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PRIVATE SECTOR ASSESSMENT

FAMILY HEALTH SERVICES PROJECT

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Revised July 27, 1992

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ACRONYMS

AAO	AID Affairs Officer
AID/W	Agency for International Development/Washington
AID	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CBD	Community Based distribution
CCCD	Combatting Childhood Communicable Diseases
CHAK	Christian Health Association of Kenya
CHAN	Christian Health Association of Nigeria
CPR	Contraceptive Prevalence Rate
CSM	Contraceptive social marketing
CYP	Couple Years Protection
DHS	Demographic and Health Survey
EPI	Expanded Programme for Immunization
FDA	Food and Drug Administration
FHS	Family Health Services
FMOH	Federal Ministry of Health
FPIA	Family Planning International Assistance
FPLM	Family Planning Logistics Management
GON	Government of Nigeria
HMO	Health Maintenance Organization
HPN	Health, Population and Nutrition
IEC	Information, Education and Communication
JSI	John Snow, Inc.
MIS	Management information system
MOH	Ministry of Health
NANGO	Nigerian Association of Non-Governmental Organizations
NANNM	Nigerian Association of Nurses and Nurse-Midwives
NGO	Non-governmental Organization
NMA	Nigerian Medical Association
OAU	Obafemi Awolowo University
OC	Oral contraceptive pill
OR	Operations research
OR/TA	Operations Research/Technical Assistance
ORS	Oral rehydration salts
OTC	Over the counter
PHC	Primary health care
PPFN	Planned Parenthood Federation of Nigeria
PSI	Population Services International
QA	Quality assurance
RFP	Request for proposal
STD	Sexually transmitted disease
TAG	Technical Advisory Group
TFR	Total Fertility Rate
USAID	U.S. Agency for International Development
VSC	Voluntary surgical contraception

EXECUTIVE SUMMARY

An assessment of the private sector activities of the Nigerian Family Health Services Project took place June 15 to July 2, 1992. The assessment team consisted of Marjorie Horn (AID/W, Team Leader), Nancy Pendarvis Harris (John Snow, Inc. - Washington), Marc A. Okunnu (JSI - Zimbabwe), and Susan Krenn (Population Communication Services, Johns Hopkins University - Nigeria).

Under the terms of the five-year FHS I Project, private sector activities have been implemented by Family Planning International Assistance (FPIA). Their contract will terminate in February 1993 and will not be renewed or extended. In addition, the follow-on project for the larger FHS umbrella program is in the design phase. This assessment was undertaken to review private sector activities carried out under FHS I, and to develop a private sector strategy that can be implemented in the transition period (between the end of the FPIA contract and the beginning of FHS II) and continued through the life of the follow-on project.

The FHS I private sector strategy was market-based, grounded on a view of Nigeria's private sector as robust and dynamic, and capable of rapid expansion if properly stimulated. A two-pronged approach was applied to project implementation: (1) commercial-retail outlets and large scale distributors; and (2) individuals or institutions providing services, preferably through umbrella organizations.

By the end of March 1992, the project had nearly met its target of establishing 12,000 service delivery points, and had exceeded its training target of 6,000 providers. Since the inception of the project, the private sector has sold commodities representing 365,000 CYP. While this figure implies that the project has fallen well short of its target of 1.2 million private sector users, it is worth noting that fully half of the total CYP were sold during the last year.

The overall strategy for the FHS II private sector program for the next seven years is to continue the basic market-based approach while refining it to incorporate longer investment periods (i.e. more institutional, less financial sustainability in the first few years), and to build in technical, managerial and research/evaluation improvements to assist FHS II to better achieve its (total project) objectives, understand the sector and adapt quickly to a rapidly changing environment. The approach to accomplishing this strategy is outlined below:

GENERAL STRATEGY

- Tailor activities in the private sector to take into account the natural market segmentation in Nigeria. Specifically, commercial and social marketing activities will continue to reach throughout the entire country. Activities with provider networks will be consolidated and expanded primarily in urban areas and in the southern zones. PPFN and NGO networks (such as the mission hospitals) will focus relatively more attention on reaching the northern zones, complemented by IEC specifically targeted to the region focused on creating awareness and developing support for family planning within these communities, and among political, traditional and religious leaders.

COMMERCIAL AND SOCIAL MARKETING

- Continue to expand the availability and accessibility of contraceptives through commercial and other private sector outlets and to insure a steady supply at reasonable prices by: 1) stimulating the straight commercial sector (i.e. no subsidized contraceptives, perhaps local production); 2) supporting social marketing of "moderately" priced contraceptives (pills, IUDs, injectables, NORPLANT) using large scale advertising and promotional activities such as nurse-vendor programs; and 3) for the first few years of FHS II, continuing to sell unbranded AID-donated contraceptives to private providers working with low income populations (particularly NGOs and nurse-midwives).

- Establish more sophisticated mechanisms to monitor market forces (e.g. price elasticity, demand, market share), to facilitate informed, strategic decision-making on gradually pulling out of the non-branded "market" and eventually the CSM market as well (if feasible).

PROVIDER NETWORKS

- Consolidate and build upon the strengths of existing work with private providers and NGOs to improve their quality, efficiency, output and method mix. Utilize performance criteria, additional funding and technical assistance to triple the capacity of the most effective programs over the next three years while adding more effective methods (VSC services or referral, NORPLANT, IUCDs). Subsequently, on an evolutionary basis, place increased emphasis on financial sustainability.

- Expand work with provider networks gradually, selecting 3-4 medium to large scale new initiatives per year among NGOs or private providers (large hospitals or provider networks) over the next 4-5 years. The most effective will be phased

up; AID assistance will be phased out of the less effective programs over the life of the project.

TECHNICAL SUPPORT

- Renew, with built-in incentives and contractual conditions if necessary, efforts to coordinate FHS technical components to address key policy questions facing the private sector, enhance IEC efforts addressed by the private sector, and insure steady GON support. A high level TAG (technical advisory group) or other mechanisms will be put into place to stimulate strategic thinking.

As the process of designing the follow-on project for FHS II takes place during the next year, decisions will be made concerning design, organization, staffing and management that will affect the functioning of the private sector. To move the private sector activities forward during the coming 18-month transition period without compromising flexibility and innovation under FHS II, the team outlined a plan of work for the areas of commercial and social marketing, provider networks (for-profit and NGO groups), IEC, policy, and program support.

I. Introduction

This assessment examines the private sector component of the Family Health Services Project, jointly supported by the Government of Nigeria and the U.S. Agency for International Development. The purpose of this five-year project, initiated in 1988, is to make family planning information and services widely available. Targets include increasing the national contraceptive prevalence rate to 12 percent, and serving 70 percent of those users through more than 12,000 commercial, community level or private outlets.

To carry out this program, an overall strategy was developed that linked private sector service delivery, public sector service delivery, information, education and communication (IEC), and policy implementation. Four prime contractors were selected to implement these components. Family Planning International Assistance (FPIA) has been the prime contractor for private sector activities. Their contract will terminate in February 1993 and will not be renewed or extended. The follow-on project for the larger FHS umbrella program is in the design phase, and is not expected to begin until June 1994.

As part of the design effort, USAID/Lagos requested AID/W to organize and carry out an assessment of the FHS private sector activities. This assessment was planned to review private sector activities carried out under FHS I, and to develop a private sector strategy that can be implemented in the transition period (between the end of the FPIA contract and the beginning of FHS II) and continued through the life of the follow-on project. Shortly before the assessment began, Sterling Products Nigeria LTD, which has been the cornerstone of the FHS project's large scale distributors network, announced that it would cease to participate in the project as of the end of October 1992 (now extended to December 1992). As a result, the team also developed an approach to replacing Sterling. The private sector assessment took place from June 15 to July 2, 1992.

II. Family Health Services I

A. Original Design

The first step in reviewing current private sector activities and identifying priority activities for the next seven years is to look retrospectively at the strategy, assumptions, tactics and objectives of the program and at how these played themselves out in project implementation.

The FHS I private sector strategy was market-based, planned on a vision of Nigeria's private sector as "vibrant" and "robust" and as having enormous potential, if properly stimulated, to rapidly expand. Reliance was placed on the entrepreneurial nature of individual Nigerians (private practitioners, pharmacists, nurse-midwives, market vendors, etc.) and organizations (retailers, hospitals, NGOs, etc.) to encourage family planning because it was in their economic interest to do so. Unlike the more passive public sector, it was assumed that the private sector can be counted on to be proactive if there is sufficient profit margin combined with a lack of external barriers or disincentives.

A strong profit motive was assumed. Prices were originally set fairly low (based on little market research), but it was expected that providers would be able to make an adequate profit through greater volume of clients or sales. Additionally, mid priced contraceptives were expected to be introduced into the market to enhance sustainability and profitability. A National Population Policy and IEC aimed at desensitizing family planning were expected to eliminate external obstacles and stimulate latent demand. Quality of care to the client was to be assured through numerous training activities.

Although the complex Nigerian market was not well understood at the time the project was designed (nor is it today, although more information is available), its multiple facets combined with Government of Nigeria/AID's desire to rapidly increase access and achieve national scope suggested a design with maximum penetration into the market. The tactic was to pursue multiple service outlets. The project aimed at establishing over 12,000 private sector "outlets" for contraceptives and/or services in just five years. Amazingly, this number will be achieved. As a result, some level of contraceptives became available in virtually every corner of Nigeria and access, while still inadequate, has increased tremendously, especially in the more commercially oriented South.

A two-pronged approach was applied in actual project implementation. One prong focuses on commercial-retail outlets and large scale distributors (e.g. Sterling, PSI, others); the second on service providing individuals or institutions,

preferably through umbrella organizations. The overall vision, however, was that the Nigerian private sector health system comprised a series of overlapping provider networks--like intersecting circles. Penetration through multiple, competing channels was expected to provide healthy competition and stimulate growth.

The limits of the multiple outlet approach were recognized (namely, saturation of a market directed mainly at middle income groups), but the assumption was made that since so much needed to be accomplished in the initial project cycle, market saturation would not pose problems until contraceptive prevalence had greatly risen. Meanwhile, through market research, MIS, etc., or through implementation experience, the project would collect information on the sector to enable it to better understand and predict the market.

