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<td>Author 1</td>
<td>ONAH, Fab. O.</td>
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<td>Title</td>
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SITUATION, ASSESSMENT AND ANALYSIS (SAA) OF CHILDREN AND WOMEN IN ‘A’ ZONE

SUBMITTED TO UNICEF ZONAL OFFICE, ENUGU

BY

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<th>Definition</th>
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<tbody>
<tr>
<td>SPA</td>
<td>State Plan of Action</td>
</tr>
<tr>
<td>SITAA</td>
<td>Situation Assessment &amp; Analysis</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>NPI</td>
<td>National Programme on Immunization</td>
</tr>
<tr>
<td>HSF</td>
<td>Household Food Security</td>
</tr>
<tr>
<td>ARI</td>
<td>acute respiratory Infection NNT = new natal Tetanus</td>
</tr>
<tr>
<td>LBW</td>
<td>Low birth weight, IUGR = Intra Uterine growth Retardation</td>
</tr>
<tr>
<td>NCFN</td>
<td>National Committee of Food &amp; Nutrition</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality rate</td>
</tr>
<tr>
<td>USR</td>
<td>Under five mortality rate</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality rate</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>ORT</td>
<td>Oral Rehydration Therapy</td>
</tr>
<tr>
<td>BI</td>
<td>Bamako Initiative</td>
</tr>
<tr>
<td>IDD</td>
<td>Iodine Deficiency Disorders</td>
</tr>
<tr>
<td>IDA</td>
<td>Iron deficiency Anemia</td>
</tr>
<tr>
<td>LNG</td>
<td>Liquified Natural Gas</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune deficiency syndrome</td>
</tr>
<tr>
<td>DES</td>
<td>Dietary Energy Supply</td>
</tr>
<tr>
<td>RDI</td>
<td>Required Dietary Intake</td>
</tr>
<tr>
<td>NDHS</td>
<td>National Demographic Survey</td>
</tr>
<tr>
<td>TSH</td>
<td>Thyroid Stimulating hormone</td>
</tr>
<tr>
<td>T4</td>
<td>Thyroxin FGM = Female genital Mutilation</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the elimination of Discrimination against women</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The preparation of the SITAN arose from the FGN/UNICEF programme of cooperation. In order to empirically ascertain whether the agreements, targets and the activities related to the cooperative endeavour are on course, and also to provide a solid footing for the mid-term review of the country programmes of cooperation, it becomes expedient and timely to carry out a SITAN of children and women as at 1999, regarding their survival, development, protection and participation as defined by the CRC and CEDAW. A right-based situation analysis through life cycle/causal analysis framework was adopted in this exercise. The participatory process was adopted in preparing the SAA. The document is, therefore, the product of the efforts made by all the states in A zone reflected in their SPAs and research effort by the Consultants.

The following areas were therefore covered:

SURVIVAL:

Survival rights as defined by CRC and CEDAW as in articles 6, 24, 27, 10h, 12, 14b and 14h states that every child has a right to life, to the highest standard of health and medical care attainable; to a standard of living adequate for his or her mental, physical, spiritual, moral and social development which would ensure his or her survival. Also, all forms of discrimination against women have been ratified by the government to ensure women's survival.

In assessing and analyzing the situation of children and women in the zone, they have become victims of economic and political stagnation. Living standards have deteriorated. Over one-third of the zonal children live in poverty stricken families. The environment in which mother and child live is stressful leading to deteriorating morbidity and mortality trends noted in the zone.
Fever, acute respiratory infection (ARI) and diarrhoea were noted as major contributors to morbidity in the zone while mortality rates from the State Plan of Action (SPA) for infants was approximately 93/1000 live births, range 143 – 205; MMR 950/100,000 live births, range 600 – 1600. The rise in mortality is the result of the demise of the health care delivery system, caused by on-going crisis which has limited the financial support/budgets for proper development of health communication, National Programme on Immunization, Integrated case management of childhood illnesses as well as maternal and reproductive health services.

Studies conducted in the zone indicated that malnutrition is on the rise. Stunting afflicts 50.9% of children with 56.6% boys stunted and 46% girls stunted. Wasting was found in 10.3% of the boys and 8.2% girls in the zone. Underweight was equally more prevalent among boys (27.6%) than girls (20.3%). Malnutrition seems to increase between the ages of 6 – 23 months, suggesting inappropriate feeding practices, inadequate household food security and cultural practices. Mothers' education and income were two major factors that positively influenced nutritional status of children under 5 years of age.

Incidence of low birth weight (LBW) babies in the zone was equally high.

Maternal deaths result from unsafe abortions. Sixty one point four (61.4%) percent of women in the zone were found to be anemic and about 20% of maternal deaths are caused by hemorrhage which often result from anemia. Adolescent mothers are prime victims of unsafe abortions and are unaware of safe birth practices. A new phenomenon noted in the zone is the increasing number of women beggars, child beggars and street children especially in River and Beyelsa States.
It is observed that there is urgent need in the zone for revitalization of some past experience and policies such as universal free primary education and mass literacy programme. There is also the need for promoting universal access to basic education through formal and non-formal channels, removing barriers to the active participation of women and girls in education, expanding family and community capacity for early childhood care and development and improving the institutional capacity of relevant agencies for improving the quality and relevance of basic education.

PROTECTION:

The rights to protection of women and children are adequately defined and contained in the CRC and CEDAW. The rights to protection of women and children can be summarized as: Protection of the legal status of children and women and their interests; protection against all forms of violence, exploitation, maltreatment and abuse.

In the zone, there is less than satisfactory attention paid to the protection of women and children. The result is that there are many manifestations in the zone. The common ones are child abandonment; street children; street hawking; teenage pregnancy; early marriage; HTFs; prostitution and maltreatment of widows. Poverty, cultural practices, ineffective law are central basic causes of these manifestations.

Although there is the Ministry of Women Affairs and Social Development, there has been few and unsatisfactory, indeed lame policies directed towards alleviating the problems of protection in the zone. It is, therefore, recommended that more capacity building efforts, advocacy, mass literacy campaign and women empowerment should be accelerated to ameliorate the situation.
The problem of survival of children and mothers have been recognized for a long time and policies and programmes have been developed and changed several times due to their being disjointed and addressing the problem in parts. Notable among them is the PHC, which today has many components but has been haphazardly handled due to lack of political commitment and poor funding. Nevertheless, PHC still remains the most cost-effective means of tackling the problem of survival among children and women in the zone.

The programme goals for survival in the zone would be reduction of IMR from 93/1000 to 60/1000 live births, USMR from 171/1000 to 80/1000 live births and MMR from 950/100,000 to 750/100,000 live births. Reduction of stunting from 50% to 12%, wasting from 10% to 5%, under-weight from 27% to 10% and low birth weight from 18% to 10%. Reduction by 50% the prevalence of iron deficiency anemia and its consequences among mother and children. Increase the rate of exclusive breastfeeding (EBF) from 2% to 25% and sustain household use of iodized salt.

DEVELOPMENT:

The major problems of development in A Zone centers around the low level of availability and access to early child care/learning centers, low level of enrolment in primary schools, high drop out rate, lack of adequate vocational education and high rate of adult illiteracy. Some of the causes of these problems are attributable to ignorance, lack of adequate sensitization, poverty, unconducive learning environments, paucity of basic instructional materials and unmotivated teachers.
PARTICIPATION:

CEDAW clearly support the right to participation of women on issues such as gainful employment, right to vote and be voted for, holding of all forms of positions in the political and economic sectors, and participation in policy making and policy implementation. The CRC on the other hand recognizes the right of the child that will enable him or her to form opinion and express his/her views.

These rights are still to be achieved considering the manifestations which include: lack of involvement of children in decisions affecting them; discrimination against women; non-inclusion of women in decision-making matters/bodies.

Ignorance, poverty, cultural practices and lack of laws are the central basic causes of matters relating to participation.

Unfortunately, very little effort has been made by government with respect to participation of children and women in affairs affecting them. There has been no concrete policy regarding that either. This is why it is recommended that extra effort should be made in areas of advocacy, mobilization, empowerment and capacity building. A combination of these would go a long way towards ensuring full participation of children and women in matters affecting them.
KEY SOCIAL STATISTICS ON ZONE A STATES

Land Area:

- Female population: 13,120,813
- Male population: 14,093,871
- Population 0 – 1 yr:
- Population Under 5 yrs:
- Population under 18 yrs:
- Women of Child Bearing Age:

Total Fertility Rate: 5.67

Population Growth Rate: 2.83%

Urban Population:

Rural Population:

Mean Age of Marriage

Infant Mortality Rate 93/1000
Under 5 Mortality Rate 171/1000
Maternal mortality Rate 950/100,000

% of Mothers Breast Feeding:
  Urban:
  Rural:
EPI/NPI Coverage (Children 0-11 months):

Water Supply Coverage:  
Urban 22%  
Rural 12%

Sanitation Coverage Total:  
Urban: 25%  
Rural: 10%

Primary School Age Population: 6-11 yrs

Primary School Enrolment: 5,589,205  
Boys: 307,734  
Girls: 313,289

No of Primary Schools:

No of Primary School Teachers:  
- Male:  
- Female:

Average Pupil – Teacher Ratio:

Adult Literacy:
CHAPTER ONE

1.0 CONCEPTUAL FRAMEWORK AND METHODS

1.1 CONCEPTUAL FRAMEWORK:

The Federal Government of Nigeria (FGN) and the United Nations Children's Fund (UNICEF) Programme of cooperation (1997 – 2001) is aimed at ensuring the commitment to and the full exercise of the Rights of the child, as well as the Elimination of All Forms of Discrimination Against Women as clearly enunciated in the convention on the Rights of the child (CRC) and the convention on the elimination of All forms of Discrimination Against Women (CEDAW).

In order to appreciate the efforts of both the Federal Government of Nigeria (FGN) and the UNICEF in this regard, a SITUATION ASSESSMENT AND ANALYSIS OF CHILDREN AND WOMEN IN ZONE A with the contexts of CRC and CEDAW is necessary.

1.1.1 IDENTIFICATION OF KEY RIGHTS SUPPORTED BY C.R.C AND CEDAW:

The starting point in the preparation of the situation assessment and Analysis is the clear identification of the key rights supported by CRC and CEDAW.

These are the Rights of the child to Survival, Development, Protection and Participation (CSDPP) as indicated in the table below.
Table I: CSDPP RIGHTS, POSSIBLE INTERVENTION AREAS AND THE RELEVANT CRC ARTICLES

<table>
<thead>
<tr>
<th>SURVIVAL</th>
<th>DEVELOPMENT</th>
<th>PROTECTION</th>
<th>PARTICIPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>NUTRITION</td>
<td>PARENTAL CARE</td>
<td>EXPRESS OPINION</td>
</tr>
<tr>
<td>Health</td>
<td>CHILD CARE</td>
<td>COMMUNITY CARE</td>
<td>ON NEEDS, RIGHTS</td>
</tr>
<tr>
<td>Child Care (CRC Articles 6,24)</td>
<td>BASIC EDUCATION (CRC Articles 28,29 17,18,23 &amp; 30)</td>
<td>NEGLECT ABUSE</td>
<td>AND SOLUTIONS (CRC Articles 12, 13, 14 &amp; 15)</td>
</tr>
</tbody>
</table>

Consequently, the conceptual framework emphasis, the Rights, instead of the Needs Approach. It aims at the ultimate goal of exercising CSDPP Rights, the capacity and the environment necessary to exercise the Rights, as well as the effective use of the services.

Of course, the effective use of these services depends critically on the Awareness about these Rights as well as their accessibility, affordability and equity in their distribution. These are, on turn, promoted and made possible by Supportive Legal Framework and Availability of Services and conductive ECONOMIC AND SOCIAL STRUCTURES. These facilitators are direct results of SUPPORTIVE SOCIAL AND ECONOMIC POLICIES of the governments in zone A as determined by the Natural Resource Endowment of the states. Diagrammatically, this can be represented thus:
Table 2: RIGHTS-BASED PROGRAMMING SITUATION ANALYSIS FRAMEWORK:

Goal: Exercise of CSPPD Rights
Capacity and Environment to Exercise the Rights
Effective Use of Services

C
E
Awareness
About Rights

C
R
Accessibility
Affordability
equity

D
A
W
Supportive Legal
Framework

C
Availability of Services
Economic and Social structures

Supportive Social and Economic Policies

Natural Resource Endowment

1.1.2: IDENTIFICATION OF MANIFESTATION OF VIOLATIONS OF THESE RIGHTS:
The utility of the Rights-Based Programming in Assessment and Analysis lies in the identification of manifestations of violations of CRC and CEDAW Rights. For example, a good assessment and Analysis will reveal the following violations of the Rights of women of child-bearing Age 15 - 49 years.

MANIFESTATION: HIGH MATERIAL MORTALITY

IMMEDIATE CAUSES: EARLY MARRIAGES
MULTIPLE and Close Pregnancies
Inadequate Pre-natal Care
Induced Abortion
Unsafe Delivery
Inadequate Obstetric Care
UNDERLYING CAUSES:  
- Decision for family planning not made by women  
- Desire or pressure to have many children  
- Food Taboo  
- Family Food Distribution  
- Heavy Domestic Chores  
- Unhealthy Environment  
- Female Genital mutilation  
- Low literacy  
- Poor awareness/knowledge of Reproductive Health Care  
- Low use of Family Planning Services  

BASIC/STRUCTURAL CAUSES:  
- Harmful Traditional Practices (HTP)  
- Subordination of women underdevelopment of women and widespread discrimination against women in resource allocation.

In addition to assisting in identification of problems (manifestations of violations of Rights), assessment and analysis help us to prioritise problems. This is important because UNICEF deals with short term and medium term problems. Moreover, they help us pay adequate attention to gender issues and to distinguish between sexes in certain problem-areas. For example, in discussing the problem – women in the age group 15-19 years are dying more than men in the same age group – Assessment and Analysis will reveal the following:

| Immediate Causes | Welfare | Death due to complications at birth  
|------------------|---------|-------------------------------------
| Underlying Causes| Access  | Too close, too many, too early births  
| Basic Causes     | Conscientization, Control (Institutional, Structural issues) | HIV/AIDS  
|                  |         | Lack of adequate Services  
|                  |         | Lack of priorities for social services  
|                  |         | Lack of Institutional Arrangements  
|                  |         | For women to influence resource allocations  
|                  |         | Provision of adequate services.  


2.0 ASSESSMENT AND ANALYTICAL METHODS AND STRATEGIES

2.1 LIFE CYCLE CAUSAL ANALYSIS

The identification of manifestations of violations of CRC and CEDAW can be fruitfully done using life cycle/causal analysis. This means that the situation in Zone A, with respect to Survival, Development, Protection, and Participation Rights can be assessed within the context of life-cycle approach from birth to adulthood (0 – 18 years) for children (both boys and girls); women (15 – 49 years) of child-bearing age to menopause. For example survival indicators like disparities throughout the life cycle of boy-child and girl-child under IMR, U5MR, can be assessed. In the same vein the Development disparities between men and women using such social indicators like literacy level, availability of pre-and post-natal health care facilities, etc. Can also be assessed. A life cycle/causal Analysis of survival problems, for example, can be demonstrated thus.

