

Population Strategy and Operations Review

Prepared for the AID Affairs Office

Lagos, Nigeria

July 8 - 27, 1985

TABLE OF CONTENTS

	<u>Page Number</u>
Acknowledgements	i
Executive Summary	ii
Recommendations	v
Acronyms Used	x
I. INTRODUCTION	1
Scope of Work	1
Methodology	2
II. EXISTING FAMILY PLANNING SITUATION	4
III. ISSUES BEFORE AID	7
IV. PROGRAM FOCUS	9
Urban Versus Rural	9
Federal Government Involvement	10
State Selection	10
Organizational Improvement	12
Other Child Survival Interventions	12
V. RELATIVE EMPHASIS OF PROGRAM ACTIVITIES	15
Policy Development	15
Training	15
Information, Education and Communication	16
Management, Statistics and Commodities	17
Basic Medical Equipment and Supplies	18
Service Delivery	18
Research and Evaluation	19
VI. IMPROVING PROGRAM PRODUCTIVITY AND COST EFFECTIVENESS	20
Management	20
Training	27
Information, Education and Communication	37
Service Delivery	41
Research and Evaluation	48

VII.	CHANGES IN MANAGEMENT APPROACH	51
VIII.	TYPE AND LEVEL OF ASSISTANCE FOR FUTURE ACTIVITIES	56
IX.	APPENDICES	
	Scope of Work	A
	Contacts and Sites Visited	B
	Project Inventory	C
	Breast Feeding and Infant Nutrition Intervention	D
	State Family Planning Checklist	E
	Contraceptive Reorder Quantities	F
	Inventory, Assessment and Future Plans for AID-Supported Training Activities in Nigeria	G
	Process of Project Evaluation and Corresponding Management Requirements	H
	Summary of Contraceptives Issued and Dispensed	I
	Theory of Organizational Coordination	J

N.B. There is no page 11 in this report due to error in numbering pages.

ACKNOWLEDGMENTS

The team was able to cover a tremendous amount of territory and to gather incredible amounts of information in a short period of time. Work was facilitated by many people. The team wishes to acknowledge, with gratitude, the assistance, support and hospitality extended by the U.S. Ambassador Thomas Smith and AAO/Lagos staff, especially Dr. Keys MacManus, Mr. Lawrence Eicher, Mrs. Shitta-Bey, and Mr. Bayo Inginla. In addition, appreciation is extended to Dr. A. B. Suliaman, Director of National Health Planning, Federal Ministry of Health, for open and candid remarks on the goals and directions of the National Family Planning Program. Thanks also must be given to all the public and private leadership in Bauchi, Benue, Imo, Lagos, Ogun, Ondo, Oyo, and Plateau States for opening their facilities and providing extensive information in response to our many questions. Finally, we thank the many international donors and cooperating agencies (CA) who willingly provided information on their current activities and future plans for Nigeria.

EXECUTIVE SUMMARY

A team of six population and family planning experts collaborated with the staff of the AID Affairs Office in the U. S. Embassy, Lagos, in reviewing strategy and operational elements of the rapidly increasing U.S. population and family planning assistance to Nigeria.

Basic Issues Addressed:

1. Can AID effect administrative or financial savings through programmatic focus or consolidation of efforts within the public sector in order to allow a greater emphasis on the private sector? If so, what kind of private sector activities?
2. Should there be any shift in relative emphasis among programmatic alternatives?
3. What can be done to improve productivity and cost-effectiveness of present program activities?
4. What changes in the management approach of AID and its cooperating agencies can enhance efficiency and effectiveness?
5. What levels of assistance will be required for future support of AID activities in Nigeria?

Procedures Followed:

The team made visits in eight of Nigeria's nineteen states; met with health officials, service providers and trainers at all levels of federal, state and local government as well as in the private sector; had discussions with Federal Ministry of Health personnel who were developing the national plan of action for family planning; and reviewed many programs and policy documents. Thus the team gained a comprehensive view of the program, if at times subjective in the absence of complete data.

Conclusions Drawn:

1. A remarkable change has occurred in the past two years in the policy atmosphere favorable to population and family planning concerns. AID has contributed effectively to assisting Nigerians review these issues.
2. Many of the essential elements of a national family planning program are in place in the public sector, at least minimally throughout Nigeria; i.e., training programs, trained personnel, facilities, equipment, commodities, IEC materials; and family planning services are being provided to a slowly growing number of clients.

3. Impressive as much of this seeding activity has been, problems and gaps ranging from minor to critical still exist. Perhaps the most noteworthy concern is the weakness of the overall public health system within which family planning services are being provided, the lack of a well defined organizational structure, and the inadequacy of management and support systems required to properly implement the family planning input. A National Plan of Action addresses these weaknesses but one can only speculate on the degree to which improvements will be accomplished.
4. Although most of the delivery of family planning services in the past has been led by the private sector, the activity has not been characterized by vigor and expansion. AID has not found an obvious front runner institution with which it could cooperate in its desire to place more emphasis on the private sector. This may change as the Planned Parenthood Federation of Nigeria shifts its role to place more emphasis on information, education and communication and outreach programs for family planning service delivery. There are great expectations for the FPIA/Sterling pharmaceutical contraceptive retail sales project but that as yet is not a proven channel.
5. AID has been successful in piecing together a comprehensive population program to meet the needs of a complex situation without a bilateral program. However, the administrative and management requirements are excessive and complicated in carrying out this program with 17 different cooperating agencies, each with a separate and narrow agency mandate and each with significant funding limitations.

General Recommendations Made:

1. To decrease some of its own management burden and improve the general management of the program, AID should support the general thrust of the government's action plan which calls for some what more federal government involvement in coordinating and facilitating the family planning program and substantial management and support inputs at the state and local implementing level.
2. To support and consolidate these management improvement efforts, AID should continue its assistance to the public sector but in ways that monitor progress against specific management and performance criteria as a basis for further expansion. This support should be in concert with UNFPA, the World Bank and other donors.

3. AID should gradually but definitely increase its support of the private sector especially in the areas of outreach-oriented information and service delivery and through commercial channels.
4. AID should continue its aggressive programming stance with its cooperating agencies to secure more cohesive and effective family planning activities in Nigeria. Changes recommended in program emphasis focus especially on substantially increasing the attention placed on information and outreach efforts. Recommendations made in individual program areas dealt particularly with shifts in training to shorter, less expensive courses with more appropriate contraceptive technology and with training firmly grounded in clinical experience. Management recommendations recognize the continuing entrepreneurial nature of a program in its early stages. Yet they also suggest ways through strategic planning to prepare for the management and coordination requirements of a maturing program. Considerable emphasis is given to the need to secure improved organizational structures and support systems especially at the state level.
5. If the present management, coordination and fund shortage problems are to be alleviated, AID should develop a bilateral or regional mechanism which makes substantially higher levels of multiyear funds available in larger blocks under the control of the AAO/Lagos.

SUMMARY OF RECOMMENDATIONS

These recommendations are noted by the section of the report in which each is found and cross-referenced by page number.

IV. Program Focus

1. AID should continue to support the public sector efforts, especially to achieve the organizational structure and management improvements called for in the FMOH Draft Plan of Action (page 13).
2. AID should initiate a gradual shift of emphasis to the private sector, substantially expanding this emphasis in a year or two (page 14).
3. AID should continue to support the establishment of EPI and ORT as child survival interventions, using non-population funds if possible, then shift its child survival emphasis to breastfeeding and infant nutrition efforts (page 14).

V. Relative Emphasis of Program Activities

1. AID should continue policy development activities at somewhat reduced levels and with an emphasis on policy as it relates to operational effectiveness of service delivery activities (page 15).
2. AID should continue to provide strong support for pre-service and in-service activities. However, training should be shorter, less expensive and directed toward more outreach and more appropriate technology as well as be management oriented (page 15-16).
3. AID should place increased emphasis on IEC efforts, including outreach activities (page 17).
4. Increased emphasis should be placed on developing improved management of program support systems, i.e., logistics, training and supervision (page 17).
5. AID may need to continue to provide limited clinical equipment and supplies in the short run, but in future AID should seek to reduce this role and encourage other donors to assume responsibility for this activity (page 18).
6. AID should continue to place major emphasis on service delivery activities with special emphasis to the private sector (page 19).
7. AID should give increased attention to research efforts, which represent a minor aspect of AID's overall effort in Nigeria. Research should focus on management and programmatic improvements, policy shifts in service delivery, and biomedical information necessary for program growth (page 19).

