

WHO COUNTRY COOPERATION STRATEGY:
FEDERAL REPUBLIC OF NIGERIA

2002–2007



World Health Organization
Regional Office for Africa
Brazzaville

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Abbreviations

ADB	African Development Bank
AFRO	WHO Regional Office for Africa
AIDS	Acquired Immunodeficiency Syndrome
AOW	Area of Work
APOC	African Programme on Onchocerciasis Control
ARI	Acute Respiratory Infection
CBO	Community-based Organization
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CHEW	Community Health Extension Worker
CIDA	Canadian International Development Agency
CSM	Cerebrospinal Meningitis
DALE	Disability Adjusted Life Expectancy
DFID	Department for International Development
DOTS	Directly-Observed Treatment Short-Course
DPC	Disease Prevention and Control
EB	Extra-Budgetary
ECP	External Cooperation and Partnership
EDM	Essential Drugs and Medicines
ENV	Environmental Health
EPI	Expanded Programme on Immunization
EPR	Emergency Preparedness and Response
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FCT	Federal Capital Territory
FTC	Free Standing Technical Cooperation
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccine and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	Gross National Product
HDI	Human Development Index
HEC	Health Economist
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
HPR	Health Promotion
HRH	Human Resources for Health
HSR	Health Sector Reform
ICC	Interagency Coordinating Committee
IDSS	Integrated Disease Surveillance System
IMCI	Integrated Management of Childhood Illnesses
IMD	Information Management and Dissemination
IMR	Instant Mortality Rate
IPRSP	Interim Poverty Reduction Strategy Paper
JICA	Japanese International Cooperation Agency
LGA	Local Government Area

MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MNH	Mental Health
MOH	Ministry of Health
NACA	National Action Committee on AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NAPCA	National Action for Prevention and Control of AIDS
NAPEP	National Poverty Eradication Programme
NCD	Noncommunicable Disease
NEPAD	New Partnership for Africa's Development
NGO	Nongovernmental Organization
NHMIS	National Health Management Information System
NHP	National Health Policy
NID	National Immunization Day
NIMR	Nigerian Institute for Medical Research
NPHCDA	National Primary Health Care Development Agency
NPI	National Programme on Immunization
NPC	National Planning Commission
NPO	National Professional Officer
NUT	Nutrition
PEI	Polio Eradication Initiative
PHC	Primary Health Care
POA	Plan of Action
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
REDUCE	Maternal Mortality Reduction Strategy
RH	Reproductive Health
SAP	Structural Adjustment Programme
SCHEW	Senior Community Health Extension Worker
SMOH	State Ministry of Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UBE	Universal Basic Education
UN	United Nations
UNAIDS	United Nations AIDS Programme
UNDAF	United Nations Development Assistance Framework
UNODCCP	United Nations Office of Drug and Crime Control Programme
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization

1. Introduction

The World Health Organization Country Cooperation Strategy (CCS) is an adaptable country specific strategy that provides the framework of cooperation between WHO and countries. It reflects the values, principles and corporate directions of WHO as one organization with three levels – country office, regional office and headquarters.

The Nigeria CCS is based on a systematic assessment of the country's health priorities and was developed in a spirit of partnership with key stakeholders. It is a product of extensive discussions between the WHO team (members from Headquarters, the Regional Office for Africa and the Nigeria Country Office), government health officials, development partners and other stakeholders. In order to reflect the fact that Nigeria is a federation, consultations were held with government officials and stakeholders in six states.

In the process of developing this CCS, a very large number of documents were consulted. After analysis and synthesis of the data gathered, a retreat was held for staff members to map out the strategic agenda. An initial draft was presented to development partners and stakeholders while the final draft was refined at a three-day retreat participated in by country team members.

The CCS document identifies a number of challenges that the Nigerian health system and the populace are facing. These include widespread endemic and emerging diseases, declining health status, weak and fragmented health system and declining external partner confidence. The document is also cognizant of the favourable political atmosphere, the democratization process and the government's growing interest in the social sector, including health.

Drawing on the opportunities and challenges facing the health sector, this document formulates selective strategies which will ensure WHO corporate response to priority health problems in the context of Nigeria's overall health development efforts. It also emphasizes the WHO role in providing government and other stakeholders with technically sound recommendations and advice on health issues.

The CCS provides the basis for WHO operations in Nigeria for the period 2002 to 2007 and will influence work at all levels. The CCS provides an opportunity for the WHO Nigeria Country Office to harmonize its planning cycle with other UN agencies in the spirit of the United Nations Development Assistance Framework (UNDAF). It is a dynamic and evolving document which will continue to be reviewed from time to time.

Government goals are stated in the National Health Policy (NHP), the Poverty Reduction Strategy Paper (PRSP), New Partnership for Africa's Development (NEPAD) and Millennium Development Goals (MDGs). Systematic and conscientious implementation of the strategic agenda includes mobilizing resources, strengthening the health system and scaling up priority interventions in communities; all of these include WHO contributions.

2. Health and Development Challenges in Nigeria

2.1 Demographic overview

Nigeria is the most populous nation in Africa. With a projected population of 118 million (2001)¹¹ and an annual growth rate of about 2.8%, Nigeria has approximately a quarter of Africa's population. In general, Nigeria has a young population with a median age of 17.4 years. Children under 15 years account for 45% of the population while the aged are estimated to be about 3.5%. The age-dependency ratio in the country is 93.2 per 100 and the index of economic dependency is 259 dependants per 100 workers.

There are over 250 ethnic groups in the country. The major groups are the Hausas in the north, Yorubas in the southwest and Ibos in the southeast. The southern population is mainly Christian while the northern population has a Muslim concentration. Rural-urban migration has resulted in cities such as Lagos, Ibadan, Kano and Port Harcourt with their associated unemployment, overcrowding, increased demand for health and social infrastructure as well as increased environmental degradation and pollution.

2.2 Governance

Nigeria is a federation. There are three tiers of government: federal, state and local. The constitution of the Federal Republic of Nigeria (1999) establishes judicial, legislative and executive branches for the federal government and for each state of the federation. There exists a complementary relationship among all the tiers of government.

The National Assembly comprises the Senate and the House of Representatives whose members are elected from state senatorial districts and constituencies, respectively. Each state has an elected executive governor, an executive council and a House of Assembly with powers to make laws. Each local government area (LGA) is administered by an elected executive chairman who works with elected legislative council members from electoral wards.

The federal government, states and LGAs have similar responsibilities for the provision of services such as health. In the present era of democracy, they also have substantial autonomy and exercise considerable authority over the allocation and utilization of their resources. This arrangement tends to constrain the leverage of the federal government. Therefore, it is imperative that WHO be present at state level to perform its core functions more effectively and give strategic directions as appropriate.

2.3 Socioeconomic situation

The Nigerian economy has fluctuated widely in the last three decades. Significant growth was recorded in real gross domestic product (GDP) in the early 1970s; however, there was negative growth in the 1980s and slow growth in the 1990s. The average GDP growth rate was -2.0% between 1979 and 1989, and 2.7% between 1989 and 1999. A narrow production base, subsistence activities and commerce characterize the economy.

