Fulani, Hausa speaking Moslem population in the core Northern States. As one moves southwards to the middle belt, the population becomes less homogenous, with an increasing number of diverse ethnic groups. Languages, socio-cultural patterns of the people are equally diverse. As one moves southwards, there is an increase in the proportion of Christians and people practicing traditional religion. In recent times there has been a rise of both Christian and Moslem religious fundamentalism and with the introduction of criminal

Sharia legal codes in 10 of the core northern States, religious intolerance and an upsurge in the number of civil unrests in the North have been recorded.

Poverty in this zone is comparatively higher than in the South. Generally, the North West zone has the highest poverty rate, 77%; this is 44% higher than the rate in the South East zone. It also has twice the rate of core poverty of the South East zone. The poverty rates in the North East and North Central zones are 70% and 65% respectively, all higher than the rates in the Southern zones(cited in UNICEF 2001).

The North also has the worst educational indicators, with literacy levels, school enrolment and retention rates decreasing the further one moves to the northern border of the country. The female literacy rate in the South East is almost three time higher than the rates of 21% in the North East zone and 22% in the North West zone while the male literacy rate of 74% in both the South East and South West zones is 1.7 times the rates in the Northern zones.

Illiterate and without economic power, women are excluded from decision making in critical areas of health and education of the household. While this is manifested in different forms in the core and Central North, the reality is that many women contribute their labor to the household either working on the fields or in the homes but are denied the opportunity to influence decision making on life and death issues of health. The recent Core Indicators Cluster Survey for Jigawa State by DfID brings out this point as it found 81%of male heads of households took decisions on health matters alone; only 3% males took decisions in consultation with spouses and no women were found to take decisions on health matters alone. A similar distribution was found for decisions on clothing, food and education expenses.

## **2.0 The Deepening Social Sector Crisis in the North of Nigeria**

Recent research findings paint a distressing picture of the poor social sector development in Northern Nigerian. Studies show that the gap between the North, especially the core North and the rest of the country has widened significantly to the extent where for certain key indicators, the Northern average distorts national trends and contributes to the widening political, socio-cultural and development gulf in the country.

### **2.1 Primary Education in the North of Nigeria**

In Northern Nigeria there exist two broad streams of education – the Islamic and the Western systems of education - which run parallel to each other with little chance for cross over by participants. The school options in the Islamic education system vary from the traditional Quranic Schools, followed by General Islamiyyah schools and Islamiyyah Primary schools.

In the core Northern States there exist a significant gap between the number of children attending Islamic schools and those attending Western type of primary schools. For example, in the case of Sokoto and Zamfara States, the National Primary Education Commission statistics shows that as at June 1995, three times as many children were attending traditional Quranic schools or 'makarantar allo' and Islamiyyah schools than primary schools. Pupils leave these schools without any skills or competences to join the modern world. To compound this situation, because of early marriage and child labor girls are more likely to be restricted to Quranic education and to be denied access to the primary school system. In the North west and east the difference between primary school enrollment rates between boys and girls is 10% in favor of boys; in the South west the figures are roughly the same (81%) while in the South east the difference is 4% in favour of boys (UNICEF, 2001:147). Findings from the 2002 Core Welfare Indicator Questionnaire (CWIQ) study of DfID further revealed a primary school enrolment rate in Jigawa state of 30% with a gender gap of approximately 10% in favor of boys. Both children and parents expressed a high degree of dissatisfaction with the primary schools in Jigawa State, only 19% of parents said that they were satisfied with primary school in the state.

Evidence on the zonal patterns of early childhood education and net primary school attendance from the Multiple Indicator Cluster Survey (MICS) 1999 reveals that with figures of 3% and 4% early childhood education is practically non-existent in the North of Nigeria and that primary school attendance is lowest in the North West and North East compared to the rest of the country. MICS data also shows that school attendance in the North West (28%) and North East (39%) was significantly lower than in the South Eastern (79%) and in the South Western (81%) parts of the country.

## **2.2 Child Survival and the health Status of children in the North of Nigeria**

From the UNICEF MICS of 1999, the under five mortality of the North West zone is almost twice as high as that of the South West zone. The infant mortality rates are also highest in the northern zones. The infant mortality rate of 114/1000 live births and 117/1000 live births in the North west and North east zone is about 2 and ½ time the rate of 45/1000 seen in the South west zone. The leading causes of child mortality in the North are comparable to those in the South include malaria, diarrhoeal diseases, vaccine preventable diseases – measles and whooping cough and acute respiratory tract infections. No local data) In recent years, because of low immunization coverage, periodic epidemics of measles and whooping have become common features in most states in the North. In addition, the zone lies in the cerebrospinal meningitist belt of Africa and cyclical outbreaks have been a recurring feature of the zone.

The highest incidence of stunting, wasting and underweight children were found to exist in the North of Nigeria. The 1999 MICS identified the highest incidence of stunting in children in the North – 37% in the North West and 44% in the North East; only (24 %) of children were stunted in the South West and 30 percent in the South East. With regard to wasting in children, again the highest figures were found in the North – 17% in the North West and 18% in the North East. The South East had the lowest prevalence of wasting (13%), while the other zonal figures were South West (15%). The zonal figures for underweight children in the MICS showed that again, the worst figures were in the North – 35% of children in the North West being underweight and 38% of children in the North East; the South West had a prevalence of 22% and the South East 25%. Vitamin A deficiency is also highest in the northern zones with the North West having a rate of 15% giving a figure times higher than the Southwest. The rate in the Northeast is 4 and ½ times the Southwestern rate.

Malnutrition is another leading cause of morbidity in the North. The rates of low birth weight and childhood malnutrition is highest in the northern states (figures NDHS and UNICEF vit A def survey) Exclusive breast feeding rates in the North are lower than in other parts of the country (figures) A study by BASICS found the EBF rate in Kano to be 3.7% compared to 10.0 % for Abia and 18.7% for Lagos.

Access to and utilization of child health services is very limited. While immunization coverage is estimated at the national level to be 18% in 1999, the realities may be much lower than that. Figures on zonal coverage of all vaccines for children show a particularly dangerous trend where only 4% of children in the North West were vaccinated, 8% of children in the North East were vaccinated; compared to 24% in the South West and 34% in the South East. The low immunization coverage in the North East was confirmed by a recent UNICEF immunization coverage survey in its focal LGAs, one in each of the 10 States in the North East zone showed immunization coverage for the zone to be 12.8% with a ranging from 3.8% in Takai LGA to 23.4% in Mubi LGA. It noteworthy that the two other LGAs with immunization coverage levels below 10 % were Machina LGA, a very hard to reach LGA in Yobe State and Langtang LGA in Plateau where there have been communal clashes were 9.6% and 5.8% respectively. The low immunization coverage has led to a rampant increase of childhood diseases such as measles and polio. UNICEF has recently reported Kano State to have the highest number of polio cases in the country.

In addition to the most recent MICS results, findings from other official sources reinforce the dismal picture of children in the North of Nigeria. In a recent Federal Office of Statistics/Dfid study for Jigawa State, for 2002 it was revealed that 42% of children were stunted in growth; 25% of children below 5 years were wasting and 48% of children under five years of age were underweight. Recent studies using vulnerability mapping methodologies in the North of Nigeria have identified new

categories of vulnerable amongst under-5 children. Such children include survivors of ethnic conflict in Kano, Kaduna, Plateau States, as well as the increasing number of children disabled by polio and the new phenomena of abandoned AIDS Orphans in large cities such as Kano and Kaduna States.

### **2.3 The Deepening Crisis in Family Planning and Reproductive Health in the North of Nigeria**

The reproductive health status of women in the North is much worse than that in the South. While the maternal mortality ratio in the country of 740/100,000 live births, is among the worst in the world it is much lower than the northern rates. The maternal mortality ratio in the North East Zone of 1,599/100,000 live births is more than twice the national rate, almost 10 times higher than the rate of 165/100,000 found in the South West Zone and seven times higher than the rate in the South East zone. The North West zone, with a rate of 1,025 /100,000 live births, is about six times higher than the rate in the South West zone and almost four times the rate in the South East zone.

For each maternal death, it is estimated that 15 to 20 other women develop various maternal morbidities. In the North, one of the most serious morbidities is vesico-vaginal fistulae. Victims of VVF are usually young, poor, illiterate rural girls having their first babies, who develop obstructed labor because their pelvises are too small to allow for the passage of the babies' head. In the absence of appropriate obstetric interventions they develop this complication. While VVF can be found in all parts of the country, Northern Nigeria has the highest prevalence, with a large backlog of cases. Its incidences of cases are estimated to be 2/1000 deliveries (Dr Kees, working in VVF centers in the North). Of the estimated 200,000 to 400,000 cases in the country, it is estimated that 70% are from the North, especially the core North. However, a large number of cases are now being documented in the North Central zone from the VVF Center in Evangel Hospital, Jos.

Several factors have been found to account for the disproportionately higher morbidity and mortality in women. The immediate underlying factor is the non-availability or poor access to and utilization of orthodox maternal health services. Availability and accessibility to both public and private health services is much less in the North West and North East Zones of the country than in other zones. The 1999 NDHS found 21%, 13% and 11% of the population in the North west, North east; North Central did not have access to health services compared to 4% in the South east and 3% in the South west. In addition to availability of facilities availability of health personnel is also a problem. For example, in Machina LGA in Yobe State, the highest qualified staff found on site in a recent study was a senior community health extension worker and there was not even a single private clinic in the whole LGA. In Kiru LGA in Kano State, there is only one Nurse/Midwife responsible for the provision of all antenatal and delivery services in all the LGA owned clinics in the LGA. Even where the services are available, the quality of care is a problem as the majority of the hospitals do not have the resources to provide basic obstetric care.

Non utilization of antenatal care services was found to be 65% in the North West zone, 13 times higher than the figure of 4% documented in the South West zone, the zone with the lowest figure; 54% in the North East Zone, 11 times higher the South West and five times higher in the North Central than South West zone. Trained birth attendants in North West, North East and North Central zones supervised only 8%, 13% and 47% of deliveries, respectively. These figures were 13, 9 and 2 times lower than the rate of 73% obtained in the South West zone, the zone with the highest rate of supervised deliveries. Conversely, they rate of utilization of traditional birth attendants in the North was very high, with as many as 5 to 6 of every ten deliveries being supervised by them in the North West and North East zones of the country.