VI. Improving Program Productivity and Cost Effectiveness

Management

1. State Family Planning Coordinators (SFPC) should meet together quarterly for two day meetings to deal with management and supervisory problems and other issues of general programmatic concern (page 21).
2. At the present stage of development of the national program, only supply data should be utilized from the various service points. Discontinue emphasis on the daily activity form in favor of concentrating only on supply records. Prepare abbreviated instructions for daily forms and use them experimentally. Utilize revisions of client records to spot check or survey for specific issues of program management (pages 22 and 24).
3. The AAO should recruit an experienced warehouseman to manage distribution of commodities and to provide logistical technical assistance to the states (page 22).
4. AID should monitor commodity drawdown experience in Ogun state as an indicator of what might be expected to happen to commodity flow as IEC activities get underway elsewhere (page 23).
5. One of the CAs involved with training activities should provide technical assistance to the SFPCs to enable them to survey the institutional capability for management training of family planning workers (page 24).
6. The AAO should investigate if INTRAH could undertake in-country training for program supervisors similar to a short version of the Santa Cruz course (page 25).

Training

7. Efforts should be made to include family planning in the pre-service training for nurse midwives, for physicians, and in the schools of health technology (page 29-30).
8. Fewer nurse-midwives should be trained in longer clinical courses which include IUD insertion; instead, more service providers should be exposed to other contraceptive methods in shorter courses (page 31).
9. Training should not be instituted at any site that does not have a fully developed family planning service. Trainers should be persons with personal experience and confidence as family planning clinicians. Some clinical training may still need to take place out-of-country or out-of-state if no services have yet been developed in-state (page 32).

10. A formal evaluation should be undertaken to determine if length and type of training is associated with differences in nurse-midwife performance (page 33).
11. AID should encourage and finance, if necessary, a state by state inventory of all persons trained in family planning to determine their location, ability to provide services, and their potential as trainers (page 33).
12. If INTRAH training is to be repeated in additional sites, efforts should be made to reduce the length and cost of training by using experienced family planning clinicians and curriculum developed in other states (page 34).
13. One or two regional centers of special competence should be developed to provide a comprehensive base for training in all aspects of family planning service delivery, including management and outreach activities (page 35).

Information , Education and Communication

14. All CAs presently involved in IEC should be utilized to the fullest extent possible; one CA or Nigerian institution should be designated to coordinate IEC activities to achieve consistency in target and content areas (page 40).
15. Additional CAs should be encouraged to become involved in IEC activities, especially outreach and CBD efforts (page 40).
16. The population section of the Five Year Development Plan for Nigeria should be used as a springboard for political support and solicitation of other donor support for IEC. Ministries in addition to Health should be involved (page 40).
17. Cost-effectiveness of IEC should be considered and cost containment measures should be undertaken (page 40).
18. IEC efforts should be evaluated, especially using quantitative measures (page 40).

Service Delivery

19. CAs should be encouraged to increase private sector activities as a complement to public sector strategies (page 47).
20. CAs should offer technology appropriate to family planning efforts in Nigeria (page 47).
21. Service guidelines should be developed through a CA-sponsored workshop with key service providers (page 47).
22. Family planning costs to the client should be reassessed (page 47).

Research and Evaluation

23. Evaluation, concentrating on program impact, as the major goal of improved family planning service outcomes, should be undertaken by all CAs (page 49).
24. Operations research should be oriented to answering specific management or policy questions (page 49).
25. Biomedical research, selected for potential positive impact on quality and quantity of services, should be undertaken and the results shared widely (page 50).
26. Research efforts should be done by CAs with specific expertise in the area or activity being studied (page 50).

VII. Changes in Management Approach

1. AID should secure a consultant to aid the AAO in developing a plan for the next two years within the framework of the National Plan of Action of the FMOH (page 51).
2. Each CA should be invited to select elements of the Plan that are within its sphere of competence (page 52).
3. Each CA should present, in its workplan, contingency plans for coping with the most likely problems. CAs should file exception reports if targets have not been met (page 53).
4. Information on CA project activities should be entered into a computerized file in the AAO office (page 54).
5. AID/W should continue its coordination of the Nigeria Working Group (page 54).
6. AID/Lagos should support the FMOH in its coordination of the donor community (page 54).
7. AID, at a later date, should explore further the possibility of contracting Sterling for an expanded role in the management information system (page 54).
8. AID should explore ways to encourage CAs to take over some of the administrative and logistical support currently handled by the AAO (page 54).
9. AID should explore all opportunities for networking for mutual program support, particularly in the private sector (page 55).

VIII. Type and Level of Funding for Future Activities

1. AID should encourage all avenues of developing local funding capabilities, especially encouraging family planning organizations gaining access to blocked Naira accounts of U.S. based firms in Nigeria (page 57).
2. AID should develop a different funding mechanism, either bilateral or regional to make available larger blocks of money on a multi-year basis (\$50 to \$60 million over a five year period) under the management of the AAO. (page 57).

ACRONYMS USED

AAO - AID Affairs Office(r)
AID - Agency for International Development
AVS - Association for Voluntary Sterilization
CA - Cooperating Agency
CBD - Community Based Distribution
CEDPA - Centre for Development and Population Activities
CHO - Community Health Officer
CYP - Couple Years of Protection
EPI - Expanded Program for Immunization
FHI - Family Health International
FPIA - Family Planning International Assistance
FMOH - Federal Ministry of Health
HSMB - Health Services Management Board
IEC - Information, Education, and Communication
INTRAH - Program for International Training Health
IPPF - International Planned Parenthood Federation
IUD - Intrauterine Device
JHPIEGO - Johns Hopkins Program for International Education
in Gynecology and Obstetrics
LGA - Local Government Authority
MCH - Maternal and Child Health
MCM - Maternity Care Monitoring
MD - Medical Doctor
MOH - Ministry of Health
NMW - Nurse-Midwife
NTA - National Television Authority
OR - Operational Research

ORT - Oral Rehydration Therapy
PCS - Population Communication Services
PHC - Primary Health Care
PHN - Public Health Nurse
PPFN - Planned Parenthood Federation of Nigeria
SFPC - State Family Planning Coordinator
SMOH - State Ministry of Health
STD - Sexually Transmitted Disease
TBA - Traditional Birth Attendant
TOT - Training of Trainers
UCH - University College Hospital (Ibadan)
UNFPA - United Nations Fund for Population Activities
UNICEF - United Nations Children's Fund
VSC - Voluntary Surgical Contraception

I. INTRODUCTION

At the request of the AID Affairs Office (AAO)/Lagos, a team of specialists was invited to visit Nigeria July 8-27, 1985 to review the status of AID-supported population activities and to make recommendations for the future emphasis and direction of the program in Nigeria.

The Strategy Review Team was composed of the following members:

William Bair, MS, Agency for International Development
(Retired) - Team Leader

Michael H. Bernhart, PhD, International Management School
of the Netherlands

Joyce M. Holfeld, MPH, Regional Population Officer, Regional
Economic Development Support Office/West and Central Africa,
Agency for International Development

Sallie Craig Huber, MSPH, Population/Health Consultant

Miriam P. Labbok, MD, MPH, FACPM, School of Hygiene and
Public Health, Johns Hopkins University

Judith Rooks, CNM, MS, MPH, Center for Health Services
Research, Kaiser Permanente Northwest

Scope of Work

The original scope of work was stated in terms of an "update of the population program strategy." When the team arrived in Lagos this was clarified by the AAO and somewhat narrowed to focus on a more specific set of issues. Following this discussion, the team restated the scope of work in the form of questions as noted in Appendix A. The questions relate to the feasibility and desirability of a more focused approach; the degree of emphasis to be placed on the private and public sectors; suggested techniques for improving various program components and shifting their emphasis; and several management issues including an improved operational structure in AID/Lagos, in the cooperating agencies (CA), and in the national family planning program; modes of coordination among all these groups; and levels and means of financing their proposed activities.