The main sectors of the economy include mining (that is, oil drilling), agriculture, livestock and industry. Nigeria is heavily reliant on oil exports which accounted for over 95% of total export receipts in 1998 and are still the major source of foreign exchange earnings. Agriculture accounted for over 80% of federal revenue in the 1960s, declined to 1.5% in 1995 but increased to 40.4% in 1999. Almost 70% of the active labour force is employed in agriculture. With a population growth rate of 2.8% per annum, a

¹¹1991 Population Census of the Federal Republic of Nigeria. National Population Commission, 1998.

vibrant and dynamic agricultural sector is important if food security is to be guaranteed. A healthy labour force will be important in this regard.

According to the 2000 Human Development Report, Nigeria's human development index (HDI) is 0.439. Nigeria is paradoxically classified among the 20 poorest countries in the world despite its rich oil reserve, natural resources, impressive human capital, agricultural potential and emerging industrialization. The current per capita income of US\$ 310 is far below that of US\$ 1,000 in the 1980s. Political and social instability, critical shifts in economic policies, inequitable wealth distribution and global oil recession are some of the reasons for the downward trend in economic growth.

Over the years, the level of poverty in the country has deepened. Estimates show that in 2000, about 66% of Nigerians lived below the poverty line of one US dollar per day compared to 43% in 1985.² Most households spend two-thirds of their income on food alone, while the poorest households spend up to 90%. The gap between the poor and rich has also widened, with marked inequalities existing in the society. For example, the poverty index is lowest in the southeast and highest in the northwest; also, 48% of the rural population and 54% of the urban population have access to safe water while 44% of the rural population and 53% of the urban population have access to sanitation. The poverty level is augmented by low literacy. According to 1999 MICS³ data, the overall adult literacy rate is 49%, a decline from 57% in 1990; female literacy declined from 44% in 1990 to 41% in 1999. The average literacy rate in sub-Saharan Africa is 57%.

Over three decades of political instability and concomitant economic decline have contributed to deterioration in the socio-economic situation, infrastructure and productive sector. Over all, the socio-demographic, political and economic challenges arising from the increased population, widespread poverty, low literacy level, urbanization and related rural-urban migration will determine the burden of disease in the country and the effectiveness of the health system.

2.4 Development policies

Revamping the Nigerian economy is a major priority of the present democratically elected government which has identified corruption and good governance as urgent issues to be addressed by the recently established Anti-Corruption Commission. It has also acknowledged that poverty is widespread and requires national poverty alleviation strategies which include a PRSP and the creation of the National Poverty Eradication Programme (NAPEP). Furthermore, the government has embarked on some reforms and has guided deregulation in order to create room for competition and thus revamp the economy. There is, however, a need for the health sector to actively participate in the formulation and implementation of PRSPs as ill-health and poverty are closely related. A number of policies and initiatives exist: the National Population Policy, Nutrition Policy, National Policy on Women, Universal Basic Education Programme and Micro Credit Scheme. These are designed to upgrade the general well-being of the population and thus enable them to have improved access to basic health care. The UBE programme aims to provide secondary as well as primary education for all Nigerian children. The NAPEP will work within the framework of the PRSP to rationalize institutions as well as coordinate implementation and monitoring of relevant schemes and programmes at all levels of government.

2.5 Health profile

²Consumer Expenditure Survey. Federal Office of Statistics, 1996.

³FOS Multiple Indicator Cluster Survey, 1999.

Demographic data are not very reliable in Nigeria. Data obtained from various census exercises, vital registration and sample surveys are often inaccurate and sometimes contradictory. However, there is evidence that the key health indicators have either stagnated or worsened. Life expectancy dropped from 53.8 years for females and 52.6 years for males in 1991 to 48.2 years for females and 46.8 years for males in 2000. The infant mortality rate (IMR) rose from 87.2 per 1,000 live births in 1990 to 105 in 1999. About 52% of under-five deaths are associated with malnutrition. The maternal mortality rate (MMR) of 800 per 100,000 live births is one of the highest in the world. This could be attributed to the shortage of skilled medical personnel at the primary health care level. For example, in a recent survey⁴ only 41.9% of primary health facilities provide antenatal and delivery services and 57.73% of such health facilities work without any midwife. Furthermore, 18.03% of such facilities operate without midwives or senior community health extension workers (SCHEWs). With disability adjusted life expectancy (DALE) of 38.3 years and the rank of 187 in the World Health Report 2000, the performance of the Nigerian health system is worse than many sub-Saharan countries. There is thus an urgent need to support the health system with adequately trained personnel in order to improve provision of the health services.

Disease prevalence rates include malaria, 919/100,000; dysentery, 386/100,000; pneumonia, 146/100,000; measles, 89/100,000. In 2001, there were 250,000 new cases of tuberculosis detected. The national median prevalence rate of HIV is 5.8%. Over 40 million Nigerians are exposed to onchocerciasis; 20 million are infected and about 120,000 have gone blind from the disease. Schistosomiasis is prevalent in rural areas which lack potable water, and control of the infection has been limited by the high cost of the drug of choice. All these diseases combine to cause high morbidity and mortality in the population.⁵

Nigeria continues to suffer outbreaks of cholera, cerebrospinal meningitis, measles, yellow fever and Lassa fever with significant human losses due to weak emergency preparedness and response mechanisms. Between 1987 and 1994, Nigeria experienced 17 severe yellow fever epidemics. Cholera outbreaks were recorded between 1996 and 1997, affecting more than 18 states and claiming over 10,000 lives. Sporadic complex emergencies from petrol explosions, floods and civil unrest are becoming common occurrences with significant human and material losses. The Integrated Disease Surveillance System will need to be strengthened for both communicable and noncommunicable diseases, while emergency preparedness and response mechanisms will need to be put in place.

There is growing incidence and prevalence of noncommunicable diseases such as hypertension, coronary heart disease, diabetes and cancer as well as illnesses related to stress, behaviour and lifestyle. In 1989, a nationwide survey revealed that 3.5 million people had mild hypertension, 1.2 million had moderate hypertension and 0.5 million had severe hypertension. The prevalence of hypertension is generally estimated at 8–10% for rural and 10–12% for urban communities. The proportion of smokers is 9%, and the prevalence of diabetes mellitus is 2.75%.⁶

Genetic diseases such as sickle-cell anaemia and, glucose-6-phosphate dehydrogenase affect an appreciable proportion of the population. In Nigeria, 2–3% of the population have sickle-cell disease, while the prevalence of glucose-6-phosphate dehydrogenase is estimated at 18% for males and 7% for

⁴Nigeria Reproductive Health Services and Manpower Survey (2001). Reproductive Health Division, Federal Ministry of Health, Abuja, Nigeria.

⁵FMOH, NHMIS (Preliminary Health Profile Figures), 1999.

⁶Health Systems Development Project II. FMOH, Abuja, 1989.

females. Control efforts in respect of noncommunicable diseases have generally received little attention in the country.