Another underlying cause of high maternal mortality in the North is risky reproductive health practices: pregnancies too early, too many and too late. Socio-cultural factors play a determining role in the promotion of these practices in the core North. Women in these areas are valued in terms of their reproductive functions. Because of the low value placed on female education and the fear of initiation of sexual activity before marriage with its attendant risk of pregnancy, girls are married off soon after the onset of puberty. Hence the mean age at marriage in the Northern zones is much lower than in the South. The mean age of first marriage from the NDHS is 14.6 years in the North west, 15.3 years in the North east, 18.3 years in the North central, while in the South east it is 18.9 years and 19.1 years in South west. Even lower figures were found in local studies in villages around Zaria, Kaduna State where the mean age of marriage has remained between 13.5 to 14 years with more than 85% of the girls being married off by the age of 15 years.

Against this background, the contraceptive prevalence rate in the North of 3.2% is 81/2 lower than the rate of 26.2% seen in the South west zone (NDHS 2002). The root causes of the distressing reproductive health indices in the North of Nigeria can be identified as poverty and illiteracy in the context of a male dominated cultural setting.

#### **2.4 The national burden of HIV/AIDS in the North of Nigeria**

There are significant variations in sero prevalence between the various geo-political regions of the country with the highest of 7.7% in the South South zone and lowest prevalence rate of 3.3% in the North West zone. The North Central and North East zones have prevalence rates of 5.5% and 5.4% respectively while the South West and South East have rates of 4.0% and 5.8% respectively. These zonal medians mask wide variations in the rates in different states even in the same zone. Remarkably, the Northern Zone has the highest and the lowest rates in the country with Benue State ranking first with a rate of 13.5% in the North Central Zone while Jigawa State in the North West Zone has the lowest rate of 1.8%. States with above national median rates in the North include Benue State, 13.5%, FCT, 10.2%, Plateau, 8.5%, all in the North Central zone. There are a number of hotspots towns where the rates were found to be very high; these include Kafanchan in Kaduna

State, Katungo in Gombe State, Nyanya in FCT, Makurdi, Otukpo and Igho in Benue States. The epidemic appears established as there are even some rural settlements, even in the North that have rates higher than in the urban centres in Jigawa, Kano, Kaduna, Bauchi, Kogi, Benue and Gombe States. Generally, the sero prevalence rate in Nigeria appears to be lowest among the Muslim North. Interestingly, the highest prevalence of syphilis from the syphilis sero-prevalence studies are from the Northern States with lower rates of HIV – Niger State 15.3%, Katsina, 7.5% and Taraba State, 6.3% while the national median prevalence rate was 0.5%

While the Southern zones showed a higher proportion of transmission in the age group 15-19 years, indicating a more recent infection, a higher proportion of the cases were found in the age group 20 to 24 years with ages in the North-West and North East zones. In the whole country the age group 15 to 29 years accounted for almost 2/3 of all sero positive population. Heterosexual transmission account for 80% of the transmission while mother to child transmission is responsible for another 10%. With the high-unregulated fertility in the core North and the universal practice of breastfeeding, which is one of the routes of mother to child HIV transmission, the potential for high transmission to children is high in the north.

There is also gender disparity in the prevalence of the disease. Women are two to four times more vulnerable to HIV infection than men. Similarly, women are more vulnerable to STIs, the presence of which greatly enhances the risk of HIV infection with almost twice as much infection among females compared to males. Although the core North of Nigeria currently records the lowest sero prevalence of HIV/AIDS, this region harbours as much potential as any part of the country for the epidemics. Northern Nigeria has the highest rates of illiteracy in the country especially among the females. The feeling of false safety created by the prevalence figures compounds this. This is dangerously demonstrated by the attitudes of some in the core north who see HIV/AIDS as other people problems. Socio-culturally, certain practices in northern Nigeria serve as good breeding grounds for the infection. Polygamy, in a context of frequent divorces and re-marriage amongst the Muslim north thus creating a large circle of sexual partners.

Migration, conflict, cross-border informal economic activities, underground and cross-border sex work in Sharia states, the high incidence of substance abuse amongst male youth and the high risk activities of long distance drivers within a context of fatalism and ignorance can lead to an explosion of infection rates in the cold zone of the core north.

Because of high levels of ignorance and poverty among Females in Northern Nigeria, the female members of this society are generally most affected by any social ills that affect the society. Women cannot take decisions independent of their male relations or husband. They may not even be able to seek medical care even when they are sick because they need the permission of the husband who foots the bills. This situation is made worst by the cultural insensitivity of

modern health care services.

### **3.0 USAID interventions in the North of Nigeria**

#### **USAID**

USAID first deliberate attempt to make inroads into the North was in 1993 when the then USAID Director convened a meeting of Northern NGOs in Katsina. The meeting was informed, in part, by the policy shift of USAID from working with government to working with the civil society, following the abortion of the transition to democracy by the military government of Babangida in July 1993. The objectives of the meeting were to identify issues peculiar to the North and evolve strategies for programming with NGOs in this part of the country. Starting with a field office in Kaduna, the office was subsequently moved to Kano in 1996. The following were identified as the Implementing Partners of USAID that have worked in the North and their areas of focus:

#### **CDC**

The focus of CDC's work in the North was child survival. It commenced work in the North in 1986, initially working with State governments to build their capacity through training, research, infrastructural and equipment support and strengthening of surveillance systems for the enhancement of child survival. It worked with the governments of Kwara, Plateau, Niger and Kebbi States and supported research in tertiary institutions in the zone. Following disengagement from government, in 1993, it began work with NGOs. Whereas its project conceptual document indicated provision of integrated maternal and child health, HIV/AIDS services and economic empowerment of the women to enable them to purchase health services, the project never progressed beyond child survival until CDC wound up its activities in 1999. It worked with two-health facility-based NGOs in the Northern cluster, ECWA Community Health Program and Alnoury Hospital in Kano State. CDC came back to Nigeria in 2001 and is currently working in the area of HIV/AIDS.

#### **CEDPA**

Currently, CEDPA's reproductive health program works with NGOs in Kano, Bauchi, Plateau and Benue States. Packard Foundation supports the adolescent component of the program. Even though it is said to be a reproductive health project, the focus has been the promotion of family planning either through community-based distribution channels using TBA/CHEWs in Kano and CHEWs only in Plateau, in addition to supporting facility-based FP services.

#### **FHI/IMPACT**

Under the Expanded Comprehensive Response methodology, the FHI program in the North of Nigeria has been concentrated on two states – Taraba in the Northeast and Kano in the Northwest; there is no intervention in the North Central region. In both Kano and Taraba States, FHI has a comprehensive multiple-risk group focus working with in and out of school youth, female sex workers, vulnerable women and divorcees, long distance transport workers and religious leaders.

## **JHU**

JHU is a health communication NGO and has as its current focus child survival – polio eradication and adolescent reproductive health. A bottom-up planning approach is used in the development of its youth reproductive health communication materials. The other communication materials are centrally produced in Lagos and only field tested in the North. The major problems JHU encounters in its work in the North are:

- Rejection of OPV because of suspicions and misinformation. The communication strategy being employed appeared unable to reverse the trend.
- Resistance to reproductive health communication efforts by the Ullamas as they perceive the adolescent reproductive health project as having a negative influence on the youths
- Problems with routine immunization – collapse.

## **BASICS**

BASICS is the lead USAID IP for child survival. In the North it works in Bauchi and Kano States. Its current areas of focus are routine immunization, polio eradication initiative, child nutrition and neonatal tetanus elimination. During BASICS I, it integrated basic human rights education, maternal health, environmental sanitation and female adult literacy programs into its northern program, which was based only in Kano then. The literacy program in Kano was organized as a response to specific request from the program beneficiaries, so also the TBA training.

BASICS work is at community level, building community structures and coalitions in each community, which serves as the platform for addressing the health problems of the community. The organizations it brings together include community-based organizations, the private health institutions, women's groups, traditional health practitioners and various other stakeholders to form community partners for health. Effort is made to also bring the LGA as partners in the program. In a very participatory manner, the communities, through the CPH are involved in the planning, implementation and monitoring of their health programs, with technical support from BASICS.

In BASICS 2, there was some effort at targeting projects to areas with the most needs, as the LGAs with the lowest immunization coverage were selected for the project in Kano State. During this phase, the State Government was brought in as a partner. The CAPA strategy and PLA methodologies, which used community participation approaches, were used for program planning and intervention. The levels of intervention are the community level, the health facility level of both private practitioners and LGA where training of personnel and resource support are provided, the LGA and State level.

The BASICS program is very popular in Kano; there is very high degree of confidence in and acceptance of its programs by the communities and government. As noted by the PHC assistant coordinator from Kano Municipal

*“ BASICS program has led to improved quality of care in the health facilities and immunization coverage has improved significantly in its target LGAs and there is generally greater awareness of health matters now.”*

It was because of the success of the BASICS I strategy that CEDPA used the structures set up by BASICS to introduce its RH program into some of the BASICS communities. The BASICS approach provides excellent lessons on needs-based programming with active community participation and intersectoral collaboration.

## **VISION**

The VISION project aims to assist USAID to develop a strategic framework which maximized the achievement its Strategic Objective 4 as well as to establish scalable models of high-impact, high-performing FP/RH service delivery networks build upon public-private partnerships in selected LGAs.

Vision, is a partnership project of four organizations, JHU, Engender Health, Society For Family Health and Intra University of North Carolina. Each of these IP focus on a different aspects of the program. The components of reproductive health being addressed by the program are child spacing, safe motherhood, STI, HIV/AIDS, adolescent reproductive health, child survival and client-provider interaction. The projects programmatic strategies are:

1. Demand creation through awareness creation
2. Improvement in supply of services through increase in service provision outlets
3. Capacity-building through training of health care providers, strengthen of facilities and provision of commodities
4. Enhancing quality of care through training in infection prevention and provision of infection prevention equipment.

Vision works in only Bauchi State in the North, where it selected five LGAs. In the State, it works with five NGO selected on the basis of their comparative strength and each of the NGOs focus on a different aspect of the RH problem, but all work in the 5 selected LGAs. NAWOJ is involved in public education and community mobilization, Rahama , a church-based NGO is involved in addressing maternal mortality, FOMWAN targets women in purdah, palaces of traditional rulers and Islamiya schools of girls, focusing on maternal mortality sensitization, service provision and counseling; Mahema is addressing male involvement in reproductive health; Community Health Agency, adolescent reproductive health communication while the Jos University Teaching Hospital and Specialist Hospital Bauchi conduct training and provide PAC.