Methodology

The AAO and her staff organized a comprehensive itinerary for the team allowing visits to national and state level public and private sector family planning and health-related institutions. Visits were made by one or more members of the team to Bauchi, Benue, Imo, Lagos, Ogun, Ondo, Oyo and Plateau States. These include states having the September 1983 "acceleration" training in the U.S. and a somewhat longer operational phase; those whose initial training was done primarily in-country by the Program for International Training in Health (INTRAH); and a state just initiating services following a group training effort in the Philippines. State visits included meetings with State Ministry of Health (SMOH) officials, visits to medical schools, schools of nursing, midwifery and health technology, pharmacies, patent medicine stores, branches of the Planned Parenthood Federation of Nigeria (PPFN) and other private sector organizations and to public and private clinics and community based distribution (CBD) programs. In Lagos, meetings were arranged with the Federal Ministry of Health (FMOH), the National Association of Nurse-Midwives, the National Council of Nurses, the headquarters of PPFN, and meetings were held with representatives of Africare, the Association for Voluntary Sterilization (AVS), the Centre for Development and Population Activities (CEDPA), Futures, the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), Pathfinder Fund, the United Nations Fund for Population Activities (UNFPA), the United Nations Children's Fund (UNICEF), and Westinghouse Health Systems. A list of places and organizations visited is attached as Appendix B.

The team took an inventory of the activities supported by the 17 CAs working in Nigeria. (See Appendix C). Midway in the country visit, the team was requested by the FMOH to consult with them in their drafting of the Action Plan for the National Family Planning Program. This provided additional insight into the objectives of the FMOH and their commitment to an improved program of national scope and impact.

These activities were complemented with review of such documents as the "Nigerian Family Health Program," American Public Health Association, December 13, 1983; the Population Strategy for Nigeria, USAID, 1984; project documents and reports of the cooperating agencies; the draft National Policy on Population and Development, Government of Nigeria, 1985; the draft Action Plan for a National Family Planning Programme, FMOH, 1985, and many others.

The scope of work was not aimed toward an evaluation per se of any particular program. Furthermore, state programs have not been in operation long enough nor are the statistical systems sufficiently developed to produce a great deal of data on program performance. Thus it was determined that a more subjective approach based on observation, interviews and the considerable experience of the team members would be more appropriate. By sharing observations through traveling together and through considerable group discussion, a team consensus was developed on the overall issues with individual members providing technical insights on programmatic components in their particular field of expertise.

II. EXISTING FAMILY PLANNING SITUATION

Many groups in the Nigerian society have had a long tradition of childspacing. This has been accomplished through the separation of husband and wife for a period of up to a year after childbirth and by prolonged breastfeeding. In addition, there are many traditional methods which have been used, if ineffectively, to prevent pregnancies. With modernization, the traditional practices of abstinence after childbirth and of breastfeeding are being rejected. Abortion, although illegal, is widely used for termination of unwanted pregnancies, often resulting in sepsis and other complications, hospitalization, and sometimes death. Modern means of childspacing are increasingly needed.

The need for a wide availability of modern contraception has been recognized officially in Nigeria at least since the Second National Development Plan under which the government strengthened the PPFN in its efforts to provide appropriate services for childspacing. The PPFN, which began its services in 1964, is now active in 15 states with 158 clinics serving approximately 80,000 clients each year.

In the current Fourth National Development Plan, the health sector includes family planning within primary health care services. Some SMOHs and local government authorities (LGA) have begun to provide family planning services.

Nevertheless, the 1981 Nigerian Fertility Survey and other studies have found that the level of knowledge about family planning is extremely low--about 33 percent. The same studies indicate that approximately 6 percent of couples in the reproductive age group currently practice some form of contraception, including traditional methods, while only 2.6 percent use modern methods. The total fertility rate is approximately 6.3 and the birth rate ranges from 46-48/1,000 population resulting in about 4.5 million births per year. The death rate has decreased to about 14-16/1,000 resulting in a population growth rate, due to natural increase, of approximately 3.2 percent per year and the addition of 3 million or more persons to the population of Nigeria each year.

Meanwhile, the health sector has accelerated its Expanded Program of Immunization (EPI) and instituted an intensified drinking water and basic sanitation program, particularly in rural areas. Oral rehydration therapy (ORT) and nutrition programs have also been initiated to strengthen the national primary health care effort. It is hoped that these and other special health services

will reduce infant and child deaths significantly. The result will be an even higher rate of population growth unless the family planning activities are also effective in reducing fertility.

The policy climate in Nigeria is becoming increasingly supportive of the development of population and family planning service programs. In August 1984, Nigeria participated in the International Population Conference (IPC) in Mexico City. The Nigerian delegation presented a statement by the Head of State calling for a national population policy and increased services for birthspacing.

The Federal Government is now preparing a National Policy for Population and Development which is expected to be promulgated by late 1985. Moreover, the timely development of this policy will allow many of the conceptual ideas to be incorporated into the Fifth National Development Plan (1986-1990). As part of that effort, the FMOH has developed a plan of action which calls for increased involvement of the Ministry in planning and supporting a much more expansive state and private sector family planning program.

Fortunately, as part of a worldwide effort, many international donors such as UNFPA, World Bank, AID and IPPF have provided assistance to Nigeria for the national family planning effort.

As a result of this assistance, many of the essentials for a major family planning program are already in place. There is an extensive basic health care infrastructure which does not appear to be attracting as large a clientele as the system can accommodate. Although there is a cadre of well trained physicians and nurse-midwives, not all of them are strategically placed or adequately supported and supervised to meet the needs of the growing family planning program. Provisions have been made for an increasing supply of contraceptives and a system is in place to deliver them to the state programs. In few states, however, is this matched with an efficient system for intrastate distribution and accurate reporting and analysis of client utilization and contraceptive flow. Informational and educational materials have been developed and plans have been made for expanding their use; these plans require additional support for implementation. Clinic systems have been stimulated to some degree, but outreach activities are extremely weak.

Private sector initiatives have been supported and increased assistance is contemplated; however, to date, potential for involvement of the private sector has not been fully realized.

Greatly constrained by shortages of foreign exchange, contraceptives are being sold in the commercial market at prices that substantially limit access of potential users from the lower economic strata.

In all the visits the team was greatly impressed by the high quality of health personnel and with the service provided. Openness in discussion and enthusiasm for family planning was pervasive throughout the system. With the federal government policy change, family planning has become more acceptable to health leaders who are now ready and willing to incorporate it into their service.

Much of this programmatic improvement, policy change and enthusiasm can be attributed to the policy dialogue, training, commodity support, technical assistance, and method of operation of AID and its cooperating agencies. Though problems were noted, the team was faced constantly with expressions of gratitude for the support of the U.S. in this area and its responsible approach.

Though much has been done, many problems and gaps exist especially in the organization and management structures required if a comprehensive national family planning program is to be developed. This need for improved organizational structures and management systems in the Nigerian family planning program is matched by a similar concern in the organization of U.S. assistance. To provide the impressive increase of multifaceted support for Nigerian initiatives has required marshalling a complex array of cooperating agencies. This has been necessary to tap the sometimes narrow scope of program approach each brings as well as to pull together adequate total financial resources. Successful as this may have been, it continues to present AID management both in Lagos and in Washington, with planning and coordination responsibilities of no small magnitude.

III. ISSUES BEFORE AID

In 1982, AID planned a substantial increase in population assistance to Nigeria which justified the assignment of an AAO/Population Officer to Nigeria in February 1983. Since that time, AID's involvement in population/family planning has evolved with changes in both magnitude and emphasis.

Initially AID's approach in response to the stated interests of the National Population Commission placed emphasis on population policy development, discrete assistance with census activities and limited family planning activities through cooperating agencies. As the government began to take a much more positive attitude toward family planning, AID support of the government health services took on greater significance. AID first focused its family planning support on training, commodity supply and management, information and education, record and statistical management activities in the public sector of three acceleration states - Niger, Ondo and Plateau. With increased federal and state support as well as increased enthusiasm and interest in family planning, AID assistance quickly extended to all nineteen states. Through a complex funding mechanism using seventeen cooperating agencies, support was directed toward delivering family planning services within the context of child survival, largely in the public sector. (See Appendix C). It should be noted at this junction that many observers are of the strong opinion that exclusive or even predominate support to the public sector without commensurate assistance to the private sector is tantamount to failure in reaching the potential target population.