In recent years, Nigeria has responded positively to global initiatives such as Roll Back Malaria (RBM), HIV/AIDS control, Polio Eradication Initiative (PEI), directly-observed treatment short-course (DOTS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Notable progress has been made towards eradication of guinea-worm disease, resulting in a decrease in the number of cases from over 600,000 in 1989 to about 13,000 per year in the late 1990s. In addition, Nigeria has reached the WHO leprosy elimination target of less than one case per 10,000 population.

For some of these initiatives, national level strategies and plans have been developed. However, there is need to develop state level plans that will make the national plan operational. There is a need to sustain the focus of disease prevention and eradication programmes and scale up various planned interventions in order to serve more and more of the population.

2.6 Health system challenges

The poor state of Nigeria's health system is traceable to several factors: organization, stewardship, financing and provision of health services. These have been compounded by other socioeconomic and political factors in the environment.

The overall availability, accessibility, quality and utilization of health services decreased significantly or stagnated in the past decade. Available data from the FMOH indicate that in 1999, there were 18,258 registered PHC facilities, 3,275 secondary facilities and 29 tertiary facilities across the country. The public sector accounted for 67% of PHC facilities, 25% of secondary facilities and all but one of the tertiary facilities.⁷

The proportion of households residing within 10 kilometres of a health centre, clinic or hospital is 88% in the southwest, 87% in the southeast, 82% in the central, 73% in the northeast and 67% in the northwest regions. However, the fact that health facilities physically exist does not mean that they function. Most of them are poorly equipped and lack essential supplies and qualified staff. In particular, the coverage of critical PHC interventions such as immunizations and access to safe water and sanitation has declined, and marked inequalities exist between the regions, the rich and the poor, and rural and urban areas.

The organization of health services in Nigeria is pluralistic and complex. It includes a wide range of providers in both the public and private sectors: private for profit providers, NGOs, community-based organizations, religious and traditional care providers.

The National Health Policy (1998)⁸ is based on the national philosophy of social justice and equity. Primary Health Care (PHC) is the cornerstone of the health system. The policy provides for a health system with three levels: primary, secondary and tertiary. The policy also spells out the functions of each tier of government and provides for the establishment of the advisory National Council on Health chaired by the Federal Minister of Health (the Minister of State for Health and State Commissioners of Health are members). Other organs set up by the policy include the State Health Advisory Committees and Local Government Health Committees. Their potential has not yet been fully realized. As part of the

⁷Children's and Women's Rights in Nigeria: A Wake up Call Situation Assessment and Analysis. UNICEF, 2001.

⁸National Health Policy. FMOH, 1998.

health sector reform process, there is a need to review the functions of these organs in order to maximize their use.

According to the National Health Policy, the federal government is responsible for policy formulation, strategic guidance, coordination, supervision, monitoring and evaluation at all levels. It also has operational responsibility for disease surveillance, essential drugs supply and vaccine management. In addition, it provides specialized health care services at tertiary health institutions (university teaching hospitals and federal medical centres). These serve as referral institutions for the secondary health facilities.

At the lower level, the states and LGAs share responsibility for health care. States largely operate secondary health facilities (general hospitals and comprehensive health centres), providing mostly secondary care and serving as referral level for the LGAs which provide the essential elements of PHC. Operationally, the decentralized health structures of the federal government are in the states, while those of states are in the LGAs. Some states build and operate tertiary facilities or specialist hospitals.

While the federal government is responsible for the management of teaching hospitals and medical schools for the training of doctors, the states are responsible for training nurses, midwives and community health extension workers (CHEWs). The LGAs provide basic health services and manage the PHC facilities which are normally the first contact with the health system.

Some parastatals exist within the health system. The National Agency for Food and Drug Administration and Control (NAFDAC), National Primary Health Care Development Agency (NPHCDA), National Programme on Immunization (NPI), Nigerian Institute for Medical Research (NIMR) and National Action for Prevention and Control of AIDS (NAPCA) were created to deal with priority health issues. Overall, the roles of the different parastatals of the public sector are not well delineated, and activities need to be coordinated in order to avoid overlapping of efforts.

As in other sectors, the federal governance arrangement constrains the leverage that the Federal Ministry of Health (FMOH) has over the State Ministry of Health (SMOH). For instance, FMOH cannot compel SMOH to implement some health policies and programmes. This makes stewardship of the health sector very challenging. Consequently, the gap between policy formulation by the FMOH and implementation by states and LGAs is wide.

2.7 Health financing

Financial resources for health in Nigeria come from a variety of sources, including budgetary allocations from government at all levels (federal, state and local), loans and grants, private sector contributions and out of pocket expenses. The value of contributions from the private sector and out of pocket expenditure is yet to be determined.

According to a World Bank source, per capita public spending for health is less than US\$ 5 and is as low as US\$ 2 in some parts of Nigeria. This is far below the US\$ 34 recommended by WHO for low-income countries. The reduction in health spending in the late 1980s was due to the Structural Adjustment Programmes (SAPs) which de-emphasized spending on health and social services. At its lowest point in 1989, federal government health expenditure was 77% less in real terms than it was at the height of the oil boom in 1980. Though there was some recovery in the 1990s, health expenditure in 1999 was still 32% less than in 1980.

In per capita terms, the decline in health expenditure was even more precipitous, 82% between 1980 and 1989 and 57% between 1980 and 1999, due to continued rapid population growth. Although the federal government recurrent health budget showed an upward trend from 1996 to 1998 and 1999 to 2000, available evidence indicates that the bulk of this expenditure goes to personnel. Recurrent health expenditure as a percentage of total federal recurrent expenditure was 2.55% in 1996, 2.96% in 1997,

2.99% in 1998, 1.95% in 1999 and 2.5% in 2000.⁹ This is an indication that the bulk of government funding is still not to the health sector.

In an effort to mitigate the low per capita funding to health, the government has embarked on a series of initiatives such as revolving fund schemes for some services in hospitals and the National Health Insurance Scheme. The government will need to initiate debate on health financing with a view to developing a national policy on this issue.

Donor assistance for the health sector also experienced a decline during the 1990s. External funding declined when many bilateral donors, including the United States and the United Kingdom, stopped aid in response to the anti-democratic military regime. While UN agencies continued to provide modest assistance to the health sector throughout the 1990s, wider donor assistance did not resume until the return to civilian government in 1999.

2.8 Health policy context

The National Health Policy is based on the fundamental principles of the second National Development Plan 1970–1974 which describes five national goals: a free and democratic society; a just and egalitarian society; a united, strong and self-reliant nation; a great and dynamic economy; a land of bright and full opportunities for all citizens. The policy states that health development shall be seen not solely in humanitarian terms but as an essential component of the package of social and economic development as well as being an instrument of social justice and national security.