Based on technical direction from AID, the original design was highly aggressive in pursuing financial sustainability. (This applies to programmatic costs; the project plan called for investing $17 million in donated contraceptives.) The design emphasized maximizing local resources, optimizing already trained personnel, testing cost recovery efforts in training, a minimalist approach to sub-project funding and reluctance to front end large sums of money for advertising, using income from sales instead. While this approach enabled the private sector to achieve its ambitious training and service outputs with a very modest financial investment, individual provider output was sometimes compromised.

The project originally planned a first year focus on nine states. These states were only partly selected based on market potential, and no secondary targets were set (other than national prevalence or service targets). In any event, USAID and the Government of Nigeria (GON) altered the focus states over the life of the project, and new states were created. Because the strategy was broad, adaptations were made to the shifting geographical focus. Still, over the life of FHS I, energy, time and resources have been concentrated increasingly in the more responsive Southern zones.

The assumption that the private sector would respond to minimal stimulation applied to technical assistance as well as to financial inputs. It was believed that basic, high quality family planning training would be sufficient to get things going. The roles of network, provider or outlet-specific IEC and strong supervision and monitoring systems were probably underestimated in the original planning. Some adjustments and additions were made over the life of the project.

The user target of 1.2 million, or about 10 per outlet, seemed doable, although some among design team members believed

that user and acceptor targets were overly ambitious. The project relied on an assumed collaborative mode wherein IEC, policy and public sector (training) components would complement private sector work. Further, it was expected that the private sector would be less vulnerable to political, economic and management changes in the operating environment.

B. Experience to Date

Notwithstanding substantial changes in Nigeria's political and economic situation, seemingly insurmountable technical problems (especially with mounting social marketing), the failure of collaboration, and inconsistent technical direction, the project functioned, in terms of overall design, remarkably closely to the way it was laid out in the original project paper. This is undoubtedly both a strength and a weakness: a strength because it enabled the project to meet many of its stated targets and retain consistent focus; a weakness because it led to inflexibility which may have cut off important opportunities for growth, improvement or strategic design adaptations.

Overall, since the inception of the project in April 1988 through March of 1992, the Private Sector Division has sold:

- 2.7 million pill cycles
- 12.6 million condom pieces
- 570 thousand vaginal foaming tablets
- 28 thousand IUDs

This represents a total of nearly 365 thousand CYP of which approximately half were sold in 1991 (183 thousand CYP). In addition, some of the private networks (eg. NKST Mission Hospital) also provide VSC, but this is still a relatively small part of the overall program.

In total, contraceptive commodities, and family planning equipment and supplies valued at $6.4 million have been shipped to Nigeria for use in both the public and private sector. Thus, the project will far short of its goal of distributing $17 million worth of contraceptives. However, as shown in Table 1, by the end of March 1992, the Private Sector had nearly met its targets for establishing service delivery points and had exceeded those for training family planning providers:

Table 1
Private Sector Outputs

OUTPUT TASK	As of 3/91	As of 3/92	EOPS
Distribution			
Commercial Outlets	3,500	4,425	4,375
Private Health Providers and Service Sites	1,525	4,938	5,650
Vendors, Work places and Associations	1,134	1,334	2,100
Training			
Pharmaceutical Personnel	3,540	4,392	4,000
Vendors and Community Workers		1,088	1,000
Nurses and Doctors	1,449	2,300	2,100

1. Service Delivery Models under FHS I

In carrying out its two-pronged approach to project implementation, several models of service delivery evolved. The first prong, as noted, focussed on large-scale distributors and commercial retail outlets. The second prong, focused on individuals and institutions, sought to establish family planning service delivery networks, preferably through umbrella organizations. This approach has included both profit-making and non-profit service providers.

a. Commercial-Retail Outlets (Vendors)

In addition to the large scale commercial distribution of contraceptives carried out by Sterling Products of Nigeria, Ltd., several sub-project activities were undertaken with groups of vendors. One approach trained volunteer market women to sell contraceptives along with their other products. Back-up referral support, resupply and coordination of project activities is provided by a trained nurse located in each market. A variation of this strategy has used only trained nurses as vendors/health educators in markets, working through branches of the National Association of Nigerian Nurse Midwives (NANNM). A related

activity focussed on selling condoms through a national network of gas station minimarts.

b. Profit-Making Service Providers

The bulk of the sub-project activities undertaken in FHS I were with profit-making providers of medical services. Activities were implemented by private doctors; private nurses and nurse-midwives, primarily through state-level affiliates of NANNM; private profit-making hospitals and clinics; and private firms as part of a package of health care provided to employees.

Nursing Associations. FHS I currently supports nine private practitioner programs with nursing associations. Each program has trained 100 to 150 private nurses and nurse-midwives in family planning methods, including IUD insertion. Nursing association staff monitor the nurses and sell them contraceptive commodities during quarterly visits. Under this model, the goal is for the programs to become self-sustaining through profit from the sales of commodities and other income generating activities.

Profit-Making Hospitals and Clinics. There are currently nine hospital-based subcontracts. In keeping with the private sector focus, the hospitals included in the project are located in urban areas with populations of at least 100,000. In addition, hospitals were eligible to participate in FHS I only if they had satellite clinics serving different towns or areas, or affiliate clinics serving the same catchment area as the hospital. In some cases, clinics extend their reach into the community through CBD workers.

Employee Health Plans. Relatively less attention has been given to efforts to provide family planning services through employer-provided health care plans. Programs have been carried out with two parastatals: NITEL, the national telephone company, and NEPA, the electric power company. At the end of year four of FHS I, it appeared that continuation rates were very low, and the number of contraceptive clients served may have been fewer than 300. During the first two to three years of FHS I, some efforts were undertaken to interest large companies such as Nigeria Airways, the Nigerian National Bank, and others. However, this strategy was subsequently dropped.

c. Non-Profit NGOs

This category of providers covers non-governmental organizations (NGOs) and church-affiliated institutions. One type of NGO activity is similar to the market vendor program, but the projects have been implemented by non-profit women's cooperative societies, which use their members as CBD and outreach workers. The hospital-based model undertaken by several

profit-making institutions was also adapted to three non-profit mission or church affiliated hospital networks, which consist of a centrally located hospital, clinics, and CBD workers. Also covered under the category are university youth programs, represented currently by two programs at the universities of Ilorin and Nigeria (Nssuka and Enugu campuses). Among NGOs, PPFN, a large single focus family planning agency, is treated as a special case. Since PPFN is the subject of a recent assessment (see E. Weiss, et al., 1992) it will not be addressed in any detail here.

d. Acceptors and Contraceptive Sales

It has not been possible to compile completely comparable information on the contribution of these several models to service provision under FHS I, due both to definitional differences between FPIA and JSI, and to differences in information obtained from vendors and that from other types of provider. Nevertheless, some general statements concerning the varying success of these models can be made based on the data that are available.

Table 2 summarizes numbers of new and return or continuing users by provider type. With few exceptions, data from the FPIA provider groups--the profit making hospitals and clinics, mission hospitals, and women's groups--cover a 12-month period ending in March 1992. The reference periods for the JSI provider groups vary from 6 to 18 months for the vendors program, from 9 to 30 months for the nursing associations, and from 7 to 12 months for the employee health plans and universities. Despite these differences, it is clear that three types of provider groups have been the most successful: the women's groups, mission hospitals, and the nursing associations. The profit making clinics and hospitals also have done well, but the total number of visits or acceptors is spread over a larger number of individual providers.

Table 2
Family Planning Visits/Acceptors* to Private Sector Providers by Provider Type

PROVIDER TYPE	NUMBER OF PROVIDER GROUPS	VISITS TO CLINICS/ACCEPTORS		
		NEW	RETURN	ALL
VENDORS PROGRAM (JSI)**	5			11,433
NURSING ASSOCIATIONS (JSI)	10	75,110	49,897	125,007
PROFIT MAKING HOSPITALS AND CLINICS (FPIA)	9	19,381	2,294	81,154
EMPLOYEE HEALTH PLANS (JSI)	2	2,655	175	2,830
MISSION HOSPITALS (FPIA)***	3	14,455	19,308	38,291
WOMEN'S GROUPS (FPIA)	3	37,935	21,754	63,752
UNIVERSITIES (JSI)	2	228	83	311

*JSI data include numbers of Return clients; FPIA data refer to Continuing users, reported under column heading "Return"
**Based on sales data using CYP formulas: 72 condoms per new acceptor; 72 foaming tablets per new acceptor; and 6.5 pill cycles per new acceptor.
***Does not include 798 VSC clients.

Within each of the provider types, certain individual groups or institutions stand out as being particularly successful, notably the women's groups in Ondo and Plateau States, and NKST in Benue State among the NGO groups. For the profit-making providers, the Borno Medical Centre, Sefa Specialist Hospital in Kaduna, and Madonna Hospital in Kano[1] have served large numbers of clients, particularly noteworthy because they are all located in the northern zones. Among the nursing associations, the groups in Oyo and Rivers States report an average number of visits per month of approximately 1,500 and 2,600 respectively.

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[1]This sub-project was terminated in October 1991 at the request of the hospital.

The full information on visits to clinics/acceptors from which Table 2 is taken is shown in Appendix Table A1.

Although less complete information is available on contraceptive sales (e.g., no data from the nursing associations, the employee groups, or the universities), the women's groups appear to be very successful providers of contraceptives, as shown in Table 3. However, it is important to note that these data also cover different time periods, extending back to February 1989 in the case of two of the three women's groups. The full data we were able to obtain on contraceptive sales by individual provider groups is included in Appendix Table A2.