<table>
<thead>
<tr>
<th>Age</th>
<th>Manifestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1 Yr</td>
<td>Infant Mortality</td>
</tr>
<tr>
<td>1 - 5 Yrs</td>
<td>U5 mortality</td>
</tr>
<tr>
<td>12 - 18 Yrs</td>
<td>Adolescent mortality</td>
</tr>
<tr>
<td>15 - 49 Yrs</td>
<td>Maternal mortality</td>
</tr>
</tbody>
</table>

2.2 IDENTIFICATION OF MAJOR PROBLEMS:

Based on the results of the Life Cycle/Causal Analysis, the major problems of Zone A in the context of the Survival, Development, Protection and Participation Rights of the child and mother can be identified.

2.3 EXAMINATION OR CONSIDERATION OF PAST EXPERIENCES:

To be able to effectively grapple with the major problems identified above, it is necessary to examine the past experiences in Zone A. Past experiences and policies of the various state governments in the zone
form the critical link between the original state and the present situation. They necessarily form the point of departure for present and future policies and actions.

2.4 OPTIONS FOR ACTION - STRATEGIES/ACTIVITIES:
Given all the past experiences and policies by the various governments in Zone A, the present thrust of action will now proceed along the lines suggested under each of the problems identified in this study.

2.5 CONCLUSION:
Thereafter, there will be a conclusion summarizing all the discussions in the study.

3.0 THE PARTICIPATORY PROCESS:
The production of this Situation Assessment and Analysis (SAA) of the Zone A benefited immensely from wide participation. As much as possible all the relevant and critical elements and actors were involved at various stages in its production.

Early in 1998, directives were sent out to all the states in Zone A to prepare their State Plan of Action (SPA) and Situation Assessment and Analysis (SAA) in readiness for a zonal workshop. Between September 20th and 26th 1998, SPA/SAA Development Workshop was held at Modotels Limited, Enugu to harmonize the state efforts.

The shortcomings of all state SPA/SAA were noted at that workshop. New concepts, methods and strategies based on Rights instead of Needs approach were introduced to the participants. Thereafter, the participants were required to retire to their respective states to prepare new SPA/SAA based on the proceedings of the workshop.
Consequently, all the states on the zone went back and produced their SPA/SAA as directed. *Between March 28th* and *April 3rd, 1999*, a zonal SAA/SPA finalization workshop was held in Dannic Hotels Limited, Enugu. Again many deficiencies were observed in many state SAA/SPAs. This tune around, most of the problems centered around lack of data in some sectors.

States were once more directed to go back and fill in the missing data and to generally improve on the quality and reliability of their SAA/SPA. A *deadline* was set for the re-submission of the raised and updated state SAA/SPAs.

In May 1999, some consultants were *contracted to prepare a Zonal SAA* based primarily on the various states' SAA/SPAs. In other words, this document is the end-product of all these processes.
CHAPTER TWO

THE ZONAL CONTEXT

2.1 PHYSICAL CHARACTERISTICS:

Zone A is comprised of 10 states namely, Abia, Akwa Ibom, Anambra, Bayelsa, Benue, Cross River, Ebonyi, Enugu, Imo and Rivers as shown in the map of Nigeria. It lies in the south-eastern zone of Nigeria. It is bordered by Taraba, Plateau, and Kogi States in the north and Delta and Edo States in the south and south-west respectively. It lies between Latitudes 4°20’ and 6°30’ north and Longitudes 5°30’ and 10°0’ east. The zone occupies very small land area in comparison to other zones, but houses very large proportion of the population, extrapolated from the 1991 census figure of (21.7m), is now estimated at 27.3 million in 1999 at the current growth rate of 2.8% per annum.

The climate is tropical and temperatures are generally high, in the south east, they vary between 23°C and 31°C. Distribution of rainfall varies since in the south you have two seasons, dry and rainy, with rainy season starting as early as January in some areas. Rainfall is heaviest in the south between June and September 3500mm in Cross River State with a two to three week break – the short dry season – between late July and early August 1500 – 2000mm. There is strong seasonality in the incidence of diseases. While ARI, for instance is more common in the dry, windy season, malaria and diarrhea are more prevalent in the rainy season. In both seasons, reduced food availability is a marked disadvantage to the survival of the child.
Map of Nigeria showing the States in UNICEF Zone A.
The vegetation is more of thick forests in the south-east with mangrove swamps in the creeks in Bayelsa and Rivers States. Crops produced in the zone are predominantly cassava, yams, plantain, maize, cocoyam, sweet potatoes, soya-beans, pineapple, and various vegetables. Palm oil is produced in the zone. Sea foods namely crabs, crayfish, etc abound in the river line areas.

The country is rich in minerals and hydrocarbons and some states in the zone produce crude oil, and negotiations are on to harness natural gas.

2.2 The People and Social Organization

Based on the 1991 census, the zonal 1999 population is estimated at about 27,214,684 with a growth rate of 2.83% per annum, as shown in Table 2.1. About % of the population live in urban areas while % are found in the rural areas.

14, 193,871 (or 52%) of the population are male while 13,120,813 (or 48%) are female. % are between zero and one year while % are aged five years old. Women of child bearing age (15 to 49) years make up % of the population.

With children (ie below 18 years) being % of the population, it means that fully % of the total population (ie all persons below 18 years plus all women of child bearing age) is the target of children and women’s SITAA in Zone A. A breakdown of disaggregated zonal population is shown in Table 2.1.
### Table 2.1

<table>
<thead>
<tr>
<th>State</th>
<th>ABIA</th>
<th>ANAMBRA</th>
<th>AKWA IBOM</th>
<th>BAYELSA</th>
<th>BENUE</th>
<th>CROSS RIVER</th>
<th>EBONYI</th>
<th>ENUGU</th>
<th>IMO</th>
<th>RIVERS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land area (Sq. km)</td>
<td>7.627</td>
<td>4.887</td>
<td>-</td>
<td>1.000</td>
<td>386.53</td>
<td>93.000</td>
<td>7.087</td>
<td>-</td>
<td>510.00</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Female Population</td>
<td>1,072,075</td>
<td>1,773,196</td>
<td>1,551,830</td>
<td>655,490</td>
<td>1,394,498</td>
<td>1,193,680</td>
<td>952,846</td>
<td>1,383,062</td>
<td>1,611,827</td>
<td>1,532,453</td>
<td>13,128,813</td>
</tr>
<tr>
<td>Male Population</td>
<td>1,044,847</td>
<td>1,719,524</td>
<td>1,460,531</td>
<td>743,943</td>
<td>2,000,744</td>
<td>1,196,277</td>
<td>817,358</td>
<td>1,257,539</td>
<td>1,453,895</td>
<td>1,503,665</td>
<td>14,093,871</td>
</tr>
<tr>
<td>0 - 1 Year Population</td>
<td>93,145</td>
<td>144,740</td>
<td>169,810</td>
<td>54,634</td>
<td>139,536</td>
<td>98,027</td>
<td>30,399</td>
<td>-</td>
<td>121,508</td>
<td>157,855</td>
<td></td>
</tr>
<tr>
<td>Under - Five Years Population</td>
<td>423,386</td>
<td>697,544</td>
<td>514,386</td>
<td>273,188</td>
<td>697,365</td>
<td>400,122</td>
<td>58,418</td>
<td>-</td>
<td>652,657</td>
<td>617,573</td>
<td></td>
</tr>
<tr>
<td>Under 15 Years Population</td>
<td>957,619</td>
<td>1,569,475</td>
<td>1,671,617</td>
<td>614,628</td>
<td>-</td>
<td>810,918</td>
<td>79,151</td>
<td>-</td>
<td>1,366,973</td>
<td>1,789,714</td>
<td></td>
</tr>
<tr>
<td>Total Fertility rate</td>
<td>6.0</td>
<td>5.0</td>
<td>6.82</td>
<td>5.2</td>
<td>-</td>
<td>6.0</td>
<td>-</td>
<td>5.5</td>
<td>5.2</td>
<td>5.2</td>
<td>5.2</td>
</tr>
<tr>
<td>Population growth rate</td>
<td>2.8</td>
<td>2.8</td>
<td>2.83</td>
<td>2.83</td>
<td>2.83</td>
<td>2.83</td>
<td>2.83</td>
<td>2.83</td>
<td>2.83</td>
<td>2.83</td>
<td>2.83</td>
</tr>
<tr>
<td>Urban Population</td>
<td>-</td>
<td>1,393,089</td>
<td>364,796</td>
<td>204,876</td>
<td>-</td>
<td>562,433</td>
<td>658,907</td>
<td>-</td>
<td>1,091,578</td>
<td>994,286</td>
<td></td>
</tr>
<tr>
<td>Rural Population</td>
<td>-</td>
<td>2,092,653</td>
<td>2,647,528</td>
<td>1,160,954</td>
<td>-</td>
<td>1,836,544</td>
<td>1,219,120</td>
<td>-</td>
<td>1,942,139</td>
<td>2,982,867</td>
<td></td>
</tr>
</tbody>
</table>

Source: STATE SPAs
The commonest unit of social organization is the extended family—Umunna. Members of the family are bound by kinship ties. And its eldest member exercises considerable power and authority over other members, (Nwosu, 1977).

In some states like Imo in particular, Abia and Anambra states, you have families where a woman would be encouraged to have as many as 10 children or more for purposes of having enough farm lands, in the end she will be honoured with having a goat slaughtered for her known as “ewu ukwu” if literally translated means “goat for her waist”.

Another social issue is that of Ozo title. Many boys are now endeared to taking this title ands before you do, you must have amassed some wealth. This has pushed the boys in the Ibo speaking states to go into trading instead of being in schools. You find high drop out rate after elementary schooling for boys than girls especially in Anambra State.

The fertility rate, which is one of the highest in Africa, is 5.5 in the south. There are many ethnic groups in the zone, the predominant group in the zone are Igbo but other major ethnic groups are Tiv, Ijaws, Ibibios and Annang. In the south-east which houses zone A you have mainly Christians but there are other religious groups.

There are more rural dwellers than urban dwellers. Subsistence or small holder agriculture dominates as farm practice. The people in the zone, mainly Igbo, are highly industrious group with contemptible and innovative spirit, they are humorously, called the “Jews of Africa”. There are community based organizations and other associations based on sex, age category, religion and trade.
The patrilineal nature of the Igbo society places some premium on the male which has the effect of engendering strong preference for the male child.

Cultural norms and practices coupled with the influence of religion have tended to determine the place of women in society. Women's contributions to the socio-economic and political life in the zone have been less than optimal on account of the existing social structure with its root in tradition, culture and religion. The situation is by no means static and government is beginning to recognize and emphasize the rights of women. Women organization and NGO's are beginning to champion the cause of women. Women earn their livelihood as farmers, petty traders, artisans and construction work. The educated women have made tremendous inroads into service rendering occupations like hair dressing, tailoring, stenography, teaching, nursing, medicine and law. Majorities of the primary and secondary school teachers are women.

The child, from cradle, obtains its early contact and information from the mother and the family. The family is the smallest social unit of any society. What happens at this level of social organization spills over into the wider society. If the family is stable so also the child, the state and consequently the nation. In most parts of the zone, especially in the rural and urban areas, a number of nagging social problems appear to threaten the very social fabric of the family, thereby making it less conducive to effective child survival and development. Some of the problems are:
- the harsh national economic situation
- prevalence of diseases, and
- harmful traditional practices
Thus, citizens of state in A Zone society especially among the Igbo look down on people who accepted superiors, depended on them, or relied on them for their progress. Subservience and unquestioning obedience, signified weakness and a lack of masculinity. It placed a premium, instead, on occupational skill, enterprise and initiative. The man who was respected, powerful and influential was the one who was sufficiently self-motivated to work hard and to successfully compete with and challenge the power and wealth of his superiors. His success was basically self-made rather than attained through climbing the socio-economic and political apron strings of his superiors. Occupational achievement in pursuit of one's interest was the primary basis for positive social evaluation, the most highly esteemed and rewarded personal quality.

During the colonial administration, the British introduced a system of political administration in Nigeria known as Indirect Rule System. The indirect rule system involved governing Nigerian people through their chiefs and traditional systems of government. British officials, such as the Residents and District officers, were simply supposed to advise and guide the chiefs without interfering unnecessarily in the daily work of administration. They should respect traditional laws and customs as far as possible and seek to support the authority of the chiefs.

The indirect rule system was very successful in the North and partially in the West. However, it was a big failure in the South east which is made up of states in A Zone. The reason is because the states in the A zone had no centralized system of government and there was absence of recognized traditional rulers. The successful operation of the indirect rule system required that there should be traditional chiefs and officials through whom the British could rule. This requirement was lacking among the
2.3 POLITICAL AND ADMINISTRATIVE STRUCTURE AND ENVIRONMENT:

The pre-colonial political and administrative structure and environment of the states in A Zone was highly diffuse. It lacked any political centralization. With few exceptions, decision-making in the society was performed not by a single leader but by a council of elders which was highly responsive to the popular will. In fact, the polity was republication in character. There was virtually no rigid stratification of individuals by blood or occupation. The only major ascriptive hierarchical distinction was between freemen and slave. The latter were either secular or religious. Otherwise, age grades, title societies, and other universalistic criteria provided the basis for social status and influence in the society. For example in the Igbo speaking states and Niger Delta area, the Ozo and Ekpe Society respectively operated as a political oligarchy controlling decision-making even at public meetings at which all men had a right to speak.

Deference to authority was very low especially among the Igbo states. Wealth conferred authority and social status. A man gained prestige and Power by accumulating the foodstuffs required to join title societies and perform other ceremonies. The ability and opportunity to engage in this process of accumulation were not limited by blood ties. The societies were open to all freemen. Social mobility, wealth and power were independent of performance in authority roles. Therefore, loyalty and obedience to superiors, so important in Hausa-Fulani Society, was virtually unknown to states in A Zone in the pre-colonial political administration. In a general sense, obedience and respect were accorded only to the elders. Authoritative individuals were significant as objects of emulation rather than as recipients of loyalty and obedience. They were to be competed with rather than deferred to. Self assertiveness and individual initiative were highly valued.
states in A zone who had no traditional central authority. There were partial exceptions in the Obi of Onitsha and the obong of Calabar but they had very little influence.

As a result, the British administrators made the mistake of electing natural rulers where there were none. They called them warrant chiefs and commissioned them to carry out such duties as were assigned to the traditional rulers of the North. These artificially created chiefs began to exercise powers they had no traditional right or ability to exercise before. They soon abused them. For example, in 1929 they imposed taxes on women. This led to the Aba Women's Riot.

At independence in 1960, which marked the end of colonial administration in Nigeria, the country adopted a federal system of government with four regional structure viz: Northern Region, Western Region, Eastern Region and Midwestern Region created in 1963. All the states in A zone with the exception of Benue State were administered as Eastern Region. The regional government had a premier who wielded executive power and a Governor who exercised ceremonial powers. Also, there was a legislative arm called the 'Regional Assembly' which legislated and made laws for the region. The regions were very strong and derived their powers from the constitution. In fact, the regions at this time could be said to be stronger than the center. The center was a loose federation of regions and therefore weak. This political administrative structure continued until 15th January, 1966 when the Military struck for the first time and overthrew the elected democratic government.

The military incursion into the country's body politics led to coups and counter-coups which eventually culminated to a thirty (30) months civil war which started on 30th May 1967 and lasted up till 1st January, 1970.
However, in 1967, which marked the beginning of the present political administrative structure in the country and in A zone, the regional system was abolished and the country divided into twelve (12) states structure. With the exception of Bayelsa, Benue and Rivers States, all the other states ------

Presently in the zone were politically and administratively merged under two major states namely, East-Central State (ECS) and South-Eastern State (SES). In 1976 seven more states were created bringing the total number of states in the federation to 19. The states in the zone that were created in 1976 include: Anambra, Benue, Cross-River and Imo States. In 1987, two new states were created bringing the number of states in the federation to 21. It was at this time that Akwa Ibom State was created. In 1991 thirty (30) states were created.