Under the leadership of the current democratic government, the Health Sector Reform (HSR) Plan of Action is being developed to guide investments and actions by all levels of government, the private sector, donors and all development partners in health. The Plan of Action maps out medium-term objectives in seven strategic intervention areas: primary health care, disease control, sexual and reproductive health including STIs/HIV/AIDS, secondary and tertiary care, drug production and management, coordination of development partners, organization and management. A dynamic policy process involving extensive consultation among all the levels of government is already being pursued in order to build consensus around health policies. The FMOH has created the Division of International Health to coordinate development aid to the health sector and the Forum of Ministers and Heads of International Agencies has also been established.

3. Development Assistance

3.1 Introduction

With the return of the country to democratic governance in 1999, and the subsequent lifting of economic sanctions, donor interests in Nigeria have increased. This is likely to reverse the declining

⁹Central Bank of Nigeria: Annual Reports and Statement of Accounts, 1972–2000.

trend in external assistance and hence lead to an improvement in the Nigerian economy. In particular, total external assistance, which was estimated at US\$ 375.1 million in 1994, declined to US\$ 83.4 million in 1998 and rose by 87% to US\$ 156.0 million in 1999 and to US\$ 185.9 million in 2000.¹⁰

The percentage of total external assistance to the health sector was 4.0% in 1994, 21.7% in 1996, 3.0% in 1998 and 19.8% in 1999. There is some indication that there will be significant increase of government funding to health because of the pledge by African leaders to increase their health budgets to 15% of annual budgets. The amount of external assistance to the health sector is already increasing, though it is likely to remain a small proportion of overall and public health expenditures. Despite limited external assistance to health budgets, health and development agencies provide significant support for programme funding.

3.2 Major contributors

There are 17 UN agencies in Nigeria, six of which provide support to the health sector: World Bank, UNDP, UNFPA, UNICEF, UNODCCP and WHO. The World Bank is developing two large health related project loans: Health Systems Development Project II and a cross-sectoral HIV/AIDS project. UNDP maintains a focus on poverty reduction activities and coordinates United Nations operational activities in the country.

UNICEF continues to focus on rights of children and issues related to child health. UNODCCP focuses on prevention of drug abuse and related issues, UNFPA spearheads population issues, UNIFEM promotes gender mainstreaming, FAO promotes food security and UNHCR is concerned with protection of refugees while UNAIDS collaborates with other members of the UN theme group on HIV/AIDS to scale up joint activities.

The EU and ADB are also increasing their interest in Nigeria. The EU and the federal government have an agreement to revitalize the PHC system with emphasis on immunization services, especially polio eradication.

There are many bilateral agencies active in the health sector, the main ones being DFID, USAID, CIDA and JICA. The scope of activities of these partners in Nigeria is determined by a common understanding of country priority needs, the specificity of each partner's mandate and the amount of funds available. It is important to note that in addition to direct funding to the government, the bilateral agencies also channel funds through some UN agencies, including WHO, for health related projects.

A sizeable number of local and international NGOs are operating in the Nigerian health sector. During the last decade, NGOs were the preferred channels for the flow of external funding into the country. This trend has reverted in favour of direct bilateral and multilateral assistance to the government. The private sector also supports the health sector to a great deal.

3.3 Aid instruments

Aid to Nigeria has been through Investment Project Assistance, Free Standing Technical Cooperation (FTC), and concessional loans and grants. Investment Project Assistance remains the major source of external assistance to Nigeria, contributing 52.4% in 1997, 56.5% in 1998 and 58.2% in 1999. Government macroeconomic reforms attracted some support to programme budgets that amounted to 1.4% of external assistance in 1998.¹⁰

¹⁰Federal Republic of Nigeria: Development Cooperation 1998/1999 Report, National Planning Commission, March 2001.

Many agencies are currently reviewing their operational strategies. Discussions are on-going; for example, the World Bank is providing assistance under a basket financing approach for some programmes such as HIV/AIDS and a loan of US\$ 237 million under concessionary terms to be repaid over 40 years with no interest charged.

Some agencies have changed the emphasis in their assistance portfolios. Most of them are moving from inputs to better outputs and outcomes. They also provide support to policy, monitoring, institutional development and service delivery, taking into account demands as well as supply factors in programme design.

In an attempt to be more focused and effective, several operational modalities are emerging to avoid duplication and overlap between agencies. For example, the alliances on key public health challenges such as PEI, RBM, IMCI, HIV/AIDS, GAVI and GFATM are likely to change the way external agencies work in the Nigerian health sector.

It is widely agreed among development agencies and the government that assistance should occur at more than federal level. Agencies therefore need to maintain a balanced presence at all government levels. For example, the EU is focusing its programme support (2001–2007)¹¹ to six states (Osun, Cross River, Abia, Plateau, Gombe, Kebbi) while DFID is in four¹² (Ekiti, Benue, Jigawa, Enugu), UNFPA in 12 (Ogun, Osun, Abia, Anambra, Rivers, Delta, Edo, Borno, Gombe, Bauchi, Nassarawa, Plateau), UNICEF in 22 selected states for water and sanitation, UNDP and FCT in all 36. WHO presence at state level offers opportunity for closer collaboration with these agencies to support programming and delivery of services to the population.

3.4 Donor coordination

The federal government and various external agencies largely agree on the key health and health system problems. This consensus has formed the basis of collaboration. There is, however, a commonly expressed desire from the agencies to provide more coordinated support coupled with consistent health policy advice. This has proved to be largely dependent on improvement of horizontal and vertical information sharing between not only different agencies at country level, but also at the respective agency headquarters levels.

Coordination of aid assistance takes place between government levels, between government and donors, and between donors. The National Planning Commission (NPC) has the statutory responsibility for coordination and management of all technical and financial assistance to Nigeria. The Federal Ministry of Finance and Ministry of Foreign Affairs provide support to NPC. Government-donor coordination is handled by NPC for assistance from UNDAF, ADB, EU, bilateral donors and NGOs, while the Federal Ministry of Finance takes charge of activities of the Bretton Woods Institutions.

At the state government level, the State Planning Commission or State Ministry of Finance is responsible for coordinating the use of external assistance and providing linkage between LGAs and the federal level. In the past, the use of development assistance was dominated by federal government agencies. Coordination therefore involved only federal agencies. With decentralization of programme support, the need for coordination at all government levels has become imperative.

¹¹Nigeria – European Community Country Support Strategy and Indicative Programme for the period 2001–2007.

¹²Nigeria: Country Strategy Paper. DFID, 2000.

The WHO programme of cooperation is principally negotiated with FMOH. As the new focus will involve ministries other than health, there is need for WHO to adapt negotiation and coordination mechanisms to this new reality.

For donor-donor coordination, a two-tier coordination mechanism has been put in place. At the first tier, high-level decision makers provide general coordination with the participation of ambassadors, high commissioners and heads of donor agencies. The second tier involves more technical coordination for sectoral thematic areas.

At the national level, the UN family has produced the Common Country Assessment (CCA) document and is finalizing the UNDAF exercise through its theme groups: governance, health, poverty, HIV/AIDS, gender, social development and emergencies. Monthly meetings are held for information exchange among development partners.

