AfriHeritage RESEARCH PAPER 10

Evaluation of State Social Protection Programmes in Nigeria

Evaluation of State Social Protection Programmes in Nigeria

Hyacinth E. Ichoku
Nathaniel E. Urama
Emeka C Nzeh
Josephine Alumanah

JEL: D61, D63, D78, H23, H30, H31, H53, H54, H55
Keywords: Social Protection, Health Insurance, Conditional Cash Transfer, Poverty, Inequality, Nigeria

AfriHeritage Research Paper 10

Evaluation of State Social Protection Programmes in Nigeria

Published by:

African Heritage Institution (AfriHeritage)
54 Nza Street, Independence Layout
P. O. Box 2147, Enugu, Nigeria
Phone: +234 706 209 3690
Email: info@afriheritage.org
Twitter: @Afri_heritage
Facebook:www.facebook.com/pages/African-Heritage-Institution
www.afriheritage.org

First Published, December 2013

ISSN 079-

ABOUT AfriHeritage RESEARCH PAPER SERIES

AfriHeritage Research Paper Series presents technical research results from work done by the Institute and/or its affiliate scientists and researchers. The purpose is to disseminate research and analyses that informs policy debate and choices. It is directed to a professional audience and readership among economists, social scientists in government, business as well as in universities, research institutes and international development agencies. Before acceptance for publication, the Papers are subjected to rigorous independent technical reviews to assure scientific quality. AfriHeritage Research Series seeks to engender high quality scientific and intellectual discourse on key development questions, and hence, enhance strategic understanding of policy and programmatic options.

The papers bear the names of the authors and should be used and cited accordingly. The findings, conclusions and interpretations expressed in this series are those of the authors and do not necessarily represent those of AfriHeritage or of the co-sponsoring organization. By emphasizing policy-relevant and evidence-based research, the series seeks to promote scientific and intellectual discourse on crucial developmental questions and enhance understanding of policy issues.

LIST OF ACRONYMS

Acronyms	Meaning
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AU	African Union
BIG	Basic Income Guarantee
BOTs	Board Of Trustees
CBN	Central Bank of Nigeria
CBOs	Community-Based Organisations
CCT	Conditional Cash Transfer
CEO	Chief Executive Officer
COPE	Care of the Poor
CSAC	Community Social Assistant Committee
DFID	Department for International Development
DFRRI	Directorate for Food, Roads and Rural Infrastructure
DRG	Debt Relief Gains
EPRI	Economic Policy Research Institute
FCT	Federal Capital Territory
FFF	Food, Fuel and Financial
FGD	Focussed Group Discussion
GDP	Gross Domestic Product
GTZ	German Organisation for Technical Cooperation
HDI	Human Development Indicator
HIV	Human Immunodeficiency Virus
HMOs	Health Maintenance Organisations
IADB	Inter-American Development Bank
ILO	International labour Organisation
KORAN	KEKE NAPEP Owners & Riders Association of Nigerian
LGA	Local Government Area
LGAC	Local Government Assessment Committee
MCHP	Maternal and Child Health Project
MDG	Millennium Development Goal
MDGs	Millennium Development Goals
NACA	National Agency for the Control of AIDS
NAPEP	National Poverty Eradication Programme
NBS	National Bureau of Statistics
NDHS	National Demographic & Health Survey
NEEDS	National Economic Empowerment and Development Strategy

Acronyms	Meaning
NGOs	Non-Governmental Organisations
NHIS	National Health Insurance Scheme
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
PIN	Personal Identification Number
PLWHAs	People Living with HIV/AIDS
PRAI	Poverty Reduction Accelerator Investment
PRSP	Poverty Reduction Strategies Programmes
PSNP	Productive Safety Net Programme
SHIS	Social Health Insurance Scheme
SPFI	Social Protection Floor Initiative
SPS	Social Protection Strategy
SSAC	State Social Assistance Committee
TISHIP	Tertiary Institutions Social Health Insurance Plan
UNICEF	United Nations Children's Fund
VVF	Vesicovaginal Fistula
WDI	World Development Indicator

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

Estimates from the United Nation show that in most West African countries, more than half of the population live below the officially defined absolute poverty line while 20-25% have standard of living inadequate even for meeting basic nutritional needs. More so, empirical evidences point towards the poor being caught up in a web of deprivations and limited opportunities that mutually reinforce one another, making it difficult for them to climb out of poverty and hence highly vulnerable to a wide range of risks including natural disasters (droughts, floods, locusts and failed harvests), economic shocks (such as the global food price crisis), civil wars and political instability, and health shocks (including HIV/AIDS).

There is a wide variation of context within the West African countries. The landlocked countries in particular have lower gross domestic product (GDP), higher poverty rates, higher Proportions of children within their population and higher household dependency ratios. These features also tend to characterize the more arid, subsistence farming zones within the multi-zone countries such as Northern Ghana and Nigeria and throw into relief the centrality of efforts in developing strategies for the reduction of poverty and vulnerability – and thus social protection programme in these countries to protect people against risk and vulnerability, mitigate the impacts of shocks, and support people who suffer from chronic incapacities to secure basic livelihoods.

Nigeria despite large resource endowment still has more than 64 percent of the population living on less than $1 per day, relatively high Gini coefficient, and a low ranking according to the OECD Social Institutions and Gender Index (Sigi), which reflects inequalities in human capital, political representation and economic participation between women and men. According to World Bank Human Development Indicator (HDI) of 2011, Nigeria's under-five mortality rate is among the highest in the world, 142.9 per 1000 in 2010 (ranking 18th out of 193 countries) with rates varying from 87 deaths per 1000 live births for children in the highest wealth quintile compared to 219 in the lowest. High rates of trafficking, prostitution and abuse also signify concern for child protection. An estimated 3.3 million people living with HIV and AIDS, representing nearly 10% of the global burden of HIV.

These lead to a growing government and donor commitment to targeted social protection programmes in Nigeria since 2004 when the National Planning Commission, supported by the international community, drafted a social protection strategy with the goal of reducing poverty and protecting vulnerable groups through effective and sustainable risk management mechanism, thereby achieving sustainable social protection by the year 2015. Among these is the Federal government-led social protection that includes three main programmes: i) the conditional cash transfer (CCT) (funded initially through the DRG fund) targeted at households with specific social categories (those with children of school age that are female-headed or contain members who are elderly, physically challenged, or are

fistula or HIV/AIDS patients; ii) the health fee waiver for pregnant women and children under five (financed through the DRG fund); and iii) the community-based health insurance scheme.

Despite the growth in social protection programmes in the country, the high level of poverty, inequality and in general, social insecurity still continues and thus, cast doubts on the effectiveness and focus of these programmes. In line with this, ODI in conjunction with UNICEF argues that social protection in Nigeria fall short as a response to the needs of the poor, and emphasized the need for an evaluation of the social protection programmes in the country to ascertain the extent of their coverage, effectiveness, equity, efficiency and sustainability.

In response to the above, this work set forth to evaluate two government social protection programmes in Nigeria namely; the National Health Insurance Scheme (NHIS), and the Conditional Cash Transfer (CCT) programme in terms of their: Participation, Equity, Efficiency, Sustainability, thereby Profiling in depth, the programmes that meet these criteria of success and analysing the possibility of scaling up some of the successful schemes.

The National Health Insurance Scheme (NHIS) was launched in October 15th, 1999 and was recommended to take off in September 2001 with the main objectives of: ensuring that every Nigerian has access to good health care services; protecting families from the financial hardship of huge medical bills; limiting the rise in the cost of health care services; ensuring equitable distribution of health care costs among different income groups; maintaining high standards of health care delivery services within the Scheme; ensuring efficiency in health care services; improving and harnessing private sector participation in the provision of health care services; ensuring equitable distribution of health facilities within the Federation; ensuring appropriate patronage of all levels of health care; and ensuring the availability of funds to the health sector for improved services. The CCT programme on the other hand was launched in December 2007, in the name Care of the Poor (COPE) as a component of the State's Social Safety Net programme, supervised by the National Poverty Eradication Programme (NAPEP) with the main objectives of breaking intergenerational transfer of poverty through human capacity development.

The study involved the collection and analysis of primary data through interviews and focus Group discussion from three states in the country and the federal Capital Territory, Published and unpublished documents from the offices involved in the programmes at both the federal and state level, and previous empirical studies. The interviews and focus group discussions were conducted in Abuja, Enugu, Delta, and Nasarawa state.

The findings of the study are not uniform across the sources of information. For the CCT programme, all the evidences from the NAPEP are pointing towards a well-functioning programme with large coverage, efficient and sustainable distribution of

resources. For instance, they have a report that: COPE phase I and II made over 109,210 basic school aged children who either were not in school (mostly from the Northern part of the country) or were in danger of dropping out (as in many states in the South) to be in school; improved the quality of life of participating households; and increased access to medical services of immunization/vaccination and Vit 'A' supplementation among children of 0-5 years of age from participating households. As of 2010, the national coordinator of NAPEP said that the COPE programme have been able to reduce the number of very poor households in the country by 6,832,851 and that the total number of households reached by the programme was 21,842. This according to him amounted to 0.32% of the core poor households in need of CCT in Nigeria.

On the sustainability of the CCT programme, NAPEP highlights: insufficient fund to reach many qualified household that are yet to be reached; right targeting and selection of qualified households, which is fundamental to the success of the scheme; and mobility to reach the difficult terrains where the core poor in the communities reside as the main obstacles. They however assured that the programme despite these problems can still be sustainable through: states supplementary effort; community involvement and ownership; establishment of community and state Social Assistant Committees; and provision of life skills training to ensure independency of the participant on exit from the scheme.

Contrary to these positive reports from the NAPEP, empirical evidences and statistical reports are suggesting that the programme is not yet functioning as it ought to. For example, data from the World Development Indicator (WDI) indicates that the country is still ranking 156 out of 187 countries, with only a little increase in the country's HDI index from 0.429 in 2005 to 0.459 in 2011. The life expectancy at birth as at 2011 is 51.9 years which is even below the benchmark for low human development index. The primary school enrolment ratio that ought to be the direct effect of the programme still has its average from 2001 to 2010 as 89.5 against the low human development benchmark of 96.5. Though the reports acknowledged that the CCT programme has not been in existence for so long, they are all of the opinion that if the programme should function as it ought to, its impact should have reflected in the county's human development index.

Most of the participants and previous studies blame the poor impact of the CCT programme on poor funding and management and hence limited coverage, and excluding the poor in the programme planning, management and implementation. The participants from Nasarawa for example said that the programme lasted only for one year in their state since the state has not received any other fund from the federal government after the first one. They also reported that only 10 participants from each village were allowed to take part in the programme. This with the above statement from the NAPEP coordinator that only 0.32% of the core poor household in need of CCT have been reached by the programme is a clear indication of its poor coverage. Lack of equity in the programme is made manifest in the equality in the

distribution of the fund across the state. This is so because, equity in this case means distribution according to need and it is clear from statistics that all the states don't have equal need for CCT as both the proportion and number of core poor varies across the states.

The survey revealed a very poor result for the NHIS in all the aspect of the evaluation; coverage, efficiency, equity and sustainability. After nearly seven years of operation and more than twelve years of existence, the scheme has covered only 5.3 million Nigerians (representing just about 3.5% of the total population). Worse still, the coverage has been mainly civil servants employed by the Federal Government who in the actual sense are not in most need of the programme. The original aim of the programme is to serve for cross subsidization, where the rich and those working subsidizes the poor and those unemployed but now, only those employed are part of the programme, reducing the cross subsidization aim. Another evidence of poor coverage in the programme is in the Maternal and Child Health Project (MCHP) scheme in Bauchi, Cross-River state which was designed for 600,000 pregnant women and under-five but ended up with only 300,000, just half of the targeted participants. Inadequacies of the law setting up the scheme, the political structure of three-tier system of governance in the country, poor economic status of great proportion of the population, the distribution of medical facilities in the country, and lack of public awareness about the scheme was however identified as factors constraining participation in the scheme.

Several indicators from the survey tend to show that the NHIS has worsened rather than improved equity in the Nigerian health care system. The evidence was revealed in the distribution of Health Maintenance Organisations (HMOs), Providers, and in participation. About 1195 representing over 20% of the total 5867 accredited health facilities under the NHIS programme are located in Lagos. At the other extreme, there are states, such as Jigawa with 23 accredited facilities, Zamfara with 27, and Kebbi with 36. Analyses of the ratio of population to accredited health facility show that Jigawa, Bauchi, Lagos, and FCT has about 189072, 120000, 7543 and 2546 people to one accredited facility respectively. Kwara, Oyo, Imo and Bayelsa states has 14727, 16255, 26768, and 26615 people to one accredited facility respectively. Unfortunately, this reveals an inverse relationship between disease burden and availability of health care facilities.

On the issue of efficiency of service, most of the interviewed participants see the NHIS programme as a good dream that still has a long way to go. Some complained that the period between registration and receiving of the ID card that qualifies one to partake in the programme takes too long. Others complained that the waiting period by the enrollees in the service delivery is embarrassing, pointing towards uncontrolled number of enrollees per Hospital as the main cause. The lack of efficiency in the programme was also linked to uniform policy implementation, inadequate infrastructure and mal-distributed human resources for health care.

The survey revealed that after close to seven years of operation, neither the employer nor the employees have been asked to make their contribution towards the programme and this cast doubt on the sustainability of the programme. This is because it will lead to low capitation to the HMOs and even delay in the payment, which will in turn, lead to sluggishness or their refusal to attend to NHIS patient.

The survey show that both the NHIS and the CCT programme are highly welcomed by the masses and are seen as a good dream towards the MDG goal of alleviating poverty and ensuring good health for the people. However, the general opinion is that both of the programmes are not yet functioning as they ought to both in terms of coverage, efficiency, and equity and that both the government and the offices in charge of the programme should increase their effort towards the programme.

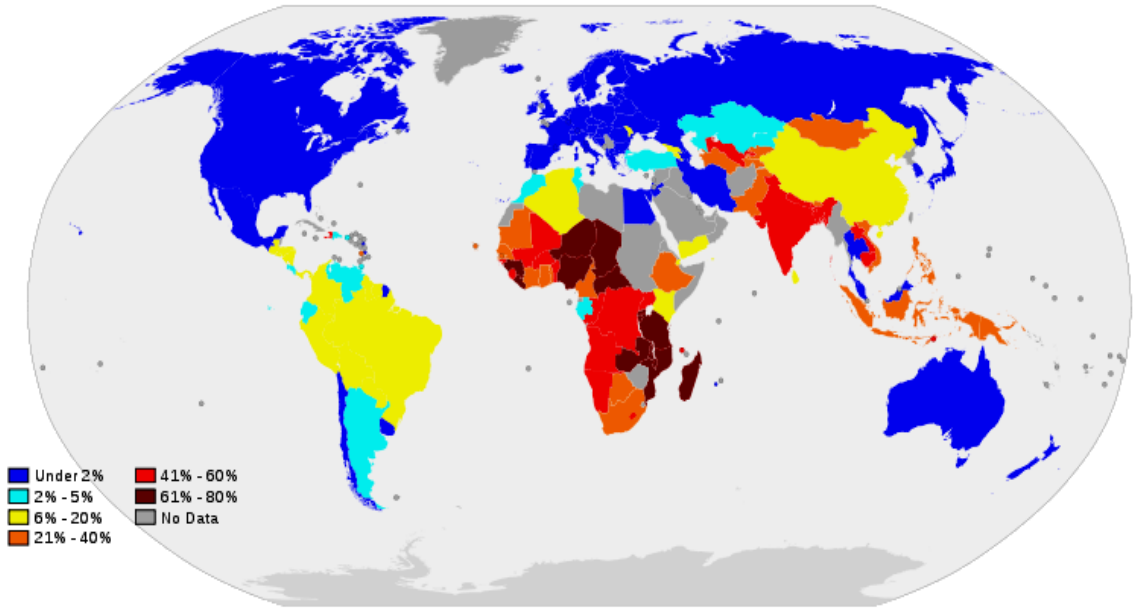
CHAPTER ONE

INTRODUCTION

1.1 Background

In many of the countries of the West African region, more than half of the population lives below the officially defined absolute poverty line while 20-25% live in extreme (food) poverty, a standard of living inadequate even for meeting basic nutritional needs. This is apparent in figure 1 below where most of the West and Central African countries (Nigeria, Niger, Chad, Central African Republic, Liberia and Guinea) rank the highest in the proportion of the population living below the poverty line of $1.25 per day.

Figure 1: Percentage population living on less than $1.25 per day 2009.svg



Source: UN Estimates 2000-2008

The poor are caught up in a web of deprivations and limited opportunities that mutually reinforce one another and make it difficult to climb out of poverty (Hodges, 2009; UNICEF, 2009; Ugoh and Ukpere, 2009; and Okoye and Onyukwu, 2007). They are also highly vulnerable to a wide range of risks which include natural disasters (droughts, floods, locusts and failed harvests), economic shocks (such as the global food price crisis), civil wars and political instability, and health shocks (including HIV/AIDS). The poor are deprived of the resources and opportunities

(assets, savings, insurance and access to credit or new forms of livelihoods) needed to cope with such risks and shocks. In short, poverty and vulnerability are inextricably inter-linked. Not only do external shocks tends to worsen the situation of the poor in the short term, but they often force the poor to resort to coping strategies that undermine still further their capacity to improve their situation in the long term. They may sell their livestock or withdraw their children from school.

Vulnerability as should be noted is not exclusively economic in nature. Social and cultural factors also play a role, and at the micro (household) level vulnerability is often a complex interplay of different factors, including gender relations, discrimination and power imbalances. Children are overrepresented among the poor and extreme poor owing to the relatively higher fertility rates among the poor (UNICEF, 2009). They, because of their age and dependence, are vulnerable to adverse intra-household dynamics, including abuse, as well as one of the greatest risks of all – the disintegration or loss of the family environment, the basic social unit for the care and upbringing of children. This is particularly important in the context of the HIV/AIDS crisis and in certain war-affected countries (Hodges, 2009). Deprivations in childhood can have life course consequences, trapping individuals in poverty and contributing to the intergenerational transmission of poverty. All these are not in line with African Charter on human and peoples' rights (1981) Article 16, on the right to physical and mental health, and article 18(4), on the rights of aged and disabled persons to special protection measures.

There is a wide variation of context within the West African countries. The landlocked countries in particular have lower gross domestic product (GDP), higher poverty rates, higher Proportions of children within their population and higher household dependency ratios. These features also tend to characterize the more arid, subsistence farming zones within the multi-zone countries such as Northern Ghana and Nigeria bordering the Sahelian countries (UNICEF, 2009). These throw into relief the centrality of effort in developing strategies for the reduction of poverty and vulnerability–and thus social protection programme in these countries.