Regardless, the responsibility for coordination and orchestrating the current complex arrangement in Nigeria has placed a management strain on AID and has taxed the financial and technical resources of the cooperating agencies. The major questions before this Strategy Review Team were what can be done to prioritize AID supported activities and how can improvements be made in efficiency of management.

Therefore, the remainder of this report addresses the following issues:

1. Can AID effect administrative or financial savings through programmatic focus or consolidation of efforts within the public sector in order to allow a greater emphasis on the private sector? If so, what kind of private sector activities?
2. Should there be any shift in relative emphasis among programmatic activities?

3. What can be done to improve productivity and cost-effectiveness of present program activities?
4. What changes in the management approach of AID and its cooperating agencies can enhance efficiency and effectiveness?
5. What levels of assistance will be required for future support of AID activities in Nigeria?

IV. PROGRAM FOCUS

As the team visited state and federal government officials and health personnel it became apparent that much of the change in policy climate can be attributed to the support for training, commodity and equipment supply, and policy dialogue provided by AID and various CAs. This backdrop of government acceptance provides a favorable policy environment for rapid growth of service delivery and information, education and communication (IEC) campaigns that will enhance both public and private sector efforts. Building this acceptance has been a time-consuming, management-intensive but fruitful state by state relationship built up by the AAO, AID staff and the CAs throughout Nigeria. This was necessary in the strongly federated political system with the pluralistic situation of each state presenting a unique set of circumstances. However, it created a situation of management overload as AID has been monitoring an inordinate number of activities, many in several states.

This approach did not leave much time for focus on the private sector. Those private sector organizations interested in family planning had geographic limitations or organizational weaknesses which would make their involvement an equally intensive management effort. This has deferred some of the emphasis other countries have been able to place on more outreach-oriented community based and/or commercially managed activities in the private sector.

In reviewing the options for future program directions the team questioned whether AID's management constraints in the public sector area could be alleviated by more involvement of the Federal Ministry of Health (FMOH); by more selectivity in state by state activities; by more concentration on the urban population rather than equal attention to both rural and urban areas; or decreasing the degree of attention paid to such child survival interventions as ORT and EPI. Assuming that some of these management savings could be affected, it would be expected that increased attention could be given to the private sector. This would also allow the cooperating agencies to return to roles more consistent with their traditional approaches.

Urban versus Rural

There was general agreement with FMOH policy and AID interests that a greater focus on urban areas should be encouraged. Conventional wisdom suggests that:

- a. with the breakdown of traditional family support structures and child spacing practices, including prolonged breast-feeding, being more pronounced in the urban areas (as demonstrated by surveys in Lagos), fertility is higher and need for family planning services may be greater in the cities.
- b. with the present health and private sector infra-

structure and means of communication available, the urban population will be substantially easier to reach and problems of supervision and long distance management will be decreased.

- c. given the amount of communication between urban dwellers and their extended families in the rural areas, many urban practices are transferred informally to the rural area.
- d. it may be as much a function of ease of access to family planning as it is difference in attitudes, but experience in other countries has demonstrated that urban women are more receptive to family planning than are rural women in the initial stages of a program.

Federal Government Involvement

There is a substantial increase in Federal Government support for an involvement with the National Family Planning Program included in the Ministry of Health draft plan of action for the 1986-1990 Fifth National Development Plan. The Office of Planning, Facilitation and Coordination for Family Planning to be developed in the FMOH may be able to take on more of the management responsibilities which AID has carried out in the past. Early in this process AID may be requested to provide additional technical assistance to enhance the FMOH efforts in strengthening state planning and management capabilities. In the longer term this should significantly reduce AID's direct involvement with individual state programs. It should also provide the framework for more substantial UNFPA and World Bank assistance which is more closely focused on family planning.

State Selection

The Federal Government is committed to initiating at least a minimum family planning program in all of the states as early as possible to demonstrate its commitment to recent high level policy statements in support of family planning. It appears prudent to support this objective, especially since sufficient trained personnel are available in nearly all states to initiate minimal family planning services. However, it will be possible to be selective in the rate at which family planning services are expanded within the various states. The FMOH draft plan of action establishes specific criteria related to the establishment of organizational structures, management systems, and program performance before assistance to a state will be increased beyond the initial minimum support.

Organizational Improvement

To accomplish this improvement in performance and consolidation of gains in the public sector, it is essential that greater attention be paid at this stage to the organizational structure and management systems at the federal, state and local levels with emphasis on the state. Several actions will be required:

- Careful monitoring of developments at the federal level as an office is established within the FMOH for planning, coordination and facilitation of the family planning program. Technical assistance should continue to be provided as requested.
- The Federal Government will work with state health leaders to review and finalize the draft action plan. If requested, AID should participate as an observer.
- Subject to FMOH concurrence, the draft plan should be made available to JHPIEGO as the basis for the September 1985 management training program at Johns Hopkins for the health leaders of 15 states.
- Technical assistance teams should be organized by the FMOH to work with the states to develop state plans of action and to put into place an organizational structure and the management systems necessary for implementing the states' family planning program--AID should provide technical expertise as requested.
- The FMOH will provide further technical assistance to work with the states to develop capacity at the local level. Limited technical assistance may be required from AID for this function. At a minimum AID should closely follow progress in this area and monitor successive steps as a basis for decisions on further program expansion.
- Networking of regional and state institutions will be encouraged, especially including plans for quarterly meetings of state coordinators discussed in the management subsection of Section VI.

Other Child Survival Interventions

AID has special non-population funds to support development activities related to nutrition and health, and it is very desirable for AID to use some of those funds in support of other child survival interventions. This is important both because combining support for family planning with support for child health may be important for the long-term acceptability of family planning inputs in a society which is so deeply concerned about children.

Previous Page Blank

In addition, although it is now appropriate for AID to support free-standing family planning service schemes, AID should continue to provide significant inputs into the effort to integrate family planning into the national maternal and child health (MCH) services. Although family planning may be administered as a vertical program at higher levels within this system, staff at the actual service delivery site often will be expected to provide a variety of MCH services. Currently external donors and the Government of Nigeria are making efforts to improve the ability of these MCH personnel to provide family planning, ORT, and immunizations. For efficiency, some activities in support of these three interventions, such as training, should be provided in a combined effort. For instance, some of the in-service training supported by UNICEF primarily for ORT or EPI should also include content on family planning, and some of the in-service training supported by AID for family planning could also continue to include content in ORT and immunizations as they have in the past.

AID is currently supporting some aspects of the ORT program, which is a particularly effective child survival intervention and a priority of the Nigerian government. UNICEF is the donor with the major responsibility for this program. Through participation in this effort AID may enhance the possibility of cooperation by UNICEF in the Nigerian family planning effort. However, as ORT comes to be institutionalized in Nigeria, it may be advisable for AID to shift its child survival efforts toward support for breastfeeding/infant nutrition. This alternative child survival intervention, which is inherently interrelated to childspacing, and, as a preventive health service for post-partum women, is especially appropriate to be provided in combination with family planning. (See Appendix D for further rationale and details).

Evolving from the above, the team concluded the following:

1. Recommendation. AID should continue to support the public sector effort especially to achieve state-level management improvements recommended in the FMOH draft plan of action.

This support should match increased Federal government involvement which still will depend strongly on state and local government implementation. Support should be selective based on monitoring of FMOH and state-level performance in reaching specified objectives. A suggested checklist for AID monitoring of state level programs is attached as Appendix E. This support should be continued at a relatively high level for the next two years to assure

consolidation of the gains achieved already and those to be instituted by the FMOH. By that time the FMOH should be in a position to negotiate substantial support for family planning from other donors. AID should be able to decrease its support of the public sector but should continue to provide assistance for those areas in which it has expertise such as contraceptive supply, technical assistance, management, and other selected training.

2. Recommendation. AID should continue to support directly, and in concert with other donors, programs of EPI and ORT as part of the strategy of child survival within which family planning should play a prominent role.