Table 3
Contraceptive Sales by Provider Type

PROVIDER TYPE	NUMBER OF GROUPS	CONTRACEPTIVE SALES			
		Condoms	Pills	VFTs	CopperT
VENDORS (JSI)	5	62,972	15,264	83,592	
MISSION HOSPITALS (FPIA)	3	51,888	11,601	11,451	2,282
WOMEN'S GROUPS (FPIA)	3	481,975	145,461	302,992	0
PRIVATE MEDICAL FACILITIES (FPIA)	9	504,192	217,001	69,362	3,777

2. Assumptions revisited

As indicated, FHS I was based on a vision of a vibrant private sector greatly influenced by the profit motive. This remains a basic FHS assumption. If anything, FHS II will place even more reliance on the private sector because reorganization, declining resource levels and other problems chronically plague the public sector. Still, the overall picture for private sector is not as bright as it appeared five years ago, and the AID/CA community has a more realistic idea of its strengths and weaknesses. John Tomaro's report summarizes economic stresses on the private health sector. (Tomaro, J. & S. Kolodin, 1992).

Ironically, the economic downtrend appears to be increasing demand for family planning while simultaneously inhibiting the consumer's ability to pay which drives the system. Competition among providers has been stimulated by the poor economy. The implication of the current economic situation for project design is probably an ongoing need for subsidized contraceptives and services, especially if the project targets include the still largely underserved urban and rural poor.

Although there is ample evidence that the profit motive is alive and well in Nigeria, the profitability of family planning, particularly in initial phases and among small-scale providers, may have been overestimated. Longer investment periods for both sub-projects with individuals and provider networks, and commercial or social marketing ventures may be required. The project may do well, at least over the next few years, to place more emphasis on developing institutional sustainability and consistent supply chains than on financial independence. (See Sturgis/Lule paper.)

Although subject to debate, the tactic of multiple outlets seems, even in retrospect, to have been appropriate for the overall project design. It enabled the private sector to keep up with the public sector growth and massive public sector training inputs. Private providers who are ignorant about family planning can be serious barriers to use; this was not the case in Nigeria since large provider networks and power groups were co-opted into the program. Also, large national and statewide IEC campaigns (e.g., the National Logo) would not have been justifiable without the access to services in the private sector. In the long or even medium term, these service sites (even relatively inactive ones) may see a steady, if small, increase in their users even without further stimulation. Stimulating the most promising programs (e.g. NANNMs, hospital and NGO networks) is proving useful in improving performance. A momentum has been created by the project's initial thrust.

Whereas a large scale "jump start" for the private sector was successful initially, the multiple outlet tactic may need to be modified in the follow on phase. A strategy of planned and more carefully targeted growth, with larger and more successful programs receiving more support, could assist the program to consolidate gains made in the initial phase of the program.

Phase two planning needs to take a more careful look, possibly at the state or zonal levels, at the places where the "circles intersect" in the marketplace. Planners tend to see the private sector as vast when they count up the number of doctors and nurses, hospitals and clinics, mission and NGOs, and work places with large numbers of employees. Taking a closer look, it is clear that these are not always separate entities. Thus a doctor-run hospital with multiple retainer contracts with large

employers may also employ a nurse-midwife who participates in the NANNM program. If planning isn't careful, there is a risk of over-serving the same acceptors--urban, employed, middle or high income people--who may comprise as little as 10% of the population. A better tactic may be to approach these groups as parts of a whole fabric of care. Working with doctors will encourage them to provide VSC and encourage contraceptive sales. A well designed education, condom distribution and referral program by nurse-midwives or young doctors in factories and work places, paid for by employers, could accomplish more than not very cost effective employer-based clinics. Likewise, certain groups, like mission hospitals in the North, are naturals to be "lead" agencies in their areas, even among nondenominational employers or private practitioners.

With respect to management, under FHS I, Family Planning International Assistance (FPIA) was the prime contractor for the private sector, and also has had responsibility for commodity distribution to both public and private sectors. In addition, FPIA was the prime contractor for training and implementation of family planning service delivery in the private sector. Training activities were sub-contracted to the Margaret Sanger Center, and some types of service provider activities were subcontracted to John Snow Inc. (JSI).

The terms of the sub-contract with JSI did not establish direct lines of authority between FPIA's Associate Regional Director, who had overall responsibility for the Private Sector Program, and local JSI staff. Instead, local JSI staff reported to their head office, which in turn provided information and progress reports directly to FPIA headquarters in New York. This arrangement hampered the ability of the Private Sector Director to obtain timely information on progress and to coordinate the diverse components of the Private Sector Division.

Similarly, lack of incentives for collaboration and cooperation among the prime contractors handicapped full utilization of IEC component of FHS I.

A further problem that affected the FHS I program overall, not just the private sector, concerned the project's relationship with USAID/Lagos. During the first years of the project, activities were hampered by staff changes at A.I.D.. Throughout FHS I, inconsistent technical direction and the lack of an HPN officer to provide technical guidance have also been constraints. It is expected that this situation will be addressed under FHS II.

C. Critical questions

In the course of reviewing the original assumptions of the FHS I project, and considering the experience to date in the private sector, the team identified several important issues for the FHS II design. The issues focus on two areas: promotion and delivery of family planning services through private provider networks; and USAID's approach to commercial and social marketing.

Regarding the provider networks, concern was directed at such issues as the number and size of service delivery sites, method mix, structural and managerial changes required to work more effectively in the private sector, needed technical improvements, the private sector in relation to the national scope of FHS, and sustainability. Questions concerning marketing focussed on profitability, targeting clients for social marketing, current pricing practices, policy barriers, appropriate qualifications of firms to carry out commercial and social marketing, and ways to facilitate better business relationships between the USAID/GON supported project and the business community.

These issues or "critical questions" were addressed in individual discussions, and in two larger meetings with representatives of Nigeria's business community and with key staff of FHS I. A full text of the questions is included in Appendix B. The program design contained in the following section was formulated based on what was learned.

III. FHS II

A. Program Goals and Objectives

The PID for FHS II specifies a number of targets in order to achieve the purpose and objectives of the project, as follows[2]:

- Reduce the national total fertility rate (TFR) from 6.0 in 1990 to 5.0 in the year 2000
- Increase the prevalence of modern contraceptive methods from 10% to 20% in the urban areas, and from 2% to 10% in the rural areas
- Increase the knowledge of methods and sources of family planning from 41% to 80% by the year 2000
- Increase the proportion who use long lasting or permanent methods of contraception to 60% of total users
- Maintain the proportion of contraceptives provided by the private sector at 60%

The Family Health Services project is national in scope, and is expected to reach into all areas of Nigeria. As such, it is appropriate that overall targets for the project should be stated in national terms. However, Nigeria is diverse in terms of religion, ethnicity, socioeconomic status and education, all of which are associated with use and knowledge of contraceptives. This diversity is acknowledged in the PID by differentiating between urban and rural areas in setting targets for increases in prevalence. However, this distinction does not fully account for differences between the northern and southern zones, which are reflected in attitudes towards family planning, contraceptive use, and demand for services, as shown in Table 4 which displays data collected on those topics in the 1990 Demographic and Health Survey.

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[2]The team did not address the feasibility of the project objectives and specific targets. We understand the targets will be revised as appropriate when the project paper is written.

Table 4
Family Planning Attitudes and Behavior by Zone

Attitude/Behavior	North-east	North-west	South-east	South-west
Percent who believe that it is acceptable to have messages about family planning on radio or television	36.7	37.2	67.4	80.8
Percent who approve of family planning among currently married women who know a contraceptive method	62.6	54.2	75.3	80.1
Percent of currently married women who want no more children	9.2	10.1	21.8	23.4
Percent of currently married women who use a modern method of contraception	1.3	0.7	3.9	10.5
Total demand for family planning services among currently married women (includes those currently using and those with an unmet need for services)	22.9	15.4	35.3	38.0

Source: Federal Office of Statistics and IRD/Macro International Inc. 1992. Nigeria Demographic and Health Survey 1990.

Women in the two southern regions are far more likely to approve of the use of mass media for disseminating family planning messages, and to have favorable attitudes towards family planning in general, than are women in the north. About twice as many women in the south reportedly want no more children compared to women in the north, and, although rates of contraceptive prevalence are low throughout the country, the highest percentage using a modern method is found in the Southwest region. Further, the total demand for family planning services is higher in the two southern zones; the lowest demand is found in the Northwest.

These variations in attitude and demand for services imply that the tasks for the private sector (as well as for the public sector) will differ by zone. There is much work to be done in the north on increasing the acceptability of family planning services, building constituencies and generating demand. Attitudes are relatively more favorable in the south, and more

attention may be focused on continuing to expand the service options available, and on moving towards greater sustainability in those zones. Because the challenges are different, it seems appropriate to set some targets at least at the zonal level to permit a clearer assessment of program achievement. Changes in overall prevalence are a poor indicator of project performance.

B. Proposed Strategy

The overall strategy for FHS II private sector program for the next seven years is to continue the basic "market-based" approach while refining it to incorporate longer investment periods (i.e. more institutional, less financial sustainability in the first few years), and to build in technical, managerial and research/evaluation improvements to assist FHS II to better achieve its (total project) objectives, understand the sector and adapt quickly to a rapidly changing environment.

The approach to accomplishing this strategy is outlined below:

General Strategy

- Tailor activities in the private sector to take into account the natural market segmentation in Nigeria. Specifically, commercial and social marketing activities will continue to reach throughout the entire country. Activities with provider networks will be consolidated and expanded primarily in urban areas and in the southern zones. PPFN and NGO networks (such as the mission hospitals) will focus relatively more attention on reaching the northern zones, complemented by IEC specifically targeted to the region focused on creating awareness and developing support for family planning within the community, and among political, traditional, and religious leaders.

Commercial and Social Marketing

- Continue to expand the availability and accessibility of contraceptives through commercial and other private sector outlets and to insure a steady supply at reasonable prices by: 1) stimulating the straight commercial sector (i.e. no subsidized contraceptives, perhaps local production); 2) supporting social marketing of "moderately" priced contraceptives (pills, IUDs, injectables, NORPLANT) using large scale advertising and promotional activities such as nurse-vendor programs; and 3) for the first few years of FHS II, continuing to sell unbranded AID-donated contraceptives to private providers working with low income populations (particularly NGOs and nurse-midwives).

- Establish more sophisticated mechanisms to monitor market forces (e.g. price elasticity, demand, market share), to

facilitate informed, strategic decision-making on gradually pulling out of the non-branded "market" and eventually the CSM market as well (if feasible). Total sales volume, expansion of numbers of outlets and market penetration into low income and underserved areas will be used to judge performance in this area.