Social protection involves policies and programmes that protect people against risk and vulnerability, mitigate the impacts of shocks, and support people who suffer from chronic incapacities to secure basic livelihoods. It can also build assets, reducing both short-term and intergenerational transmission of poverty. It includes social insurance (such as health, life, and asset insurance, which may involve contributions from employers and/or beneficiaries); social assistance (mainly cash, food, vouchers, or subsidies); and services (such as maternal and child health and nutrition programmes). Interventions that provide training and credit for income-generating activities also have a social protection component (Adato and Hoddinott, 2008).

Three concerns are often expressed about social-protection interventions: (1) they might create work disincentives and reduce informal transfers; (2) they might

compete with growth-promoting expenditures; and (3) they are unaffordable. Existing evidence, however, casts serious doubt on all three. In terms of creating disincentives or reducing informal transfers, most studies find that public transfers have modest or no effect on work effort or private transfers. The main exception is for children, where studies of conditional cash transfers have found that the programmes significantly reduce child labour, a desirable outcome. Evidence from South Africa suggests that receipt of social grants is associated with increased labour-force participation, possibly because cash makes job seeking easier (Adato and Hoddinott, 2008).

1.2 Statement of Research Problem

Many West African countries seem to lack a clear vision of their development options. It is difficult for them to plan strategically when a desire for long-term investments competes with the need for immediate alleviation of extreme hunger (BAN, 2008). The government of Nigeria in particular faces an enormous challenge: the strong economic growth (5% as at 2010) has not served to substantially reduce poverty, inequality or instability. The poverty rate doubled in the past 20 years and, although rates have decreased in recent years, report by DFID still has it that more than 100 million Nigerians, representing over 64 per cent of the population live on less than $1 per day. Close to this, Holmes *et al*, (2011 and 2012) also reports that 54 per cent of the population lives in poverty – approximately 75 million people. The *Gini* coefficient which as of 5005 was 43% is relatively high (Ortiz and Cummins, 2011). Close to half of the population works in the agricultural sector which has a poverty rate of 62.7% (Ojowu et al., 2007). Over 60% of the population is below 18 and children are represented disproportionately in poor households.

Nigeria has a low ranking according to the OECD Social Institutions and Gender index (Sigi), which reflects inequalities in human capital, political representation and economic participation between women and men. According to World Bank Human Development Indicator, (HDI), 2011, Nigeria's under-five mortality rate is among the highest in the world, 142.9 per 1000 in 2010 (ranking 18th out of 193 countries) with rates varying from 87 deaths per 1,000 live births for children in the highest wealth quintile compared to 219 in the lowest. High rates of trafficking, prostitution and abuse means that child protection is also a key concern. Also, the country has an estimated 3.3 million people living with HIV and AIDS, representing nearly 10% of the global burden of HIV (Holmes et al, 2011). These entire poverty indexes has also been worsened by the recent Food, Fuel and Financial (FFF) crises in the country with its accompanied increase in unemployment and decrease in remittances.

These lead to a growing government and donor commitment to targeted social protection programmes in Nigeria, reflected in some national Poverty Reduction Strategies programmes (PRSPs) (HelpAge and AU, 2008). Nigeria's Social Protection Strategy (SPS) was developed in 2004 when the National Planning Commission, supported by the international community, drafted a social protection

strategy. The Strategy was a follow up to a comprehensive RVA in 2002/3 and series of National and Zonal Consultations in 2003/2004. The goal of social protection in Nigeria is to reduce poverty and protect vulnerable groups through effective and sustainable risk management mechanism thereby achieving sustainable social protection by the year 2015 (National Social Protection Committee, 2005).

The government has prioritised pro-poor expenditure, especially expenditure resulting from debt relief (Debt Relief Gain (DRG)) – negotiated with the Paris Club in 2005. The DRG stipulated among its conditions that resources should be allocated to pro-poor financing of the social sector to address poverty and advance progress towards the Millennium Development Goals (MDGs). Resources from the fund have been allocated to government-led conditional cash transfer programmes (focusing on health, education and economic productivity) and a maternal and child health fee-waiver programmes, alongside supply-side interventions in health, education, water and sanitation.

A mapping of the current social protection landscape in Nigeria indicates that a significant number of actors are getting involved in funding and implementing social protection, including those from government, donors, international non-governmental organisations and civil society. Federal government-led social protection includes three main programmes: i) the conditional cash transfer (CCT) (funded initially through the DRG fund) targeted at households with specific social categories (those with children of school age that are female-headed or contain members who are elderly, physically challenged, or are fistula or HIV/AIDS patients; ii) the health fee waiver for pregnant women and children under five (financed through the DRG fund); and iii) the community-based health insurance scheme, which was redesigned in 2011 because the previous scheme had design challenges (Rebecca et al, 2011).

Despite the growth in social protection programmes in the country, the high level of poverty, inequality and in general, social insecurity cast doubts on the effectiveness and focus of these programmes. In line with this, the Overseas Development Institute (ODI) in conjunction with UNICEF in their September 2011 project briefing argues that social protection in Nigeria is falling short as a response to the needs of the poor. They said that discussions on the appropriateness of the different types of social protection programmes are limited and suggest that discussions/surveys should focus on the efficiency and equity of different types of social protection programmes in the country.

Sanubi, (2011) also identified the need for a survey on the efficiency of social protection programmes in Nigeria. He said that seven years after the introduction of NEEDS with colossal financial and material commitments made, the level of countryside poverty has remained unchanged if not worsened. Pro-poor agricultural assistance programmes to farmers, especially in terms of new seedlings, fertilizers have been hijacked by a few privileged government officials who divert supplies to private locations where they are sold for personal enrichments. Farm subsidies and

soft loans to co-operative farmers have reached fewer *original targets* than expected as imaginary co-operative societies with illusive corporate identities and comprising privileged political and government officials secure most of the these facilities than the "real targets" of the programmes.

Given the inter-linkages between social protection and other services, there is a need to promote improved institutional coordination and efficiency among a variety of actors and programmes. In the absence of an overarching framework, the existence of multiple actors at federal, state and LGA levels results in social protection programming that is ad hoc and fragmented. Weak institutional capacity at the federal level, high staff turnover and limited coordination structures are key challenges. Although the MDG office has been spearheading the social protection agenda within the MDG framework, the sustainability of this agency post-MDG DRG funding is of critical concern. There is currently no institutional lead on social protection with the requisite political authority to foster improved coherence between ministries, departments and agencies; harness political and financial commitment; or take on a coordination and leadership role to drive the agenda forward at federal and state level.

1.3 Objectives of the Study

The section on the problem statement (section 1.1) made it clear that though state social protection programmes exist in the country, the position of the country in the world rating of poverty index, health status and income inequality are very low. These statistical data are supported by imperial and practical evidences. There is therefore the need to undertake an evaluation of the state social protection programmes in the country to ascertain the extent of coverage, their effectiveness, equity, efficiency and sustainability.

This is considered critical not only for evolving a comprehensive policy of social protection in the country but also for scaling up the successful models. There is increasing recognition among many governments and donor organizations that rigorous evaluations of public interventions should feature in the social policy decision making process (Blomquist, 2003*)*. Comparative analysis of successful and less successful models of initiatives based on a priori criteria including extent of coverage, benefits, efficiency, effectiveness, equity, accountability and democratic principles, among others will help to highlight critical lessons for improvements in the design of social protection schemes in Nigeria.

The objective of this work therefore, is to evaluate two government social protection programmes namely, the National Health Insurance Scheme (NHIS), and the Conditional Cash Transfer (CCT) programme in the country.
Specifically, the study will:

- Evaluate the above social protection programmes in terms of their:
  - Participation

- Equity
- Efficiency
- Sustainability

❖ Profile in depth, the programmes that meet these criteria of success.

❖ Analyse the possibility of scaling up some of the successful schemes

The above stated objectives will be achieved through answering the following questions:

- Do the programmes or interventions directed to those it was meant for?
- Do the benefit from the programme or intervention accrued to individuals according to their need?
- Does the programme or intervention achieve the stated goals?
- Does it have unintended effects on participants?
- Are programme impacts stronger for particular groups or subsets of participants?
- Is the programme cost effective in relation to other options?
- What are likely reasons why the programme is or isn't successful?
- How can the design or implementation be changed to improve performance?

CHPATER TWO

BRIEF PROFILE OF THE SELECTED AGENCIES

2.1. National Health Insurance Scheme (NHIS)

On October 15th, 1999 the National Health Insurance Scheme was launched. The enabling law Decree 35 of 1999, (now Act 35 of 1999) was signed in May 1999. National Council on Health special meeting on NHIS held in Port Harcourt in July 2001 recommended the need for the scheme to take off. There after an Implementation Planning Committee was set up which met in September 2001 and submitted its report recommending the immediate take off of the Scheme (http://www.nhis.gov.ng).

2.1.1. The Main Objectives of the Programme

- To ensure that every Nigerian has access to good health care services
- To protect families from the financial hardship of huge medical bills
- To limit the rise in the cost of health care services
- To ensure equitable distribution of health care costs among different income groups
- To maintain high standards of health care delivery services within the Scheme
- To ensure efficiency in health care services
- To improve and harness private sector participation in the provision of health care services
- To ensure equitable distribution of health facilities within the Federation
- To ensure appropriate patronage of all levels of health care
- To ensure the availability of funds to the health sector for improved services

In order to ensure that every Nigerian has access to good health care services, the National Health Insurance Scheme has developed various programmes to cover different segments of the society and these are: Formal Sector Social Health Insurance Programme, Urban Self-employed Social Health Insurance Programme, Rural Community Social Health Insurance Programme, Children Under-Five Social Health Insurance Programme, Permanently Disabled Persons Social Health Insurance Programme, Prison Inmates Social Health Insurance Programme, Tertiary Institutions and Voluntary Participants Social Health Insurance Programme, Armed Forces, Police and other Uniformed Services.

2.1.2. Formal Sector Social Health Insurance Programme

This programme covers employees of the formal sector, i.e., the public sector and the organized private sector. It is mandatory for every organization with ten (10) or more employees.

Health Care Benefits

- Out-patient care (including consumables)

- Prescribed drugs as contained in the NHIS Essential Drugs List
- Diagnostic tests as contained in the NHIS Diagnostic Tests List
- Antenatal care
- Maternity care for up to four (4) live births for every insured person
- Post natal care
- Routine immunization as contained in the National Programme on Immunization
- Family planning
- Consultations with a defined range of specialists e.g. physicians, surgeons, etc.
- Hospital care in a public or private hospital in a standard ward during a stated duration of stay, for physical or mental disorders;
- Eye examination and care excluding prescription glasses/spectacles and contact lenses
- Dental care, i.e., pain relief and treatment
- Prostheses, i.e., Nigerian-made simple artificial limbs.

2.1.3. How the Programme Works

An employer registers itself and its employee with the Scheme. Thereafter, the employer affiliates itself with an NHIS-approved Health Maintenance Organization(s), who now provides the employees, with a list of NHIS-approved Health Care Providers (public and private). The employee registers itself and dependants with such Provider of his/her choice. Upon registration, a contributor will be issued an identity card with a personal identification number (PIN). In event of sickness, the contributor presents his/her identity card to his/her chosen Primary Health Care Provider for treatment. The contributor will be able to access care after a waiting period of thirty (30) days. This will enable the completion of all administrative processes.

A contributor has the right to change his/her Primary Health Care Provider after a minimum period of three (3) months, if he/she is not satisfied with the services being given. The Health Maintenance Organization (HMO) will make payment for services rendered to a contributor to the Health Care Provider.

The contribution to the scheme per employee is 15% of the basic salary – out of which the employer contributes 10% and the employee contributes 5%. For the employee's family it is free for the spouse and four (4) children under 18 years. For an employee who has registered less than four children at the initial registration, any additional child as they are born requires the payment of ₦500 by bank draft for printing of ID card. This addition to the family is called "Additional Dependants". The employee can also register other dependants, for example, children over 18 years, grand-parents, etc. and this is referred to as "Extra Dependants". Nine thousand Naira (₦9000) is paid for each extra dependant per year. For drugs, participants pay 10% of the total cost, but for other benefits like counselling, surgery, diagnostic test up to a limit, there is no payment (The scheme does not cover chronic diseases, for

example, cancer, HIV, TB , etc. as there are other agencies covering them {e.g. NACA for AIDS}, but could give first aid). Malaria is however covered by the scheme for AIDS patients. The scheme does not cover self-inflicted injury.

2.1.4 Payment System to the Health Care Providers

Health Care Providers under this Scheme will either be paid by capitation or fee-for-service or per diem or case payment.

a. Capitation

This is payment to a Primary Health Care Provider by the HMOs, on behalf of a contributor, for services rendered by the Provider. This payment is made regularly in advance for services to be rendered.

b. Fee-for-Service

The HMO makes this payment to non-capitation-receiving Health Care Providers who render services on referral from other approved Providers.

c. Per Diem

Per Diem fees are payments for services and expenses per day (medical treatment, drugs, consumables, admission fees, etc.) during hospitalization.

d. Case Payment

This method is based on a single case rather than on a treatment act. A Provider gets paid for every case handled till the end.

Arbitration

The State Health Insurance Arbitration Boards in each state of the Federation and the Federal Capital Territory shall consider complaints by aggrieved parties.

2.1.5. Urban Self-Employed Social Health Insurance Programme

This is a non-profit health insurance programme covering groups of individuals with common economic activities run by their members. Individuals who are members of socially cohesive groups, which are occupation-based, are free to join the Programme. The participants, based on their health needs, will choose the health care benefits. The Participants will pay their contribution as a flat monthly rate. The contribution rate will depend on the health package chosen by members of the User Group. A seven-member Board of Trustees, elected from among the members, i.e., Chairman, Secretary, Treasurer and four others, will manage the funds and run the User Group formed. Each component Association is to be represented on the Board.

How the Programme Works

A prospective participant must be a member of an already existing Association. This Association, together with other Associations, come together to form a User Group.

There must be a membership of at least 500 participants for each User Group to ensure adequate pooling of resources. The User Group will elect its Board of Trustees which will administer it and set up Quality Assurance and Health Education Committees. Each contributor will be given an identity card with which he/she will obtain health care from the chosen Health Care Provider (public or private) after a specified waiting period.

2.1.6 Rural Community Social Health Insurance Programme

This is a non-profit health insurance programme for a cohesive group of households or individuals (i.e. a community) which is run by its members. Membership comprises individuals in the community and based on their health needs, will choose the health care benefits. Their Contributions will be in cash, paid as a flat monthly rate or on instalment by participants. This contribution rate will depend on the health package chosen by members of the User Group. A seven-member Board of Trustees, elected from among the members, i.e., Chairman, Secretary, Treasurer and four others, will manage the funds and run the User Group formed.

How the Programme Works

A prospective participant must be a member of a community. Individuals from the community organise themselves and form a User-Group. There must be a membership of at least 500 participants for each User Group to ensure adequate pooling of resources. The User Group will elect its Board of Trustees which will administer it, and set up Quality Assurance and Health Education Committees. Each contributor will be given an identity card with which he/she will obtain health care from the chosen Health Care Provider (public or private), after a specified waiting period.

2.1.7 Stake Holders in the NHIS Scheme

The Stakeholders in the National Health Insurance Scheme include the Government, Employers, Employees, other contributors**,** Health Maintenance Organisations, Board Of Trustees (BOTs) and Healthcare Providers**.**

Government

Government, through the National Health Insurance Scheme, sets standards and guidelines, while protecting the rights and enforcing the obligations of all stakeholders. There is the State Health Insurance Arbitration Board in each state of the Federation and the Federal Capital Territory to consider complaints by aggrieved parties.

Employees

These are the contributors in the Formal Sector Social Health Insurance Programme. Their contributions (5% of basic salary), paid regularly in advance will guarantee them and their dependants good quality healthcare whenever they fall ill. Though till now, no deductions are being made from the basic salaries of the registered civil servants. The Federal Government gave a moratorium of 2 years

(2005 – 2007) before deduction, for the labour unions to see the benefit of the scheme.

Employers
These are public or private sector organizations employing ten (10) or more persons, for whom they are required to pay contributions (i.e., 10% of an employee's basic salary). In the Formal Sector Social Health Insurance Programme, employers are guaranteed good quality health care for their workers at cheaper rates and a resultant increase in productivity. In addition, employers with in-house health facilities will run them cheaper and make them earn income by registering them as Providers under the Scheme.

Other Contributors
Contributors making small, affordable regular payments in the Urban Self-employed and Rural Community Social Health Insurance Programmes are guaranteed access to quality healthcare whenever they fall ill.

Health Maintenance Organisations (HMOs)
These are limited liability companies which may be formed by private or public establishments or individuals for the sole purpose of participating in the Scheme. They are registered by the Scheme to facilitate the provision of health care benefits to contributors in the Formal Sector Social Health Insurance Programme. Their functions include the following:

- Receive/collect contributions from eligible employers and employees
- Collection of contributions from voluntary contributors
- Payment of Health Care Providers for services rendered
- Maintenance of quality assurance in the delivery of healthcare benefits in the Formal Sector Social Health Insurance Programme.

The HMOs are not allowed to introduce any differentiated contributions or benefits. The HMOs do act as the regulatory agency for standard quality assurance, and act as brokers between participants and providers.

Board of Trustees (BOTs)
Participants in the Urban Self-employed and the Rural Community Social Health Insurance Programmes, through their elected Boards of Trustees, plan, run and manage their own health care, thereby engendering a sense of ownership and true community participation.

Healthcare Providers
A Health Care Provider as provided for in the NHIS Act, is a licensed government or private health care practitioner or facility, registered by the Scheme for the provision of prescribed health benefits to contributors and their dependants. Health Care Providers can either be Primary, Secondary, or Tertiary.

I. Primary Health Care Providers will serve as the first contact within the health care system, and they include:

(a). Private clinics/hospitals;
(b). Primary Health Care Centres;
(c). Nursing and Maternity homes; and
(d). Out-patient Departments of General Hospitals, Out-patient Departments of the Armed Forces, the Police and other uniformed services, University Medical Centres and Federal Staff Clinics

II. Secondary and Tertiary Health Care Providers (Fee-for-service providers) These include:

(a). General hospitals (Out-patient and in-patient care for medical, surgical, paediatric, obstetric gynaecological patients, etc.).
(b). Specialist hospitals
(c). Pharmacies
(d). Laboratories
(e). Dental Clinics
(f). Physiotherapy clinics
(g). Radiography, etc.

2.2 Conditional Cash transfer Programme (CCT)

Conditional Cash Transfers (CCTs) are social protection programmes that transfer cash to households with children and young family members based on premise that they will spend it on health, education or other services that policymakers consider of public interest (Gasper, 2010). Economic Policy Research Institute (EPRI) defined CCTs as regular payments of money (or in some cases in-kind benefits) by government or non-governmental organisations to individuals or households in exchange for active compliance with some human capital conditionality, with the objective of decreasing chronic or shock-induced poverty, providing social protection, addressing social risk or reducing economic vulnerability, while at the same time also promoting human capital development (EPRI, 2003).