Preferably, the non-family planning activities will be supported from health accounts. As ORT and EPI programs become better established, AID should shift its emphasis to programs in support of breastfeeding and child nutrition which are even more closely related to family planning and fertility reduction objectives.

3. Recommendation. AID should initiate a gradual shift in emphasis to the private sector.

This shift will gain momentum quickly with the initiation of the FPIA/Sterling contraceptive sales program and with the planned support of information and education programs with PPFN. Desirable as it may be to see an even more rapid growth in the private sector, it may be necessary to restrict other initiatives to experimental, pilot activities. These are especially needed in outreach to generate more client demand; providing information and service to adolescents and men; supporting family planning services of private physicians and maternity homes; and experimenting with other commercial approaches such as the Columbia University and PCC/PSJ marketwomen projects. These activities should be well monitored to evaluate their potential for demonstration and replication. Various channels should be explored for private sector expansion such as religions groups, women in development networks, and agricultural cooperatives.

4. Recommendation. Within a year or two, AID should substantially expand the emphasis on the private sector encouraging the CAs especially adept at this type of programming to return to their traditional role of experimentation and support in this area.

V. RELATIVE EMPHASIS OF PROGRAM ACTIVITIES

Policy Development

Given the necessity for a positive policy climate conducive to and supportive of population activities in Nigeria, the 1984 AID population strategy placed considerable emphasis on policy dialogue to encourage the development of a national population policy. These policy development activities, particularly the technical assistant and projects supported by the Future's Group-RAPID II Project and the Research Triangle Institute's INPLAN Project, have been highly successful. The Federal Government has now drafted a comprehensive multi-sectoral population policy statement and this national policy is expected to be promulgated by late 1985. Many of the policy concepts supporting population and family planning activities will be incorporated into the Plan of Action for a National Family Planning Program of the FMOH as part of the Fifth National Development Plan (1986-1990) currently being developed.

Recommendation. It is recommended that AID continue with policy development activities but that future emphasis in this area be directed toward securing improvements in operational elements of the service delivery program, e.g., building a stronger organizational structure.

Overall, this recommendation implies somewhat less emphasis on policy activities relative to other service components supported by AID assistance. It is expected that World Bank and UNFPA interventions will maintain a policy emphasis at the national level.

Training

Implementation of an effective family planning service delivery system for Nigeria will require significant changes in the ideas, knowledge, skills and behavior of many people in a wide variety of roles. Training activities to date have focused on preparing graduate nurse-midwives to provide a full range of clinical family planning services, including intrauterine device (IUD) insertion and training physicians in a wide range of reproductive health techniques, including laparoscopic sterilization.

Recommendation. Although the continuation of a high emphasis on training is recommended, future AID-supported training should be refocused to emphasize training more people in shorter, less expensive courses; extending training to include people lower in the health service hierarchy, and training traditional birth attendants (TBA) and other outreach workers outside the official

health system as part of organized programs for service delivery. In addition emphasis should be shifted towards training for provision of pills and condoms instead of IUDs, training in minilaparotomy instead of laparoscopic sterilization, and training to prepare people for management and administration of the family planning service system. Highest priority should go to integrating clinical family planning training into the basic pre-service curricula for all health service personnel in order to make possible the eventual phase out of in-service clinical training.

Information, Education and Communication

The need for information, education, and communication (IEC) in Nigeria is emphasized by the findings in the 1981-82 Nigeria Fertility Survey that: (1) nearly 85 percent of all fertile women desire more children, (2) only 16.3 percent of the women with a stated desire for no more children were using any kind of family planning method, and (3) the prevalence of family planning use is less than 6 percent only half of which is due to modern methods. Other studies have shown that less than one-third of the women interviewed have any knowledge of family planning. Available family planning materials are extremely few in number; those that exist are primarily a result of AID efforts. The impact of the person-to-person field work of the PPFN and other teaching institutions has not been evaluated, but it is recognized that these efforts reach a miniscule proportion of the target population.

Presently, approximately 5-10 percent of the AID family planning effort in Nigeria is used in support of IEC activities. This effort has consisted primarily of small projects varying in nature with a large proportion of funds allocated to the development of printed materials for clinic use. There is a need for increased emphasis on IEC. This is based not only on the apparent low levels of knowledge and acceptance of the family planning concept; it also stems from several current issues relevant to AID/Lagos:

1. Present shipping and logistic costs for IEC materials borne by the Mission must be covered by program budgeting.
2. Communication efforts enjoy economies of scale; therefore, expanded efforts may be desirable.
3. The cognitive steps that lead to behavior change include exposure to the concept of social acceptability of that behavior. Therefore increased person-to-person communication is needed and this necessitates considerable increases in funding.

4. At present, no other major donor has contributed significantly in this area.

Recommendation. Therefore it is recommended that, in addition to any growth that may occur with the general growth of the AID family planning effort, a significantly increased relative emphasis be placed on IEC activities.

Management, Statistics and Commodities

Although many observers, including this team, readily acknowledge the need for an increased emphasis on developing managers and management systems for the Nigerian family planning effort, it is important to understand how the management needs of a new program evolve.

In the initial stages of a program, the most important managerial qualities are essentially entrepreneurial in nature. The successful manager of an infant program is long on energy, missionary zeal, and tolerance for risks and often short on attention to detail and coordination of efforts. Most, if not all of the state programs are still firmly in their infancy. That means that entrepreneurial behavior must continue to be encouraged. As outside observers, however, the team was keenly aware of the absence of support systems that will allow these programs to grow, and control systems that will permit them to be managed efficiently. In fact, some of the states visited may be at a point within the near future when their further expansion is constrained by the absence of adequate support elements.

Recommendation. Increased management emphasis needs to be placed on the development of improved management of the following support systems:

1. Logistics - to instill the perception and insure reality of sufficient supplies at all points in the system.
2. Training - to ensure an adequate balance of trained personnel in support and delivery positions-- particularly for outreach activities--without producing redundant trainees with attendant loss of skills and enthusiasm due to an absence of sufficient demand for services or other kinds in the support systems.
3. Supervision - This function needs to focus initially on support of operations and refining practical skills. Within a few months, however, increasing emphasis on unit goals and performance will be appropriate.

An increased emphasis on control systems must be tempered in the immediate future by concern for maintaining enthusiasm and the willingness to take risks.

Statistics

The record keeping systems and statistics management activities of the family planning program are presently limited and initial efforts have produced mixed results. The most urgent need for data is to feed the commodity resupply process. The relative emphasis on information systems need not change greatly in quantity, but might be shifted in kind as will be discussed in the subsection on management in Section VI.

The second need for data is to document program accomplishments. Since rough indicators, suitable at this stage of development of the program, may be derived from the logistics data, no separate effort need be initiated immediately.

Commodities

The level of commodity support is not a policy decision; it is a function of effective demand for services. Methods of gauging the demand are presented in Appendix F. The emphasis in this area, i.e., commodities, must remain responsive to successes in other areas.

Basic Medical Equipment and Supplies

Due to extreme shortages of medical equipment and supplies in Nigeria, AID has provided basic equipment sets and expendable medical supplies to selected clinical sites during the past year. These clinics are key referral centers and are locations for clinical practical training.

Recommendation. Over the next few months, if Nigeria continues to experience equipment/supply shortages, AID may need to continue to provide limited equipment and supplies as a stopgap measure to ensure the continuity of service delivery. In the long run, however, AID should seek to reduce this role. Meanwhile, AID should encourage those agencies such as World Bank and UNFPA who have a greater capability to undertake this function to become the key agencies involved in upgrading facilities and providing necessary medical equipment and supplies, which should be targeted for placement in facilities having trained staff.

Service Delivery

In general, AID does not support recurrent costs of national family planning service delivery. Therefore, AID's role in the area of service delivery as used here, is primarily in the area of pilot projects supportive of entrepreneurial efforts both in the public and private sectors. It should be noted that this

category is separate from, and additional to, the many support activities--training, IEC, commodities supply, etc. described elsewhere, which are essential to service delivery in its broadest sense. At present, support for this form of service delivery programming constitutes approximately one-third of the AID effort in Nigeria.