Stakeholder committees with broad-based representation, including the NGOs, community members, government officials have been formed at all levels, from the community to LGA and State. All these communities have been involved in a participatory manner in needs assessment and program planning, They will also be involved in program implementation and monitoring when implementation begins. This project demonstrates elements of synergistic partnership between IP, participatory planning and a more comprehensive RH agenda than family planning.

### **Pathfinder International**

Pathfinder International has had extensive experience working in the North of Nigeria. Pathfinder's current Packard-supported project is to increase the access of underserved populations in northern Nigeria to FP/RH information and services through a network of private sector service providers. The focus states in Northern Nigeria are Borno, Katsina, Kaduna, Kano, Niger, and Sokoto. The Objectives of the Pathfinder project are:

1. To strengthen the capacities of a cross-section of private sector providers through an effective, efficient and transparent re-granting mechanism to Nigerian NGOs:
2. To establish a cohesive network of stakeholders and affinity groups in the private commercial and NGO sectors;
3. To conduct six international study tours and six in-country exchanges for Nigerian professionals to identify issues, challenges and opportunities in the private sector and to share lessons learned and best practices for service delivery and advocacy; and,
4. To conduct annual site-specific cluster evaluations and six semi-annual stakeholder meetings to share lessons learned and best practices.

Pathfinder has been programming with several NGOs and private sector providers under this program. Pathfinder programs received positive comments from NGO leaders at the NGO FGD conducted by the Assessment team. One NGO member present said - *'it is only Pathfinder that understands Northerners and how to work with NGOs in the North'*.

**ADF**

The African Development Fund (ADF) is a US congress established foundation set up to support self help activities at the local levels and to enlarge opportunities for community development. ADF works with NGOs and CBOs and is concentrating on community development and in communities to mitigate the impact and reducing community vulnerability to HIV/AIDS. The ADF uses participatory methodologies and provides assistance directly to the poor to carry out activities to promote the participation of Africans in the economic and social development in African countries. The ADF office in Kano has recently been taken over by a Nigerian intermediary NGO – the Diamond Development Initiative (DDI). ADF has developed integrated programs of HIV/AIDS and micro finance and is programming mainly in the North of Nigeria. The ADF/DDI is in Bauchi, Plateau, Kaduna, Jigawa and Kano States.

### **LEAP**

USAID is implementing the Literacy Enhancement Assistance Program (LEAP) in collaboration with the Federal Government of Nigeria. Focal states in the North include Kano and Nassarawa States. In these states LEAP is programming through an innovative combination of policy support, interactive radio instructions, teacher training and community involvement. LEAP aims to assist the Federal Ministry of Education on Educaiton Sector Analysis (ESA) through targeted state and local government area activities and to improve the quality of education and increase civic participation in education. LEAP is working in 330 schools in 3 states. In Kano and Nassarawa States, LEAP is working in 3 LGAs each.

### **Winrock International**

The girl's scholarship program of Winrock International is working in Kano, Borno and Sokoto States in the North (to complete) . . . . .

### **3.1 Environmental Obstacles to social sector program performance**

What are some of the socio-cultural factors in the environment which inhibit social sector program performance in the North? While there are factors specific to both health and education, in many cases similar factors reoccur.

#### **3.1.1 Environmental Obstacles - Education**

1. Low value placed on Western education especially in the core North
3. Low value placed on girl child education
4. High demand for child labor especially to support the economic activities of poor women and agricultural production
5. Gender inequality and low decision making power of women
6. Poverty

7. The traditional nature of civil society organizations working in the area of primary school education. These organizations are sometimes resistant to modernizing and to working with international development organizations.
8. Teacher absenteeism is a problem in nomadic education due to the poor conditions of teachers who are paid by the Local Government and the poor physical facilities at the camps
9. Poor quality of teachers because of politicization of criteria of employment
10. Non-employment of teachers with specializations in Primary Education Studies
11. Some teachers have no proficiency in English
12. Non-implementation of language policy with regard to mother tongue as stated in the National Policy of Education
13. Little support for primary school education by the local government and the emphasis on contracts and construction rather than systems improvement by the state government
14. The recent campaign waged in the media against implementation of the new Sexuality Education Curriculum in the primary and secondary school system in the North of Nigeria has had a lasting negative effect to the extent where the long held view in the North that Western School (*boko*) is associated with moral decadence and corruption of tradition values has been reinforced.

### **3.1.2 Environmental Obstacles - Health**

1. Suspicion and fear of foreign supported interventions and USAID in particular as having a population control agenda
2. Poverty and the low value placed on health care
3. The limited number of health care providers and facilities available. On this issue a senior UNFPA officer had this to say 'in Plateau and Nassarawa you can find nurses and midwives to train, but you can't find them in Borno and Bauchi States. As a result, in collaboration with the FMOH, we are developing a curriculum for CHEWS in for maternal health.' Of special concern is the problem of lack of female staff to provide maternal health care in a cultural environment where women are averse to men examining them.
4. The low level of development of NGOs and CBOs
5. The negative attitudes and ignorance were also cited as major impediments to facility based health care services
  7. Feeling that there is politicization of the selection of the beneficiary communities by the State
8. The collapse of the primary health care infrastructure in the country, hence the problems using the COPE strategy.
  8. Low demand for health services
  9. Lack of vaccines for routine immunization.

10. Immense power of religious and traditional rulers to sway community opinion, for example, regarding polio campaigns
11. The lack of access to women for research and programming as they are in seclusion
12. Reluctance of state governments to work with international funding agencies in health, e.g. MSF left Kano and relocated to Gombe where the policy environment was considered more favorable

#### **4.0 Government of Nigeria Approach**

At the Federal level the GON has sought to address the problems of RH in general and C/S and HIV/AIDS in particular. There has been a number of initiatives by the Federal Ministry of Health and Education in conjunction with funding agencies. Health initiatives include - The National Policy on RH, the HIV/AIDS emergency action plan and the formation of committees to actualise these concepts. Education initiatives include the Universal Basic Education program and the Education for All program both of which are informed by millennium development goals.

#### **4.1 Government Response — Education**

Since the first Republic, State governments in the core Northern states of Nigeria have, from time to time, affirmed their commitment to primary education for both girls and boys. In many cases state governments' responses have been truly independent initiatives, introduced without the prompting of the international development community. What is characteristic about government's initiatives is that they have been closely supported by civil society organizations and leading Northern individual philanthropist. It is against this background that the State Development Foundation in Kano, Sokoto, Katsina, and Zamfara must be viewed.

Within states in the North of Nigeria, however, there has been a ground swell of positive initiatives in the past years in support of child development. A total of 12 states have introduced Edits in support of primary education and girl child education in particular. Moreover, since the return to democracy in 2001, 8 states in the North have on various occasions identified child development goals as being central to their government's programs (Kano, Katsina, Jigawa, Borno, Yobe, Kebbi, Sokoto and Kaduna States). Some states such as Jigawa have increased primary school teachers salaries beyond the Federal government established level and intensified recruitment of youth corpers to fill teacher vacancies in primary and secondary school. Some states such as Sokoto and Jigawa have also been very supportive of nomadic education and taken the lead in this area. Overall however it has been pointed out that 'Sadly, the Northern States are not as supportive of nomadic education programs as their Southern counterparts whose response to the nomadic migrant fishermen programs is commendable and encouraging' (Interview with the Executive Secretary, National Commission for Nomadic Education, ...:

2003). The work of the umbrella Northern quasi-political association the NERP has been significant in setting a collective agenda regarding education in the North of Nigeria.

On the issue of the Almajirai education system, however, it must be noted that government's efforts have ranged between banning migration of itinerant scholars from rural areas as in the case of Katsina, Adamawa and Kano state immediately after the 1984 Maitatsine riots to trying to modernize the system as formulated in the Kano State government new social welfare development policy of 1994. All these efforts have been ineffective as the Almajiri problem is not an education problem but a social one.

#### **4.2 Governments of Nigeria Approach in CS,FP, RH, HIV/AIDS**

In contrast to government's initiatives in the area of primary education, responses in the areas of CS, FP, RH, HIV/AIDS have been largely donor driven in the North of Nigeria. This is largely due to the fact that Southern phenomena of First Lady child and women development programs are virtually non-existent in the North. In all the states of the core North, state governments have not been proactive in the establishment of SACAs and LACAs virtually non-existent.

VVF is perhaps the only area that governments in the North have taken the lead in the North. Since 1990 when women's civil society organizations spearheaded by the National Foundation on Vesico-Vaginal Fistulae put the VVF issue on the national agenda and transformed this issue from a purely medical paradigm to a social one. There have since been a number of positive responses by the Federal and State governments in the North. From 1991, advocacy by the NF-VVF resulted in the Federal Government, through the FMOH, to contract the services of Dr Kees for a five-year period. He was, during the five-year period, expected to train 50 Nigerian doctors in VVF repair surgery, and work in Kano and Katsina to clear the VVF backlog. Since then, his contract has been renewed twice and he has repaired approximately 15,000 VVF patients, trained 120 doctors, extended VVF surgical repair by supporting the opening of VVF treatment centers in Gusau, Sokoto, Kebbi, Zaria, and Niamey, where he goes to support his graduate trainees in VVF repair work.

Kano State runs a VVF rehabilitation center in Kano and currently funds the repairs of 40 VVF victims per month. The Katsina State government runs the VVF center at Babban Ruga Fistula Center, with the support of philanthropists in the State and resources mobilized by Dr Kees and NF-VVF. The Plateau State government through the office of the First Lady built the fistula center in Evangel Hospital, an ECWA facility, in Jos. Sokoto State recently opened the Maryam Abacha VVF Hospital. Other State governments either subsidize or provide free treatment for the VVF victims. Unfortunately, none of the state governments invests in primary prevention or have a strategic plan.

One final observation is the initiatives of the Kano State government on the free maternal health services program. The state government provides a range of free services ranging from ante-natal care to post abortion care services for women in public health facilities located in urban areas. The Kano State governor received an award for his contribution towards the reduction of maternal mortality and morbidity in the 2002 International SOGON Conference.

### **5.0 Other donors in the Social Section in the North of Nigeria**

Several donors are actively working in the area of social services in the North of Nigeria. Multilateral donors such as UNICEF are working in both education and health.

#### **UNFPA**

UNFPA is currently working in 12 focal States in Nigeria. Currently, it works in Borno, Gombe and Bauchi States in the North East and Plateau and Nassarawa States in the North Central Zones. It has no presence in the North West zone because of lack of requests from any state there, though it is considering programming in Katsina and Kano States. Currently, this agency works in Borno, Gombe and Bauchi States in the North East and Plateau and Nassarawa States in the North Central Zones. It has no presence in the North West zone because of lack of requests from any state there. UNFPA's programmatic focus is particularly in the area of advocacy and BCC through culturally sensitive IEC materials. It has supported the introduction of RH curricula at the National TV Training College in Rayfield, Plateau State as well as in the National Institute of Policy and Strategic Studies, NIPSS in Jos.