Conditional Cash Transfer programmes (CCTs) provide cash payments to poor households that meet certain behavioural requirements, generally related to children's health care and education. The combination of cash and conditionality allows CCT programmes to boost household consumption in the short-term while providing an incentive, and helping to offset the costs, for poor families to invest in long-term human capital development (Bassett, 2008). By building healthier, stronger, and more productive future generations, CCTs aim to interrupt the intergenerational transfer of poverty by broadening the developmental impact of growth (Gasper, 2010). It is an overarching strategy for Social Protection which was developed in 2004 based on a life cycle approach that includes support for child care development centres, school feeding programmes, scholarships for the most

vulnerable, loan schemes, public works programmes, and nursing homes (http://www.ipc-undp.org).

Although CCT is a new term, the idea of using cash transfer programmes to create incentives for service has always been there. The Europeans after the Second World War, used birth registration as a condition for birth grant. The Romania conditioned universal Child allowance to school attendance due to decrease in school enrolment following the 1989 revolution. In the same vain, Bangladesh in 1993 started female secondary school assistance conditioned on enrolment and continued attendance of secondary school by the females in the family.

In its new form, CCTs have become one of the most popular social protection programmes in developing countries. Gasper, (2010) has it that the number of people who benefit from these programmes in the developing world as at 2010 is already quite large and that makes CCTs a valued tool for fighting poverty and generating support for reforms. According to him, CCTs such as the Bolsa Família in Brazil and Oportunidades in Mexico cover approximately 12 and 5 million families respectively with relatively modest budgets (less than 0.5% of GDP). They have therefore been called an "innovative and increasingly popular channel for the delivery of social services" and one of the "best practices" in social protection in Latin America (Rawlings, 2005a; Britto, 2004). There is also considerable evidence on the linkages between incentives and behaviour change, both from CCTs and other incentive-based intervention programmes (Medlin and de Walque, 2008).

Also, Cash Transfer Programmes are now growing rapidly in Africa under broader Social Protection frameworks, most often with the support of donor organisations and multilateral agencies such as the UK's DFID, Sweden's SIDA, Germany's GTZ, UNICEF and the World Bank. Previously, in-kind transfers were the main strategy for fighting chronic food insecurity in Africa. The solution is now turning to be targeting 'predictable hunger with predictable cash transfers' instead of food aid (Save the Children et al., 2005). They usually start small (as pilot experiences) and using international expertise.

Most of the programmes in Africa are in their early development stage – in some cases being considered as a possibility (Nigeria, Uganda). In other cases, countries are either starting the pilot or finishing it just now and are about to expand it (as it is the case in Kenya, Zambia and Malawi). In some cases, programmes are being adapted to focus more on cash transfer, as it happens in Ethiopia with the Productive Safety Net Programme (PSNP). South Africa is an exception, with consolidated programmes which basically consist of cash transfers to different target groups (elderly, orphans etc.). There are also few cases where there are long standing cash transfer programmes in place, such as the *Programa de Subsídio de Alimentos* (Food Subsidy Programme) in Mozambique. Another highlight in the region is the case of non-contributive universal old-age pensions as in the small country of Lesotho.

In 2006, the African Union, in collaboration with the Government of Zambia and with the support of HelpAge International and the UK's Department for International Development, organised the Livingstone Intergovernmental Conference on Social Protection where the main focus was on Cash Transfers. Several countries took part and displayed their experiences, thus showing how this type of programme is gaining increasingly space in the African public agenda (Samson *et al*, 2006).

In 2008, a new set of Regional Conferences on Social Protection was held in Africa by Help Age International and the African Union with the support of the British Department for International Development.

2.2.1 Conditional Cash Transfer Programme in Nigeria

In December 2007, the government of Nigeria launched a conditional cash transfer as a component of the State's Social Safety Net programme, supervised by the National Poverty Eradication Programme (NAPEP). The programme in its initial phase was implemented in 12 states besides the federal capital, Abuja, and was intended to assist roughly 12,000 households (Kpakol, 2010).

As of Early 2012, there is one main Nationwide CCT programmes going on in Nigeria, the In Care of the Poor (COPE) in addition to other smaller ones at the state level like the CCT for Girls Education supported by DFID, UNICEF and the World Bank, in Kano, Bauchi and Katsina states, Small Scale Cash Transfer in Bayelsa State, the Disability Allowance in Jigawa state (Holmes et al, 2012), and CCT programme of the FCT Millennium Development Goals (Romoke and Hussein, 2012).

2.2.2 Justification for the COPE programme

Majority of the current poverty eradication efforts, particularly of government, focus on supply side projects like education, health, infrastructure and micro credit for empowerment. These have no doubt contributed to the reduction of poverty. However, in many instances, a good number of the poor still remain unable to access these facilities. In the case of education for example, the heads of poor households would rather send their children or wards to the farm, or to go hawking than attend school even though education is free. COPE is intended to fill these gaps thus taking care of those who fall through the cracks.

2.2.3 Targets of the COPE

- Poor female headed households
- Poor aged-headed households
- Households headed by physically challenged persons
- Households headed by special groups such as victims of VVF, PLWHAs and other vulnerable groups

The children however must be of basic school age, since the objectives is to break intergenerational transfer of poverty through human capacity development. Quoting

the President's speech on the day of launching of the CCT programme in Nigeria as contained in nigeriafirst.org, "In contributing to enhanced enrolment and retention of primary school-age children, as well as immunization of children under age five, the programme (CCT) will impact positively on reducing poverty over time, and will boost our steady progress towards the attainment of the millennium development goals". Also, quoting the coordinator of National Poverty Eradication Programme (NAPEP), in an interview with Emma Okereh on 18 February, 2012, "the initial design of NAPEP has been to have a social net through the Conditional Cash Transfer (CCT) Programme, and also through initiatives which directs government attention towards the underprivileged, the weak, the orphans, the widows and so on in the society".

2.2.4. Conditions for participation in the programme

The following conditions are necessary for one to benefit from the programme:

- Enrolment and retention of children of basic school age in basic education (Primary one to junior secondary school).
- The child must maintain at least 80% of school attendance.
- Attendance in training for life and vocational skills, basic health and sanitation available in the community.
- Participation of qualified children under five years in all government free immunization; and
- Acceptance by the participants of the conditions of the savings arrangement of the programme

2.2.5 The formula for the disbursement of COPE's fund is as follows:

COPE = BIG + PRAI

BIG stands for Basic Income Guarantee, a monthly grantee income of ₦5000 (Five thousand Naira) given to the heads of participating households. It is disbursed monthly on the satisfactory fulfillment of specified conditions as stipulated under condition for participation.

PRAI stands for poverty reduction accelerator investment. It is a guaranteed investment of ₦84, 000 (Eighty four thousand naira) given to the heads of the households at the end of the seventh month to start a business of his/her own or to invest in any profitable business venture that will yields sufficient income that will sustain the household after the completion of the twelve months of receiving the BIG. The PRAI represents the compulsory saving and hence unique component of the COPE.

Unlike other CCTS, participants of the COPE graduate off the programme after a period of one year. With a monthly savings of ₦7,000 by NAPEP, participating heads of households will receive the PRAI as investment fund.

2.2.6 The Implementation Mechanism of the COPE

The implementation mechanism of the COPE is designed to ensure that the programme is truly community owned and that the selected households represent

the collective decision of the village. The following committees are used in the implementation of the programme;

- State Social Assistance Committee (SSAC), headed by the state governments representatives
- Local Government Assessment Committee (LGAC), headed by local government chairman
- Community Social Assistant Committee (CSAC), headed by the village head

CHAPTER THREE

CONCEPTUAL ISSUES AND STUDY METHODOLOGY

3.1 Introduction

Social protection is an agenda primarily for reducing vulnerability and managing the risk of low-income individuals, households and communities with regard to basic consumption and social services. However, it remains a confusing term mainly due to the range of existing definitions and the variety of ways it is interpreted by policy-makers implementing social protection programmes. The ranges of definitions of social protection currently used by different agencies are quoted below. To confound matters further, within the range of definitions of social protection, vulnerability is conceptualized in different ways. At times vulnerability is limited to 'economic vulnerability'. For instance, in the World Bank definition, vulnerability is seen in terms of risk in relation to income and consumption instability. The International labour Organisation (ILO) tends to define social protection in terms of living standards and human rights. Other agencies focus on health and physical vulnerabilities in relation to adequate consumption (IADB). The ODI definition emphasizes normative and contextually specific notions of vulnerability and focuses explicitly on the poorer individuals and groups in society. The focus of any one agency or actor depends on a variety of factors related to the mandate of the agency, the position of the agency in relation to other actors and the path-dependent way in which social protection discourse has emerged in that agency.

3.1 Definitions of Social Protection

International Labour Organisation (ILO) defines social protection as provision of benefits to households and individuals through public or collective arrangements to protect against low or declining living standards. They laid conceptual emphasis mainly in terms of insurance and extension of provision to those in the informal sector.

The World Bank defines social protection as public measures intended to assist individuals, households and communities in managing income risks in order to reduce vulnerability and downward fluctuations in incomes, improve consumption smoothing and enhancing equity. Their conceptual emphasis is on risk management which frames social protection as both safety net, and spring board through human capital development.

IADB defines social protection as the set of public policies directed towards lessening the impact of adverse shocks on consumption over time. Their own conceptual emphasis is on the fact that people are vulnerable to risk without social protection and the deleterious effect of the lack of social protection on human and physical capital.

For ODI, Social protection refers to the public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society. Hence, their emphasis is on specific understanding of vulnerability and deprivation. Social protection is targeted at the poorest and most vulnerable.

The AU's definition of social protection aligns with the SPFI. The AU defines Social Protection as a "package" of policies and programmes with the aim of reducing poverty and vulnerability of large segments of the population. This it does through a "mix" of policies and programmes that promote efficient labour markets, reduce people's exposure to risks, and contribute to enhancing their capacity to protect and cover themselves against lack of or loss of adequate income, and basic social services, (Nicola and Rebecca, 2010).

Asian Development Bank (ADB) defined Social protection as the set of policies and programmes designed to reduce poverty and vulnerability by promoting efficient labor markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption/loss of income. Social protection consists of five major elements: (i) labor markets, (ii) social insurance, (iii) social assistance, (iv) micro and area-based schemes to protect communities and (v) child protection.

When these various definitions are translated into policy and actions, a common range of public programmes of assistance, insurance and benefits emerge. These include:

- Social insurance: Combines a large number of similarly exposed individuals or households into a common fund, thus eliminating the risk of loss to individuals or households in isolation. Formalized programmes such as pensions, health insurance, maternity and unemployment benefits are financed by contributions that are either earnings related or collected through payroll taxes. Non-state (or informal) mechanisms, such as savings clubs and funeral societies also function on the same principles.
- Social assistance: All forms of public action which are designed to transfer resources to groups deemed eligible due to deprivation. Formal programmes are usually financed from tax revenues and include targeted resource transfers – disability benefit, single -parent allowances, and 'social pensions' for the elderly poor that are financed publicly. Non-state provision may be in the form of extended family support, religious support, or borrowing from friends.

It is widely agreed that while social insurance and social assistance are clearly elements of social protection. In practice, most agencies view social protection as more than just this traditional package of social security. Social protection also differs from assistance in the sense that unlike assistance it involves the recognition of the

rights of those exposed to social and economic risks to demand for remedy when such remedies are available (Cain, 2009). However, there is lack of consensus on what else 'social protection' includes. Some stakeholders see social protection narrowly, essentially as a new label for old-style social welfare provided to conventionally define 'vulnerable groups' (e.g. people with disabilities, widows, and orphans). Others adopt a very broad approach to social protection, including even universal primary education, micro-credit and job creation programmes, as well as safety nets and social services for groups that may be vulnerable to shocks, but are not usually regarded as among the poorest strata of society (Henriques, 2008). Still others conceptualize social protection so broadly as to include the majority of development activities. Crucially though, the majority of agencies take an instrumentalist approach to social protection policies, seeing it as a collection of measures to manage risk and thus improve or protect livelihoods.

Rather than focusing on changing the source of risk itself, current conceptions of social protection are about managing the risk as an exogenously given factor so that one or more vulnerability (economic, physical, consumption) can be alleviated. While this is certainly an important focus, especially when one thinks of natural disasters and other shocks that could be argued to be exogenously determined, there is little discussion on the endogeneity or socio -political construction of most shocks and risks. Thus, a different way of conceptualizing vulnerability is to focus on the construction of the source of vulnerability, rather than vulnerabilities reflected in group or individual characteristics.

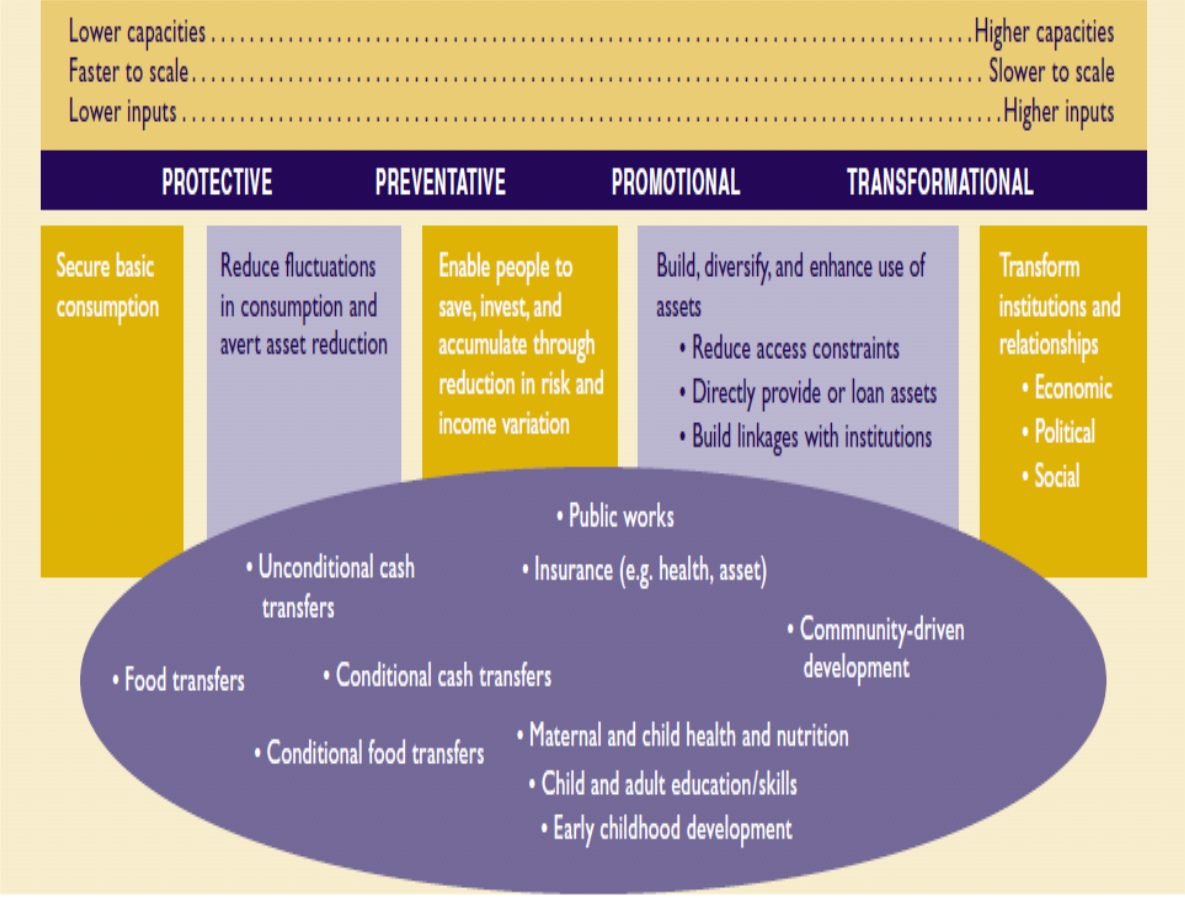
From the above different conceptions we distinguish between the following general functions and objectives of social protection:

- Promotive measures, which 'aim to improve real incomes and capabilities'. These may include macroeconomic, sectorial and institutional measures relevant to poverty reduction, such as improving primary education, reducing communicable diseases and facilitating access to land or sanitation.
- Transformative measures, which aim to alter the bargaining power of various individuals and groups within society such that social equity concerns are addressed, and people are protected against social risks such as discrimination or abuse. A 'transformative' view extends social protection to areas of equity, empowerment and 'social rights', rather than confining the definition to targeted income and consumption transfers or insurance mechanisms.
- Preventative measures aim to 'avert deprivation in specific ways'. These typically refer to both state and non-state social insurance provision.
- Protective measures are even more specific in their objective of 'guaranteeing relief from deprivation', which are narrowly targeted safety net measures aiming to provide relief from poverty and deprivation to the extent that promotional and preventative approaches have failed to do (Kabeer 2002: 595).

- Developmental and generative function by increasing consumption patterns of the poor, local economic development and enabling poor people to access economic and social opportunities.

Adato and Hoddinott(2008) captured these in diagrammatic form below in figure 2 below

Figure 2: Functions of Social Protection programmes



Source Adato and Hoddinott (2008)

These may be overlapping categories in that measures can simultaneously 'promote' as well as 'prevent.' Promotive, preventive and protective measures can be thought of as a gradation of social protection programmes (Adato and Hoddinott, 2008)

3.2 Overview of the Different Instrument used for Social protection

Table 1: Instruments Used for Social Protection

Component of Social Protection	Examples of Instrument used
❖ Social Insurance programme-financed by contribution and based	❖ Pension ❖ Health insurance

Component of Social Protection	Examples of Instrument used
on Insurance principle	❖ Other social insurance
• Social assistance to the Vulnerable-protection and Mitigation	• Cash transfer • Food transfer • Social services • Old age grant Targeted to persons with disability, older persons, children, orphans, persons affected with HIV/AIDS
➢ Promotive and transformational-aimed at building capabilities	➢ Health assistance ➢ Free primary and secondary education ➢ School feeding schemes ➢ Scholarships and fee waivers ➢ Child support grants ➢ Water and sanitation ➢ Asses to basic housing
✓ Labour market programmes	✓ Public works programmes ✓ Small business/enterprise development ✓ Micro-financing ✓ Skills training

3.3 Research Methods

The research involves primary information collected on the two social welfare programmes. Interviews were conducted with operators of the scheme and the participants. The study relies heavily on published and unpublished information from the programmes. Other sources of information about the programmes were also explored. These include internet sources, grey literature and opinions of experts.