An innovation specific to the health sector and spearheaded by WHO has been the establishment of the expanded Interagency Coordinating Committee on Health (ICC) made up of all partners in health. The Minister of Health chairs this committee. The same ICC has held meetings with state governors. In recent times, the President of the Federation has met with ambassadors and heads of agencies on health issues. WHO, UNICEF and other partners have developed an operational coordination model for NPI, TB, RBM, APOC and HIV/AIDS. There is need to create similar ICC at all levels of government for other important programmes.

A major concern is how to coordinate activities at state level and make an impact in LGAs where the majority of health related problems are encountered. The State Programme Coordination Committees require adequate support to implement and coordinate partner activities. It is hoped that with guidance and coordination from the national health authorities, all health partners will be able to allocate resources equitably to various levels of the health system.

In conclusion, with the rapid growth in the number of development partners (bilateral, multilateral, CBOs, national and international NGOs) and the proliferation of cross-sectoral initiatives, the role of the government as the overall coordinator of all development efforts is imperative.

4. Current WHO Country Programme

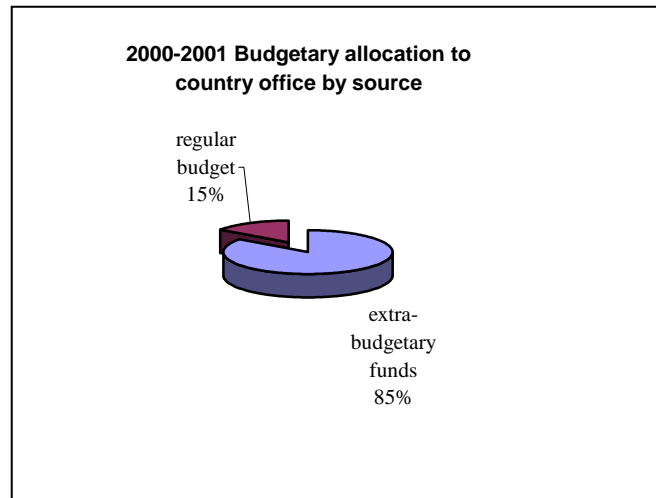
Nigeria became a member of the World Health Organization in 1960 and signed the Basic Agreement in 1962. Over the last four decades, WHO has worked in close collaboration with the Nigerian government, mainly with the Federal Ministry of Health, to establish a wide array of collaborative programmes. Given the fact that many key determinants of health are multisectoral, there is a need to adapt the Basic Agreement and take advantage of strengths and opportunities that are emerging in the environment.

In the mid-1980s in compliance with regional consensus, Nigeria adopted the three-phase health development scenario. This subsequently stimulated the development of the National Health Policy (1988) which gave the FMOH the responsibility of formulating policies, setting standards, issuing guidelines, monitoring and evaluating health programmes. The SMOHs offer technical advice and supervision to the LGAs who implement PHC at operational level. Over the years, the roles of the three government levels began to overlap with the result that the FMOH directly implemented programmes at state and LGA levels. This reduced the development of lower level technical capacity to plan and effectively execute health programmes.

4.1 Country office operations

The main WHO country office is currently located in Lagos with the Support Team structured according to priority programmes. The office has evolved from a handful of international experts in the 1970s to a larger team of national experts. Currently, there are 270 staff, including more than 60% technical staff and five international staff.

The country office operates on the basis of a biennial programme of cooperation which takes into account national health priorities as well as WHO regional and global orientations. In 2000/2001 the regular budget was US\$ 3.5 million with an extra-budgetary allocation of about US\$ 20 million. For 2002/2003 the regular budget is US\$ 4.2 million. In addition, extra-budgetary funds arising from current global initiatives on polio, HIV/AIDS, GAVI, GFATM, etc. have greatly increased the amount of resources available to the country. This has been particularly important in sustaining current country level operations and bringing greater visibility to WHO.



A network of offices has been established in all 36 states and the FCT to provide appropriate and accessible technical support to states and LGAs. The opportunities and resources arising from extra-budgetary funds facilitated this move to state level. While collaboration with stakeholders and partners as well as the visibility of WHO at state level have improved, there is need to institutionalize and sustain current operational mechanisms.

WHO presence in the states is highly imperative due to the huge size of the country, the complex semi-autonomous government administrative structures and the evolving coordination mechanisms among programmes and development partners.

The relocation of the federal capital, embassies and international institutions to Abuja and the near completion of UN House have also made the relocation of UN agencies very imminent. While liaison between the FMOH and members of the UN family will be facilitated, relocating the WHO country office must be well planned and executed.

4.2 WHO support in the country

Over the years, WHO has intensified its cooperation in the areas of disease prevention, eradication and control; health systems and community health; sustainable development and healthy environment; social change and mental health; health technology and pharmaceuticals; evidence and information for policy.

Currently, there are 23 WHO Areas of Work in Nigeria. These are emergency preparedness and response; evidence for health policy; resource mobilization, external cooperation and partnerships; communicable diseases surveillance; communicable diseases prevention; malaria; tuberculosis; HIV/AIDS; immunization and vaccine development; surveillance, prevention and management of noncommunicable diseases; tobacco; nutrition; food safety; health promotion; mental health; child and adolescent health; making pregnancy safer; women's health and development; sustainable development; health and environment; essential medicines access, quality and rational use; blood safety and clinical technology; and organization of health services.

WHO support to Disease Prevention, Eradication and Control covers the prevention of vaccine-preventable diseases, the control of locally endemic and epidemic diseases as well as diseases earmarked for elimination and eradication. In the 2000-2001 biennium, up to 43% of the regular budget and 77% of the total allocation, including extra-budgetary funds, was spent on this area. Even though over 96% of the country office resources are primarily attached to activities in these areas, cooperation and team spirit allow staff and programme resources to be available to others.

Notable achievements include the strengthening of integrated disease surveillance and early detection and response to epidemics. Most of the major disease control programmes, including noncommunicable diseases, have developed their policies and strategic plans. Routine immunization coverage, however, is low, and several rounds of NIDs had to be undertaken to increase OPV coverage and achieve polio eradication. A renewed emphasis is still required in the scaling up of IMCI, HIV/AIDS, TB, routine immunization and NCD activities.

Health Systems and Community Health activities focus on strengthening district health systems; developing human resources for health at all levels; promoting reproductive health, school health, adolescent health and women's health. Up to 34% of the regular budget or 13% of the total budget was spent on activities in these areas in the 2000-2001 biennium. WHO support includes policy and technical advice as well as national capacity building aimed at improving policy development as well as programme planning, implementation, monitoring and evaluation.

The weak and fragmented health systems as well as high MMR are major concerns for the country. It is highly imperative for WHO to facilitate and expedite the Health Sector Reform (HSR) process as well as continue to support the development of strategies and tools for the promotion of women's health, school and adolescent health and making pregnancy safer. Two technical staff members coordinate these activities.