Recommendation. Recognizing the extremely positive results of AID's present encouragement of entrepreneurial family planning activities in Nigeria, and recognizing that there is need for some readjustment in relative emphasis among the categories within this effort, it is recommended that service delivery remain a significant and major component of the overall program.

Research and Evaluation

Research and evaluation provide vital information for management decisions; however, at present it is a minor aspect of AID's overall effort in Nigeria. The AID family planning effort during recent years has been extremely dynamic. It will continue to be subject to management pressures due to the complexities of both the subject area and the necessity of utilizing many organizations to carry out its programs. In addition to evaluative research, including socio-demographic and operational studies, biomedical research has been shown to serve as a necessary stimulus to create interest among high level medical decision makers. Biomedical research has also allowed acceptance of new methodologies and services that may be contrary to previous training. In addition, by its very nature it is an adjunct to training and leads to an increased knowledge base.

Recommendation. Therefore, it is recommended that the research activities be continued and receive additional emphasis, especially those efforts focused to aid in management and programmatic decisions, to ameliorate policy shifts in service delivery, and as appropriate, to yield the applied biomedical findings necessary for program growth.

VI. IMPROVING PROGRAM PRODUCTIVITY AND COST EFFECTIVENESS

Management

The management needs of any service program differ with its stage of development. A full description of this process, in general terms, is included as Appendix H.

Family planning programs commonly go through a series of stages in their development which also have specific implications for management. For better or worse, family planning programs commonly start with clinic based services and heavy involvement of medical professionals. The program then advances, depending upon its ability to de-medicalize services, and moves to delivery modes that have strong promotional capabilities and are more cost effective. The hidden danger with the clinical model is not that it outlives its usefulness nor that its vested interests impede progressing to other approaches, but that it calls forth an administrative apparatus that is ill-suited to other delivery modes. For example:

- the handful of supply recipients in a clinic based program does not compare with the hundreds found in a CBD program.
- the formal, medically-oriented courses for clinicians are managed far differently from the approach needed to turn street hawkers into effective salespersons of contraceptive supplies.

One does not wish to have to replace or retool the management team as a program moves out of the clinic. For that reason, the skills and systems that are developed early in a program's history need to be fairly general or, at best, transferable to more aggressive program modes.

In Nigeria, the above mentioned shifts in the challenges facing program managers must be confronted in an extremely difficult context. Absent are the vocal political foes who perform the small but useful service of promoting staff dedication and clarity of mission. Present is a very fragmented health service system in which there is no single focal point for management development efforts. Nor are there a few points; at a minimum there are 20 on the government side and at least as many in the private sector. In the immediate future AID will not be able to address the management development needs of private sector organizations with the exception of PPFN. (These needs will have to be dealt with, however, by CAs working with some volunteer or non-profit organizations). The Ministry of Health (MOH) is the first target for management assistance. Here we find a FMOH with no sure links to the SMOHs who do not actually implement anything but are either divorced from, at war with, victorious over, subsumed by, or merged into the Health Service

Management Boards (HSMB) which provide some, but not all, of the official health care. The rest is provided by local government authority (LGA) facilities and the links to them from any of the preceding appear to be extremely tenuous.

The team agreed that there must be a point of program focus and that the SMOH, although far from ideal, is perhaps the most promising point. It should be borne in mind, however, that in most states the SMOH lacks the usual controls over operational personnel (salaries, promotion, transfers, etc.) and most other resources. As it turns out, however, that is not a fatal impediment during the entrepreneurial phase of program growth. This does become a problem later on; however, it is hoped that by the time the entrepreneurial steam is exhausted, other donors will have provided additional resources to strengthen the control of the state family planning coordinators (SFPC).

The structure is given: SFPCs answering to or leading family planning advisory councils (whose membership is governed by principles of co-optation as well as an earnest desire to be in touch with relevant collaborating units); HSMB facilities answering to the Board but whose staff may be loyal to medical/professional supervisors in the SMOH, and LGA facilities operating essentially on their own with little direction or interference from other units.

The primary management skill needed by the SFPC is the ability to influence others to support the program--both supervisors and peers, as well as operational personnel--without having access to conventional sanctions and rewards. Since this type of leadership is difficult to develop, if possible at all, the best that can be done is to enable the coordinators to maintain their own sense of mission while providing information that might be of practical use in their daily battles.

Recommendations. The SFPCs should meet quarterly to discuss a single general topic for one day, e.g., how to evaluate clinic performance, how to set program objectives, how to access the local media, how to provide in-service training, etc., utilizing success stories from the field if possible. A second day would be dedicated to providing "encouraging" information, e.g., donor agency plans, updates on contraceptive technology, experience with outreach programs, etc. Any CA who can be trusted not to load the program with its own agenda could arrange these sessions. Topics should be cleared by the AAO whose grasp of the relevance of issues, as they fit the program needs of the moment, is excellent.

In addition to "general" management, there are four support systems requiring management attention: logistics, training, statistics and supervision.

A. Logistics

This system starts at the clinic and, in the present situation, immediately fails. Maintaining adequate stock levels is simple and only requires the collection of very basic information. Requirements to integrate other information with supply data, as a convenience and as a cross check, complicates the system.

Recommendation. At this point in the program, only supply data should be collected from the service points. The form to be used for this data collection is attached (Appendix I). The genesis of this form will be obvious. It should also be clear how the existing stock of forms can be utilized.

The second point in the supply system is the zone or state where the information is gathered and supplies dispensed. At the present, the lack of transport available to family planning supervisors has meant that clinic staff must come to the coordinator to collect supplies. This provides a useful point of contact but does not permit the supervisor to observe clinic operations nor is it known whether clinic staff are more mobile than supervisors. State level stock management remains primitive, at best. To improve the collection and analysis of data and warehousing of supplies, the team suggests the following:

Recommendation*. The AAO should have, on staff or on contract, an experienced warehouseman or other individual who has worked in health supply systems. This person will manage the distribution of commodities and provide technical assistance to the states. This individual's responsibilities will include:

- forecasting commodity needs,
- analyzing drawdown data and estimating couple years of protection (CYP),
- assisting SFPCs in setting up warehouses and inventory control systems and analyzing supply data, and
- overseeing the distribution of AID supplied commodities.

* This position is in addition to the present FSN who does an exceptional job of receiving and clearing shipments through customs and delivering them to the first level of distribution.

If it is determined that the field logistician-- to give the position a title--is imperfectly prepared for the job, CDC should be requested to provide technical assistance and training. Because this is a sensitive job involving control over donated resources, the individual selected should have as few previous ties with the recipients of the commodities, as well as with AID officials, as possible.

A further area of concern in the supply management chain revolves around estimates of the extent and duration of Sterling's distribution efforts. Is there an alternative organization that could quickly step in to keep the supplies moving should Sterling tire of its philanthropic efforts? We did not find one on this trip. FEMOPE lacks the infrastructure and experience to carry out the task. PPFN has some of the elements but has over the years, developed a hoarding mentality that may be difficult to overcome and would initially prejudice program performance. PPFN's record in the logistics field is not great but it is not clear that this is entirely their own fault.

Forecasting demand is another difficult logistics area as the likely impact of the proposed IEC campaign cannot be judged. If prevalence rates remain steady, there is enough stock in country to carry the program for two years. However, if prevalence jumps to 3-4 percent, there could be a crunch as early as next March. As always, the counsel of caution is to hope for program improvements and be prepared to support them. (See Appendix F).

Recommendation. The AAO/Lagos should monitor, on a monthly basis, the drawdown rates in Ogun. We propose this state because it is the first to get IEC activities underway and if those activities are to have an impact, it will be first detected in Ogun. Ogun also enjoys the advantage of propinquity to Lagos so monthly data collection visits are feasible. It may be necessary to increase commodities requested if the Ogun experience so dictates; it might also be necessary to delay the order if the IEC effort is less than successful.

B. Training in Management

One support system that is often undermanaged is that of training. To date this has been exclusively and effectively done by the AAO, an arrangement the team finds appropriate as she has been the only one with resources to commit to training. Now training is being programmed

by the states themselves--effectively in some, as in Ogun, and in others less effectively. To assist the states to improve the utilization of training resources and trained personnel, the team proposes the following:

Recommendation. One of the CAs in the training area should provide technical assistance, as opposed to another course, to SFPCs in the conduct of a survey of institutional capacity to prepare individuals for different roles in family planning. It may be appropriate to use one of the quarterly SFPC meetings to launch this exercise. A two to three day workshop in the methods and rationale for assessing training needs may be justified.

