

PD-A1011-893

Prepared for

Office of Population  
Bureau for Science and Technology  
Agency for International Development  
Washington, D.C.  
Under Contract No. DPE-3024-Z-00-8078-00  
Project No. 936-3024  
and for USAID/Lagos  
under PIO/T 620-0001-3-80011

**EVALUATION OF THE NIGERIA  
FAMILY HEALTH SERVICES PROJECT  
(Covering April 1988 to December 1989)**

by

John McWilliam  
Anita Barbey  
Sam Fadipe  
Matthew Friedman  
Paulina Makinwa-Adebusoye  
I.V. Mako  
Wale Shobowale

Fieldwork  
November 27 - December 15, 1989

Edited and Produced by

Population Technical Assistance Project  
DUAL & Associates, Inc. and International Science  
and Technology Institute, Inc.  
1601 North Kent Street, Suite 1014  
Arlington, Virginia 22209  
Phone: (703) 243-8666  
Telex: 271837 ISTI UR  
FAX: (703) 358-9271

Report No. 89-060-101  
Published April 20, 1990

## Table of Contents

Table of Contents .....	i
Glossary .....	v
Acknowledgments .....	ix
Project Identification Data .....	xi
Executive Summary .....	xiii
Part I Project Approach, Management, and Components .....	xix
1. Introduction .....	1
1.1 Project Grant Agreement .....	1
1.2 The Evaluation .....	1
1.3 Overall Project Objectives .....	1
1.4 Project Strategy .....	2
2. Program Status .....	3
3. Program Approach .....	9
3.1 FHS Program Approach .....	9
3.2 FHS and Federal/State/LGA Collaboration .....	9
4. Management .....	13
4.1 Management Issues .....	13
4.1.1 Collaborative Assistance Mode for Project Execution .....	13
4.1.2 Role of the Government of Nigeria .....	15
4.1.3 Role of USAID .....	15
4.2 Other Issues .....	16
4.2.1 Fiscal Control .....	16
4.2.2 Coordination among Contractors .....	17
4.2.3 Project Identity .....	18
5. Project Components .....	19
5.1 Public Sector Component .....	19
5.1.1 Background .....	19
5.1.2 Performance .....	22
5.2 Private Sector Component .....	25
5.2.1 Overview .....	25
5.2.2 Marketing Issues .....	29
5.2.3 Sustainability of Subprojects .....	32
5.2.4 Future Activities .....	33
5.2.5 Contractor and Subcontractor Management .....	34

5.3	IEC Component	35
5.3.1	Overview	35
5.3.2	National Program	41
5.3.3	State-Level Programs	43
5.4	Policy Component	45
5.4.1	Overview	45
5.4.2	Strengths	46
5.5	Administration and Logistics Component	47
Part II Functional Analysis: Future Directions		49
6.	Service Delivery	51
6.1	Coverage	51
6.1.1	Service Delivery Points	51
6.1.2	Use of Services	51
6.2	Quality of Services	52
6.2.1	Assessment	52
6.2.2	Quality Assurance	53
7.	Training and Technical Assistance	55
7.1	Training	55
7.1.1	Need for Training	55
7.1.2	Project Approach	55
7.1.3	Training Approach	56
7.1.4	Clinical Training	57
7.1.5	Other Types of Training	57
7.2	Technical Assistance	59
8.	IEC/Constituency Building	61
8.1	National Attitudes toward Use of Contraceptives	61
8.1.1	Country-wide Views toward Contraception	61
8.1.2	Factors Affecting Use of Contraception	61
8.1.3	Factors Affecting Methods Used	61
8.2	Implications for IEC	61
8.3	Inclusion of Constituency Building in IEC Component	62
9.	Evaluation and Research	63
9.1	Evaluation	63

9.1.1	Management Information Systems	63
9.1.2	Use of MIS to Evaluate Program Progress	64
9.1.3	Implications for Project Future	65
9.2	Operations Research	65
10.	Commodity Logistics	67
10.1	Source of Supply	67
10.2	Contraceptive Method Availability	67
10.2.1	Methods Available	67
10.2.2	Public Sector Commodities	68
10.2.3	Private Sector	68
10.3	Forecasting and Monitoring	68
10.4	Diversion of Commodities	69
11.	List of Recommendations	71

#### List of Tables

Table 1	Activities Initiated by the FHS Project, by Zone	4
Table 2	New Acceptors by Method and Year, Public Sector	7
Table 3	Public Sector New Acceptors	8
Table 4	Contribution of Nigerian Implementing Agencies to FHS Component Activities	10
Table 5	Public Sector Component Project Outputs	20
Table 6	Public Sector Component Contracts	21
Table 7	Private Sector Component Project Outputs	26
Table 8	Private Sector Component Activities	27
Table 9	Private Sector Subcontracts	28
Table 10	IEC Component Project Outputs	37
Table 11	IEC Subcontracts	39
Table 12	Policy Component Project Outputs	44
Table 13	Policy Component Contracts	45
Table 14	Estimated Person Days Generated by FHS	60
Table 15	Percent Distribution of Estimated Person Days Generated by FHS	60

#### List of Appendices

Appendix A	Scope of Work and Evaluation Methodology
Appendix B	List of Persons Interviewed
Appendix C	Bibliography
Appendix D	Summary of Marketing Analysis

## Glossary

AAI	African American Institute
AED	Academy for Educational Development
A.I.D.	Agency for International Development
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CBD	Community based distribution
CCCD	Combatting childhood communicable diseases
CDC	Centers for Disease Control
CEDPA	Centre for Development and Population Activities
CYP	Couple year of protection
DHS	Demographic and Health Surveys (project)
DPA	Department of Population Activities (FMOH)
DPRS	Department of Planning, Research, and Statistics (FMOH)
EPI	Expanded Program of Immunization
FDAC	Food and Drug Administration and Control
FHI	Family Health International
FHS	Family Health Services (project)
FLE	Family life education
FMOH	Federal Ministry of Health
FOS	Federal Office of Statistics
FP	Family planning
FPC	Family Planning Coordinator
FPIA	Family Planning International Assistance
FPQ	Family planning questionnaire
GON	Government of Nigeria

<b>HEB</b>	<b>Health Education Bureau</b>
<b>IEC</b>	<b>Information, education, and communication</b>
<b>IHP</b>	<b>International Health Programs</b>
<b>IUCD</b>	<b>Intrauterine contraceptive device</b>
<b>JHU/IIP</b>	<b>Johns Hopkins University/Institute for International Programs</b>
<b>JHU/PCS</b>	<b>Johns Hopkins University/Population: Communication Services Project</b>
<b>JSI</b>	<b>John Snow, Inc.</b>
<b>LGA</b>	<b>Local government authority</b>
<b>MCH</b>	<b>Maternal and child health</b>
<b>MIS</b>	<b>Management information system</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MSC</b>	<b>Margaret Sanger Center</b>
<b>MSH</b>	<b>Management Sciences for Health</b>
<b>NANNM</b>	<b>National Association of Nigerian Nurses and Midwives</b>
<b>NCPA</b>	<b>National Council for Population Activities</b>
<b>NCWS</b>	<b>National Council of Women's Societies</b>
<b>NERDC</b>	<b>Nigerian Educational Research and Development Council</b>
<b>NGO</b>	<b>Non-governmental organization</b>
<b>NISER</b>	<b>Nigerian Institute of Social and Economic Research</b>
<b>NISH</b>	<b>National Integrated Survey of Households</b>
<b>NPC</b>	<b>National Population Commission</b>
<b>NPP</b>	<b>National Population Policy</b>
<b>ORT</b>	<b>Oral rehydration therapy</b>
<b>PAN</b>	<b>Population Association of Nigeria</b>
<b>PATH</b>	<b>Program for Appropriate Technology in Health</b>
<b>PHC</b>	<b>Primary health care</b>
<b>POPTECH</b>	<b>Population Technical Assistance Project</b>

<b>PPFN</b>	<b>Planned Parenthood Federation of Nigeria</b>
<b>REDSO</b>	<b>Regional Economic Development Services Office</b>
<b>SDP</b>	<b>Service delivery point</b>
<b>SMOH</b>	<b>State Ministry of Health</b>
<b>SPEC</b>	<b>State Population Education Committee</b>
<b>STD</b>	<b>Sexually transmitted disease</b>
<b>TBA</b>	<b>Traditional birth attendant</b>
<b>TFR</b>	<b>Total fertility rate</b>
<b>TOT</b>	<b>Training of trainers</b>
<b>UBTH</b>	<b>University of Benin Teaching Hospital</b>
<b>UCH</b>	<b>University College Hospital (Ibadan)</b>
<b>UNFPA</b>	<b>United Nations Population Fund</b>
<b>UNICEF</b>	<b>United Nations Children's Fund</b>
<b>USAID</b>	<b>Agency for International Development (mission)</b>
<b>VHW</b>	<b>Village health worker</b>
<b>WHD</b>	<b>Women in Health Development</b>
<b>WHO</b>	<b>World Health Organization</b>

## **Acknowledgments**

The evaluation team would like to express its appreciation to USAID and the Federal Ministry of Health for inviting it to undertake the evaluation of the Family Health Services Project (FHS). The responsibility for evaluating the largest USAID-assisted family planning effort in sub-Saharan Africa was taken very seriously by the team and it hopes that the findings, conclusions and recommendations of this report will be useful in guiding the project through the next phase of its implementation.

The team could not have accomplished its task without the help and cooperation of many individuals working in the FHS project, the Federal Ministry of Health, the Ministries of Health in Bauchi, Bendel, Benue, Imo, Kaduna and Plateau states, the non-governmental organizations involved in family planning information, education and service delivery, and commercial sector distributors of contraceptives.

Special thanks is given to the general service staff of FHS who served as the team's secretariat during the evaluation, and to the drivers who drove the team safely throughout Nigeria on its field visits. The hospitality extended by FHS staff and USAID made the team feel very much at home, for which it is particularly grateful.

## Project Identification Data

1. **Scope** Nigeria  
2. **Project Title** Family Health Services Project  
3. **Project Number** 620-0001

### 4. Critical Project Dates

Authorization Date: 07/09/87  
Initial Obligation Date: 07/30/87  
Grant Agreement Amendment 1: 08/24/87  
Grant Agreement Amendment 2: 09/21/87  
Grant Agreement Amendment 3: 07/10/88  
Grant Agreement Amendment 4: 06/01/89  
Project Ending Date: 12/31/92

### 5. Project Funding to Date

	<u>USAID proposed funding levels</u>	<u>Funds obligated to date</u>
• IEC Component	\$15.0 million	\$9.3 million
• Private Component	\$10.7 million	\$6.8 million
• Public Component	\$11.0 million	\$6.6 million
• Policy Component	\$ 2.5 million	\$2.3 million
Administration/Logistics	\$ 6.0 million	\$4.5 million
Evaluation/Audit	\$ 1.5 million	\$0.9 million
Contraceptives	\$16.3 million	\$4.6 million
Project Support	\$ 4.0 million	\$2.7 million
	<u>\$67.0 million</u>	<u>\$37.7 million</u>

### 6. Mode of Implementation

Bilateral Agreement: collaborative assistance mode

### 7. Contractors/Subcontractors

Administration: Prime - African American Institute  
Sub. - Sweethill Associates  
Public Component: Prime - Pathfinder  
Subs. - Africare, IHP, MSH  
Private Component: Prime - FPIA  
Subs. - JSI, Margaret Sanger Center  
IEC Component: Prime - JHU/PCS  
Subs. - AED, CEDPA, PATH  
Policy Component: Prime - JHU/IIP  
Sub. - Africare

### 8. A.I.D./Nigeria Project Monitors

Field Project Officer: G. Cashion  
A.I.D./W Backstop Officer: A.V. Getson

### 9. Previous Evaluations/Reviews

Regional Inspector General's Report, September 1989

## Executive Summary

### Introduction

This report presents the first external evaluation of the Project Agreement between the U.S. Agency for International Development and the Federal Government of Nigeria for the Family Health Services (FHS) Project, which began in 1988. This evaluation covers the period from April 1988 to December 1989.

The purpose of the Project Agreement is, by the end of this five-year project, to make family planning information and services widely available. This will be reflected in a nationwide contraceptive prevalence rate of 12 percent or approximately 2.5 million users. Seventy percent of the users will be served by the private sector, receiving information and contraceptives through more than 12,000 commercial, community level or private outlets. In the public sector, information and services will reach 30 percent of contraceptive users through 3,600 government hospitals, maternities, health centers, and dispensaries.

To reach these end-of-project goals, a four-pronged strategy was developed linking together four distinct but inter-related components: private sector service delivery, public sector service delivery, information, education and communication (IEC), and policy implementation. Four prime contractors were chosen to implement each of these components assisted by U.S.-based subcontractors. An administrative and logistics contractor was chosen to service the project, and a Project Administrator was hired to coordinate component activities and manage the project.

### Project Outputs

After only 18 months, progress is being made in achieving project outputs.

#### Public Sector

- Project activities in 16 states initiated.
- 107 public health service delivery facilities staffed and equipped for clinical and non-clinical family planning (FP) services.
- 150 clinics in 11 states surveyed for provision of equipment and supplies.
- Pre-service family planning midwifery curriculum developed and being tested.

#### Private Sector

- 3,500 commercial outlets now selling FP commodities.
- \$2.2 million of commodities procured.
- 250 private nurses/midwives trained to provide services including IUCD insertions.
- Employment-based detailing of contraceptives under way.

### Information, Education and Communication

- FP logo designed and plans made for mass media promotion.
- "Choices" and "Wait for Me" (album and music video promoting FP) released. Media campaign using Sunny Ade and Onyeka Onwenu being planned.
- Four statewide IEC campaigns initiated and three statewide campaign strategies developed.
- Over 400 nurses who teach FP in state institutions trained in counseling methodology and motivational skills.
- Family life education materials for schools developed and pretesting being initiated.

### Policy Implementation

- FP module developed for annual rounds of the Federal Office of Statistics (FOS) National Integrated Survey of Households; pilot survey scheduled for January 1990.
- Technical assistance provided to FOS for planning the upcoming Demographic Health Survey.
- State-by-state FP resource survey initiated.
- Technical assistance provided to the Department of Population Activities and Department of Planning Research and Statistics of the Federal Ministry of Health (FMOH).

## **Project Impact**

It is too early in project implementation to assess project impact. The management information system (MIS) of the project is not operational and the family planning statistics collected so far are not reliable. From the statistics that are available, there is evidence that the number of new acceptors has gone from approximately 96,000 in 1985 to over 400,000 in 1988, an increase of approximately 300 percent. The number of new acceptors in 1988 represents approximately 2 percent of all women in the childbearing years of 15-49. If this trend continues, the project would come close to achieving its planned objective of 12 percent contraceptive prevalence by 1993.

At this stage, however, it may be more appropriate to look at process measures to understand the progress being made. These might include that

- FHS-funded subprojects are ongoing in 16 states.
- 104 subcontracts with Nigerian institutions to carry out FHS activities have been signed or are in process.
- The estimated number of person days generated by FHS is 97,936. In work years, this is about 377. About 264 (70 percent) of these work years are from FHS subprojects being carried out by Nigerian institutions.

- 12 work years (3 percent of the total work years generated to date) of technical assistance have been provided by outside consultants and about 5 work years (1 percent) by Nigerian consultants.
- Out of the \$67 million to be contributed by the United States to the project, \$37.7 million has been obligated.

## Project Issues

Against the progress that has been made in the implementation of FHS, there are also areas in which the project needs to undertake remedial actions.

- Reassessment of Program Approach. Although the project's contraceptive prevalence goal will likely be achieved, the organized nature of the family planning effort may not, if the resources of FHS are not better coordinated with those of the government and other donors. At the state level, there is little coordination among the FHS components in planning and programming their resources.
- Overlap in Functions Among Components. As a consequence of the original project design, the project components have responsibility for undertaking certain functional activities (e.g., training, MIS, constituency building/IEC and commodity logistics) within their components. This has the potential of causing duplication and inefficiencies in project execution.
- FHS and Government Relations. The process by which the project was designed and the evolving structure of the FMOH have necessitated intense communication between the project and the Ministry to ensure concurrence in project execution. While this may have delayed the implementation of some activities, in the long run, the close collaboration between the Ministry and FHS will facilitate the accomplishment of project objectives.
- Administrative Delays. The initiation of a project as large and complex as this one, the recruitment of staff and setting up of offices, the requirements for each subproject budget to be approved by the contractor headquarters, and the establishment of new guidelines and procedures by the USAID office for project execution have all had a negative impact on the pace of project implementation. The management ability of the Project Administrator and his close working relationship with USAID staff have overcome many of these delays, but their continued collaboration will be necessary to facilitate project execution.
- Coordination Among Contractors. Coordination among contractors and among components is not as effective as it should be. This is because the components were designed to be largely independent of each other, because coordination meetings have not been frequent enough and have been used at times for purposes other than coordination, and because the Project Administrator does not have the formal authority to compel coordination. This situation has had serious effects on the development of standardized training curricula and an overall project training program, the commodity supply system, the collection of service delivery data and commercial sales data, and effective use of the IEC component by the private and public sector programs.

**Slow Start of the Private Sector Program.** Since the private sector will be pivotal in the success or failure of the family planning acceptance goals of the project, the lack of strong progress in this component is of great concern. Private sector companies are participating in the distribution of contraceptives, but commercial marketing and advertising have not as yet taken place; after 18 months of the project, the plans for these critical activities are still in preliminary form. In addition, the strategy used by the private sector component in some of its service delivery projects with private providers is not sustainable.

## **Principal Recommendations**

### **FHS Approach and Management**

1) The draft FMOH program for population activities, once approved, should be closely studied by FHS, and project component activities should be included within this work program (Recommendation 1).

2) The prime contractors should cooperate in the development of state work plans in collaboration with the FMOH and its primary health care (PHC) zonal officers, State Family Planning Coordinators, and other donor representatives. One strategy that should be considered is a phased state-by-state implementation of family planning activities. The state workplans and strategies to carry these out would be developed on a phased basis. In Year 3, for example, all FHS components would develop a common workplan and coordinated strategy in one state per zone; in Year 4, two states per zone; and in Year 5, three states per zone, thus covering all states during the life of the project (Recommendation 3).

3) The prime contractors of the project, together with the Project Administrator, USAID, and the Government of Nigeria (GON), should reconfigure some of the project components on a functional basis to the extent possible under the present contracts. The functional components would include training, constituency-building/IEC, MIS, and commodity logistics (Recommendation 5).

4) The ultimate goal of the training and commodity logistics functions as reconfigured above should be a uniform standard of clinical services delivery based on a uniform standard of training for various cadres and a nationally recognized set of clinical protocols for use in the public and private sectors. Further standardized supervisory, reporting and evaluation procedures should be developed for the whole project (Recommendation 6).

5) The USAID mission should develop a general framework for operations with the Project Administrator and should give him greater latitude to act on the behalf of USAID in agreed upon areas (Recommendation 7).

6) USAID, REDSO and the contractors should establish guidelines on the approval of subcontracts that would facilitate their expeditious processing. For small subcontracts, the review by Lagos-based Project Directors and the Project Administrator may suffice if new fiscal review policies and procedures are instituted (Recommendation 8).

### **Component Areas**

7) FHS should work with the FMOH and the SMOHs in the development of institutional in-service training for all cadres of FP providers in each state. Consideration should be given to designating one training institution in each state to institutionalize FP

clinical training. Such training would become a regular feature of these institutions' programs; each could run three or four training sessions a year with 20 to 30 trainees per session. This would cover the in-service training needs of the state for at least the present cadre of providers, in a limited period of time. The pre-service training that has already begun would take care of the new service provider entrants. This system of in-service training would support the pre-service training done in the same institutions. It would also serve as the base for refresher training (Recommendations 15 and 18).

8) As part of the overall social marketing approach, vigorous and persuasive communications and advertising need to be launched as soon as possible. Local and international technical assistance in marketing and advertising will be required (Recommendation 28).

9) FHS/private should place greater emphasis on more effective family planning methods that have a higher potential for reducing fertility; i.e., pills and IUCDs (Recommendation 38).

10) For future subprojects, programs in the private sector that have a reasonable chance of becoming sustainable should receive the greatest emphasis. Private sector programs that require substantial subsidies should be avoided (Recommendation 35).

11) The IEC component should take immediate action in both the public and private sectors to follow up on the success it has had from the record and music video, "Choices" and "Wait for Me" (Recommendation 43).

12) Constituency building activities should be included in the IEC component (Recommendation 76).

13) FHS/policy should play a major role in the quality control of the data generated from the various service delivery components of FHS including the revision of training curricula, if necessary, and training of MIS state officers. This is essential if policy is to have the ability to use the data to evaluate program performance. A collaborative MIS effort among the FHS components, the FMOH and the SMOHs is necessary to ensure the success of this data gathering endeavor.

14) FHS/policy should play an important role in coordinating operations research activities to identify problems arising during program implementation (Recommendation 86).

15) The use of Sterling Products Ltd. to distribute commodities for the public sector should continue while PHC further develops its capacity to carry out this activity (Recommendation 89).

## **Part I**

### **Project Approach, Management, and Components (Chapters 1-5)**

# 1. Introduction

## 1.1 Project Grant Agreement

The 1987 Project Grant Agreement between the Federal Government of Nigeria and the United States for the Family Health Services (FHS) Project provided for "technical assistance, training and commodities to assist Nigeria in the implementation of its national population program and the managerial process for primary health care through both the public and private sectors." The Agency for International Development's (A.I.D.) contribution to the Family Health Services Project (FHS) was to be provided incrementally up to a total amount of \$67 million. The Government of Nigeria's (GON) contribution to the Project was to be up to the total amount of \$33.5 million. The five-year project, beginning officially April 1, 1988 has a Project Assistance Completion Date of December 31, 1992.

There have been four amendments to the Agreement. The latest, dated June 1989, reaffirms the commitment of the GON and A.I.D. to the project. This amendment also clarifies that the primary responsibility for the administration of the project rests with the Director of the Department of Population Activities (DPA) of the Federal Ministry of Health (FMOH).

The FHS project is made up of six elements: Two provide for administration and logistics and four provide for project implementation. The two administrative elements are provided through contracts for a Project Administrator and an Administrative and Logistics Unit that supports all project elements. The four project implementation components are comprised of Public Sector, Private Sector, Information, Education and Communication (IEC), and Policy Implementation.

## 1.2 The Evaluation

Evaluation is included in the Project Agreement to ensure that the project purposes are being attained and to measure what changes have taken place and the impact of the project during its life. The first implementation evaluation, scheduled for November 1989, was to "focus on the performance of the contractors in terms of how effective they are in producing the outputs required by the project. Attention will concentrate on management issues such as coordination of inputs with program activities; quality of the training and service delivery; effectiveness of program planning and management systems being established; coverage of the population being achieved by contraceptive services; operational utility of information systems; effectiveness of IEC activities; and degree of collaboration among the contractors and any efficiencies that are being achieved in this collaborative assistance approach... Major mid-course changes in project approach, operations and/or process may be recommended as a result of this evaluation."

USAID/Lagos in consultation with the FMOH requested that the Population Technical Assistance Project (POPTECH) undertake an evaluation to ascertain the answers to the above questions (see Appendix A for the full scope of work of the evaluation, the composition of the evaluation team and the methodology used to carry out the evaluation). The evaluation took place from November 27, 1989 to December 15, 1989.

## 1.3 Overall Project Objectives

As set forth in the Project Paper: "By the end of this five-year project, it is expected that there will be a broad political and social constituency supportive of family planning policies and

programs. Family planning information and services will be widely available at reasonable cost through both the private and public sectors. This will be reflected in a nationwide contraceptive prevalence rate of 12 percent or approximately 2.5 million users. Seventy percent of the users will be served by the private sector, receiving information and contraceptives through more than 12,000 commercial, community level or private outlets. In the public sector, information and services will reach 30 percent of the contraceptive users through 3,600 government hospitals, maternities, health centers, and dispensaries."

#### **1.4 Project Strategy**

To reach these end-of-project-goals, a four-pronged strategy was developed linking together four distinct but inter-related components. These components are

- **Public sector service delivery.** This component is to strengthen management systems and service delivery capacities in order to provide clinic-based services in all levels of government facilities, from large teaching hospitals to local government authority (LGA) clinics and dispensaries.
- **Private sector service delivery.** This component is to develop, refine, implement and expand large-scale, private sector initiatives in family planning that provide services through a variety of commercial, workplace and community outlets, and private maternity homes and medical facilities.
- **Information, education and communication.** This component is to enhance the acceptability of smaller family norms and family planning as well as to provide information on available family planning options and services.
- **Policy implementation.** This component is to strengthen the process of policy implementation and strategic planning for efficient mobilization of an effective and self-sustaining national family planning program.

## 2. Program Status

The activities of all the FHS components from the beginning of the project to date are summarized in Table 1.

### Family Planning Results to Date

Two types of data are generated by the FHS Project that can be used to assess project impact. The first is clinic based and is tabulated from monthly returns (by state Family Planning Coordinators [FPC]) from family planning service points. The second set of data is derived from the quantity of commodities issued to clinics (including those supplied from outside the FHS project). The latter figures are supplied by FHS commodities logistics officers, who make periodic visits to state warehouses.

### Clinic-Based Data

Data on new acceptors are available for two time periods: for the year 1988, and for the first six months of 1989. They refer to public sector clinics only (see Tables 2 and 3). If it is assumed that the trends in the first half of 1989 will continue for the rest of the year, it can be concluded that numbers of new acceptors will have increased in only five states (Abuja, Bauchi, Bendel, Cross River, Oyo) between 1988 and 1989. Country-wide, the quantities of oral contraceptives, IUCDs, condoms and foaming tablets accepted in 1989 are lower than in the previous year. This decrease in overall number of users most likely reflects the questionable nature of available data. In particular, monthly clinic returns are usually incomplete. The Federal Ministry of Health (FMOH) is taking steps to improve the MIS and efforts are being made by the FMOH and the project to improve the process for generation, collection and collation of data from FHS activities. Until these improvements are made, however, big gaps in data will make it very difficult, if not impossible, to arrive at any meaningful interpretation of data. For this reason, no attempt has been made to calculate, couple years of protection (CYP) for any period since project inception.

### Commodity Data

The second type of data is reported quarterly and indicates quantities of USAID funded commodities issued both to family planning clinics and to other organizations, and commodities issued by other donors, notably the UNFPA (UNFPA provides commodities [injectables] separate from the project). These records are incomplete since quantities supplied to some states and for some periods are not recorded. In addition, it is also not always possible to assign foaming tablets issued to clinics organized by the army, air force and navy to any particular State, since they are listed separately. This set of incomplete and rather confusing data is of little use for project evaluation even after making the unjustifiable assumption that commodities issued directly translate to commodities accepted by family planning clients.

From available, though highly unsatisfactory data, the FHS/policy publication, "Family Planning Growth in the Public Sector," provides evidence that "new acceptors have gone from approximately 96,000 in 1985 to over 400,000 in 1988, an increase of approximately 300 percent" and that "the number of new acceptors in 1988 represents approximately 2 percent of all women in the childbearing years of 15-49." If this trend continues, the project should come close to achieving its planned objective of 12 percent contraceptive prevalence by 1993.