UNFPA works with State governments in its Northern focal state to strengthen the PHC systems to provide maternal health, HIV/AIDS, adolescent health and family planning services. It also supports operations research and is currently supporting the study of essential obstetrics care in the six zones of the country.

#### **UNICEF**

UNICEF's mandate is child survival. To promote child survival, it addresses the broader issues that impact on the health of children immunizations, nutrition, curative child health services, early childhood education, safe motherhood, public education/community sensitization, water and sanitation through a wide range of programs that are modified according to local needs and preferences. The expanded program of immunization (NPI), hospital baby friendly initiative (HBF), for the promotion of exclusive breastfeeding, Community Level Nutrition Information for Action (COLINSA), a community-based nutrition program, community level IMCI – integrated management of childhood illness aimed at improving quality of care of ill children and promoting positive child health practices at community level are the programs that UNICEF is associated with.

In the area of education, UNICEF is involved in early childhood education and girl child education in Jigawa, Yobe, Bauchi, Sokoto and Kebbi in the North where the problems of female education is greatest. In Sokoto State, to reduce drop-out rate and redress poverty, it incorporated vocational training into the curriculum. Reorientation of teachers is also part of the project. This project is supported by funding from Sweden. In these States, it promotes activities aimed at fostering community participation and ownership of the primary schools and it encourages school gardening and develops BCC packages that addresses health including VVF, HIV/AIDS and girl education for use in the schools. It is also foraying into Quranic schools in the North because of its patronage by girls. In this program it focuses on functional literacy and integrates health and sanitation education in the curriculum. UNICEF works primarily with government but sometimes with non-governmental organizations. It adopted an integrated life-cycle approach to the programming in its current program cycle 2002-2007

Using set criteria UNICEF selects one LGAs and in each LGA two communities as the target for its interventions. Criteria aims to identify the most deprived LGAs in each State. UNICEF has recently decided to focus on a few communities instead of spreading all over the State so as to have greater impact. In each community a bottom-up approach is used to planning and implement programs.

UNICEF works primarily with government but sometimes with non-governmental organizations. It adopted an integrated life-cycle approach to the programming in its current program cycle 2002-2007. It began with a needs assessment to determine needs and priorities. Following that it designed programs around life stages of children

- a. Survival and early care — addresses health and early child care of children aged 0-5 years.
- b. Integrated growth and development for school aged children —6-12 years
- c. Protection and participation for the vulnerable groups — adolescents

In each State, in collaboration with State governments, it selects one LGAs and in each LGA two communities as the target for its interventions. It has a set of criteria that is used to select the most deprived LGAs in each State. It has decided to focus on a few communities instead of spreading all over the State so as to have greater impact. In each community it uses a bottom-up approach to planning programs.

The major challenges it faces in its work are:

- Politicization of the selection of the beneficiary communities at the Federal level
- The collapse of the primary health care infrastructure in the country. It has attempted to address the problem using the COPE strategy.
- Low demand for health services
- Lack of vaccines for routine immunization.

### **Bilateral — Countries**

With regard to bilateral assistance the British Council in Kano has awarded grants for primary School construction in the Sharada community to the NGO Sharada Women's Cottage. The Italian government has awarded bilateral grant to the Kaduna State Government for the Strategic Strengthening of SACA. The British High Commission has recently introduced a small grant's program administered through NGOs in Nigeria. Special attention has been given to the North as grant application forms were physically distributed throughout this region during the First Secretary's recent visit. Applications have been received from health and child welfare NGOs and CBOs from the North.

### **DfID**

The main DfID program in the area of FP/RH is the Partnership for Transforming Health systems (PATHS). The PATHS program covers the DfID Northern focal states of Benue and Jigawa. Amongst its various objectives, PATHS aims to reduce maternal mortality and to increase access to reproductive health. Its goal is to achieve sustainable benefits for the poor by helping to get basic health systems functioning effectively and accessible to all. Underpinning this program is a commitment to strong partnerships with stakeholders for full local ownership and sustainable impact. Communities and stakeholders are supported to define the content of the program in the focal states. The programmatic approach of DFID involves community problem diagnosis, solution seeking, planning for and implementing of the programmes by the communities themselves. DFID facilitates all these by providing technical assistance and funds for implementation. The communities therefore feel a high sense of ownership of the programmes. DfID is also working in the area of HIV/AIDS, TB Control and Child Survival.

### **Bilateral, European Union**

The European Union is programming in Kebbi State in the North West, Gombe State in the North east and Plateau State in the North Central regions. European Union programs are in the area of water and sanitation, budget support and civil society capacity building. Action Aid is likely to be a local partner working in the area of civil society capacity building.

### **Foundations**

Ford Foundation and MacArthur Foundation have put their major institutional support in the North to support the implementation of the Sexuality Education Curriculum through the work of the NGO-Adolescent Health Information Project (AHIP). MacArthur Foundation has funded AHIP to implement the curriculum in 4 states in the North of Nigeria — Jigawa, Kano, Gombe and Katsina State. The MacArthur Foundation has two programs, the leadership program and the institutional program. The institutional program targets the north only and has two components: reduction of maternal mortality and promotion of young people's sexual and reproductive rights. The institutional grants are based in

Kano, Plateau and Borno States. Criteria used for deciding the selection of States were geographical spread, government 'on the move', availability of NGOs to partner with government, absence or appreciable presence of other donors, marginalized States and needy States.

### **Packard Foundation**

The USAID and Packard Foundation have been in the forefront of RH support in Northern Nigeria. The main difference between the Packard programmatic approach and that of USAID is that while USAID emphasises FP, Packard tends to look at the issue of RH in its entirety including PAC, STI and HIV/AIDS. Packard has also consistently been focusing on creating a critical mass of Leaders in RH/FP in Northern Nigeria through short term Fellowships and Mid career Emerging Leadership programmes (IFPLP and LDM programmes). Packard, even though is relatively new, has recorded success in the north because of the sense of community ownership inbuilt in their programs.

### **International NGOs**

Action Aid, Nigeria is the only organization working in both primary education and HIV/AIDS in the North of Nigeria. Currently, Action Aid's work is mainly in the mid-Central region. The International NGO—the Bernard Van Leer Foundation has awarded planning grants to AHIP and Women Farmers Association of Nigeria (Wofan) of 50,000.00 each followed by subsequent full grants to carry out research and pilot intervention in community based primary school interventions. The International Women's Health Coalition has supported AHIP to provide adolescent sexuality education for multiple states in the North of Nigeria.

### **ACORD**

This is a British based NGO with its African Headquarters in Nairobi working exclusively in the remote local government areas of Borno and Yobe States along the Lake Chad Shoreline in Northern Nigeria. The ACORD program aims to build capacity of small CBOs and livelihood community based organizations to respond to the problems of HIV/AIDS, poor access to education for the children of female fisherwomen and nomads, conflicts and threats to sustainable livelihood. Gender is a cross-cutting issue in the ACORD Nigeria program. The methodology used is that of sub-grant making supported by capacity building participatory project management and advocacy training for the CBOs. This is complemented by training for the local government in participatory decision making and governance for health, education, agricultural development, fisheries policy areas. The ACORD Nigeria program works within a milieu of the cross border realities of Northern Borno/Yobe and sees HIV/AIDS risk factors, threats to sustainable livelihood and conflicts particularly in cross border terms.

### **World Bank**

The World Bank is supporting collection of baseline data —school census for 1999, 2000 and 2001 and also pledged to support data collection for 2003. World Bank is supporting 16 states in Nigeria, 8 of which are in the Northern states — Kaduna, Borno, Taraba, Plateau, Niger, Katsina, Jigawa and Benue States; Kano State has not participated in this program. Under the World Bank program, each state will access a soft loan of \$5 million for priority projects determined by the State. Projects include construction of classrooms, rehabilitation of classrooms and other school buildings, information management system, training of civil servants, procurement of instructional materials. The World Bank works with NGOs, community leaders and the public sector to develop strategies for promoting enrollment and retention of girls in school. Girl child education is a priority for the World Bank.

### **6.0 Civil society response**

Throughout the Northern states there have been different types of Islamic civil society organizations working to improve access to education for children. The best known of such organizations are the numerous traditional and community based development associations throughout the North which have made great efforts to establish and run educational institutions combining Islamic and Western educational streams. Some of these associations include the Jama'at al-Nasil Islam (JNI) which established the Nizzamiyyah Primary School in Sokoto in the 1960s. Today, a total of 38 of these schools exist in Sokoto State alone. Other Islamic civil society associations include the Islamic Education Trust (IET) which established Islamic Model Primary/Nursery Schools at Sokoto and later at Minna. In these schools equal attention is given to Islamic Studies and the formal subjects with emphasis on good moral training. Islamic Education Trust (IET) also established the New Horizon College at Minna. The Federation of Muslim Women's Association in Nigeria (FOMWAN) has a total of 35 Islamic Model primary and nursery schools in various states, Kebbi, Niger, Sokoto, Adamawa, Kogi, Bauchi, Abuja and Yobe States. In the North East, the Abdulfathi Organization in Maiduguri had incorporated enough modern subjects into the curricula of their general Islamiyyah School (established in 1952) to be accredited by the Borno State government as a standard primary school. The Imam Malik Centre Maiduguri has also established a primary and secondary school as part of its efforts in the promotion of modern education in Borno State. In addition, the Indimi Islamic Trust, Maiduguri has established a reputable Islamic Primary School in Maiduguri. In Gombe, the Doma Education Development Foundation (DEDF) is training teachers including Islamiyyah school teachers.

The second group of civil society association working for child education in the North is the myriad development associations found throughout the North, they include the Kano Foundation, the Sokoto State Development Foundation and the Katsina State Development Foundation. Similar to the community based associations, the Development Foundations are also traditional with a high degree of emphasis given to integrating Islamic and Western education and traditional leaders assuming leadership roles in such associations.

The third group working for the promotion of education are the more formal organizations including - NGOs, old boys and old girls associations with its coalition of Northern States Old Students Associations (NOSOSA) and Parent Teachers Associations. These groups have a high degree of legitimacy in the community and include NGOs such as the Pastoral Resolve (PARE) which work with children in the Fulani nomadic community, the Kano Forum which promotes girls education and NGOs such as WOSDI in Sokoto and PEDO in Zamfara State. Vision Trust Foundation has recently established a model Almajiri project in Rigausa near Kaduna.