C. Information Management/Statistics

A series of clinic statistical forms has been developed starting at the bottom of the system. A more logical approach would be to start by designing the forms on which information will be presented to decision makers. That is, start with the output form, not the input form. The presentation may seem obvious from the input data, but must be done to ensure that program managers have legitimate needs for the information.

The present much maligned forms have many virtues; however, they are not simple. Although deceptively straightforward in design, the team found no clinic where they were being correctly prepared in their entirety.

Recommendation. Discontinue emphasis on the daily activity form for the present and use only the sections of the monthly summary form indicated in Appendix I.

Recommendation. Although a number of daily forms have been distributed to clinics, there seem to be no written instructions for their completion. Since this form is a basis for better control systems in the future, it might be useful for an enterprising SFPC to prepare a stencil of abbreviated instructions and mimeograph those instructions on the back of several hundred daily activity forms to be used for a time in specified clinics and monitored closely. This would provide a fairer test of their feasibility.

Recommendation. Utilize reviews of client records to spot check or survey for specific issues of interest to program management. State coordinators will need some guidance in record review--possibly in their quarterly meetings.

D. Supervision

Rather than move toward a more elaborate information system in a rapidly developing program, we would prefer to see the emphasis placed upon field supervision. It is recognized that field supervision is going to be difficult unless the transport problem is resolved-- either by an infusion of Bank of UNFPA purchased vehicles or through a shift of priorities in the states that would free one of the scarce MOH cars for family planning. -It should be noted that many of the supervisors have their own cars. If there is an avenue by which a mileage allowance could be granted them, they might be willing to use personal vehicles for official duties.

Of central concern to the team is what a supervisor might do once in the field. As indicated earlier, the primary focus should be on clinic performance and secondarily on medical skills. Little time should be spent on clerical items, other than to assure that there is sufficient stock, and to strengthen what appears to be limited concern at the clinic level for bringing in and maintaining active users in the program. Emphasis is placed on performance because the team noted the following:

1. It appears that continuation rates are low. The supervisor should establish, through a review of client records with the staff, whether this is the case, and set the staff to work on investigating and resolving the situation.
2. It further appears that general clinic attendance is low. We suspect that only the most desultory outreach efforts are undertaken by the clinic staff. There is occasional reference to home visits, but spot checks of client records and logs indicate that few, if any, women cite a home visit or other contact with clinic personnel as the factor motivating their attendance at the clinic.

To improve supervisory skills and increase attention to clinic performance measures, the team reluctantly (due to the cost and uncertain efficacy) recommends the following:

Recommendation. The AAO should explore the possibility with INTRAH/Santa Cruz of providing in-country training among the general lines of their three week course for clinic directors. The course should be shorter and since fifty to eighty supervisors should participate this rules out U.S.-based training.

The course should attempt to instill a strong results orientation among the supervisors. Since they control few incentives in their jobs, they also need to master motivational techniques that do not rely on the use of tangible incentives.

Future training of field supervisors will depend on program developments. Normally one would anticipate a need to tighten program controls within two or three years. This would entail training supervisors at that time in a concerted effort to improve conventional administrative systems. In the meantime some attention should be given in the various ongoing training courses to better performance in carrying out the administrative and supervisory responsibilities of the present system, especially the reporting and logistics, as well as elements of individual clinic management.

Training

Training is needed to prepare people for diverse roles in family planning including the development of public policy; administration and management of the service program at various levels; provision of services to individuals; education of individuals and the public; and training of trainers. The categories of people who will need to be trained range from religious and political leaders to pharmacists and traditional birth attendants (TBA). The subject matter and skills to be taught are equally diverse. Heretofore, AID-supported training has focused heavily on the training of nurse-midwives to provide a range of temporary contraceptive methods, including IUDs. A second major focus has been on the training of physicians to provide a variety of modern reproductive health interventions, including laparoscopic sterilization and, to a lesser degree, management training and training experiences for physicians and civil servants in key policy and administrative roles, as well as for certain other important opinion leaders, including women. To meet the needs for the greatly expanded family planning service delivery system now envisioned by the FMOH and needed by the families of Nigeria, new initiatives are required to train people to plan, administer and manage the service delivery system, to develop effective IEC programs, and to organize and implement outreach programs. In addition training to prepare additional people to provide clinical family planning services will be essential to realize the goal of integrating family planning into the MCH services which are already being provided by state and local governments.

Because training in clinical family planning service delivery has been the main focus of AID-supported training efforts to date, because of the expense of this kind of training and because clinical family planning training will continue to be an important need, this area of training was singled out for special attention by the strategy team. Therefore, most of the specific and detailed recommendations regarding training in this report are focused on how clinical training can be accomplished more effectively and efficiently. However, the attention given to clinical training should not lead the reader to misinterpret the importance which the team gives to the need for other types of training, some of which are also addressed in other sections of the report.

AID has supported clinical family planning training in Nigeria for more than a decade. These training inputs are described and discussed in some detail in Appendix G. The reader is urged to refer to this Appendix in order to understand what has already

been accomplished and the current situation regarding the training of family planning clinicians for Nigeria. The rationale for many of the training recommendations which follow in this section is based on our assessment of these past and current training efforts. The remainder of this section addresses primarily the question of how AID can more effectively and efficiently support in-service training in family planning skills for the people who are already providing MCH services within the existing health care system, how to institutionalize the capacity to produce these skills in such people during their basic, preservice education, and how to motivate and train TBAs and other outreach workers to extend the delivery of family information and services beyond the established health care system. Because nurse-midwives (NMW) and physicians play key roles in the delivery of all MCH services in Nigeria, including family planning, most of the discussion which follows addresses issues regarding the training of nurse-midwives and physicians.

Including Family Planning in Preservice Curricula

1. Schools of Nursing and Midwifery

The majority of female nurses in Nigeria eventually become nurse-midwives and most of the MCH services in the country are provided by this cadre. It is essential, therefore, that family planning clinical skills training be incorporated into the basic midwifery curriculum. Paradoxically, the preservice nursing school curriculum currently contains more family planning content than is contained in the midwifery curriculum.

The nursing curriculum was revised in the mid-1970s and is oriented toward American nursing education models and textbooks; whereas, the midwifery curriculum is overdue for revision and is based on British midwifery models and textbooks which include no family planning. Midwives in Great Britain have been slow to incorporate family planning into their practice, whereas family planning is a "core competency" for all American nurse-midwives.

The midwifery curriculum is being revised now for presentation to the Nursing and Midwifery Council this fall. This council is the body responsible for the overall design of the curriculum. As the revision is evolving, the curriculum will contain theoretical family planning content but no expectation of clinical competency, and thus no requirement for schools to provide clinical experience in family planning for their students.

Recommendation. Efforts should be undertaken to delay completion of the Council's revision of the midwifery curriculum and to convince them of the appropriateness of including initiation and management of clinical contraception as a competency expected of every midwifery graduate. (Where there are not enough family planning clients to provide adequate IUD insertion experience for every student, they could be graduated with less than clinical competency but with a plan to obtain the necessary supervised insertion experience in order to obtain full credentials.)

2. Schools of Medicine

Neither family planning nor community medicine is mandated in the undergraduate medical curriculum. Because most Nigerian physicians do not have specialty training, it is important that family planning theory and practice be included in the undergraduate medical curriculum. The lack of community medicine courses in most medical schools also means that most physicians are not trained in health services administration and community medicine concepts such as coverage.

JHPIEGO has planned a workshop to be held at the University of Ibadan in March 1986 for deans and Ob/Gyn chairmen from all medical schools and from selected hospitals. They will compile the major components of information and clinical skills pertaining to reproductive health that all medical students and interns should master. This workshop also is designed to produce recommendations regarding general curriculum changes to improve medical students' and interns' knowledge and skills in reproductive health, including family planning.

Recommendation. The team commends these plans and urges the AAO to follow the workshop and to encourage any positive curriculum changes which may be recommended.