**Table 1**  
**Activities Initiated By The FHS Project, By Zone**  
**April 1988 - December 1989**

	Policy	IEC	Public	Private
<b>Zone A</b>				
Anambra	-	Radio/poster campaigns <sup>a</sup>	LGA mgnt. training	Apex training & services; NANNM/Enugu training services; Univ. of Nigeria Teach Hospital training and services.
Akwa Ibom	-	-	-	-
Benue	-	State-wide campaigns	-	NKST training & services
Cross River	-	-	-	-
Imo	-	State-wide campaign <sup>a</sup>	-	PPAANM/Aba training & services MOH Owerri training & services
Rivers	-	State-wide campaign	-	Port-Harcourt Nursing Home & Maternity training & services; U. of P. Harcourt Teaching Hospital training & services
<b>Zone B</b>				
		Zonal Officer	Zonal Officer	
Bendel	-	-	Service delivery & training at teaching hospitals	U. of Benin Teaching Hospital training & services
Lagos	-	State-wide campaign <sup>b</sup>	Integrate FP in PHC	NANNM/Lagos training & services; Lagos Univ. Teach. Hosp. training & services; Excell clinics training & services; Eko Hosp. training & services
Ogun	-	State-wide campaign <sup>a</sup>	Service delivery; Clinical training; CHEW training supervisory training	MOH Abeokuta training & services; NANNM/Ogun training & services
Ondo	-	-	Integrate FP in PHC Physicians refresher training; In-service training	Country Women Assoc. of Nigeria (COWAN) services
Oyo	-	State-wide campaign <sup>b</sup>	Service delivery; Curriculum development CHEW training; Clinical training; Supervisory training; CBD/VHWS training Integrated FP in PHC	NPNMA/Oyo training & services
Zonal	-	Ministry of Information Film Zonal Officer	Clinical training of service providers from all states and armed forces at 2 teaching hospitals MIS TOT Zonal Officer	

**Table 1**  
**Activities Initiated By The FHS Project, By Zone**  
**April 1988 - December 1989**

	Policy	IEC	Public	Private
<b>Zone C</b>			Zonal Officer	
Abuja	-	-	-	-
Kaduna	-	State-wide campaign	LGA mgnt. training	NANM/Kaduna training & services; Ahmahu Bello U. Teaching Hosp. Zaria training & services; Sefa Specialist Hosp. training & services
Katsina	-	-	-	-
Kwara	-	-	Service delivery; Clinical CHEW training; Refresher training; Integrate FP in PHC	NANM/training & services; U. of Ilorin Teaching Hosp. training & services
Niger	-	State-wide campaign <sup>b</sup>	-	-
Sokoto	-	-	Assist. to teaching hospital in setting up FP services	-
Zonal	-	IEC Materials development workshop	MIS TOT; Physicians training at Teaching Hospital for C & D Zones	-
<b>Zone D</b>		Zonal Officer	Zonal Officer	-
Bauchi	-	-	-	-
Borno	-	State-wide campaign	-	Borno Medical Clinics training & services
Gongola	-	-	-	-
Kano	Policy Intro Management	-	LGA mgnt. training	National Council of Women's Societies training & services; Jos Univ. Teach Hosp. training & services
Plateau	-	-	Supervisory training	
Zonal	-	-	MIS TOT	

- 5 -

**Table 1  
Activities Initiated By The FHS Project, By Zone  
April 1988 - December 1989**

Policy	IEC	Public	Private
<b><u>National</u></b>			
<p>Questionnaire development with FOS                      Support with equipment to DPA and DPRS (FMOH)                      Group meeting to plan data analysis of DHS; FPQ instruments for POP program assessment                      Plan for HIS for the DPRST completed                      NCPA support activities being implemented                      Plan for managerial process workshops being completed                      State by state "Facts Book" starting with Ogun State                      Service directory completed.                      Key group characterization processing.</p>	<p>PPFN: Methods booklets;                      Music campaign; IEC workshop                      NERDC: Family life education                      NCPA: Media/Magazine                      FMOH/HEB: IEC workshop; FP logo; Print materials                      FMOH/DPA: RAPID video                      NCWS: Radio workshop (music)                      Counseling: Master trainers' workshop                      NTA: Scripting workshop                      Audience research: Literature review (surveys)                      Music video: Formative evaluation, production and promotion and impact evaluation</p>	<p>Development of network of management trainers                      MIS TOT; 2 FPC workshops                      Development of prototype lesson plans for midwifery schools</p>	

<sup>a</sup> Pre-FHS activity, new proposals are being developed  
<sup>b</sup> Awaiting approval from USAID

**Table 2**  
**New Acceptors By Method And Year, Public Sector**  
**(1988-1989)**

	1988						Total	
	Pills	Injectables	IUCDs	Condoms	Foaming Tablets	Others	1988	1989 <sup>a</sup>
Abuja	4,580	1,964	535	4,680	3,257	47	15,062	20,330
Akwa Ibom	7,519	89	1,232	2,169	929	139	12,077	2,938
Anambra	701	1,686	2,997	6,615	2,265	804	15,068	NA
Bauchi	1,255	879	347	126	347	79	3,033	11,272
Benue	1,546	887	2,081	708	349	256	5,827	9,224
Benue	1,855	1,416	791	1,028	1,416	150	6,656	6,540
Borno	4,009	1,413	2,297	2,489	1,413	2,092	13,713	5,608
Cross River	11,182	616	3,785	24,554	8,255	,096	49,488	105,016
Gongola	3,151	1,474	2,241	4,385	1,855	226	13,332	10,022
Imo	953	2,064	8,918	10,321	2,551	1,135	25,942	15,844
Kaduna	13,708	2,819	2,764	4,403	2,086	169	25,949	20,748
Kano	5,910	3,953	5,170	4,971	1,407	0	21,411	13,498
Katsina	2,553	577	494	301	358	8	4,291	786
Kwara	4,323	832	2,442	8,737	1,345	58	17,737	NA
Lagos	7,433	2,824	7,339	6,168	2,780	805	27,349	20,724
Niger	3,159	2,132	796	1,019	335	55	7,496	5,400
Ogun	3,751	216	5,054	14,804	3,098	592	27,515	26,802
Ondo	3,331	2,070	1,860	1,303	453	571	9,588	NA
Oyo	7,178	1,843	10,043	10,852	5,140	380	35,436	52,430
Plateau	5,317	2,542	1,101	2,480	1,193	78	12,711	12,198
Rivers	2,611	1,459	959	2,181	685	415	8,310	7,520
Sokoto	10,449	3,807	889	3,271	236	0	18,652	9,046
<b>Totals</b>	<b>106,474</b>	<b>37,562</b>	<b>64,135</b>	<b>117,565</b>	<b>41,753</b>	<b>9,155</b>	<b>376,643</b>	<b>355,944</b>

<sup>a</sup> The data for 1989 are for the first six months and have been extrapolated for one year for comparison purposes. Therefore, the number of new acceptors for 1989 may or may not be lower than the 1988 figures, depending on the results of the program from July through December.

**Table 3**  
**Public Sector New Acceptors**  
**Total All Methods 1988, 1989**

	<b>Pills</b>	<b>Injectables</b>	<b>IUCDs</b>	<b>Condoms</b>	<b>Foaming Tablets</b>	<b>Others</b>	<b>Totals</b>
1988	106,474	37,562	64,135	117,565	41,753	9,155	376,643
1989 <sup>a</sup>	93,802	38,678	49,711	71,504	30,738	NA	284,433 <sup>b</sup>

<sup>a</sup> The data for 1989 are for the first six months and have been extrapolated for one year for comparison purposes. Therefore, the number of new acceptors for 1989 may or may not be lower than the 1988 figures, depending on the results of the program from July through December.

<sup>b</sup> Discrepancy with Table 2 reflects lack of data for "others" category.

## 3. Program Approach

### 3.1 FHS Program Approach

The underlying assumption of the FHS project is that an organized family planning effort with a national scope can be implemented within a five-year period, if enough resources and technical assistance are provided to enable federal, state and local governments to provide family planning information and services; to enable key public and private sector organizations to provide information and services; and, to enable the private, commercial sector, which is very extensive in Nigeria, to make contraceptives available in the national market place.

The level of resources committed by USAID to Nigeria is substantial: It represents the largest amount of funds committed to a single family planning effort in sub-Saharan Africa by the U.S. Government. The technical resources available are also substantial. A number of the most experienced technical assistance agencies in the family planning field are involved in providing their expertise. In addition, the available Nigerian technical resources that can be utilized for the effort are plentiful. Moreover, Nigeria offers a conducive environment and framework for an organized family planning effort, both because of the political commitment of the GON and the impetus given to the family planning effort by the promulgation of the National Population Policy and the implementation of the FMOH's National Health Policy and Strategy to Achieve Health for All Nigerians.

Finally, other donors are supporting family planning, and there is the expectation that substantially more funds will be provided through grants and loans to Nigeria for family planning in the near future.

As stated above (see Chapter 2), the present level of effort should result in the achievement of the project's goal of reaching a certain level contraceptive prevalence. With respect to the project's underlying assumption that family planning will become an organized effort, however, progress is expected to be less certain unless the resources of the government, FHS contractors, and other donors are better coordinated. Strategic planning has begun, with the Federal Government having drawn up a draft population program. This will help determine how technical assistance, financial resources and contraceptive commodities provided by FHS, other donors and the government can be better programmed, and how the necessary systems to service the organized family planning effort can be developed and institutionalized.

The success of this program will depend in part on the continuation of FHS' effort to collaborate more closely with the federal and state ministries of health and LGAs, and to consolidate the programming of its resources.

### 3.2 FHS and Federal/State/LGA Collaboration

**Family Health Services and Federal Government.** Between the time the FHS project was designed and the start of implementation, three changes took place which together have resulted in the project's now dealing with a different structure and different individuals than were in place when the project was designed. These include the following: 1) Staff changes within the FMOH have meant that key ministry personnel involved with the project design were no longer available to participate in the implementation. 2) The Department of Population Activities (DPA) was created to coordinate all population related activities. 3) A new director was appointed for the Department of Planning Research and Statistics of the FMOH.

With time, all concerned have developed a better understanding of the project. What was initially perceived as a project planned for the FMOH, with little input from the Ministry as a whole, is now seen as a project of the FMOH. It therefore enjoys the political good will and commitment of the Federal Government (see Section 4.1.2 for discussion of the management implications of this reorganization).

**Component's Counterparts in Government.** The issue of who in the government constitute the counterparts to each of the component directors has been allowed to evolve rather than to be specifically defined. From the government's view, the Director of DPA is officially the Project Director (per Project Amendment 4). The individual components relate directly to positions recently created in the DPA (though not all positions have been filled). The FHS/public sector component relates primarily with the Primary Health Care, Maternal and Child Health/Family Planning (PHC MCH/FP) Division; the FHS/IEC component deals primarily with the Health Education Bureau; and the FHS/policy component relates largely to the DPA. The FHS/private sector component does not relate to the government to any significant degree. Dialogue has begun among all the parties. (Table 4 shows the level of government involvement in the various FHS project components.)

**Table 4**  
**Contribution of Nigerian Implementing Agencies to FHS Component Activities**  
**(Percent of Total Time Allocated to Project)**

Nigerian Counterpart Agencies	FHS Components				Percent of Contribution To All FHS Activities
	IEC	Policy Implementation	Private Sector	Public Sector	
MOH-Dept. of Population Activities	10%	45%	5%	10%	17%
MOH-PHC (MCH/FP), Federal and State	50%	10%	5%	80%	39%
MOH-Other Directorates, e.g., Planning, MOED and MOI at Federal and State levels	10%	15%	5%	5%	9%
Private sector medical, private business and parastatals	30%	30%	85%	5%	35%
Total	100%	100%	100%	100%	100%

Source: FHS

**FHS and State/Local Governments.** All the states of the federation have a generally high level of understanding of the goals of the FHS project and a correspondingly high level of political commitment to the success of the project. In many states, however, the political commitment has not been matched by a sufficient budgetary commitment to ensure achievement of FP targets.

**Zonal Offices.** The creation of four zones (A and B in the south and C and D in the north) has been found necessary by the FMOH to implement its PHC program. Some international agencies (e.g., UNFPA) and some components of the FHS project, notably the public and IEC components, have hired zonal officers to transfer management and technical assistance to a level closer to the states. There is, however, very little coordination and collaboration among these various agencies at the zonal level, with the result that the support expected by the states is not reaching them and one zonal officer rarely knows what the other zonal officers are doing. In one instance, FHS and FMOH/PHC have discussed how their zonal officers should relate; the relationship that is expected to be established in this case should serve as a model for other zonal officers.

Among the components of the FHS, the public sector and the IEC components have varying, but relatively high, levels of activities with the different states, while the policy component is yet to operate at the state level. The private sector component, by design, has rather little to do with state governments, but it is nevertheless active in most states. Public sector and the IEC component state-level projects are designed in conjunction with FPCs.

Although there is some activity in all states by most of the FHS components, component staff have made little effort to coordinate resources at the state and LGA levels where family planning services are offered. Some information may be exchanged among the components, but there is little evidence that they plan together to devise common strategies.

At the local government level, health and policy officials have been involved in project activities, but overall project involvement at the LGA level has been minor. This has been due in part to the high level of turnover of policymakers at the LGA level. In those LGAs where FP management training has been carried out, and where there has been follow-up, the results of this training, according to an evaluation of management training in Anambra State, have been very encouraging. LGAs have an increased awareness of the need for family planning and are taking steps to institute population-related activities. The implementation of this program is at the state and local levels, but sufficient effort has not been made as yet to coordinate the resources and workplans of the several components at these levels.

#### **Recommendations:**

1. **The draft FMOH program for population programs, once approved, should be closely studied by FHS, and project component activities should be included within this workplan.<sup>1</sup>**
2. The FHS Project Administrator and FHS Component Project Managers should continue their dialogue with the relevant FMOH departments and work closely with DPA in the planning, implementation and evaluation of FHS activities. FHS should also continue to support activities to strengthen the DPA as the central coordinating unit for population activities of the government.

---

<sup>1</sup> Recommendations in boldface are those that are identified in the Executive Summary as the principal recommendations of this report.

3. **FHS contractors should cooperate in the development of state workplans in collaboration with the FMOH and its PHC zonal officers, State Family Planning Coordinators, and other donor representatives. All information about each others' activities in each state should be shared to facilitate planning and cooperation. One strategy that should be considered is a phased state-by-state implementation of family planning activities. The state workplans and strategies to carry them out might be developed on a phased basis, applying lessons learned from one state to the planning for the next. In Year 3, for example, all FHS components would develop a common workplan and coordinated strategy in one state per zone; for Year 4, two states per zone; and in Year 5, three states per zone, thus covering all the states during the life of the project. This might limit the ability of each component to respond to the needs in non-targeted states at any given time; however, by the end of the project all states will have received coordinated assistance from the project.**
4. National and zonal level activities should be coordinated as much as possible, particularly in the context of state-level programs. For example, as more and more states launch their state level population policies, FHS should have a specific role in supporting states to develop or implement their strategies.

## 4. Management

### Introduction

The SOW identified project management as a major area to be investigated at this early stage in project implementation. The principal areas that affect project management are the collaborative assistance mode for project execution; the role of GON in the administration of the project; and the role of USAID vis-a-vis the management structure of FHS.

In addition, three other management issues were identified by the evaluation team: fiscal control, coordination among contractors, and project identity.

### 4.1 Management Issues

#### 4.1.1 Collaborative Assistance Mode for Project Execution

A predominant feature of the FHS project design is the collaborative assistance mode for project execution (i.e., all contractors selected to design the project were anticipated to be the implementors as well). When the project was conceived, many centrally funded, U.S.-based population projects were already working in Nigeria, assisting the GON in family planning service delivery, policy development, training and IEC. Many of the Cooperating Agencies (CA) had developed projects, and these, together, formed the nucleus of a population program. The extension of the work of the CAs in a more organized family planning effort was therefore seen by USAID as a very positive step: The CAs were familiar with Nigeria and were in a position to carry on and expand upon what they were already doing.

One problem existed, however. Throughout the period 1983 to 1987, managing the number of centrally funded projects that were working in Nigeria had become a major task, and, therefore, in the development of a new project, some consolidation of these centrally funded projects was envisaged. To reduce the number of contractors, the project design divided the project activities into four components: public sector family planning, private sector family planning, IEC and policy implementation. Dividing the project in this way allowed for inclusion of most of the contractors that had previously worked in Nigeria. These contractors formed design teams in early 1987 to draw up the project. Subsequently, contracts were negotiated with the separate contractors for the four components. The project officially started on April 1, 1988.

Since each component was being implemented through a separate contract, there remained a void with respect to central management. During the pre-project period, the USAID Affairs Officer had been able to provide administrative and logistics assistance, as well as program guidance, to the centrally funded projects. With a new project, particularly one of the magnitude of the one designed, administration and logistics and project management could not remain the responsibility of the USAID office, unless the staff of that office were increased dramatically. Therefore, a separate contract was let for administration and logistics.

In addition, to administer and coordinate the work of these five separate contractors, an individual was hired under a personal services contract with the USAID mission.

### Experience with the Collaborative Mode

Division of the project into five separate contracts and project components, each with its own output targets and contractual obligations, has made it difficult to coordinate activities among the components.

**Consolidation of contractors.** As stated above, it was anticipated that the number of contractors would be reduced under the collaborative mode of execution. Each of the major contractors, however, subcontracted with other centrally funded projects that had worked in Nigeria during the 1983-1987 period, with the result that the project is now being implemented by five prime contractors and ten subcontractors, or a total of fifteen separate entities. For the public sector component, a prime and three subcontractors; for the private sector component, a prime and two subcontractors; for the IEC component, there are a prime contractor and three subcontractors; for the policy component, a prime contractor and a subcontractor; and for administration and logistics, a prime and a subcontractor. Although there has been some consolidation of contractors from the pre-project period, the large number contractors that remain has not been ideal in terms of management and has resulted in some inefficiencies in the provision of technical assistance.

In addition to the FHS contractors, four centrally funded projects are also allowed to work in Nigeria. These are The Population Council for operations research, Family Health International (FHI) for biomedical research, the Association for Voluntary Surgical Contraception (AVSC) for voluntary surgical contraception, and Demographic and Health Surveys (DHS) for surveys.

**Division of the project into separate components by sector.** As the project is currently designed, a number of functional activities are being carried out in parallel fashion within the components. Assistance in clinical training, for example, is being carried out in both the public and private sector components, and constituency building is an activity of both the IEC and policy components. Likewise, MIS and commodity logistics are being carried out by more than one component. This results in duplication of effort. An alternative design would have been to divide the project into functional components. For example, it could have included a training component under which most of the training would have been consolidated. Likewise, there could have been an MIS component, which could have been in charge of all data collection, whether in the public or private sectors, and which would have ensured complementarity of data and the development of a comprehensive system. Such an approach might have encouraged more collaboration among the components, as each component would have been dependent on another to accomplish project activities.

### **Management Implications**

The contractual arrangement between USAID and the prime contractors makes it difficult for USAID to hold any contractor responsible for the achievement of project goals and objectives, rather than component outputs. It has been left up to the Project Administrator, in many cases, to attempt to coordinate project activities so that project goals and objectives are reached. Although coordination of project activities was expected, in practice, in most cases, each contractor implements activities independently of the other contractor, and the Project Administrator does not have authority to compel contractor compliance. Unless there is clarification of the appropriate roles of USAID (see 4.1.3), the Project Administrator and the component Directors, the success of the project will be in jeopardy.

In light of the limitations of the present mode of execution, it is suggested that the following actions be taken at this early stage to remedy some of these deficiencies.

### **Recommendations:**

5. The prime contractors of the project, together with the Project Administrator, USAID and the GON, should reconfigure the project components on a functional basis to the extent possible under the present contracts. The functional components would include training, constituency-building/IEC, MIS, and commodity logistics.

There are various ways that this configuration could be implemented: e.g., one contractor could assume responsibility for each functional activity, or the Project Administrator's office could take responsibility for the direction and coordination of each of these functional components. Other cooperative avenues to solve the duplication of function among the contractors for these areas should be explored and agreed upon. If agreement is not possible under the present contracts, actions should be considered on how to amend the various contracts to achieve a better functional division of labor.

6. **The ultimate goal of the training and commodity logistics functions as reconfigured above should be a uniform standard of clinical services delivery based on a uniform standard of training for various cadres and a nationally recognized set of clinical protocols for use in the public and private sectors. Further standardized supervisory, reporting and evaluation procedures should be developed for the whole project.**

#### **4.1.2 Role of the Government of Nigeria**

The role of the FMOH in the execution of the FHS project is critical to its success. The perception early on of the relationship between the FHS project and the FMOH was problematic, due to a number of factors, including primarily the process by which the project was designed and the evolving structure of the FMOH (see Section 3.2).

##### **Management Implications**

Two problems have arisen as a result of the design phase of FHS not having included all relevant units of the FMOH, and the responsibility for FHS having shifted to a newly created department after the design was completed. The FMOH has felt distanced from responsibility for the project, execution and success, and FHS staff and FMOH staff have been compelled to learn more about each other and to analyze how FHS can be more closely linked to the FMOH's program. This has been a very time-consuming but necessary task, requiring FHS management, both at the project level and USAID mission level, to communicate frequently with FMOH officials to ensure that the work program of FHS is congruent with FMOH guidelines and wishes.

DPA's recent development of a draft population program represents a pivotal step in the development of an organized family planning effort. Once this program is approved, it will be possible to fit FHS activities within it. The program will provide clarity regarding the relationship between FHS and FMOH.

#### **4.1.3 Role of USAID**

During the pre-project phase of USAID assistance, a few of the contractors had Lagos-based offices and provided logistics, administrative and technical assistance for their family planning activities in Nigeria. Most of the logistics, administration, and management of the technical assistance were carried out by the USAID Affairs Officer, however.

Just as the project was beginning, the USAID staff responsible for designing and working with the FMOH and the contractors were transferred without their having developed an institutionalized set of guidelines and procedures for project implementation. In the project design, a management committee was to have been set up to effect the development of administrative and management procedures for contractor compliance. Because this committee has not fulfilled this responsibility, it has fallen to new USAID officers to establish these guidelines and procedures.

This task has taken considerable time and has now extended into efforts to ensure that these guidelines are being properly implemented.

Guidelines and procedures are needed to provide some conformity in administrative and management procedures among contractors. If each of the contractors operates under its own rules and regulations, fee structures, system of project development, contracting requirements, etc., it will remain extremely difficult to administer project activities in an orderly way.

### **Management Implications**

The guidelines and procedures developed by USAID greatly affect many aspects of day-to-day project implementation, e.g., minimum length of stay of consultants. At times, contractors feel that the procedures are too stringent and that they should be implemented in a more flexible fashion.

In dealing with this issue, the Project Administrator is caught between USAID and the contractors, on the one hand, being expected to carry out the directions of USAID and on the other, to assist the contractors to meet their deliverables. At this point, there is no consensus on how to resolve this situation.

### **Recommendation:**

7. **The USAID mission should develop a general framework for operations with the Project Administrator and should give him greater latitude to act on behalf of USAID in agreed upon areas.** This would give the Project Administrator the authority to make the day-to-day decisions on the implementation of the program based on USAID administrative guidelines and the USAID approved overall work program. Once this general framework is agreed upon, this delegation of responsibility to the Project Administrator should simplify the work of both parties.

## **4.2 Other Issues**

### **4.2.1 Fiscal Control**

As part of the cooperative mode of execution, the fiscal control of the project rests with the U.S.-based headquarters of the five prime contractors, the USAID mission and the contracting officer of REDSO. Each of these parties has an important role to play in ensuring the fiscal integrity of the project, but the result of this arrangement is that the approval process is protracted. Moreover, it takes almost as long to process and approve a \$1,000 subcontract as it does a \$100,000 subcontract. Since the beginning of the project, 104 subcontracts have been signed or are in the process of negotiation (see Project Components [Chapter 5] for a listing of local subcontracts). Since subcontracts for the different components must be coordinated to ensure maximum impact and since the pace of implementation should quicken to achieve results as soon as possible, the fiscal control of the project should be made more efficient.

There is little effort at present to differentiate between either the size or the level of risk of subprojects, although both factors would affect the relative need for supervision. For example, cost-reimbursable subcontracts are less risky than fixed-cost contracts, and large subcontracts are more risky than small subcontracts. Risks could also be reduced by frequent audits of subcontracts. With the urgency to initiate activities at the federal, state, and local government levels, hold-ups in approval of subcontracts at any stage sets the individual activity back and adversely affects the desired synchronization with the other project components. It should be noted

that one contractor has delegated authority to its Lagos office to commit up to \$15,000 locally for subproject activities with USAID concurrence as the only requirement. The others, however, have not addressed the issue of delegating more fiscal responsibility to their national staffs.

The USAID mission's concern with ensuring local subcontractors' fiscal standards is rightly placed. The recent audit report carried out by the Regional Inspector General of West Africa of A.I.D. pointed out areas requiring immediate attention. The action taken by USAID to contract with a local firm to undertake regular audits of project accounts is a positive step.

**Recommendations:**

8. **USAID, REDSO and the contractors should establish guidelines on the approval of subcontracts that would facilitate their expeditious processing.** These guidelines should take into account the size of the subcontract, the type of subcontract, and mechanisms that can be put into place to assure fiscal compliance, e.g., system of auditing projects of various types and sizes. For large and more risky subcontractors, a more rigorous fiscal review by all parties may be necessary. For smaller and less risky subcontracts, the review by the Lagos-based Project Directors and the Project Administrator may suffice.
9. To ensure tighter financial control and to facilitate the fiscal review of subcontracts in Nigeria, an assessment of the accounting and financial human resources in the FHS Lagos office should be undertaken. Based on this assessment, decisions should be taken on whether increasing the personnel in the finance area for the various components is necessary.
10. Controllers/financial monitors of the prime contractors should be very familiar with field operations. They should conduct a thorough assessment of field fiscal operations at least once a year. This will become even more important as more contracting authority is moved to FHS component heads.

#### **4.2.2 Coordination among Contractors**

Formal coordination among contractors takes place at two levels: at yearly meetings to integrate the component workplans into an overall project workplan; and at triennial meetings of the component contractors to discuss project implementation issues. Not all U.S.-based contractors attend all these meetings. Less formal coordination takes place through frequent interventions by the Project Administrator with the component contractors. These mechanisms, have not been as successful as hoped. Reasons include that 1) the components have been designed to be largely independent of one another and, therefore, there is no imperative among the contractors to synchronize their activities; 2) the triennial meetings have not been used to focus on the progress made in implementing the project and on what needs to be done in the next period to achieve activity targets. Rather, they have dealt with immediate project issues or topics of importance to the project. For example, the last triennial meeting discussed project sustainability, project monitoring and evaluation. These immediate and topical issues need to be discussed by the contractors, but not to the exclusion of project implementation issues. Attempts at coordination by the Project Administrator have achieved some results; however, these results have been accomplished on a collegial basis. The Project Administrator does not appear to have the authority to require compliance by the contractors.