Minimal primary information was obtained from the operators of the schemes, actual and potential beneficiaries. Interviews were conducted through telephone, e-mail, Tele-conferencing and others. There were also reviews of similar programmes in other countries. This helped in benchmarking the performance of these schemes. The performance of the schemes was assessed through the social protection programmes assessment indicators listed in Table 2 below.

Table 2: Parameters and their Indicators

Parameters	Meaning	Indicators	Sources of Data
Participation	Number of people involved in the	• Entry into the programme is open to all in the same socioeconomic class/condition (measured by employment, sex.)	From reports, evaluations of the

Parameters	Meaning	Indicators	Sources of Data
	programme	• Participation is not limited by gender, race, ethnicity, ability, income, education, workers, NGOs, CBOs, etc • Participation takes place at LGA, state and national levels • Participation is sufficiently *representative* (i.e. if not everyone participates the participants are representative of stakeholder groups) • Participation *formalized*, legalized or institutionalized	programmes, interviews with beneficiaries and potential beneficiaries. FGD
Awareness	Degree of information available to participants and non-participants	• Adequate *amounts of information* are made available to all potential participants • Information is accessible to all participants irrespective of gender ethnicity, educational level, socioeconomic categorization • [What are the sources and channels of information for the service? Is it suitable for the various potential groups?]	Interviews of participants and non-participant, the agencies, reports from previous studies/evaluations/assessments, FGD
Equity	Extent individuals in equal social position are given opportunity to benefit from the scheme	CCT: • Level of difference in availability of service by gender, age, geographical location, class, ethnicity • A sample of beneficiaries will be compared with a sample of non-beneficiaries in the same community who fulfil all the required conditions for CCT. • The value of benefit among beneficiaries will be compared among themselves for horizontal equity • Is equity made explicit in the organization's status • Pre-selection criteria • Effectiveness of discrimination between beneficiaries and non-beneficiaries • Ability of the programme to screen out non-target candidates. NHIS:	Agencies themselves, the participants, interviews, FGD, [telephone or internet interviews, snowballing interviews]

Parameters	Meaning	Indicators	Sources of Data
		• Level of difference in coverage by gender, age, geographical location, class, ethnicity • Among beneficiaries – contributions are made according ability to pay (proxied by earnings) • Benefits are distributed according to need (patients are treated irrespective of their health conditions) • There are no socioeconomic differences between enrolees and non-enrolees (where socioeconomic differences are measured by sector or occupation, employment status,) • Is equity made explicit in the organization's status?	
Efficiency	The degree to which the programme achieves its objectives	• Ratio of number administrative staff to the benchmark • The ratio of the administrative/running expenses to total expenses • The proportion of the fund/resources that is directed to the rightful recipients. • Operational/overhead cost per head (beneficiary) • Average time interval between request and attendance in the programme. • Outcomes in terms of results from benefits (to obtained from previous evaluation results) • Percentage of the recipients that are satisfied with the programme. • Are adequate investments being made in maintenance, e.g. what percentage of the budget of the organization is spent on: • Equipment • Personnel • Do efficiency gains undermine other potentially positive outcomes (e.g. equity, affordability, wages, health and safety, quality, etc.)?	• From the reports of the agencies, other evaluative reports, interview with beneficiaries, FGD.
Quality Indicator	The quality of service provided by the programmes	• Services provided by the programme are comparable to those provided by alternative health care facilities?, *Quality is proxied by the waiting time, neatness of environment of delivery, qualifications of staff, minimum	Personal observations of the processes and

Parameters	Meaning	Indicators	Sources of Data
		service package – for CCT for example, are there other complimentary services within or outside the programme that help to achieve the objective of the programme?) • Regularity framework • Is the overall quality of the service acceptable to participants? • Is quality improving over time?	environment . Comparing
Sustainability	The extent to which the programme will last even when the current source of fund is withdrawn. (also whether the beneficiaries are able to achieve higher status [or standard of living based on the initial benefit from the programme]	• Number of fund sources. • Regularity of fund replacement • Percentage that renew membership on Yearly basis • Rate of yearly growth of the programme • Level of support from different tiers of government • Percentage of fund from donor agencies • Level of political support for the programme (interview with policy makers) • Are there replications of the programmes [Is there buy-in from groups outside the immediate constituency of the programme?]	•

Source: Author's

CHAPTER FOUR

FINDINGS OF THE RESEARCH

4.1 Introduction

The entire aim of this work as contained in the first section is to evaluate the selected state social protection programmes in the country on the basis of their coverage, efficiency, equity and sustainability. In addition to the review of previous works on the issue, the research work involved field work in four different locations in the country: Abuja (FCT), Nasarawa state, Enugu and Delta state. The survey involved mostly collection of relevant information (Primary and secondary) from the stake holders in the respective places through interviews and focus group discussion. The evaluation programme was conducted using information from three different sources

- The office in charge of running and or coordinating the programme (NAPEP and NHIS)
- World development Indicator data base , and
- Findings from other works.

By indication therefore, the evaluation especially in terms of efficiency and equity will be done alongside these three different angles.

4.2 Conditional Cash Transfer (CCT) Programme

4.2.1 Evaluation Based on Documentations from the NAPEP office

This section of the report evaluates the degree of participation, impact, equity, efficiency and the sustainability of CCT programme in the country using various documents and survey reports of the agency in charge of managing the programme (NAPEP).

4.2.2 Participation and Fund Disbarment in Conditional Cash Transfer (CCT)

As earlier stated, the CCT programme in Nigeria is called COPE and it is being supervised by National Poverty Eradication Programme (NAPEP). From the available information, there has been two phases of the COPE programmes since its inception, COPE phase I and COPE phase II.

I. COPE phase I

The funding for the COPE Phase I was a total of ₦1,063,000,000 (one billion, sixty three million naira only) and it was received from the office of the senior special assistance to the president on MDGs. The disbursement of the fund is as shown in table 3 below: (Kpakol, 2010).

Table 3: Fund Disbursement for COPE Phase I

S/N	States	BIG (₦m)	PRAI (₦m)	NGO Pay Masters (₦m)
1	BALYESA	30	42	2.4
2	BORNO	30	42	2.4
3	CROSS RIVER	30	42	2.4
4	EBONYI	30	42	2.4
5	ENUGU	30	42	2.4
6	FCT	15	21	2.4
7	JIGAWA	30	42	2.4
8	KEBBI	30	42	2.4
9	NASSARAWA	30	42	2.4
10	NIGER	30	42	2.4
11	OGUN	30	42	2.4
12	OYO	30	42	2.4
13	YOBE	30	42	2.4
	SUB-TOTAL	375	525	31.2
	TOTAL			**931.2**
	Coordination and monitoring of the states and HQ			131.8
Grand Total				**1,063**

Source: Kpakol, 2010

Outcome of the Programme

It is contained in NAPEP press briefing that the outcome of the above distribution of the COPE phase I project include:

- Over 61,950 children who were in danger of being dropped out of school were kept in school (see table 4) below.
- A mid-term assessment of the project according to NAPEP, 'indicated a remarkable improvement in the quality of life of the participating households
- Many state governments have heeded to the call of Mr. President to provide matching grants and this has led to more households being reached in the state.
- Over 8,850 households nationwide have been reached.
- Another monitoring carried out in 2010 showed that participating households are committed to keeping their children in school until completion of junior Secondary school especially because of community pressure and cohesion as provided by the village heads in participating communities.

Table 4: Allocation of Project Funds and State Matching Grants

S/N	States	Funding				Households Reached	Number of people Impacted
		MDG (₦m)	State govt. pledge (₦m)	Actual (₦m)	Total (₦m)		
1	BALYESA	72	72		72	500	3500
2	BORNO	72			72	500	3500
3	CROSS RIVER	72			72	1000	7000
4	EBONYI	72	72		72	500	3500
5	ENUGU	72	72	72	144	1000	7000
6	FCT	36			36	250	1750
7	JIGAWA	72	72	72	144	1000	7000
8	KEBBI	72	150	150	222	1600	11200
9	NASSARAWA	72	150	150	222	500	3500
10	NIGER	72	300		72	500	3500
11	OGUN	72			72	500	3500
12	OYO	72			72	500	3500
13	YOBE	72			72	500	3500
	TOTAL	900	888	444	1344	8850	61950

Source: Kpakol, 2010

II. COPE Phase II

Due to the "success" recorded in the pilot, the COPE programme was scaled up to cover the remaining 24 states of the federation and the FCT. In this Phase of the Programme, funding was provided from the Debt relief gains by the office of the senior special assistant to the president on MDG. With the funds from MDG (₦2,265,000,000.00) at least, 500 households was intended to be reached on the scaled up Phase. The release of fund for the COPE phase two programmes as contained in the briefing is here shown in table 5 below.

Table 5: Release of Fund to States for COPE Phase II

S/N	STATE	MDG Funds(₦m)	Expected state Govt. contributions (₦m)	Local Govt. contributions (₦m)	Actual Households Reached	Number of people Impacted
1	ABIA	72	72		500	3500
2	ADAMAWA	72	72		532	3724
3	AKWA IBOM	72	72		500	3500
4	ANAMBRA	72	72		540	3780

S/N	STATE	MDG Funds(₦m)	Expected state Govt. contributions (₦m)	Local Govt. contributions (₦m)	Actual Households Reached	Number of people Impacted
5	BAUCHI	72	72		509	3563
6	BENUE	72	72		500	3500
7	DELTA	72	72		500	3500
8	EDO	72	72		508	3556
9	EKITI	72	72		510	3570
10	FCT	72	72		500	3500
11	GOMBE	72	72		537	3759
12	IMO	72	72		500	3500
13	KADUNA	72	72		500	3500
14	KANO	72	72		500	3850
15	KATSINA	72	72	72	1000	7000
16	KOGI	72	72		590	4130
17	KWARA	72	72		500	3500
18	LAGOS	72	72		523	3661
19	ONDO	72	72		500	3500
20	OSHUN	72	72		500	3500
21	PLATUE	72	72		537	3759
22	RIVERS	72	72		500	3500
23	SOKOTO	72	72		556	3892
24	TARABA	72	72		500	3500
25	ZAMFARA	72	72		600	4200
COPE pay Master		120				
Co-ordination and monitoring (State)		45.97				
Co-ordination and monitoring H/Q		95				
Baseline survey in state and LG		50.03				
Sensitization of community/Stake holders		65				
Communication and Documentation		64				
Evaluation and impact Analysis		25				
TOTAL		**2,265**	**1,800**	**72**	**13,442**	**94,444**

NAPEP 2011

Outcome of COPE phase II

- Over 13,492 households across the 24 states and the FCT have been reached in this phase of COPE.
- Over 94,444 children who were in danger of dropping out of school were kept in school.
- A mid-term assessment of the project also indicated a remarkable improvement in the quality of life of the participating households.
- About 18 state governments have already made some commitments to partner with NAPEP in the next phase of COPE (COPE Phase III) implementation.
- Another monitoring carried out in 2010 showed that participating households are committed to keeping their children in school until completion of junior Secondary school especially because of community pressure and cohesion as provided by the village heads in participating communities.

4.2.3 Overall Impact of PILOT COPE Phase I and II

- Over 109,210 basic school aged children who either were not in school (mostly from the Northern part of the country or who were in danger of dropping out as in many states in the south) were prevented from leaving school.
- The quality of life of participating households improved.
- An increase access to medical services of immunization/vaccination and Vit 'A' supplementation among children of 0-5 years of age from participating households.
- Over all increased awareness among state governments on the success and use of COPE as a viable tool in addressing challenges of extending support to the core poor.

As of 2010, the national coordinator of NAPEP said that the COPE programme have been able to reduces the number of very poor households in the country by 6,832,851 and that the total number of households reached by the programme was 21, 842. This according to him amounted to 0.32% of the core poor households in need of CCT in Nigeria.

4.2.4 Equity in COPE Programme

Judging from the information provided in various publications of NAPEP (National Press Briefing: "…Journey So Far", Success Stories, Investing in People, Score on Poverty, Understanding the Role of NAPEP on poverty Eradication in Nigeria, etc.), and the data above on the fund disbursement and number of households and people impacted upon, one may think that there has been equity in the execution of the programme state wise. This however may be misleading since there were no indicators to show the needs of those states and it will be difficult to believe that the states have equal number of core poor households that needs the conditional cash transfer.

4.2.5 Sustainability of the COPE programme

The conditional cash transfer programme is a new concept in the country and thus, face some challenges:

- Insufficient fund to reach many qualified household that are yet to be reached; Right targeting and selection of qualified households, which is fundamental to the success of the scheme; and
- Mobility to reach the difficult terrains where the core poor in the communities reside.

All these challenges notwithstanding, NAPEP ensure the sustainability of the programme through;

- Soliciting for the states to supplement the effort of the federal government through matching grants;
- Strong community involvement and ownership, particularly in the selection process;
- Establishment of community Social Assistant Committees (CSAC) to oversee the implementation of the programme in the community;
- Establishment of State Social Assistant Committees (SSAC) at the state level; and
- Provision of life skills training to ensure Independence of the participant on exit from the scheme.

4.2.6 Evaluation of the COPE based on Human Development Indicators and Previous Research Findings.

Going by the information provided by the agency in charge of the scheme, NAPEP, it appears the programme is both efficient and sustainable. One therefore believes and expects that after five years of its operation in Nigeria, its impact would be felt in the rank of the country in international human development index (HDI). On the contrary however, data from the World Development Indicator (WDI) data base as contained in table 6 below indicates that the country is still ranking 156 out of 187 countries. Though there has been a little increase in the country's HDI index from 0.429 in 2005 to 0.459 in 2011, the table still indicates that the presence of the COPE programme notwithstanding, we are still unable to come out from low human development.

Nigeria's HDI indexes from 2005 to 2010 were all below the low human development index. The value in 2011, 0.459 though a little above the low HDI benchmark, is still very far from getting to the medium human development benchmark (0.630). The life expectancy at birth as at 2011 is 51.9 years which is even below the benchmark for low human development index. The primary school enrolment ratio that ought to be the direct effect of the programme still has its average from 2001 to 2010 as 89.5 against the low human development benchmark of 96.5.

Table 6: Human Development Index

Human Development Index	**Human Development Index (HDI)**				**Life expectancy at birth**	**Mean years of schooling**	**Expected years of schooling**	**Prim Sch. enrolment ratio**
HDI rank	Value				(years)	(years)	(years)	(%)
	2005	2009	2010	2011	2011	2011[a]	2011[a]	2001–2010[b]
156/187.	0.43	0.45	0.45	0.46	51.9	5.0	8.9	89.5
Benchmarks								
Very High Human Development	0.889				80.0	11.3	15.9	120.7
High Human Development	0.741				73.1	8.5	13.6	110.3
Medium Human Development	0.630				69.7	6.3	11.2	113.3
Low Human Development	0.456				58.7	4.2	8.3	96.5

Source: WDI Data Base

The above findings indicate a large disparity between the paper report and practical evidence of the successfulness (Coverage, Equity and Efficiency) of the CCT programme so far in the country. While the paper reports from the NAPEP as contained in their various publications are showing success in their programmes including the CCT, the practical and survey evidences are not.

World Bank report has it that the CCT programme after being in operation in Mexico for 11 years was able to reduce poverty by 25 per cent. In line with this, Ariel et al., (2009) found that *Oportunidades* decreased the squared poverty gap in Mexico by approximately 29 per cent, PATH reduced the squared poverty gap index by 13 per cent from its pre-transfer value in Jamaica, the Bolsa Família programme in Brazil, reduced the squared poverty gap by 15 per cent. Also, Foguel, and Ulyssea (2006) in Ariel et al., (2009), suggest that there is a strong link between the introduction of CCTs and the fall in inequality in Brazil.

On the contrary, all the previous evaluations of Poverty Alleviation Programmes in Nigeria, including the CCT are pointing towards failures. Homles et al, (2012) pointed out some of the likely reasons for not having had a noticeable impact of the CCT programme in Nigeria;

- ♣ limited coverage of the current transfer, (0.001% of the poor),
- ♣ low value of the transfer compared to family need, especially for large households,
- ♣ uniform nature of the programme across the states regardless of their need,
- ♣ the programme delivery has not been uniform or consistent,

- ♣ even the little impact leads to improving access to service and not the quality,
- ♣ limited institutional capacity at the Federal and state level to choose appropriate CCT programme and deliver and monitor the existing ones which has led to poor administration and monitoring ,
- ♣ training components to support households' investment in productive activities have not always been delivered,
- ♣ short period nature of the recipient of the transfer(One year),
- ♣ Lack of transparency and accountability.

The last point above justifies the news report of 21 February, 2012 from Agande that most of the claimed cash transfer by the NAPEP may not actually have gotten to the rightful recipients. "A clear case example" he said, "is the issue of KEKE-NAPEP that was introduced into the country in the year 2000 as a veritable tool for wealth creation and poverty alleviation". The project was designed such that subsidized tricycles are given to young Nigerian youths who are expected to pay off the subsidy over an agreed period of time. The news report has it that while the first two phase of the project which involved the supply of 2000 units of tricycles were done successfully, the execution of the third phase was caught with problem as a result of "The Dismal Performance of National Poverty Eradication Programme (NAPEP)".

Also, as at February 21, 2012, it was in the news that NAPEP received over 33 queries from the office of the Auditor-General of the Federation regarding how funds allocated to the agency was utilized and that led to a decision by the senate to carry out a full enquiry into the activities of NAPEP between 2005 and 2011.

The result of the above investigation shows that "the collection and distribution of the assembled tricycles was surrounded with lots of shoddy manipulations between NAPEP, the Initiative for Peace Empowerment and Tolerance International (IPET) and the KEKE NAPEP Owners Riders Association of Nigerian (KORAN)". It also found that those mandated to handle the project especially from the third phase devised series of devious schemes aimed towards the commercialization of the project for personal gains. There were cases of diversion of funds; unqualified and unregistered micro-finance institutions engaged by NAPEP in the disbursement of funds to beneficiaries, and the use of fake names and unverifiable addresses. There were also indications of coalition with the supply company and the Nigerians in charge to increase the supply price of the product still for personal and selfish gains. Now the tricycle that was meant to be for poverty alleviation is so expensive that even an average citizen cannot afford it.

In analysing the Nigerians past poverty alleviation programme in Nigeria, Ovie, (2011) also found that past poverty alleviation programmes in Nigeria failed to achieve their desired goals and targets. He has, misunderstanding of the policies made for the people by the policy makers, misplaced priorities, favouritism and benefit capture which breeds contempt for the policies as the factors that relates to

and have bearing to these failures. He emphasized the involvement of the poor in all the stages of poverty alleviation programme from development to implementation as a way of ensuring that these programmes and polices achieve their desired target and goals.