Provider Networks

- Consolidate and build upon the strengths of existing work with private providers and NGOs to improve their quality, efficiency, output and method mix. Utilize performance criteria, additional funding and technical assistance to triple the capacity of the most effective programs over the next three years while adding more effective methods (VSC services or referral, NORPLANT, IUCDs). Subsequently, on an evolutionary basis, place increased emphasis on financial sustainability. CYP, method mix and user profiles will be used to judge performance in this area.

- Expand work with provider networks gradually, selecting 3-4 medium to large scale new initiatives per year among NGOs or private providers (large hospitals or provider networks) over the next 4-5 years. The most effective will be phased up; AID assistance will be phased out of the less effective programs over the life of the project. Performance criteria will be the same as for older programs, taking into account "scaling up" time.

Technical Support

- Renew, with built-in incentives and contractual conditions if necessary, efforts to coordinate FHS technical components to address key policy questions facing the private sector, enhance IEC efforts addressed by the private sector, and insure steady GON support. A high level TAG (technical advisory group) or other mechanisms will be put into place to stimulate strategic thinking.

C. Program Design

1. Commercial and Social Marketing Component - Inputs

This is the most important component of the FHS II project and the key to its overall success. It is the component for which informed decision-making and rapid response to changing conditions is vital, yet despite five years' experience, it is the sector where we still have inadequate in depth knowledge. Although in the future better research would undoubtedly facilitate decision making, lack of definitive data--or even good notional information--for decision making is only partially due to inadequate research to date. Basically, this is a sector and

a market which is changing very rapidly, due in some measure, in fact, to AID's interventions. Six years ago there was little interest in large scale contraceptive marketing schemes; at least five major firms have expressed interest now.

AID's dilemma in decision-making concerning which activities to support at what financial and technical levels in this sector center on how to resolve two seemingly (or potentially) conflicting programmatic objectives. On one hand, to achieve the overall project objective of reducing the TFR, services need to be provided on a large scale to both middle class AND poor people. Because of restructuring and other difficulties, it is unclear to what degree public sector programs can achieve this in the short or medium term, so 60% of the contraceptives are to be distributed through private sector channels. Unlike the private sector, AID also has an obligation (not just an inclination) to monitor quality of care.

Taking advantage of Nigeria's dynamic private sector, on the other hand, involves facilitating and enabling market forces to work. Too much interference at the operational level inhibits the private sector, which essentially applies only one criteria to its activities--profitability. Nigerian businessmen are, quite properly, not interested in ventures which will not be profitable. Since AID cannot subsidize contraceptives or services indefinitely, it is in the program's interest to foster healthy markets which turn a profit on selling a large volume of contraceptives at moderate prices (rather than the current modest volume at high prices).

In many other AID programs, social marketing or commercial market stimulation is an important but discrete component of AID's overall portfolio. Because of its unique, highly innovative design, in Nigeria marketing of contraceptives is the core of its entire private sector effort. Its success or failure will determine not just whether commercial sources can service the B, C or even D client, but literally whether the project succeeds or fails.

The original project design tacitly recognized a segmentation of supply and marketing approaches. Marketing of non-branded, low priced contraceptives was expected to gradually give way to social marketing of higher priced contraceptives. (Condoms were the only product actually launched.) Not expressly written into the design, but implied, was that the commercial sector would also be stimulated by intensive demand generation activities, particularly generic promotion of contraceptives, and overall prices would fall. (Anecdotal and survey evidence suggests that this did indeed happen.) Leakage of public sector commodities was anticipated, but it was not expected to make up a significant share of the market. (Anecdotal and sketchy MIS data

suggest it may be a more important market force than previously thought.)[3]

Thus the contraceptive picture has moved from one of having essentially three supply systems competing for the market--1) high priced commercial brands; 2) low quality, often expired inexpensive contraceptives in informal channels; and 3) free or inexpensive but often out-of-stock donated contraceptives though the public sector or NGOS--to the current situation, as shown in Table 5.

Table 5

Current Contraceptive Market in Nigeria

Type	Price	Supply-Reach
Commercial brands	High to Moderate	Depends on distributor; market growing
CSM Program (only condoms) - AID Supplied	Moderate	Doing fairly well in targeted markets; serving middle class
Unbranded contraceptives- AID supplied; UNFPA injectables	Low	In outlets throughout the country; also through provider networks; not clear if poor are using
Leaked, unbranded public sector - donor supplied	Very low	Unclear; reputed to be widely available in markets, pharmacies, etc.
Public sector product - donor supplied	Free - cost recovery to be initiated	Widely available, vulnerable to stock-outs
Other - adulterated, old	Unknown	Very little information available

The picture, though more complicated and confusing now, is also more positive. Multiple delivery networks cause healthy

[3]A recent FPLM report (see Olson, et al) indicated that its possible to adequately account for less than 49% of contraceptives which left the warehouse. Although much of this discrepancy is due to MIS deficiencies, a significant percentage could also be assumed to be "leakage."

competition in spite of some unhappiness among program managers. The positive results are increased availability of supplies to consumers and a cushion for consumers when stock-outs occur in any given part of the system. Stock-outs plague the public sector particularly, but they appear to be widespread, even with commercial sector products. Prices also have been kept low, though whether the market (or given segments) could pay higher prices is still unknown and needs to be studied.

Another critical variable in the Nigerian contraceptive marketing equation is the impact of injectables and NORPLANT on the overall market, particularly the pill market. Injectables are already highly acceptable to clients and are constrained mainly by bad publicity, provider bias and poor availability. FDA approval in the United States could open the door to wider availability throughout Africa. Even at a slightly higher price, Depo Provera, if and when it becomes available through AID or commercial means, is likely to replace some of the pill market and perhaps a significant portion of it. NORPLANT will have a longer introduction period, but also will be a popular method eventually. Its reliance on medical practitioners makes provider programs even more important.[4] More analysis or study of the potential market share of injectables, and a strategy for procurement, needs to be made over the next six months. AVSC or other technical groups need to team up with business and marketing people to present options to AID on NORPLANT.

Notwithstanding unanswered questions, AID needs to make some choices in resource allocation and approach. The pull out of Sterling Products after almost seven years presents a challenge to the program. The suggested approach aims at striking some balance between AID's demographic goals and social concerns and the clear long range advantage of maximizing the commercial viability of the sector. Like all compromises, this one will not satisfy everyone. An underlying assumption is that as long as there continues to be money to be made, especially given AID's heavy subsidy to the sector, the private sector will be responsive.

The suggested approach is designed to continue stimulating the commercial sector, gradually increase sustainability through efficient social marketing programs and insure supplies of low cost contraceptives for low income groups.

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[4]Reliance on medical personnel has negative as well as positive aspects. Access is decreased and cost increased but, on the other hand, NORPLANT is somewhat likely to be a good revenue generator for private practitioners who will thus market it more aggressively than OCs, which have a low profit margin.

a. Commercial Stimulation

This will include a number of investments and joint ventures designed to stimulate growth and development in for-profit Nigerian businesses such as pharmaceutical manufacturers and distributors, private health care firms, and HMOs. Particularly targeted is the importation and marketing of contraceptives and, if it proves feasible, local manufacturing. AID's PROFIT project will play a key role in these activities.

Policy activities such as targeted reductions of duty on contraceptives, plus motivational activities among the business community will be undertaken. A heightened effort will be made to study and monitor growth of the contraceptive market, so that AID can adapt its program to insure that it stimulates this market as much as possible. Also, through advisory committees and other mechanisms, the business community will be drawn into the process of strategic planning.

b. Social Marketing

FHS II will develop two types of socially marketed products, one geared for middle income people, the other for mid to lower income groups. Products will have separate packaging and marketing strategies. Items to be socially marketed over the next seven years include condoms (mainly with an AIDS/STD prevention message), oral pills (the first "new launch"), injectables (expected to overshadow the popularity of the pill), IUCDs (with special education programs for doctors and nurses), and perhaps NORPLANT (pending feasibility studies, first phase introduction and creation of medical back-up networks throughout Nigeria).

Part of any social marketing contract will be a closer monitoring--by the contractor--of the retail sales situation. AID will endeavor to refrain from micro-managing the private sector contractor. The contractor(s) will be contractually responsible for quarterly reports which, along with sales data, will include analysis of trends and changing client profiles.

The STRONG recommendation of the team is that CSM (possibly including other products such as treated mosquito nets) be competitively procured. Between one and three contracts could be let for: (1) condom social marketing with a strong AIDS/STD prevention focus;[5] (2) social marketing of contraceptives

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[5]A low-cost, AID supplied condom is currently being marketed by PSI under the name "Gold Circle". Since the product is doing well, USAID should continue this strategy "as-is", over the next 18 to 24 months.

directed at middle income consumers; and (3) social marketing of contraceptives directed at lower income groups.

Advantages of fewer (one or two, maximum) contractors are better control over the process, more profitability for the potential contractor (and thus more incentive for potential bidders) and ease of management by AID. Disadvantages include providing a corner on the market with attendant risks if the contractor performs poorly. Advantages of multiple contractors might include enhanced healthy competition; disadvantages, administrative and programmatic complexity.

The steps and time frame of the process are:

• Prepare scope of work for the RFP	July-Aug
• Contact potential bidders and begin soliciting interest. Based on qualifications of potential bidders, request expressions of interest and pre-qualify bidders	July-Aug
• RFP distributed and returned	Sept-Oct
• Contract awarded	Oct-Nov

c. Distribution of Non-packaged and Branded Contraceptives

The distribution of non-packaged or non-branded contraceptives (i.e. just as AID donates them, not repackaged for CSM) through various commercial, market vendor and service provider networks is well developed. As a formal social marketing program is launched, the non-packaged contraceptives will be gradually replaced by the low priced contraceptives in the social marketing program. In the interim, and until the low priced socially marketed products are fully launched, non-branded contraceptives will continue to be distributed through two channels, namely: (1) normal commercial channels and (2) the FHS Project directly (as is currently being done for many of the FPIA-funded programs. The AAO and Project Manager will monitor the situation and withdraw non-branded contraceptives at the appropriate time. It is expected that non-branded contraceptives will be sold for at least 12-24 months in some parts of the market.