In the area of child survival, family planning, HIV/AIDS and RH programming in the North there is a high civil society presence, though it is important to note that many of these organizations do not exist as developed NGOs. Groups working in the area include - Multi-focus NGOs working in the area of literacy, vocational skills, micro finance and faith based activities which often combine RH interventions such as sexuality education for adolescents, counseling or referral services with their non-RH activities. There is also community based Development Associations upon which BASICS built its Community Partners intervention strategy.

In addition, branches of Networks and umbrella organizations such as PPFH, Society for Women and AIDS in Africa, Nigeria (SWAAN), Women in Nigeria (WIN), the National Council of Women's Societies (NCWS) provide health based support. NGOs representing nomadic peoples such as the Pastoral Development Initiative and the Pastoral Resolve. Faith based NGOs of both the Christian and Muslim Faiths have been carrying out reproductive health projects in the North. Ecumenical Church of West Africa (ECWA) and the Church of Christ in Nigeria (COCIN) are the dominant faith based Christian Groups that have been carrying out RH interventions such as family planning clinics. The Federation of Muslim Women of Nigeria (FOMWAN) has been running family planning/birth spacing clinics in Northern states such as Kaduna, Plateau and Bauchi States. Islamic health workers who address reproductive health concerns from a humanitarian point of view. The most developed Islamic health workers associations are — the Muslim Health Workers in Kebbi State and the Islamic Medical Association (ISMA) with branches throughout the North.

Youth groups in the North have been engaged by international organizations to provide reproductive health services. Most of these groups have an adolescent focus and their membership is made up of young people who are either students or graduates. Groups of medical students or recently graduated health workers are also quite active in states such as Borno, Katsina, Kaduna, Taraba and Kano. In Taraba State, for example, an association of Youth Corpers on assignment in this state has been serving as a referral point for adolescents. In addition, throughout the North, the Nigeria Youth Council has been active in the area of youth economic empowerment and in some states such as Kebbi, in adolescent focused reproductive health programs. Trade unions and professional associations such as the Nurses and Midwives Association, the National Union of Road Transport Workers, the

Nigeria Medical Association; the Association of Resident Doctors have been engaged by international organizations in the past in order to reach members to update their knowledge of best practices in the field of RH. Media Associations highlighting women's health issues such as NAJOW have reported on women's reproductive health problems such as the plight of VVF patients, the problems of early marriage, of the absence of emergency obstetric care and of harmful traditional practices.

## **7.0 Issues**

This section addresses the key set of programmatic and technical issues in USAID social sector programming. One key factor linking both technical and programmatic issues is huge disconnect between assumptions in the USAID programming system and process and the realities of the North. The disconnect impacts on the design, implementation, evaluation, acceptance and results of USAID programs. In a sense it is as though USAID systems and structures were designed for and are oriented to the South of the country rather than the more traditional North. This issue is manifested in the following ways:

1. While USAID views education in secular terms where primary, second, and tertiary are separated and emphasis placed on the 3 Rs at primary level, for many people in the North, education is a religious rather than a secular pursuit. It is the morals and values imparted through the education process which is more important than the paper qualification for employment. Moreover, the fact that education is a continuous process makes it difficult for communities to accept USAID programs at only one level, the primary level.
2. While the OVC component of the HIV/AIDS makes sense in USAID program design identification of AIDS orphans at community level proved difficult in a recent survey for FHI as cause of parent's death was either not known or attributed to Allah.
3. While USAID interventions have specific timelines in which activities are expected to be completed and results achieved, in traditional societies where there is resistance to change, timelines are too short and results cannot be determined within project specific timelines. In many cases NGOs in the North do not get pass the community mobilization and confidence building phases of the project when the endline has is apparent and similar projects in the South west are ready for their second cycle of funding. In such cases process are more important than outputs.
4. USAID decision whether to partner with government or NGOs is perhaps the most critical issue for public officials. In the North where governmental authority is readily accepted and respected, working with government is sometimes more effective than working with weak or un-influential civil society organizations.
5. While the USAID programming cycle assumes an enabling environment, in reality, ethnic conflict in the programming environment has led to goal displacement and mistrust in communities in Plateau, Kano and Kaduna States.

6. From interviews in the field, it was pointed out that USAID's attempt to document figures of contraceptive use and high risk behavior through questionnaire administration in a non-verbal culture is destined to result in under reporting of positive trends that may be occurring.

### **8.0 Northern programmatic success and failures**

The programmatic realities from the field made it apparent that interventions could not be wholly classified as successes or failures. Rather, most projects appeared to have successful components while they had experiences of failure. In this report, success and failure are seen in terms of achievement of stated project goals and objectives.

The key factor which contributed to project success was found to be flexibility, harmony and responsiveness to the Northern environment during design, implementation and evaluation stages of interventions. Examples of successes and failures in Northern projects are given below. Mystery

### **8.1 Successes and failures in Education**

The LEAP program has achieved success in community acceptance, skills building and modernization of traditional Islamic teachers, and pupil performance enhancement. The program has been accepted by the Kano State Government which is now about to replicate it throughout the State. The critical factor in this program's performance was the fact that the program built on an already existing program and only sought to address gaps in this system rather than to develop an entirely new program. The program management also invested tremendous time understanding the environment, talking to stakeholders and targeting the appropriate change agents.

#### **Failures**

The communication and community outreach aspects of the Winrock girl's scholarship program in Kano State can be viewed as a failure. Too little time was invested in the terrain, not enough attention was given to identifying the appropriate entry point and no attention was given to identifying existing girls scholarship schemes and to learn from their experiences. Moreover, in selecting Biu, the most educationally advanced area of Borno State as the site for the program's implementation, Winrock has failed to go to the areas where there is greatest need.

Bilateral donor organizations as the Embassy of Japan, SIDA in the Embassy of Sweden, and the British Council in Kano have supported the construction of primary schools as well as teaching programs in remote areas in the Northern states such as in Taraba, Borno and Zamfara States. In such projects the donors found that they were unable to monitor projects located in remote areas and therefore.

### **8.2 Success and failures in CS, FP/RH, HIV/AIDS**

Successes - In HIV/AIDS programming, Family Health International's Commercial Sex Workers project in Kano State has successfully targeted female sex workers from both indigenous and non-indigenous communities in Fagge LGA. This was achieved by FHI programming with 2 NGOs through a sub-agreement backed up by a Memorandum of Understanding developed by the Network of FHI supported NGOs in Kano State. This intervention responded to the fact that Christian and Muslim female sex workers in brothel based settings are often separate and require separate BCC strategies.

The BASICS approach of bottom- needs responsive, partnership building programming is a real success. Also, the new UNICEF and DfiD programs have a lot of potential for success.

The SWODEN Badawa Clinic in Nassarawa LGA, Kano State, funded under the Packard project has been able to build trust in the community by adding a primary education component on to its family planning services. For the community, the fact that SWODEN is taking care of its children free of charge is an indication that it has no ill-intensions by providing services to women.

By using community participatory methodologies, the Vision Project in Bauchi has succeeded in getting a wide cross-section of community stakeholders to address the burden of RH problems for women, families and the community and to search for solutions by working together.

The experience of The Federation of Muslim Women Associations of Nigeria (FOMWAN) with Training of Muslim Health Workers on Integrated RH, PAC,STI and HIV/AIDS and that of the Christian Health Association of Nigeria (CHAN) are examples of how respect for cultural and religious sensitivity made programs accepted and successful. In the last two years, FOMWAN has trained 144 Muslim Health Workers on Integrated RH ,PAC, STI and HIV/AIDS prevention and syndromic management in Kaduna, Kano, Plateau and Sokoto States. This program was specifically designed by the federation taking into cognisance the specific needs of the Muslim Communities they serve. The program was sponsored by Packard Foundation and is currently being expanded to three more states of northern Nigeria. What is distinct about this program is that all the training was conducted within the context of the Muslim belief.

### **Failures**

Adolescent sexuality education and services have been an area of greatest challenges in the Northern States. The Packard funded and CEDPA implemented basic life skills project (Northern Youth Strategy) sought to provide RH information to adolescents in the North of Nigeria. Over the life of the project, 1999-2002, objectives of numeracy and literacy became more important than the objectives of information, education and communication on relevant RH topics leading to the project being viewed as a failure by the funding agency.

The Adolescent Health Information Project (AHIP) has been supported by the Packard Foundation, the Ford Foundation, CEDPA, the MacArthur Foundation, DfID and the International Women's Health Coalition to carry out programs in the areas of youth friendly service delivery and the implementation of the National Sexuality Education Curriculum in 4 states in the North. The fact that this NGO lacks community links, has had conflictual relations with the state government and has failed to build partnerships with health service providers in the public and private sector has put its programs in jeopardy and led to a outpouring of negative comments in the folk, popular and print media on this organization. In a recent interview with AHIP the problems of reproductive health in the North were identified as the problems of 'those Northerners'.

### **9.0 Lessons learned**

Several key lessons were learned from the experiences of USAID funded and other donor supported programs in the area of health. They included:

- a) That USAID supported programs have merely paid lip-service to the use of participatory approaches and integrated programming strategies. In reality, what transpires is that program designs are too rigid to enable true community participation and family planning programs with a few soft maternal health components are passed off as Integrated Programs. In reality they are not integrated programs and monitoring and evaluation indicators merely track commodity movement. No attention is given to softer indicators such as awareness creation and the creation of an enabling environment for RH programming.
- b) That there is a huge information gap and mis-conceptions regarding the programs, activities and the developmental role of funding agencies such as the USAID in the North of Nigeria. Without accurate information suspicion builds up, mistrust develops and communities are reluctant to accept development programs of international funding agencies. Not only is there lack of information coming from the USAID head quarters but the assessment team was told that the Kano Field Office now appears to be too busy to act a clearing house for NGO opportunities in the social sector. One NGO respondent in Jigawa said 'formally the office in Kano use to send us the Japanese grant application forms and other types of information now we do not even know when they are looking for NGOs to start programs'.
- c) That NGOs have found condoms difficult to market in both the Christian North Central and the core North. One NGO respondent in Plateau State said 'In our project our community based health providers go out everyday with condoms and come back with them every single day'. However, condoms are in high demand when sold by private providers. Anonymity is important for men purchasing condoms.
- d) Given the resistance to providing sexuality education information and RH services to adolescents in the North of Nigeria, international funding agencies appear to be reluctant to

- incorporate sexuality and RH components into education curricula, less it puts entire education interventions at risk. Thus the case for integrated education and RH programs has not been made and the mutual programmatic effect of education and RH has not been established.
- e) There are several change agents in the North who are working on integrating Islamic and Western educational streams. These change agents are willing to work with USAID.
  - f) That programming in the area of Islamic/Western education by targeting the Almajirai has to be approached with extreme caution for fear of negative reactions. In this regard findings of a recent UNICEF report are useful.