This boils down to the opinion of Maduagwu (unpublished), who traced the past attempts by the government to alleviate poverty in Nigeria from National Accelerated Food Production Programme (NAFPP) of Gowon regime in 1972, Operation Feed the Nation of Gen. Olusegun Obasanjo's military regime in 1976, Green Revolution Programme of Shehu Shagari's regime in 1979, Go Back to Land programme of Buhari's regime, the Directorate of Food, Roads and Rural Infrastructure (DERRI) of Gen. Babangida's regime and its associated Better Life for Rural Women by his Wife in 1986, the Family support Programme and the Family Economic Advancement Programme of Abacha's regime in 1993, to NAPEP and concludes that what caused failures in all of them is the top-down approach. He explained that the 'Abuja big men' who in all the poverty alleviation programmes, has been both the developer and implementer cannot possibly claim to understand what it is to be poor and hence what it needs to come out of it. He said that only the poor understands poverty and it is also the poor that knows how their poverty could be alleviated. He therefore suggested the theory of Humble Approach to Development, which says that it is appropriate for government "to ensure their citizens' active participation in formulating and implementing projects of which they are supposed to be the beneficiaries".

In line with the above, Orji, (2005) found that,

> *Despite the various poverty alleviation programmes by successive governments, and the huge budgeting outlays attached to (Poverty Alleviation) programmes, the rural areas and the people have remained poor. Some of the features of this poverty are lack of basic social amenities, malnutrition, disease and ignorance. It is argued that all these problems resulting from policy inconsistencies, lack of political will, bureaucratic red tape, lack of transparency in business of government, lack of consumer oriented consultations in policy initiation or formulation, lack of capacity for policy implementation, obstacles arising from political and social considerations, poor leadership, inadequate support institutions and resources for policy implementation; all these are exacerbated by political instability and social crises.*

According to him, poverty not only persists, but also tends to exacerbate.

4.3 Analyses of CCT Based the Survey Result: Case Study of Conditional Cash Transfer [CCT] in NASARAWA State

As contained in the methodology, the study also involved field work in some states in the country including Nasarawa state. The survey was targeted towards finding out

the rate of participation, equity, quality, efficiency and sustainability of the programme. The major aim was to find out from the operators and the beneficiaries, their level of involvement in the programme. Below is the report of the survey of the operations of CCT programme in the state.

(A) Participation

The state is made up of nine LGAs and the programme allows 100 participants per LGA. As of the time of the survey, the CCT operators in the state indicated that the total number of the participating communities is around 300. They also revealed that one can only participate based on recommendation from his/her wards which must be confirmed by the committee at the ward and up to LGAs. The state committee will equally confirm the participant and final approval is by the headquarters of NAPEP. It was also reported that 10 beneficiaries from each community in all the nine LGAs of the state are participating in the programme.

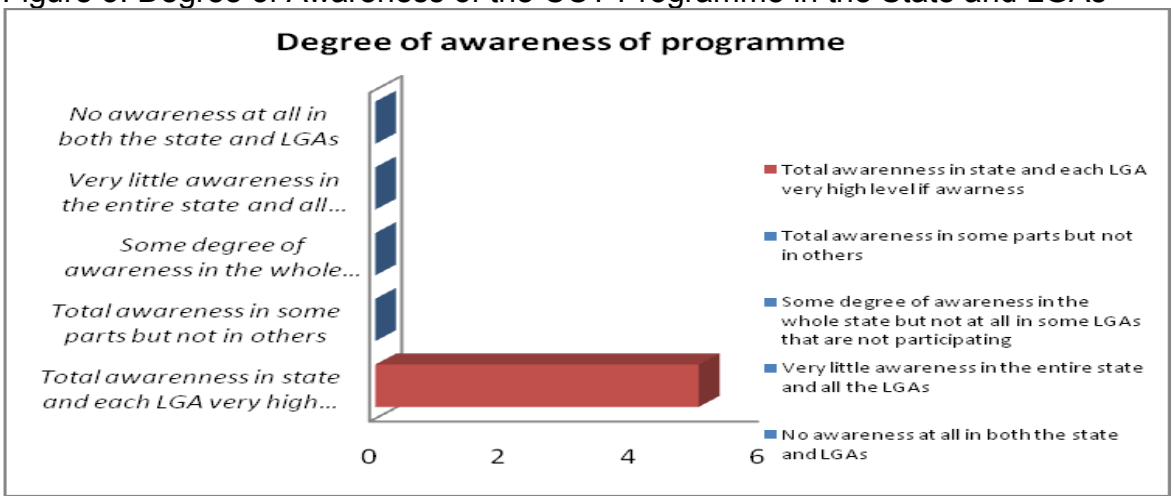
The survey data show that 60% of the CCT beneficiaries in the state are female, whereas the male counterparts are 40%, larger proportion of the beneficiaries fall within the age group of 21-40 years. Widow headed households constitute more than 50 per cent of the population of beneficiaries. The rest are farmers and timber sellers.

The CCT operators while explaining how beneficiaries are paid said that, there is master list that contains the details (names and photographs) of all the participants in the state called the Baseline data on selected households for CCT scheme in Nasarawa State which is always used for payment. Any participant(s) is always required to have his/her picture in the form which they filled before they were accepted for the CCT. The Desk Officer for the CCT in each LGA will always be there during the payment, the participants must be at the payment ground and the community leader must be there to confirm the participants.

(B) Awareness

Figure 3 below shows the level of awareness of the indigenes of the state and the LGA on the issues relating to the programme. The table indicate that a large proportion of the population have total awareness of the programme both in the state and in the LGAs.

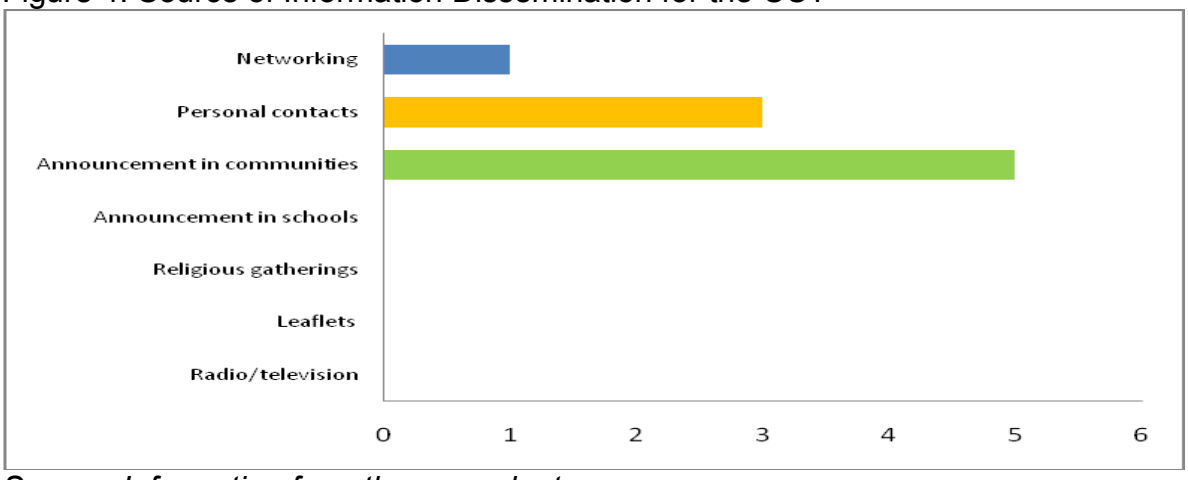
Figure 3: Degree of Awareness of the CCT Programme in the State and LGAs



Source: Information from the repondents

Figure 4 on the other hand, indicate that the major source of information for the participants is oral announcements in communities followed by personal contacts and networking. The survey showed that radios, leaflets, religious gathering and announcement in schools are not a significant source of information for the beneficiaries. This may be the result of another finding of the survey that almost 90 per cent of the beneficiaries of CCT in Nasarawa don't have formal education.

Figure 4: Source of Information Dissemination for the CCT



Source: Information from the repondents

(C) Equity

According to CCT operators in Nasarawa state, the programme gives equal opportunity of participation to all indigenes that meet its baseline specification. However, a maximum of 100 is allowed from each LGA and they are accepted on first come first serve based on the recommendation from the community leaders.

According to the operators, a thorough screening is done to ensure that non-target candidates (those that do not qualify based on the CCT specifications) do not benefit from the programme. Report from the field work show that as at early 2012, only 5 per cent of the targeted participants are benefiting from the programme and that all participating households are given the same amount of N5000.00 per month.

(D) Efficiency

The assessment from the survey result shows that over 70% of the participants are satisfied with the programme. Within the one that the programme lasted in the state, a total sum of 72 million naira was received from the Federal Government and was disbursed accordingly to the beneficiaries. The CCT operators said that registration on the programme takes only one day, however it takes up to four weeks for participants to obtain CCT services. This is because there is need for confirmation from the local government committee members, state committee members and approval given from the NAPEP headquarters. The quality of service provided in the programme within the state as reported by the operator was excellent and there were great improvement in the programme within the period it lasted.

(E) Sustainability

The findings of the survey is that the sustainability of the programme in the state is not guaranteed as there has not been a renewal of the fund from the Federal Government after the first 72 million naira that was used to sponsor the programme for one year. As of the time of this survey, (Jan, 2012), NAPEP officials in the state in reported that though the state government promised to release the sum N50million in support of the programme, they were yet to receive such.

4.4 National Health Insurance scheme (NHIS)

The overall performance of the NHIS has been a source of concern to many observers. Many believe that after about seven years, this organization has performed well below expectation and that the promise of delivering health to the Nigerian has not materialized. Some however believe that NHIS faces many challenges that have constrained its performance and that it has delivered on its promise within the financial and political constraints it has faced from inception.

This study accesses the performance of the Scheme using the parameters highlighted above, namely: Participation, Equity, Efficiency, Quality, and Sustainability. The sources of data for this assessment include information from primary field surveys, published and unpublished reports of the Scheme and other sources.

4.4.1 Participation in the NHIS Programme

As noted above, the NHIS was set up under Act 35 of 1999 by the Federal Government with the aim of improving the health of Nigerians at an affordable cost

through prepayment system. This implies a system of risk-pooling and cost sharing arrangement that leads to effective cross-subsidization. The scheme was formally launched in 2005. The target population of the Scheme is all Nigerians, but the scheme started off with the population in the formal sector of the economy - the civil servants, employees of ministries, parastatals, military, and paramilitary are beneficiaries.

To achieve its objectives, NHIS developed series of programme that should cover every Nigerian. These includes, Formal Sector Social Health Insurance Programme; Urban Self-employed Social Health Insurance Programme; Rural Community Social Health Insurance Programme; Children Under-Five Social Health Insurance Programme; Permanently Disabled Persons Social Health Insurance Programme; Prison Inmates Social Health Insurance Programme; Tertiary Institutions and Voluntary Participants Social Health Insurance Programme; Armed Forces, Police and other Uniformed Services. But the question is how many of the programmes developed have been made operational since them? The available information is indicating that only about two or three of the programmes are operational. This explains the negligible number of participants in the programme.

After nearly seven years of operation and more than twelve years after it was set up, the scheme has covered only 5.3 million Nigerians (representing just about 3.5% of the total population). The coverage has been mainly civil servants employed by the Federal Government. Field data suggest that 70% of the Civil Servants under the Federal government have been covered by the scheme. There is limited information available about demographic characteristics of households and individuals so far covered by the scheme. There are no records about the geographical, gender and socioeconomic status of those covered except that that they are civil servants under the federal government employment.

Moreover, reports indicate that only, 300000 pregnant women in Bauchi and Cross-River states have been brought under the scheme through the Maternal and Child Health Project (MCHP) scheme that was planned to cover about 600000 women and under five children by the end of 2010 with funds from the Debt Relief Gain (DRG). Till date, there is no evidence that this target was achieved.

Factors Affecting Participation

A number of factors have been identified to be the major constraints to expanded participation in the scheme. These factors include the inadequacies of the law setting up the scheme, the political structure of three-tier system of governance in the country, poor economic status of great proportion of the population, the distribution of medical facilities in the country, and lack of public awareness about the scheme.

The fundamental flaw in the Act setting up the scheme is that it makes NHIS an optional social insurance scheme instead of making it a mandatory scheme. This implies that a number of potential participants in the scheme are not participating.

Explaining in an interview, Dogo Mohammed, the Executive secretary of NHIS, pointed out that because the scheme is non-mandatory, states and local governments are not eager to join the scheme despite advocacy to these tiers of government.

Furthermore, the Executive Secretary points out that the Act as currently designed does not cover private insurance. It does not also cover the large number of vulnerable groups including women and children who are outside the formal sector. It is estimated that over, 65% of Nigerians work in the informal sector of the economy.

Given this situation, it implies that the Act did not provide for the coverage of these large populations of Nigerians working in the informal sector. The only provision the Scheme makes for the coverage of these large populations is that communities could organize themselves and select ten trustees from among themselves and then report to the NHIS to be given an HMO. Their contribution could then be assessed after an actuarial study has been undertaken of the community. So far there is no indication that this has happened in any community or that informal sectors have so organized themselves for the purpose of coverage by NHIS.

Also, the Act makes the NHIS a mere scheme suggesting that it should undertake the direct provision of Health Insurance Services rather than a regulatory authority with powers to establish and enforce rules for the various actors in the health insurance sector. Such powers would enable the NHIS to regulate not only the HMOs, the healthcare providers and enrollees, but also able to regulate and monitor the activities of the private health insurance sector in the country.

The second factor constraining the scheme from attaining universal coverage is the three tier governance structure of the country. When the country was under the military rule, the military command structure ensured that states complied with orders from the federal government. However, under the democratic regime, the states are not necessarily bound to accept orders from the federal government particularly on maters in which the states have concurrent legislative authority. Thus, while the federal government may have its ideas about the NHIS, the 36 states may have different plans. Even within the states, the Local Governments (LGs) may also not be in complete agreement with the states. Thus, bringing the employees of the states and LGs into the scheme is especially difficult.

The third factor is poor economic status of large proportion of the population. Recent statistics suggest that poverty has not only been widening, it has also been deepening in the country. This implies that less number of people can afford to contribute any amount to the scheme.

The skewed nature of the distribution of health facilities in the country also contributes to slow down efforts to universal coverage. Statistics show that there are far more health facilities in the south than in the north (NBS 2009). In addition, over

90% of disease-burdens are in the rural areas while less than 10% of health facilities are located in the rural areas. The implication of these is that there is complete mismatch between disease burden and supply of health services. Health human resources are similarly mal-distributed such that there is a concentration of health human resources in the cities whereas the rural areas with heavy disease burdens are hardly served.

Finally, lack of public awareness of the scheme in spite of efforts of the operators to reach out contributes to slow down participation in the scheme. Although field information suggests that in some urban states as much as 70% or even 80% of the population are aware of the existence and functions of the NHIS, it may not necessarily be the case for many large population in rural areas who are in most need of the intervention provided by the scheme. There are also others who do not believe in any project or programme sponsored or supported by government. This lack of trust leads to skepticisms and non-participation in government programmes including NHIS.

Addressing these factors is fundamental for progress towards increased participation in the NHIS. Solutions to these problems are not easy but there is advocacy towards amending the NHIS ACT to transform it into an agency with authority to establish rules and regulate the entire sector. More importantly addressing constraints to the participation of the large population in the Nigerian informal economic sector is critical for any progress towards universal coverage. A possible solution to the problem of governance structure of the country could be the decentralization of the scheme such that states could establish their own schemes while the NHIS assume the role of a regulator. This will in addition address the fears of the states and LGs that sometimes see their participation in the scheme as a way of transferring resources from states and LGs to the federal government.

4.4.2. Equity of NHIS

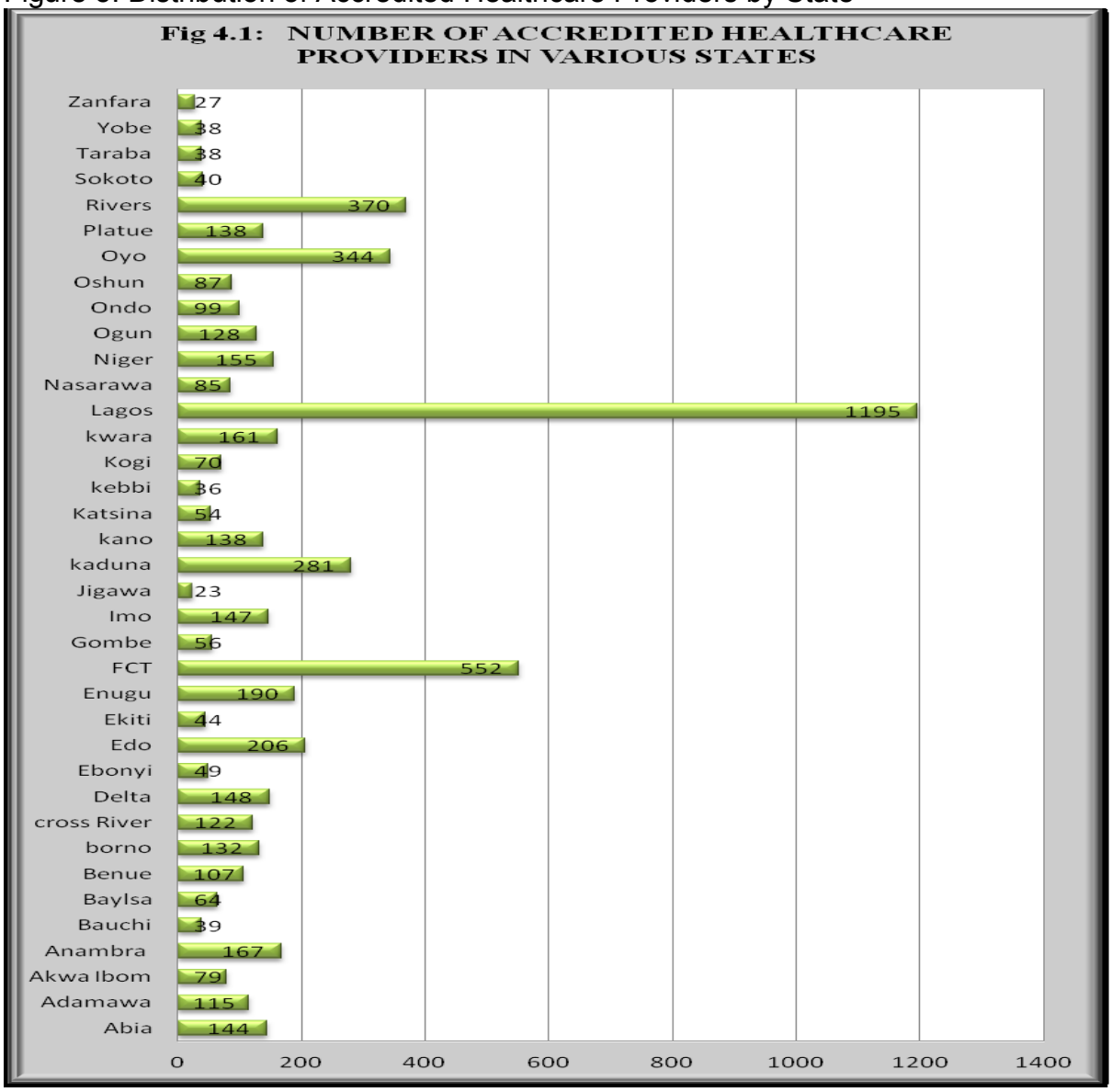
Social health insurance schemes (SHIS) like NHIS are anchored on equity. SHIS are designed primarily to achieve the objective of equity in health care payment and healthcare utilization among the target populations. The underlying equity principle is payment according to ability and healthcare utilization according to need. Fundamental to achieving this objective is cross-subsidization in which the rich subsidizes the poor, the healthy subsidizes the sick, the employed subsidizes the unemployed and the young subsidizes the old etc. When such a system is functioning effectively, it becomes possible for people to access quality care irrespective of their socio-economic status and geographical location.