**Recommendations:**

11. The planning meeting and progress review meeting should have in attendance representatives of each of the prime contractors and possibly important U.S. subcontractors to ensure their full agreement and cooperation in the design of the

workplan and its implementation. For the yearly meeting, their attendance is essential to ensure that the synchronization of activities enables them to meet their contracted deliverables. For the triennial meetings, their attendance is required to ensure that implementation is proceeding as planned. Particularly since there have been delays in getting subcontracts approved by contractors (see Fiscal Control, Section 4.2.1), these meetings will reinforce the need for contractors to take action to facilitate the flow of funds to the project. At a later stage, after more synchronization among the contractors is achieved and more authority is given to the Project Administrator and the Lagos-based Project Directors, there may be less need to have the full representation of the contractors. Taking into account the recommendations presented in this report, however, it is recommended that U.S.-based contractor representation at these meetings be required for at least the next two years.

12. At the working level, there should be bimonthly meetings of the Lagos-based Project Directors responsible for the various aspects of the project chaired by the Project Administrator. The purpose of these meetings should be to exchange information on the status of the various aspects of the project and to ensure coordination of on-going activities. These meetings would identify the bottlenecks in carrying out project activities so that appropriate actions can be taken by the Project Administrator or the Directors themselves. The frequency of such meetings is important to reinforce the interrelatedness of the various aspects of the project. Monthly meetings may not be frequent enough to foster the collegial interchange necessary to affect the quick response that is necessary to solve project problems.
13. USAID should reaffirm that the Project Administrator's role is to review and recommend for USAID approval all subcontracts issued by the project contractors. Consideration should be given to hiring one or two administrative assistants to the Project Administrator to oversee and manage many of the routine tasks of project administration so that the Administrator can concentrate on planning, coordination and monitoring. These steps would put the Administrator in a far stronger position than he is at present.

### 4.2.3 Project Identity

The FHS project is essentially a continuation of activities undertaken by the major contractors before the project was formally started. The work of each contractor is usually identified by the contractor's name -- not the project's, e.g., if a training program is being held with the technical assistance of The Pathfinder Fund or JHU/PCS, the program is under their aegis rather than that of FHS, the government or USAID. Although under most circumstances, this would be a minor problem, it is not with the FHS project. Identity of the contractor seems to have taken precedence over identity with the project; the crediting of activities by contractor is a symptom of this problem.

USAID, moreover, is concerned that the U.S. government is not always fully acknowledged for providing the funds for FHS activities.

#### Recommendation:

14. Since this is a project between the GON and the U.S., the sponsorship of project activities should be identified as the project, the Federal Ministry of Health and, as appropriate, USAID. The name of the implementing contractor should not be the main focus of attention.

## 5. Project Components

### 5.1 Public Sector Component

#### 5.1.1 Background

##### Objectives

The Public Sector component's objective is to strengthen the service delivery capacity and management systems in government facilities at all levels, from teaching hospitals to village dispensaries. It is expected that by the end of the project, 30 percent of the estimated 2.5 million users of modern contraceptives in the country will be receiving services and supplies from these public sector outlets.

In specific terms, this component has set objectives in four main areas: training, FP management, equipment supply, and management information systems. In training, the objective is to train about 4,500 service providers in improved clinical and communication skills, and -- as part of this initiative -- to develop pre-service training curricula. In management, the objective is to train approximately 700 public sector staff (federal, state and LGA) in management of FP programs. In addition, it is planned to develop clinical service procedures and protocols to be utilized in all public FP service delivery points with the aim of standardizing the quality of services being provided. The equipment supply activities, combined with training, are expected to lead to staffing and equipping of 1,000 service delivery points offering full FP services and of about 2,600 others for non-clinical FP services. The focus on MIS is expected to lead to strengthening the use of service statistics, supervisory systems, and strategic and financial planning.

##### The Contractors

The Pathfinder Fund is the main contractor for this component. It has subcontracted with three U.S.-based subcontractors: Management Sciences for Health (MSH), Africare, and International Health Programs (IHP). Efforts to conduct clinical training are to be implemented through subcontracts with the state ministries of health.

##### Outputs

Tables 5 and 6 provide information on the status of component outputs to date in each the above-mentioned areas and the local subcontracts given to carry out these activities.

##### Strategies

#### 1) Training

At the national level, strategies being utilized by the contractor are as follows:

- Supporting the development of pre-service training curricula in FP for schools of midwifery, schools of nursing, and schools of health technology, and later of physicians. Once well under way, this training should significantly decrease the need for in-service training efforts.
- Supporting institutionalized in-service training of clinical FP providers at the University College Hospital (UCH), Ibadan and the University of Benin Teaching Hospital (UBTH), Benin.

**Table 5**  
**Public Sector Component**  
**Project Outputs**

End of Project Status Requirements	Output Status
<p>1. <u>Incorporate family planning services into those already offered at 3,600 public health service delivery facilities</u></p>	<p>107 have been staffed and equipped for clinical and non-clinical FP services 1,600 IUCD Insertion kits and 125 Ob/Gyn tables</p>
<ul style="list-style-type: none"> <li>● 1,000 staffed and equipped for IUCD insertion; staff trained in clinical/communication skills</li> </ul>	<p>82 facilities have been staffed and equipped for non-clinical FP services.</p>
<ul style="list-style-type: none"> <li>● 2,600 staffed and equipped to provide non-clinical FP services</li> </ul>	<p>No equipment provided yet</p>
<p>2. <u>Train at least 5,200 public health personnel to incorporate family planning</u></p>	<p>No training yet, but state level needs assessment has been completed for 8 states</p>
<ul style="list-style-type: none"> <li>● 350 tutors and trainers (290 new and 60 refresher training)</li> </ul>	<p>267 personnel trained</p>
<ul style="list-style-type: none"> <li>● 1,000 health personnel through clinical FP</li> </ul>	<p>No activity, but needs assessment will help identify persons to be trained</p>
<ul style="list-style-type: none"> <li>● 300 update training</li> </ul>	<p>194 personnel trained</p>
<ul style="list-style-type: none"> <li>● 2,000 new non-clinical trainees</li> </ul>	<p>No activity, but needs assessment done</p>
<ul style="list-style-type: none"> <li>● 800 refresher non-clinical trainees</li> </ul>	<p>599 personnel trained. they include family planning coordinators</p>
<ul style="list-style-type: none"> <li>● Management training for at least 768 LGA, state and federal planners and managers</li> </ul>	<p>Specialized training to be undertaken in year two</p>
<ul style="list-style-type: none"> <li>● Specialized training</li> </ul>	<p>Originally planned for year two, but has received increased emphasis from the FMOH, and will receive greater effort than originally planned.</p>
<ul style="list-style-type: none"> <li>● Training in communication and outreach</li> </ul>	<p>Midwifery curricula completed-being tested</p>
<p><u>Develop and standardize curricula</u></p>	<p>School of Health Technology curricula evaluation to begin next period.</p>
<p>Medical school curricula development to be undertaken with FMOH support during coming year</p>	<p>IHP subcontract personnel along with Pathfinder and FMOH staff developing a set of standards.</p>
<p>4. <u>Develop and standardize service protocols, procedures, standing orders</u></p>	<p>Needs assessment protocol developed and has been used in 8 states.</p>
<p>5. <u>Provide equipment and supplies</u></p>	<p>150 clinics in 11 states surveyed. Equipment ordered to be delivered in year two.</p>
<p>6. <u>Develop and make operational a management information system (MIS)</u></p>	<p>Revised MIS developed, 214 personnel from all the states and armed forces trained as trainers; clinic manual developed.</p>
<p>MIS being developed and integrated into PHC monitoring system; should be completed in April 1989.</p>	

**Table 6**  
**Public Sector Component**  
**Contracts**

<b>Subproject Identification Number</b>	<b>Description</b>	<b>Beginning Date</b>	<b>Ending Date</b>	<b>Total N's<sup>a</sup></b>
Con: 101-1	FPC Workshop, Ibadan	06/15/89	08/15/88	79,636
Con: 102-1	National & Zonal TOT Workshop for MIS	08/15/88	12/31/88	315,110
Con: 103-1	Ondo State In-Service Training	08/15/88	12/31/88	98,275
Con: 104-1	Support for Ogun State FP Program	01/01/89	12/31/89	341,550
Con: 105-1	Mgt. Trainers' Network Development Workshop	11/01/88	12/31/88	109,160
Con: 106-1	FP Training for Nurse/Midwives at UCH	01/01/89	01/31/90	566,260
Con: 107-1	UBTH FP Service Delivery & Training Prog.	01/01/89	06/30/90	455,500
Con: 108-1	LGA FP Management Workshop, Kaduna State	01/15/89	03/31/89	81,590
Con: 109-1	FP In-Service Workshop for Physicians at Unilorin Teaching Hospital	03/01/89	02/28/90	147,900
Con: 110-1	Support for FP program in Kwara State	04/01/89	03/31/90	135,350
Con: 111-1	FHS/Public Sector Staff Development Workshop	04/01/89	05/31/89	4,360
Con: 112-1	Prototype Lesson Plan for Schools of Midwifery	04/01/89	08/31/89	338,271
Con: 113-1	Oyo State Supervisory Skills Workshop	04/15/89	06/30/89	69,825
Con: 114-1	Kano State LGA Management Workshop	04/15/89	05/31/89	129,849
Con: 115-1	Anambra State LGA Management Workshop	06/01/89	09/30/89	242,000
Con: 116-1	Support for Oyo State FP Program	07/01/89	12/31/90	639,450
Con: 117-1	Training Support for Mrs. Pawa at CEDPA	07/01/89	09/15/89	72,172
Con: 118-1	Training Support for Dr. Ogundeji and Alhaji Anka at MSH	07/01/89	09/15/89	133,110
Con: 119-1	FPC Workshop, Kaduna	06/25/89	07/30/89	207,506
Con: 120-1	Support for Lagos State FP Program	10/01/89	09/30/90	171,890
Con: 121-1	Support for Bendel State FP Program	10/01/89	09/30/90	370,005
Con: 122-1	Plateau State Supervisory Skills Workshop	08/15/89	10/30/89	93,568
Con: 123-1	Follow-up to MIS Training	09/01/89	12/31/89	59,600
Con: 124-1	Storekeepers Workshop	11/01/89	01/31/90	408,025
			<b>Total</b>	<b>5,269,962</b>

a \$1.00 = N 7.5

- Developing state-level networks of core trainers through training of trainers (TOT) courses and a national-level network of trainers to support state-level training needs. These core trainers are expected to travel within the states and provide in-service refresher courses to FP providers.

Since UNFPA was already involved in TOT training in some states, the strategy for training includes an agreement with UNFPA to divide geographic responsibility for state-level TOT for FP providers. The organizations are using different TOT curricula, although they have agreed to use the same curriculum for supervisory training.

## 2) FP Management

Annual national FPC and deputy coordinator meetings, usually designed to address specific management issues, are organized by the public sector component. In addition, three LGA workshops for FP policymakers and managers have been arranged at the state level. All have included a follow-up component to assess the impact of the training.

A beginning has been made in the production of standardized service protocols, procedures and standing orders. This effort should be completed early in 1990 (see Section 6.2.2 for more detail). These new standards should help to ensure an acceptable and fairly uniform quality of FP services nationally.

## 3) Equipment Supply

The effort to equip clinics for full service is designed as a two-step process. The first step is to carry out surveys of target clinics to assess their readiness to use equipment. The second is to place equipment orders. The innovative aspect of this approach is the set of criteria developed by Africare, against which it is possible to judge where equipment has the best chance of being properly used by trained staff. This strategy replaces a less organized earlier approach, in which equipment might be provided to clinics that had no staff who were trained to use it. In addition, these surveys have greatly enhanced the knowledge concerning the status of public sector clinics.

Attention is now being directed to supplying more rural clinics, although FP client volume will be lower. Equipment sets currently being provided include a privacy screen, bed, flashlights, sphygmomanometers, stethoscopes, thermometers, an instrument tray, basin stand, covered dressing jar, gooseneck lamp, scale, exam stool, iodine cups, emesis basins, stock pot with lid (for boiling) and gloves. Equipment supplied is often locally made, decreasing its cost. Africare plans to provide equipment maintenance instructions to clinics that have received supplies.

## 4) MIS

Training in filling out MIS forms and in using MIS manuals has been carried out on a national and zonal basis. It is planned to integrate this MIS into the PHC system by April 1990, and at that time the training will need to be updated.

### 5.1.2 Performance

#### Achievements

The pre-service training component is making good progress. A midwifery curriculum has been developed and is currently being tested in selected states. The curriculum is expected to be implemented nationally by March 1990, assuring a reliable supply of clinical FP

providers for each of the participating states. Progress is also being made in curriculum development for schools of health technology, with the expectation that the new curriculum too will be implemented sometime in 1990. Together, these initiatives should reduce the need for in-service training.

Because as yet very few individuals have received pre-service training, trained FP workers to date have been produced through the in-service training component. With some limitations, provision of in-service training through university teaching hospitals and through state-level core trainers is making some headway. The support of clinical in-service training through the university teaching hospitals (UCH and UBTH) is not only helping produce trained staff. It is also contributing to developing the institutional capabilities of the two hospitals and thus represents a useful institution building approach that also helps to strengthen the country in the area of FP training.

As mentioned above, thanks to Africare's survey work, equipment is being placed only in those clinics in which staff can be expected to use it correctly.

### Issues

One major issue within the public sector component training strategy is that there is no control on the placement of the staff who have been trained. The effect of this is that, despite the considerable training that has taken place, many FP service points and potential service points remain without trained staff. This problem is being addressed to some extent through management training activities in the states. This management training emphasizes the importance of placing staff with appropriate service delivery skills at service delivery points. The government, however, has the final say on staff placement.

With respect to the training itself, although good progress is being made in the area of pre-service training, it is not expected that pre-service training institutions will produce sufficient numbers of clinically trained FP providers within the life of the project. Therefore, it will be necessary to continue to focus on in-service training. It is highly appropriate that teaching hospitals be involved in this effort, but currently, the level of participation is far too limited. Only two of the twelve federal teaching hospitals in the country are currently being used. Support for training in teaching hospitals was an important part of the public sector contractors' work before the FHS project. Administrative problems of the teaching hospitals in connection with this training, however, have precluded continuation of support to some of these institutions. The curtailment of involvement with these institutions represents a serious underutilization of resources. No one teaching hospital can be expected to accommodate more than a few trainees a year, given the press of other teaching commitments. Therefore, the two hospitals currently involved can only produce a modest number of graduates annually. An added issue is that both these hospitals are located in one health zone (zone B), seriously limiting the geographic reach of the pre-service training efforts.

With respect to state-level training, the expression of political will in many states is not always accompanied by a sufficient level of budgetary commitment and support for FP activities. Many scheduled or intended activities remain unaccomplished, particularly for second generation training after core trainers have been trained. The FHS project is trying to influence state governments to increase their funding commitment by sending to FPCs and state FP officers quarterly and annual data on new and continuing acceptors in each zone. The FHS newsletter that is being planned should facilitate this education process.

It is not just insufficiency of state-level funding that is a problem, however. Due to bottlenecks in the signing of state level subcontracts (see Section 4.2.1), some state-level training

activities have not yet been able to start. These delays are largely responsible for the inadequate presence or total absence of this component in many states.

Although the insistence on equipment surveys is sound, progress in this area is not keeping pace with the production of trained staff. Africare's current contract calls for equipping 500 clinics. Taken together with their equipping of 500 clinics before the FHS project began, a total of 1,000 full-service delivery points will have equipment at the end of the project. Additional equipment needs may need to be considered as staff increases later in the project.

**Recommendations:**

15. **FHS should work with the FMOH and the SMOHs in the development of institutional in-service training for all cadres of FP providers in each state.** Such an arrangement should be carried out collaboratively by the FHS training contractors, the FMOH and the SMOHs.
16. In-service training efforts must be maintained to provide an adequate supply of trained FP staff for service delivery points (SDP). Specifically,
  - More teaching hospitals or other health institutions, e.g., schools of midwifery, should be enlisted in efforts to provide institutionalized training for FP providers. These efforts should be focused primarily in Zones C and D.
  - At the state level, priority should be given to assisting states without core trainers to develop these cadres.
17. Pre-service training should continue to be done in schools of midwifery. Efforts to begin pre-service training at schools of health technology should be continued and accelerated. Whether schools of nursing should be included in clinical pre-service training needs further evaluation.
18. **Consideration should be given to designating one training institution in each state to institutionalize FP clinical training.** The best candidates would be schools of midwifery or teaching hospitals. Preference should be given to those institutions that have already participated in training of clinical service providers to date. Such training could become a regular feature of these institutions' programs; they could run three or four training sessions a year with 20 to 30 trainees from their states. This would provide for the in-service training needs of the state for at least the present cadre of providers in a limited period of time. The pre-service training that has already begun would cover the need for new service provider entrants. This system of in-service training would support the pre-service training done in the same institutions. It would also serve as the base for refresher training.
19. A standardized TOT curriculum should be used by FHS and the UNFPA trainers.
20. An effort should be made to facilitate the approval of subcontracts with state governments so that training programs can be initiated more quickly.
21. The various state governments should make larger budgetary allocations to their FP programs.

22. Africare should accelerate its efforts to conduct clinic surveys and consideration should be given for providing additional equipment as more staff are trained.
23. A brief training curriculum for the repair and maintenance of FP equipment should be developed. It should be designed to be used as an on-the-job-training mechanism, with training to be provided to clinic staff at the time that new equipment is delivered. The curriculum should be made available to all FPCs at the annual state FPC workshop.

## 5.2 Private Sector Component

### 5.2.1 Overview

#### Objective

The private sector component is designed to contribute to achieving FHS's overall 12 percent prevalence goal by directly providing family planning supplies and services to 1.2 million couples through private sector outlets.

#### General Activities

To realize this objective, activities and operations are to take place in the following areas:

- 1) Supply of contraceptives and family planning equipment;
- 2) Distribution and service delivery network and support; and
- 3) Support activities for the above activity areas including training, MIS establishment, market research, and technical assistance.

Table 7 provides a summary of the private sector's deliverables and their status to date and Table 8 provides a summary of private sector component activities.

#### Contractors

The prime contractor for the private sector component is Family Planning International Assistance (FPIA). FPIA has developed subcontracts with two major U.S.-based organizations -- John Snow, Inc. and the Margaret Sanger Center.

Table 9 provides a summary of the Nigerian subcontract activities for FPIA and its two U.S.-based subcontractors.

#### Distribution and Service Delivery Networks

FHS/private uses several approaches to distribute family planning commodities and provide services. These range from a large distribution program with Sterling Products Ltd., which distributes family planning products to pharmacies throughout the country, to programs working with private clinics that sell family planning products and provide services (see Table 8 for a summary of these approaches).

#### Meeting Deliverables

FHS/private is expected to provide services in the following numbers of outlets: 4,375 commercial, 5,650 private health service providers, and 2,100 vendors, workplaces and associations (12,125 total). The commercial outlet target will probably be reached through Sterling

**Table 7  
Private Sector Component  
Project Outputs**

End of Project Status Requirements	Output Status
<b>1. <u>Private Sector Distribution Network</u></b>	
● 4,375 commercial outlets	3,500 outlets now selling FP commodities
● 5,650 private health providers and service delivery sites	627 sites trained and supplied (private health care centers)
● 2,100 vendors, workplaces, and associations	503 now providing services
<b>2. <u>Private Sector Training</u></b>	
● 4,000 pharmaceutical personnel trained in FP methods and counseling	939 pharmaceutical personnel trained in FP methods and sales
● 1,000 vendors trained in family planning methods and sales	473 private vendors trained in FP methods
● 2,100 nurses and doctors trained in IUCD insertion	27 trainers trained; 720 nurses/ doctors trained
<b>3. <u>FP Commodity Procurement and Distribution</u></b>	
● \$17 million of FP commodities	Commodities valued at \$2.5 million have been procured
<b>4. <u>Management Information System</u></b>	
● Establish and provide all necessary and appropriate support for a private sector MIS	Sales information portion of system is operating; service delivery acceptor recording developed
<b>5. <u>Market Research</u></b>	
● Conduct commercial sales market research that collects and analyzes information on current contraceptive mix, sales quotas, and profitability	Contract signed for first market research activity; early results beginning to come in; analysis and marketing strategy taking place
<b>6. <u>Technical Assistance to Nigerian Subcontractors</u></b>	
● Periodic monitoring visits to all Nigerian subcontractors	35 contracts have been initiated; TA is taking place as projects get under way
<b>7. <u>IEC Related Activities</u></b>	
● Work closely with IEC contractor in areas of market research, FP promotion, and advertising	Marketing study initiated will help determine collaboration with IEC component

Source: FHS Implementation Report

**Table 8**  
**Summary of Private Sector Component Activities**

<b>Approach</b>	<b>Organizations Involved</b>	<b>Potential Sites<sup>a</sup></b>	<b>Sites To Date</b>	<b>Examples</b>	<b>Description</b>
<b>Commercial</b>					
Sterling Distribution	1	4,500	3,500	Sterling	Distribution of FP products through Sterling's established retail network. Sterling provides salespersons and detailers to market the products along with their own pharmaceutical products. (Ongoing.)
Trade Companies Distribution	3	2,500	-	W.F. Clarke Leventis Morrison	Distribution of FP products to other trading companies. Sterling will sell to these companies at wholesale prices. (Still in the development stage.)
<b>Health Clinics And Hospitals</b>					
Umbrella Support to Private Hospitals and Clinics	6	250	160	Apex Hospital and six others	Medical staff and CBD workers trained to sell products and services, with commodity support provided by a central fixed clinic. Revolving fund for commodities used. (Three ongoing and four under development.)
Association Support for Private Clinics	7	700	467	Nursing Assoc. (NANNM)	Nurses/midwives trained to sell products and provide services including IUCD insertions, with commodity and monitoring provided by the nursing association monitors. Revolving fund for commodities used. (Three ongoing and four under development.)
Nurse Vendors	2	20	-	Nursing Assoc. Lagos and Ogun	Train nurses to sell condoms, foaming tablets, and possibly pills in the marketplace. Act as educators and provide referral. (Under development.)
<b>Vendors, Associations, Employment-Based Activities</b>					
Parastatal Support	5	46	22	NITEL and four other groups	Provide training and seed money to help initiate family planning services and IEC activities in their in-house clinics. Commodities purchased by the parastatal. (Under development.)
Employment-based Detailing Support	44	210	8	Sterling F-04: Detailing	Train personnel managers and clinic staff to provide family planning services. Nurse detailers provide follow-up commodity support. Commodities purchased by the company. (Ongoing.)
Gasoline Outlets Distribution	8	500	-	National Petro. and six others	Distribution of products directly to petroleum gasoline retail outlets by dealers for a profit. Sterling will provide the commodities at wholesale prices. (Still in development stages: distribution approach yet to be developed.)
Market Vendors Distribution	2	50	80	Two national women's groups	Trained market women sell condoms in the market place for a small profit. (Ongoing: previously a CEDPA project.)
Transport workers	7	840	393	Transportation Unions	Transportation workers, e.g. cab drivers, are trained to sell condoms to their customers. To support these activities, the transportation union will set up a revolving fund. (Just getting started.)

Source: Compiled by evaluation team and confirmed by FHS/private.

<sup>a</sup> The numbers of potential sites may differ from the planned outputs in Table 7 because they reflect activities actually identified at this point.

**Table 9  
Private Sector Subcontracts**

Subproject Identification Number	Subcontractee Location Obligation	Estimated Obligation (In U.S. \$'s)	Status	Description
<b>Family Planning International Assistance</b>		<b>1,310,378</b>		
F-03	Sterling Sales	150,600	Signed	Comm. Distributor
F-04	Sterling Services	154,299	Signed	Comm. Distributor
F-04/2	Sterling Sales/Tr.	87,384	Signed	Comm. Distributor
F-05	NKST	31,801	Signed	Clinical Services
F-06	COWAN	3,729	Signed	Market-based Sales
F-06/1	COWAN	16,277	Signed	Market-based Sales
F-07	NCWS	1,471	Signed	Market-based Sales
F-07/1	NCWS	15,714	Signed	Market-based Sales
F-07/2	NCWS	180	Signed	Market-based Sales
F-10	MIS Company	160,000	Development	MIS Development
F-11	Churches/Mosques	60,000	Development	Clinical Services
F-12	Sml-scale Comm.Dlst.	10,000	Development	Community Distr.
F-13	Clarke	10,000	Development	Comm. Distributor
F-14	Leventis	10,000	Development	Comm. Distributor
F-15	Morrison	10,000	Development	Comm. Distributor
F-17	Apex Hospital	14,706	Signed	Clinical Services
F-18	Maiduguri	35,000	Development	Clinical Services
F-19	Abuja	30,000	Development	Clinical Services
F-20	Port Harcourt	30,000	Development	Clinical Services
F-21	Lagos Harcourt	50,000	Development	Clinical Services
F-22	Advertising Co.	350,000	Development	Promotion
F-23	Excell Clinics	11,524	Development	Clinical Services
F-24	Audits	50,000	Signed	Audit Support
<b>John Snow, Inc.</b>		<b>1,080,541</b>		
F-01	SWH - 1-01 Sweethill Associates		Signed	Mini-market Act.
	RMS - 1-02 Research Marketing Services		Signed	Mini-market Act.
	AML - 1-03 Associated Markets, Ltd.		Signed	Mini-market Act.
	NNM - 2-01 NANNM/Lagos		Signed	Private Clinic Supp.
	NNM - 2-02 NANNM/Imo State		Signed	Private Clinic Supp.
	NNM - 2-03 NANNM/Anambra		Signed	Private Clinic Supp.
	NNM - 2-04 Nig. Pri. Nurse & Mld./Oyo		Signed	Private Clinic Supp.
	NNM - 2-05 NANNM/Kwara		Signed	Private Clinic Supp.
	NNM - 2-06 NANNM/Kaduna		Signed	Private Clinic Supp.
	NNM - 2-07 NANNM/Ogun		Signed	Private Clinic Supp.
	NTL - 3-01 NITEL		Development	Employment-based
	NEA - 3-02 Nat. Electric Power Auth.		Development	Employment-based
	NA - 3-03 Nigeria Airways		Development	Employment-based
	CBN - 3-04 Central Bank of Nigeria		Development	Employment-based
	UL - 3-05 University of Lagos		Development	Employment-based
<b>Margaret Sanger</b>		<b>300,000</b>		
F-02	ABU-01 Ahmadu Bello University		Signed	Assort. Training
	ILU-01 University of Ilorin		Signed	Assort. Training
	IMO-01 Ministry of Health/Imo		Signed	Assort. Training
	JTH-01 Jos University Teaching Hospital		Signed	Assort. Training
	LUT-01 Lagos University Teaching Hosp.		Signed	Assort. Training
	OGN-01 Ministry of Health/Ogun		Signed	Assort. Training
	UBT-01 Univ. of Benin Teaching Hosp.		Signed	Assort. Training
	UNT-01 Univ. of Nigeria Teaching Hosp.		Signed	Assort. Training
	UPH-01 Univ. of Port Harcourt Teaching Hosp.		Signed	Assort. Training

and subcontracts with other trading companies, e.g., W.F. Clark, Leventis, and Morrison. It will be more difficult, however, to reach the targets in the other two categories: 18 months into the project, only 627 private health service providers (11 percent) and 503 vendors, workplaces and associations are offering contraception (24 percent). Most of these activities have begun within the last six months.