In dealing with Alajirai, . . . programmes should be designed to help Almjirchi and disseminated as such. Any act or utterance which is capable of arousing suspicion or ulterior motives should be avoided. Otherwise, they will simply revolt against changes. (Imam, UNICEF, 1999:105)

- g) The process of partner selection by USAID IPs is seen to be subjective and lack transparency even when this process is conducted by the field office. In cases where open advertisements are made (e.g. LEAP) poor communication to unsuccessful potential partners leads to negative perceptions and hostility to the intervention
- h) In integrated communities it is difficult to single out girl children for special support without arousing suspicion or mistrust. Although it is acceptable to target girls and boys separately it is necessary to target both groups.
- i) Strong lines of communication must be opened between the funding agency and the State Ministry of Education and to the Local Government.
- j) Choice of civil society partner is a very important issue
- j) It is not enough to involve Government officials at the start-up, baseline and mobilization phases of USAID projects without involving them during the implementation, monitoring and evaluation stages. This merely creates expectations that are not met as in the case of FHI's work in Kano State. Participation must be genuine involvement.
- k) Donor agency emphasis on polio eradication is not reflected in the child survival needs of communities. Communities are more interested in the eradication of measles and CSM.
- l) There is little involvement of PABAS and PLWAS in HIV/AIDS programming
- m) Federally introduced Public Policies and laws such as the Age of Marriage Bill, the National Sexuality Education Curriculum and the National Policy on Reproductive Health have very little influence on State policy making and selection of priority projects. Such issues are determined by internal state specific factors.
- p) Most USAID IPs are providing technical trainings in specific areas such as condom logistics to grantee NGOs rather than institutional capacity building.
- q) Faith based organizations are particularly advantaged to address the issues of HIV/AIDS and RH in a culturally sensitive and integrated manner. The experience of The Federation of Muslim

Women Associations of Nigeria (FOMWAN) with training of Muslim Health Workers on Integrated RH, PAC, STI and HIV/AIDS and that of the Christian Health Association of Nigeria (CHAN) are examples of how respect for cultural and religious sensitivity led to programs acceptance and success.

In the case of Christian churches in the North Central which are located throughout rural communities, these are powerful agencies of change and instruments for integrated development

## 10.0 Findings, Conclusions and Recommendations

### 10.1 Programming gaps

### 10.2 Design Gaps - Top-Down and non-participatory approaches

All stakeholders consulted — the NGOs, field office staff and government officials indicated that the approach the Implementing Partners all adopt a top- down planning approach. The content of the programs to be implemented, their location for implementation and the methodologies for carrying them out seem to all decided centrally. There is a perception that the field offices are just given directives on what to do, with hardly any room for flexibility. Thus programs are seen as not always

respond to the needs of the people. These issues were captured succinctly by some of the interviewees as stated above.

“I thought USAID is about international development and working with communities to get them to change, using their processes from their realities. But they come with their own agenda, strategies and work plans from outside. --- There is incongruity between USAID goals and strategies and ours”. (Participant at a stakeholder meeting in Kano)

“They give you money to do what they want you to do and not what you want to do” (CEDPA grantee in Bauchi)

“They decide what they want to do from Washington and paste it on you. You are in a straight jacket. They need to look at the local environment, which they don’t”. (NGO leader in Jos)

### 10.3 The Understanding Gap

Stakeholders interviewed reported that IP headquarters failed to take the time to understand the North and in many cases held false assumptions about what would work

or not work. Two responses came from this lack of understanding — one is that all consultants, staff, project designs and project evaluation teams were brought in from other zones or they are over-cautions in implementing programs fearing that a Northern failure will impact negatively on the country program. The quotations below bring out these views:

“ The north is projected by IPs as backward, difficult to work with and with no resource persons etc because the people of the north are different. If things are not done their way or are not accepted, then the north is backward” (NGO leader at Kano Stakeholders meeting)

***“You cannot come from Ibadan and implement FP in the North. That is why ‘kayyade iyali’ failed” (Northern IP, Kano )***

***“Blaming Northerners and labeling them as deviants because they have imported, wholesale, successful***

***programs from the South to the North and they failed. They think what works in Lagos should work in Kano; if it does not, something is wrong with the North”. (Participant at a stakeholders’ meeting in Kano)***

#### **10.4 The Poverty Gap**

Poverty and illiteracy were highlighted as the root causes of most of the problems in the North. The failure of USAID programs to define programmatic targets within the wider context of the poverty in the North is a significant gap.

#### **10.5 The Felt Needs Gap**

Measles and whooping cough were identified as priority vaccine preventable diseases for eradication by most stakeholders consulted. The diseases are still very endemic with recurrent epidemics and vaccines are hardly available for them. The stakeholders wondered why the focus on polio eradication, when the disease is not even a perceived threat to the complete neglect of those that are killing their children. They also pointed to the fact that there were times NIDs were taking place and measles epidemics were raging with no interventions at any level. It is not surprising, that there is rejection to the polio vaccines.

One Community Partner at the Kano Stakeholders meeting had this to say about priorities in community needs –

*“If you ask a community what are its most pressing needs, I can assure you that no-one will say family planning”.*

#### **10.6 The RH Gap**

Even though CEDPA claims that its program it is running reproductive health programs, the general complaint was that such programs are family planning commodity driven and the contraceptive prevalence rate (CPR), is the only indicator of interest to USAID and CEDPA. It was noted that availability and access to quality antenatal and delivery services are very limited in the North. If improvement in the health of women and reduction in maternal mortality and morbidity is the goal, this is unlikely to be achieved through promotion of family planning alone. Maternal health care was rated as having higher priority than family planning.

#### **10.7 The Culturally responsive BCC Gap**

Some IP develop IEC materials for the Northern audience with restricted inputs from Northern offices. Consequently, USAID IEC materials in the North are largely viewed as dull, culturally inappropriate and linguistically inaccurate messages presented on high quality paper. The example was given of the IEC materials developed by IMPACT on HIV AIDS which was said to be replete with Quranic verses and reference to condoms. When it was rejected as religiously insensitive and returned to Lagos, the Northerners were accused of displaying their deviant behavior yet again.

### **10.8 The Gender blindness Gap**

Inadequate attention is given to the gender component of the community participatory programs particularly in the predominantly Muslim areas of the North. For example, PTAs lack women members in Tsanyawa where the teacher of the Quranic school admitted that there were at least 10 women teachers who qualified to participate.

### **10.9 Vision — Deepening the Advocacy Component**

Despite the obvious conceptual merits of the Vision project there is need to deepen the community empowerment component of the Vision project by (Judith to complete)

### **10.10 The neediest gap**

It was not clear to the stakeholders what criteria USAID and its partners to determine where to cite their projects use. What was evident was that epidemiological information does not appear to support the selection of project sites by USAID. The most deprived states, LGA or communities are not targeted by USAID projects in the North.

### **10.11 The Institutional Capacity Building gap**

The NGO culture in the North is comparatively very young. Consequently, majority of the NGOs lack institutional capacity- no skilled staff, no equipped offices, hardly any full time staff etc. For these NGOs to be effective, they require capacity building. Recognizing, this gap, when USAID decided to work with NGOs, investments should have been made in capacity building for the Northern NGOs. Unfortunately, both the field program staff and the NGOs stated that USAID does not provide support for institutional development; merely for technical capacity building. In this context, it is being unrealistic to expect the northern NGOs to deliver at the same level as the southern NGOs. One NGO leader in Kano puts it this way —

*‘ We need seed money to develop our NGOs not seed stocks of commodities’.*

### **10.12 The USAID System gap**

The procedures, reporting and assessment requirements of the USAID system, per se, is a gap towards the effective participation of smaller CBOs as USAID partners. Given the lack of capacity of the NGOs, many of the respondents observed that the guidelines for proposal writing and reporting are too stringent. As only a few NGOs are able to comply with these requirements they become over-funded by USAID and other donors, the case of AHIP is an example. Other funding agencies such as Action Aid, British High Commission and the MacArthur Foundation have addressed this problem by reducing grant- making requirements and by re-granting through intermediary NGOs.

### **10.13 The Communication Gap**

There appears to be a disconnect between USAID and their IP. It was alleged that USAID does not interact sufficiently with their IP and they do not come to the field to monitor program implementation in the field. Also, it was reported that there is verticalization of programming and work by the different IP, with IP not knowing what the others are doing. This lack of harmonization of programs by IP, the alleged competition between the IP and the apparent poor working relationship between and within IP in the field office negates program synergies and optimization of impacts.

### **10.14 The Poor Strategic Support Gap**

All stakeholders across board complained of comparatively poor support for the Northern Cluster from USAID. For example, it was noted that the current USAID Director and Country Director of CEDPA was said to have never been to Kano Field Office. The results of the poor support were seen to lead to:

Poor representation of Northerners in USAID. It was observed that there is only one management staff from the North in USAID and very few in the IPS head offices. As a result, there is marginalization of the North in programmatic decisions at management level; ‘the voice of the North is stifled where it matters most in USAID.’

Specific USAID and IP program managers were out rightly labeled as anti-North. The attitude of the headquarters was described as accepting of programmatic failures in the North but questioning of successes.

### **10.15 NGO/Field Office communication gaps**

There were complaints that communication between the FO and the NGOs is poor. Many of the NGOs complained that often, they are asked to write proposals or letters indicating interest in proposals. They said that groups never get a feedback after submission of the documents. There were also observations by some NGO that there were instances the IP communicate with them directly, bypassing the Field Office who are often unaware of these communications as they are not even copied.

## **11.0 Opportunities for Future USAID Investment**

Opportunities for future programming will be identified in terms of gaps, as well as USAID comparative advantages working in the North of Nigeria. Gaps have been discussed above. Compared to other donors working in the North of Nigeria USAID comparative advantages in key areas.