Sterling Products, Ltd. is currently marketing the non-branded contraceptives for AID, but is pulling out of this activity at the end of December 1992. If AID acts quickly, it could have a CSM contractor in place by that time.

2. Profit-Making Providers

At the present time, there is a need to strengthen or create referral and back-up systems for providers in the private sector. This is particularly the case for providers who are not directly affiliated with hospitals or clinics. Attention should be given to creating links between current service delivery points such as CBD workers, pharmacists, market women, and even nurses in some cases, and other providers, including individual practitioners or hospitals, clinics and health posts that have staff trained under the FHS project to handle problem cases, dispense more information on various contraceptive methods and side-effects, and provide more effective methods such as IUDs, VSC or NORPLANT. This referral system should bring clients from the community to a specific individual or site. To insure that such a system functions properly, it will likely be necessary to include some co-payment for those who sell non-clinical methods to refer clients to another facility or provider. A small scale test using a referral card that the client would give to the back-up provider, that would in turn entitle the referring agent to a co-payment might be tried (either with one of the profit-making groups such as the market vendors, or in conjunction with one of the women's society CBD programs).

Provider Networks. The work of FHS I with some 26 private provider networks has been among its most encouraging. Some projects have demonstrated a far faster upward curve in serving family planning users than similar efforts (without the market incentive) in much of Africa. Projects have experienced a normal (or less than normal)level of attrition (i.e. lost to program but not necessarily no longer providing services) and have achieved their targets. Typically, some providers or clinics are more productive than others, just as some programs using similar models achieve different results. For example, the recent situation analysis study of service delivery in Nigeria found that 19% of surveyed service delivery points provided services to 75% of all new clients in 1991 (Obafemi Awolowo University and Population Council, May 1992).

In its work with for-profit provider networks, FHS II will: (1) consolidate and improve existing programs; (2) expand through existing or improved models and umbrella groups; and (3) match IEC, policy and research assistance to program needs.

a. Consolidation of Networks

Initially, all ongoing FHS I sub-projects with for-profit provider networks will be continued. These projects will be assessed to identify improvements which have potential for increasing output, particularly in terms of CYP generation. The Private Sector Division will be restructured so that time saved

on not administering commodities procurement can be spent providing additional technical assistance while continuing monitoring and management of programs. Additional funding will be provided for activities supporting key program improvements, including, but not limited to the following:

- Establish revenue-sharing referral systems for VSC and other more effective methods. Enhance volume of private sector training in VSC, counselling and management of VSC programs.

- Diversify the revenue generating potential through adding new products (e.g. baby products, medicines, etc.) to providers lines and/or marketing of health education to private employers.

- Integrate ORS, EPI and other PHC activities into ongoing networks as appropriate.

- Improve quality of care through introduction of Total Quality Management techniques at larger hospitals or clinics, in-service training and method update, counselling training and support, locally available consultants for special questions or medical back-up and regular professional upgrading.

- Simplify reporting and management procedures while maintaining adequate levels of supervision through field visits.

- Introduce CYP and other planning tools.

- Introduce multi-year funding.

- Strengthen management and planning capacity of subproject program managers and foster inter-project sharing and technical assistance.

CYP and other measures such as number of new users, revisits and referrals, method mix trends and user profiles will be used to judge performance. CYP generation is expected to triple in the next three years. Part of the work scope, beginning in year two of FHS II funding, will be to develop viable long range plans for program sustainability and a performance-based system for retaining or discarding elements of the program to enhance output. Phase down to sustainability will begin in year three or four, unless programs have special value (e.g. are doing a great number of VSC procedures but cannot sustain themselves on fees, are piloting new approaches, etc.)

b. Expansion of Networks/Development of New Models

During the first 4-5 years of FHS II, between 4-5 medium to large projects will be initiated using both existing models and, where feasible, umbrella groups. "Sister" programs will be tried where national federations are too weak. In these programs, successful and well managed networks will be funded (project support and management and monitoring costs) to adopt a like institution and replicate their program with the new institution. Efforts will be made to identify, and work with, umbrella organizations, where possible in conjunction with other AID-funded private sector health ventures.

Existing models which have proven useful and will be replicated in new areas include the networks established by the state-level affiliates of NANNM, and the hospital or clinic-based networks such as that of the Excel Clinic, Lagos or the Port Harcourt Nursing Home.

c. Employee Health Plans

Based on FHS I, Enterprise and TIPPS Program experience in Nigeria and elsewhere, there are several reasons why this model was less successful and why it may not be useful to pursue actively except in special situations: (1) work-based services are only useful in large employers (over 500 workers concentrated in one site), with large numbers of female employees and/or workers living on site (e.g. plantations or mines), and existing full service health facilities. Only a few employers meet this criteria. Most parastatals have many employees, but they are dispersed throughout a large system; (2) factory and work place clinics, where they exist, are sometimes served by nurse vendor programs or hospital programs; (3) most employees seek services at retainer hospitals, employees are sometimes shy to seek services at the worksite; and (4) the program failed to mount an active constituency building campaign among employers using both health and cost benefit rationales.

Given Nigeria's circumstances and the widespread use of retainer hospitals, a better model could be to use provider network programs as vendors of IEC on family planning, AIDS/STD and health, perhaps combined with condom sales through employers. If a very professionally prepared curricula (with visual aids) were prepared, and providers were armed with the right type of presentation to employers (e.g. stressing cost benefit using Nigerian and other data), they could possibly convince employers to pay a fee for each health education talk and to subsidize condoms for their male employees as well. This would enhance the provider networks' profitability, generate resources through employers and reach a crucial target group for AIDS prevention and family planning messages. This activity could be targeted as

an add-on to existing programs, with materials prepared through the IEC Division of FHS.

3. Private Non-Profit Providers (NGOs)

Private, non-profit providers (mission hospitals and clinics, women's groups, university programs) are addressed separately from profit-making private providers in this analysis so that the project design could identify special needs and features. Features which differentiate this category include a not-for-profit end, which often corresponds with a public health perspective; lower potential for sustainability because of non-profit status; fewer business and management skills; and a tendency to target lower socioeconomic groups than private for profit providers.

Except for PPFN, which is a special case, much of what is recommended in terms of program improvement and performance outputs is the same for NGOs as for-profit. In terms of geographic coverage, however, PPFN and the NGOs are better suited to continue to pioneer family planning activities in the north where attitudes are less favorable, and programs are still in the developmental stage. PPFN traditionally has played the role of innovator, introducing services in areas where the government activities might be viewed as intrusive and might be politically sensitive. Similarly, the mission hospitals have a certain moral force which helps to legitimize family planning activities, even in conservative communities. Thus, it is expected that these networks will be encouraged to reach into the northern zones, aided by targeted IEC activities focussed on creating awareness and constituency building.

a. Planned Parenthood Federation of Nigeria (PPFN)

The recent assessment of PPFN (Weiss, et al., 1992) provides details on its role and activities, and contains a number of recommendations for improving and strengthening the organization, management and programs of PPFN. The comments below are intended to supplement the assessment recommendations.

During the transition and implementation of FHS II, support should be provided to PPFN for:

- Organization and management development:
  - Training and hands-on TA in strategic planning to:
    - -- re-examine and redefine the role/mission of PPFN;
    - -- identify clear and specific directions, strategies and programs emanating from the mission;

  - -- determine appropriate geographic and programmatic targets;
  - -- establish clear roles and responsibilities at central, state and LGA levels consistent with the overall PPFN strategy.

- Develop new, or revise and streamline existing policies, organization and management structures, management systems and procedures as well as staffing, to be in line with the new strategy, focussing, for example on supervision, financial management, accountability, monitoring and evaluation and planning.

- Design and implement a comprehensive human resources development and utilization plan, including competitive compensation packages and more international training for staff.

- Place short to medium term (3-24 months) management advisors (preferably Nigerians) to assist in undertaking the tasks above, if PPFN is agreeable.

- Provide program development support to address key program areas (e.g. specific aspects of advocacy, IEC, service delivery and reproductive health programs for adolescents and young people) as may emerge from the strategic planning exercise.

b. Non-profit Hospitals and Clinics

To date NKST, EYN and Baptist Hospital/Eku have emerged as strong Church-affiliated family planning service providers in the non-profit private sector. Activity monitoring and progress (quarterly) reports by FPIA clearly document the success of this category of providers, from the standpoint of coverage, acceptor levels, method mix, management and provider motivation, commitment and enthusiasm as well as cost consideration. Issues related to sustainability, turn-over of trained staff and quality care should be addressed as part of providers issues affecting all aspects of the private sector.

These hospitals are part of the Christian Health Association of Nigeria (CHAN), a national umbrella organization for church-affiliated health institutions. With a membership of 316 hospitals, maternities, clinics, dispensaries and health program with over 2,000 health posts and similar facilities all located among rural communities and city slums nationwide, CHAN represents a significant national infrastructure. Its members serve an estimated 40 million Nigerians; employ 16,000 workers; operate 15,000 hospital beds; and record 12 million outpatient visits per year.

CHAN serves its members in four areas: (1) administrative and management support and training; (2) procurement and distribution of high quality pharmaceuticals; (3) primary health care promotion and coordination; and (4) a holistic health care project. For family planning activities, CHAN's greatest constraint is its Catholic members. To date, this has meant that member institutions must be approached individually concerning family planning. However, in FHS II, some attention should be given to determining whether the experience of the Christian Health Association of Kenya (CHAK) might suggest a strategy for working with CHAN without encountering resistance from its Catholic members.

Apart from service provision which is best handled by individual members, in FHS II CHAN might play an important role in constituency building, serving as a conduit for reaching clients as well as its member institution. FHS II could work with CHAN to establish and apply criteria for selecting members institutions for new provider networks.

Attention in FHS II should also be addressed to investigating the possibility of working with the Nigerian Association of Non-Governmental Organizations (NANGO).

c. University-based programs

In view of the number of people who come in contact with the university system, university-based programs can be beneficial in reaching young people before they begin their reproductive lives, and encourage them to be long-term contraceptive users. Current program development efforts are still evolving. In terms of implementation, one potential model is for a "mature" program, such as those at the Universities of Ilorin, Lagos or Ibadan (the latter is not AID funded) to be supported to provide financial and technical assistance to one of their "sister" universities. Obafemi Awolowo University (OAU) has been identified as a potential new site. Alternatively, a set of interventions and procedures could be pre-packaged and offered to several universities, based on a qualifying or quasi-bidding process, as with foundation research grants.