The states created in the zone at this time were Abia and Enugu States. Finally, in 1996, six (6) more states were created bringing the total number of states created in the federation to thirty-six (36). It was at this time that Bayelsa and Ebonyi States which are part of the zone were created. There are 171 Local Government Areas in the zone.

The Local Government Areas are the smallest administrative units of government.

The political and administrative structures and even the environment of the states in the zone are virtually the same. The State Chief Executives before the military hand over to the civilians (democratically elected government) were military administrators. The local governments were run by caretaker committees whose chairman were civil servants seconded to the local governments. Legislative responsibilities were
shares among the various tiers of government. The federal Government exercised exclusive responsibility in issues of overriding national interest such as defense, external relations and immigration. While decrees were enacted at the federal level, there were provisions for state edicts on items in the concurrent list. In cases of conflict however, Federal decrees take precedence. Social sector concerns, such as health, education and water and environmental sanitation fall within the concurrent list.

The military regimes which had ruled the country and the component states for over twenty-two years (22 years) were terminated on 29th May, 1999, and this marked the end of the protracted transition program in the country, and the ushering in of a democratically elected government.

The states now have elected governors as Chief executives, while at the local government level the elected chairman is the Chief executive. Also, there is now a State House of Assembly which makes laws for the state and approves the state’s annual budget. The Local Government has an elected council with a speaker who presides over the council. The role of the local government council at the local government level is similar to that of the state house of assembly at the state level.

The political and administrative set-up in the states is made up of a cabinet of civil commissioners responsible for the affairs of various ministries and answerable to the state chief executive. The commissioners, together with the Secretary to the State Government and the Head of civil service, supervise and co-ordinate the administrative and development oriented affairs of ministries, bureaus, boards, and commissions. The State Planning Commission which came into being in 1997 have assumed the role of development planning, policy co-
ordination, external agency support co-ordination and monitoring of plans and budgets at both the state and local government area level. Key ministries and bureaus in the states in the zone include:

- Ministry of Finance and Economic Development
- Ministry of Works, Housing and Transport
- Ministry of Health
- Ministry of Information and Culture
- Ministry of Education, Youth Development and Sports
- Ministry of Agriculture
- Ministry of Justice
- Ministry of Women Affairs
- Ministry of Commerce, Industry and Technology
- Bureaus of Utilities and Rural Development
- Bureaus of Lands and Survey
- Bureaus of political, Local Government and Chieftaincy Matters.

In addition to the above, a number of Boards, parastatals and other commissions exist. With the exception of the State Planning Commission which is answerable to the state Chief Executive and domiciled in the Government House, other Boards, Commissions and Parastatals are under the overall supervision of an appropriate ministry.

The political, Economic, social and Administrative environment of the states in the zone has been vicariously unstable. Politically, there has been frequent changes in government especially with the former military administrators, Directors-General, Permanent Secretaries, Commissioners, Chairmen of Local Governments and other administrative heads of ministries and departments. The country has experienced several coups and counter-coups during the past Military administration.
However, there is now hope of a stable polity with the recent democratization of the government and the transfer of political power from the military to the elected civilians. The economic environment is fraught with hyperinflation, unemployment and general impoverishment of the citizens. The social environment is also fraught with crisis especially in the oil producing areas of the states in the zone. The administrative environment has not fared any better. There have been protests and agitation from Labour (workers) unions over non-payment of minimum wage and arrears of salaries. Work in most ministries and parastatals has virtually grounded to a halt. It is strongly hoped that the new civilian regime in the country led by President Obasanjo will address some of these inadequacies or shortcomings within the environment.

2.4 ECONOMY:
Like most part of the country, agriculture is the dominant economic activity of the inhabitants in the A zone. Over 60 percent of the active labour force depend on the agricultural sector for their livelihood. Major arable crops grown are cassava, maize, rice, Soya bean, yam, groundnut and Barbarea nut during the wet season, while crops such as tomatoes, pepper, ginger and other vegetables can be grown during the day season. Other crops commonly found in the zone are castor seed, pineapples, Banana, Plantain, Cashew and Palm Kernel.

The states in A zone are located in the rainforest belt of the country. This provide an ample opportunity for growing most of the stable crops required for domestic consumption and raw materials for industries. Major livestock species include goats, sheep, poultry and pigs. Livestock production serve as a stable income generating activity through the provision of food (meat and egg) and raw materials (hide and skin) for industrial uses. Also, fish production and general sea food farming constitute another major economic activity for inhabitants in the Niger
Delta area of States in the A zone compris of Akwa-ibom, Bayelsa, Cross-River and Rivers.

Within, the rural society in A zone, the major traditional economic activity of women is subsistence farming. A few women engage in petty trading. In the urban areas only a relatively small proportion of women is employed in mainstream economic activities. The majority of them live as full time housewives and petty traders.

Beyond Agriculture, there are other economic activities in the A zone such as Gold smiting, Black Smiting, Distributive and Commercial trading, Import and Export activity, manufacturing and public service.

Gold smiting and Black smiting is very common among the Igbo states especially in Anambra state (Awka). It is through this means that local guns used by hunters, hoes and cutlass used by farmers as well as other useful implements required for production and survival are produced locally. Gold smiting and black smiting are full time professional occupation for those who engage in it and they are all men. Distributive and commercial trading is very common in the zone but more pronounced in some states such as A big (Aba town), Arambra (Onitsha and Nnewi towns); Rivers (Port Harcourt town). There are big time merchant traders who are engaged in import and Export activities. The most common items and articles of trade include - Clothes, Motor Spare Parts, Tyres, Plastic wares, food stuff, second hand vehicles and petroleum products. The heavy presence or dominance of commercial activities in some of the states in the zone especially among the Igbo speaking, have been partly responsible for high non-completion rates and male-drop-out from primary schools which is now a new phenomenon in the area. To complement commercial trading is commercial transport services which is a major economic activity especially among the Nnewi people of Anambra state.
The A zone states provide most of the luxury bus transport services required for long distance travelling to all parts of the country especially from East to North and West.

The states in A zone are blessed with natural resources especially crude oil. The Niger Delta area in the zone produces the major percentage of crude oil in the country. There is a big refinery in Port Harcourt and other petrochemical industries. There is heavy presence of oil companies in the zone especially in Akwa-Ibom, Bayelsa, Cross-River and Port Harcourt. All these belong to the oil producing states of the country. Crude oil is the Mainstay of Nigerian economy and major foreign exchange earner. The presence of large oil companies in the zone has helped to boost the economy especially in those states where they are located. Many of the oil companies provide employment for indigenes of the state and also assist in the provision of some basic social services. The heavy presence of oil companies boost commercial activities in the states through pumping of money into the economy.

Another major area of economic activity in the zone is public service. The zone is one of the educationally advantaged part of the country. They have a lot of educated human resources and labour force. The public and civil service in A zone states are saturated with qualified manpower. There are a lot of unemployed, but educated and employable youths. Many of the children abandon school and refuse to complete their basic education because of lack of any meaningful employment for those who have done that earlier and the get rich quick syndrome which is now parading the area.

The A zone states is accessible by road, rail, air and sea. The major railway lines run from Port Harcourt to Umuahia, Enugu, Makurdi and Kaduna. The A zone states have international Airports situated at state
Postal services are readily available in strategic locations in the state capital and most of the Local Government Headquarters. A modern digital telephone exchange operated by the Nigerian Telecommunications Limited (NITEL) is also operational in the states. There is also different courier services available in the states. There are major sea ports in the zone especially in Port Harcourt and Calabar. These sea ports are used for importation and exportation of goods and services.

2.5 HUMAN DEVELOPMENT:
The process of striking a balance between negative and positive consequences in the society brings about development and thus upliftment of standard of living and welfare of the people. Human development in the zone has been affected by numerous negative social conditions which have been difficult to counter or balance by positive activities. The population of the zone, for instance, has been growing rapidly without adequate matching resources to balance the negative effect. The estimated population of the zone is put at 27.2 million with an annual growth rate of 2.81 per cent.

As a result of the obvious mismatch between population and resources, there is observable poverty, ignorance, low literacy rate, high morbidity and morality rates in the zone. Under such situations, human development is highly constrained.

Also, the Structural Adjustment Programme (SAP) has produced a large number of anticipated side-effects, particularly for vulnerable sections of the society, namely children and women. For example, most public enterprises have collapsed, there is high unemployment and low infrastructural development. These conditions have negatively impacted upon human development generally. As indicated above, poverty is widespread, involving more than 1.01 million people in the zone living.
below poverty line. More and more families, especially in the urban areas,
are grouped into one-room apartments and a substantial percentage of
the families is food poor.

Another strong factor in human development is the state of the physical
environment in the zone. Erosion has rendered many hands
uninhabitable and many road impassable. In the oil-producing areas, the
situation is bad, as the activities relating to oil exploration keep displacing
the needed balance in the natural environment. The state of
environmental sanitation, especially in the urban areas, is also despicable.
These negative factors combine to rather slow down the rate of human
development.

Central to human development is education. Education reduces
ignorance, poverty, malnutrition and poverty. Education, especially basic
education, experiences setbacks in the zone. These setbacks are related
to lack of infrastructure, frequent closure of public schools as a result of
teachers’ strikes, low school enrolment for boys, especially in Anambra
and Abia States, low school enrolment for girls in Rivers and Ebonyi
states; and poor incentives for teachers. Low school enrolment is,
therefore, a manifestation of poor human development in the zone.

Related to the above, is gender development. Women’s development is
still a relatively new concept, hence it is still at a low ebb. Women political
and economic empowerment is still far-fetched. The position of women in
the family and society is still largely secondary. Women play more role in
agriculture and in the domestic domain. Women are more often illiterate
than men. In most settings in the zone, they do not assume leadership
positions and do not often take part in decision-making. While the heavy
involvement of women in farming may be viewed as their contribution to
economic development of the zone, the case of children is pathetic as farming deprives them of the right to education and future well-being.

The table below gives a picture of the states of women and children in Nigeria. Although the data was assembled in 1988, the situation is still largely, the same and has direct bearing with human development.

Table 1. States of Women in Nigeria

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>INDICATOR</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH</td>
<td>Infant &amp; Child Mortality</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Mortality - Child bearing years</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Life expectancy</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Female/Male differential life expectancy</td>
<td>2.0</td>
</tr>
<tr>
<td>MARRIAGE AND CHILDREN</td>
<td>Teen Marriage</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>Total fertility rate</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Contraceptive prevalence</td>
<td>0.5</td>
</tr>
<tr>
<td>EDUCATION</td>
<td>Secondary School Teachers</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Primary/Secondary School enrolment</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>University enrolment</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Female/Male differential literacy rate</td>
<td>2.0</td>
</tr>
<tr>
<td>EMPLOYMENT</td>
<td>Self employed</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>Paid employees</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Professionals</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Share of paid employment</td>
<td>1.5</td>
</tr>
<tr>
<td>SOCIAL EQUITY</td>
<td>Economic equality</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>Political and Legal equality</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>Equality in Marriage and Family</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Female/Male Social Equality</td>
<td>1.5</td>
</tr>
</tbody>
</table>
Totals

a. Women's status subtotal 20.5
b. Gender gap subtotal 8.5
c. Grand total score out of maximum score of 100 29.0

Each of the 20 indicator has a maximum of 5 points, 5 indicating the highest status.

**SOURCE POPULATION CRISIS COMMITTEE (1988 CHART)**

The population crisis committee that rated the status of women in 99 countries in 1988 ranked Nigeria sixth to the last. Although some of the indicators of status need to be accepted with caution, a low score of 29 percent obviously indicate that Nigerian women are performing poorly in terms of marriage and children and accessibility to health-care, education, employment and social equality.

**2.6 BASIC SOCIAL SERVICES (BSS):**

Basic Social Services (BSS) are provided by Government, NGOs and community organizations. In some cases, donor agencies help out in the provision of Basic Social Services. Some of the ministries responsible for the provision and administration of social services in the zone are Health and Social Services; Agriculture, Water and Rural Development; Education; Works, Land, Survey and Transport; Information, and Social Development.

UNICEF Zone A also collaborates with Governments and NGOs to facilitate and provide Basic Social Services, especially with respect to Health, Education and Water in the zone. UNICEF, activities on Health and Nutrition in the zone are particularly noticeable.
The pivot of health care in the zone is the Primary Health Care (PHC) services. Although the coverage is yet to be total because of some constraints, the PHC programme constitutes the strategy for the provision of health services to the rural areas. The components of the programme include good nutrition, control of communicable diseases, treatment of endemic diseases, health education, provision of drugs, Oral Rehydration Therapy (ORT), Expanded Programme on Immunization (EPI) and National Programme on Immunization (NPI). The realization of the bold objectives of PHC has, however, been constrained by poor economy, corruption and political instability.

Water supply and safe disposal of human waste are Basic Social Services that have attracted much comments as their coverage has been less than satisfactory in the zone. Water supply and Environmental sanitation (WES) programme is handled by the State Agencies under the supervision of the Ministry of Agriculture, Water Resources and Rural Development. Considering the link between safe water supply, safe human waste disposal and health, the low coverage of both is a source of worry.

Educational services are provided by Government in keeping with its National Policy on Education (NPE). Consequently, the emphasis is on primary, secondary and tertiary education. Churches, private individuals and NGOs are also involved in provision of educational services, especially pre-primary education.

Going by the number of public schools in the zone, the impression would be that the number is sufficient.

But the problem is that most of these schools are without facilities. Majority of the schools were built by missionaries between 1940 and 1965.
Few new schools were built directly by Government. The result is that these old schools, both primary and secondary are dilapidated and easily carried away by rain storm. The trend is that more and more people are turning to private schools, especially in the urban areas. Lack of adequate budgetary provision is frequently mentioned when there are complaints about inadequate facilities in the public schools.

Regarding the basic need of shelter, it is pretty unfortunate that since the end of the second republic (1983) there has been no concrete housing policy aimed at alleviating housing problems in the zone. Yet in some urban areas as Port Harcourt, shelter is a problem resulting in the increase in the number of slums with their obvious implication for environment and health. Government’s involvement in the provision of shelter is highly limited, probably because its need is compromised.

With respect to roads and road network in the zone, a disturbing situation is noticeable. Only 16 percent of the roads in the zone is tarred. Others are earth roads of which 48 percent are unmotorable during rainy season. Anambra State is the worst in this regard, owing to its peculiar erosion problems. Most of the rural dwellers have no access to markets where to reasonably dispose farm produce. Lack of roads also affects provision of health and social development.

In general, community organizations, town unions and other social organizations help to provide Basic Social Services in most of the states, especially the Igbo-speaking states in the zone. These services include roads, water, markets, schools, health and recreation centers. In effect, Government’s effort in the provision of BSS is highly complemented by self-help activities in the communities.
CHAPTER THREE

SURVIVAL

3.1 Survival is a natural phenomenon and one of the fundamental rights enshrined in the CRC and CEDAW. Promotion of survival for children and women is the hallmark of CRC and CEDAW and which is the cardinal emphasis of SDPP and it calls for mobilization, political will, policy efforts on the part of the government to eradicate all inhibitors impinging on the full implementation of the relevant articles of CRC namely articles 6 and 24, CEDAW articles 10h, 12, 14b and 16e. Other relevant articles aimed at survival are CRC articles aimed at survival are CRC article 27 and CEDAW article 14h which is advocating means of survival for children and women and reducing physical workload on women. Based on these articles, survival is the right to continue to live or exist the right to the highest standard of health and medical care attainable and the right to a standard of living for his or her physical, mental, spiritual, moral and social development. The zone has an obligation to provide children and women with these rights.