### USAID Comparative Advantages:

1. Presence of a field office in the North
2. Long history of working in the North
3. USAID has extensive experience working with NGOs in the North of Nigeria. IPs having done a large number of assessments
4. USAID strategic health and education objectives and the USAID commitment to objective integration are congruent with the development priorities and implementation strategies of many State governments in the North
5. USAID has a long experience of supporting community- based programs through its IPs BASICS in particular whose programs are implemented at the LGA level.
6. Compared to other donors who work either with government or with NGOs, USAID is the only funding agency which has supported programs bringing civil society organizations and government together and building the capacity of each group to work with each other. This was done through the CEDPA Model Local Government Project in Kano and Plateau States in the North.
7. USAID has strong connections with a new breed of traditional leaders who are supportive of USAID initiatives in the North. They include the Wakili Arewa who received his teacher education training as a result of a link program between the Ohio State University and the Kano State College of Education. Against all criticism, he participated in a CEDPA run and Packard supported Northern Youth Strategy project and facilitated a pilot in his local government — Dala LGA one of the most conservative and traditional LGAs within the city walls of Kano. A second leader is the Chiroman Kano who hosted a meeting on Peace, Poverty in conjunction with the Department for Homeland Security in Kano in February. The Chiroman Kano is also working with Winrock International on their Farmer to Farmer program.
8. USAID has been associated with bringing Northern NGOs together with other groups at the National level forums to discuss and explore the theme of programming in RH/FP/RR and other programming streams in the Advance Africa Workshop of 2001.
9. USAID is also associated with high degree of scientific steps in carrying out programs. NGOs often feel that they are learning when working with USAID. Similarly, USAID is also associated with strong monitoring and evaluation systems.
10. Several community development activists who have been exposed to past USAID funded programs throughout the North have recently offered themselves as political candidates or have taken up advisory positions to Governors or are now highly placed within the public service in the North. They can serve as a resource for the support of USAID interventions.
11. USAID is perhaps one for the few bilateral funding agencies which is funding primary education at the state level.
12. The Spielman legacy of genuine concern for and interest is still remembered by many.

13. The technical expertise of CDC and its experience at strengthening surveillance systems by working with state governments in the North

Given these comparative advantages, what are the opportunities for future USAID investment in the north?

1. Opportunities for programming with local and state governments
2. Opportunities for working in government facilities at community level
3. Opportunities for working with women and girls in education
4. Opportunities for working in hard to reach and border communities where conflict, migration and trade drives the HIV virus
5. Opportunities to work with reform oriented agents and community leaders at the community level who are concerned with girls education and the integration of Islamic and Western education streams
6. Opportunities for working with community based organizations
7. Opportunities for incorporating the previously unaddressed problem of the high incidence of adolescent male substance abuse into HIV/AIDS and education interventions.

The highest incidence of substance abuse is in the North where the life styles of young male abusers also put them at risk of HIV infection.

8. Opportunities for working with state governments committed to introducing RH initiatives such as in Kano State.
9. Opportunities for synergies in states where UNICEF activities in the area of HIV/AIDS and child survival are effective, eg. Borno State
10. Opportunities for working in less conservative states in the North and then replicating as programmatic success is apparent
11. Opportunities to have synergies with the Packard Foundation Leadership Development Programs in Reproductive Health by identifying and working with a core group of change agents who have been trained in the Packard Future Leaders Program which draws its fellows from both the North east, west and central
12. Opportunities for working in the area of girl child education in the North with faith based NGOs in support of girls education such as FOMWAN, Muslim Sisters Organization, the Church of Christ in Nigeria, Ecumenical Church of West Africa.
13. Opportunities for working with Old Boys/Girls associations and umbrella old students associations which have influential members committed to education in the North
14. There is a great opportunity for integrated programming at both community and state level as most civil society organizations are still largely multi-focused in the North.

*This is a strength - not a weakness.*

## **12.0 Local Capacity for Social Sector Programming**

While local capacity for social sector programming exists in some areas there is also a dearth of capacity in other areas. Areas of capacity are - human, institutional, technical, systemic and methodological capacity.

1. Human resource capacity for social sector programming is required at the level of program design, implementation, monitoring and evaluation. There are a large number of senior experts at Universities, Colleges of Education and even within NGOs in the North who do possess capacity in education and health programming. There are also a large number of dynamic and qualified individuals in both the public and private sectors who are available for full-time employment with USAID and its IPs at both field office and headquarters level. While DfiD appeared to have been successful in recruiting on short and long term basis the cream of Northern Consultants and experts in the social sector and security, this is not the case for USAID. The team found that in most cases, Northern experts do not believe that the USAID system to be an open one, thus few Northern experts take the trouble to find about USAID programs and to offer their services accordingly.
2. With regard to institutional capacity there is a large availability gap in this area. Most civil society organizations in the North of Nigeria are small, informal, multi-focused and lack systems and procedures required to qualify for USAID funding. This leaves USAID IPs with few NGOs from which to
3. Technical capacity ..... (to be completed)
4. Methodological capacity ..... (to be completed)

## **13.0 Recommendations and Suggestions for Future Directions in USAID Social Sector Programming**

The suggestions for further directions for USAID can be divided into 2 categories – strategies for implementation in the near future, that is, before the strategic planning period and strategies for implementation in the future planning period of 2004-2009.

### **13.1 Suggestions for implementation in the near future**

1. USAID should establish an electronic data base of human resources available for short term and long term engagement on social sector programming. If well handled, the electronic data base would lend transparency to what is now perceived to subjective and inaccessible system.
2. USAID should establish a simple and reader-friendly Development medium in print form to inform CBOs, NGOs, governments and other stakeholders in about new programs, call for proposals, expressions of interest and about achievements and best practices in the social sector. In this way competition

will be increased amongst civil society organizations and a better selection of organization will be available for engagement.

3. USAID should commence building the capacity of a core group of local media personnel in all aspects of BCC drawing from local folk media and popular youth culture. While the argument for economies of scale in centralized IEC material production is a convincing one, especially where IPs such as JHU do have comparative advantage, local production is imperative for increased ownership and the development of more creative and culturally relevant messages. The generally dull and occasionally culturally inappropriate nature of IEC materials has been told time and time again to the assessment team.
4. USAID should also commence an extensive process of identifying change agents in the social sector for leadership support.
5. It is expected that elected officials at state and local government levels will be assuming office throughout the country following the April 2003 elections. USAID must design a program of participatory social sector planning for elected officials as a matter of urgency. While such a program is need throughout the country, in the North where D&G initiatives are few and human rights NGOs are none-existent such a program is even more required.
6. There is an urgent need for USAID to design and commence programs which targets tradition, religious and community leaders in the FHI, expanded comprehensive response intervention in Kano State. This is an important programming gap which must be address in order to create an enabling environment for care and support components of programs. The FHI Kano Staff interviewed has suggested working closely with the state government in such programs.
7. Action Aid is currently carrying out a study on the perceptions and attitudes to girls education in Nigeria, with a focus on the North. A similar inquiry on the boys and adolescent males – their attitudes, aspirations, behaviour, practices regarding health and education in the North of Nigeria is recommended. This has implications for Strategic Objectives for social sector, D&G and Economic development objectives.

### **13.2 Suggestions for the 2004-2009 Strategic Planning period**

1. Broaden the basic education to include adult education. This will give more opportunities for synergies with Child survival, HIV/AIDS and RH in its broad definition not just FP.

2. There is an urgent need to build a reproductive health constituency at the grassroots in the North. This should be the priority of all USAID reproductive health interventions. USAID should begin to focus on what they have not done to raise community and public awareness and CBO commitment on reproductive health issues in the North. The issue of the recent debate on adolescent sexuality education in the Trust Newspaper clearly brought to the fore the need to always devolve the engagement and sensitization of stakeholders and not limit it to those at the top, hoping that they will continue the sensitization. Funds need to be committed and strategies evolved to reach out to the media and the public as once the environment is poisoned by misinformation, it can mar all other health programs. USAID needs to learn from the experience of the MacArthur Foundation and start being proactive and not reactive.
3. Expand the basic education program to cover more areas and to include the training of teachers. On this issue, one traditional leader in Kano State made the statement quoted below.

**“USAID should learn from the same agency’s experience over 30 years ago when their education aid was very successful because it involved extensive training and building capacities of Teachers. That programme was very successful in northern Nigeria and produced Excellent Teachers. I am a beneficiary and a product of that USAID programme**

3. Community based and run Pre-nursery programs should be designed for support in rural communities in particular. Such programs contribute to breaking down the barriers to Western education and offers opportunities for child survival interventions in combination with education.
4. USAID Monitoring and Evaluation methodologies should be developed to reflect the realities of a silent culture where key respondents are do not openly speak about matters related to sex and sexuality. The challenges in monitoring and evaluation are many in the North especially as women are not easily accessible for questionnaire administration and USAID M&E methodologies do not lend themselves to true participatory approaches. What is used by most IPs as participatory M&E is no more than qualitative approaches in M&E.
5. Reforms to the USAID, IP grant making system must be effected in the new Strategic Planning period to ensure that NGOs do not wait for 9 months between

proposal development and the commencement of programming. This truncated process leads to the loss of interest on the part of NGOs.

6. Learn from the Packard Foundation's Future Leaders Strategy which has identified and supported a core group of change agents in RH in the North of Nigeria. A similar program can be developed for change agents in education while the RH focus can also be deepened.
7. The Vision Project's focus on community participation has important lessons for the next strategic planning period. However, it is recommended that the community stakeholder participation mechanism be fine-tuned to assign specific roles groupings of community members with the necessary competences. Currently, there appears to be a conflict of interest in the program design and supervision assigned to the same community members in the Vision Project. USAID can learn from the experience of ADF on its Jigawa State community based housing project where community groupings are divided into design, supervision, service delivery teams and are trained accordingly.
8. An extensive program training of female community health extension workers should be supported for rural areas in the Northern States. For this activity to be successful, however, it is imperative that USAID designs and supports a program of capacity building for community health committees. A mechanism must also be found to ensure women's participation on such committees. Ideas can be drawn from the experience of the CEDPA Model Local Government project in Bauchi, Kano and Plateau.
9. Integrated programs on HIV/AIDS and substance abuse must be developed and targeted at male in and out of school youth in the next programming period of 2004-2009.
10. Programs should be designed so that points of synergy in the development of the Strategic Objective can come from the community needs assessment. This implies that community based interventions can have several permutations and combinations consistent with needs. Both governmental and non-governmental stakeholders should be involved in identifying needs and selecting programming combinations. However, there are some natural combinations and points of synergy which are presented in the appendix attached. The appendix also contains specific recommendations on processes to be followed and potential partners in community based integrated programming in the North

#### **APPENDICES**

#### **Programmatic synergies and specific recommendations for implementing community based integration programs**

Specific recommendations for implementing Community based integrated programs. The experiences VISION, LEAP, ADF, CEDPA and BASICS as well as the experiences of other funding agencies inform these recommendations.