While the design of NHIS includes mechanism for achievement of equity objectives in the health sector, the implementation does not seem to as yet address some of the key equity issues for which the scheme was set up. Several indicators tend to show that the NHIS has worsened rather than improved equity in the Nigerian health care system. The evidence is reviewed under the following critical indicators: Equity

in the distribution of HMOs, equity in the distribution of Providers, and equity in participation.

Figure 5 below shows the distribution of number of accredited health care providers that currently operate under the NHIS by state. A very distinctive feature of the distribution is the clear dominance of Lagos state in the distribution of accredited providers. About 1195 representing over 20% of the total 5867 accredited health facilities under the NHIS programme are located in Lagos. At the other extreme, there are states such as Jigawa with 23 accredited facilities, Zamfara with 27, Kebbi with 36 and many others who have minimum coverage under this accreditation.

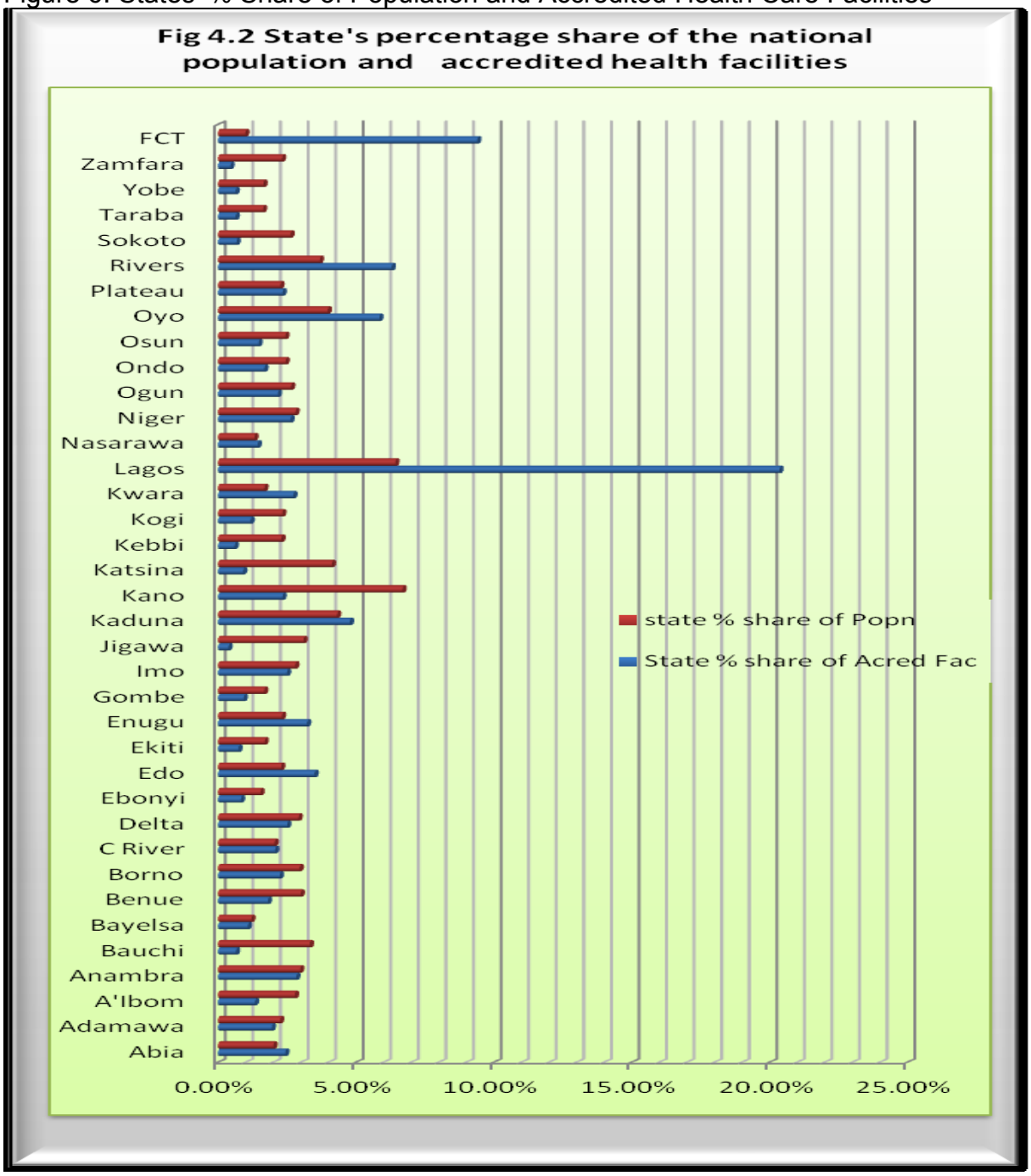
Figure 5: Distribution of Accredited Healthcare Providers by State



Source: Authors'

Figure 6 below compare each state's percentage share of the national population and its percentage share of accredited health facilities. The comparison is quite revealing. It shows the huge gaps between states' share of population and their percentage shares of the accredited health facilities. For example, while Lagos state has a 6.4% of Nigeria's population, according the 2006 census, it has 20.37% of the accredited health facilities which is more than three times its due share of accredited health facilities. Similarly, the FCT has 1% of Nigeria's population, yet it has 9.41% of the total accredited hospitals. On the other hand Jigawa has 3.11% of Nigeria's population but has only 0.39% of the total accredited health facilities. In the same category with Jigawa is Katsina with 4.14% of Nigeria's population but its share of the total accredited health facilities is only 0.92%.

Figure 6: States' % Share of Population and Accredited Health Care Facilities

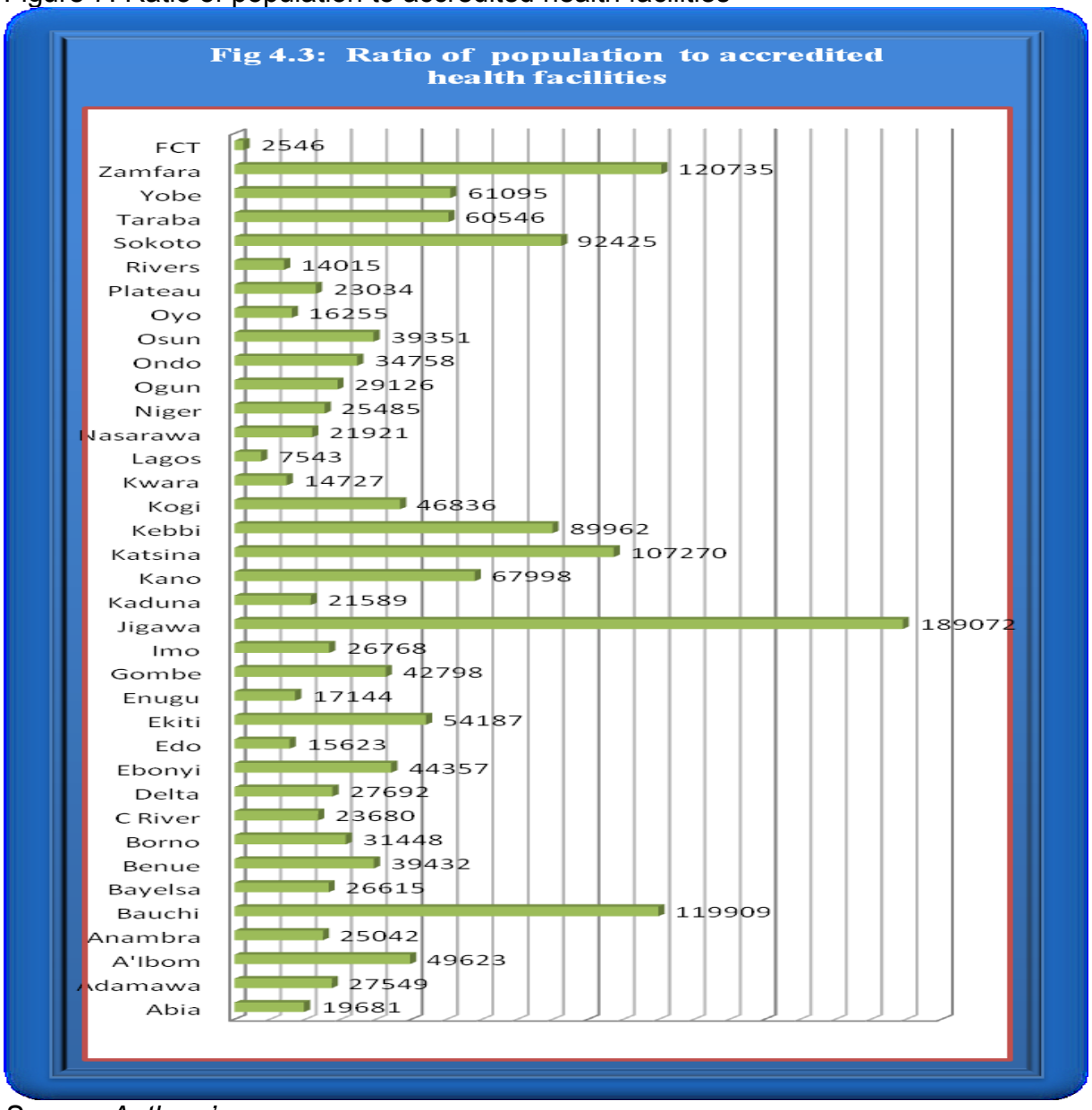


Source: Authors'

Figure 7 below further show the ratio of population to accredited health facilities. Following the trend of other indicators, this particular indicator shows that Jigawa, Bauchi, Lagos, and FCT has about 189072, 120000, 7543 and 2546 people to one

accredited facility respectively. Kwara, Oyo, Imo and Bayelsa states has 14727, 16255, 26768, and 26615 people to one accredited facility respectively. Unfortunately, the states with highest disease burdens are also the states with highest population to accredited health facility ratios. For example, according to 2003 NDHS survey child mortality in the North West was more about three times the rate of Child mortality in the SE. In general, most of the northwestern states have high levels of maternal mortality and yet have also least access to NHIS accredited health facilities. Conversely, states with relatively low disease burdens are also the ones with highest levels of access to NHIS accredited facilities.

Figure 7: Ratio of population to accredited health facilities

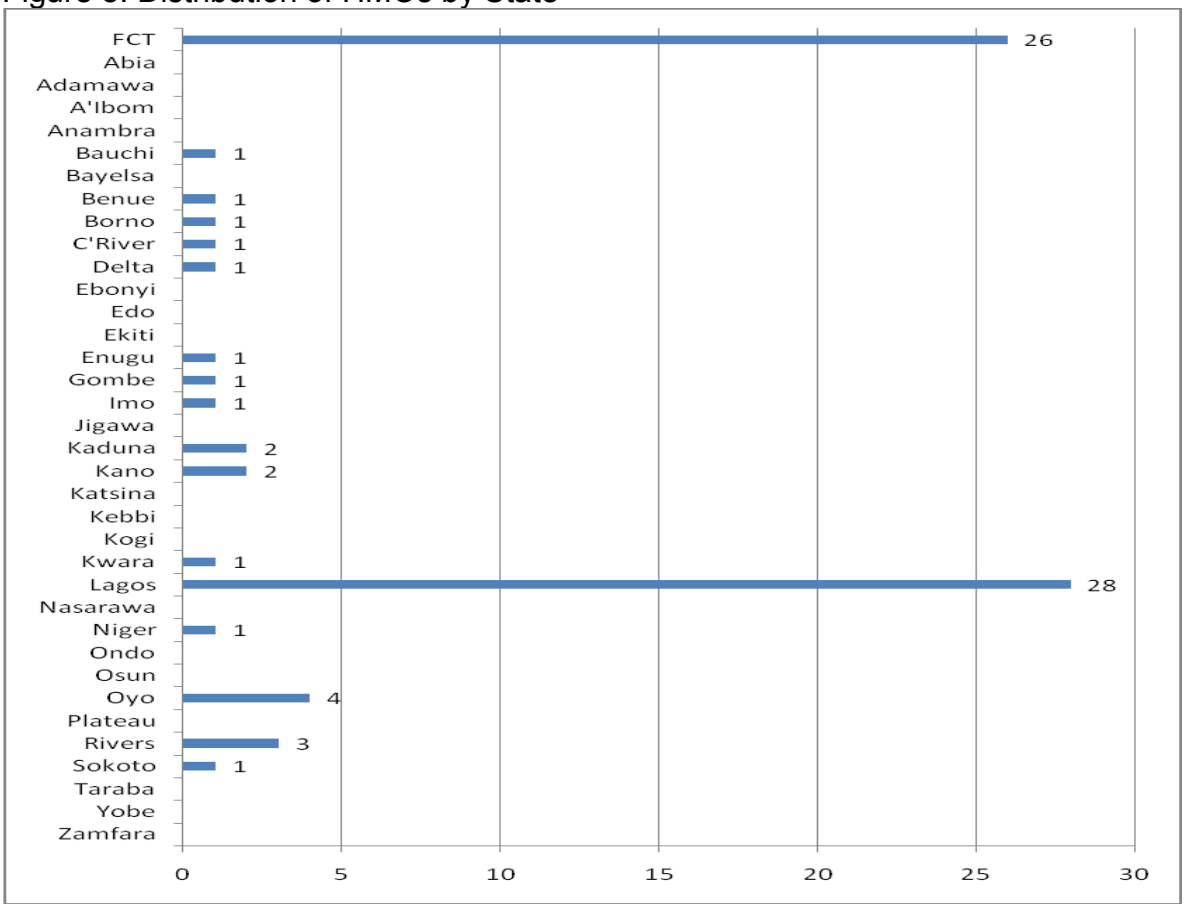


Source: Authors'

The root of this inequity however, goes beyond NHIS. It is indeed historical, political, as well as ideological. The historical roots could be traced to the colonial policies of Indirect Rule in the North which shielded much of the region from the influence of Christian Missionaries who were at the same time the bearers of western medicine and western education in the country. The political roots could also be traced to the feudal system that makes access to social services including health as preserve of the rich and the elites. The ideological roots of these disparities in the distribution of health facilities between the North and South is to be found in the more welfarist approach to social provision of social services in the North than in the South. Most of the health facilities in the southern part are owned by private healthcare providers while the opposite is the case in the north. The inability of state governments in the North to provide enough health facilities and lack of adequate complement from the private sector in the region accounts for the relatively huge deficit of health facilities in the North.

In addition however, it is the tendency of Health Management Organizations to use the easily accessible health facilities as providers of health services for the scheme. In this regard, the distribution of Health Management Organizations in the country also comes to play an important role. Worse than the distribution of accredited health care providers under the NHIS, the distribution of the HMOs (see figure 8) shows that Lagos and FCT with 28 and 26 HMOs respectively, share between them, virtually all the HMOs in the country.

Figure 8: Distribution of HMOs by State



Source: Authors'

4.4.3 Efficiency of the NHIS Programme

The efficient deployment of human and material resources in the health sector has become a cardinal pursuit of most health systems particularly since after the publication of World Health Report 2000 by the World Health Organization. This report was devoted to identifying the determinants of and measure of health system efficiency. The key question raised by this report was whether national health systems were deploying scarce resources in efficient manner.

The pursuit of efficiency in the health sector has also become a central concern for policy makers because many sources of finance including tax revenues are under pressure. Developmental needs of the society increases the opportunity costs of health expenditure. There is therefore the need to ensure that expenditure in the health sector is given value for money. Cost effectiveness analysis of medical technologies are also being undertaken in many health systems to ensure that only the most cost effective systems are deployed in health systems. Furthermore, the increasing cost of healthcare globally has put pressure on health system managers to adopt cost-containment approaches to healthcare delivery.

In Nigeria inefficiencies in the healthcare care sector generally arise due to several factors among which are the following:

- Sub-optimal use of factors of healthcare production;
- Allocation of public resources towards higher levels of healthcare system and towards urban areas;
- Ineffective deployment of public resources at those points where they would have greater impact such as Primary Health Care (PHC) and endemic disease control; and
- Corruption in the health system.

A number of recent studies undertaken to examine the level of efficient deployment of resources in Nigeria indicate that there is high level of inefficient use of scarce resources in the Nigerian health system. Olayiwola (2010) measured the level of efficiency in the control of HIV/ASIDS in Nigeria using the data envelopment analysis. The results show that resources in the segment of the health sector were being deployed inefficiently. Similarly Ichoku et al (2011) analyzed the efficiency of hospitals in two states in South-East Nigeria using a sample of 200 hospitals. The results indicate gross inefficient deployment of human and material resources. More importantly, the results indicate that the present levels of outcome could be achieved using only 60% of the resources currently deployed in the health sector. In other words, there are rooms for cost savings in the Nigerian health sector.

4.5 Contribution of NHIS towards advancing the efficiency in the Nigerian health system

An important channel through which the NHIS contributes to improved efficiency of the Nigerian health system is through effective gate-keeping and referral system. The NHIS ensures that health seekers are made to obtain primary health care services at the Primary Healthcare Centres, that secondary care is obtain at the general hospitals while tertiary health care are referred to the tertiary health institution – the Teaching hospitals and Specialist Medical Centres. Effective gate-keeping implies that simple malaria cases are treated at PHC while only cases requiring procedural treatments are treated at the specialized hospitals. This leads to efficient use of human and material resources in the health sector.