3.2 Assessment and Analysis of current situation in zone A

3.2.1 Manifestations of violations of the right of survival

The situation of children and women in the zone is far from attaining the condition or ensuring the full enjoyment of the right to survival, as contained in the CRC and CEDAW articles. Available data on the right to survival is not being fulfilled in the zone. It is important to highlight manifestation of violations of this right. The unacceptable high level of infant, under 5, adolescent and maternal mortality rates in the zone amply demonstrate this.
Infant mortality rate in the zone is estimated at 93/1000 live births, range 80/1000 in Anambra to 120/1000 in Bayelsa State. This does not compare favorably with the national rate which is 114/1000 live births and the target set by the year 2000 which is 60/1000 live birth as shown in Table 3.1.

Under five mortality rate in the zone is estimated at 171/1000 live births, range 143/1000 in Abia to 205/1000 in Ebonyi. The Nigerian average is 191/1000 live births and the target by year 2000 is 80/1000 live births. These show violations of the right of the child as shown in Table 3.1.

Table 3.1
Showing mortality rates of infants, under-five and maternal in the states in the zone, compared to Nigeria average and target by the year 2000.

<table>
<thead>
<tr>
<th>States</th>
<th>Infant mortality rate Per 1000 live births</th>
<th>Under five mortality Rate per 1000 live birth</th>
<th>Maternal mortality rate Per 100,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abia</td>
<td>82</td>
<td>143</td>
<td></td>
</tr>
<tr>
<td>Akwa-Ibom</td>
<td>84</td>
<td>-</td>
<td>780</td>
</tr>
<tr>
<td>Anambra</td>
<td>90</td>
<td>150</td>
<td>600</td>
</tr>
<tr>
<td>Bayelsa</td>
<td>120</td>
<td>195</td>
<td>400</td>
</tr>
<tr>
<td>Benue</td>
<td>95</td>
<td>145</td>
<td>1500</td>
</tr>
<tr>
<td>Cross River</td>
<td>90</td>
<td>160</td>
<td>750</td>
</tr>
<tr>
<td>Ebony</td>
<td>98</td>
<td>205</td>
<td>1600</td>
</tr>
<tr>
<td>Enugu</td>
<td>110</td>
<td>170</td>
<td>900</td>
</tr>
<tr>
<td>Imo</td>
<td>95</td>
<td>191</td>
<td>800</td>
</tr>
<tr>
<td>Rivers</td>
<td>95</td>
<td>180</td>
<td>800</td>
</tr>
<tr>
<td>Zonal Average</td>
<td>93</td>
<td>171</td>
<td>950</td>
</tr>
<tr>
<td>Nigerian Average</td>
<td>114</td>
<td>191</td>
<td>1000</td>
</tr>
<tr>
<td>Target by Year 2000</td>
<td>60</td>
<td>80</td>
<td>750</td>
</tr>
</tbody>
</table>

Source: 10 STATES PLAN OF ACTION 1999
Health is an essential element of human development that affects nutritional status (ICN, 1993). The intricate relationship between health and nutrition therefore needs to be understood before appropriate programmes can be designed to improve nutritional status at the household level.

There is high rate of childhood morbidity. Commonest causes of morbidity in under fives hospital based studies were fever, acute respiratory infection (ARI) and diarrhoea.

Recent trends document a declining performance in the health sector, while there have been some achievements in the past five years, they have not prevented a significant rise in both infant and child mortality. For 4 – 5 children, malaria, diarrhea, ARI and vaccine preventable diseases are the most common killers. Their impact is amplified by major underlying factors such as malnutrition, lack of access to basic services (e.g. clean water and sanitation) and poorly functioning health services – without adequate drug supplies and equipment in many locations. (MPO 1997 – 2001). In the zone, traditional practitioners are still the first source of health care for poor people living in communities with limited access to basic health services.

Low birth weight (LBW) defined by WHO as a body weight of less than 2500g at delivery, is a major public health problem. Low birth weight (LBW) babies need special attention since their morbidity and mortality was much higher than for normal average weight babies. Incidence of LBW babies varied from 9.6% to 23.1% (ACC/SCN 1992). Table 3.2 show the incidence of LBW in some studies in Benin and Ilesha in 1991 which showed a range of 15.6 – 23.1%. this picture is applicable to some states in the zone.
Low birth weight implications include greater mortality and morbidity, prolonged impairment of physical and cognitive development, and higher risk of adult degenerative disorders. Among possible corrective measures, prevention of adolescent pregnancy, and general improvements in education, nutrition hygiene, antenatal care and socioeconomic condition promise the fretters benefit.

Studies conducted in the zone indicated malnutrition to be on the increase.

Table 3.3 show nutritional status by demographic characteristics. Stunting was more prevalent among boys (66.6%) than in girls (46.0%). The prevalence of wasting was higher in boys (10.3%) than in girls (3.2%). The prevalence of underweight was equally higher in boys (27.5%) than in girls (20.0%).
In zone A, one thousand and eighty children (1080) of both sexes, age 59 months, made up of 426 girls (39.4) and 654 boys (60.6%) were measured.

Stunting was the major form of malnutrition identified in the children studied. The peak prevalence in the zone for stunting was in children aged 48 – 59 months (57.4%). Prevalence of stunting was generally high in the zone for all age groups ranging from 47.6% in children aged 24 – 35 months to 52.0 in children aged 12 – 23 months. Prevalence of stunting was higher in boys (56.6%) than in girls (46.0%). Yola Local Government Area had the lowest (24.0) prevalence for stunting in the zone while the highest prevalence were recorded in Akarkpa (64.0%) and Katsina Ala (63%) respectively (FGN/UNICEF, 1994).

Table 3.3

Prevalence of Nutritional Status by Demographic Characteristics in Zone A

<table>
<thead>
<tr>
<th>sex</th>
<th>Stunting Ht/Age</th>
<th>Wasting Wt/Age</th>
<th>Underweight Wt/Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>56.6</td>
<td>10.3</td>
<td>27.5</td>
</tr>
<tr>
<td>Female</td>
<td>46.0</td>
<td>8.2</td>
<td>20.0</td>
</tr>
<tr>
<td>Age (Months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 – 11</td>
<td>48.0</td>
<td>18.3</td>
<td>33.8</td>
</tr>
<tr>
<td>12 – 23</td>
<td>52.0</td>
<td>12.8</td>
<td>31.7</td>
</tr>
<tr>
<td>24 – 35</td>
<td>47.6</td>
<td>8.9</td>
<td>31.3</td>
</tr>
<tr>
<td>36 – 47</td>
<td>51.1</td>
<td>9.2</td>
<td>28.1</td>
</tr>
<tr>
<td>48 – 59</td>
<td>57.4</td>
<td>8.9</td>
<td>23.0</td>
</tr>
</tbody>
</table>

Source: FGN/UNICEF (1994)
### Table 3.4
Prevalence of Nutritional Status by Socio-Economic Characteristics in Zone A

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Stunting Ht / Age</th>
<th>Wasting Wt / Ht</th>
<th>Underweight Wt / Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>10.5 29.0</td>
<td>16.76 17.36</td>
<td>9.0 22.0</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's Education</td>
<td>Non-formal</td>
<td>59.9 60.5</td>
<td>61.3</td>
</tr>
<tr>
<td></td>
<td>Primary/Secondary</td>
<td>34.2 32.3</td>
<td>32.1</td>
</tr>
<tr>
<td></td>
<td>Not completed</td>
<td>5.9 7.3</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Secondary/Higher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's Income</td>
<td>Above (\geq5000)</td>
<td>6.5 5.5</td>
<td>5.6</td>
</tr>
<tr>
<td></td>
<td>2000 - 5000</td>
<td>27.4 26.4</td>
<td>28.1</td>
</tr>
<tr>
<td></td>
<td>Below 2000</td>
<td>66.1 68.2</td>
<td>68.4</td>
</tr>
</tbody>
</table>

Source: FGN/UNICEF (1994)

The prevalence of wasting in the zone was more in infants 0 – 11 months (18.3%) and young children 12 – 23 months (12.8%) than in older children aged 24 months and above. The prevalence of wasting recorded was higher than what was deemed acceptable in well nourished populations where the rate was only 2%.

In the zone, the prevalence of wasting was higher in boys (10.2%) than in girls (8.2%). Among the focus LGAS, the highest prevalence of wasting was recorded in Yala LGA (18.3%) which incidentally had the lowest stunting in the zone. Ogoja and Biase Local Government Areas had comparatively lower prevalence of wasting (7.4%) each. (FG/UNICEF, 1994).
In Zone A, the prevalence of underweight (weight/age) ranged from a low of 17.0% in Ogoja Local Government Area to a high of 32.5% in Katsina-Ala. The peak prevalence of underweight was in infants 0 – 11 months (33.8%) while the lowest prevalence 23.0% was recorded in children 48 – 59 months as shown in Table 3.3. The gender difference followed the same pattern in stunting and wasting (FCN/UNICEF, 1994).

Table 3.4 shows prevalence of nutritional status of children by sector and socio-economic characteristics in zone A.

Stunting was more prevalent in rural area (29.0%) than in urban area (10.5%). Wasting was also more prevalent in rural (17.36%) than urban (16.76%) and underweight followed the same trend with stunting and wasting in the zone.

In general, mother’s education and income were two factors identified which appeared to strongly influence the nutritional status of children under five years of age.

Studies show that educated women have different styles of interacting with children, which reinforces their developmental progress (Richman et al., 1992) moreover, mothers with more schooling often have greater nutritional knowledge (Ruel et al., 1992) and are thought to have increased assertiveness and higher status within the household, better ability to make use of health care systems, and more capacity to allocate resources on their own.

With regard to micronutrient deficiencies, zonal disaggregates showed children in zone A 5.8% were deficient in vitamin A. The overall prevalence of iodine deficiency was 44.1% but in zone A prevalence was
65.6% in mothers and children (91.3%) using levels of T4 < 50 n mol / L and TSH > 5.0 µg/L which are indicative of Iodine deficiency. For anemia, one out of every 4 women aged 15 – 45 in the Local Government Areas studied was anemic. The highest prevalence was in zone A where 61.4% of mothers were anemic. Three out of every 10 Children were equally anemic in zone A with 49.6% prevalence rate. These micronutrient deficiencies namely, Vitamin, Iron and Iodine contribute significantly, to morbidity and mortality among children and women.

3.2.2 LIFE CYCLE CAUSAL ANALYSIS OF VIOLATIONS IN ZONE A:

Table 3.5 shows the right based situation analysis through the life cycle causal analysis framework. The immediate causes of mortality in zone A experienced by children and women is the morbidity state.

In zone A, infant mortality rate which was estimated at 93/1000 live births, range 80 – 120 with Anambra State having the least rate and Bayelsa State with the highest rate of 120/1000 live births has immediate causes as diarrhea, ART, Measles, Neonatal Tetanus, Malaria low birth weight, iron deficiency anemia and malnutrition. Diarrhea was extremely implicated in Bayelsa state and moderately implicated in Ebonyi and Rivers State. Underlying causes are poor personal hygiene, contaminated water, overcrowding low level of immun!izations. Inadequate dietary intake. Inappropriate breastfeeding practices, inappropriate complementary feeding practices and worm infestation. While the major basic causes of IMR in the zone were poverty and ignorance with poor refuse and excreta disposal systems, and inadequate resources as shown in Table 3.5.

The 1990 FCN/UNICEF baseline surveys indicated ARI accounted for 26 – 42% of all cases admitted to health facilities. The study showed that younger mothers had frequently ill children in the zone. Also morbidity
was higher among the 'ultra poor' those who earned less than \( \geq N=2000 \) per annum and those as 'chronic poor', that is those whose annual income was between \( \geq N=2000 \) and \( =N=4,999 \).

Surviving LBW infant demonstrate significant growth retardation, which persist until adulthood, as well as retardation in motor and cognitive development until at least the age of five. Studies have shown that intrauterine growth retardation (IUGR) is the main reason for low birth weight. Therefore effect of IUGR cannot be completely be versed, even if the infant are provided with an ideal environment and nutritional impact. Growth retarded (stunted / underweight) mothers are likely to give birth to LBW infant themselves thus perpetuating a vicious cycle through generations.

Malaria and diarrhea were highly implicated in U-5 mortality rate in the zone and as a major cause of 20 – 30% of deaths in under 5 year olds. Guinea worm was implicated in Ebonyi and Enugu States with 2847 and 1840 cases in the two stated respectively (CSPD), 1998). The underlying causes of these were unsanitary environment, lack of portable water, low immunization coverage, poor child care practices and inadequate health services. Basic causes were poverty and ignorance and low level of maternal education.

Education of mothers had effect on the prevalence of under nutrition in children under 5 years of age probably because of the strong association between educational attainment and income. Of all stunted children identified in the (FCN/UNICEF), 1994) study, 59.9% came from mothers who had no formal education in contrast to 34.2% from mothers.
Table 3.5