Two factors are contributing to this shortfall. First, the subprojects initiated to date are taking longer to develop than anticipated, and second, once developed, these subprojects often require a great deal of monitoring. One implication is that, as more projects get started, there may be less time available to support additional project development activities. Another is that the pressure to reach targets has, and will continue to, influence programmers to develop subprojects that offer many outlets without sufficient concern for whether they can become sustainable (see Section 5.2.3).

**Recommendation:**

24. The FHS project should seriously consider whether the number of outlets required for the private sector component is realistic in light of the effort that is required to establish subprojects.

## **5.2.2 Marketing Issues**

### **Sterling Activities**

Sterling provides a ready-made distribution network with 50 distributors and 2,650 retailers nationwide. This represents a good and inexpensive approach to distributing commodities to its distributors and to private hospitals and clinics (see Appendix D for an analysis of the present distribution system and a marketing assessment). FPIA is making plans to involve other distributors to supplement the Sterling network. Sterling would sell commodities to these distributors at wholesale prices.

In addition to its regular salespersons, who can sell only condoms and vaginal tablets, Sterling's sales force includes medical representatives and nurse detailers who can sell the whole range of family planning products (including oral contraceptives) to pharmacies and private clinics. Since Sterling has a limited number of medical detailers, they are unable to cover more than a small number of these outlets. Thus, condoms can be distributed more extensively than pills.

At present Sterling has little incentive to increase sales because it receives a fixed management fee for providing services. The fee was instituted to ensure that the company not run a financial risk in distributing the product, but likewise, it does not provide any commission incentive to support the product.

At present, products are distributed through Sterling's network with little marketing support from FHS/private. Efforts to develop appropriate marketing approaches, e.g., advertising, promotion, and packaging, have been slow, and little effort has been made to bring in marketing services that would help develop these approaches, either from international or from local marketing consultants. Technical assistance for this area has been successfully used in other countries such as Indonesia, e.g., in the development of the Blue Circle program for the marketing and distribution of contraceptives.

A second issue is that Sterling is not actively involved in marketing activities, although it has a vested interest in the impact. Some progress is being made in marketing, however. A full-time sales administrator will be placed at Sterling (paid for by FHS/private) to

focus on the contraceptive product line. In addition, in July, sales targets were given to Sterling's sales staff. This change appeared to increase the sales of condoms significantly.

In addition, the project has made a sound strategic decision by naming three contraceptives (out of the ten different family planning products being sold through Sterling) to receive marketing attention -- 1) Blue Panther -- renamed "RIGHT-TIME"; 2) Noriday pills -- renamed "Gynovol"; and 3) vaginal foaming tablets -- renamed "Foamax." This will ensure that staff efforts and attention are focused on establishment of brand recognition.

#### Recommendations:

25. While maintaining good contact with Sterling, the project should continue to carry out its plans to explore and establish distribution through additional commercial channels nationwide. This should serve both to increase the overall distribution of products and to ensure that alternative distribution approaches are in place, should Sterling ever stop participating. Developing new channels is a long, drawn-out process that needs extensive preparation. Not to have alternative channels in place could jeopardize the whole program.
26. As planned FHS/private should work to develop a new payment formula that would provide a greater incentive for Sterling to make active efforts to sell products. This formula should ensure that Sterling continue to receive at least a minimum fee that would eliminate the possibility of its taking a financial risk, but this fee should be lower than the present one. This should be supplemented by the potential to make additional money through commission on sales.
27. While focusing on three brands, Sterling should continue to sell (but not market) its other products directly to its own outlets and to private hospitals and clinics. This would provide greater choice for the consumers.

#### Advertising and Promotion

As stated above, a major shortcoming of the private sector program is its lack of demand creation through promotion and advertising activities. At the 18-month mark, the advertising and promotion brief was still in the development stages, and no Nigerian company had been selected to carry out advertising. This slow start reflects a basic design/implementation flaw. Activities concerning demand creation should have been initiated from the start of the project. Even if mass media approaches were not possible at early stages, an attempt should have been made to develop point-of-purchase posters or handouts.

Based on the pharmacist Act Cap 152 Part 8, it is necessary to clear all the products and register them with the Food and Drug Administration and Control (FDAC) before embarking on mass media campaigns. The advertising materials must also be reviewed and approved by the FDAC before they can be used. At this point oral contraceptives cannot be advertised because they are ethical products.

#### Recommendations:

28. As part of the overall social marketing approach, vigorous and persuasive communications and advertising need to be launched as soon as possible. Products should be properly branded and packaged attractively to aid customer identification and recognition. The generic logo developed by the FMOH's Health Education Branch should be considered for use in packaging of contraceptives. Proposals from

ad agencies to oversee this new approach should be elicited. **Local and international technical assistance in marketing and advertising will be required.**

29. Multiple strategies for advertising contraceptives in different geographical zones should be considered in order to take into account Nigeria's complex cultural and religious diversity.
30. FHS/private should request assistance from the policy component to work with the Government to help alter the FDAC restrictions related to advertising ethical products, e.g., orals.
31. If a solution cannot be found in the near term (see Recommendation 30), alternatives should be explored. These might include 1) advertising condoms only; 2) advertising the family planning concept to increase general awareness, while leaving the choice of the product to the consumer; or 3) advertising the concept together with the logo and asking consumers to buy from stores that have the logo.

### Product Packaging

At present, Sterling products are not packaged. Condoms are sold in strips of four, and orals are sold as single, unwrapped packs. This approach poses a problem in Nigeria because consumers are very concerned about tampering and fake products. It also makes brand recognition more difficult.

The project is planning to put its products (condoms and orals) in packages bearing different names, e.g. "Panther" condoms in a box labeled "RIGHT-TIME" (see above, "Sterling Activities"), but this carries a risk that consumers would be confused or even concerned that the product had been tampered with.

### Recommendation:

32. FHI/private should review the decision to package Panther condoms in "RIGHT-TIME" boxes, and explore the possibility of procuring a generic brand of condom instead.

### Marketing/Market Research

The market research conducted by the project to date has been limited to the following: 1) product/packaging/concept statement; 2) price study in relation to competition; 3) product new brand names; 4) attitude/usage; and 5) awareness/usage.

The most useful of the various studies appears to be the Omnibus study of usage/attitude, judging from the number of respondents (4,000 in 24 urban towns and 48 rural areas across the country). Less valid may be the choice of participants for the condom name test, which was conducted in Lagos and Kano and included only 120 persons in all -- 12 focus groups of 10 persons each. Given that the focus groups were to test a national brand name, the groups selected were too few. Focus groups can be very useful in determining the public's reaction to marketing ideas. In a multi-ethnic society such as Nigeria, however, the selection of participants from different tribal groups and the number of groups need to be carefully determined. In addition, some of the research related to product naming and packaging was not carried out according to accepted research protocols (e.g., condom name test).

**Recommendations:**

33. The project should attempt to use additional types of market research to assess the impact of retail sales, e.g. retail audits, consumer identification. In addition, market research should continue to be used by the project prior to the initiation of any new ventures. This research should determine the feasibility of activities in terms of their potential for both impact and sustainability.
34. FHS/private should oversee all research activities. It should interview the researchers to authenticate research report statements and ask for all completed questionnaires for each research item, to be reviewed by an independent source. Until the above verifications are made, the research reports should not be relied upon for serious decisions.

**5.2.3 Sustainability of Subprojects**

In addition to issues related to project impact, a major goal of private sector programs is to transfer resources from the public to the private sector. To achieve this end, subprojects developed in the private sector program must reach a point where they become sustainable without continuous donor support upon their completion. To date, the subprojects developed by FHS/private vary in their apparent potential for sustainability.

One set of subprojects with good prospects for sustainability is the effort being carried out with national nursing/midwives associations. The overall purpose is to train private sector nurses and midwives to provide family planning services and to assure them the commodities and supplies they need to provide these services. The key to the approach is the existence of two revolving funds. The first revolving fund contains funds from sale of services and commodities by the nurses and midwives with which they can purchase resupplies of commodities. (The initial supply of commodities is provided by the project.) The same mechanism operates between the project and the associations: The project provides an initial supply of commodities to the associations, which in turn sell them to the providers. With revenues generated from these sales, the associations both purchase resupplies and finance monitors. These monitors act as distributors to the nurses and midwives and are available to provide quality control. This approach offers several important advantages: 1) the profit motive provides an incentive for private clinicians to sell services; 2) the revolving funds provide a good potential for sustainability; 3) the use of monitors allows the project to monitor the quality of services and assure the resupply of contraceptives to nurses/midwives; and 4) since distances are often great and transportation difficult, supply by the monitor is advantageous for the clinician.

Another approach to dealing with nurse midwives will, however, not be sustainable because trainees do not receive commodity support from the project after their training is completed. Trainees are expected to purchase their supplies on their own after the initial supply of contraceptives given to them has been used up. Because of travel, funding, and time constraints, this is usually not possible. To remedy this situation, FHS/private is exploring the possibility of using the nursing associations to resupply this group in the future.

Because they will need continued subsidization in staff salaries as well as for commodities, other program activities sponsored by the private component also appear to offer less potential for sustainability. One example is the NKST subproject, a large Christian mission activity in Benue State that also uses nurse midwives to provide services. In this case, however, the subproject pays for the salaries of project staff, and there is little prospect that these costs can be recovered through the sale of commodities. Likewise, market women's subprojects, while

generating a small profit for the market women, do not generate enough revenues to cover program costs (i.e., salaries of project monitors).

FHS/private has entered into these arrangements, despite the problems with sustainability, for two reasons: 1) because these projects offer additional outlets and thus help achieve project targets and 2) because they represent a wide range of activities within the private sector that have the potential for reaching a variety of family planning acceptors.

Another issue with implications for sustainability relates to training for commercially oriented providers. Staff from one site that was established early on in the project commented that they had little idea of how to get started in private practice after they had been trained. They indicated a need for frequent initial assistance to identify their market, promote their practice and put accounting procedures in place.

#### Recommendations:

35. For future subprojects, programs that have a reasonable chance of becoming sustainable over time should receive the greatest emphasis. Private sector programs that require substantial subsidies should be avoided. For existing subprojects that do not appear to be sustainable, efforts should be made to develop a mechanism for ensuring that they survive beyond the life of the project.
36. A reliable resupply for supplies and commodities should be established for all subprojects. No person should be trained without having such a system in place. For those who have already been trained, but are not being resupplied, a way to ensure a regular supply of commodities must be developed. For example, FHS/private's plan to use the nursing and midwives associations' monitors to resupply trained private nurses/midwives should be encouraged.
37. Adequate technical assistance should be provided to project-trained private sector providers to get established in practice. This TA should be provided separately from ongoing clinical quality assurance supervision and commodity resupply.

#### 5.2.4 Future Activities

##### Change of Emphasis to Increase Overall Impact

A major emphasis of this component is on activities geared to the sale and distribution of condoms and foaming tablets. These are carried out by Sterling and through a number of other subprojects -- market women programs, nurse vendors, transport workers, and mini-marts. The Sterling approach and retail sales efforts are cost effective because they are not labor-intensive, but other program approaches (market women, transportation workers, etc.) often require substantial project back-up.

Condoms represent a good method for developing awareness of family planning, but their potential for having a significant impact on overall fertility is limited. This is especially true in Nigeria where condoms are used, in large measure, for control of sexually transmitted diseases (STD) rather than for birth control.

IUCDs and pills have a greater potential for reducing fertility, and therefore, if the project is to have maximum impact on fertility using the private sector, it needs to place more emphasis on these products.

Certain constraints, however, make distribution of both IUCDs and pill more difficult than that of condoms. First, the distribution of these products is limited to specific markets. Pills can be distributed only through pharmacies or clinics, and the IUCD can be distributed only to clinics with trained staff. Second, unlike condoms and vaginal tablets, service care providers who are inserting IUCDs and distributing pills, and to a certain extent pharmacists who are selling pills, require specialized training.

**Recommendations:**

38. **FHS/private should place greater emphasis on family planning methods that have a higher potential for reducing fertility, i.e., pills and IUCDs.** Approaches might include the following:
  - 1) Expanding the involvement of work with association of nurses and midwives, using the approach presented in Section 5.2.3 above. This approach could be significantly expanded to more states, with larger numbers of trainees; and
  - 2) In the identification of additional distributors, FHS/private should attempt to enlist pharmaceutical companies that could be used to sell prescription products to clients. It would also be helpful if more medical representatives could be hired through Sterling.
39. Sterling activities and the sale of condoms and vaginal tablets through retail sites should continue, but no new subprojects that focus on these products and work with transportation workers and market women should be developed.

**Exploration of New Activities**

Although the project has made some progress in developing innovative approaches for utilizing the private sector, other avenues remain to be explored, particularly in the realm of employment-based efforts. For example, in Imo state, representative from large businesses regularly request support from the Ministry of Health to provide IE and commodities for their employees. This suggests that there is room for expansion of efforts, both with business and trade unions.

**Recommendation:**

40. To help develop project ideas, the project should take advantage of the vast number of business people and labor leaders in Nigeria who could be used as resources to the project to provide advice and guidance on issues related to the private sector.

**5.2.5 Contractor and Subcontractor Management**

Overall management of FHS/private is centered in the prime contractor's New York office. In addition to three professionals who provide substantial inputs to the project, nine other members of the prime contractor's staff are billable to the project (5 to 30 percent time). Although the prime contractor has extensive experience developing effective family planning programs around the world, it is a relative newcomer to private sector family planning.

The staff in the Nigeria office is made up of four professionals and one support person. Two additional professional staff members are scheduled to be hired. The Nigerian staff appear to have the experience needed to implement this component, but because much of the decision making takes place in New York, their skills are not fully tapped. For example, marketing research studies designed in Nigeria are sent to New York to be analyzed. This step appears

questionable since project staff members in Nigeria are capable of analyzing and making recommendations on these studies. In addition, most strategic plans for the private sector component are produced in New York. The second year workplan, for example, was developed in New York and sent to Nigeria when it was completed. A request was made at the last management meeting for contractors to involve their Nigerian staff and collaborative groups in annual planning exercises, but there is every indication that the next workplan will be developed in the same manner as before. Project staff also have no control over the budget and often do not know whether there is money available for various activities.

Communication between the prime contractor and the subcontractors, and between all three and the Lagos-based staffs, is minimal. Subcontract staff who travel to Nigeria to implement activities often carry out their work without FHS/private's being aware of the nature of these visits. This prevents the two parties from benefiting from each others' experiences. To improve this situation, one of the FHS/private subcontractors recently requested, and was given, approval to hire a Nigerian representative to oversee its project activities and act as a liaison with the local FPIA program director. This should greatly improve communication.

**Recommendations:**

41. Private sector staff in Nigeria should be more fully involved in the decision making and strategic planning process if FHS/private staff are to develop their capabilities and achieve the goals and objectives originally envisaged for FHS/private. This should include their developing priorities and new project concepts. The Lagos office should be fully cognizant of the financial status of the project and be given the authority to commit funds for subprojects with concurrence of the prime contractor.
42. Communication for subprojects should be improved between the prime contractor's New York office and its office in Nigeria, and among the prime subcontractors and the Lagos office.

**5.3 IEC Component**

**5.3.1 Overview**

**Objectives**

The IEC component has three objectives: (1) to assist in the preparation, approval, and execution of national, state and LGA IEC action programs, ensuring that they incorporate a broad range of mass media activities, mobilization campaigns, family life education-related efforts, training, and printed material design, preparation, and dissemination; (2) to help make 80 percent of the population aged 15 to 45 knowledgeable about family planning concepts; and (3) to develop and distribute wall charts, posters, picture books, and promotional displays on the benefits of child spacing and modern methods of contraception to at least 12,000 private sector outlets and 3,600 public sector delivery points.

**Progress Made toward Objectives**

**Objective 1**

**National IEC plan.** FHS/IEC has been invited to participate in the DPA's IEC Task Force that is to review and put into the final form national FP/IEC workplan. The draft workplan

is scheduled for completion in December and will be ready for review by the Task Force in early 1990.

**State IEC programs.** Four statewide IEC programs have been initiated under this component; three statewide programs initiated prior to FHS have been continued; and, three statewide programs have been developed and are awaiting USAID approval.

**LGA IEC programs.** FHS/IEC has either involved all LGAs in its statewide IEC program (e.g., Ogun, Benue, Imo) or focused on LGAs including the LGAs targeted through the PHC program (e.g., Borno, Rivers). Because there are about 450 LGAs, it is more cost-effective and programmatically practical to incorporate LGA participation within state-level project development plans.

### Objective 2

**Increase family planning knowledge of 80 per cent of the population were aged 15-45 years.** It is too early to assess progress in this area. A recently completed Ondo State Demographic Health Survey, however, suggests that it will be difficult to achieve this goal. This survey showed that only 48 percent of women aged 15 to 49 years knew of a contraceptive method. Knowledge of contraceptives was highest among women who were in their 20s and early 30s, educated, married and lived in urban areas. A significant proportion of women in Nigeria who are below the age of 20 and at risk of childbirth live in rural areas and lack educational opportunities.

### Objective 3

**Distribution of IEC materials to 12,000 private sector outlets and 3,600 public sector delivery points.** FHS/IEC has undertaken multistate workshops in materials development and counseling and is discussing with Planned Parenthood Federation of Nigeria (PPFN) the possibility of creating an IEC foundation for their 14 state branches to design and implement statewide IEC should contribute to the achievement of this objective.

Table 10 provides an overview progress toward project outputs in the IEC component.

### Contractors

To carry out IEC activities, the Johns Hopkins University/Population Communication Services (JHU/PCS) Project was contracted by A.I.D. Three U.S.-based subcontractors were contracted by JHU/PCS to develop, monitor, evaluate and provide technical assistance for various aspects of the IEC component: the Centre for Development and Population Activities (CEDPA), the Program for Appropriate Technology in Health (PATH), and the Academy for Educational Development (AED).

To implement IEC activities in Nigeria, subcontracts are given to various Nigerian government entities, private and public organizations, and commercial companies (see Table 11 for the list of subcontracts issued or in process for IEC to date).

### IEC Strategy

The IEC component has both a national and a state focus. At the national level it is working primarily with the FMOH's Health Education Branch to develop a family planning logo and produce materials. Materials production is also being financed through the PPFN and plans are being made to use PPFN as a major IEC disseminator. Mass media activities at the national level

**Table 10  
IEC Component  
Project Outputs**

End of Project Status Requirements	Output Status
<p><b>1. <u>Mass Media</u></b></p>	
<ul style="list-style-type: none"> <li>● Design national FP logo to be printed on posters, decals, banners for distribution in at least 15,000 outlets</li> </ul>	<p>Competition and pretests held. Final design to be submitted by the DPA to the Minister October 1989. Ad agency solicited for bids on refinement, printing, distribution and mass media promotion of logo</p>
<ul style="list-style-type: none"> <li>● National music project to distribute and air songs with FP themes composed and recorded by popular local musicians</li> </ul>	<p>Two recordings have been made by King Sunny Ade and Onyeka. Album and music video released August 1989, and distributed through sales. Initial printing of 100,000 cassettes and 50,000 records. Activities included radio workshop by Nat'l Council of Women's Societies to promote songs, orientation workshop for state branches by PPFN to promote songs, national press conference and simulcast of songs on radio. USAID/WashDC gave special award to the two artists for their recording Wait for Me album.</p>
<ul style="list-style-type: none"> <li>● Produce 1,000 television, radio, film, folk media programs, and newspaper/magazine inserts</li> </ul>	<p>Promotion of messages in advertising campaign to start early 1990.</p>
<ul style="list-style-type: none"> <li>● Produce 1,000 television, radio, film, folk media programs, and newspaper/magazine inserts</li> </ul>	<p>26 radio drama episodes aired in Igbo - Imo State; 52 radio drama episodes aired in Anambra State; 32 folk dramas, mobile theater performed - Ogun State First magazine insert planned and contracted; will appear during next period. Over N60,000 in free newspaper editorials obtained on FP through music project. 44 copies of RAPID video distributed to State MOH's and TV stations for broadcast, especially during National Policy State launchings.</p>
<ul style="list-style-type: none"> <li>● Sponsor workshops, study tours, and other training for media practitioners and MOI/MOH personnel</li> </ul>	<p>Sponsored 2 participants in Cameroon workshops on TV production/editing; 3 state FP coordinator participants sent to Zimbabwe for FP male motivation workshop.</p>
<ul style="list-style-type: none"> <li>● Sponsor workshops, study tours, and other training for media practitioners and MOI/MOH personnel</li> </ul>	<p>Two singing stars and 2 media professional attended the International conference on Education through Entertainment in Los Angeles.</p>
<ul style="list-style-type: none"> <li>● Sponsor workshops, study tours, and other training for media practitioners and MOI/MOH personnel</li> </ul>	<p>Four Nigerians went to Baltimore "Advances in Family Health" communications workshop July 1989.</p>
<ul style="list-style-type: none"> <li>● Sponsor workshops, study tours, and other training for media practitioners and MOI/MOH personnel</li> </ul>	<p>Workshop and training activities are either in the planning stage for implementation within the next six months or have been conducted in 11 of the 22 states and the capital territory, plus a workshop for PPFN and FMOH health education staff June 1989.</p>
<ul style="list-style-type: none"> <li>● Provide AV and recording/editing equipment to selected radio stations and MOI offices</li> </ul>	<p>AV equipment purchased and delivered to IEC component for distribution.</p>
<p><b>2. <u>FP Promotion to opinion leaders</u></b></p>	
<ul style="list-style-type: none"> <li>● Organize at least 40 FP orientation symposia and campaigns for traditional and religious leaders and for organizations having outreach potential</li> </ul>	<p>Planned in each of 11 states where FP/IEC programs are under way or planned to begin.</p>
<ul style="list-style-type: none"> <li>● Publish special materials addressed to specific groups</li> </ul>	<p>Photo-novel on FP developed for Leventis employees, the first such FP tool to be developed in Africa.</p>
<ul style="list-style-type: none"> <li>● Publish special materials addressed to specific groups</li> </ul>	<p>RAPID video aired on national TV in conjunction with launching of the National Population Policy.</p>

**Table 10  
IEC Component  
Project Outputs**

End of Project Status Requirements	Output Status
Assist NCPA and PPFN in developing packages for constituency building activities	Subcontract submitted to NCPA for review; contract signed with PPFN; training of trainers materials development workshop completed June 1989.
<b>3. Private and clinic-based outreach activities</b>	
6 million copies of promotional and educational materials to be produced and distributed	Assisted PPFN with revision of FP methods booklets, with 900,000 reprinted; produced 1,000 Yoruba clinical posters, 500 Igbo posters; 1,600 fabric wrappers, 2,500 photo-novels.
Provide AV equipment to regional training sites	AV equipment purchased and delivered.
<b>4. Specialized IEC training</b>	
Conduct 20 IEC workshops for appropriate target groups	Workshops held in Ogun, Kaduna, and Benue states and national level.
Short-term IEC training provided in the U.S.	Four Nigerian participants attended 3-week IEC workshop in Baltimore.
Provide training in counselling methodology and motivational skills to all trainees who teach FP at regional or state training institutions	First workshop held in Ogun State FP school in Jan. 1989. First workshop sponsored by JHU/PCS ended October 1989; over 400 nurses trained in counseling. TOT on counseling held in Benue Sept. 1989; multistate counseling (Kwara, Borno, Kaduna, Lagos, Oyo, PPFN, FMOH) held Oct. 1989.
Conduct workshops for selected state and LGA government workers already involved in social mobilization and promotional materials development	Initial discussions under way with Africa Regional Health Education Council (ARHEC) in Ibadan; work with ARHEC will assist to develop IEC capabilities and they will in turn work with states and LGAs.
Conduct FLE workshops in at least 15 states for a minimum of 200 urban secondary and post secondary teachers	Contract signed with NERDC for FLE development workshop in April 1989; Conducted materials development/materials editing workshop in Oct. 1989 to be pretested at state level in January 1990.
30,000 copies of at least 5 types of contractor prepared Nigeria-specific FLE materials to be introduced and distributed to teachers and students	See above.
AV materials to support FLE programs to be introduced	See above.
FLE contests and debates and a national population quiz show, eliciting competition from at least 300 secondary schools	See above.
IEC subjects to be integrated into training conducted by other components, reaching at least 10,000 service delivery, sales, and motivational personnel	Advertising campaign to complement private sector activities.
	IEC counseling module has been adapted into public and private sector clinical training, school of midwifery curriculum and FMOH standards of protocol manual for FP service providers.