However, while appropriate gate-keeping leads to improved health resources utilization, there are also complaints that the HMOs frustrate the referral system by making it difficult for cases to be referred because, they want to save money for their pockets. A health care provider operating under the NHIS complained about this and several other sources of inefficiencies and frustrations of health seekers:

i. *I am a Care provider in this Scheme and also advice my CEO on all matters related to health of the employees, therefore I have seen all sides of the equation. While I appreciate the efforts being made by the NHIS, especially in the recent past, I believe they also need to improve their capacity and be*

more dedicated to be able to handle the job especially with regard to registration. In my organisation a lot of people have sent their forms for the last 6months and there has been no reply, the HMO says they have sent it to NHIS but that NHIS keep telling us that it is the responsibility of the HMOs to register enrollees.

ii. *The HMOs on the other hand need to be properly regulated. I believed the HMOs are currently only killing the system. Everybody is complaining that they don't allow referrals simply because they want to keep the fee for service to themselves. I believe that is the greatest obstacle to the take up of TISHIP. Most of the HMOs have tied significant percentage of the fund to fee for service and most of us that are involved in the business know that the money will only end up in their pockets*

iii. *I totally agree with you on the issue of enrollees waiting forever to get registered after filling the necessary forms. I am a care provider as well as an enrollee. The other area is that of mix-up in enrollees' details: wrong pictures, mis-spelt names etc. The painful thing however is that there is usually no responses from NHIS if you complain either through email or through your institution. Can we improve on this? Can we defend our cold action to our customers who seem to be wrong all the time in the Nigerian context?*

iv. *I think the NHIS monitoring unit will have to start applying serious sanctions to the HMOs who do not settle Claims (especially Fees-For-Services) promptly. The present attitude of some of the HMOs towards claims payments is making Secondary Providers refuse enrollees needing Secondary Care. Hence enrollees will suffer most. NHIS will have to begin to set vivid examples in order to sanitize the system. For the Scheme not to fail, NHIS will have to cub the current sharp practices by the HMOs in the field.*

v. *I disagree with you on payment of fee for service. Most of the providers don't send the bills on time, that is, within the month of treatment, while some if they do, it is usually not in the right format or some of the documents are not available. We have to understand that the HMO has to give account for funds collected from NHIS, be it fund for payment of capitation or fee for service.*

vi. *The providers need to know their limit on the scheme, there is no "one Dr do all" on the scheme. The patient needs to be referred according to the guidelines of NHIS. We have working documents on the scheme. A lot of providers don't read these documents, rather they handover all affairs of NHIS patients to their desk officer, who sometimes when not on sit no one within the hospital can give you information on NHIS.*

On the issue of efficiency, awareness and quality of service provided, some of the participants in the programme commented on NHIS online forum as follows:

i. *Many of the HMOs have more than enough enrollees they can take care of perfectly, while others only pay capitation to providers and leave the hospital bills [claims] procured by their enrollees unpaid to the secondary providers which in turn delay the care provision for the enrollees or better put denies them care. This is not part of the aim and objectives of this scheme.*

ii. *To move the nation healthcare forward, we need positive reaction towards the scheme on the sides of both the providers and the commoners [enrollees/non enrollees]. The government should create more awareness for the people to get to know how the scheme will better their lifestyle and lifespan. In developed countries where this scheme is been practiced, peoples' response is encouraging just because they had good orientation about the scheme.*

iii. *This is a good dream towards good health for all at least if our government cannot afford free health for all due to our economic mess. We need to encourage it and sustain the dream to make our nation.*

More complaints from participants in the NHIS project points to other critical weaknesses of the system as currently run. An anonymous stakeholder complained,

> *"Having worked in healthcare delivery in Nigeria, and witnessing first hand, the nefarious activities of many HMOs, Medical directors along with the difficulty faced by many hospitals in coping with low capitation payments. I will say that Nigeria's Social Health Insurance still has a long way to go. However I believe the idea of health insurance is a noble one.*
>
> *In theory social health insurance works at spreading risks, improving access to healthcare and reducing catastrophic costs. To expand the coverage of the NHIS, I will suggest the parastatal de-evolves control, by setting up regional and state health insurance offices- which can work towards capturing and managing populations within their areas of control.*
>
> *As health and education patterns are different across Nigeria, it would be folly to assume that an intervention that works well in Lagos State will work well in Sokoto state or even Anambra State. In addition, as health systems possess undefined boundaries, there are many elements of our healthcare which as the commenters have noted are outside the realm of control of NHIS e.g. inadequate infrastructure and mal-distributed human resources for health. Nevertheless NHIS should continue to communicate the benefits of the scheme.*

Another area that concerns me, which may or may not be related to this article, is the ridiculous number of enrollees assigned to some hospitals. I believe this is one area that should thoroughly be examined, as it is unfair to newly established health providers. A clear standard should be set for the number of enrollees a hospital can accept.

Capitation amounts should also be increased, because whether we like it or not Healthcare is expensive. The NHIS talks about driving health costs down but I wonder how it can do this when government expenditure on health is still low, Medical equipment's are imported, competition to retain skilled staff exists in many hospitals. Let us not also forget the global recession. I believe the NHIS should be realistic in determining this sum.

These complaints summaries the key short-comings of the NHIS in attaining the objective of efficiency in health care in Nigerian health system. In a very real sense, the role of the HMOs seems to be inimical to the public expectations of healthcare delivery system within the vision of NHIS. They short-change the system to increase their profit.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Summary and Conclusion

Despite the existence of some social protection programme in Nigeria for some time now, both statistical evidences specifically from the World Bank Development Indicators and the World Health Organisation data base, not excluding the CBN statistical Bulleting, evidences from imperial studies and practical observations still rank the country very low in human development and health outcome. This motivated this research which was aimed at evaluating the performance of the existing state social protection programmes in the country with specific emphases on the National Health Insurance Scheme and the Conditional Cash Transfer programmes in the country.

The study methodology involved the collection and analysis of primary data from interviews and focus Group discussion from three states in the country and the federal Capital Territory, Published and unpublished documents from the offices involved in the programmes at both the federal and state level, and previous empirical studies. The interview and focus group discussion was conducted in Abuja, Enugu, Delta, and Nasarawa state.

The findings of the study are not uniform across the sources of information. For the CCT programme, all the evidences from the NAPEP are pointing towards a well-functioning programme with large coverage, efficient and sustainable distribution of resources. For instance, they have a report that COPE phase I and II made over 109,210 basic school aged children who either were not in school (mostly from the Northern part of the country or who were in danger of dropping out as in many states in the South) to be in school. As of 2010, the national coordinator of NAPEP said that the COPE programme have been able to reduces the number of very poor households in the country by 6,832,851 and that the total number of households reached by the programme was 21,842. This according to him amounted to 0.32% of the core poor households in need of CCT in Nigeria.

On the contrary, empirical evidences and statistical reports are suggesting that the programme is not yet functioning as it ought to. Though the reports acknowledged that the CCT programme has not been in existence for so long, they are all of the opinion that if the programme should function as it ought to, that close to five years should have been enough for its impact to reflect on the county's human development index.

Most of the participants and previous studies blame the poor impact of the programme on poor funding and management and hence limited coverage, and

excluding the poor in the programme planning, management and implementation. The participants from Nasarawa for example said that the programme lasted only for one year in their state since the state has not received any other fund from the federal government after the first one. They also reported that only 10 participants from each village were allowed to take part in the programme. This with the above statement from the NAPEP coordinator that only 0.32% of the core poor household in need of CCT have been reached by the programme is a clear indication of the poor coverage of the programme.

Lack of equity in the programme is made manifest in the equality in the distribution of the fund across the state. This is so because, equity in this case means distribution according to need and it is clear form statistics that all the states don't have equal need for CCT as both the proportion and number of core poor varies across the states.

The survey revealed a very poor result for the NHIS in all the aspect of the evaluation; coverage, efficiency, equity and sustainability. After nearly seven years of operation and more than twelve years after it was set up, the scheme has covered only 5.3 million Nigerians (representing just about 3.5% of the total population). Worse still, the coverage has been mainly civil servants employed by the Federal Government who in the actual sense are not in most need of the programme. The original aim of the programme is to serve for cross subsidization, where the rich and those working should subsidize the poor and those unemployed but now, only those employed are part of the programme, reducing the cross subsidization aim. Another evidence of poor coverage in the programme is in the Maternal and Child Health Project (MCHP) scheme in Bauchi, Cross-River state which was designed for 600000 thousand pregnant women and under-five but ended up with only 300000 which is just half the targeted participants. Inadequacies of the law setting up the scheme, the political structure of three-tier system of governance in the country, poor economic status of great proportion of the population, the distribution of medical facilities in the country, and lack of public awareness about the scheme was however identified as factors constraining the expanded participation in the scheme.

Several indicators from the survey tend to show that the NHIS has worsened rather than improved equity in the Nigerian health care system. The evidence was revealed in the distribution of HMOs, Providers, and in participation. About 1195 representing over 20% of the total 5867 accredited health facilities under the NHIS programme are located in Lagos. At the other extreme, there are states, such as Jigawa with 23 accredited facilities, Zamfara with 27, and Kebbi with 36 and many others who have minimum coverage under this accreditation. Analyses of the ratio of population to accredited health facility show that Jigawa, Bauchi, Lagos, and FCT has about 189072, 120000, 7543 and 2546 people to one accredited facility respectively. Kwara, Oyo, Imo and Bayelsa states has 14727, 16255, 26768, and 26615 people to one accredited facility respectively. Unfortunately, this reveals an inverse relationship between disease burden and availability of health care facilities.

On the issue of efficiency of service, most of the interviewed participants see the programme as a good dream but are of the opinion that the programme still has a long way to go. Some complained that the period between registration and receiving of the ID card that qualifies one to partake in the programme takes too long. Others complained that the waiting period by the enrolees in the service delivery is embarrassing, pointing towards uncontrolled number of enrolees per Hospital as the main cause. The lack of efficiency in the programme was also linked to uniform policy implementation of the policy, inadequate infrastructure and mal-distributed human resources for health care.

As the survey revealed that after close to seven years of operation, neither the employer nor the employees have been asked to make their contribution towards the programme, the sustainability of the programme is in doubt. This is because it will lead to low capitation to the HMOs and even delay in the payment. This in turn will lead to sluggishness or their refusal to attend to NHIS patient.

In summary therefore, the survey show that both the NHIS and the CCT programme are highly welcomed by the masses and are seen as a good dream toward the MDG goal of alleviating poverty and ensuring good health for the people. However, the general opinion is that both of the programmes are not yet functioning as they ought to both in terms of coverage, efficiency, and equity and that both the government and the offices in charge of the programme should increase their effort towards the programme.

5.2 Recommendations

From the findings of the survey, the following recommendations are made;

(A) For CCT

i. There should be increase in the fund for the CCT programme. This can be achieved by not allowing only the Federal government to fund it. The state, Local and other organisation should also be encouraged to be part of funding for the programme.

ii. The distribution of the fund and resources should be primarily according to need. Since the programme's main aim to ensure school retention, most of the fund should be directed to zones and states with low primary school enrolment-population ratio.

iii. The poor should be involved in decision making in the programme. This is needed for the survey found that at times some of the policies do not address the need of the poor. One of the respondents suggested the theory of Humble Approach to Development, which says that it is appropriate for government "to ensure their citizens' active participation in formulating and implementing projects of which they are supposed to be the beneficiaries".

iv. It was also suggested that there should be increase in the school facilities both in terms of human and material resources otherwise the programme may lead to increased attendance with a reduced quality.

v. More importantly, efforts should be made to ensure accountability and transparency in the programme through monitoring and regular evaluations. Tis off course should be done with information from the beneficiaries and not the offices managing the programme.

(B) For NHIS;

i. If the government really wants the programme to be efficient, the capitation amounts should be increased, to motivate the heath care provider. To achieve this, the 15% contribution from the employers and the employees should be started to generate enough fund for the programme and to ensure that the programme meets its basic goal of cross-subsidization.

ii. The NHIS talks about driving health costs down but one wonders how it can do this when government expenditure on health is still low, Medical equipment's are imported, competition to retain skilled staff exists in many hospitals. Let us not also forget the global recession. One therefore, believes the NHIS should be realistic in determining this sum.

iii. The coverage of the programme should be expanded by setting up regional and state health insurance offices- which can work towards capturing and managing populations within their areas of control.

iv. The HMOs need to be properly regulated. This is to ensure among other things that HMOs don't have more enrollees that they can efficiently handle (standard should be set for the number of enrollees a hospital can accept.), that they allow referrals for cases that they are not meant to treat, settle claims (especially Fees-For-Services) promptly and to cub the current sharp practices by most HMOs in the field.

v. The government should create more awareness for the people to get to know how the scheme will better their lifestyle and lifespan.

REFERENCES

Adato M., and Hoddinott,J., (2008), 'Social Protection Opportunities for Africa', *IFPRI Policy Brief No. 5.*

Angrist J. and A. Kreuger, (1999), 'Empirical Strategies in Labour Economics', *Handbook of*

Angrist, J. and S. Pischke, (2008), '*Mostly Harmless Econometrics: An Empiricist's Companion*', Princeton University Press.

Arial F., and Norbert S., (2009), 'Conditional Cash Transfers: Reducing Present and Future Poverty', *World Bank Policy Research Report*, World Bank, Washinton D.C.

Asian Development Bank, (2003), 'Social Protection: Policies and strategies'.

Barham T, (2006). 'Providing a Healthier Start to Life: The Impact of Conditional Cash Transfers on Neo-Natal and Infant Mortality'*, Department of Economics and Institute of Behavioral Scienc*e, University of Colorado, Boulder

Barrientos A, and Santibanez, C, (2011), 'New Forms of Social Assistance and the Evolution of Social Protection in Latin America', *Journal of Latin American Studies* 41. 1-26 Cambridge University Press

Bassett, L., (2008), 'Can Conditional Cash Transfer Programmes Play a Greater Role in Reducing Child Under-nutrition?' *Social Protection and Labour discussion paper*, World Bank

Booth, D., R. Crook, E. Gyimah-Boadi, T. Killick, and R. Luckham, with N. Boateng, (2005), 'What are the Drivers of Change in Ghana?', *CDD/ODI policy brief no. 1*, Legon and London:

Britto, T., (2004), '*Conditional Cash Transfers: Why Have They Become So Prominent in Recent Poverty Reduction Strategies in Latin America',* The Hague: Institute of Social Studies.

Chen MA, (2001), 'Women and Informality: A Global Picture, the Global Movement, *SAIS Review* 21.1 p71-82

Cain, E., (2009), 'Social Protection and Vulnerability, Risk and Exclusion across the Life Cycle', in Promoting Pro-Poor Growth: Social Protection, *OECD DAC*, Paris, pp. 129-144

De Brauw A, and Hoddinott J, (2008), 'Must Conditional Cash Transfer programmes be conditioned to be effective? The impact of conditioning transfers on school enrollment in Mexico, *IFPRI Discussion Paper 00757*, March 2008 International Food Policy Research Institute, Washington DC

De Janvry A, and Sadoulet E, (2006), 'Making Conditional Cash Transfer Programmes More Efficient: Designing for Maximum Effect of the Conditionality', *World Bank Economic Review* 2006: 20

DFID Nigeria Operational Plan 2011-2015, Updated June 2012.

Dijkstra, G., Akanji, B., Hiddink, C., Sangarabalan, S. and de Mevius, F.X., (2011), 'Mutual Interests – Mutual Benefits: Evaluation of the 2005 Debt Relief Agreement between the Paris Club and Nigeria', *Ecorys Nederland and Oxford Policy Management*.

Duflo E, (2004). *Grandmothers and Granddaughters: Old Age Pensions and Intra-household Allocations in South Africa',* World Bank Economic Review Vol. 17 No 1. 1-25

EPRI, (2003), '*Designing Conditional Cash Transfer Schemes'*, *in "Designing and Implementing Social Transfer Programmes",* Policy Guide Ch.9

Gasper F.and Claudia V., (2010), 'Conditional Cash Transfer: a Global Perspectives', *MDG Insight,* issue 01, Feb., 2010l.

Hagen-Zanker, J. and Tavakoli, H., (2011), 'Fiscal Space for Social Protection in Nigeria', *ODI Project*

Harper, C. and Jones, N., (2009), 'Child Rights and Aid: Mutually exclusive?' *ODI Background Note*, London: ODI.

HelpAge International and African Union, (2008), 'Investing in Social Protection in Africa'

Henriques, J.M., (2008), 'Social Protection, Employment and Local Development: Guidelines to Help Partners to Consult Local Organisations in the Social Economy in the Area of Social Exclusion', *Bridges for Inclusion, International Labour Office (ILO),* Geneva.

Holmes, R., Akinrimisi B., Morgan J., and Buck, R., (2011), 'Social Protection in Nigeria: an overview of programmes and their effectiveness', *Project briefing,* Overseas Development Institute, London.

Holmes, R., Samson, M., Magoronga, W., Akinrimisi, B., and Morgan, J., (2012), 'The Potential for Cash Transfers in Nigeria', *ODI/UNICEF Nigeria*

ILO, (2003), '*ILO launches global campaign on social security for al*', Geneva, International Labour Organization, (http://www.ilo.org/global/About_the_ILO/Media_and_public).

Kaufmann, D., Kraay A. and Mastruzzi, M., (2006), 'Governance Matters V: Governance Indicators for 1996-2005, *World Bank Policy Research Working Paper 2259*

Labor Economics, Volume 3, Ashenfelter, A. and D. Card, eds., Amsterdam: Elsevier Science, Many Challenges but Great Initiatives.

Michelle Adato and John Hoddinott, (2008), 'Social Protection Opportunities for Africa, *IFPRI Policy Brief 5* • September 2008

National Social Protection Committee, (2005) 'Social Protection in Nigeria', SP Conference TUNIS 2005

Nicola Jones and Rebecca Holmes, (2010), 'Tackling child vulnerabilities through social protection: lessons from West and Central Africa', *Overseas Development Institute.*

Notorn A, Conway T and Foster, (2001), 'Social Protection Concepts and Approaches: Implications for Policy and Practice in International Development', *Overseas Development Institute*, London SE1 7JD UK.

Maduagwu A, (Unpublished), 'Alliviating Poverty in Nigeria.

Okoye U.C. and Onyukwu, E.O. (2007), 'Sustaining Poverty Reduction Efforts through Inter-Agency Collaboration in Nigeria' in Kenneth Omeje (ed), *State, Society Relations in Nigeria, Democratic Consolidation, Conflicts and Reforms, London*: Adonis and Abbey.

Orji A., (2005), '*An Assessment of the Impact of Poverty Reduction Programmes in Nigeria as a Development Strategy'*, PhD Dissertation, Clement University, Turks and Caicos Island.

Ortiz, I. and Cummins, M., (2011), 'Global Inequality: Beyond the Bottom Billion: A Rapid Review of Income Distribution in 141 Countries', *Social and Economic Policy Working Paper*. New York: UNICEF.

Ovie F. E, (2011), 'An Appraisal of Poverty Alleviation Programmes in Nigeria', *JORIND (9)1.*

Rawlings, L. (2005), 'Evaluating the Impact of Conditional Cash Transfer Programmes', *World Bank Research Observer.* 20(1): 29-55.

Romoke W. Ahmad and Hussein Yahaya, *'Nigeria: 88 Families Benefit From MDGs Cash Transfer Programme*' in Daily Trust *20 March 2012*.