<table>
<thead>
<tr>
<th>Age</th>
<th>Manifestation</th>
<th>Immediate Causes</th>
<th>Underlying Causes</th>
<th>Basic Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 yr</td>
<td>Infant Mortality</td>
<td>Diarrhea</td>
<td>Poor personal Hygiene</td>
<td>Poverty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ARI</td>
<td></td>
<td>- Ignorance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Measles</td>
<td>Contaminated Water</td>
<td>Lack of adequate Resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NNT</td>
<td>Poor environmental Sanitation</td>
<td>Low maternal Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Malaria</td>
<td>Overcrowding</td>
<td>Poor Housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LBW</td>
<td>Low level of PHC Services</td>
<td>Poor refuse and excreta Disposal systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Malnutrition</td>
<td>Low immunization Coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Lack of information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Poor quality care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Inadequate breast-feeding intake and practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Inappropriate complementary feeding practices</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Manifestation</td>
<td>Immediate Causes</td>
<td>Underlying Causes</td>
<td>Basic Causes</td>
</tr>
<tr>
<td>--------------</td>
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<td>------------------</td>
<td>-------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>1-5 yrs</td>
<td>Morbidity</td>
<td>1. Malaria</td>
<td>Unsanitary</td>
<td>- Poverty</td>
</tr>
<tr>
<td></td>
<td>Malnutrition</td>
<td>2. Diarrhea</td>
<td>environment</td>
<td>- Ignorance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. ARI</td>
<td>Water</td>
<td>- Low Maternal education</td>
</tr>
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<td></td>
<td></td>
<td>4. Measles</td>
<td>Low level of</td>
<td>- Poor resource allocation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Under Malnutrition</td>
<td>Lack of access to information</td>
<td>- Poor funding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. IDA</td>
<td>Low Immunization</td>
<td>- Poor refuse disposal system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Guinea Worm</td>
<td>Inadequate</td>
<td>- Inadequate water supply</td>
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<td></td>
<td></td>
<td>8. Typhoid</td>
<td>household food</td>
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<td></td>
<td></td>
<td>security</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>9. Cholera</td>
<td>Inadequate health</td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td>services</td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td>- Worm infestation</td>
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</tr>
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<td></td>
<td></td>
<td></td>
<td>- Contaminated water</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Poor sanitation</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Poor personal</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hygiene</td>
<td></td>
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<tr>
<td>12-18 yrs</td>
<td>Adolescent</td>
<td>1. Induced abortion</td>
<td>Teenage pregnancy</td>
<td>- Poverty</td>
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<tr>
<td></td>
<td>Mortality</td>
<td>2. Hemorrhage</td>
<td>- Lack of sexual</td>
<td>- Ignorance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. IDA</td>
<td>education</td>
<td>- Culture/ Tradition (FAM)</td>
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<td></td>
<td>4. Septis</td>
<td>- Female genital</td>
<td>- Inadequate resource allocation</td>
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<td></td>
<td></td>
<td>Mutilation</td>
<td></td>
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<td></td>
<td></td>
<td>- Peer influence</td>
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<td>5. Obstructed</td>
<td>- Lack of information</td>
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<td>6. Malnutrition</td>
<td>- Poor access to</td>
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<td></td>
<td>FP services</td>
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<tr>
<td></td>
<td>STD/HIV/AIDS</td>
<td>7. Delivery Services</td>
<td>- Lack of obstetric care</td>
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<td></td>
<td>- Early marriage</td>
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<td></td>
<td>- Poor feeding habit</td>
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</tr>
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<td></td>
<td></td>
<td></td>
<td>- Low dietary intake</td>
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<td></td>
<td>- Inappropriate processing method</td>
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<td></td>
<td></td>
<td></td>
<td>- High intake of goitrogenous foods in endemic areas</td>
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</tr>
<tr>
<td>Age</td>
<td>Manifestation</td>
<td>Immediate Causes</td>
<td>Underlying Causes</td>
<td>Basic Causes</td>
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<td>-----</td>
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</tr>
<tr>
<td>15-49</td>
<td>Morality</td>
<td>1. Hemorrhage</td>
<td>- Too many too close deliveries</td>
<td>- Poverty</td>
</tr>
<tr>
<td></td>
<td>Malnutrition</td>
<td>2. Sepsis</td>
<td>- Unhygienic delivery</td>
<td>- Ignorance</td>
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<td>3. Multiple and close deliveries</td>
<td>- Lack of access</td>
<td>- Harmful (FAM)</td>
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<td></td>
<td>4. Induced abortion</td>
<td>- Practices</td>
<td></td>
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<td></td>
<td>5. Malaria</td>
<td>- Lack of access to modern FP practices</td>
<td>- Low Societal value for women</td>
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<tr>
<td></td>
<td></td>
<td>6. Anemia</td>
<td>- Lack of adequate ante-natal care</td>
<td>- Underdeveloped health facilities</td>
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<tr>
<td></td>
<td>Malnutrition</td>
<td>7. Malnutrition</td>
<td>- Poor drainage system</td>
<td>- Lack of resources</td>
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<td></td>
<td></td>
<td></td>
<td>- Inadequate health services</td>
<td>- Subordination of women</td>
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<td>- Inadequate dietary intake of iron foods/other foods</td>
<td>- Unprotected houses</td>
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<td>- Inadequate HFS</td>
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<td></td>
<td></td>
<td></td>
<td>- Food taboos</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Intake of proteinous foods</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Inappropriate processing methods</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Unhealthy environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Heavy domestic chores</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Family food distribution</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Pressure/desire to Have many children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Decision for family planning not made by women.</td>
<td></td>
</tr>
</tbody>
</table>
Who completed at least primary education and 5.9% from mothers who completed full secondary or higher. Th pattern was same for wasting and underweight children (Table 3.4). Adolescent mortality is primary attributed to induced abortion hemorrhage, IDA, sepsis, obstructed labour malnutrition and STD/HIV/AIDS. Then for maternal mortality, immediate causes are hemorrhage, sepsis, multiple and close pregnancies, induced abortion, malaria, anemia and malnutrition.

Problem of survival for 12 – 18 years old and 19 – 45 years in the zone is adolescent and maternal mortality. Pregnancy is a high risk period in Nigeria and in the zone.

Child marriage at such a tender age is physically and mentally unfit to carry out the reproductive roles trust on her when pregnant. First is the incapability of young girls who are not physiologically mature to deliver safely. It has been argued that they face a variety of hazards that threaten their sexual and reproductive health. By teenage age, your adolescent have not reached complete physical maturity, and their pelvis may not be wide enough to accommodate a body's head. As a result, obstructed delivery prolonged labour may occur and this may lead to vesicle Vagina Fistula (VUF) if inappropriate surgical intervention is not applied; apart from hemorrhage. Secondly, VUF may occurs as a result of Female genital mutilation (FGM) practices. It has been argued that in the process of circumcision certain part of the vagina may have been damaged which will have a resultant effect during deliver. This may have accounted for the prevalence of the problem among older women in the southern part of the country (Rivers 86.6%, Cross river 77.1%, Imo 77.5%, Anambra 70.1% in female children and Adult women; Imo 95.4%, Cross River 93.1% Anambra 82.4%, Abia 75.5% all in zone A) as shown in figure 3.1 where female circumcision is highly practiced (Report of National Baseline survey of positive age harmful Traditional Practices affecting...
women and girls in Nigeria 1998). The reduction of adolescent and maternal mortality requires the availability of safe affordable means of voluntary contraception, early identification of high risk pregnancies and births, and an enhanced access to basic and emergency obstetrical care. To tackle these health needs in an integrated manner, would need working at community level, harnessing local resources and establishing co-management through the BI approach. These can effectively improve performance and enhance the sustainability of essential health services.

In general, micronutrient deficiencies have immediate, underlying and basic causes. For all micronutrients under consideration, their immediate causes are inadequate dietary intake and/or impaired utilization. The underlying causes include inadequate quantity and/or quality of the diet, poor environment, poor health and an excessive losses from the body, household food insecurity and ignorance about food values.

The basic causes arise from the nature of the political economy and lack of adequate government policy. Specific causal factors are also important. In areas with high prevalence of endemic goiter e.g. Enugu and Ebonyi States, it is usual to find low iodine in soil and most foods, low consumption of sea foods, insufficiently iodized salts or the presence of goitrogen in the commonly available staples. Cases of inadequate processing of cassava has been implicated in the etiology of goiter because of the presence of cyanide (NASENT 1992, UNICEF 1992). The most important clinical abnormalities attributable to iodine deficiency are goiter and cretinism. The latter leads to irreversible psychomotor retardation.

Iodine deficiency may also lead to reproductive dysfunction, manifesting as high rates of abortions, stillbirths, dysmorphic features, low birth weight and high infant and under-5 mortality.
<table>
<thead>
<tr>
<th>State</th>
<th>Female Children</th>
<th>Adult Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edo</td>
<td>24.4</td>
<td>11.7</td>
</tr>
<tr>
<td>Lagos</td>
<td>93.3</td>
<td>91.6</td>
</tr>
<tr>
<td>Ogun</td>
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<td>98.5</td>
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<td>Ondo</td>
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<td>96.8</td>
</tr>
<tr>
<td>Osun</td>
<td>31.2</td>
<td>75.5</td>
</tr>
<tr>
<td>Oyo</td>
<td>77.5</td>
<td>82.4</td>
</tr>
<tr>
<td>Abia</td>
<td>70.1</td>
<td>17.5</td>
</tr>
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<td>95.4</td>
</tr>
<tr>
<td>Enugu</td>
<td>77.1</td>
<td>65.3</td>
</tr>
<tr>
<td>Imo</td>
<td>86.6</td>
<td>58.3</td>
</tr>
<tr>
<td>Akwa Ibom</td>
<td>77.1</td>
<td>93.1</td>
</tr>
<tr>
<td>Cross River</td>
<td>69.1</td>
<td>91.4</td>
</tr>
<tr>
<td>Delta</td>
<td>86.6</td>
<td>58.3</td>
</tr>
<tr>
<td>Rivers</td>
<td>77.1</td>
<td>93.1</td>
</tr>
<tr>
<td>Adamawa</td>
<td>44.3</td>
<td>77.9</td>
</tr>
<tr>
<td>Bauchi</td>
<td>44.3</td>
<td>77.9</td>
</tr>
<tr>
<td>Borno</td>
<td>44.3</td>
<td>77.9</td>
</tr>
<tr>
<td>Yobe</td>
<td>44.3</td>
<td>77.9</td>
</tr>
<tr>
<td>Taraba</td>
<td>44.3</td>
<td>77.9</td>
</tr>
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<td>44.3</td>
<td>77.9</td>
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<tr>
<td>FCT</td>
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<td>77.9</td>
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<tr>
<td>Kano</td>
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<td>77.9</td>
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<tr>
<td>Katsina</td>
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<td>77.9</td>
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<td>77.9</td>
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<tr>
<td>Sokoto</td>
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<td>77.9</td>
</tr>
<tr>
<td>All</td>
<td>44.3</td>
<td>77.9</td>
</tr>
</tbody>
</table>

Figure 3.1 Profile of Female Genital Mutilation (FGM) in Nigeria: Reports from Household Heads, Female Children and Adult Women
Despite the paucity of comparable nutritional trend data at the zonal level, it seems likely that the prevalence of children stunted, wasted and underweight has risen from the 1980s into the 1990s and is now an increasingly serious problem in the zone. The most recent data by FCN/UNICEF 1994 survey data showed stunting in U-5 children ranging from 41.2% in infants to 50.1% in children aged 36 - 47 months which is higher than the 1990 NDHS study which had it at 36% in the zone. The prevalence of stunting was higher in boys than in girls.

Nutrition has become very important in both preventive as well as curative health care. Dietary factors have been implicated in the etiology of many diseases including several diseases of children. The most devastating problems facing the world’s poor currently, especially in the developing countries are hunger and malnutrition.

Therefore, nutritional deficiencies in the zone resulting from the poor state of health care services and of food security are exemplified by:

(a) Prevalence of stunting, underweight and wasting in several communities and high incidence of low birth weight which is an indicator of maternal malnutrition.

(b) Prevalence of micro-nutrient deficiencies such as anemia, iodine deficiency disorders (IDD) and vitamin A deficiency. Prevalence rates of 24% to 36% have been reported for goiter.

(c) Low dietary energy supply (DES) which ranges from between 40% to 60% of RDI (FCN/UNICEF, 1994).

Women and children under five form half of the zonal population and are nutritionally disadvantaged (UNICEF 1990). In a recently published of nations report (UNICEF, 1993) malnutrition among the under five population is estimated at 36%, a rate that was higher than the regional
average. The incidence of low birth weight (a good indicator of maternal malnutrition) ranges from 9.6 – 23.9% (NASENT, 1992). Both protein-energy malnutrition and low birth weight are considered leading causes of infant mortality. The infant mortality rate in 1990 was 98/1000 live births above average for sub-Saharan Africa. The fertility rate is quite high at 6.3, and the maternal mortality rate is 800 – 1600/100,000 live births which is one of the highest in the world, attributed primarily to maternal malnutrition, anemia and poor obstetric care. Life expectancy in 1989 was low at 49 for males and 54 for females (ACC/SCN 1992).

A new phenomenon is the trend in rivers and Bayelsa States where you find intensive in-migration from all parts of the country to the states, following oil exploration activities and the Liquefied Natural Gas (LNG) project. Young girls now run after these oil workers with fat salaries leading to prostitution, teenage pregnancy, single parents and STD/HIV/AIDS problem.

Another new phenomenon is the increasing number of apparently women beggars on the streets most of whom are nursing mothers. Child beggars and street children have increased rapidly over the last two years.

3.2.3 MAJOR IDENTIFIED PROBLEMS OF SURVIVAL:

Based on the manifestations of violations of the right of survival and the right based situation analysis through the life cycle/causal analysis framework, the major problems are infant under five, adolescent and adolescent maternal mortality in the zone. Other issues are micro-nutrient deficiencies, low birth weight, malnutrition, and inadequate water supply. In order of priority infant mortality would have highest priority followed by U-5 mortality and maternal mortality.
Listed:
- Infant mortality
- Under 5 mortality
- Maternal mortality
- Adolescent mortality
- Micro-nutrient deficiencies
- Low birth weight.

3.3 PAST EXPERIENCES AND POLICIES:
In the past, these identified priority problems namely IMR, U-5 mortality and maternal mortality have all been recognized as priority problems at all level of the systems namely National, state and LGA level and even the international organization that have been assisting in tackling these problems. Their have been appreciated by all.

The introduction of Primary Health Care (PHC) with EPI and ORT as the lead elements in the 1980s after the Alma Ata declaration in 1978 was one of the efforts to tackle survival problems of children and women. However, PHC was designed to provide integrated low cost, community based and community supported preventive and curative health systems which was made the statutory responsibility of local governments. With this, there was lack of political commitment and poor funding with the result that its implementation and achievement has not been remarkable. Hope were not lost since in 1991 – 96 cycle the main aim was to support national PHC policy formulation, simultaneously strengthening PHC through the Bamako Initiative (BI). Support to onchocerciosis control was considerably increased after the 1993 Mid-term Review. Other major health problem such as ARI, poor maternal/reproductive health and malaria received less attention.
Greater awareness and implementation of draft policies on malaria and maternal and child health improved through cooperation with the states and local government areas coordinated by the UNICEF zonal office in the zone. Nevertheless, PHC still remains the most cost effective means of tackling the problem of survival among children and women.

Earlier nutrition work concentrated on household food security by promoting women’s contribution processing and storage. After the midterm review in 1993 more emphasis was given to networking with partners and support for the development of a national nutrition policy. Micro-nutrient deficiencies, including iodine and vitamin A, were on the agenda. Baby friendly hospitals and community-based growth monitoring were also components of the program. There were major achievements with 95% of the salt being used in the zone iodized. Vitamin A supplementation has been promoted and around 50% of all children aged 6 – 24 months were given high potency vitamin A in 1995/96. Community based growth monitoring activities have been promoted but needs documentation.

Malnutrition is increasingly been less perceived as either a purely 'health' or a purely 'agriculture' matter and a draft national Nutrition Policy has been drawn up with the principal coordinating body, the NCFE, located directly under the presidency/National Planning Committees to monitor nutrition programmes.

**Constraints and Gaps:**

Many factors militate against achieving goals set for the zone under survival:

- Financial constraints both on the part of states and UNICEF.
- Serious logistic problems – access (transport) roads, no cars etc.
- Inadequate staffing with respect to data collection, collation, statistical analysis of reports, supervision and evaluation of programme impact.
- Lack of political will and commitment.
- Acute shortage of water in Bayelsa State.
- Lack of basic tools and equipment
- Poor attitude to work by health workers.

3.4 Options for Action:
In view of the fact that past experience and policies have been analyzed, the next line of action is to tackle the immediate and underlying causes identified in the life cycle causal analysis framework. The goals of the zone in the area of survival will be the following:

- Prevention / treatment /management of malaria, diarrhea, ARI, measles, neonatal tetanus, worm infestation and malnutrition especially micro-nutrient malnutrition.
- Improvement in acceptability availability and use of family planning service.
- Improvement in availability of obstetric care and member of attended deliveries.
- Improvement in access to safe drinking water
- Increase in sanitary excrete disposal and level of personal hygiene and environmental sanitation.

For survival, the areas to concentrate are health and nutrition, water and environmental sanitation. There is need to break the vicious cycle, convert the vicious cycle to a virtuous cycle knowing that the problem is multifaceted, there is need to use inclusive approach rather than linear/ selective approach. There should be no "either / or" approach.

The strategies to be adopted are social mobilization, capacity building and service delivery.

For zone A, the actions are:
- Reduction of infant mortality and morbidity by 30% by the year 2001, since 70% of child mortality is attributable to
preventable diseases. The leading diseases identified among 0 – 1 year olds are malaria, ARI, diarrhea, pneumonia and measles. Eradicate polio by year 2001.