WHO support to Sustainable Development and Healthy Environment includes environmental health promotion, poverty and health, emergency preparedness and response, occupational health, nutrition and food safety. In the 2000-2001 biennium, only 8% of the regular budget or 4% of the total budget was spent on this area which presently does not have a full-time programme officer attached to it. Although WHO demonstrated its comparative advantage in emergency response and supported the training of occupational health and safety officers nationwide, much work remains to be done to integrate poverty and health as well as the promotion of healthy environment.

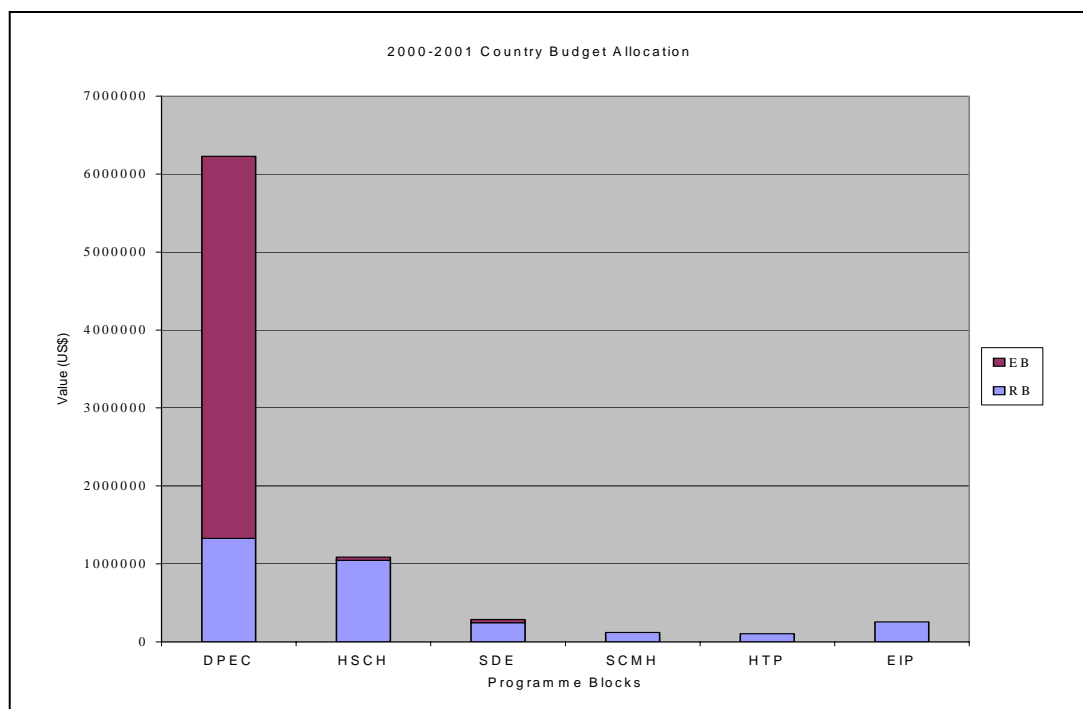
The Social Change and Mental Health area includes health promotion. Not more than 4% of the regular budget or 2% of the total budget was devoted to this area in the 2000-2001 biennium. WHO supported the development of a National Health Promotion Policy and Plan of Action and provided training to over 260 health educators. Work on mental health has just started. There is a need to document the mental health profiles for the country.

Under the Health Technology and Pharmaceutical area, WHO actively supports promotion of rational prescription and use of drugs, as well as training in essential drug prescription and management. In this era of HIV/AIDS, more efforts need to be put into promoting safe blood and blood products and

improving blood transfusion services countrywide. Another major challenge is strengthening effective regulatory mechanisms for the control of fake and substandard drugs as well as traditional medicine. In the 2000–2001 biennium, 3% of the regular budget or 1% of the total operational budget was devoted to these activities. One programme officer is responsible for coordinating activities in this area.

Activities in Evidence and Information for Policy aim at strengthening the National Health Management Information System (NHMIS) with a view to enhancing policy, planning, monitoring and evaluation at all levels of the health system. Further effort should go into institutionalizing and improving the quality of routine data collection, analysis and dissemination. In the 2000–2001 biennium, 8% of the regular budget or 3% of the total budget was spent on this area. Two technical officers coordinated activities.

The figure below presents the proportion of the 2000–2001 budget spent on each activity area described above.



4.3 WHO regional and headquarters support

WHO regional and headquarters support to Nigeria has been in the areas of policy and technical advice, research and development, information sharing and national capacity building. Appreciable financial and technical support have also been given to Nigeria towards the eradication or elimination of vaccine-preventable diseases, particularly poliomyelitis, TB, leprosy and guinea-worm disease. Furthermore, with support from WHO regional and global programmes, Nigeria has developed a substantial network of collaborating centres in the areas of community-based experience service, virology, reproductive health, traditional medicine, neuropsychiatry, oral health, health education, orthopaedic services and reference services to other African countries.

WHO capacity building efforts in Nigeria also bring essential dividends to the Organization through the many trained Nigerian health professionals presently providing consultancy services to other countries within the African region and beyond.

5. WHO Corporate Policy Framework: Global and Regional Directions

WHO has been - and is still - undergoing changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges. This organizational change process has, as its broad frame, the WHO Corporate Strategy.¹³

5.1 Goal and mission

The mission of WHO remains “the attainment by all peoples of the highest possible level of health” (Article 1 of WHO Constitution). The Corporate Strategy and the Policy Framework for Technical Cooperation with Member Countries of the African Region outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

5.2 New emphases¹³

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

- (a) adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;
- (b) playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;
- (c) triggering more effective action to improve health to reduce inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;
- (d) creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

5.3 Strategic directions¹³

On the basis of these new emphases, WHO has set out four strategic directions for its contribution to building healthy populations and combating ill-health. These strategic directions, which are interrelated, provide a broad framework for the technical work of the Secretariat:

- (a) reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
- (b) promoting healthy lifestyles and reducing risk factors to populations;
- (c) developing health systems that equitably improve health outcomes, respond to peoples’ legitimate demands and are financially fair;
- (d) developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

5.4 Core functions¹³

¹³WHO EB105/3. A Corporate Strategy for the WHO Secretariat.

The list of WHO core functions presented below is based on the comparative advantage of the Organization at all levels:

- (a) articulating consistent, ethical and evidence-based policy and advocacy positions;
- (b) managing information, assessing trends and comparing performance of health systems; setting the agenda for and stimulating research and development;
- (c) catalysing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;
- (d) negotiating and sustaining national and global partnerships;
- (e) setting, validating, monitoring and pursuing proper implementation of norms and standards;
- (f) stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health-care management and service delivery.

5.5 Global and regional priorities¹⁴

In order to be more effective and efficient in its interventions, the Organization has selected a limited number of global priorities on which to focus over the four-year period (2002–2005). The global priorities selected on the basis of these criteria are: malaria, HIV/AIDS and TB; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco; maternal health; food safety; mental health; safe blood; and health systems.