**Table 11**  
**IEC Subcontracts**  
 (as of 12/4/89, including pending modifications)

Project No.	Recipient	Start Date	Termination Date	Approved Budget (In U.S. dollars)	Funds Provided To Date (In U.S. dollars)
AF-NGA-01	Kwara MOH	04/01/84	09/30/87	49,246.61 742.17 <u>49,988.78</u>	49,246.61 <sup>a</sup> 742.17 <sup>b</sup> <u>49,988.78</u>
AF-NGA-02	PPFN	11/01/84	07/31/86	64,641.15	64,641.15 <sup>a</sup>
AF-NGA-03	PPFN	01/01/85	08/31/87	211,954.95	211,954.95 <sup>a</sup>
AF-NGA-04	FRU	03/01/86	09/30/87	16,365.71	16,365.71 <sup>a</sup>
AF-NGA-05	PPFN	10/01/86	09/30/87	31,007.87	31,007.87 <sup>a</sup>
AF-NGA-06	MOH/Imo	08/01/86	10/31/89	11,614.10 4,561.54 25,014.36 <u>41,190.00</u>	11,614.10 <sup>a</sup> 4,561.54 <sup>b</sup> 8,003.75 <sup>c</sup> <u>\$24,179.39</u>
AF-NGA-07	NTA/Enugu	02/25/86	02/28/87	24,629.50	24,629.50 <sup>a</sup>
AF-NGA-08	NTA/Enugu	02/25/87	09/30/88	14,001.20	14,001.20 <sup>b</sup>
AF-NGA-09	PPFN	05/20/87	03/31/89	63,014.76	63,014.76 <sup>b</sup>
AF-NGA-10	MOH/Borno	07/01/87	12/31/90	695.83 56,243.17 <u>56,939.00</u>	695.83 <sup>b</sup> 21,204.17 <sup>c</sup> <u>21,900.00</u>
AF-NGA-11	MOH/Ogun	07/01/87	12/31/90	9,134.49 42,395.51 <u>51,530.00</u>	9,134.49 <sup>b</sup> 38,350.94 <sup>c</sup> <u>47,485.43</u>
AF-NGA-12	NTA/Ibadan	09/04/87	03/31/88	13,606.00	8,946.25 <sup>b</sup>
AF-NGA-13	Prime TV	08/13/87	08/31/89	27,378.00	27,378.00 <sup>b</sup>
AF-NGA-14	Mut-Moksons	09/01/87	06/30/88	13,000.00	13,000.00 <sup>b</sup>
AF-NGA-15	ABS	10/02/87	03/31/89	1,329.23 7,809.05 <u>9,138.28</u>	1,329.23 <sup>b</sup> 2,461.00 <sup>c</sup> <u>3,790.23</u>

**Table 11**  
**IEC Subcontracts**  
 (as of 12/4/89, including pending modifications)

Project No.	Recipient	Start Date	Termination Date	Approved Budget (In U.S. dollars)	Funds Provided To Date (In U.S. dollars)
AF-NGA-16	John Snow Inc.	04/29/88	12/31/89	7,000.00	0.00 <sup>c</sup>
AF-NGA-17	MOI/Oyo	11/15/88	02/28/90	19,920.24	13,665.12 <sup>c</sup>
AF-NGA-18	MOH/Benue	01/01/89	12/31/90	58,675.24	9,375.97 <sup>c</sup>
AF-NGA-19	MOH/Kaduna	01/01/89	12/31/90	54,689.52	5,410.24 <sup>c</sup>
AF-NGA-20	MOH/Cross River	09/01/89	08/31/91	47,730.29	9,165.43 <sup>c</sup>
AF-NGA-21	PPFN	07/01/89	06/30/90	98,028.00	79,808.26 <sup>c</sup>
AF-NGA-22	RBNL	08/15/89	08/14/90	30,770.00	13,920.17 <sup>c</sup>
AF-NGA-23	Grace Delano	06/01/88	12/01/88	990.32	990.32 <sup>c</sup>
AF-NGA-24	Grace Delano	07/01/88	05/30/89	1,823.81	344.12 <sup>c</sup>
AF-NGA-25	Grace Delano	08/01/88	11/31/88	6,971.44	6,971.44 <sup>c</sup>
AF-NGA-26	RMS	08/01/88	09/30/88	4,000.00	4,000.00 <sup>c</sup>
AF-NGA-27	FMOHED	11/27/88	03/31/90	3,200.00	3,043.52 <sup>c</sup>
AF-NGA-28	P.O. Emeharole	12/09/88	03/31/90	4,642.86	2,900.53 <sup>c</sup>
AF-NGA-29	Okoli/Iroku	11/01/88	03/31/90	2,791.19	813.64 <sup>c</sup>
AF-NGA-30	King Sunny Ade	02/13/89	09/30/89	30,000.00	30,000.00 <sup>c</sup>
AF-NGA-31	NERDC	03/31/89	06/30/89	13,918.61	13,918.61 <sup>c</sup>
AF-NGA-32	MPP	04/18/89	05/17/89	13,117.99	13,117.99 <sup>c</sup>
AF-NGA-33	MPP	04/18/89	05/17/89	8,000.00	8,041.38 <sup>c</sup>
AF-NGA-34	PPFN	05/12/89	08/12/89	17,077.00	15,479.25 <sup>c</sup>
AF-NGA-36	MPP	07/22/89	07/21/90	12,835.69	12,835.69 <sup>c</sup>
AF-NGA-37	NCPA	12/01/89	11/31/91	107,911.00	0.00 <sup>c</sup>
AF-NGA-38	Priestman	12/15/89	06/15/89	12,692.00	0.00 <sup>c</sup>
AF-NGA-39	NERDC	01/01/90	12/31/91	133,870.00	0.00 <sup>c</sup>

<sup>a</sup> Funded under Cooperative Agreement No. DPE-3004-A-00-2018-00

<sup>b</sup> Funded under Cooperative Agreement No. DPE-3004-A-00-6057-00

<sup>c</sup> Funded under Contract No. 620-0001-C-00-8013-00 (FHS)

have focused on the production of a RAPID video and on the production of a record and music video by Sunny Ade and Onyeka Onwenu ("Choices" and "Wait for Me") promoting family planning. The RAPID video has been distributed to the national and state television stations to be aired particularly in conjunction with the launching of the national population policies in each of the states.

A proposal is pending for the NCPA to develop inserts on population and family planning to be included in a popular national Nigerian magazine. The IEC component is also working at the national level to incorporate family life education into school curricula through the National Educational Research and Development Council (NERDC), and in training master trainers in counseling skills. It is planned to integrate the latter into public sector clinical training.

At the state level, the IEC component is working with the state level family planning coordinators and their staff in the state ministries of health. Comprehensive IEC proposals are developed by the FPC, with some technical assistance from the IEC component personnel, and submitted for review, revision and eventual approval by the IEC contractor and USAID. These comprehensive plans include activities in all communication sectors of the state: mass media (radio, television); folk media (traditional dramas, songs); public awareness (posters, leaflets, cloth materials); and commercial (development of jingles). Another major part of IEC state-level projects is training in counseling skills.

An important aspect of the FHS/IEC component is the importance given to evaluation of IEC interventions, both in terms of changes in attitudes and knowledge, and in clinic attendance. Results of such evaluations have shown an effect on knowledge, attitude and practice of family planning. The evaluation of IEC interventions is not an easy task, and the FHS/IEC component should be commended for its efforts and encouraged to continue them.

### **5.3.2 National Program**

#### **Strengths of the National Focus**

- 1) Although institutional development of national institutions for IEC is a difficult task, the IEC component has begun to make progress in this area. Strengthening the capability of PPFN to undertake IEC activities nationally and through its state branches is a well-conceived approach and could possibly provide a national base for family planning IEC.
- 2) The record and music video concept is a good one. It has proven successful in other countries (the Philippines and Mexico) where, under the rubric, the "entertainment education" strategy, it has incorporated a range of follow-up activities. In Nigeria, this approach should also work well. Plans are being developed to give more attention to the promotion of the record and video. The IEC contractor is experienced in this type of promotion and could provide the technical assistance to capitalize on the success to date.
- 3) The family life education curricula development activities have been effectively integrated into the on-going work of the NERDC. The IEC component has collaborated with UNFPA, which is also providing technical assistance to the NERDC for curricula development, to ensure that its assistance will be complementary.
- 4) The counseling training modules developed by the IEC component are of a high standard, and, particularly when the planned integration with the ongoing training

of the public and private sectors takes place, should increase the quality of service provision. Good counseling skills are necessary if informed choice (i.e., the client knowledgeably selecting among the various methods of family planning that are available) is to become a regular feature of family planning service provision in Nigeria.

#### Constraints in Nationally Focused IEC

- 1) To date, very little IEC activity has begun in the private sector or through the FHS/private sector component. This lack of cooperation has retarded nationwide advertising (see Section 5.2 above). The FHS/IEC component has access to very reputable advertising and marketing firms (e.g., the firm that helped develop the Blue Circle approach in Indonesia -- see Section 5.2) that could provide the technical assistance necessary to get commercial advertising for family planning off the ground. Such technical assistance, even though expensive, is vital if a well-conceived IEC/advertising approach for family planning is to be developed.
- 2) The IEC component recognizes that the cultural and ethnic diversity in Nigeria represents a constraint to the development of a nationally focused IEC strategy for family planning. The activities that require a national orientation -- e.g., the logo, the record and music video, the curricula development -- require careful planning, whether in the public or private sectors. Except for these, however, the IEC component conceptualizes its IEC initiatives on a zonal and state basis. This is a wise strategy.
- 3) The development of national, zonal and state activities has been constrained by a lack of IEC component personnel. Currently, the IEC component staff spends most of their time on administration, financial management and bureaucratic activities. Little time is left to provide assistance to ministries and NGOs in the development of projects. With the recent appointment of two zonal IEC officers, this should change to some degree. Lifting the bureaucratic burden of the IEC component Project Director by detailing some of the administration and financial aspects of the component to a planned additional staff member may also provide him more opportunity to provide technical assistance.

### 5.3.3 State-Level Programs

#### Strengths of the State Level Strategy

- 1) The IEC component contractor has developed a very useful project development manual for FPCs and their staffs to assist them in developing the first draft of their IEC proposals. Although these proposals may be amended by IEC component staff, the state ministries of health are clearly ultimately responsible for the proposals.
- 2) The objectives of the state-level plan are twofold: 1) institutional development, so that when the state project is completed, the capability to continue the work will remain through existence of trained communication staff, established linkages among communication sectors in the state, and mechanisms for evaluating and monitoring the effects of IEC; and 2) the detailing of how the project is to effect changes in family planning information and practice. To accomplish these objectives, a great deal of technical assistance and training are required, since there is little expertise in IEC strategic planning within the states. Although such technical assistance and

training are expensive and time consuming, if the institutional development objective is to remain, then the commitment of resources is appropriate.

- 3) Considerable cross-fertilization of ideas is taking place: states that have already implemented their projects are visited by ministry of health personnel from other states in order to learn how to develop their own state-level projects.
- 4) The IEC component recognizes the individuality of the different states and takes care to ensure that content, language, and media used in each state are appropriate in that context. This helps to assure that the particular sensitivities to family planning in the different states are taken into account.

#### Constraints to State-Level Strategies

- 1) The lack of coordination of the IEC component with the public and private sector components in the development of state-level programs is a major deficiency. In particular, it has not always proved practical to begin IEC state level activities in places in which there are no trained public sector service providers and equipped clinics, although attempts are made to do so.
- 2) As stated previously, the lack of IEC component staff to assist family planning coordinators in developing and implementing the program has been a problem, but it may soon be solved with the hiring of two zonal officers.

#### Recommendations:

43. **The IEC component should take immediate action to follow-up on the success it has had from the record and music video, "Choices" and "Wait for Me."** The "entertainment-education" strategy should be used to initiate the full range of follow-up activities in Nigeria. Technical assistance from the contractor will be required and should be provided as soon as possible to capitalize on this successful beginning.
44. The IEC component should also work closely with FHS/private to take advantage of an advertising follow up to the music video in the private sector, as well as the public sector. This might involve using spots from the videos in advertising or working with the recording artists and FHS/private to make new advertisements. The point is to take every possible opportunity to gain exposure of the music and video in advertising, private sector and public sector.
45. The family planning logo developed by the FMOH's Health Education Bureau should be incorporated into the strategy to market the record and music video. It will be important to include this well-done logo in advertising and IEC endeavors undertaken by the project.
46. State-level IEC plans should include a section on how the IEC components are expected to be coordinated with public and private sector training and service delivery. To facilitate coordination, state-level planning of the private, public and IEC components should be done together and should involve the state FPCs, their staffs, and other relevant MOH officers in the states, e.g., PHC coordinators.

**Table 12**  
**Policy Component**  
**Project Outputs**

End of Project Status Requirements	Output Status
<p><b>1. Strategic Planning</b></p> <ul style="list-style-type: none"> <li>● TA to MOH and other ministries to refine planning process</li> <li>● TA to state FP planners to evaluate and refine policies, action plans and programs</li> <li>● Sponsor 13 strategic planning workshops for state and LGA planners</li> <li>● Financially support evaluation team to review policy implementation process</li> <li>● Organize and financially support annual strategy planning "summit" meeting</li> <li>● Support indigenous groups to utilize data for policy planning</li> </ul>	<p>TA is being provided to the FMOH/Department of Population Activities (DPA), the FMOH/Department of Planning, Statistics and Research (DPSR).</p> <p>Fact finding activity to begin in Ogun State on Dec. 3</p> <p>Hiring local consultants to work with FMOH/DPRS on plans for state HIS programs</p> <p>First workshop in Kano in May 1989. Two additional workshops planned for early 1990.</p> <p>To be arranged for 1990</p> <p>DHS further analysis group to work with FMOH/DPA met on October 30. Three meetings to be sponsored.</p>
<p><b>2. Fiscal Planning</b></p> <ul style="list-style-type: none"> <li>● 5 simple, innovative cost recovery pilot surveys</li> <li>● Adapt RAPID-type cost/benefit models of FP</li> <li>● Provide assistance to indigenous leadership group to conduct at least 20 state-level cost/benefit seminars</li> <li>● Commission a financial diagnostic study of FP in selected states</li> </ul>	<p>Terms of reference under preparation</p> <p>Work on RAPID modifications is under way. Final product is expected in Nov. 1990</p> <p>Support has been given to NCPA to hold 3-4 seminars during year two. One lecture and one state level seminar have been held.</p> <p>Terms of reference issued. Proposals received from Coopers &amp; Lybrand, BEMS and Highfield Assoc. Study scheduled for commission in Nov. 1989</p>
<p><b>3. Constituency Building</b></p> <ul style="list-style-type: none"> <li>● 7 national 3-5 day workshops for 420 leaders</li> <li>● 30 regional 2-5 day workshops for 740 leaders</li> <li>● 125 state and LGA 1 day seminars for 1,750 leaders</li> <li>● Other</li> </ul>	<p>Two workshops are being planned with PPFN. These will be for 66 leaders targeted for January 1990.</p> <p>Workshops are being planned with PPFN, NCPA and the Nigerian Women's Association</p> <p>Seminars are being planned with NCPA and PPFN</p> <p>Development of mailing list of key constituency groups and leaders. Activity is part of subproject with NCPA.</p>
<p><b>4. Institutional Support</b></p> <ul style="list-style-type: none"> <li>● Provide TA to administrative and consultative groups</li> <li>● RAPID sector-specific models</li> <li>● Trend monitoring</li> </ul>	<p>TA is being provided to the FMOH/DPA, FMOH/DPRS</p> <p>TA provided to the FOS to develop and include a FP module in its national household capabilities survey program</p> <p>Work is under way on RAPID revisions. Revised RAPID due.</p> <p>Trend monitoring activities and reports prepared</p> <p>Family planning facilities directory compiled. Final version to be printed by NCPA.</p>

**5.4 Policy Component**

**5.4.1 Overview**

**Objectives**

The objective of FHS/policy is "to strengthen processes of policy implementation and strategic planning needed in Nigeria for efficient mobilization of public and private sector resources into a dynamic, effective and self-sustaining national family planning program." In order to realize this objective, Policy implementation identified the following five general categories of project activities, namely:

- 1) Strategic planning
- 2) Fiscal support
- 3) Constituency building
- 4) Institutional support and
- 5) Program evaluation and feedback.

Outputs planned under these categories and outputs achieved by November 1, 1989 are provided in Table 12 (above).

**Contractors**

To carry out these activities, The Johns Hopkins University, Institute for International Programs (JHU/IIP) was contracted by A.I.D., which subcontracted for some activities with Africare. Actual implementation of activities is through Nigerian subcontracts (see Table 13 for a list of subcontracts issued to date).

**Table 13  
Policy Component  
Contracts**

<b>Subproject Identification Number</b>	<b>Description</b>	<b>Beginning Date</b>	<b>Ending Date</b>	<b>Total S's</b>
H.51.7550.08/DPA	Support to DPA/FMOH further analysis group for DHS/FPQ reviews	11/15/89	12/31/90	13,616
H.51.7550.01/NCPA	Operational support for NCPA	04/01/89	03/01/90	53,000
H.51.7550.07/DPRST	Support to DPRST/FMOH for information	09/01/89	05/31/89	8,500
H.51.7550.03/AFRICARE	AFRICARE support for some policy activities	04/01/89	12/01/92	<u>267,840</u>
			<b>Total</b>	<b>342,956</b>

### **Strategy**

The Draft Workplan for Year 2 of FHS/policy contains plans for several programs to be implemented under the five groups of activities. These include provision of technical assistance to develop the capacities of federal and state officials to evaluate and refine state policies and action plans. Assistance is also planned for FMOH and NGOs to adapt and utilize data from the public and private sector. MIS and fiscal planning, including a financial diagnostic study to be done by contractors, will also be undertaken. Also, activities in constituency building, policy trend monitoring, and institutional support to various organizations are planned.

FHS/policy started its activities late. The Country Representative and the Program Officer were hired only in 1989. The contractor also indicated that home office resources had been absorbed by the annual USAID procurement bidding season.<sup>2</sup> These constraints explain the paucity of program output to date.

#### **5.4.2 Strengths**

FHS/policy has become the research, evaluation and monitoring component of the FHS project. In research and evaluation, progress has been good, as is evident from the following accomplishments:

- 1) Technical assistance has been provided to the Federal Office of Statistics (FOS) to conduct the national DHS survey.
- 2) A Family Planning Questionnaire (FPQ) module has been developed for inclusion in the annual rounds of the National Integrated Survey of Households (NISH) conducted by the FOS. The FPQ will be tested in a pilot survey scheduled for January 1990.
- 3) A further analysis group has been identified to review the DHS questionnaire and the FPQ and plans drawn up for detailed analysis of data to be generated by these surveys.
- 4) A survey of clinic facilities has taken place and training registration reports compiled under a subcontract to Africare.
- 5) The National Council on Population Activities has been contracted to compile a directory of service points.
- 6) A study has been proposed to examine how cost recovery programs in FP could affect the program and modifications have been made on the RAPID program.
- 7) Technical assistance has been proposed to assist in the preparation of annual action plans and program strategies for family planning coordinators.

According to the initial plan, the National Population Commission (NPC), with FHS/policy's assistance, would carry out a survey baseline (Sentinel) survey covering approximately 500 women in the urban and rural areas of four states. This will not be necessary, however, because the nationwide DHS survey will provide information on retrospective fertility histories, use of modern contraception and traditional methods, source of supply for users, related knowledge and attitudes, contacts with health services and more. Policy's input into DHS will make it possible

---

<sup>2</sup>Project Implementation Report, November 1, 1989.

to generate relevant state-level data (e.g., contraceptive prevalence). The DHS will provide necessary baseline data for future project evaluation.

The policy component is also supporting a further analysis working group of Nigerian demographers and policy makers to provide guidance to ensure that the DHS provides policy and program relevant information. In addition, analysis of periodic data from the FPQ module will provide quick indicators of population needs and project implications and will facilitate planning for appropriate responses.

Policy is already engaged in very important project monitoring activities, namely:

- 1) Monitoring and evaluation of the population environment, particularly the public and political environments, through analysis of newspaper, radio and television news. These analyses will result in an annual summary of policy developments which should serve as a useful input for the activities of the other components of FHS.
- 2) Monitoring of overall family planning program achievements through key indicators (e.g., contraceptive acceptors and types of methods) that provide inputs for calculation of indices such as continuation rates and CYP. Compilation of these data offers the single most important quantitative evaluation of overall performance of all FHS components.

In addition to its roles of research, evaluation and monitoring, FHS/policy provides TA to FMOH, and especially to its Department of Planning, Research and Statistics (DPRS). Institution building for DPRS is to be designed to increase its capability to serve other departments of FMOH. Currently MIS data go to the PHC and then to DPRS. In addition, policy's work with the DPRS may lead to the provision of assistance in establishing state MOH/FP planning guidelines. Institution building for FMOH is geared to helping it become a major resource center, housing a population library and other facilities. This will enable DPA to become a central point for further analysis of data.

These institution-building efforts are being well received by FMOH. Additional resources will be required to achieve the long-range plans of these departments, but policy will have provided the critical initial inputs to allow for future expansion.

**Recommendations:**

47. FHS/policy should continue with its proposed research activities.
48. TA to DPA and DPRS should be continued, not only in the name of institution building, but also to help both DPA and DPRS prepare proposals to other donor agencies to support future expansion.
49. Policy should continue to provide TA to DPA to refine the draft workplan on the Implementation of Population Programs into specific action programs for states and LGAs.

## **5.5 Administration and Logistics Component**

The objective of this component is to provide comprehensive administrative and logistical support for the four technical components and the Project Administrator to facilitate the implementation of project activities. Its responsibilities are to provide

- 1) Office space
  - furnishings, equipment and supplies
  - maintenance
- 2) Office administration
- 3) Monitoring assistance for contraceptives
- 4) Comprehensive transport system
- 5) Coordination for project meetings, workshops and conferences, and
- 6) Zonal office support.

To carry out this component, The African American Institute (AAI) was awarded a two-year contract, with the anticipation that the contract would be renewed upon satisfactory performance for another three years. Sweethill Associates provides facility and equipment support in Nigeria. Major contractual issues are referred to AAI headquarters in New York, while day-to-day issues are handled on site by AAI and Sweethill staff.

USAID has officially informed AAI that it is highly satisfied with the work of AAI/Sweethill Associates and that it intends to continue its contract.

This component should be given high marks for providing the competent and professional services essential for supporting an efficient administrative and logistics system and thus helping to ensure effective project performance. Systems and procedures have been developed, staff hired, and equipment and supplies have been purchased and delivered close to plan. Although there is generally room for improvement in providing supplies and equipment, this component has consistently provided logistics service in a timely and efficient fashion.

A challenge awaiting this component in the next year is the equipping of four zonal offices, which are to be provided by the FMOH. It is anticipated that these offices will house the zonal coordinators from the FMOH, FHS, and presumably other agencies dealing with PHC and family planning and thus will serve as a venue for better planning, coordination and monitoring of efforts in the four zones.

**Recommendation:**

50. USAID and the FMOH should extend the contract with AAI/Sweethill Associates, as planned.

## **Part II**

### **Functional Analysis: Future Directions (Chapters 6 - 10)**

## **6. Service Delivery**

## 6. Service Delivery

### 6.1 Coverage

#### 6.1.1 Service Delivery Points

One of the major project goals is to increase the number of service delivery points (SDP) at which FP services can be obtained. The project strategy has been to begin by focusing on increasing the number of urban SDPs and SDPs in 52 model LGAs where transportation, supervision and commodities are most accessible and awareness of modern methods of contraception highest.

#### Public Sector

A majority of FP services are offered within the primary health care system of state owned hospitals, clinics and health posts. Prior to this project and its USAID sponsored predecessors, few clinical sites excluding training institutions were adequately equipped, staffed, and supplied with commodities to provide a full range of FP services. Since the project's start, at least two clinics (one rural, one urban) per LGA in each of the states have been adequately supplied, staffed and equipped to provide complete clinical FP services. Non-clinical services are available in up to one-third of the remaining clinical sites. Urban areas and states in Zones A and B tend to have more trained personnel and equipped facilities than do rural areas and states in Zones C and D. It is appropriate, however, for the early project focus to be on areas of higher population density and areas in which the population has already had exposure to FP information and services.

#### Private Sector

Although the majority of SDPs are in government facilities, about 40 percent of SDPs are in private hands, either mission-run or for-profit private practitioners. Remaining private sector health services are delivered through private hospitals and clinics throughout Nigeria. Full-service FP sites may consist of private hospitals, clinics and maternity homes which vary in number by state and population density. Their development as SDPs for FP cannot be assessed at this time since the in-service training of the initial sets of private sector providers has just been completed and most of these trainees have not yet been supplied with commodities (see Section 5.2). Other cadres such as transportation workers, mechanics, market vendors, pharmacists, pharmacy attendants, patent medicine dealers, and storekeepers have been trained and equipped to sell condoms and foaming tablets.

#### 6.1.2 Use of Services

Although there has been a significant increase in use of urban sector SDPs equipped and staffed through the project, a number of factors outside the control of the project may also affect clinic utilization. For example, family planning services in urban public sector SDPs are typically provided separately from other PHC services including MCH, an approach that may decrease attendance. Clinic hours vary, and FP services through public clinics are often limited to weekday and daytime hours, also discouraging use. In addition, clinic use by individual clients may be inhibited or unnecessarily frequent due to their inability to pay for sufficient contraceptive supplies and services. The fee structure, or lack thereof, varies by government authority. How this affects acceptance rates is not known.

Private sector clinic hours, by contrast, are generally longer and include weekends. Use of these services has yet to be evaluated.

With the growing availability of SDPs in both the public and private sector, a recent FHS survey on the use of modern contraception in three Nigerian cities found that 47 percent of the sample was currently reporting FP practice. Of the 1,031 respondents, 19 percent used pills, 19 percent condoms, 6 percent foaming tablets, 3 percent safe period, 1 percent IUCDs, and 53 percent none (Research and Marketing Services, *Usage and Attitude Study*, August 1989). Rural population use of FP can be assumed to be much lower. Recent Africare survey data indicate that FP clinic volume varies from none to high across the country. Mean client volume per clinic per week was 23 clients. Only one clinic per LGA was surveyed. By far the biggest demand for service appears to be for child spacing or among older women seeking to avoid health risks and costs associated with an additional high parity child.

**Recommendations:**

51. FP services should be integrated into MCH services whenever possible to eliminate the need for a client to use more than one provider for service.
52. Hours of service at public sector clinics should be extended to include some evening and weekend hours.
53. An operations research study should be undertaken to ascertain the effects on acceptance rates of charging for contraceptives in public clinics as compared with providing them free. This would help to establish guidelines on fee-for-service for family planning.

**6.2 Quality of Services**

**6.2.1 Assessment**

**Public Sector**

If the quality of public sector services can be assessed through the brief observation of a small sample of FP staff working in urban FP training or model PHC facilities, then quality can be described as very good. Few complications associated with various methods were reported. A system of referral and follow-up for managing complications was in place.

Commodity supply was often uneven. Concerns have also been voiced that where commodities such as IUCD kits are available, untrained individuals may be trained on the job to perform technical procedures beyond their ability, or that unsterile equipment may be used because of lack of time or knowledge. Oral contraceptive availability is also a concern because of data describing urban pill users' lack of information regarding correct pill use (Research and Marketing Services, *Usage and Attitude Study*, August 1989). Multiple brands of a single method (such as injectables or pills) in a single clinical facility tends to lead to brand switching and confusion.

No further evaluation of service quality or client satisfaction has been completed to date.

**Private Sector**

Because FP service sites visited were new, no client care was observed. Staff interviews and site observation revealed a range of results -- low- to high-quality service availability.

**Recommendation:**

54. An evaluation should be undertaken to assess a spectrum of factors including quality of FP service delivery, availability of clinics, client satisfaction with care, and understanding of current use of selected method.

**6.2.2 Quality Assurance**

Supervision of staff in both the public and private sectors for the purpose of maintaining program quality and delivering commodities is accomplished separately by sector. The effort is often hampered by transport difficulties, long distances to be covered, few supervisors (typically only one per LGA), and impassable roads. Supervisors often are not fully aware of how to identify systematically areas needing attention. Although a single system of supervision and commodity supply would be preferable, the government is not prepared at this point from a staffing, logistics, or fiscal point of view to implement such an approach. If sustainability of private sector family planning in the future is envisioned, plans regarding government assumption of these tasks, at least in some parts of the country, will be necessary.

A standard clinical protocol manual for FP is being created through the project. Once it is completed and field tested and staff are trained to use it, the manual will provide a firm basis for training and supervision of FP personnel. Since reference material is not widely available at the clinic level, these manuals should provide the necessary information regarding the management of common contraceptive side effects to those who read it. This will be particularly useful since no uniform system exists for the follow-up of complications associated with contraceptive use and defaulters. Although complication data are typically collected in the clinic registration book at each clinical site, private sector supervision of clinical staff is just beginning within the project and is too new to evaluate. It is not done for all trainees and should be. Evaluation checklists, however, have been designed and are in place where private sector monitoring has begun.

**Recommendations:**

55. Provision should be made for the uniform supervision and follow-up of trainees and staff at their FP work-sites whether public or private. FPCs and state-level FP supervisors should be encouraged to spend time during supervisory visits observing and assessing key clinical skills of all FP staff, i.e., IUCD insertion, client counseling regarding method contraindications, side effects and use. If there are gaps in service provision of a more general nature, these need to be identified by the supervisor and refresher training programs initiated.
56. A standard FP quality assurance checklist should be prepared for supervision of both public and private sector staff.

## **7. Training and Technical Assistance**

## 7. Training and Technical Assistance

### 7.1 Training

#### 7.1.1 Need for Training

There are at present approximately 6,000 trained FP workers in Nigeria or about 10 per LGA. In the public sector, these personnel include physicians, general nurses, nurse midwives, community health extension workers and volunteers. In the private sector, in addition to the above cadres, transport workers, gas station attendants, market women, pharmacists, pharmacy attendants, patent medicine dealers, and storekeepers have received brief training in the sales and use of barriers methods.

In the public sector, decisions regarding deployment of personnel do not always take into consideration whether an individual has received FP training. In addition, staff transfers, retirement and promotion all result in loss of personnel to the FP network. This is particularly true of nurse midwives, although in their case, the need for remaining competent in their other skill areas provides a sound professional justification for some transfers.