- Reduction of under 5 mortality and morbidity rates by 60% by year 2001 with preventive measures through the formation of a three-tiered system. PHC as defined in the Alma Ata declaration, is the main vehicle for realizing the health objectives. Raise IMCD coverage from 30% to 60% by the year 2001.

- Reduction of maternal mortality rate by the year 2001 by raising the present immunization coverage from 35% to 80% by year 2001 and sustain it. Provide access to reproductive health, maternal health care, including obstetric cases by increasing it from the present level of 30% to 60% by year 2001.

- Reduction in micro-nutrient deficiencies through appropriate mix of dietary diversification, fortification, supplementation strategies and public health measures.

- Increase in access to safe drinking portable water.

- Increase in sanitary means of refuse and excreta disposal

- Improvement in awareness creation of the people on healthier living.

Finally, there is need for comprehensive research into food and nutrition in the zone and finally in Nigeria. The research already conducted are weak because of the methodology. Conceptual definitions vary from one study to another hence there are variations in techniques and procedures. What is needed is an interdisciplinary studies, which would involve policy makers and practitioners to ensure that programmes respond to local needs and are backed up by resources.
More trained personnel is needed in the zone in the areas of health and nutrition to cater for survival needs of children and women specific objectives, activities, time frame for action and cost related to these goals are presented in each state Plan of Action (SPA) under survival.

3.5 CONCLUSION:

The situation of children and women in the zone calls for a coherent government policy on food and nutrition and a health policy which will provide guidelines for improving and sustaining a high nutritional status for all citizens. The most vulnerable are children and women of child bearing age, and because of the adverse effects of malnutrition on cognitive development, school age children should also be targets.

The prevalence of stunting and underweight were high in the zone. This shows a decline in the nutritional status and the increasing deterioration of the economy. Intervention programmes to increase household food security, increase nutrient disease complementary foods, improvement environment are already in place with the assistance of UNICEF but needs to be intensified to improve achievement rate in the states in the zone.

Micro-nutrient deficiencies are national nutrition problem but zone A had highest rates 61.3% and the zone has states that some micro-nutrients are endemic namely Enugu and Ebonyi States, with ID0 problem. Iron deficiency anemia had high vicious cycle to a virtuous prevalence in the zone 61.4% and should be given priority attention in the 1999 – 2001 UNICEF/FCN programme of operation.

Infant feeding and child care targets could be achieved and more progress made if local women's groups are used as anchor for the programmes.
They are the ones that need convincing before good results can be achieved in the exclusive breastfeeding programme in the zone. The rate is improving from the 2% rate to 5 - 15% with some researches carried out in some communities in the zone. There is need for IEC materials to infuse more effective outreach programmes than hospital based outreach.

Effort should be made to train and retrain health officials who would in turn train other facilitators. Women are more and more getting involved in economic activities and this has created the need for child care services to ensure adequate care for children. The situation is that children are either taken to the workplace in an unsuitable environment or left to the care of untrained persons. Time has come for programmes of action to be set up to take care of the needs of different categories of women. Farming households require community day care centers, market women, creches in the market and private sector should be mobilized to contribute substantially to the provision of child care services.

Women who are main food producers should be targeted for household food security programmes. There should be decentralization of agricultural development programmes to make them effective. Women should be empowered to contribute more to household food security. If women are encouraged and empowered to farm commercially through cooperatives there will be improvement in HFS.

In keeping with the slogan "Health for all the year 2000", the government's health policy is to get health services to all nooks and corners of the states in the zone. The emphasis is on preventive health services which is being operated through the Primary Health Care Service (PHC). The out of stock syndrome is gradually being eliminated from the states in the zone with the Petroleum Trust fund (PTF) drugs being distributed to all health facilities in the states in the zone. The revolving drug account,
maintained by all hospital and health institutions in the states in the zone
to make sure that drugs are available. The PHC programmes main thrust
is provision of health services to the rural areas especially. The
component of the programme include good nutrition control of
communicable diseases, treatment of endemic diseases, health
education, provision of drugs. These require both the active support and
participation of communities in the planning and execution of the
programmes.

UNICEF in collaboration with the Federal Government has been
implementing a number of PHC programmes in the states in the zone.
First is the ORT which has proved to be effective in the treatment of
dehydration due to diarrhea. It has saved a lot of children from untimely
death due to diarrhea. Second is the national programme on
Immunization (NPI) which has been on in all states in the zone and it is
aimed at immunizing children 0 - 2 years against the six childhood killer
diseases namely: measles, tuberculosis, whooping cough, neonatal
tetanus, poliomyelitis and diphtheria. UNICEF and WHO are assisting the
states especially Ebonyi and Enugu State in the control of guinea worm
infestation. UNICEF is equally assisting all states in the zone to control
HIV/AIDS, maternal and child care programmes and various capacity
building activities.

The situation of women and children in terms of survival in the zone is
improving but is improving slowly. The inaccessibility to adequate basic
health facilities which are affordable, unsafe human waste disposal
facilities, inadequate water supply, household food insecurity, micro-
nutrient deficiencies, energy and protein deficiency, inadequate feeding
and child care practices have all been strongly linked to the poor survival
profile of women and children.
CHAPTER FOUR

DEVELOPMENT

4.1 DEVELOPMENT RIGHTS AS DEFINED BY CRC AND CEDAW:
The CRC (Article 28:1a) supports the right to free and compulsory primary education. Article 28:1c supports accessibility to higher education. Article 28:1b and e support, for those it is relevant, alternative forms of secondary education including vocational education which should be made free and accessible.

For women, CEDAW (Article 10) complements those above, by emphasizing the right of the girl-child and women to completion of basic education and the availability of vocational training. Taken together, Article 28 of CRC and Articles 5, 10, and 11 of CEDAW point to the need to guarantee access to, education and training for women and children on the basis of equal opportunity and equality between boys and girls and men and women reduction of female drop-out rates and the organization of programmes for girls and women who have left school prematurely.

4.2 MANIFESTATION OF VIOLATIONS OF CRC AND CEDAW RIGHTS ON DEVELOPMENT:
In A zone more than 30% of children who should be in primary schools are not there. This is a violation of the CRC (Article 28:1a) which supports the right to free and compulsory primary education. The accessibility of the children to higher education is low and limited, because most of the schools are located far away from their homes and most of the parents cannot pay for the cost of boarding. Furthermore, the problem of low completion rate and high drop out rate in primary school limit accessibility to higher education. It is equally important to mention that the cost of school fees and learning materials also limit the accessibility of the
children to higher education as supported by CRC (Articles 28:1c). There are very few centers for vocational education in the zone. Most important is that the vocational education is not made free and accessible. Most willing beneficiary are denied access to vocational education because they could not afford the financial cost. This problem of limited access to vocational education in the zone is a violation of articles 28:1b and 6 of CRC.

The right of the girl-child and women, to completion of basic education and the availability of vocational training are seriously being violated in the zone, especially in some states. For example, there is high preference for boys than girls to obtain basic education. Most parents especially in Anambra, Ebonyi, Benue and Bayelsa prefer to send their male children to schools than the female counterpart. Also, the completion rate for basic education for both the girl-child and women are low especially in Ebonyi, Benue and Bayelsa states. The reasons for low completion rate of the girl-child and women in basic education in the zone are: withdrawal from school by parents to look after the younger ones and to assist in farm work; Teenage pregnancy, Early marriage and ignorance.

Another manifestation of violation in A zone is lack of guarantee of access to education and training for women and children on the basis of equal opportunity and equality between boys and girls and men and women. Similarly female drop-out rate is high and there is no organization of programmes for girls and women who have left school prematurely.

In summary therefore, available data in A zone show that the rights of children and women in development in A zone are not being fulfilled. These violations are manifested in low level of early childhood stimulation, low level of enrolment in primary schools, High drop out rate in primary
schools, illiteracy, low level of enrolment for secondary education and high rate of adult illiteracy.

4.3 SITUATION IN A ZONE:
Available data from state ministry of Education, NPEC, SPEB and PRS, indicates that primary school enrolment rate among children 6-11 years old is under 70% with the average school enrolment for boys being 59.6% and girls 60.4%. This means that fully more than 30% of children in a zone who should be in primary schools are not there. The problem of low level of enrolment in primary schools is more pronounced in states like Ebonyi, Benue and Bayelsa. The primary school attendance rate in the zone is 72.5% with boys having 75% and girls 70%. However, attendance rate for boys in Anambra is very low which is 54.5%, while those of girls in Ebonyi state is too poor which is 42%. The completion rate for basic education in the zone is under 60% with boys having 53% and girls 47%. The problem of non-completion rate were more pronounced in Anambra, Bayelsa and Ebonyi states.

Beyond basic/primary education, and irrespective of the paucity of reliable data, it is the general belief that fewer girls/women as opposed to boys/men go on to attend and/or complete secondary education after completion of primary education. The situation is further compounded by the fact that there are no strong organized efforts to ensure the availability, accessibility and desirability of vocational education. However, the reserve is the case in Anambra, Abia and Imo states as fewer boys/men as opposed to girls/women go on to attend and/or complete secondary education after completion of primary education. The problem of high drop out rate from primary schools which has emerged as a new phenomenon in the affected states is responsible for the reverse situation.
## 4.4 LIFE CYCLE/CAUSAL ANALYSIS OF THE PROBLEM DEVELOPMENT IN A ZONE:

The table below shows that the immediate causes of the low level of early childhood stimulation experienced by under 5 children in A zone are caused by low number of available day care centers and low quality of the existing day care centers. For children 6-11 years, low level of enrolment in primary schools are attributable to inadequate infrastructural facilities, inadequate number of teachers and low level of awareness.

<table>
<thead>
<tr>
<th>AGE YRS</th>
<th>MANIFESTATIONS</th>
<th>IMMEDIATE CAUSE</th>
<th>UNDERLYING CAUSE</th>
<th>BASIC CAUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>Low level of early Childhood stimulation</td>
<td>- Low number of day care centers</td>
<td>- Low literacy Level of parents</td>
<td>- Wide spread poverty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Low quality of Existing day care centers</td>
<td>- low awareness of early child care benefits</td>
<td>- Inadequate resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Low number of awareness</td>
<td>- Greed for money</td>
<td>- Lack of political will</td>
</tr>
<tr>
<td>6-11</td>
<td>Low level of enrolment In primary school</td>
<td>- Inadequate infrastructural facilities</td>
<td>- Over loaded Curriculum</td>
<td>- Low parental level of Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Inadequate number of teachers</td>
<td>- Low priority for education</td>
<td>- Inadequate resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Low level of awareness</td>
<td>- Poor teacher ennumeration</td>
<td>- Poor performance in schools</td>
</tr>
<tr>
<td></td>
<td>High dropout rate in Primary school</td>
<td>- Inadequate working Materials</td>
<td>- Preferential posting of teachers</td>
<td>- Politically induced sitting of schools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Lack of Role Models in schools</td>
<td>- Spatial location of Schools</td>
<td>- Lack of organized educational facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Poor performance in Schools</td>
<td>- Get rich quick syndrome</td>
<td>- Child exploitation and labour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Lust for money</td>
<td>- Get rich quick syndrome</td>
<td>- Low societal value of Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Early marriage</td>
<td>- Lack of organized vocational activities</td>
<td>- Poverty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Poor performance in schools</td>
<td>- Child exploitation and labour</td>
<td>- Poor funding</td>
</tr>
<tr>
<td>12-18</td>
<td>Illiteracy low level of Enrolment for secondary Education</td>
<td>- Low level of enrolment in basic education</td>
<td>- Poor performance in schools</td>
<td>- Shortage of trained Guidance Counselors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Inadequate Career and vocational guidance</td>
<td>- Insufficient educational facilities</td>
<td>- Insufficient skilled personnel</td>
</tr>
<tr>
<td>18-49</td>
<td>High Rate of Adult Illiteracy</td>
<td>- Drop-out</td>
<td>- Lack of functional literacy services</td>
<td>- Insufficient skilled personnel</td>
</tr>
</tbody>
</table>
This table also shows that high drop out rate in primary schools being experienced in A zone especially among the five Igbo states of Akwa, Anambra, Ebonyi, Enugu and Imo, are caused by inadequate working materials in schools, lack of role models in schools, spatial location of schools, poor performance in schools, Get rich quick syndrome, lust for money and craze for title. Similarly illiteracy, low level enrolment for secondary education and high rate of adult illiteracy being experienced by 12 – 18 Years and 18 – 49 Years respectively are attributable to early marriage, poor performance in schools, high drop out rate and low level of enrolment in basic education. These in turn, derive from the basic causes of poverty, socio-cultural impediments, lack of social amenities in rural areas, lack of political will, low societal value for education, poor funding and shortage of trained guidance counselors.

4.5 PRIORITY/MAJOR PROBLEMS:
The preceding analysis indicates that the major problems as far as development is concerned in A zone are the low level of availability and access to early child care/learning centres, for less than full enrolment in primary schools especially among the boys in the five Igbo-speaking states and specifically among the girls in Ebonyi State; Lack of adequate opportunities for vocational education, absence of organized programmes for girls and women who left school prematurely, and adult illiteracy.

4.6 Past Experience and Policies:
Prior to the ratification of CRC and CEDAW rights to development, no conscious concerted effort was made to address matters related to development of children and women as discussed above within the context of human rights. There have been several attempts at providing various forms of educational services for the enhancement of the development and well being of children and women in A zone.
Some of the past efforts especially by Government in A zone aimed at development of children and women are the introduction of Universal Free Primary Education (UPE) in 1976, the Launching of Mass literacy programme in 1991, and the expansion of Basic Education in 1992 consisting of a 6 Years of primary school and a 3 Years Junior secondary education. Other past efforts include: the Promulgation of Decree 96, which transferred the running of primary school to a commission. This led to the establishment of the National Primary Education Commission (NPEC), the State Primary Education Board (SPEB), the Local Government Education Authority (LG EA) the District Education Committee (DEC) and the Village Education Committee (VEC). Also the involvement of Communities in the Planning, Monitoring and Management of their schools using the catchment area planning, Management and Monitoring (CAPMM) strategy have contributed a lot in the improvement of quality of instructions in the schools and teachers’ welfare in the past. Generally, the past efforts and policies proved effective to some extent in tackling the problems of development at the grass roots level and enhancing the reduction in illiteracy level. However, the problems of poor funding, non-payment of teachers' salaries, non-provision of instructional materials, lack of infrastructural facilities and poor management have combined to make the past experiences and policies less effective than needed in A Zone.

There is consensus that with good Planning, Monitoring, Evaluation, Supervision and Management, some of the past efforts and Policies like the UPE, Establishment of various commissions to run primary education, mass literacy programme etc, would enhance school enrolment, attendance rate, completion rate, literacy rate, prompt payment of teachers' salaries, provision of instructional materials, infrastructural facilities and improved quality instruction.
4.7 OPTIONS FOR ACTION:

As for as development is concerned, in A zone the recommended options for action based on the situation Analysis of Identified problems and practices and policies are:

- revitalization of some past policies and programmes such as Universal Free Primary Education (UPE) and Mass Literacy Programme
- Improvement on the present level of Monitoring and Evaluation, as well as effective supervision of school activities and Teachers performance through adequate of the already established commissions eg. NPEC, SPEB, LGEA etc.
- Adequate and regular payment of teachers salaries to ensure commitment, motivation and dedication to duty. It is suggested that the salary of primary school teachers should be paid from the consolidated Fund account.
- Improvement on the number of available early childhood day care and vocational Educational Education centres.
- Improvement in the provision of Instructional Materials, Training and retraining of Teachers, infrastructural facilities and learning environment to make the school child friendly.
- Government legislation and legal framework making it compulsory for every child and adults to possess basic education certificate as a requirement to enjoy social and political rights as a citizens of the State.
CONCLUSION:

The major problems of development in A Zone centres around the low level of availability and access to early child care/Learning centres, low level of enrolment in primary schools, high drop out rate in primary schools, Lack of adequate vocational education and high rate of adult illiteracy. Some of the general causes of these problems are attributable to unconducive learning environments, widespread poverty, paucity of basic instructional materials and unmotivated teachers. Gender disparity in favour of boys/men as opposed to girls/women are apparent in almost all the States in the zone. High boys' drop out rates from primary schools are emerging as a serious concern in the zone, especially among the five Igbo Speaking States of Abia, Anambra, Ebonyi, Enugu and Imo, where apprenticeship is now preferred by both parents and children as a result of the get rich quick syndrome.