Given the size and potential reach of universities and university-dependent population, and the fact that university acceptors can be expected to be "lifelong users" (versus a 35 year old woman who already has 4-6 children), efforts need to be made to refine a model for rapid program expansion. There are currently a number of University-based programs. It is suggested that several of these be considered to evaluate the different approaches and impact before expanding this aspect of the FHS project.

The following steps/process could be implemented under FHS II:

- establish criteria for selecting participating universities;
- mail information on the program and invite strategically selected universities to indicate interest in participating;
- organize training course/seminars for technical and managerial personnel;
- select, train and follow-up students and workers as counsellors/distributors;
- contribute a strong IEC component.

4. Program Support

a. Policy and Strategic Planning

The "Strategy for Increasing the Private Provision of Health and Family Planning Services in Nigeria" paper (Tomaro and Kolodin, May 1992) briefly discusses the policy environment affecting private sector health and family planning programs and identifies a number of issues and actions to be addressed. The overriding concern is to ensure that no unnecessary regulatory barriers exist that inhibit the wider availability and accessibility of family planning services, within the need to guarantee the safety and quality of service. Equally important is the need to recognize obstacles that make it unprofitable for sections of the private sector to undertake truly commercially viable ventures within the framework of competition and free market force.

There are a number of policy issues that are said to impinge on the ability of the private sector to provide a full range of contraceptives, but there is no widespread agreement on the extent to which each issue actually poses serious barriers. Examples include:

- Whether pharmacists are "officially" permitted to give injections and thus allowed to administer injectable contraceptives. In practice, most already give injections.
- Whether CBD workers and/or market traders are allowed to sell oral contraceptives in addition to condoms and foam; or are they simply prohibited from initiating pill use, but permitted to resupply users (In fact, the

practice is widespread, and many vendors are also trained nurses).

- The level, nature and cost of screening tests, and the frequency of follow-up visits required for users of selected methods

- The potential impact of Nigeria's liability laws on distributors of contraceptives

- The prospects for reducing or eliminating the 35% import duty levied by the Government of Nigeria (GON) on all contraceptives

While further action is needed on all of the above, the most pressing to be tackled in the short term is the reclassification of the pill as an over-the-counter (OTC) rather than an ethical product. The social marketing component under FHS II should include plans for widespread distribution and marketing of low cost OCs. This is already taking place with GON approval, so OCS have become, tacitly, an OTC preparation. Unfortunately, mass media brand advertising, which is more highly regulated, is prohibited for ethical products, the category under which the pill is currently classified. Actions to be taken in relation to this issue include: (1) determining what steps are required for reclassification of OCs; and (2) developing full scale plan to attempt reclassification. A first step in this process should be to look at the evidence within and outside of Nigeria on safety issues and to explore approaches used elsewhere for reclassification. The plan should also address the issue of soliciting support from influential bodies such as the FMOH, pharmacists, manufacturers, distributors, physicians, etc. who play a formal or informal role in reclassification of drugs. An alternative to reclassification of OCs is to obtain GON permission (perhaps as a special condition on FHS II) to allow the CSM program to advertise low-cost pills, injectables, NORPLANT, etc. A strong policy effort needs to be made to resolve these issues.

In order to effectively deal with policy issues in general, FHS II should institute an ongoing process with appropriate authorities, and develop specific interventions to address policy issues. This process should include the following elements:

- Desk or other research studies regarding explicit, implicit or perceived policies, for example, on individual methods of contraception, various providers, etc.

- Preparation/compilation of reactions to the findings in the form of issues paper for discussion with appropriate public and private sector authorities.

- Dissemination of information on policy changes or directions to affected personnel at all levels in the form of:
  - Seminars/workshops by themselves or integrated into other activities;
  - Written communication, as an alternative or in addition to seminars/workshops;
  - Incorporation of changes or new policies into training curricula, service delivery and supervision protocols;
  - Inclusion of policy issues or directives in meetings of appropriate FHS and FMOH (as possible) organs. Resolutions passed or decisions made in such meetings should aim at facilitating higher level approval.

For the private sector alone there needs to be a forum for setting, reviewing and monitoring sector goals and targets. A small technical advisory group (TAG) is proposed that would be convened on a regular basis (at least twice a year). The TAG should draw high level membership from the three sub-sectors of the private sector which complement one another: commercial/social marketing; private profit-making institutions; and private non-profit institutions. Representatives from the FMOH and AID/Lagos should also be included. The TAG would assist with: 1) long range strategic planning; 2) assessment of market trends and influences, and recommendations for program action; 3) soliciting the support and commitment of private sector entities for family planning; and 4) technical expertise contributions where and when appropriate.

The major concern of this group should be for the sub-sectors to recognize, accept and fulfill their respective, mutually supportive and complementary roles in moving the private sector towards its goal. It should also be a forum for identifying, discussing and deciding on actions to strengthen facilitating factors and to eliminate or at least mitigate hindering forces.

In order to maximize its efforts, work should be carefully guided and directed through, for example, preparation and advance circulation of background papers and presentations on issues and options. To this end, support for a strategic planning group secretariat should be considered.

b. Technical Support

The private sector program unit will need to work closely with the various technical support units to ensure appropriate support and collaboration for its activities. The most critical areas for technical support to the private sector are discussed below. AVSC and IEC are already part of the organization chart

included in the PID, while the Marketing and Business Unit is recommended to be included as an additional technical division.

i) Marketing and Business Support

FHS II will plan for enhanced technical support in the key areas of marketing, market research, analysis and business skills. Two professional positions will be added, one for a marketing analyst, another for a small business development specialist to provide technical assistance to NGOs and provider networks. Tools such as existing handbooks and curricula for business skills will be used in training efforts. The business analyst will be responsible for analyzing MIS and sales data and predicting trends. He/she will work closely with the Operations Research Network based at Obafemi Awolowo University in Ife, PCS and private research firms to plan and conduct special studies outside the scope of the direct social marketing contract(s). Examples of needed studies include contraceptive pricing, consumer demand, and quality of care.

At the present time, there is little agreement on the views of consumers towards the pricing of contraceptives. In the opinion of some observers, the recent downturn in the economy has meant that people have an even greater need for low-priced, readily available contraceptives. Others point out that consumers are suspicious of drugs and commodities that are much less expensive than those sold at an unsubsidized price. Consumers fear that the subsidized price commodities are "second hand"; if they were any good, they would cost more. Thus, there is an immediate need for studies of contraceptive pricing, with particular attention given to the elasticity of demand. Results of this research can help ensure the future sustainability of private sector activities by enabling the project to set reasonable prices, and provide estimates on the length of time required for activities in the private sector to become self-sustaining.

Consumer demand for family planning services and their willingness to obtain commodities and services in the private sector are also critical areas to explore. These issues might be considered in studies addressing the wider topic of demand for health care services, and could be carried out in collaboration with demand studies currently being developed by R&D/Health staff.

Quality of care is a particular concern in the private sector because of the distribution of contraceptives by non-medical or non-clinical providers. Thus, special studies can be carried out to address this issue. For example, "mystery" shopper studies can be undertaken to learn how well providers counsel their customers on method choice, including whether they discuss contraindications for particular methods, and whether

they know and convey information on proper use of methods. Similarly, client or customer intercept studies may be undertaken to measure satisfaction with services, accuracy of information received by the customer, reasons for use of private rather than public service providers, etc. Again, the OR network might be utilized to conduct these studies.

ii) Information, Education and Communication

Strong linkages with the IEC Technical Support Unit will be an important element of FHS II. In line with the overall private sector strategy, IEC efforts during FHS II will concentrate on demand generation in urban areas, particularly in the South. In the North, increased attention will be given to creating awareness and approval for family planning. IEC activities to support this strategy will be incorporated into national programs, as well as specific private sector projects with for-profit and non-profit providers.

In addition, the IEC Unit will work with the private and public sectors and AVSC to explore the feasibility of promoting specific methods or services, i.e., OCs, sterilization and NORPLANT. Generic promotion of methods will be particularly important for the private sector if such barriers as the classification of OCs as an ethical drug cannot be removed.

At least one additional staff member will be recruited to join the IEC Unit to work specifically with the private sector. This person's function will be to provide technical assistance to private sector projects, as well as to ensure appropriate coordination with other national and state-level IEC activities.

A number of specific IEC initiatives to support the private sector will commence during the transition phase and be expanded during FHS II. These include:

- <u>Information Dissemination to Private Sector Providers:</u> NANNM, the Pharmaceutical Society, the NMA and CHAN are four strong networks of providers which can be used to distribute family planning information to their members and their members' clients. The IEC Division will work closely with these umbrella organizations to disseminate appropriate materials such as Population Reports, a family planning bulletin and other materials produced specifically for their members, or sub-membership groups.

- <u>Integration of ORS, EPI, AIDs, etc. in IEC Activities:</u> This integration will be pursued through several channels. Based on discussions with the private sector, Aidscap, and CCCD, the IEC Division will develop a plan to provide materials to professional

providers on different topics through selected networks. The specific network(s), along with the information to be distributed, will be determined in consultation with the groups mentioned above.

- Marketing Health Education: Private providers currently carrying out motivational and educational activities will be assisted to market their health education activities, integrated or otherwise, to employers. These efforts will first focus on private sector sites which have retainer contracts with large companies.