In short, there remains a great shortage of personnel to reach targeted clinics, particularly in the north and rural areas, let alone to cover a significant proportion of the population. For example, in Benue and Plateau states, most clinics are staffed with only one or at most two trained nurse midwives plus some others who claim that they were trained on the job.

#### 7.1.2 Project Approach

##### • Training under the Four Project Components

Each of the four prime contractors has a training component within its overall strategy, as follows:

- Public Sector. The public sector component's main focus is training, and the four types of training being provided are discussed in full in Section 5.1.
- Private Sector. A major thrust in the private sector is training of nurse midwives in FP, together with -- at least in some cases -- provision of contraceptives. In addition to this clinical aspect, groups of locally based distributors mentioned above (e.g., patent medicine storekeepers, gas station attendants, etc.) are being trained through the project.
- IEC. FHS/IEC has a strong training component. As discussed in Section 5.3, it includes IEC TOT to incorporate family life education into school curricula and training master trainers in counseling skills. In addition, staff have been trained in technical aspects of IEC (script writing and radio) and nurse midwives and extension workers have been provided some training in materials development.
- Policy. A number of workshops for LGA leaders and other groups is planned.

It is difficult for contracts to coordinate all training efforts. For example, public sector training efforts do not always keep pace with IEC efforts to prepare states for acceptance of FP. In some states (e.g., Kaduna, Benue, Plateau, and Bauchi), the population seems very receptive to increasing the level of contraceptive use, but there is a shortage of service providers

to meet the demand. Moreover, training efforts could also be better coordinated with government bodies. This is particularly true of the private sector component, in which collaboration with federal, state and local governments, in particular state planning coordinators, is weak to nonexistent.

### Project Training Objectives

Together, the four components have these overall training objectives:

- Provision of administrative, clinical, and educational personnel to plan, educate, implement and evaluate basic family planning services in public facilities from teaching hospitals to basic dispensaries; training of community leaders, representatives of women's groups, and teachers;
- Training of more than 10,000 individuals in both the private and public sectors; and
- Training of all levels of personnel in communication skills.

## 7.1.3 Training Approach

### Curriculum Development

Each component has developed its own curricula to satisfy its individual training needs. All public sector service provider curricula were developed by a single group of in-country trainers. These are competency-based. As a result, the length of training will vary according to trainees' needs identified by the pre-training assessments. The management curriculum was developed by MSH consultants in collaboration with in-country trainers. The private sector curricula also were developed by in-country training officers, but with external technical assistance through TOT workshops held in Ogun and Kaduna states. The IEC counseling and materials development curricula were developed by PCS staff, subcontractors and participants during TOT workshops and adapted by the private and public sectors.

FMOH and FHS/public sector are currently undertaking an effort to standardize all curricula being used by public sector staff. The private sector is not involved in this effort. State-level trainers are not being asked to participate.

### Technical Assessment

Each curriculum is based on accepted teaching/training principles and includes segments on teaching methodology, lesson plans, course objectives and contents, principles of adult learning, time tables, and evaluation methods.

On the other hand, course length has varied and no effort has been made to ensure that training for the various cadres is uniform from one component to another. Supervision of trained staff and their opportunities for continuing education have also been uneven. In general, continuing education workshops are not available.

All project components employ training officers to ensure that training activities are of high quality. These training officers monitor and evaluate training sessions, most of which are carried out by a network of state-level in-country trainers. An attempt has been made by the FMOH and FHS/public to review and standardize the curricula in order to develop national curricula for the different cadres of personnel in order to assure quality. There is, however, very little involvement in this effort by state trainers.

Another issue is that materials are often lacking. This is true for all types of training activities. In addition, no reference materials are provided that trainees might keep and use on-the-job in future.

#### **7.1.4 Clinical Training**

Curriculum content for the training of clinical nurse midwives is not uniform. Some public sector institutions are conducting training for eight weeks, some for seven, and some for six, whereas the private sector training period lasts only five. In the public sector, trainees are required to observe 5 IUCD insertion and to insert 10 (the accepted practice of the FMOH), while in the private sector, with a shorter training period, trainees must both insert and observe 10 procedures. Variations of course length are said to be justified by the wide variety of trainee backgrounds, which in turn arises from lack of any uniform entry criteria for training. Entry qualification into some of the basic training programs for nurses is general nursing, while in some others, it is a nurse midwife or midwifery background.

It is evident that the five-week training for nurse midwives provided through the private sector is too short. Trainees have insufficient time to perform the required 10 IUCD insertions during the three weeks allotted for practical training. Furthermore, trainers in the private sector do not always have basic skills in family planning. Another shortcoming of the briefer time span is that it does not always contain segments on such critical subject areas as MIS, clinic management, client counseling, and IEC training. Such skills are necessary for offering quality service, and their absence can compromise the quality of FP practice. The only alternative in many cases is to learn these skills in a separate course, but such courses are not always available.

The standard clinical protocol manual now under development should also serve to improve the overall quality of clinical training (see Section 6.2.2). Nonetheless, it will remain true that even if a clinician has received excellent training in FP, he or she must be updated periodically to learn new information.

#### **7.1.5 Other Types of Training**

##### **MIS training**

As part of the public sector component, FPCs and their assistants have been trained at the state level in various aspects of FP and health care management, including how to use the new MIS. As yet, however, these cadres do not appear to have adequate understanding of how to interpret clinic-level data for planning, implementation and evaluation of their programs. The FPCs and their assistants are also expected to train clinic staff to use the MIS. At these point, few have conducted state-level training. This, plus the staff reassignments that are endemic to the system, has meant that many service providers do not understand the MIS.

##### **Training of market women**

The Jos market women project has trained market women to sell non-clinical methods of contraception. The training curriculum had some design flaws, and too little effort was made by the SMOH to coordinate and monitor the effort. In future efforts of this type, more involvement of the FPC and her training officer might improve the training, heighten the interest of private sector field supervisors, and contribute to the ultimate viability of the type of program.

### Community volunteers

To supplement the clinical and non-clinical SDPs, LGAs in some states have instituted the training and use of community volunteers to dispense condoms and foaming tablets and to make referrals to clinical facilities. This training represents an effort to reach the unserved rural population. Much more needs to be done to reach this population with FP information and service however.

### Recommendations:

57. In planning for its third-year work program with the government, the project should give top priority to ensuring better collaboration in training among the FHS project components.
58. More attention should be focused by FHS/public on the training of service providers in states that appear ready to increase use of FP.
59. Uniform course curricula and course length should be established for each cadre of FP personnel. These should be standard for both public and private sector cadres.
60. The national curricula standardization exercise now going on between FMOH and the FHS/public sector should be expanded to include the FHS/private sector. This would ensure compliance with the recommendation above. Allowance should be made for minor differences to take into account that the private sector deals with commercially oriented providers.
61. The involvement of state trainers in the curricular review exercise for all FP cadres should be encouraged.
62. FMOH should continue to provide training and monitoring guidelines to the states but should not be actively involved in state or LGA training activities.
63. Adequate training materials should be made available for all project training activities. Reference materials to be taken home by the trainees for their use in practice should be provided, e.g., the clinical protocol manual.
64. Uniform entry requirements should be instituted for all clinical in-service training programs for the public and private sectors.
65. Candidates for clinical skills TOT training should already have received full training in clinical skills.
66. The length of time for clinical training should be standardized -- preferably at seven weeks.
67. All subjects necessary for the delivery of quality FP services, i.e., clinic management, counseling, IEC, and MIS, should be included in the basic clinical FP course. The course should also use the standardized clinical protocol manual, once this has been completed.
68. Refresher courses should be organized for service providers after three years of practice by both public and private sectors. This might be accomplished through reprogramming training funds as needed.

69. Considerably more emphasis should be placed on training all levels of staff to use and understand the MIS. This should include training in all procedures involved (e.g., filling out the client card forms properly) as well as providing explanations as to the role MIS should play in client and clinic management. When the integrated PHC/FP MIS forms are available, all FP clinic staff should be trained to use them.
70. A standard curriculum should be developed for private sector market based training activities, e.g., Jos market women project. Both training and service delivery activities projects should be supervised by the SMOH staff to assist in promoting sustainability.

## 7.2 Technical Assistance

The FHS project, to a very large extent, is a funding mechanism that subcontracts project activities to Nigerian government entities, private non-profit organizations, and private, for-profit organizations. Of necessity, the Lagos-based staff of the components spend most of their time in administration and development of the project's subcontracts, with little time left for technical monitoring and provision of technical assistance.

An estimate of the person days generated by FHS from the beginning of the project until October 31, 1989 was computed (see Tables 14 & 15). In terms of provision of consultant technical assistance provided in Nigeria over this period, this analysis shows that only 4 percent of FHS's total effort has been spent to date for technical assistance (1 percent for Nigerian consultants and 3 percent for expatriates, including technical assistance and on-site project monitoring).

This level of effort appears low in terms of the magnitude and diversity of activities being carried out under the project. Developing country experience has demonstrated that the kinds of innovation being introduced in this project (e.g., introduction of modern logistics systems, MIS, IEC, marketing) initially require substantial inputs of technical assistance from individuals who are thoroughly acquainted with these technologies.

There also appears to be an issue as to whether sufficient effort has been made to enlist the services of Nigerian technical expertise. Particularly in the private sector, no local consultants have been utilized, although there appears to be ample expertise in this area (see Section 5.4). FHS is developing a Nigerian consultant roster, to help identify the national consultants more easily. It should be commended for this effort.

### Recommendations:

71. In the development of all FHS subprojects, technical assistance requirements should be taken into account. If Nigerian expertise is available (e.g., from business, labor, or universities), such expertise should be used. If not, expatriate consultants should be contracted to provide the requisite technical inputs (see Section 5.2.4).
72. In particular, expatriate consultants are needed in some specialized training areas, e.g., IEC, operations research, and advertising and market research. Consultants should work closely with Nigerian consultants and assist them in the development of these special skills.

**Table 14**  
**Estimated Person Days Generated By FHS**  
**(April 1, 1988 thru October 31, 1989)**

Component	FHS Staff in Nigeria	Subprojects in Nigeria	Consultants in Nigeria	Consultants From Outside Nigeria	Days Outside Nigeria	Total Days
Admin/Logistics	11,615	9,752	375	181	943	22,866
IEC <sup>a</sup>	1,995	4,499	271	820	2,996	10,581
Policy Implementation	229	196	48	181	428	1,082
Private Sector	870	52,760	0	848	1,188	55,666
Public Sector	1,876	1,516	603	1,098	218 <sup>b</sup>	7,276
Administrator	465	-	-	-	-	465
	<u>17,050</u>	<u>68,723</u>	<u>1,297</u>	<u>3,128</u>	<u>7,738</u>	<u>97,936</u>

<sup>a</sup> The IEC component calculations are based on the time period April 1, 1988 thru December 31, 1989.  
<sup>b</sup> Pathfinder "Days Outside Nigeria" time is estimated to be 30% of its total person days.

**Table 15**  
**Percent Distribution of Estimated Person Days Generated by FHS**

Component	FHS Staff in Nigeria	Subprojects in Nigeria	Consultants in Nigeria	Consultants From Outside Nigeria	Days Outside Nigeria <sup>b</sup>	Total Days
Admin/Logistics <sup>a</sup>	51	42	2	1	4	100%
IEC	19	42	3	8	28	100%
Policy	21	18	4	17	40	100%
Private Sector	2	95	0	1	2	100%
Public Sector	26	21	8	15	30	100%
PSC	100	0	0	0	0	100%
	<u>17 %</u>	<u>70 %</u>	<u>1 %</u>	<u>3 %</u>	<u>8 %</u>	<u>100 %</u>
Total FHS Project	17 %	70 %	1 %	3 %	8 %	100 %

<sup>a</sup> Source: FHS, December 1989.

Admin/Logistics figures (11,615) are for non-professional staff.

<sup>b</sup> Days outside Nigeria (7,738) include monitoring and backstopping.

## **8. IEC/Constituency Building**

### **8.1 National Attitudes toward Use of Contraceptives**

#### **8.1.1 Country-wide Views toward Contraception**

Strong pronatalist views are the norm in Nigeria. The average family has 6 to 8 children. Limiting family size is almost unknown. In some areas of the country, large family size is rewarded. Some groups in Nigerian society value having a certain number of male children per family. Some people feel contraception leads to infertility or promiscuity.

It has been estimated that only 2 to 5 percent of Nigerians use modern methods of contraception. Furthermore, traditional sexual abstinence and breastfeeding as a means of child-spacing are being abandoned and not being replaced with modern methods.

#### **8.1.2 Factors Affecting Use of Contraception**

A prime factor affecting use of contraception is the level of contraceptive knowledge. Project data (Research and Marketing Services, *Usages and Attitude Study*, August 1989) suggests this is fairly low. Findings include that in three urban centers of Nigeria, half the population is knowledgeable about modern methods of contraception such as pills and condoms, whereas other methods are less known: safe period (28 percent), IUCD (26 percent), injection (20 percent) and foaming tablets (17 percent). Economic pressure may affect use, notably leading to an increase the demand for services.

#### **8.1.3 Factors Affecting Methods Used**

Level of education, religious beliefs, desire for more children, and societal pressures all may shape attitudes and approval of various methods.

In some areas, sterilization is unacceptable due to a belief in reincarnation; in general, vasectomy has not been accepted by Nigerian men. On the other hand, voluntary surgical contraception for women is quite acceptable to some groups (some NKST mission hospitals are doing significant numbers of these procedures). Increasing preference for long-term methods such as the IUCD and injectables is occurring in both urban and rural areas. Injectables have been found to be popular in certain parts of the country -- perhaps due to desired secrecy regarding contraceptive use. Men may not be inclined to use condoms with their wives and may only use them to prevent STDs. Catholics may choose the Billings Ovulation Method exclusively.

Diaphragms are generally unavailable in the public sector due to a lack of acceptance of the method. Fitting rings were not observed at any public or private clinical site visited.

### **8.2 Implications for IEC**

The low level of knowledge of contraceptive use combined with some skepticism about contraceptive use provide a strong justification for increasing efforts to provide IEC through the project. The increase in use of contraception in areas in which the project has concentrated (see Section 6.1.2) suggests that there is considerable demand that can be triggered with an appropriate mix of IEC combined with service availability. If individuals know the benefits of FP and how they can obtain it if they want it, they may well become users.

Level of outreach and public information efforts vary by location and local commitment. Lack of coordination of IEC and service delivery activities is apparent in some locations. In some areas, demand may have been generated, but there is no nearby staffed and equipped clinic to meet that demand (see Section 7.3) and prevalence cannot increase. Longer term methods and sterilization are often less available in rural areas where there are fewer trained FP staff.

In other instances, the opposite is true. Indeed, in most states, IEC support for clinical services is grossly inadequate, and despite well-equipped facilities with adequately trained staff, the client loads in many of these clinics are very low. IEC activity outside of clinical facilities is critical particularly at the village level to increase awareness and method use. Some clinics, however, cannot carry out motivation campaigns because of shortage of trained staff. In Imo State, the family planning radio play series -- "Ezindu" -- was terminated after project funds finished.

### **8.3 Inclusion of Constituency Building in IEC Component**

Constituency building is written into the contract of the policy implementation component, but in reality this kind of work is better suited to the IEC component. For example, visits to the states (Benue and Plateau) revealed that they have begun constituency-building type activities -- i.e., seminars and symposia -- under their IEC components. Policy's efforts in this area would constitute duplication.

It is also difficult to justify (1) the need, in an effort at constituency building, for FHS/policy to get involved in certain types of financial support for NGOs such as funds for payment of staff salaries or for reconstruction or remodelling of rented premises; and (2) the creation, as now planned, of two similar population resource center libraries within metropolitan Lagos.

#### **Recommendations:**

73. IEC processes and products for the clinics and for motivating the community at large should be increased to generate sufficient clientele for already functioning clinics and new ones to be opened.
74. In each area where full service FP SDPs exist, intense locally appropriate IEC efforts should be made to inform the population of the benefits of FP.
75. IEC efforts must be made outside of FP clinical sites to make modern contraceptive methods known.
76. Policy should be discouraged from executing constituency building activities. Rather, **constituency building activities should be included in the IEC component.**

## 9. Evaluation and Research

### 9.1 Evaluation

#### 9.1.1 Management Information Systems

The policy component has responsibility for a range of data-gathering and evaluation-related activities that must depend on the data generated by the three other project components, e.g., sales data, commodity records, etc. None of these components has yet achieved the ability to generate very reliable data, and the data that are generated are not fully compatible.

#### Client Charts

The medical record system varies by clinical facility, public to private. No public site visited was without a system, but use of the data varied. In the public sector, service statistics are collected on the same forms that collect commodity inventory and utilization data (Form 1), the principal instrument for data collection. These forms are simple yet include client referral service and the minimum screening data required to assess candidacy for various method use, significant medical conditions, obstetric history, physical findings if assessed, defaulter data, and complications. The record format is systematic and easy to use. Use of this client data for ongoing client management and follow-up and for clinic level management, however, appears not to be not well understood (see Section 7.7).

The private sector facilities each have their own systems, and another FP record system is being introduced by the project monitors to the newly trained private sector clinicians.

#### Clinic Level Record Keeping

The availability of service statistics varies widely by state. Some states report a 70 percent return. Furthermore, accuracy of data is questionable. Data analysis is by hand.

#### Issues

In more detail, the problems with the current clinic-based MIS are as described below.

- 1) Because the private sector does not use the client card (Form 1), there is no consistency between the information from the public and the private sectors.
- 2) State MOH officers do not all use the same data sources to prepare Form 3, which provides monthly returns of acceptors and methods. Some use more initiative than others to ensure comprehensive reporting. For example, in Plateau State, the state MOH MIS Officer includes in her monthly returns acceptors in state-owned clinics, PPFN clinics, army, air force and police clinics and market outlets under the Jos market project. This contrasts with returns from Benue, which cover only state-owned clinics.
- 3) Collection of data on all methods of contraception does not occur routinely. A significant omission is data on surgical contraception, because this is viewed as the "property" of AVSC. Other providers, including AVSC and PPFN, normally tally up client data for their own uses, but this should not prevent them from then routinely providing these forms to FHS/policy for compilation and further analysis.

- 4) Forms from the state level are often late, making timely central-level tabulation very problematic.
- 5) State officers complained of a shortage of forms, particularly of Forms 2A and 3. This shortage may have been due to the delay in approval of the Integrated MIS form by the FMOH.
- 6) The difficulty in providing adequate staff supervision to ensure quality control was discussed in Chapter 6. These same staff are responsible for overseeing commodity supply during their trips, and the same constraints of lack of transport, time, and staff also result in difficulties in adequate oversight of commodity supply.
- 7) FHS/private does not routinely collect information on sales records from commercial outlets.

#### **Recommendations:**

77. It is essential that an MIS be developed for the project that consolidates in a consistent fashion data being generated from the other project components. The integrated MIS system should be used by both the public and private sector providers for the purpose of commodity resupply, clinic evaluation and clinic management.
78. Once the integrated MIS form is initiated, an adequate supply of forms (namely Forms 1, 2, 2A, 3 and 4) must be available at each SDP. FPCs and supervisors should assume this responsibility.
79. A uniform FP client record form (such as those supplied by the project) should be utilized in all public sector clinics. This same record should be used by private sector clinics wherever possible.
80. State MOH MIS officers should include all public and private sector providers in preparing monthly reports on acceptors and methods.
81. Provision should be made that monthly returns can be updated if necessary to allow for inclusion of information on forms that are received late. It may be necessary to allow a three-month grace period at the end of each publication period.
82. The private sector should routinely collect data from all its commercial outlets. Such information would include number of pill cycles, number of condoms, foaming tablets, etc. sold, and socio-demographic backgrounds of purchasers. There are various types of market research techniques that can be used to get this type of information on a sample basis.
83. It may be necessary to find a way of providing travelling assistance and other logistic support so that supervisory personnel responsible for data collection can travel to retrieve MIS records.

#### **9.1.2 Use of MIS to Evaluate Program Progress**

In the private sector, information related to program impact is collected in two ways: acceptor data and sales data. For those subprojects that work directly with family planning clients, e.g., clinics, hospitals, etc., acceptor data can be compiled through standard MIS and clinic records. From commercial sites, however, since no records are kept by retailers as to who buys what

products and in what quantity, it is difficult, if not impossible, to determine numbers of acceptors with any accuracy. It is possible only to identify total numbers of contraceptives that are sold.

The difficulty of deriving numbers of acceptors from commercial sales has important implications for two of the private sector objectives: 1) The quantitative goal for the private sector is now expressed in terms of acceptors (i.e., 1.2 million couples to be reached) and 2) the private sector is expected to develop a management information database that is consistent with that of the public sector program (i.e., both should be based on numbers of acceptors).

To achieve these objectives, FHS/private is in the process of attempting to find a way to convert sales data into acceptor data. This is a very difficult task, requiring wide-ranging, sophisticated market research to determine actual consumer-buying trends in different regions, types of retail outlets, cultural settings, etc.

There is another approach, however -- to use CYPs rather than acceptors. Since clinic record data can also be converted in CYPs, using CYPs this would allow the program to make direct comparisons between clinic-based and commercial-based programs.

**Recommendation:**

84. The project should consider changing the overall target from acceptors to CYPs.

### **9.1.3 Implications for Project Future**

The data needs of the different departments of the FMOH and the project vary. An important role for the project is to assist the FMOH in developing appropriate data collection systems. FHS/policy has almost no control over the data collection processes described above, although it must rely on the data provided through existing mechanisms to carry out its evaluation responsibilities. Broadening control of the policy component to encompass the various MIS systems now in effect would appear to be a reasonable solution to this problem.

**Recommendation:**

85. FHS/policy should play a major role in the quality control of the data generated from the various service delivery components of FHS, including the revision of training curricula, if necessary, and training of MIS state officers. This is essential if policy is to have the ability to use the data to evaluate program performance. A collaborative MIS effort among the FHS components, the FMOH and the SMOHs is necessary to ensure the success of this data gathering endeavor.

## **9.2 Operations Research**

In addition to data collected through the MIS, the project needs OR to address such operational issues as effective incorporation of FP into existing health systems (notably PHC and MCH); establishment of clinics; gaining of new acceptors; and continuation rates among continuing users.

A council to oversee population research is soon to be established. This council, working through the Nigerian Institute of Social and Economic Research (NISER), will coordinate population research in the country. Its planned composition is as follows: Federal Minister of Health (Chairman), Director General of NISER (Deputy Chairman), plus one representative of the

relevant Department of the Ministry of Health, the Ministry responsible for Social Development, and representatives from NISER, NPC, and PPFN.

The functions of the council will be to

- 1) approve annual research,
- 2) approve the annual research budget,
- 3) consider decisions of NISER on applications from interested Nigerian individuals and institutions for population research grants,
- 4) receive the research reports of grantees, and
- 5) approve publications emanating from research reports.

A research committee including representatives of collaborating agencies and based at a national institution will be directly responsible to Council. The Committee will, among other responsibilities, call for research proposals, assist in study design, and disseminate research findings.

**Recommendations:**

86. **FHS/policy should play an important role in coordinating OR activities to identify problems arising during program implementation.**
87. All project OR should be carried out under the direction of the new council to oversee all population research. The capacity of Nigerian investigators and institutions to conduct OR activities should be strengthened through provision of technical assistance from The Population Council. With this technical assistance and funding from FHS, research design workshops and information dissemination seminars should be conducted.
88. In order to ensure that family planning is effectively incorporated into existing health care systems, medical doctors and other health care personnel and social scientists should be involved in OR. This approach would help sustain OR's impact on the present FHS project. Sustainability is crucial since OR is expected to gain added importance as family planning activities increase in the years ahead.

## 10. Commodity Logistics

### 10.1 Source of Supply

Commodities for both the private and the public sectors are being supplied by Sterling Products (Nigeria) Ltd., one of the major distributors of pharmaceuticals in Nigeria. Commodities for both sectors are delivered to Sterling's central warehouse in Lagos after customs clearance. Use of Sterling as the central supplier has resulted in a reasonably steady supply system while allowing the FMOH sufficient time to build up its own capacity. The Family Health Division of the PHC Department has started to renovate the central warehouse in Lagos, and zonal PHC officers are exploring ways to set up zonal warehouses.

#### Recommendation:

89. **The use of Sterling Products Ltd. to distribute commodities for the public sector should continue while PHC further develops its capacity to carry out this activity.**

Before it takes over, PHC needs to demonstrate that it has

- 1) a sufficient number of warehouses nationwide,
- 2) an appropriate number of trained staff,
- 3) adequate logistic support, and
- 4) the capability to reduce pilferage to an acceptable level.

### 10.2 Contraceptive Method Availability

#### 10.2.1 Methods Available

The FHS project is currently the sole supplier to public sector clinics of oral contraceptives (Lo Feminal only), foaming tablets (Conceptrol only), IUCDs (Copper T only), and condoms (Sultans only). UNFPA provides injectables, both Norsterat and DepoProvera, and formerly provided orals (Microgynon and Logynon) to public clinics, of which quite a bit of stock remains.

The project provides the following contraceptives to private sector clinics and other outlets that are a part of the Project: orals (Noriday,<sup>3</sup> Norquest, Lo Feminal), condoms (Blue Panther,<sup>3</sup> Majestic, Gold Coin), IUCD (Copper T 380A), foam (Emko), foaming tablets,<sup>3</sup> diaphragms, and vaginal jelly.

Physicians trained in various sterilization techniques at local medical schools offer sterilization procedures on a referral basis at local hospitals in most states. AVSC provides training funds for physicians to learn to perform voluntary surgical contraception at regional pilot project sites in state and federal teaching institutions. AVSC also is participating in a clinical trial of NORPLANT<sup>•</sup> and thus is making NORPLANT<sup>•</sup> available on a trial basis at selected institutions.

---

<sup>3</sup>To receive marketing attention through the project -- see Section 5.2.

## **10.2.2 Public Sector Commodities**

Public sector commodities are supplied through the project to FP clinical sites by the state FPC or his/her supervisory staff. State warehouse commodity inventories are assessed by two FHS staff who visit each state storage facility at least once a quarter to determine amounts of commodities needed. FHS/public sector zonal program officers also monitor commodity inventories at state and clinical facilities within their zones. Orders are placed by the FPC if supplies get low. Most states have supplies delivered by Sterling, although in some cases, FPCs will collect supplies from Sterling's zonal warehouses. Supplies to the state warehouses vary from available as needed for all methods to all methods unavailable. Commodity shortages at the state level were observed in one state and reported in the others.

Conditions in state warehouses ranged from secure, clean, cool, and properly inventoried to warm, dusty, insecure, and disorderly. Four regional storehouse manager workshops are currently under way.

## **10.2.3 Private Sector**

Private sector commodities are issued from Sterling's central warehouse to the 12 regional warehouses, the quantity for each warehouse being based on the returns of their previous sales in those regions. From the regional warehouses, commodities are issued to Sterling's salesmen and medical representatives, who sell them to registered pharmacies, based on requests for types and brands. In addition, contraceptives are supplied to supermarkets, patent medicine stores, CBD vendors, and nurse midwife state offices, as well as to private hospitals and clinics, and to maternity houses (see Section 5.2 for further information on distribution to nurse midwives). Transport workers obtain their commodities through their union which is supplied by Sterling.