There is urgent need in the zone based on situation analysis for revitalization of some past policies such as UPE; for promoting universal access to basic education through Formal and non-Formal channels, removing barriers to the active participation of women and girls in education, expanding family and community capacity for early child care and development and Improving the Institutional Capacity of relevant agencies for improving the quality and relevance of basic education.
CHAPTER FIVE

5.0 PROTECTION

5.1 PROTECTION RIGHTS AS DEFINED BY CRC AND CEDAW:

The rising increase and rampant exposure of children and women to the ravaging effects of wars, social, economic and political conflicts, and at the least domestic provocation were problems addressed under the convention on the rights of the child (CRC) and Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).

The CRC and CEDAW are directed at protecting children and women against all forms of discrimination of any type – discrimination that hinders their development.

The CRC Articles 1, 7, 9, 10, 37 and 40, and CEDAW Articles 2, 5a, 6, 7, 15 and 16 provide legal status for children and women to defend their rights, if breached. The state is expected to protect the children and women against all acts of inhumanity and discrimination. These include torture, sexual abuse, Female Genital Mutilation (FGM), exploitation of child labour, sale of children, widowhood practices, battery, forced marriage etc. Therefore, CRC articles 2, 17e, 19, 32 – 37, 39 and 40 and CEDAW articles 5a, 6, 11(2) provide protection against all violence, exploitation, maltreatment, abuse, torture, and other acts of inhuman treatment to children and women.

The CRC and CEDAW provide protection for the less privileged persons, notably children and women. These rights are stated in CRC Articles 19, 20, 21, 22, 30, 38 and 39, and CEDAW Articles 2 and 14.
Protection also extends to the advancement of socio-economic life of women (CEDAW Articles 11 e-d and 33). It also includes protection for adequate health-care services for children and women (CRC 25 and CEDAW Article 12).

5.2   THE SITUATION IN ZONE A:

5.2.1   Manifestation of violation of Rights to Protection.

In zone A there is high incidence of child abandonment. Child abandonment frequently occurs in cities especially model town and tramscnt motor stations that labour intolerant motor drivers and passengers, vulnerable school girls get pregnant and frequently abandon their children on delivery. Enugu state for instance has many model towns characterized by child abandonment.

Street children are also common in the zone. Children are left to roam about in the streets without protection. Street children are common in urban slums in Enugu, Port Harcourt, Makurdi and Owerri. Many a time these children run the risk of being wounded by moving vehicles. They are also exposed to kidnappers and others who traffic in children.

Related to the above is street hawking, child labour, child begging and juvenile delinquency. These manifestations are common in the zone, especially for those between the ages of 6 – 11 years. The all indirect violation of protection right of children. Also identified is sexual abuse of kids between the ages 6-11 years by their peers. This is largely due to lack of parental care and, of course control.
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Other identified manifestations of violation of protection, rights are teenage pregnancy, early marriages, drug abuse and prostitution of children aged 12-18 years. Teenage pregnancy is especially high in Enugu, Anambra and Rivers State. While early marriage is considerably high in Ebonyi and Beyelsa state. Prostitution especially for school girls is pronounced in Enugu and Rivers States.

Ebonyi and Beyelsa states also recorded high incidence of Female Genital Mutilation (FGM). Generally FGM is as high as 65% for female children in the zone.

Also significant in the violation of protection rights are sexual harassment, dispossession of widows and women of property and male child preference. These manifestation which are generally gender based also include wife beating.

5.2.2 ASSESSMENT AND ANALYSIS OF THE SITUATION OF PROTECTION IN A ZONE:

Table 5 below represents the right based analysis of the situation of protection in Zone A.

Table 5
Right-Based situation Analysis Through Life-Cycle Causal Analysis Framework on Protection:
<table>
<thead>
<tr>
<th>Age</th>
<th>Manifestation</th>
<th>Immediate Causes</th>
<th>Underlying Causes</th>
<th>Basic Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 yrs</td>
<td>Child Abandonment</td>
<td>- Unwanted pregnancy</td>
<td>- Poor access to Fp service</td>
<td>- Ignorance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Single motherhood</td>
<td>- Prostitution</td>
<td>- Poverty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Unpreparedness for parenthood</td>
<td>- Lack of parental care</td>
<td>- Harsh Economic Conditions</td>
</tr>
<tr>
<td>2-5 yrs</td>
<td>Street Children,</td>
<td>- Large family size</td>
<td>- Broken homes</td>
<td>- Illiteracy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Low parental love</td>
<td>- Unemployment</td>
<td>- Poverty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Hunger</td>
<td>- Of parents</td>
<td>- Ignorance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Poor dietary habits</td>
<td>- Lack of parental care</td>
<td>- Harsh Economic Situation</td>
</tr>
<tr>
<td>6-11 yrs</td>
<td>Street Hawking</td>
<td>- Large family size</td>
<td>- Poor moral education</td>
<td>- Poverty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Low parental love</td>
<td>- Inadequate access to vocational training</td>
<td>- Ignorance</td>
</tr>
<tr>
<td></td>
<td>Sexual abuse</td>
<td>- Peer group influence</td>
<td>- Child begging,</td>
<td>- Poor National economy</td>
</tr>
<tr>
<td>12 yrs</td>
<td>Teenage</td>
<td>- Peer group</td>
<td>- Low literacy level</td>
<td>- Cultural practices</td>
</tr>
<tr>
<td>18 yrs</td>
<td>Pregnancy</td>
<td>Influence</td>
<td>- Upbringing,</td>
<td>- Practices</td>
</tr>
<tr>
<td></td>
<td>Early Marriage</td>
<td>- Poor guidance &amp; Counselling</td>
<td>- Religious values</td>
<td>- Ignorance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Lack of</td>
<td>- Unemployment</td>
<td>- Poverty</td>
</tr>
<tr>
<td></td>
<td>Drug abuse</td>
<td>Parental care</td>
<td>- Low literacy Level</td>
<td>- Poor national economy</td>
</tr>
<tr>
<td></td>
<td>Prostitution</td>
<td></td>
<td></td>
<td>- Religious beliefs</td>
</tr>
<tr>
<td>18.49 yrs</td>
<td>Prostitution</td>
<td>- Greed</td>
<td>- Low literacy</td>
<td>- Ineffective laws</td>
</tr>
<tr>
<td></td>
<td>FGM</td>
<td>- Unemployment</td>
<td>- Inadequate</td>
<td>- Cultural and Religious Practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Lack of skills</td>
<td>vocational</td>
<td>- Poverty</td>
</tr>
<tr>
<td></td>
<td>Male child Preference</td>
<td>- Low morals</td>
<td>- Multiple</td>
<td>- Lack of women empowerment</td>
</tr>
<tr>
<td></td>
<td>Dispossession Of widows and Women of property</td>
<td></td>
<td>dominance</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- The table lists various ages and corresponding manifestations, immediate causes, underlying causes, and basic causes.
- The table highlights the complexity of underlying causes, including factors like ignorance, poverty, and harsh economic conditions.
5.2.3 Major problems of Protection

Based on the result of the analysis of the situations, the major problems as far as protection is concerned in zone A are:

- Child abandonment
- Street children
- Street hawking
- Child Labour
- Child begging
- Teenage Pregnancy
- Early marriage
- Female genital nutrition and
- Male child preference

5.3 PAST EXPERIENCES AND POLICIES:

Much was not done to effectively address the issue of protection of children and women within the context of human right until rather recently. There have however been several lame attempts at providing various forms of rights for the protection of children and women in the zone. Some states in the zone had banned corporal punishment in primary and post primary schools. Some states, e.g. Benue State has adopted the National Child Welfare Policy of 1989. In addition, the 1979 and 1999 Nigerian Constitution also provision the legitimacy of the child protection under wedlock or during separation/divorce.

One of the significant events in respect of protection in the recent time is the establishment of the Ministry of Women Affairs and Social Development. Its establishment at Federal and State level has brought about intensification in the enlightenment of the rural women on their rights in the zone.
As a result of several seminars and workshops in the zone, some of them sponsored by UNICEF, most states in the zone have been making policies aimed at addressing the harmful traditional Practices (HTPS) against children and women. These (HTPS) which violate protection rights include wife beating, killing of twins, female Genital Mutilation (FGM) and forced/early marriage.

Although there is decline in most of the HTPS, much needs to be done with respect to the policies. They need to be signed into law and enforced otherwise they will merely remain in the pages of office files.

5.3 OPTIONS FOR ACTION:

Give the nature of the problem of protection, the options for action include:

(a) Capacity building: Those involved in welfare services should be regularly trained to develop their skills. Institutions involved in welfare matters, rehabilitation and resettlement should be adequately equipped.

(b) Advocacy: More mobilization and advocacy activities should be accelerated so that the desired attitude change will be achieved. This effort should also include adult literacy education and campaign, Information, Education and Communication (IEC) materials and behaviour communication and change (BCC) materials should be developed and distributed in strategic places. The materials should communicating messages sensitizing the people towards the protection needs of children and women.
Empowerment: Efforts towards women empowerment should be stepped up. Government, UNICEF and NCOS should collaborate effectively in this respect so that women will indeed be economically empowered. Once empowered, the women stand better chance of protecting their rights.

5.5 CONCLUSION:

The rights to protection of women and children are adequately defined and contained in the CRC and CEDAW. The rights to protection of women and children can be summarized as: Protection of the legal status of children and women and their interests; protection against all forms of violence, exploitation, maltreatment and abuse.

In the zone, there is less than satisfactory attention paid to the protection of women and children. The result is that there are many manifestations in the zone. The common ones are child abandonment; street children; street hawking; Teenage pregnancy; early marriage; HTS; Prostitution and maltreatment of widows. Poverty, cultural practices, ineffective law are central basic causes of these manifestations.

Although there is the Ministry of Women Affairs and Social Development, there has been few and unsatisfactory, indeed lame policies directed towards alleviating the problems of protection in the zone. It therefore recommended that more capacity building efforts, advocacy, mass literacy campaign and women empowerment should be accelerated to ameliorate the situation.
CHAPTER SIX

6.0 PARTICIPATION

6.1 PARTICIPATION RIGHTS AS DEFINED BY CRC AND CEDAW:
Participation of children and women in matters affecting them according to their ages as well as the participation of women in the social, economic, and political life of the society are also important aspects of rights supported by the CRC and CEDAW.

The CRC Article 12 recognizes the right of the child that is capable of forming his or her own view not only to express the view but also the right to have the view given due weight. In other words, the child shall the right to participate in the matters affecting him or her either in ordinary everyday life or in special circumstances such as in judicial and administrative proceedings.

CEDAW supports the right to participation of women in the social, cultural, political and economic life of the society (Articles 3, 7, 8, 11, 13, and 14). Included here are rights of gainful work, to vote and be voted for, to hold all kinds of positions in the political and economic sectors, participate in the formulation and implementation of public policy, participate in NGOs concerned with the public and political life of the country, to represent their Government at the International level and participate in the work of international organizations.

6.2 THE SITUATION IN ZONE A:

6.2.1 Manifestation of violation of Rights to participation in A zone.
Available information from the zone show that there is lack of involvement of children aged 6 – 11 year in decisions that affect them. In addition, this is clear evidence of restriction of children from associating with voluntary
associations and free clubs. There is also high incidence of non-inclusion of women in decision-making bodies. In the present political dispensation, for instance, there is no women governor in the zone, only seven out of nearly 3000 assembly men/women in the zone are women. Women commissions are six. Enugu State has no women commissioner. Women are also restricted to low level of income generating activities and lower levels of organized labour.

6.2.2 ASSESSMENT AND ANALYSIS OF THE SITUATION OF THE PARTICIPATION IN ZONE A:

Table 6 below represents the right basal analysis of the situation of participation in Zone A.

<table>
<thead>
<tr>
<th>AGE</th>
<th>MANIFESTATION</th>
<th>IMMEDIATE CAUSES</th>
<th>UNDERLYING CAUSES</th>
<th>BASIC CAUSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-11 Yrs</td>
<td>Lack of involvement in decision that affect the children</td>
<td>Inaccessibility to information</td>
<td>Extremely in control and dominance of parent over children especially over girls</td>
<td>Ignorance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-18 Yrs</td>
<td>Restriction of Children from Associating with Voluntary association And peer clubs</td>
<td>Fear and prejudice on the part of parents</td>
<td>Poor understanding of children's needs and potentials.</td>
<td>Traditional cultural and religious beliefs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-45 Yrs</td>
<td>Non-inclusion of women in high decision-making bodies.</td>
<td>Gender discrimination</td>
<td>Low literacy level of women generally</td>
<td>Traditions, cultural and religious Practices.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Poor empowerment (economically, politically and socially).</td>
</tr>
</tbody>
</table>
6.2.3 MAJOR PROBLEM OF PARTICIPATION:
Based on the result of the analysis of the situation, the major problems as far as participation is concerned in zone A are:

- Non-inclusion of women in high level decision making bodies
- Restriction of women to low level of income generating activities as farming and petty trading, and low empowerment of women, politically, economically and socially.

6.3 PAST EXPERIENCES AND POLICIES:
Prior to the ratification of CRC and CEDAW, no conscious effort was made to address matters related to effective participation of children and women in economic, political, and social cultural affairs of the zone within the context of human rights. Education of women, for instance, was considered a waste as all emphasis is on the male child. Ignorance, socio-cultural considerations and low literacy level of the people played a big role on the denial of the child's and women's rights to participation in the zone.

There have however, been some attempts at mobilizing the women to enhance the level of participation of women in some matters, especially politics. The Democracy and Government (D & G) project sponsored by USAID is a typical example of recent efforts towards encouraging women participation in politics and public affairs.
There are other mobilization efforts here and there in the zone, aimed at sensitizing women to rise up to their rights, but a concrete and directional Government policy aimed at enhancing effective participation of children and women determining issues that directly affect their welfare and development one strong constraining factor for women’s participation in politics is money. It appears that political positions especially those that would ensure participation in policy making are given to the highest bidder. Women do not have sufficient money to throw around and hence their insignificant representation in such bodies, particularly under the current dispensation.

6.4 OPTIONS FOR ACTION:

Considering the nature of problems, focus will be on programmes and projects in the following areas:

- **Mobilization**: Effort should be made to organize the women in groups to enable them make impact in their communities. Once in groups, they will be in better position to press for their rights to participation.

- **Empowerment and Literacy Enhancement**: Popular education activities should be encouraged. Government, UNICEF and NGOs should accelerate Non-Formal Education (NEF) programmes. The target group should include both men and women, community-based organizations (CBOs) and the youth.