- Promoting the Provider Approach: Opportunities for promoting specific private sector providers will also be explored. For instance, a project could be designed to promote the state NANMN nurses providing family planning services. Such nurses and/or their facilities could be identified with a special logo, as was done in Indonesia.

iii) Voluntary Surgical Contraception and NORPLANT Network

AVSC will manage and provide technical support and medical back-up during FHS II to Nigeria's growing number of public and private sector providers. They will also play a lead role in developing long range strategies for a sound medical "network" for VSC. In collaboration with other program components, AVSC should plan for more pro-active private sector (fee-for-service) provision (with publicity and promotion activities) and for the design and implementation of a private sector referral network. The goal over the next seven years is to have the capacity, infrastructure and referral networks in place to undertake between _____ to _____ VSCs per year in the private sector.

iv) Training

The subject of training for the private sector is not addressed in detail in this assessment, as it is the topic of a separate analysis. As the public and private training activities are combined into a single unit in FHS II, however, we urge that careful attention be given to tailoring courses to private sector needs. Private providers have a limited tolerance for bureaucratic procedures, and also may have more stringent constraints on their time than providers in the public sector. Thus, efficient use of resources and time for training will be particularly important for private providers, although the location and content of courses may be the same for both public and private groups.

A specific training issue relates to the private sector strategy for VSC/NORPLANT. In order to increase availability of these longer term methods, more private physicians should be trained. The private sector division should work in consultation with AVSC, Department of Hospital Services and the Public Sector Division to set up criteria and systems for training x number of private sector physicians in these techniques over the next 18 months. The possibility of the physicians financing their own training should be strongly pursued.

v) Management Information System (MIS)

Comments and recommendations concerning an MIS for the private sector are included in the following section on monitoring, evaluation, and research. If a separate MIS technical unit is included in the final design for FHS II, the recommended approach would become their scope of activities for the private sector.

c. Monitoring and Evaluation

Under FHS I, three key output indicators were used to measure private sector achievements: commodities and equipment distributed; number and type of service delivery points established; and number and type of providers trained. The number of service delivery points and number of providers trained will continue to be targets under FHS II.

FHS I efforts to establish a private sector management information system (MIS) to complement that of the public sector proved difficult because of the number and variety of private sector providers and the lack of incentives to provide accurate information on new and continuing users. Ironically, the very diversity of the private sector that makes it attractive for service delivery also makes monitoring and evaluation challenging.

In FHS II, it is proposed that a basic minimum set of data be requested from service providers. In the case of hospitals, clinics, and other providers who may provide an array of health and family planning services beyond contraceptives, quarterly data on numbers of visits for new users and revisits, by method (or numbers of new acceptors and continuing users) should be collected. A common set of definitions will need to be adopted and used by all service providers falling into this category. For providers who sell contraceptives, but do not provide other services (e.g., the market vendors), FHS II will request only information on the number and type of contraceptives sold on a quarterly basis.

To supplement this basic information, FHS II will establish sentinel sites for the various categories of service providers to

collect additional information on clients or customers. These sites will be given an incentive, such as a higher percentage of sales or a fee for each completed form, to keep accurate records. These data collection systems should be designed carefully to be sure that the data needs of other parts of the project, e.g., IEC, are also addressed, for greater efficiency.

The quarterly survey that the Federal Office of Statistics (FOS) is conducting throughout 1992 on family planning knowledge, use and source of services, in addition to serving as a means of evaluating FHS I will also provide important baseline data for FHS II.

Although FHS II will not formally begin until 1994, a redesigned Private Sector component, as outlined in this document, will begin operation in early 1993. As a means of tracking progress towards the established targets of FHS II, and in order to monitor utilization of public and private providers, it is recommended that support be provided for collection of basic information (knowledge of family planning, contraceptive use, and source of services, in addition to minimal demographic and socioeconomic characteristics such as marital status, age and education) at least annually by the FOS. It will be important to ensure an adequate sample size to permit analysis by zone.

An additional important source for evaluating progress towards achieving the project's goals will be the Demographic and Health Survey, scheduled to be repeated in 1994 and 1998/99.

5. Integration

Opportunities for expanding private sector activities to include delivery of other basic health care services such as AIDs education, ORS, EPI, malaria treatment, provision of analgesics, blood testing, etc. should be explored and tested under FHS II. Although the various subgroups of the private sector--commercial sector, for-profit providers and non-profit providers--function differently, all groups should ultimately be concerned with improved services and in many cases, profit margins.

In addition to the health benefits of expanding the population's access to basic care, integration of new health services into existing projects may enhance profitability for the family planning provider through income generated from new products and/or services, and an increase in clientele resulting from a fuller range of services offered. It should be noted that representatives of the public sector fully support an expanded role for the private sector in primary health care delivery.

Options for integrating additional primary health care services into private sector activities will need to be determined based on the type and function of the private sector

entity involved. Some possibilities that could be tested on a pilot or demonstration basis follow:

- Delivery of ORS Technology, Analgesics, etc. through Nurses, Pharmacists, CBDs: These cadres of personnel could be trained in ORS preparation and administration. If ORS packets become available they could be distributed through these networks in much the same way contraceptives are currently delivered. Training could be included as part of the workshop(s) they attend for their involvement in private sector family planning activities. For the Nurses and CBD agents in particular, the distribution of ORS packets could be an important income-generating activities.

- EPI, Malaria Treatment through Doctors, Nurses: Private sector providers involved in family planning activities can be encouraged to add other primary health care services to their practices at their own initiative. Where possible, FHS II could provide linkages to training opportunities and supplies through CCCD and the public sector. Programs that successfully integrate new services can be used as models to show other providers how profits can be increased through such efforts.

- Income-Generating Services for Doctors and Nurses: Blood and Urine Testing: Increased profit through the introduction of new services such as blood or urine testing could help subsidize less profitable, but important health services such as family planning. Small capital investments for such ventures could be made through the FHS II project in a few selected sites, with a reinvestment scheme for family planning or other primary health care services.

- AIDS, EPI, ORS, Information, Education and Communication through Doctors, Nurses, Pharmacists, CBDs, NGOs: Education on topics such as AIDS, EPI, ORS, etc. can be integrated into private providers' normal service routine. Although the payoff may be less direct than with the introduction of an actual product or service, the IEC efforts can:

  - Inform clients about additional services provided thus generating interest and demand;

  - Demonstrate the provider's concern for the overall welfare of the client, helping to maintain them as satisfied users of family planning as well as for other services.

Integration of IEC efforts can be approached in a variety of ways. Education and information on different topics can be shared and discussed during family planning workshops and distributed to providers through umbrella organization publications and/or distribution systems. The providers themselves can become distribution points for client materials and can integrate new topics into their ongoing health education and community mobilization efforts. Successful integration will depend largely on ensuring provider access to up-to-date information, and identification of appropriate opportunities and channels for information dissemination.

Additional information is required to assess which approaches are most viable for integration under FHS II and under what conditions, i.e., financial support, institutional collaboration, etc. Based on this assessment a comprehensive action plan should be developed for FHS II, in collaboration with Aidscap and CCCD. As FHS II moves ahead with its integration plans, AIDSCAP and CCCD should explore what opportunities for integration of family planning exist within their own programs.

IV. Transition Work Plan

Over the next year, AID/Lagos must design the follow-on project for FHS II and complete the approval/signature cycle. A number of important decisions will be made about the design, organization, staffing and management of the follow-on project; these will undoubtedly affect the way the private sector functions. The following activities suggested for the 18 month transition period are designed to move the private sector program forward without compromising flexibility and innovation under FHS II.

A. Commercial and Social Marketing

- Fund selected commercial market stimulation activities, such as profit-making HMOs, or encouraging purely commercial contraceptive distribution systems.
- Prepare a Scope of Work for a CSM Project (to include ORS); issue an RFP to pre-qualified bidders; award a contract by December 1992.
- Transfer public sector commodities distribution.
- Undertake an assessment of the market potential for injectables; make decision on procurement and adjust CPTs.
- Close out Sterling Project.

B. For-Profit Private Providers (Hospital and NANNM networks)

- Reorganize the private sector division to use time saved by transferring administration of public sector commodities to focus on technical assistance. Simplify project systems; design TA package and train staff.
- Continue funding (most) existing provider networks and extend for 18 months (through June 1994); provide additional technical assistance.
- Fund two to three additional network provider programs, one as an add-on to existing networks.
- Design and implement pilot referral systems for VSC and NORPLANT with one to two existing networks.

C. NGOS (PPFN, Mission hospital and women's society networks, and universities)

- Implement technical assistance to PPFN; provide funding for IEC, management and clinic improvement.

- Continue funding existing NGO networks and extend for 18 months (through June 1994); test improvement strategies; integrate quality assurance and primary health care interventions (where they are absent).

- Fund one additional mission network and one or two additional university programs, using a university-to-university approach.

- Undertake discussions with CHAN and NANGO to begin planning potential joint activities; fund a workshop or training to test capacities.

- Assess potential of additional women's groups and other NGO networks to operate CBD and referral programs in selected target areas.

D. IEC

- Recruit an IEC Program Officer to work specifically on private sector activities; reactivate private sector IEC plan with specific targets.

- Disseminate materials, such as Population Reports, through professional organizations including NANNM, the Nigerian Pharmaceutical Society, the Nigerian Medical Association, and CHAN.

- Provide support for existing provider networks (profit-making and NGOs), including equipment/materials, technical assistance, or financial support for specific IEC activities.

- Integrate information on ORS, EPI and AIDS into family planning IEC activities, and vice versa.

- Develop marketable health education series for the work place.

- Improve working partnership between IEC and Private Sector Divisions.

E. Policy

- Establish the TAG; plan and convene the first meeting of this group.

- Address question of reclassifying oral pills as an OTC rather than an ethical product.

- Seek reduction of duties on commercially imported contraceptives.

F. Program Support

- Implement a monitoring system based on a minimum data set, and undertake pilot sentinel surveys.

- Design and implement TOT for "refresher" training with larger VSC counselling component (Margaret Sanger Center).

- Undertake special studies on price elasticity, demand for health and family planning services, and OR on referral systems.