### **Processes**

- Ensure joint program planning by all working in the area of the intervention
- Set criteria for identification of communities that will most benefit from the intervention
- Community participation in needs assessment, priority setting, ,project design, implementation, monitoring and evaluation is required
- Work through existing structures and build their capacity to deliver program objectives
- Explore innovative partnerships or strengthen existing ones between local governments, the private sector and the community
- Spend time doing ground work for development with traditional, community and religious leaders

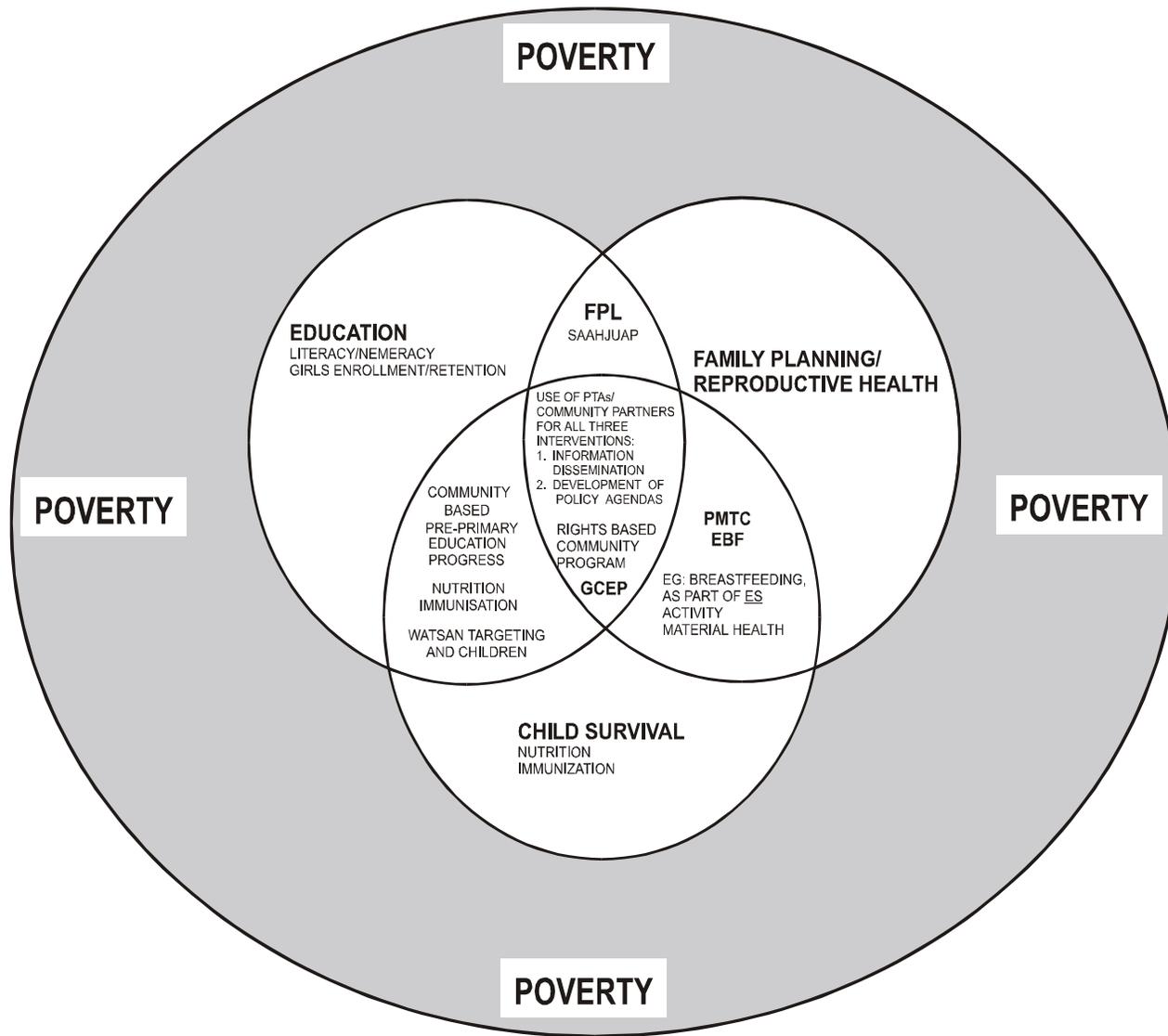
### **Strategies**

- Use traditional interpersonal communication channels, for example, the folk media and the popular Hausa videos
- Work with religious, community and traditional rulers
- Because of gender segregation women should be consulted separately
- Work through intermediaries and intermediate organizations
- Build upon existing efforts and accomplishments in the community — do not impose new ones

**Programmatic recommendations for integration (see figure below)**

**Conceptual framework for integrated social sector programming (see figure below)**

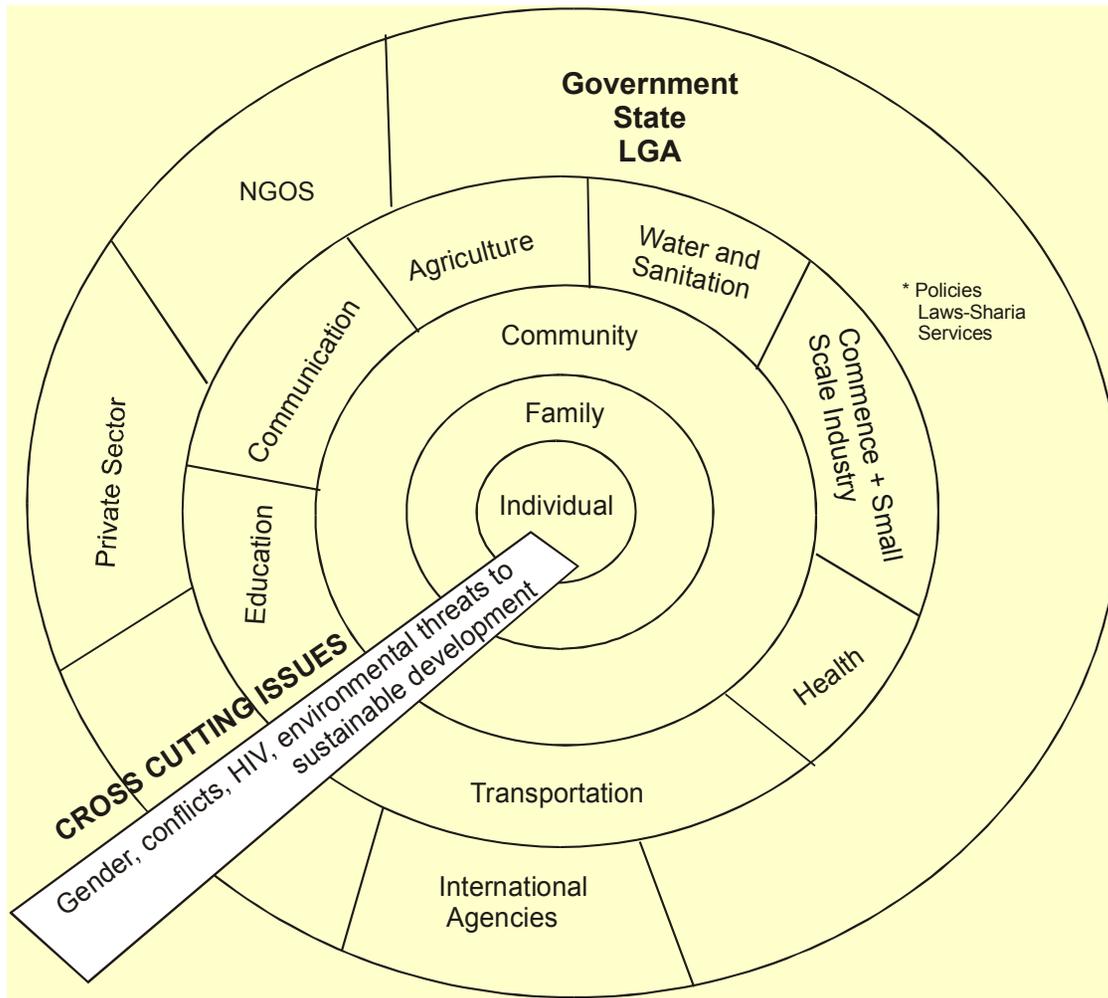
# POINTS OF PROGRAM SYNERGY



## KEY

- FFL – Female Functional Literacy Programs**
- SAAHJUVAP – Substance Abuse +**
- HJV – Awareness Program**
- WATSAN – Water Sanitation**
- GCEP - Girl Child Education Program**
- EBF - Exclusive Breast Feeding**
- PMTC - Prevention of mother to Child Transmission**

# CONCEPTUAL FRAMEWORK FOR COMMUNITY-BASED SOCIAL PROGRAMMING



- Women's Groups
- CBOS
- PTAs
- Religious Leaders
- Traditional Leaders
- Community Leaders
- Youth Group
- Development Association
- Local Government
- Religious Organizations



### Appendix on Summary of key Social Sector Indicators

CATEGORY	NORTH WEST	NORTH EAST	SOUTH EAST	SOUTH WEST	NATIONAL
Number of States	7	6	5	6	36
Number of LGAs	186	112	95	137	774
Total Population*					130,000,000
Population of children under five					
Infant mortality rate	114	117	112	45	105
Under five mortality rate	217	199	130	119	178
Immunization coverage	4%	8%	25%	29%	
Percentage of children that had never received any vaccines	67%	61%	18%	14%	
Maternal Mortality rate	1,025	1,599	286	165	704
No ANC	65%	54%	8%	4%	
Delivery by trained health worker	8%	13%	65%	73%	
Prevalence of PEM (stunting)	37%	44%	30%	24%	27% (rural) 24% (urban)
Prevalence of Vit A deficiency in under fives	17%	12%	6%	2%	9%
Prevalence of Vitamin A deficiency (mothers)	15%	9%	4%	2%	7%
Literacy level (Female)	22%	21%	60%	55%	41%
Percentage of children aged 36-59 months in early education programs	4%	3%	39%	41%	18%
Primary school enrolment rate	28%	39%	79%	81%	55%
Mean Age at marriage	14.6%	15.0%	20.2%	20.2%	19.9%
Total Fertility Rate	6.5	6.8	4.6	4.5	
Population below poverty line	77%	70%	43%	61%	