- **Advocacy**: More advocacies with leaders of thought (LOT) should be undertaken. The aim is to get these leaders especially the men of appreciate the need for women and children’s participation, in the affairs that relate to their well-being.
6.5 **CONCLUSION:**
CEDAW clearly support the right to participation of women on issues such as gainful employment, right to vote and be voted for, holding of all forms of positions in the political and economic sectors, and participation in policy making and policy implementation. The CRC on the other hand recognizes the right of the child that will enable him or her to form opinion and express his/her views.

These rights are still to be achieved considering the manifestations which include: lack of involvement of children.
CHAPTER SEVEN

7.1 SUMMARY OF KEY FINDINGS:

According to the FAO address to the International Conference on Nutrition (ICN) in 1992, it is "known that people's health and their physical and mental development and thus their capacity to learn, to work and to play their full role in society are wholly dependent on nutrition" (FAO, 1992). Women and children under 5 form about half of the zonal population and are still nutritionally disadvantaged. Malnutrition among the under 5 population in the zone is estimated at 62% using height/age parameter, a rate that is higher than the national average. The incidence of low birth weight varied from 9.6% and 23.1% (NDHS 1990). There is high incidence of IMR, USMR and maternal mortality rates in the zone.

Prominent micro-nutrient deficiencies in the zone are IDD in Benue and Enugu States and IDA that is prevalent in all states among women and children. Vitamin A deficiency is not very prominent in the zone but needs total elimination and reduction by the year 2000 A.D. Prevalence rates of anemia in the zone are 64.9% in women and 57.6% children, in the zone (FGN/UNICEF 1994).

In general, micronutrient deficiencies have immediate, underlying and basic causes. For all micronutrients under consideration, their immediate causes are inadequate dietary intake and/or impaired utilization. The underlying causes include inadequate quantity and/or quality of the diet, poor environment, poor health and excessive losses from the body, household food insecurity and ignorance about food values. The basic causes arise from the nature of the political economy and lack of adequate government policy. Specific causal factors are also important. In states with high prevalence of endemic goiter eg. Enugu and Ebonyi States, it is usual to find low iodine in soil and most foods, low consumption of sea
foods, insufficiently iodized salts or the presence of goitrogen in the community available staples. Cases of inadequate processing of cassava has been implicated in the etiology of goiter because of the presence of cyanide (NASENI 1992, UNICEF 1992). The most important clinical abnormalities attributable to iodine deficiency are goiter and cretinism. The later leads to irreversible psychomotor retardation. Iodine deficiency may also lead to reproductive dysfunction, manifesting as high rates of abortions, stillbirths, dystrophic features, low birth weight and high infant and under 5 mortality.

Reports also indicate that dietary intake is insufficient relative to needs and infections. In Nigeria, it has been reported that 15% of severely anemic infants died in the first year of life and 4% of severely anemic mothers died at child birth (ICN, 1992). Iron deficiency anemia impairs physical and mental development in children while in adults, it results in fatigue and low work productivity. Maternal anemia leads to low birth weight, while in school age children. IDA has been found to negatively affect attention and concentration (ICN, 1992).

In Zone A 99% of salt has been iodized while 4% is yet to be iodized (Nutrition Section, UNICEF, Lagos). Phenomenon of high boys drop-out rate in the five Igbo speaking areas of the Southeast zone. The girls enjoy some advantage over the boys in terms of participation rates in vocational training. The girls through home economics and Nutrition which are offered as subjects in schools and which seem not to attract the boys, had better participation in vocational training. Handicrafts which the boys use to learn are virtually non-existent in most of the schools. The incentive and scholarship programmes are equally accessible and appropriate to the boys and girls in terms of formal and non-formal education; career and vocational guidance; information on reproductive health; libraries; community centers; recreation and athletic facilities; youth groups and
access to media. The services although equally available to girls and boys in especially difficult circumstances but are not appropriate.

For example, disabled children, orphaned children and working children attend the same school with normal children and are exposed to the same stiff competition for the limited available services without any regard to their disability and the advantage normal children enjoy over their handicapped colleagues. The available services are equally utilized by girls and boys with particular reference to location, type and quality of schools, incentives such as scholarships, food subsidies, family-based loans/grants, vocational options and facilities, domestic and public access to media, including radio/Tv/newspapers. There is gender disparity and discrimination in favour of boys and against girls in terms of services and opportunities being of equal benefit to both sexes.

For example, in leadership and decision-making roles in schools and community groups, boys seem to be preferred. Also, with regard to completion ratios of school education, parents have greater preference for boys than girls. Similarly, in terms of opportunities for employment, application of skills and decision making, boys are given greater support and encouragement, from the society to dominate their female counterpart. The social factors which has inhibited both girls and boys from equally realizing or maximizing the opportunities offered by society for their development include - unequal inheritance rights which favours the boys. By custom and tradition especially among the Igbo speaking areas of Southeast states, girls and women have no inheritance right. Also, early marriage and early pregnancy, seclusion of girls, restricted mobility, domestic work and child care responsibilities, all tend to inhibit girls from fully exploiting the available opportunities for development. There are existing legal framework and development policies by the states to provide equal opportunities for girls and boys to develop their full
potential (eg, the constitution and the ratification and implementation of CRC and CEDAW and other human rights Conventions), but these are
vigorously pursued. There is no special legislation, policies or programmes which exist to protect and advance the rights of girls to
development. For examples, there is no law on prohibition of child marriage or continued schooling of teenage mothers as well as flexible
school schedules and access for out-of-school girls.

There is economic disparities, and gender inequality and discrimination in terms of development of men and women, in the Southeastern States.
Men seem to be favoured against women. The gender inequity and
discrimination seems to be manifest in terms of income and employment rates, income generation opportunities, access to career and vocational
guidance and application of technology; inheritance and property rights,
marginalization of women's work and shifting of profitable work to men etc.
In terms of equal development and gender equity between men and women in the Southeast States, the goals of CEDAW is yet to be firmly
institutionalized. The current level of achievement of CEDAW goals and objectives are not satisfactory. However, reasonable improvement has
been recorded in the implementation of both CRC and CEDAW goals vis-
à-vis the situation in the past, but the current expected target is yet to be
met.

The situation of women and children in terms of survival in Nigeria is
improving but slowly so. The inadequacies of portable water and safe
human waste disposal have rendered women and children vulnerable to
water-borne diseases, etc. The situation has been strongly linked to the
poor survival profile of women and children.

Inaccessibility to safe water and safe human waste disposal has obvious
gender and development implications. The women and children bear the
brunt as they spend their time looking for water. The time the women would have used for more useful activities related to their development and empowerment is used for searching for water.

On the other hand, the children spend hours queuing for water causing them to attend school late and at times missing their school assignment.

Growing in a poor sanitary environment affects the general behaviour of children, as such children might not be able to appreciate the virtues of hygienic environment and hygienic behaviour.

7.2 **POLICY AND ACTION RECOMMENDATIONS FOR THE FUTURE:**

The situation of children and women in the zone calls for a coherent government policy on food and nutrition which will provide guidelines for improving and sustaining a high nutritional status for all citizens. The most vulnerable are children and women of child bearing age, and because of the adverse effects of malnutrition on cognitive development, school age children should also be targets.

The prevalence rate of stunting, wasting and under-weight are high in the zone. This shows a decline in the nutritional status and the increasing deterioration of the economy. Intervention programmes to increase household food security, improve maternal and child health, increase health facilities and improve the environment are already in place with the assistance of UNICEF but needs to be intensified to improve achievement rate in the states in the zone.

Micro-nutrient deficiencies are national nutrition problem but zone A had highest rates 61.3% and the zone has states that some micro nutrients are endemic namely Enugu and Ebonyi States, with IDD problem. Iron deficiency anemia had high prevalence in the zone 61.4% and should be
given priority attention in the 1999-2001 UNICEF/FGN programme of operation.

Infant feeding and child care targets could be achieved and more progress made if local women's groups are used as anchor for the programs. They are the ones that need convincing before good results can be achieved in the exclusive breastfeeding program in the zone. The rate is improving from the 2% rate to 5 - 10% with some researches carried out in some communities in the zone. There is need for IEC materials to infuse more effective outreach programs than hospital based outreach.

Effort should be made to train and retrain health officials who would in turn train other facilitators. Women are more and more getting involved in economic activities and this has created the need for child care services to ensure adequate care for children. The situation is that children are either taken to the workplace in an unsuitable environment or left to the care of untrained persons. Time has come for programs of action to be set up to take care of the needs of different categories of women. Farming households require community day care centers, market women groups in the market and private sector should be mobilized to contribute substantially to the provision of child care services.

Women who are main food producers should be targeted for household food security programs. There should be decentralization of agricultural development programs to make them effective. Women should be empowered to contribute more to household food security. If women are encouraged and empowered to farm commercially through cooperatives there will be improvement in HFS.

Finally, there is need for comprehensive research into food and nutrition in the zone and finally in Nigeria. The research already conducted are weak
because of the methodology. Conceptual definitions vary from one to another hence there are variations in techniques and procedures. What is needed is an interdisciplinary studies, which would involve policy makers and practitioners to ensure that programs respond to local needs and are backed up by resources.

More trained personnel is needed in the zone in the areas of health and nutrition to cater for survival needs of children and women.

In keeping with the slogan “Health for all by the year 2000”, the government’s health policy is to get health services to all nooks and corners of the states in the Zone. The emphasis is on preventive health services which is being operated through the Primary Health Care Services (PHC). The out of stock syndrome is gradually being eliminated from the states in the zone with the Petroleum Trust Fund (PTF) drugs being distributed to all health facilities in the states in the zone. The revolving drug account is maintained by all hospitals and health institutions in the states in the zone to make sure that drugs are available. The PHC programmes main thrust is provision of health services to the rural areas especially. The component of the programme include good nutrition, control of communicable diseases, treatment of endemic diseases, health education, provision of drugs. These require both the active support and participation of communities in the planning and execution of the programmes.

UNICEF in collaboration with the Federal Government has been implementing a number of PHC programmes in the States in the zone. First is the ORT which has proved to be effective in the treatment of dehydration due to diarrhea. Second is the National Programme on Immunization (NPI) which has been on in all states in the zone and it is aimed at immunizing children 0 – 2 years against the six children killer
diseases namely: measles, tuberculosis, whooping cough, neonatal tetanus, poliomyelitis and diphtheria. UNICEF and WHO are assisting the states especially Ebonyi and Enugu States in the control of guinea worm infestation. UNICEF is equally assisting all states in the zone to control HIV/AIDS, maternal and child care programmes and various capacity building activities.

In line with the rights for survival, articles 6, 24, 27, of CRC and 10h, 11f, 12, 14b, and 14h of CEDAW specifically support better health and well-being of children and women.

1. Reduction of infant mortality and morbidity by 30% by the year 2001, since 70% of child mortality is attributable to preventable diseases. The leading diseases identified among 0 – 1 year olds are malaria, ARI, diarrhea, pneumonia and measles. Eradicate polio by year 2001.

2. Reduction of under 5 mortality and morbidity rates by 60% by year 2001 with preventive measures through the formation of a three-tiered system. PHC as defined in the Alma Ata declaration, is the main vehicle for realizing the health objective. Raise IMCD coverage from 30% to 60% by the year 2001.

3. Reduction of maternal mortality rate by 30% by the year 2001 by raising the present immunization coverage from 35% to 80% by year 2001 and sustain it. Provide access to reproductive health, maternal health care, including obstetric cases by increasing it from the present level of 30% to 60% by year 2001.

4. Reduction in micro-nutrient deficiencies through appropriate mix of dietary diversification, fortification and supplementation strategies.

5. Increase in access to safe drinking portable water.

6. Increase in sanitary means of refuse and excreta disposal.

7. Improvement in awareness creation of the people on healthier living.
From the situation analysis in the Southeast Zone, the areas that present opportunities for future intervention and actions are:

(i) The establishment of more Early Childcare Centers (ECC). There is lack of access to Early Childcare Centers (ECC) and inadequate UNICEF/SPEB assisted ECC centers linked to primary schools.

(ii) Establishment of Vocational Adult Educational programme for women/girls drop-out, and for boys especially in the five Igbo speaking states where the phenomenon has assumed a new dimension.

(iii) UNICEF assistance in the Non-Formal activities that will benefit girls and women under the Basic Education Programme.

(iv) Improvement on attendance/retention and completion rate at the primary school level.

(v) Empowerment of women and development of women's capacity.

(vi) Provision of adequate infrastructural facilities, conducive teaching/learning environment; training of committed teachers and provision of adequate instructional materials.

(vii) Institutionalization of government policies and legal framework of government policies and legal frameworks against teenage sexual exploitation, teenage pregnancy, child abandonment, child labour, early marriage and other harmful traditional practices against girl-child and women.

In summary therefore, the special areas that requires urgent future intervention programme are:

(a) Access, equity and quality education;

(b) Training and retraining of teachers;
(c) High drop-out rate
(d) Adult and Non-Formal education for girls that drop-out and women who cannot continue their education.

The recommended strategies for the intervention programme are:
(i) Advocacy and social mobilization
(ii) Capacity building
(iii) Community empowerment
(iv) Technical material support
(v) Programme monitoring and evaluation.

Regarding WES, UNICEF should work more closely with State Agencies responsible for water supply and sanitation. UNICEF should increase its capacity building efforts for State workers and also Local Government workers involved in water and sanitation.

UNICEF should pay particular attention to the water supply problem in Bayelsa State where there is water every-where but none to drink.

There is need for a comprehensive need assessment for the zone in order to generate dependable information on water and sanitation issues and also to develop opposite technologies for tackling matters relating to water supply and sanitation matters. For now information collected and collated are mainly from Government Agencies. The extent to which these agencies keep up-to-date information is obviously questionable.

Finally, hygiene and environmental education should be accelerated and integrated in school schemes so that the required coverage can be achieved.
THE ROLE OF FEDERAL, STATE AND LOCAL GOVERNMENTS, UNICEF AND OTHER PARTNERS:

The Federal, State and Local Governments in Nigeria have made several attempts at providing various forms of services for the enhancement of the health and well-being of children and women. The most recent of these efforts is the PHC Programme (including the NATIONAL PROGRAMME ON Immunization, family planning, and use of Traditional Birth Attendants) which shifted emphasis away from curative to low cost community based preventive and curative health care.

On development, the Federal State and Local Governments have at one time or the other promoted universal free primary education, launching of mass literacy programme, building of some vocational Education Centers, payment of Teachers Salaries, provision of some school equipments and maintenance of infrastructural facilities.

The Federal, State and Local Governments through various legislations, enactments, Decrees, Edicts, Legal frameworks and policies have contributed to the protection and participation of children and women in the country.

Unicef and other partners through their various supports and assistance have contributed immensely in the area of Health, Basic Education, water and environmental sanitation, Nutrition, urban basic services, planning, monitoring and Evaluation, Advocacy and programme communication. All these support and assistance have been directed to ensure the survival, Development, protection and participation of children and women in Nigeria.
7.4 **SOCIAL MOBILIZATION AND COMMUNITY PARTICIPATION:**
Social mobilization and community participation is needed at the rural areas in A zone to sensitize and create awareness of all concerned about the need to deal urgently with problems associated with the survival, Development, protection, and participation of children and women in Nigeria. There is need to involve the communities both at the planning and implementation stages of any programme for which they are the beneficiary. This is necessary to ensure sustenance, maintenance and continuity of such programme. The problem of ability for sustainability and replicability of programmes of experienced after the withdrawal of donor agencies has been traced to non-involvement social mobilization and community participation abinlion.
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