The WHO African Region¹⁵ is facing enormous health challenges in relation to health. The WHO Regional Office for Africa has decided to focus its attention on 12 priorities closely related to the 11 global priorities but adapted to the regional context. These priorities are: HIV/AIDS; tuberculosis; malaria; maternal health; child and adolescent health; strengthening of health systems; blood safety; humanitarian and emergency action; health promotion; noncommunicable diseases control, including mental health; and poverty and health.

5.6 Making WHO more effective at country level

The expression of WHO Corporate Strategy at country level will vary from country to country. Taking into consideration country-specific health and development challenges, the involvement of other external partners, current WHO work in and with the country, and the global and regional policy frameworks, WHO will look at balancing the key functions at country level. This means that the Organization will act more as adviser, broker and catalyst and will involve itself in routine implementation in case of specific, clearly identified initiatives with a time-limited perspective. A classification of WHO functions at country level has been developed based on the broader core functions presented above.

The specific functions at country level are:

- (a) supporting routine long-term implementation;
- (b) catalysing adoption of technical strategies and innovations; country-specific adaptation of guidelines; and overseeing large-scale implementation;

¹⁴WHO: General Programme of Work 2002-2005.

¹⁵The Work of WHO in the African Region, Strategic Framework 2002-2005.

- (c) supporting research and development; policy experimentation; development of guidelines; stimulating monitoring of health sector performance; and trends assessment and anticipation;
- (d) sharing information; generic policy options and positions; guidelines and standards; case studies of good practice; and advocacy;
- (e) providing specific high-level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and expenditure of government and development partners.

6. WHO Strategic Agenda for Nigeria

In line with the purpose of the CCS, which is to delineate the WHO strategic role in contributing to health development in Nigeria, the CCS process provided an opportunity to seek partners' perceptions of current and future WHO roles. Such perceptions include:

- “WHO Nigeria should adopt a strategy of doing less but better”;
- “before WHO was doing things for us, now it is working with us”;
- “decentralization of WHO in Nigeria is a real revolution; it brought the Organization’s technical support closer to the people”;
- “WHO should have some poverty alleviation demonstration projects at grassroots level”;
- “WHO should be more proactive in mobilizing resources for health”;
- “WHO should act as a broker between MOH and donors”;
- “WHO is playing a key role to improve coordination among partners in health”;
- “stronger technical direction is required from WHO, especially in the area of evidence based policies and standards”;
- “WHO should identify commonalities among donors and avoid duplication”.

From the above perceptions, an analysis of health and development challenges in Nigeria and in line with WHO functions, the strategic agenda for WHO in Nigeria for the next 6 years will cover the following broad areas:

- (a) resource mobilization for health;
- (b) strengthening the health system;
- (c) scaling up priority interventions;
- (d) health promotion, sustainable development and healthy environment;
- (e) partnerships and coordination.

These areas are consistent with the government’s strategic intervention areas outlined in the Health Sector Reform Plan of Action.

6.1 Resource mobilization for health development

Increasing the current level of per capita expenditure will require substantial efforts in resource mobilization using the opportunities created by increased donor interests in Nigeria. Funding from domestic sources, all government levels as well as the private sector will need to be harnessed for rational utilization and sustainability. WHO together with other partners will continue to support advocacy for

resource mobilization at all levels of government (federal, state and local) and from the private sector in order to ensure that additional resources are allocated to the health sector. This is necessary for the health budget to meet the per capita requirement of US\$ 34–40 recommended by the Commission on Macroeconomics and Health.¹⁶

In addition, WHO will actively work with bilateral and multilateral partners and government to facilitate access to the various health fund initiatives such as GFATM and GAVI. Furthermore, WHO will work with ministries of health, finance and planning as well as other relevant bodies at federal and state levels to generate evidence about the economic burden of diseases and utilize such evidence as advocacy tools. WHO and partners will work with ministries of health and finance and various offices of statistics to audit resources to the health sector and monitor the impact of health resources on developmental goals.

6.2 Strengthening the health system

WHO will support strengthening of the health system by advocating and providing technical support to health sector reforms by:

- (a) supporting FMOH to coordinate, monitor and evaluate the implementation of the National Health Policy and give technical support to the functioning of various organs such as State Health Advisory Committees and the Local Government Health Committees;
- (b) promoting an integrated approach to health programmes within the health system through joint planning, implementation and evaluation of activities;
- (c) reviewing and refocusing WHO support in human resource development to make it more responsive to priority needs and to contribute to national capacity efforts; to do this, WHO will support the MOH and relevant agencies to develop a health human resources management system that will address skill mix requirements, strengthening the network of WHO collaborating institutions and awarding fellowships for priority training areas;
- (d) supporting stewardship function of government through capacity building and facilitating policy development for contractual arrangement of health services;
- (e) supporting the development of a national and state level health accounts;
- (f) supporting the formulation of a health financing policy that ensures fairness and financial risk protection to the poor;
- (g) strengthening the capacities of regulatory institutions to improve the quality control of both orthodox and traditional medicines;
- (h) strengthening national capacity to formulate, implement, monitor and update national drug and blood policies within the framework of the national health policy;
- (i) promoting rational drug prescription and the safe use of drugs, vaccines, blood and blood products;
- (j) promoting equitable access to essential drugs, vaccines, safe blood and appropriate health technology;
- (k) promoting intra- and inter-sectoral collaboration for health and interagency coordination mechanisms at all levels;

¹⁶Macroeconomics and Health: Investing in Health for Economic Development – Report of the Commission on Macroeconomics and Health (WHO, 2001).

- (l) supporting national health management information systems, linkage to community based information systems and dissemination of health information;
- (m) facilitating sharing experiences, evidence-based best practices and the use of research findings in policy development;
- (n) strengthening national capacity in health policy analysis and health systems monitoring.

6.3 Scaling up priority interventions

Most of the priority interventions have already developed tools and strategies. The challenge is to adapt these tools and strategies to meet local realities as well as strengthening local capacities for scaling up. The role of WHO will be to make current international standards and treatment guidelines available to FMOH and promote their adaptation and adoption. Furthermore, states will be supported to develop micro plans and implementation strategies. In particular, efforts will be made to:

- (a) strengthen Integrated Disease Surveillance and Response (communicable and noncommunicable) and strengthen capacity of public health laboratories to support disease control and eradication efforts; specifically, WHO will support capacity building to harmonize and expand current surveillance system;
- (b) sustain the focus on IMCI, RBM, polio eradication and routine immunization;
- (c) provide technical leadership in HIV/AIDS prevention and control by strengthening the capacity of MOH for HIV/AIDS surveillance and provide technical support for the implementation of HIV/AIDS Emergency Action Plan (HEAP);
- (d) support the expansion of DOTS/TB services;
- (e) advocate for making pregnancy safe and other women's health and development initiatives;
- (f) support capacity building for the implementation of adolescent health strategy;
- (g) advocate for scaling up the noncommunicable diseases programme;
- (h) strengthen the emergency preparedness and response capacity within and around the country through provision of logistics and training support;
- (i) assist in the establishment of a national mental health profile and support the development of mental health policy and programmes;
- (j) support the development of a psychosocial rehabilitation strategy and strengthen the capacity for implementation of rehabilitation programmes targeting victims of man-made and natural disasters.