No expired commodities were issued from Sterling warehouses, but expired commodities were often found with retailers -- most commonly condoms and vaginal foaming tablets.

Commodity shortages in the private sector have been reported in some states. Most serious from a project perspective have been shortages in states in which nurse midwives who had just completed clinical training could not get contraceptives. In Imo state, providers could not get commodities even to start their own FP revolving accounts.

Modern contraceptive methods and/or a specific method are not always available at a particular clinical site. Concern arises that clients may be encouraged to choose a method they will not use or which is not appropriate given their health status because it is the only method in stock or may generate the most income for the provider.

## **10.3 Forecasting and Monitoring**

The forecasting of commodity needs for both the public and the private sectors was initially undertaken through a joint effort that included officials of CDC, FPIA, Pathfinder, John Snow, Inc., the FMOH and the FHS/administrative and logistics component. Recently, however, it has been requested by USAID and agreed to by FPIA that the forecasting should be turned over to FPIA. This new arrangement has not been tested as the first forecast has not been submitted by FPIA.

In both the private and the public sectors, attempts are made to monitor the commodities stocked in both the Sterling warehouses and the warehouses of the individual state stores. FHS/private visits Sterling warehouses to monitor stock levels and storage conditions, but each warehouse can only be visited once or at most two times in a year.

#### **10.4 Diversion of Commodities**

One major problem being faced by the private sector commercial outlets is the diversion to private sector outlets of commodities (especially condoms and oral pills) meant for public sector facilities. The result is that these products not only compete with private sector brands in the market; exercise of quality control becomes impossible.

##### **Recommendations:**

90. A complete range of commodities should be uniformly available at all times at all SDPs. Coordination with other donors such as UNFPA will be needed.
91. State FPCs and supervisors should ensure that essential commodity storage requirements are observed by all FP providers.
92. FHS/private should ensure that commodities are readily and easily accessible to all persons trained by FHS/private.

## **11. List of Recommendations**

## 11. List of Recommendations

### Chapter 3: Program Approach

1. **The draft FMOH program for population programs, once approved, should be closely studied by FHS, and project component activities should be included within this workplan.<sup>4</sup>**
2. The FHS Project Administrator and FHS Component Project Managers should continue their dialogue with the relevant FMOH departments and work closely with DPA in the planning, implementation and evaluation of FHS activities. FHS should also continue to support activities to strengthen the DPA as the central coordinating unit for population activities of the government.
3. **FHS contractors should cooperate in the development of state workplans in collaboration with the FMOH and its PHC zonal officers, State Family Planning Coordinators, and other donor representatives. All information about each others' activities in each state should be shared to facilitate planning and cooperation. One strategy that should be considered is a phased state-by-state implementation of family planning activities. The state workplans and strategies to carry them out might be developed on a phased basis, applying lessons learned from one state to the planning for the next. In Year 3, for example, all FHS components would develop a common workplan and coordinated strategy in one state per zone; for Year 4, two states per zone; and in Year 5, three states per zone, thus covering all the states during the life of the project. This might limit the ability of each component to respond to the needs in non-targeted states at any given time; however, by the end of the project all states will have received coordinated assistance from the project.**
4. National and zonal level activities should be coordinated as much as possible, particularly in the context of state-level programs. For example, as more and more states launch their state level population policies, FHS should have a specific role in supporting states to develop or implement their strategies.

### Chapter 4: Management

5. **The prime contractors of the project, together with the Project Administrator, USAID and the GON, should reconfigure the project components on a functional basis to the extent possible under the present contracts. The functional components would include training, constituency-building/IEC, MIS, and commodity logistics. There are various ways that this configuration could be implemented: e.g., one contractor could assume responsibility for each functional activity, or the Project Administrator's office could take responsibility for the direction and coordination of each of these functional components. Other cooperative avenues to solve the duplication of function among the contractors for these areas should be explored and agreed upon. If agreement is not possible under the present contracts, actions should be considered on how to amend the various contracts to achieve a better functional division of labor.**

---

<sup>4</sup> Recommendations in boldface are those that are identified in the Executive Summary as the principal recommendations of this report.

6. **The ultimate goal of the training and commodity logistics functions as reconfigured above should be a uniform standard of clinical services delivery based on a uniform standard of training for various cadres and a nationally recognized set of clinical protocols for use in the public and private sectors. Further standardized supervisory, reporting and evaluation procedures should be developed for the whole project.**
7. **The USAID mission should develop a general framework for operations with the Project Administrator and should give him greater latitude to act on behalf of USAID in agreed upon areas. This would give the Project Administrator the authority to make the day-to-day decisions on the implementation of the program based on USAID administrative guidelines and the USAID approved overall work program. Once this general framework is agreed upon, this delegation of responsibility to the Project Administrator should simplify the work of both parties.**
8. **USAID, REDSO and the contractors should establish guidelines on the approval of subcontracts that would facilitate their expeditious processing. These guidelines should take into account the size of the subcontract, the type of subcontract, and mechanisms that can be put into place to assure fiscal compliance, e.g., system of auditing projects of various types and sizes. For large and more risky subcontracts, a more rigorous fiscal review by all parties may be necessary. For smaller and less risky subcontracts, the review by the Lagos-based Project Directors and the Project Administrator may suffice.**
9. **To ensure tighter financial control and to facilitate the fiscal review of subcontracts in Nigeria, an assessment of the accounting and financial human resources in the FHS Lagos office should be undertaken. Based on this assessment, decisions should be taken on whether increasing the personnel in the finance area for the various components is necessary.**
10. **Controllers/financial monitors of the prime contractors should be very familiar with field operations. They should conduct a thorough assessment of field fiscal operations at least once a year. This will become even more important as more contracting authority is moved to FHS component heads.**
11. **The planning meeting and progress review meeting should have in attendance representatives of each of the prime contractors and possibly important U.S. subcontractors to ensure their full agreement and cooperation in the design of the workplan and its implementation. For the yearly meeting, their attendance is essential to ensure that the synchronization of activities enables them to meet their contracted deliverables. For the triennial meetings, their attendance is required to ensure that implementation is proceeding as planned. Particularly since there have been delays in getting subcontracts approved by contractors (see Fiscal Control, Section 4.2.1), these meetings will reinforce the need for contractors to take action to facilitate the flow of funds to the project. At a later stage, after more synchronization among the contractors is achieved and more authority is given to the Project Administrator and the Lagos-based Project Directors, there may be less need to have the full representation of the contractors. Taking into account the recommendations presented in this report, however, it is recommended that U.S.-based contractor representation at these meetings be required for at least the next two years.**

12. At the working level, there should be bimonthly meetings of the Lagos-based Project Directors responsible for the various aspects of the project chaired by the Project Administrator. The purpose of these meetings should be to exchange information on the status of the various aspects of the project and to ensure coordination of on-going activities. These meetings would identify the bottlenecks in carrying out project activities so that appropriate actions can be taken by the Project Administrator or the Directors themselves. The frequency of such meetings is important to reinforce the interrelatedness of the various aspects of the project. Monthly meetings may not be frequent enough to foster the collegial interchange necessary to affect the quick response that is necessary to solve project problems.
13. USAID should reaffirm that the Project Administrator's role is to review and recommend for USAID approval all subcontracts issued by the project contractors. Consideration should be given to hiring one or two administrative assistants to the Project Administrator to oversee and manage many of the routine tasks of project administration so that the Administrator can concentrate on planning, coordination and monitoring. These steps would put the Administrator in a far stronger position than he is at present.
14. Since this is a project between the GON and the U.S., the sponsorship of project activities should be identified as the project, the Federal Ministry of Health and, as appropriate, USAID. The name of the implementing contractor should not be the main focus of attention.

#### **Chapter 5: Project Components**

15. **FHS should work with the FMOH and the SMOHs in the development of institutional in-service training for all cadres of FP providers in each state.** Such an arrangement should be carried out collaboratively by the FHS training contractors, the FMOH and the SMOHs.
16. In-service training efforts must be maintained to provide an adequate supply of trained FP staff for service delivery points (SDP). Specifically,
  - More teaching hospitals or other health institutions, e.g., schools of midwifery, should be enlisted in efforts to provide institutionalized training for FP providers. These efforts should be focused primarily in Zones C and D.
  - At the state level, priority should be given to assisting states without core trainers to develop these cadres.
17. Pre-service training should continue to be done in schools of midwifery. Efforts to begin pre-service training at schools of health technology should be continued and accelerated. Whether schools of nursing should be included in clinical pre-service training needs further evaluation.
18. **Consideration should be given to designating one training institution in each state to institutionalize FP clinical training.** The best candidates would be schools of midwifery or teaching hospitals. Preference should be given to those institutions that have already participated in training of clinical service providers to date. **Such training could become a regular feature of these institutions' programs; they could run three or four training sessions a year with 20 to 30 trainees from their states.**

**This would provide for the in-service training needs of the state for at least the present cadre of providers in a limited period of time. The pre-service training that has already begun would cover the need for new service provider entrants. This system of in-service training would support the pre-service training done in the same institutions. It would also serve as the base for refresher training.**

19. A standardized TOT curriculum should be used by FHS and the UNFPA trainers.
20. An effort should be made to facilitate the approval of subcontracts with state governments so that training programs can be initiated more quickly.
21. The various state governments should make larger budgetary allocations to their FP programs.
22. Africare should accelerate its efforts to conduct clinic surveys and consideration should be given for providing additional equipment as more staff are trained.
23. A brief training curriculum for the repair and maintenance of FP equipment should be developed. It should be designed to be used as an on-the-job-training mechanism, with training to be provided to clinic staff at the time that new equipment is delivered. The curriculum should be made available to all FPCs at the annual state FPC workshop.

#### **Private Sector**

24. The FHS project should seriously consider whether the number of outlets required for the private sector component is realistic in light of the effort that is required to establish subprojects.
25. While maintaining good contact with Sterling, the project should continue to carry out its plans to explore and establish distribution through additional commercial channels nationwide. This should serve both to increase the overall distribution of products and to ensure that alternative distribution approaches are in place, should Sterling ever stop participating. Developing new channels is a long, drawn-out process that needs extensive preparation. Not to have alternative channels in place could jeopardize the whole program.
26. As planned FHS/private should work to develop a new payment formula that would provide a greater incentive for Sterling to make active efforts to sell products. This formula should ensure that Sterling continue to receive at least a minimum fee that would eliminate the possibility of its taking a financial risk, but this fee should be lower than the present one. This should be supplemented by the potential to make additional money through commission on sales.
27. While focusing on three brands, Sterling should continue to sell (but not market) its other products directly to its own outlets and to private hospitals and clinics. This would provide greater choice for the consumers.
28. **As part of the overall social marketing approach, vigorous and persuasive communications and advertising need to be launched as soon as possible. Products should be properly branded and packaged attractively to aid customer identification and recognition. The generic logo developed by the FMOH's Health Education Branch should be considered for use in packaging of contraceptives. Proposals from**

ad agencies to oversee this new approach should be elicited. **Local and international technical assistance in marketing and advertising will be required.**

29. Multiple strategies for advertising contraceptives in different geographical zones should be considered in order to take into account Nigeria's complex cultural and religious diversity.
30. FHS/private should request assistance from the policy component to work with the Government to help alter the FDAC restrictions related to advertising ethical products, e.g., orals.
31. If a solution cannot be found in the near term (see recommendation 30), alternatives should be explored. These might include 1) advertising condoms only; 2) advertising the family planning concept to increase general awareness, while leaving the choice of the product to the consumer; or 3) advertising the concept together with the logo and asking consumers to buy from stores that have the logo.
32. FHI/private should review the decision to package Panther condoms in "RIGHT-TIME" boxes, and explore the possibility of procuring a generic brand of condom instead.
33. The project should attempt to use additional types of market research to assess the impact of retail sales, e.g. retail audits, consumer identification. In addition, market research should continue to be used by the project prior to the initiation of any new ventures. This research should determine the feasibility of activities in terms of their potential for both impact and sustainability.
34. FHS/private should oversee all research activities. It should interview the researchers to authenticate research report statements and ask for all completed questionnaires for each research item, to be reviewed by an independent source. Until the above verifications are made, the research reports should not be relied upon for serious decisions.
35. **For future subprojects, programs that have a reasonable chance of becoming sustainable over time should receive the greatest emphasis. Private sector programs that require substantial subsidies should be avoided.** For existing subprojects that do not appear to be sustainable, efforts should be made to develop a mechanism for ensuring that they survive beyond the life of the project.
36. A reliable resupply for supplies and commodities should be established for all subprojects. No person should be trained without having such a system in place. For those who have already been trained, but are not being resupplied, a way to ensure a regular supply of commodities must be developed. For example, FHS/private's plan to use the nursing and midwives associations' monitors to resupply trained private nurses/midwives should be encouraged.
37. Adequate technical assistance should be provided to project trained private sector providers to get established in practice. This TA should be provided separately from ongoing clinical quality assurance supervision and commodity resupply.
38. **FHS/private should place greater emphasis on family planning methods that have a higher potential for reducing fertility, i.e., pills and IUCDs.** Approaches might include the following:

- 1) Expanding the involvement of work with association of nurses and midwives, using the approach presented in Section 5.2.3 above. This approach could be significantly expanded to more states, with larger numbers of trainees; and
  - 2) In the identification of additional distributors, FHS/private should attempt to enlist pharmaceutical companies that could be used to sell prescription products to clients. It would also be helpful if more medical representatives could be hired through Sterling.
39. Sterling activities and the sale of condoms and vaginal tablets through retail sites should continue, but no new subprojects that focus on these products and work with transportation workers and market women should be developed.
  40. To help develop project ideas, the project should take advantage of the vast number of business people and labor leaders in Nigeria who could be used as resources to the project to provide advice and guidance on issues related to the private sector.
  41. Private sector staff in Nigeria should be more fully involved in the decision making and strategic planning process if FHS/private staff are to develop their capabilities and achieve the goals and objectives originally envisaged for FHS/private. This should include their developing priorities and new project concepts. The Lagos office should be fully cognizant of the financial status of the project and be given the authority to commit funds for subprojects with concurrence of the prime contractor.
  42. Communication for subprojects should be improved between the prime contractor's New York office and its office in Nigeria, and among the prime subcontractors and the Lagos office.

#### IEC

43. The IEC component should take immediate action to follow-up on the success it has had from the record and music video, "Choices" and "Wait for Me." The "entertainment-education" strategy should be used to initiate the full range of follow-up activities in Nigeria. Technical assistance from the contractor will be required and should be provided as soon as possible to capitalize on this successful beginning.
44. The IEC component should also work closely with FHS/private to take advantage of an advertising follow up to the music video in the private sector, as well as the public sector. This might involve using spots from the videos in advertising or working with the recording artists and FHS/private to make new advertisements. The point is to take every possible opportunity to gain exposure of the music and video in advertising, private sector and public sector.
45. The family planning logo developed by the FMOH's Health Education Bureau should be incorporated into the strategy to market the record and music video. It will be important to include this well-done logo in advertising and IEC endeavors undertaken by the project.
46. State-level IEC plans should include a section on how the IEC components are expected to be coordinated with public and private sector training and service delivery. To facilitate coordination, state-level planning of the private, public and

IEC components should be done together and should involve the state FPCs, their staffs, and other relevant MOH officers in the states, e.g., PHC coordinators.

### **Policy**

47. FHS/policy should continue with its proposed research activities.
48. TA to DPA and DPRS should be continued, not only in the name of institution building, but also to help both DPA and DPRS prepare proposals to other donor agencies to support future expansion.
49. Policy should continue to provide TA to DPA to refine the draft workplan on the Implementation of Population Programs into specific action programs for states and LGAs.

### **Administration and Logistics**

50. USAID and the FMOH should extend the contract with AAI/Sweethill Associates, as planned.

## **Chapter 6: Service Delivery**

51. FP services should be integrated into MCH services whenever possible to eliminate the need for a client to use more than one provider for service.
52. Hours of service at public sector clinics should be extended to include some evening and weekend hours.
53. An operations research study should be undertaken to ascertain the effects on acceptance rates of charging for contraceptives in public clinics as compared with providing them free. This would help to establish guidelines on fee-for-service for family planning.
54. An evaluation should be undertaken to assess a spectrum of factors including quality of FP service delivery, availability of clinics, client satisfaction with care, and understanding of current use of selected method.
55. Provision should be made for the uniform supervision and follow-up of trainees and staff at their FP work-sites whether public or private. FPCs and state-level FP supervisors should be encouraged to spend time during supervisory visits observing and assessing key clinical skills of all FP staff, i.e., IUCD insertion, client counseling regarding method contraindications, side effects and use. If there are gaps in service provision of a more general nature, these need to be identified by the supervisor and refresher training programs initiated.
56. A standard FP quality assurance checklist should be prepared for supervision of both public and private sector staff.

## **Chapter 7: Training**

57. In planning for its third-year work program with the government, the project should give top priority to ensuring better collaboration in training among the FHS project components.

58. More attention should be focused by FHS/public on the training of service providers in states that appear ready to increase use of FP.
59. Uniform course curricula and course length should be established for each cadre of FP personnel. These should be standard for both public and private sector cadres.
60. The national curricula standardization exercise now going on between FMOH and the FHS/public sector should be expanded to include the FHS/private sector. This would ensure compliance with the recommendation above. Allowance should be made for minor differences to take into account that the private sector deals with commercially oriented providers.
61. The involvement of state trainers in the curricular review exercise for all FP cadres should be encouraged.
62. FMOH should continue to provide training and monitoring guidelines to the states but should not be actively involved in state or LGA training activities.
63. Adequate training materials should be made available for all project training activities. Reference materials to be taken home by the trainees for their use in practice should be provided, e.g., the clinical protocol manual.
64. Uniform entry requirements should be instituted for all clinical in-service training programs for the public and private sectors.
65. Candidates for clinical skills TOT training should already have received full training in clinical skills.
66. The length of time for clinical training should be standardized -- preferably at seven weeks.
67. All subjects necessary for the delivery of quality FP services, i.e., clinic management, counseling, IEC, and MIS, should be included in the basic clinical FP course. The course should also use the standardized clinical protocol manual, once this has been completed.
68. Refresher courses should be organized for service providers after three years of practice by both public and private sectors. This might be accomplished through reprogramming training funds as needed.
69. Considerably more emphasis should be placed on training all levels of staff to use and understand the MIS. This should include training in all procedures involved (e.g., filling out the client card forms properly) as well as providing explanations as to the role MIS should play in client and clinic management. When the integrated PHC/FP MIS forms are available, all FP clinic staff should be trained to use them.
70. A standard curriculum should be developed for private sector market based training activities, e.g., Jos market women project. Both training and service delivery activities projects should be supervised by the SMOH staff to assist in promoting sustainability.
71. In the development of all FHS subprojects, technical assistance requirements should be taken into account. If Nigerian expertise is available (e.g., from business, labor,

or universities), such expertise should be used. If not, expatriate consultants should be contracted to provide the requisite technical inputs (see Section 5.2.4).

72. In particular, expatriate consultants are needed in some specialized training areas, e.g., IEC, operations research, and advertising and market research. Consultants should work closely with Nigerian consultants and assist them in the development of these special skills.

#### **Chapter 8: IEC/Constituency Building**

73. IEC processes and products for the clinics and for motivating the community at large should be increased to generate sufficient clientele for already functioning clinics and new ones to be opened.
74. In each area where full service FP SDPs exist, intense locally appropriate IEC efforts should be made to inform the population of the benefits of FP.
75. IEC efforts must be made outside of FP clinical sites to make modern contraceptive methods known.
76. Policy should be discouraged from executing constituency building activities. Rather, **constituency building activities should be included in the IEC component.**

#### **Chapter 9: Evaluation and Research**

77. It is essential that an MIS be developed for the project that consolidates in a consistent fashion data being generated from the other project components. The integrated MIS system should be used by both the public and private sector providers for the purpose of commodity resupply, clinic evaluation and clinic management.
78. Once the integrated MIS form is initiated, an adequate supply of forms (namely Forms 1, 2, 2A, 3 and 4) must be available at each SDP. FPCs and supervisors should assume this responsibility.
79. A uniform FP client record form (such as those supplied by the project) should be utilized in all public sector clinics. This same record should be used by private sector clinics wherever possible.
80. State MOH MIS officers should include all public and private sector providers in preparing monthly reports on acceptors and methods.
81. Provision should be made that monthly returns can be updated if necessary to allow for inclusion of information on forms that are received late. It may be necessary to allow a three-month grace period at the end of each publication period.
82. The private sector should routinely collect data from all its commercial outlets. Such information would include number of pill cycles, number of condoms, foaming tablets, etc. sold, and socio-demographic backgrounds of purchasers. There are various types of market research techniques that can be used to get this type of information on a sample basis.

83. It may be necessary to find a way of providing travelling assistance and other logistic support so that supervisory personnel responsible for data collection can travel to retrieve MIS records.
84. The project should consider changing the overall target from acceptors to CYPs.
85. **FHS/policy should play a major role in the quality control of the data generated from the various service delivery components of FHS, including the revision of training curricula, if necessary, and training of MIS state officers. This is essential if policy is to have the ability to use the data to evaluate program performance. A collaborative MIS effort among the FMOH and the SMOHs is necessary to ensure the success of this data gathering endeavor.**
86. **FHS/policy should play an important role in coordinating OR activities to identify problems arising during program implementation.**
87. All project OR should be carried out under the direction of the new council to oversee all population research. The capacity of Nigerian investigators and institutions to conduct OR activities should be strengthened through provision of technical assistance from The Population Council. With this technical assistance and funding from FHS, research design workshops and information dissemination seminars should be conducted.
88. In order to ensure that family planning is effectively incorporated into existing health care systems, medical doctors and other health care personnel and social scientists should be involved in OR. This approach would help sustain OR's impact on the present FHS project. Sustainability is crucial since OR is expected to gain added importance as family planning activities increase in the years ahead.

## Chapter 10: Commodity Logistics

89. **The use of Sterling Products Ltd. to distribute commodities for the public sector should continue while PHC further develops its capacity to carry out this activity. Before it takes over, PHC needs to demonstrate that it has**
  - 1) a sufficient number of warehouses nationwide,
  - 2) an appropriate number of trained staff,
  - 3) adequate logistic support, and
  - 4) the capability to reduce pilferage to an acceptable level.
90. A complete range of commodities should be uniformly available at all times at all SDPs. Coordination with other donors such as UNFPA will be needed.
91. State FPCs and supervisors should ensure that essential commodity storage requirements are observed by all FP providers.
92. FHS/private should ensure that commodities are readily and easily accessible to all persons trained by FHS/private.

## Appendices

## **Appendix A**

### **Scope of Work and Evaluation Methodology**

## **Appendix A**

### **Scope of Work and Evaluation Methodology**

#### **Scope of Work**

As specified in the Project Agreement, the first implementation evaluation will focus on the performance of the contractors in terms of how effective they are in producing the outputs required by the project. Attention will concentrate on management issues such as coordination of inputs with program activities; quality of the training and service delivery; effectiveness of program planning and management systems being established; coverage of the population being achieved by contraceptive services; operational utility of information systems; effectiveness of IEC activities; and degree of participation being enlisted from the private sector. Also, the degree of collaboration among the contractors and any efficiencies that are being achieved in this collaborative assistance approach will be assessed. Major mid-course changes in the project approach, operations and/or process may be recommended as a result of this evaluation.

Additional issues to be addressed by the evaluation team that have been jointly identified by the Federal Ministry of Health and USAID are:

#### **MOH/FHS Linkages**

1. What is the Nigerian government's commitment to the project and its planned activities?
2. Does the project complement the Federal Ministry of Health's policies, particularly in primary health care?
3. Does the project and its personnel collaborate effectively with federal, state, and local government personnel?

#### **Training and Technical Assistance**

4. Is the training being provided technically appropriate, culturally relevant, and sufficient?
5. Given the existing curricula, is the development of new or revised training curricula a necessary project activity?
6. Should training responsibilities remain divided among several contractors and subcontractors?
7. Should the education sector -- rather than or in addition to the health sector -- receive more emphasis for training, such as expansion of the Family Life Education effort to other formal instructional settings?
8. Does the amount and nature of technical assistance foreseen at project design remain a valid requirement for successful project implementation or is sufficient Nigerian expertise, both public sector and private sector, available to replace expatriate consultants?

#### **IEC**

9. Are the information educational messages developed by the project relevant, appropriate, useful, and cost effective?

10. Are there ways and means, other than those currently employed or contemplated, to inform and educate Nigerians about family planning?
11. Are appropriate associations and institutions (professional, academic, corporate, social, students', women's, men's) targeted for education and information?

**Private Sector**

12. Is the market development strategy appropriate?
13. Is the project making a sufficient and effective effort to expand private sector involvement in the provision of family planning information and services?

**Services**

14. Are clinical FP services provided by public sector personnel integrated with other public health services?
15. To what extent is the project serving the grassroots/ village level population?

**Project Organization**

16. Is the project's internal structure and functional organization appropriate for achieving objectives?

**Evaluation Team Composition**

The team was made up a multi-disciplinary team of both Nigerian and expatriates consultants.

- |                                   |   |
|-----------------------------------|---|
| • Dr. Anita Barbey                | Public Health/Services                  |
| • Mr. Sam Fadipe                  | Advertising/Private Sector              |
| • Mr. Matthew Friedman            | Quantitative Information/Private Sector |
| • Mrs. I.V. Mako                  | Nurse/Training                          |
| • Prof. Paulina Makinwa-Adebusoye | Demographer/Policy                      |
| • Mr. John McWilliam              | Team Leader                             |
| • Dr. Wale Shobowale              | Physician/Services                      |

**Methodology**

Interviews and document collection for this evaluation began in Washington in mid-November. John McWilliam and Matthew Friedman interviewed representatives from each of the major contractors, representatives from A.I.D./W, and others involved in the design and implementation of the project.

Field work in Nigeria began November 27. During the first week, the team reviewed the scope of work, read project documents and interviewed representatives from FHS, the FMOH, non-governmental organizations involved in family planning, the private sector, and significant donor organizations.

54'

During the second week, the team broke into two groups to travel to the field. Field protocols were developed for the collection of data. One group went to Benin City, and Owerri, while the other traveled to Makurdi, Gboko and Mkar in Benue State and to Jos. Each team was designed to have members with comparable skills and experience to cover all areas of the project. Both groups met with private and public sector representatives, officials of state ministries of health, religious mission health services. Both teams visited warehouses where family planning commodities are stored. They visited family planning clinics, hospitals and pharmacies. In order to get more perspective on the situation of the project in the northern zones, the family planning coordinators from Kaduna and Bauchi states meet with one of the teams in Jos. Altogether the team gather first hand data from six states in all four zones.

The team returned from the field on December 7 and continued interviewing FHS staff and USAID. The draft report was submitted to USAID on December 13 and debriefings were held with FHS, the FMOH and USAID.

#### Constraints of the evaluation methodology

The main constraint was time. The evaluation team was given three weeks to evaluate a very complex national project, including the submission of the draft report. More time would have allowed the team to gather additional data so that it may have been able to provide greater guidance on solutions to some of the difficult problems that FHS is facing to achieve its objectives.