APPENDIX A

TABLES

Table A1
Family Planning Visits/Acceptors[1] to Private Sector
Providers by Provider Type

PROVIDER TYPE AND AGENCY	PERIOD COVERED	VISITS TO CLINICS/ACCEPTORS			VISITS OR ACCEPTORS PER MONTH[2]
		New	Return	All	
LARGE SCALE COMMERCIAL DISTRIBUTION					
VENDORS PROGRAM (JSI)[3]					
NANNM/Lagos	7/90 - 12/91			6,053	336 (18)
NANNM/Anambra	9/91 - 2/92			1,381	230 (6)
Associated Markets/National Oil	5/91 - 2/92			128	13 (10)
NANNM/Kwara	6/91 - 12/91			1,281	183 (7)
PNA/Ogun	6/91 - 1/92			2,590	324 (8)
TOTAL				11,433	
PROFIT-MAKING PROVIDERS					
NURSING ASSOCIATIONS (JSI)					
NANNM/Lagos	10/89 - 12/91	4,734	4,371	9,105	337 (27)
NANNM/Imo	Tracking just begun	0	0	0	
NANNM/Anambra	10/89 - 6/90	6,243	2,640	8,883	987 (9)
MPMNA/Oyo	10/89 - 1/92	26,934	15,356	42,290	1,533 (28)
NANNM/Kwara	10/89 - 3/92	11,870	5,624	17,494	583 (30)
PNA/Ogun	1/90 - 12/91	9,860	8,202	18,062	753 (24)
NANNM/Bendel	4/91 - 12/91	1,635	932	2,567	285 (9)
NANNM/Ondo	4/91 - 2/92	1,908	1,088	2,996	272 (11)
NANNM/Rivers	4/91 - 12/91	11,926	11,684	23,610	2,623 (9)
NANNM/Plateau	Monitoring not begun	0	0	0	
TOTAL		75,110	49,897	125,007	
PRIVATE MEDICAL FACILITIES (FPIA)					
Apex Medical Center, Anambra	4/91 - 12/91	1,688	1,221	2,909	323 (9)
Borno Medical Centre, Borno	4/91 - 3/92			17,854	1,488 (12)
Sefa Specialist Hosp., Kaduna	4/91 - 3/92			24,738	2,062 (12)
Port Harcourt Nursing Home and Maternity, Rivers State	4/91 - 3/92			5,588	466 (12)

Table A1 Cont.

PROVIDER TYPE AND AGENCY	PERIOD COVERED	VISITS TO CLINICS/ACCEPTORS			VISITS OR ACCEPTORS PER MONTH[2]
		New	Return	All	
PRIVATE MEDICAL FACILITIES cont.					
The Eko Hospital, Lagos (terminated)	4/91 - 3/92	809	173	982	82 (12)
Excel Clinics, Lagos	4/91 - 3/92			11,299	942 (12)
Pope Paul Specialist Hospital,Imo	4/91 - 3/92	1,390	400	1,790	149 (12)
Sokoto Clinic, Sokoto	4/91 - 3/92	5,195	500	5,695	475 (12)
Madonna Hospital, Kano (terminated)	4/91 - 10/91	10,299		10,299	1,517 (7)
TOTAL		19,381	2,294	81,154	
EMPLOYEE HEALTH PLANS					
NITEL	12/89 - 6/90	2,435	0	2,435	348 (7)[4]
NEPA	1/91 - 12/91	220	175	395	33 (12)
TOTAL		2,655	175	2,830	
NON-GOVERNMENTAL ORGANIZATIONS					
MISSION HOSPITALS (FPIA)					
EYN Rural Health Program/Adamawa	4/91 - 3/92	1,726	68	1,794	150 (12)
NKST, Gboko/Benue	4/91 - 1/92	12,729	19,240	31,969	3,197(10)[5]
EKU Baptist Hosp/Delta	4/91 - 3/92			4,528	377 (12)
TOTAL		14,455	19,308	38,291	
WOMEN'S GROUPS (FPIA)					
COWAN, Ondo State	4/91 - 3/92	19,378	10,094	29,472	1,615 (12)
NCWS, Plateau State	4/91 - 1/92	18,557	11,660	30,217	1,546 (12)
Mbakor Women's Coop., Benue State	4/91 - 1/92			4,063	406 (10)
TOTAL		37,935	21,754	63,752	
UNIVERSITIES (JSI)					
University of Ilorin, Kwara	4/91 - 1/92	228	83	311	31 (12)
University of Nigeria, Nsukka and Enugu	No data received yet	0	0	0	
TOTAL		228	83	311	

Table A1 - cont.

[1]JSI data include numbers of Return clients; FPIA data refer to Continuing users, reported under column heading "Return"
[2]Based on number of months indicated in parentheses for both new and continuing users
[3]Based on sales data using CYP formulas: 72 condoms per new acceptor; 72 foaming tablets per new acceptor; and 6.5 pill cycles per new acceptor.
[4]No return visits or continuing acceptor figures included.
[5]Does not include 798 VSC clients.

Table A2:
Contraceptive Sales and Income Generated by Provider Type and Agency
for Selected Sub-Projects under the Nigerian Family Health Services Project

CONTRACEPTIVE SALES					PERIOD COVERED	INCOME (IN NAIRA)
PROVIDER TYPE AND AGENCY	Condoms	Pills	VFT	CopperT		
VENDORS (JSI)						
NANNM/Lagos	222	5,619	212		7/90 - 12/91	
NANNM/Anambra	321	889	171		9/91 - 2/92	
NANNM/Kwara	87	1,182	12		6/91 - 12/91	
PNA/Ogun	403	1,998	189		6/91 - 1/92	
Associated Markets/National Oil	128	0	0		5/91 - 2/92	
TOTAL	1,161	9,688	584			
NON-GOVERNMENTAL ORGANIZATIONS						
MISSION HOSPITALS (FPIA)						
NKST, Gboko	35,028	3,544	1,380	168	8/90 - 7/91	74,472.70
EKU Baptist Hospital, Sapele	12,226	4,029	8,351	2,114	6/90 - 10/91	14,750.60
EYN Rural Health Program, Garkida	4,634	4,028	1,720	0	7/90 - 8/91	7,655.50
TOTAL	51,888	11,601	11,451	2,282		
WOMEN'S GROUPS (FPIA)						
Country Women Association of Nigeria (COWAN), Akure	388,212	57,743	267,790	0	2/89 - 11/91	203,748.20
National Council of Women's Societies (NCWS), Jos	71,538	69,831	14,948	0	2/89 - 8/91	87,619.50
Mbakor Women Cooperative Society	2,225	17,887	20,254	0	8/90 - 7/91	37,450.25
TOTAL	481,975	145,461	302,992	0		

Table A2 Cont.

CONTRACEPTIVE SALES					PERIOD COVERED	INCOME (IN NAIRA)
PROVIDER TYPE AND AGENCY	Condoms	Pills	VFT	Copper T		
PROFIT-MAKING HOSPITALS (FPIA)						
Apex Medical Center, Igbo-Ukwu	27,561	20,930	5,236	80	9/89 - 9/91	42,371.25
Borno Medical Clinic, Maiduguri	11,545	14,216	8,168	256	3/90 - 5/91	20,948.00
Sefa Specialist Hospital, Kaduna	4,018	18,518	704	61	5/90 - 8/91	8,922.00
Port Harcourt Nursing Home and Maternity, Port Harcourt	189,508	33,242	2,726	471	3/90 - 11/91	991,155.50
Excel Clinics, Lagos	41,762	81,391	15,621	656	5/90 - 9/91	105,126.10
The EKO Hospital, Lagos (terminated)	3,734	5,101	162	236	6/90 - 12/91	11,912.00
Pope Paul Specialist Hospital , Aba	95,118	15,682	5,202	185	9/90 - 8/91	59,862.50
Sokoto Clinic, Sokoto	38,738	11,228	11,562	1,149	9/90 - 8/91	25,328.50
Madonna Hospital, Kano (terminated)	92,208	16,693	19,981	683	9/90 - 8/91	364,472.91
TOTAL	504,192	217,001	69,362	3,777		

APPENDIX B

CRITICAL QUESTIONS

The Private Sector assessment team has been reviewing the original project strategy for FHS I. In the course of looking at assumptions made in the beginning and experiences to date in the private sector, we have generated a series of key questions concerning future activities. In preparation for our meeting on Monday we would appreciate your thoughts on these issues, as well as suggestions of additional strategic issues.

Questions on Family Planning Promotion and Services through Private Provider Networks

1. The first project targeted multiple service delivery points, about 11,000. In phase II, should there be a concentration on fewer and larger sites which produce a higher volume of users, or continue with the current strategy?

2. In order to achieve more rapid demographic impact and provide the widest possible method mix, more effective methods need to gradually integrated into the existing program. What should be the strategy for integrating methods like NORPLANT, Injectables and VSC and increasing IUCD use?

3. Are there structural and managerial changes needed in the project design to enhance our ability to work with the private sector?

4. Can we achieve economies of scale and more efficiency by using certain delivery models more systematically? Can performance criteria be built into sub-projects?

5. What are the most important technical improvements which need to be made in our programs, e.g., quality care, medical back-up, referral systems, etc.

6. Will integration of other activities such as EPI, ORS enhance or diminish the effectiveness of the family planning program.

7. How can the private sector operate efficiently and still achieve national scope? Should there be focused targets for different zones or localities? Should the private sector target urban areas?

8. How much investment does FHS II need to make in institution building in the private sector? When in the life cycle of the project is sustainability reasonable?

9. How can the design highlight the community mobilization role (demand generation function) that private providers have played?

Questions concerning USAID's Approach to Commercial and Social Marketing

1. How potentially profitable is marketing pills, IUCDs, Injectables, condoms, etc. within the Nigerian context?

2. There are two types of social marketing programs. One that aims at lowering unit cost and increasing efficiency to serve low income clients, and the other to stimulate development of a purely commercial market which often serves a slightly higher market segment. What type of client should be targeted with USAID or GON subsidized contraceptives? How many years should GON or USAID plan on maintaining subsidized sales? How do they determine when to stop or phase out subsidies?

3. What is the price elasticity in the current market? Are prices too high? Too low? How can FHS better track subtle changes in the market so they can forecast needs and adjust accordingly?

4. Are there important policy barriers to contraceptive marketing? How does public sector "leakage" affect commercial or CSM sales?

5. What are the qualifications of firms that could/would qualify and would be willing to manage such a program? Should this be with a single firm, a consortium or more than one competing firm?

6. What has been the private sector's experience working with USAID or GON? Can anything be done to make these business relationships go more smoothly in the future?

APPENDIX C
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APPENDIX D
Key Documents Reviewed

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