Sanubi F. A. (2011), "Social Protection as A Residual Safety Net in Democratic Governance in Nigeria: A Critical Analysis of Some Current Policy Initiatives" *Institute of Development Studies*, UK

Samson, M., van Niekirk, I. and Mac Quene, K., (2006), 'Designing and Implementing Social Transfer Programmes', Economic Policy Research Institute (EPRI), Cape Town

Social Protection in West Africa, Brazil and African Newsletter, August 2008.

Summary report of national consultations held in Burkina Faso, Cameroon, Mozambique, Rwanda, Sierra Leone and Tunisia, London

Svensson, J and Pettersson-Lidbom, P, (2008) *'Impact Evaluation of Service Delivery Programmes: Methods and Concepts for Impact Assessments in Basic Education, Health, Water and Sanitation*', Paper prepared to the African Economic Research Consortium.

Taylor V, (2008), '*The study on social protection systems in Africa: An overview of the challenges*', Paper prepared for the First Session of the AU Conference of Ministers in charge of social development held from 27 to 31 October 2008 in Windhoek, Namibia. UN, 2001, Enhancing Social

Ugoh, S. C. and Ukpere, W.I. (2009), 'Appraising the Trend of Policy on Poverty Alleviation Programmes in Nigeria with Emphasis on a National Poverty Eradication Programme (NAPEP)', *African Journal of Business Management Vol.3 (12), pp. 847-854.*

UNICEF, (2009), 'Strengthening Social Protection For children in west and central Africa'.

Van Ginneken, W. (2003, 'Extending Social Security: Policies for Developing Countries. *Geneva, International Labour Organization* (ESS Paper No. 13)

APPENDIX 1: STANDARD WDIs ON HEALTH.

WDI on Health					
	Health				
	One-year-olds lacking immunization against		Mortality		
	DTP	Measles	Under five	Adult (per 1,000 people)	
HDI rank	(%)	(%)	(per 1000 live births)	Female	Male
	2009	2009	2009	2009	2009
156/187	58	59	138	365	377
Very high human development	5	7	6	60	114
High human development	6	5	19	106	223
Medium human development	19	18	44	131	204
Low human development	26	28	117	287	346

APPENDIX 2: LIST OF HEALTH MAINTENANCE ORGANISATIONS

Code	Name of HMO/Address	Telephone
001	HYGEIA HMO LIMITED Bank of Industry Building 2nd Floor, 21/22 Marina Lagos	01-4517071 01 -4617073 08036710207 Adebajo (Abuja)
002	TOTAL HEALTH TRUST LIMITED 2 Marconi Road Palmgrove Estate, Lagos	01-4701813 01-7737150
003	CLEARLINE INTERNATIONAL LIMITED 16 Oyefe Avenue, Off Ikorodu Road, Savoil B/Stop/Halimark Assurance Plc. Obanikoro, Lagos.	01-7741092, 4977542 09-675605, 2730839 0806006004
004	HEALTHCARE INTERNATIONAL LIMITED 308A Murtala Mohammed Way, Yaba, Lagos Abuja Office: 3rd Floor UACN Commercial Complex Plot 272/273, Beside Arewa Suites Central Business District, Abuja. Port-Harcourt Office Kano Office Hadejia Liaison Office Sokoto Liaison Office Bauchi Office Azare Liaison Office Ibadan Office Enugu Office	08052099094-99, 01-4489821 08052099066, 08052099069 08052099077-82 08052099057, 08052099059-60 08052099055, 08052099056 08052099058 08052099061-64 08052099065 08052099072-76

Code	Name of HMO/Address	Telephone
	Minna Office	08052099083-87 08052099068
005	MEDIPLAN HEALTHCARE LIMITED Plot 286B, Ajose Adeogun Street Victoria Island, Lagos. Abuja: Suite 42-44, God's Own Plaza Takun Close, Off Nkwere Street By Ahmadu Bello Way Behind Unity House (Rochas Foundation)	01-2611012 01-2614828 08033081650
006	MULTI SHIELD NIGERIA LIMITED 17A Commercial Avenue, Yaba, Lagos Abuja: Metro Plaza Suite F18, 1st Floor (Opp. Nat. War College Central Area, Abuja	01-7737579 01-7910807 09-4619127 09-4619128 Fax 08032916251 (Amana)
007	UNITED HEALTHCARE INTERNATIONAL LIMITED NICON Plaza, 2nd Floor, Abuja.	08034086095
008	PREMIUM PRIVATE HEALTH TRUST LIMITED 31b, Itafaji Road, Dolphin Estate Ikoyi, Lagos Abuja: No. 5B Kabo Street Garki II Opposite Eddy Vic Hotel Abuja	01-4614498 08023387494
010	RONSBERGER NIGERIA LIMITED Plot 359,Mambolo Street, Zone 2, Wuse District, Abuja	09-5234162 09-6709889 08035053179 (Mr. Ben. Chukwu)
011	INTERNATIONAL HEALTH MANAGEMENT SERVICE LTD 2, Joseph Street, Off Broad Street, Lagos 3, Gwani Street, IGI House, Wuse Zone 4, abuja	01-2716441, 07028097372 09-2909336
012	EXPATCARE HEALTH INTERNATIONAL LIMITED. 39A, Sura Mogaji Street, Off Coker Road, Ilupeju, Lagos	08055890010, 08055274020 08055890025, 08025240194 08025240418
013	SONGHAI HEALTH TRUST LIMITED. Ground Floor, Nigeria Re-Insurance Building Beside Unity Bank, Plot 78a Herbert Macaulay Way, Central Area, Abuja.	09-2223636, 08033571011
014	INTERGRATED HEALTHCARE LIMITED 12 Jos Street, Area3, Garki, Abuja	09-2342199 09-2342299
015	PREMIER MEDICAL LIMITED Olive House, No. 6/53 Fajuyi Road Adamasingha, Ibadan Abuja Office: No. 4 Takum Close Area 11, Garki, Abuja	01-2410052 08037866956 Steve Auta 08063446465
016	MANAGED HEALTHCARE SERVICES LIMITED 16 Obokun Street, Off Coker Road Ilupeju, P.O Box 641, Oshodi, Lagos Abuja: 1st Floor Tofa House Central Business District, Abuja	01-4931629-32 08059705441 08033206673

Code	Name of HMO/Address	Telephone
017	PRINCETON HEALTH GROUP 25, Mogaji-Are Road, Opposite D-Rovans Hotel Ring Road, P.O. Box 23512, Mapo, Ibadan. 42, Adetokunbo Ademola Crescent, Wuse 11, Abuja, FCT Abuja.	TEL 0700-400-4000 TOLL FREE 0800-400-4000 OTHERS 0806-042-9280, 0802-313-7463, 0805-872-4571 EMAIL info@princetonhmo.com 0803-430-6380
018	MAAYOIT HEALTHCARE LIMITED 1, Ilofa Road, G.R.A, P.O Box 5504 Ilorin, Kwara State. Abuja Office: No. 5 Mahathma Gandhi Street Off Shehu Shagari Way Asokoro Extension, Abuja	031-229898 08058026841 09-3145815 08050825957 08023240467 08050825957 Adesuyi P. R.O
019	WISE HEALTH SERVICES LIMITED Plot 533, Durban, Off Adetokunbo Ademola Crescent, Wuse II, Abuja	09-6723065 09-5238935 01-2623114 09-5238925 09-5238923 (08023355000) Mr. Ayo Rabiu (o8o36339696)
020	WETLANDS HEALTH SERVICES LIMITED 80B Peter Odili Road Opp Trans Amadi Garden Gate, Trans Amadi, Port Harcourt	084-750952 084-771691 08023373103 08033551351, 08050981840 (Praise Jimoh) Abuja
021	ZENITH MEDICARE LIMITED No. 65 Usuma Street, Off Gana Street, Maitama Abuja	09-4133870-1 Fax: 09-4131660
022	DEFENCE HEALTH MANAGEMENT LTD. Plot 1323, Adesoji Aderemi Street Gudu District Abuja	09-2348096
023	UNITED COMPREHENSIVE HEALTH MANAGERS LTD. Suite 40, 24 Old Aba Road, Rumuogba P.O. Box 6150, Trans Amadi, Port Harcourt, Rivers State	08033419470 08036194392 – Rita (Abuja)
024	HEALTHCARE SECURITY LTD. 3 Kanta Road (Near NNDC), P.O. Box 8318 Kaduna. Abuja: Bannex Plaza BPS 6, 750 Aminu Kano Crescent Wuse II, Abuja	08052745337 08033148050 Augustine Igomu 08055121516
025	STRATEGIC HEALTH PLANNERS CO. LTD. BK International House SPC Junction, Murtala Mohammed Highway P.O Box 3047, Calabar, Cross River State	08050233249 08037091628 08037871484 Mr. Ezete – Abuja 08055353370
026	ROYAL HEALTH MAINTENANCE SERVICES 24 Wetheral Road, Owerri, Imo State.	08037956689 083-231053
027	AREWA HEALTH MAINTENANCE SERVICES Plot 645, Alex Ekwueme Street, Jabi, Abuja	09-2908529, 08067184058 09-5231162, 08027128412
028	ZUMA HEALTH TRUST 1235, No. 6 Sapele Street, Opp. NSMP Quarters, Garki, Abuja.	09-5236159 Dr. C.D. Ali 08033147249

Code	Name of HMO/Address	Telephone
029	MARKAFEMA NIGERIA LTD. 4A Gurara Street Ibrahim Abacha Estate Zone 4, Abuja	09-5238945 6725510 08033109117 Dr. Femi Onimole 08054472099
030	PREPAID MEDICARE SERVICES LTD. 9A Ganges Street Off Alvan Ikoku Way Ministers Hill, Maitama, Abuja	09-5240697, 5240428 - Office, 08023379420 - Medical Manager 08033831737 - Customer Service Dr. Gbolahan Olagbegi 08058959065
031	CIGNET HEALTH LIMITED 15 Admiralty Way Lekki Phase 1, Lagos	01-2706697, 5555603, 5555567, 01-276697 Hon Jeff
032	FORTECARE LIMITED 303 Nnebisi Road Asaba, Delta State	056-280855, 282157, 282164, 08033185341 Dr. Onyia I. Odaniba 08033085205 Valentine - Abuja
033	PHB HEALTHCARE LIMITED 2nd Floor, Bank PHB Building 1, Keffi/Manuwa Street, South West IKoyi, Lagos.	01-4610266, 2625682, 2625684-5 08034963464 Mr. Martin Chukwu
034	Sterling Health Managed Care Services Limited Valley View Plaza 99 Opebi Road, Ikeja, Lagos	01-2790698, 08023020934
035	Health Partners Limited 12, Sobo Arobiodu Street G.R.A, Ikeja, Lagos	01-2716982-4
036	Precious Healthcare Limited No 8, Lungi Street, Off Cairo Wuse II, Abuja	234-9-4139411
037	Kaduna GMD Healthcare Limited 13 Isa Kaita Road Kaduna	062-213122, 213120
038	Diamond Shield Health Services Limited 73A, Mainland Way Dolphin Estate, Ikoyi, Lagos	01-4620601, 08033092081
039	Oceanic Health Management Limited 20, Ozumba Mbadiwe Avenue, VI, Lagos	01-46154546, 01-7614947
040	UNIC Health Managed Care Services Ltd. Plot 144, Oba Akran Avenue ikeja, Lagos	01-2709728
041	INVESTCORP MEDICARE LTD Plot 1619, Danmole Street Victoria Island Lagos.	07028006610
042	COMPLETE MEDICARE LTD Nig. Re-Insurance Building 784A Herbert Macaulay Way Abuja.	09-6738983,07036041270

Code	Name of HMO/Address	Telephone
043	GREENBAY HEALTHCARE SERVICES LTD The White House 2nd Floor Metro Plaza Abuja.	08033585100, 08056013652
044	MEDEXIA Ltd 221 Ikorodu Road Lagos.	
045	PARAMOUNT HEALTHCARE SERV. LTD 62, Seriki Aro Avenue Ikeja Lagos.	08059736905, 07063357143, 08024308447, 07090917524
046	ROYAL EXCHANGE LTD 13, Oke Olowogbowo Str. Apongbon, Lagos	08053775743, 01-7411372, 01-2665188, 01-2665128,
047	EMERALD HEALTHCARE LTD 8, Ladipo Adeyemi Street Antonhy Village Lagos	08022920263, 08050513069
048	MARINA MEDICAL SERV. HMO LTD 3rd Floor Wesley House 21/22 Marina to 24, Montgomery Rd., opposite All Saints Church, Iyaba. P. O. Box 5544, Lagos	07023028780, 08027256325
049	OLUMA HEALTH TRUST LTD 5 Ochalefu Street Otukpo Benue State	08055221615, 08025182521 08027674480, 044660130 08033165487
050	CAPEX MEDICARE LTD 10A, Gbagada Express Way, Anthony Village, Lagos	08023073818, 07028417187
051	NONSUCH MEDICARE LTD Plot 1, Abimbola Estate, Lafia Hosital Complex (2nd Floor) Opposite NNPC, Abeokuta Road, Apata, Ibadan	08034080055, 08034545334
052	HEALTHSTONE HMO LTD Gidan Buhari12/13 zoo Road Kano	08037869609, 08052448626
053	HEALTHWYSE GLOBAL SERVICES LTD 2 Adebambo Street Off Ikorodu Road Lagos.	09-4173256, 08033017659
054	SALUS TRUST GTE LTD Catholic Secretariat of Nigeria Force Road Tafawa Balewa Square Lagos.	01-2636670, 01-2635849
055	SAHEL HEALTH TRUST LTD 6, Dipcherima Street, GRA Maiduguri Borno State	08028430599 08030830763
056	GUARDIAN HEALTHCARE LTD. 240cC Kofo Abayomi Street, Victoria (Island, Lagos	08038455148, 08028518794, 08037212117, 08068338896
057	PROHEALTH LTD NSITF BUILDING, PLOT 794, Muhammadu Buhari Way, Central Business District, Abuja	08077834786, 08062691967, 08033497651

Code	Name of HMO/Address	Telephone
058	PRUDENT HEALTHCARE MGT. LTD 17, Aswan Street, Wuse Zone 3, Abuja	098748489
059	PROCARE HEALTH PLAN NIGERIA LTD 18A Dapo Solanke Close, Lekki Phase 1, Lagos	08025144905
060	UNIVERSAL MEDICAL SERVICES LTD 109, Western Avenue, Iponri, Lagos	08033524202
061	ULTIMATE HEALTH MANAGEMENT SERVICES LTD Wema Bank Building, 4th Floor, Airport Retrun Road, Central Business District, Abuja	08060665572, 07027853908, 08059065192
062	ACCESSIBLE MANAGEDCARE LTD NIG Rr-Insurance Building, 7844 H/Macaulay Way, Abuja	0702879387

APPENDIX 3: DISTRIBUTION OF ACCREDITED FACILITIES AND POPULATION BY STATE

State	No Acred Fac	% of Acred Fac	Population	% Popn.	pop2fac ratio	zone
ABIA	144	2.45%	2833999	2.02%	19681	SE
ADAMAWA	115	1.96%	3168101	2.26%	27549	NE
A'IBOM	79	1.35%	3920208	2.80%	49623	SS
ANAMBRA	167	2.85%	4182032	2.99%	25042	SE
BAUCHI	39	0.66%	4676465	3.34%	119909	NE
BAYELSA	64	1.09%	1703358	1.22%	26615	SS
BENUE	107	1.82%	4219244	3.01%	39432	NC
BORNO	132	2.25%	4151193	2.97%	31448	NE
C RIVER	122	2.08%	2888966	2.06%	23680	SS
DELTA	148	2.52%	4098391	2.93%	27692	SS
EBONYI	49	0.84%	2173501	1.55%	44357	SE
EDO	206	3.51%	3218332	2.30%	15623	SS
EKITI	44	0.75%	2384212	1.70%	54187	SW
ENUGU	190	3.24%	3257298	2.33%	17144	SE
GOMBE	55	0.94%	2353879	1.68%	42798	NE
IMO	147	2.51%	3934899	2.81%	26768	SE
JIGAWA	23	0.39%	4348649	3.11%	189072	NW
KADUNA	281	4.79%	6066562	4.33%	21589	NW
KANO	138	2.35%	9383682	6.70%	67998	NW
KATSINA	54	0.92%	5792578	4.14%	107270	NW
KEBBI	36	0.61%	3238628	2.31%	89962	NW
KOGI	70	1.19%	3278487	2.34%	46836	NC
KWARA	161	2.74%	2371089	1.69%	14727	NC
LAGOS	1195	20.37%	9013534	6.44%	7543	SW
NASARAWA	85	1.45%	1863275	1.33%	21921	NC
NIGER	155	2.64%	3950249	2.82%	25485	NC
OGUN	128	2.18%	3728098	2.66%	29126	SW
ONDO	99	1.69%	3441024	2.46%	34758	SW

State	No Acred Fac	% of Acred Fac	Population	% Popn.	pop2fac ratio	zone
OSUN	87	1.48%	3423535	2.45%	39351	SW
OYO	344	5.86%	5591589	3.99%	16255	SW
PLATEAU	138	2.35%	3178712	2.27%	23034	NC
RIVERS	370	6.31%	5185400	3.70%	14015	SS
SOKOTO	40	0.68%	3696999	2.64%	92425	NW
TARABA	38	0.65%	2300736	1.64%	60546	NE
YOBE	38	0.65%	2321591	1.66%	61095	NE
ZAMFARA	27	0.46%	3259846	2.33%	120735	NW
FCT	552	9.41%	1405201	1.00%	2546	NC
	5867		140003542			

APPENDIX 4: PICTURE OF SOME COMMUNITY LEADERS WITH ONE OF THE RESEARCHER DURING THE FIELD WORK IN NASARAWA STATE.

AFRIHERITAGE RESEARCH PAPERS

Research Paper 1: Renewable Natural Resources, Sustainable Economic Growth and Poverty Reduction in Nigeria

Research Paper 2: Does Subsidy Removal Hurt the Poor? Evidence from Computable General Equilibrium

Research Paper 3: Measurement and explanation of the Informal Sector of the Nigerian Economy

Research Paper 4: Fiscal Federalism, Subnational Governance and MDGs in Nigeria

Research Paper 5: On the Determinants of Energy Poverty in Sub-Saharan Africa

Research Paper 6: Cost-Effective Agriculture Growth Options for Poverty Reduction in Nigeria: Evidence and Policy Implications

Research Paper 7: Towards Accelerated Growth and Transformation of the Nigerian Economy: Missed Opportunities, Existing Prospects and the way forward

Research Paper 8: Drivers and Sustainability of Agricultural Growth in Nigeria

Research Paper 9: Public Spending Effectiveness and Distribution of Education and Health Services Benefits in Nigeria