85

## **Appendix B**

### **List of Persons Contacted**

## **Appendix B**

### **List of Persons Contacted**

#### AID/Washington

Dr. Sarah Clark, Deputy Director, Office of Population  
Dr. Gary Merritt, Chief HPN, Africa Bureau Technical  
Mr. Allan Getson, Chief, Resources

#### Washington/Others

Ms. Keyes McManus, Project Director, Women in Development Project, The Futures Group

#### US-Based Contractors

Mr. James Crawford, The Pathfinder Fund  
Ms. Connie O'Conner, Family Planning International Assistance  
Dr. Stella Goings, Institute for International Programs, Johns Hopkins University  
Dr. Phyllis Piotrow, Director, Center for Population Communication, JHU  
Mr. Patrick Coleman, Director, Population Communication Services, JHU  
Mr. Jose Ramon, Deputy Director, Population Communication Services, JHU  
Mr. Paul Bankerd, Finance Director, Population Communication Services, JHU  
Ms. Susan Krenn, Program Officer, Population Communication Services, JHU

#### Lagos - Based Subcontractors and Consultants

Dr. Becki Johnson, Director, Africare  
Dr. William Barber, Consultant, Management Science for Health  
Dr. Kelly O'Hanley, Consultant, John Snow Inc.  
Ms. Lisa Howard-Grabman, Consultant, John Snow Inc.

#### FHS Staff

Mr. Richard Sturgis, Project Administrator  
Ms. Elizabeth Lule, Data Coordinator  
Ms. Wilma Nwanze, Administrative Office Manager  
Mr. Taiwo Kehinde, Manager, SHA  
Mr. Rasheed Iginla, Contra./Log Officer

#### IEC:

Mr. Kim Winnard, Country Representative, JHU/PCS

#### Policy Implementation

Mr. Akin Akinyemi, Country Representative, JHU/IIP

#### Public Sector

Mr. Victor Oluyemi, Country Representative, The Pathfinder Fund  
Mr. Mike Egboh, Program Officer, The Pathfinder Fund  
Ms. Bola Lana, Training Officer, The Pathfinder Fund

#### Private Sector

Mr. Uche Azie, Associate Regional Director, FPIA  
Mr. Ifeanyi Ibe, Program Officer, FPIA  
Mr. Olubunmi Dosumu, Program Officer, FPIA

USAID/Lagos

Mr. Henry Merrill, AID Director  
Dr. G.A. Cashion, AID Deputy Director  
Mrs. H.O. Shitta-Bey, Program Officer  
Dr. A.E. Olesky - Ojikutu, Program Officer

Federal Ministry of Health

Dr. O.E.K. Kuteyi, Director, Department of Population Activities  
Dr. A.A.O. Sorungbe, Director, Department of Primary Health Care  
Dr. J.K. Makanjuola, Director, Department of Planning, Research and Statistics  
Dr. Kayode Oyegbite, Special Assistant to the Minister  
Mrs. E.A. Ubok-Udom, Chief Pharmacist, Department of Food and Drug Administration and Control  
Mrs. Felicia Henshaw, Chief, Health Education Unit  
Dr. A. Dada, Chief Program Officer, Department of Population Activities  
Mrs. B.U. Nakpodia, Program Officer, Department of Population Activities  
Mrs. R.E. Gabriel, Planning Officer, PHC Department  
Mrs. A. Omolaja, Planning Officer, PHC Department  
Mrs. F.F. Gbadamosi, Planning Officer, PHC Department  
Mrs. J.K. Thompson, Planning Officer, PHC Department

Non-Governmental Organizations, Lagos

Dr. B. Sulaiman, Director, Planned Parenthood Federation of Nigeria  
Mr. Joseph Olomejeye, Program Director, Planned Parenthood Federation of Nigeria  
Dr. Deji Popoola, Executive Director, National Council for Population Activities  
Mrs. Ajobola, Nigerian Association Of Nurses and Midwives

Commercial Organizations

Sterling Products (Nigeria) Ltd.  
Mr. William Ogden, Managing Director  
Rev. T. Fawole, Chief Auditor  
Mr. Bello, Area Manager, Sterling Depot, Ibadan  
Mrs. A.O. Masha, Project Coordinator  
Mr. S.A. Bulakos, Area Manager, Sterling Depot, Jos  
Mr. J.A. Ali, Area Sales Manager

United Nations Population Fund

Dr. Alphonse McDonald, Country Representative

Benue State

Ministry of Health

Dr. D.O. Ityonzughul, Deputy Director, PHC  
Dr. O.A. Amali, Director General  
Mr. MMS Ugye, Director, Pharmaceutical Services  
Dr. V. I. Bur, SCH  
Mr. Felix B. Gbilla, Director, Nursing Services  
Mrs. J. S. Abedu, State Family Planning Coordinator  
Miss Nor, IEC Coordinator

State Hospital

Mrs. Victoria Damker, Clinic Supervisor  
Mrs. Margaret Awoni, FP Provider

Mkar KST Hospital/Clinic

Mrs. Lydia M. Vanger, FP Coordinator  
Mrs. Veronica Igbudu, Assistant FP Coordinator  
Rev. (Dr.) J.Y. Akpem, FPIA Authorized Official [Selected by NKST (the church) to take care of family planning]

Mbaakon NKST Hospital/Clinic

Mr. David Shimbe, Director of Nursing Services  
Mrs. Phoebe Antyo, Nursing Sister in Charge of FP  
Mr. Abraham Ngutsar, Field Worker  
Dr. J.A. Bassey, Medical Practitioner  
Dr. Eric Akpejunor, Medical Practitioner  
Dr. Thomas Adesagbon, Medical Practitioner

Plateau State

Alheri House for the Needy

J.A. Kwakfut, Project Manager  
Mrs. Joluis Danjuma, Accounting Officer  
Mrs. Mary Fompan, Project Field Officer (in the market)  
Mrs. Salomi Thomas, Medical Practitioner  
Mrs. Lydia Kumbak, Medical Practitioner

Ministry Of Health

Mr. Anthony Homsuk, K.S.M.D.G.  
Mrs. Mary Shemu, Director FP Project  
Ms. Susan Ayima, FP Coordinator  
Mrs. Tabita Dashe, FP IEC Officer  
Mrs. Larai Lillian Dashi, Medical Practitioner

MCH Unit, Jos

Mrs. Umoru, Principal Health Sister/FP Zonal Coordinator  
Mrs. Lydia Choji  
Mrs. Juliet O. Imiduraye  
Mrs. N.C. Okwudili

Sterling Warehouse

Mr. J.A. Ali, Area Sales Manager  
Mr. S.A. Bulakos, Territorial Manager  
Mrs. Sarah Yusef, Nurse Detailer

Jos University Teaching Hospital

(Sterilization Dept. of Obs. & Gyn.)  
Dr. I.O. Ujan, Deputy Director ASC Project  
Mrs. Okwudili, Nurse working with ASC Project

FP Coordinators from other States who met us in Jos

Mrs. Hassana Y. Sheget, Acting FP Coordinator for Bauchi State  
Mrs. Halima K. Zubair, FP Coordinator for Kaduna State

Others

Mr. Moses Olabode, National Secretary NANNM

Kaduna State

Mrs. Halima Zubair, Family Planning Coordinator, Ministry of Health

Benin City, Bendel State

Ministry of Health

Dr. Stephen Irune, Commissioner  
Dr. (Mrs.) C.R. Akele, Director General  
Dr. D.A. Bazuaye, Director of Medical Services  
Mrs. A.C. Chizea, State FP Co-ordinator  
Mrs. J.O.E. Anidi, Deputy FP Co-ordinator  
Mrs. C.E. Iremireni, Zonal Supervisor, Oredo L.G.A.  
Mrs. R.I. Osagiede, C.H./S.M./F.P.P.  
Mrs. Monica Usifo, RN/RM, Public Health Nurse/FP  
Mrs. A.B. Osakue, CM/R/NS/FP  
Mrs. C. Ogunbor, CM/R/NS/FP  
S.O. Eyinla, Stores Officer

Sterling Products (Nigeria) Ltd.

Dr. E.M. Akinluyi, CM/R/NS/FP

Imo State

Ministry of Health

Dr. Chigozie Ogbu, Commissioner for Health  
Mrs. C.A. Ukadike, FP Co-ordinator  
Dr. R.A. Eke, Director, PHS/PHC  
Mr. I.D. Nwoga, Director General, M.O.H.  
Mrs. A. Onyerika, I.E.C. Project Manager  
Rev. Canon J.U.A. Alozie, B.C.C.C. Atta Warden  
Dr. Benjamin Ibezim, Anara Basic Health Center, Isiala Mbanu  
Nze Bertram A. Nwansi, Director of Services, Agnes Memorial Hospital, Akabo Ikeduru

## **Appendix C**

### **Bibliography**

**Appendix C**

**Bibliography**

Audit of the Family Health Services Project in Nigeria. Project Number 620-0001. Audit Report Number 7-620-90-01. October 16, 1989

Overview: Population Policy Implementation and Family Planning in Nigeria

Project Grant Agreement Between the Federal Ministry Government of Nigeria and the United States of America for Family Health Initiatives II Project. A.I.D. Project Number 698-0462.20, July 30, 1987

Trend in Contraceptive Methods: The Public Sector in Nigeria

**Training Component**

Family Planning Lesson Plans for Schools of Midwifery in Nigeria, Volume 1, 2 and 3, (Pathfinder Supported by USAID)

Oyo State P.H.C./Family Planning Project Curriculum Development for Six Weeks Training for Clinic Service Providers of Family Planning (July 1989) by Oyo State Ministry of Health Clinical Service Providers Training Team

Oyo State PHC/Family Planning Project Curriculum for 3 Weeks Training Community Health Extension Workers in Motivation and Counseling (July 1989)

Kano State L.G.A. Planning Workshop Training Materials

Supervisory Skills Family Planning Workshop, Jos Plateau State

Oyo State PHC/Family Planning Project Curriculum for 2 Weeks Training of Trainers Village Health Workers (July 1989)

Draft of the Nigeria Family Planning Providers Manual

Interpersonal Communication and Counselling, Three Day Curriculum - A Trainer's Guide

IEC Media Materials Development - A Trainer's Guide

Draft Private Sector Component Objectives

Private Sector Component Output

Project Design

F.H.S. Project, IEC Component Year Two Workplan

Nigeria Family Health Services Project, Public Sector Program Support, Year Two Workplan and Budget

Monitoring Supervision and Evaluation of the Pathfinder Program - Nigeria

Project Implementation Report

Policy Component

USAID/The John Hopkins University, Institute for International Programs. 1988 (14th October)  
Contract No. 620-0001-C-00-9001-00 Family Health Services/Policy Component

The John Hopkins University, Institute for International Programs. 1989. Strengthening Public Health Programs in Developing Countries. The John Hopkins University Press, Baltimore

The John Hopkins University, Institute of International Programs, 1989, Update Vol. 4, No. 1. Nigeria Family Health Services Project: Policy Implementation Component. 1989. "Support to Nigerian Federal Ministry of Health Department of Planning, Research and Statistics: Information Center Subproject." Contract No. REDSO/WCA 620-0001-C-00-9001-00

Nigeria Family Health Services Project. Policy Implementation Component. May 30, 1989. "Response to Project Committee Generic Comments." Contract No. REDSO/WCA 620-0001-C-00-9001-00

Nigeria Family Health Services Project: Policy Implementation Component. 1988. "Quarterly Performance Reports October 1988 - December 1988." Contract No. REDSO/WCA 620-0001-C-00-9001-00

\_\_\_\_\_ 1989. "Quarterly Progress Report (Financial and Performance Reports) January 1, 1989 - March 31, 1989." Contract No. REDSO/WCA 620-0001-C-00-9001-00

\_\_\_\_\_ 1989. "Quarterly Progress Report (Financial and Performance Reports) April 1, 1989 - June 30, 1989." Contract No. REDSO/WCA 620-0001-C-00-9001-00

\_\_\_\_\_ 1989. "Quarterly Progress Report (Financial and Performance Reports) July 1, 1989 - September 30, 1989." Contract No. REDSO/WCA 620-0001-C-00-9001-00

\_\_\_\_\_ 1989. "Workplan for Year 2 of Project April 1, 1989 to March 31, 1990." Contract No. REDSO/WCA 620-0001-C-00-9001-00

\_\_\_\_\_ 1989 (November 20). "Draft Report of the Subcommittee on Quality Indicators in Family Planning Service Delivery." Submitted to the Task Force on Standardization of Family Planning Program Performance Indicators

Federal Ministry of Health, 1988. The National Health Policy and Strategy to Achieve Health For All Nigerians

USAID, 1987. Family Health Initiatives II: Nigeria Subproject Paper 098-0462.20 Vol.1

\_\_\_\_\_ 1987. Family Health Initiatives II - Nigeria Sub-Project Paper. Vol. II Annexes

**Public Sector Component**

Nigeria FHS Project: Public Sector Component, Pathfinder's Contract. Contract No. 620-0001-C-00-8018-00

Nigeria FHS Project: Public Sector Program Support. Year Two Workplan and Budget. June 1989

Nigeria FHS Project Public Sector Component. Quarterly Report January to March 1989 and annual summary for year one

Nigeria FHS Project, Public Sector Component, Quarterly Report for April - June 1989

Pathfinder Fund, November 1989: Letter from James Crawford to Matthew Fieldman on Population Technical Assistance

AID Subject Paper, Family Health Initiatives II, July 1987

Draft Report of the Sub-committee on Quality Indicators in FP Service Delivery

Federal Ministry of Health: National Health Policy to Achieve Health for all Nigerians, 1988

**Private Sector Component**

Nigeria FHS Project: Private Sector Component, FPIA's Contract. Contract No. 620-0001-C-00-8018-00

Nigeria Family Health Services Project: Private Sector Component. Quarterly Progress Reports (Financial and Performance Reports) August 1988 - Present

Private Sector: A presentation to the Evaluation Team, November 1989

Marketing of Contraceptive commodities in Gasoline Retail Outlets, Sweethill Associates

Market-based Distribution of Contraceptives: A Needs Assessment Survey, August 1989

RMS: Report on pack/concept statement Evaluation

RMS: Report on Condom Name Test

RMS: Report on Usage and Attitude Study, August 1989

RMS: Family Planning Study - Omnibus

FPIA: FO3 Contract with Sterling

FPIA: FO4 Contract with Sterling

Qu

IEC Component

FHS, Status Report: IEC Component Outputs November 1989

National Family Planning Logo: Summary of Activities. Prepared by The Federal Ministry of Health April 27, 1989

PCS Country Project Status Sheet, Contract No. 620-0001-C-00-8013-00 November 8, 1989

Project Title: Plateau State FPILEC Campaign Family Planning/Information Education and Communication Project Proposal for Two Years

The Johns Hopkins University, Population Communication Services. Award/Contract 620-0001-C-00-8013-00 March 15, 1989

\_\_\_\_\_ . Family Health Services Project: "Administrative and Logistics Component

\_\_\_\_\_ . Family Health Services Project. Benue State Ministry of Health Project Title: Benue State FP/IEC Campaign AF-NGA-18 Project Document, January 1, 1989 - December 31, 1990

\_\_\_\_\_ . Family Health Services (FHS) Project: "Information, Education, Communication (IEC) Year Two: Second Quarterly Progress Report July - September, 1989"

\_\_\_\_\_ . Financial Report 1989 (30 June) Contract No. 620-000-1-C-00-8013 Nigeria Family Health Services (FHS) Project

\_\_\_\_\_ . Financial Report 1989 (30 September) Contract No. 620-000-1-C-00-8013 Nigeria Family Health Services (FHS) Project

\_\_\_\_\_ . "Information, Education, Communication (IEC) Year Two: First Quarterly Progress Report April - June, 1989"

\_\_\_\_\_ . IEC Component Year Two Workplan April 1989 - March 1990

\_\_\_\_\_ . IEC Component Year Two Workplan Description of Activities, (In Preparation for Project Management Committee Meeting, January 18 - 20, 1989) Year Two: April 1989 - March 1990

Documents Provided by the FHS Project Administrator and the Components:

Areas for Team Evaluation

Private Sector Component: A Presentation to the Evaluation Team

Policy Support Component - Activities Progress Made

Project Implementation Report

USAID's Family Planning Effort in Nigeria: Focus on FHS Project Information Note #5, July 1989

Family Planning: Growth in the Public Sector, Nigeria 1985 - 1988, Information Note #10

95

**The Public Sector Pathfinder Fund, Overview of Activities**

**Sustainability of FHS Project Activities - A Beginning Look**

**FHS: September 1989, Triannual Management Meeting - Workshop Recommendations**

**Impact and Evaluation Activities for IEC**

**Fertility and Family Planning in Nigeria - Some Pieces of a Puzzle, Information Note #4, July 1989 (R. Sturgis)**

**Overview - Population Policy Implementation and FP in Nigeria**

**The Nigerian Population Policy**

**Appendix D**  
**Summary of Marketing Analysis**

## Appendix D

### Summary of Marketing Analysis

#### MARKETING ANALYSIS: A SUMMARY

##### A. Evaluation Objectives

The objectives as related to marketing inter-alia include:

- 1) To assess FPIA's development and implementation of private sector family planning activities.
- 2) To determine the extent to which FPIA has:
  - developed marketing communications related to private sector family planning;
  - distributed and made available family planning commodities through the private sector; and
  - provided training to medical personnel working in the private sector.

##### B. Marketing: General Achievements

Through the efforts of FHS/private, a good foundation has been laid for private sector family planning activities. There is, however, much ground to be covered in this sector.

The level of public awareness of family planning products in the private sector appears to have increased over the last year. This increase can be demonstrated through sales figures which have been on the rise, despite the fact that nothing has been done to-date in the area of marketing communications.

##### C. Product Line/Packaging

FHS/private offers one product line, which consists of over ten family planning products. Out of the different methods being sold currently through Sterling, FHS/private has decided to actively market the following three contraceptives:

1. Blue Panther - Renamed "RIGHT-TIME."
2. Noriday Pills - Renamed "Gynovol."
3. Virginal Foaming Tablet - Renamed "Foamax."

The three brand names were selected using market research efforts which determined that they were acceptable to the Nigerian market. This included focus groups which tested the names in terms of their ease of pronunciation, ability to remember, and any negative connotations.

FPIA has made a good decision with regard to marketing three major products out of the many available. This will ensure that FHS/Private efforts and attention are not thinly distributed. The project should, however, continue to sell (but not market) the other seven products "silently" and directly to private hospitals and clinics. Most of these are prescriptive items.

D. Product Positioning

Target Group

To date, market research efforts have focused attention on male and female members of the C, D and E socio-economic groupings. This research focus excludes the A and B groupings for the following reasons: 1) FHS/private is mandated to work with this lower income populations, and 2) members of the A and B groupings often tend to be more aware of family planning.

Positioning

Contraceptives should be positioned taking Nigeria's unique cultural and religious diversity into consideration. Furthermore, family planning products should be positioned in order to emphasize their importance in reducing mortality rates, improving quality of life, etc. Advertising messages should emphasize:

- smaller families ensure sound education for children;
- a reduced population helps to improve the Nigerian economy, which in turn provides a better standard of living for Nigerians; and
- how family planning activities complement and support the Federal Government's recent population policy.

E. Market Research

To date, the project has carried out the following market research:

- 1) Product/Pack/Concept statement
- 2) Price study in relation to competition
- 3) Product new brand names
- 4) Attitude/Usage
- 5) Awareness/Usage (Omnibus study method).

The Omnibus study of usage/attitude appears the best study carried out to date. Judging from the number of respondents (4,000 in 24 urban towns and 48 rural areas across the country) the results can be taken as fairly representative.

On the other hand, it is clear from the research reports available that some of the marketing research may not have been carried out using appropriate methodologies. In these cases, the choice of participants was inadequate for a fair representation of the "universe." For example, the condom name test conducted in Lagos and Kano had 120 persons in all - 12 focus groups of 10 persons each. The population of Lagos and Kano which runs into millions calls for more focus groups with more participants before the results can be useful. Focus groups can be very useful in determining the public's reaction to marketing ideas. However, in a multi-ethnic society such as Nigeria, the selection of participants from different tribal groups and the number of groups need to be carefully determined.

To determine the authenticity of report statements, FHS/Private should interview the researchers. The project should also call for all completed questionnaires for each research item and get an independent expert to review them. Until the above verifications are made, caution should be taken in making serious decisions based on research results to date.

F. Distribution

Sterling provides a ready made network distribution for the project, with 50 distributors and 2,650 retailers nationwide. The Sterling approach is very suitable for reaching a network of appointed distributors and private hospitals and clinics, and provides an effective, inexpensive conduit distribution pipeline. To ensure this productive relationship, the project should maintain good contact with Sterling's management, remembering that Sterling carries out many activities out of "good will." The project should also work to develop effective schemes to motivate Sterling to further support the family planning products, e.g. a new payment fee based on a sales commission, further target setting, etc.

While nearly all commercial distribution of commodities is provided through Sterling Products (Nigeria) Limited, there are plans by the FHS/Private to involve other major distributors such as Pharco, WAD, Clarke, etc. If achieved, this would ensure that there are other networks in place should Sterling stop participating. To develop new channels at a point of sudden stop is not easy and can jeopardize the whole project.

While developing alternative distribution approaches should be encouraged, a controlled policy should also be maintained. Care should be taken not to let distribution get out of hand -- saturating all segments of the market with the products. For example, a contraceptive's reliability might be doubted if it were sold in a barber's shop or market stall.

Another way to supplement the present commercial approach would be to identify independent distributors or a group of distributors to cover a pre-determined market territories. While such distributors can only handle non-prescriptive items, they would be able to reduce the product/market reach workload on the project.

G. Pricing

Current FHS/private commodity prices are as followed:

	<u>Product</u>	<u>Price Range</u>
1.	Durex (a pack of 3)	N2 - 3
2.	Sultan (a pack of 4)	N1 - 2
3.	Blue Panther (strip of 4)	N1
4.	Gold circle (strip of 4)	N1
5.	Neosampon (a pack)	N3 - 5
6.	Petal	N1 - 2

Because FHS/Private has a mandate to sell to a specific target group, e.g. low income acceptors, these prices appear to be appropriate at this time.

H. Marketing Activities

The marketing input provided to Sterling by FHS/Private has been minimal to date. Solid assistance is needed to accelerate the development and implementation of sustained marketing strategies. To do this, the following needs to be carried out as soon as possible:

- FPIA's three major Nigerian products need to be properly branded for customer identification and recognition. The branding should not be underrated. It will play an important role on product customer perception, preference and choice;
- Vigorous commercial persuasive communications need to be launched as quickly as possible;
- Marketing consultants as well as advertising agencies need to be hired.

Both international and domestic consultants should be brought in to provide periodic marketing assistance. These consultants could help to spot problems and offer suggestions to correct them.

#### I. Promotion: Above-the-line Activities

At this time, no advertising activities have been carried out, since the advertising brief is still in draft form. To facilitate the process, the following activities should be undertaken as soon as possible:

- Employ the services of registered AAPN Agencies.
- Develop a time table to meet target.
- Seek to have less control on advertising from N.Y. and make it a local affair so that major decisions can be made locally to save time.
- Constitute an "Ad plans Board" for ratification of all ad materials.

#### Advertising Agency

Because of the complex cultural and religious diversity found in Nigeria, it may be necessary to have two advertising agencies on this job: one agency to serve the northern market and a second (Lagos-based) to serve the southern part of Nigeria. The activities of the two would be coordinated at the center by an Ad Plans Board. This arrangement poses tremendous advantages of ensuring that advertising tasks are monitored and money is well spent.

The two appointed advertising agencies should be asked to present and compete creative ideas related to: generic logo; concept message (corporate); radio script; press designs; billboard designs; TV/cinema storyboard or creative sequence; and suggested POS materials. Whichever agency has the better ideas should handle all the production and make copies available to the other agency. It is necessary to have one advertising agency handle the production of all materials because of the required standardization and uniqueness in message (though modifications will be required to carry the culture of the target audiences along).

#### Ad Plans Board

The following can be considered as suitable members of the Board.

- Project Administrator (FHS)
- Head of IEC (FHS)
- Head of FPIA (FHS)
- Marketing Consultant
- Representative of Sterling (Nigeria)
- Representative of Health Ministry (Chief Pharmacist of FDA)
- FPIA N.Y. Representative

### Advertising Legal Requirements

Because of the pharmacist Act Cap 152 Part 8, it is necessary to clear all products and register them with FDA before embarking on mass media campaigns. The advertising materials also have to be vetted and approved by same FDA before they can be used. What is certain is that the pills cannot be advertised at all because it is a prescriptive product and not over-the-counter.

Because of these restrictions, the following alternatives should be explored: 1) advertising condoms only; 2) working with the government to change the law; 3) getting special concession from government for FPIA products to advertise them; 4) advertising the family planning concept only on a general awareness basis and leaving the buyers to purchase any family planning products based on their choice and product availability; 5) advertising concept only plus FPIA logo and asking people to purchase from stores that have FPIA logo. The stores should be motivated through market incentives to push FPIA contraceptives; and 6) advertising family planning and the FPIA generic logo, stressing the importance of family planning and encouraging the public to buy products with FPIA logo on the pack - "Buy genuine, buy contraceptives with this logo on them."

### J. Promotion: Below-the-line Activities

It must be said that much has been done already under this sub-heading by the IEC. The level of awareness obtained hitherto is to a large extent associated with IEC activities. Some of the jobs already done:

- IEC sponsored Sunny and Onyeka records.
- Secondary School debates and women programmes in Kano.
- Many press editorial reports.
- Electronic media news items and public interviews.
- Radio plays and discussions on family planning.
- Sponsored full page write-ups in some local magazines

The IEC has a lot of below-the-line activities in the pipeline like family planning seminars for Obas, Chiefs, Emirs, Church leaders, etc.

**Attachment A**

**Sources of Information**

1. **FHS Materials**

- Project Components and goals
- Draft of Ad Brief
- FGN National Policy on Population
- Marketing of Contraceptive commodities in gasoline retail outlets
- Private Sector: A presentation to the Evaluation Team
- FPIA: FO4
- RMS: Report on pack/concept statement evaluation
- RMS Report on Usage and Attitude Study
- RMS Family Planning Study - Omnibus
- FPIA: FO3
- RBNL: Music campaign Evaluation (Focus Group Discussions)
- IEC: What has been in the press
- The National Health Policy and Strategy by FMH, Nigeria
- RMS Report on Condom Name Test
- FHS: Project background information
- Family Health Initiative II - Nigeria

2. **FHS Staff talked with**

- Dr. Richard Sturgis
- Dr. Uche Azie (FPIA)
- Dr. B. Ifeanyi Ibe (FPIA)
- Mr. Uche O Ekenna (FPIA)
- Mr. Kim Winnard (JHU/PCS)

3. **Places Visited**

- Sterling Product (Nigeria) Ltd., Lagos
- Sterling Lagos warehouse
- Sterling Ibadan Depot
- FDA Dept., Fed. Ministry of Health, Lagos

4. **People talked with outside FHS Staff**

- Rev. T. Fawole, Chief Auditor, Sterling, Lagos
- Mr. Bello, Area Manager Sterling Depot, Ibadan
- Mrs A. O. Masha, Project Co-ordinator, Sterling, Lagos
- Mrs. E. A. Ubok-Udom, Chief Pharmacist, FDA, Lagos