6.4 Health promotion, sustainable development and healthy environment

Additional roles of WHO are to:

- (a) promote healthy cities, healthy villages and healthy workplace programmes;
- (b) support the implementation of the African Regional Strategy in Health promotion and facilitate the integration of health promotion into disease control and community health programmes
- (c) support the review and update of public health laws;
- (d) support improvement of the national nutrition programme and surveillance system;
- (e) support the generation of evidence on health and poverty linkages;

- (f) strengthen the poverty reduction and gender dimensions of priority health programmes;
- (g) advocate for the mainstreaming of health into the plans and activities of other ministries and agencies whose activities impact on health such that good health can be seen as an input for development as well as a result of development.

6.5 Partnerships and coordination

WHO will carry out these strategic agenda activities in partnership with bilateral, multilateral and international agencies. This will necessitate building new partnerships and fortifying existing ones. Using its comparative advantage as an international agency with a global mandate on health, WHO will engage partners in dialogue on regional and global strategies. WHO will encourage linkages with other sectors by advocating for the mainstreaming of health into their activities and stress the fact that investments in these sectors do have a lasting impact on health and that adequate investments should be made in such sectors.

WHO will work with FMOH to broaden the partnership with NGOs and CBOs as vehicles to be used for the scaling up of priority interventions. In addition, WHO will advocate for the establishment of an Interagency Coordination Committee (ICC) for health at all levels. Finally, WHO will continue to play an active role in UNDAF and the UN Country Team as well as support the Ministry of Health to coordinate partners in health sector.

7. From Strategy to Implementation

It is understood that the strategic agenda and subsequent shift in function will affect the work of WHO in Nigeria and have certain implications on the Organization's work at all levels.

7.1 Country office

The CCS provides a framework for the country office to enhance its role in directing and coordinating international health and better focus its work on key priorities. It will also enable WHO to better play its role as a broker and an advocacy agent for health, making the Organization and the UN more visible and accessible in Nigeria. It is recognized, however, that a period of transition will be required for making incremental changes on the status quo.

As a priority, the WHO Representative will inform the country team as well as key stakeholders on the strategic agenda and the implications arising from the CCS. Subsequently, a joint meeting between the country team and the FMOH should be held to reflect the new thrust identified in the CCS in the 2002–2003 work plans. The CCS should further influence the development of subsequent biennial plans and provide the basis for coordination and management of technical programmes.

In order to play its technical role as lead agency in health, it is imperative to establish an information centre (including web-site) in the country office and network with other information centres. WHO should also invest in appropriate communication and information technology so that information on health and development can be smoothly disseminated.

With regard to the mix of functions performed by the country office, it is expected that the present trend of providing direct support to operations will continue for some time given the ongoing disease eradication and other initiatives requiring massive efforts from WHO. It is hoped, however, that over time, the Nigerian office will achieve a balance between programme delivery and policy advice. Furthermore, there is a need to realign the country office's human resource mix to reflect the WHO strategic agenda. Specific areas requiring urgent action include poverty and health, environmental health, emergency preparedness and response.

WHO presence at state level will enhance close monitoring of WHO-supported state and LGA-based programmes as well as ensure increased interaction with those partners who collaborate directly with states or LGAs. Also, imprest accounts have been created for the state offices; this arrangement can be used to facilitate flow of funds from such partners to the funded projects at LGA levels.

While the current country office decentralization efforts are being implemented with the resources available to the country office, the medium and long term financial, infrastructure, human resource and operational implications need to be addressed to ensure their continuous functioning. The country office needs to finalize the plan and cost estimates, including the fixed and recurrent cost implications so that it can serve as a basis for resource mobilization and support phased implementation.

With regard to the relocation of the country office to Abuja, the country office will need extra-budgetary funds to meet the additional financial requirements. Given the importance of Lagos as the economic capital of Nigeria, it will be necessary to maintain the current Lagos office as a liaison as well as Lagos State office.

Substantial financial, logistics and human components in the country office at present are from resources for the polio eradication initiatives. There is need to capitalize on this, and sustaining the vision articulated in the CCS will require increases in funds during and beyond polio eradication. Also there is need to broaden the sources of funds. In the meantime, the Nigerian context presents a lot of opportunity for resource mobilization. Subsequently, there is need to increase the focus on resource mobilization while maintaining administrative systems that ensure accountability. Coupled with the need for donor coordination, it will be crucial for the country office to designate a focal point for the Resource Mobilization and External Cooperation and Partnerships Area of Work (AOW).

Furthermore, the ongoing ICC mechanisms provide a golden opportunity for closer collaboration with stakeholders and partners thus minimizing possible overlapping of efforts and opening new avenues for resource mobilization. The country office should therefore continue to participate actively and commit technical and logistic support to the ICC Secretariat in order to ensure its functionality.

The country office needs to document results and demonstrate that WHO as an organization is making a difference in the health of the people of Nigeria. In addition, it will implement the strategy for the promotion of its image through technical support to World Health Days, launching and dissemination of the World Health Report, supporting Healthy City, Healthy Village, Health-promoting School initiatives and disseminating information on major health events in the world.

In the medium term, the country office will need a complete review of the organizational structure to reflect the various programmes and conduct an administrative and programme audit. Based on the audit findings, a human resource development plan aimed at filling gaps in the various programmes should then be developed to guide the process of human resource strengthening in the office. To maintain the WHO comparative advantage in Nigeria, a mix of highly experienced NPOs and international experts is needed to meet the challenges of decentralization.

An internal note and a six-year (2002–2007) plan have been developed to operationalize the CCS. Finally, the country office should monitor and report on the progress of the implementation of the CCS on a biennial basis.

7.2 Regional office

The WHO Regional Office for Africa (AFRO) will create an enabling environment that will facilitate the organizational change and institutional development issues arising from the CCS. Bearing in mind the need for additional resources to support the implementation of issues arising out of the CCS,

AFRO will also use the document to mobilize resources for the Nigeria country office. In this regard, the CCS document will be disseminated to key donors and stakeholders in health.

In resource allocation, AFRO will continue to give priority to Nigeria bearing in mind the health system challenges. It is also clear that the decentralization of AFRO financial responsibilities has facilitated work in the country office and needs to be sustained.

7.3 Headquarters

In line with the principle of “ONE WHO”, headquarters will work with AFRO and the country office to mobilize and provide resources for strengthening technical programmes of collaboration in Nigeria. Headquarters will also work with AFRO to document lessons arising out of the CCS process and its impact on WHO work as a whole as well as in individual countries. Headquarters should make the CCS an official document through endorsement by WHO governing bodies. Finally, Headquarters will review the CCS document and use it as a basis for revisiting the WHO reform agenda.

8. Conclusion

In conclusion, it is hoped that implementation of the strategic agenda in this document will find support from all levels of the WHO as well as from all partners and stakeholders in health.

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