3. Schools of Health Technology

Three of the four new cadres being trained in conjunction with the effort to realize "primary health for all by the year 2000" are trained in Nigeria's 27 Schools of Health Technology. Those cadres are community health aides, community health assistants, and community health supervisors.

Community health aides have had at least 6 years of primary school plus one year of special training. They are supposed to work in the community, going from house-to-house to provide health education and treat minor illnesses. Unfortunately, most of the community health aides trained to date have been men, which may limit their ability to deliver family planning information and services to women in most parts of the country.

Community health assistants have had at least 11 years of primary and secondary education plus two years of special training. They work in government primary health care centers and also supervise the community health aides. Because most of them are also men, community midwives are currently being used to provide MCH services in the primary health care centers. Community midwives have completed elementary school plus a three year course in midwifery; however, community midwifery training has been discontinued so this is a dying cadre.

Community health supervisors are selected from other cadres, e.g., experienced community midwives and dispensary attendants, and are trained in an 18 month program. They are in charge of health centers or work in clinics. Good family planning units are incorporated into the basic curriculum for each of these cadres trained in the Health Technology Schools.

The fourth and highest cadre in the primary health care (PHC) scheme consists of community health officers (CHO). They are trained in one year programs offered in 9 medical schools. Students for these programs are selected from the ranks of NMWs, health sisters, senior community midwives or experienced dispensary superintendants. Their curriculum includes a well-developed family planning unit.

Although the family planning content in all four programs is strong, it is not clear that the tutors for these programs are themselves well-trained in family planning. Tutors of these cadres should be given priority for AID-supported family planning skills training and training-of-trainers (TOT) courses.

In-Service Training for Existing Health Workers

Although it is essential that family planning eventually be incorporated into the basic health professions curricula, most of the thousands of nurse-midwives and hundreds of physicians who currently occupy the key administrative and service-delivery positions in the nation's MCH system will continue in their present jobs for many years. It will be impossible to provide family planning in that system without their support and active participation. Therefore, training of these individuals cannot be ignored. Although trained and committed personnel are not the only inputs necessary to create an effective family planning program, there can be only a limited program in their absence. How to train enough people, fast enough, without bankrupting either Nigeria or AID, in a society with a minuscule existing capacity for family planning training is now a major question. The team recommends a strategy which requires gearing the training toward more use of pills, injections and condoms, with less reliance on the use of IUDs.

Although IUDs are relatively popular in Nigeria, they may be a less appropriate method in a society which dreads infertility and has a relatively weak health care system. In addition, IUDs greatly complicate and add to the length of clinical family planning training.

Recommendation. We recommend, therefore, that fewer nurse-midwives be trained to insert IUDs, and that most be prepared to provide hormonal and barrier contraception, which can be taught in 1-2 week courses.

Currently, INTRAH and its alumnae in various states are planning to experiment with a five day course and Pathfinder is considering a two week course in two states. None of these courses will include IUD insertion. Some longer NMW training including IUD insertions should continue in order to staff additional focal areas of the country. In addition, NMWs trained in the shorter courses must be prepared to provide follow-up care for women using IUDs, especially to be aware of possible IUD complications, and understand the importance of rapid referral for medical care.

The capacity to conduct short courses without training in IUD insertion should be developed in a fairly large number of places, certainly in at least one location in every state. In addition, some NMWs who prove themselves as eager and able family planning clinicians based on the short training should be selected for additional training in longer courses which stress IUD insertion, clinic management (including setting goals and using clinic statistics to assess progress and identify problems), methods of supervision, family planning IEC, and ways to train and work with traditional birth attendants. This longer, more complex type of training should be conducted in relatively few major centers of special family planning competence, as described later in this section of the report.

Service-Based Training

Regardless of the type of course, i.e., with or without IUDs, successful family planning training must produce changes not only in the knowledge, but also in some of the attitudes and behaviors of the trainees. The objective should be to achieve more than just the ability to go down a list of screening criteria and give instructions on how to take the pill. Especially at this time in the evolution of family planning in Nigeria, newly trained nurse-midwives are expected to return to the workplace and begin family planning services where they did not previously exist. Therefore, they need to experience a functioning family planning service with a trainer who has had sufficient family planning experience to be comfortable, competent and confident in this clinical role.

For some kinds of training, such as for learning technical skills in minilaparotomy or IUD insertion, fairly large volume family planning services may be necessary both to assure the clinical competency of the teacher and to provide access to enough patients for the trainee to practice and learn the new technique. Although less clients are required to train nurse-midwives in hormonal contraception, they need to learn from someone with experience. This may be even more important for a short course, in which the student is given only limited, if any, opportunity for supervised clinical experience. Although much can be taught by tutors with training skills and accurate knowledge but no actual personal experience, influencing the trainee to try new behaviors and adopt a new role may require an authentic role model.

Recommendation. It is recommended that training not be instituted at any site until it has developed a successful family planning service, and furthermore that persons with personal experience, competence and confidence as family planning clinicians always play key roles in family planning training. Because of the early stage of development of Nigeria's family planning program, implementation of this recommendation means that some states should delay attempts to develop a training course until at least one reasonably successful service can be established.

Although it is perhaps too early to assess the real outcome of the INTRAH-sponsored intensive six week training in Manila, our early assessment leads the team to predict that this may be a successful way to "seed" family planning in new states. Some critical mass of training may be necessary to stimulate rapid start up of successful services. Favorable characteristics of the Manila training were that it involved training a team of two people from one place; both of the key professions (medicine and nurse-midwifery) were represented; the likelihood of a congenial working relationship between the two trainees was enhanced because one of the pair selected the other, so they were not just thrown together by chance; the training was relatively long and was based on a high-volume, successful family planning service.

Recommendation. It is recommended that the approach of sending a team out of state or out of country may be repeated for other states where it may be necessary to go through several steps, (i.e., sending people away for training and then establishment of a local family planning service base) before the state can proceed to developing its own training course.

Conduct Evaluation

Training programs of various lengths (one or two weeks for programs without IUD insertion and 3-6 weeks for programs with IUD insertion) have been implemented or proposed.

Recommendation. A formal, systematic evaluation should be conducted to determine if the length and type of training is associated with significant differences in the performance of NMWs.

The evaluation should assess (1) objective and subjective measures of the success of the family planning service, (2) specified elements of knowledge and performance which are critical to the safety and effectiveness of services rendered to individual contraceptive users, and (3) the effective and efficient management of the service at the facility level. Only NMWs who have had at least six months of clinical experience since their training should be assessed. Public health nurses responsible for supervising MCH/FP services should be used to help plan and conduct the evaluation so that the evaluation itself can serve an important training purpose.

Initiate an Inventory

Because of the various training inputs described in Appendix G, some people in every state have been trained. Some of these returned from their training and for one reason or another, especially lack of management and infrastructural support as well as active demand for family planning, did not initiate local family planning services and by now have essentially lost their skills. In other places individuals have learned through the informal apprenticeship model. Some of the people currently providing services acquired their skills in this way but consider themselves "untrained" and will not be recognized by the system until they have certificates.

Recommendation. As a first step in gearing up to accomplish the considerable training task which lies ahead, a state-by-state assessment should be conducted through the SMOHs and coordinated and financed by an AID-funded CA to determine the numbers and location of people trained (through whatever mode, including apprenticeship), their ability to provide services, the types of services they are able to provide, and any special preparation or experience as a trainer. The military services, PPFN, the health professions schools, and church and other private sector providers should all be included in the inventory.

Trainers to teach both the short hormonal contraceptive courses and to staff larger, perhaps regional training centers should be selected from among existing trained personnel to the greatest possible extent. Where enough people with both family planning training skills and experience are not available to recruit for new training programs, experienced clinicians should be selected to receive additional preparation in training methodology.

Institutionalizing the Capability to Identify and Provide Training in Support of Family Planning

INTRAH's approach of creating state family planning training teams described in Appendix G costs approximately \$120,000 per state and appears to have been effective in at least one state but, to date, has yielded little second-generation training in another. This approach is still in process in two states and is due to start in Bauchi later this year. The inputs invested in each INTRAH state training team are certainly of a critical magnitude. If the right people are included in the team and it is based in the right institutions, this approach may prove to be highly effective in producing the long-term flexible training capacity that is needed.

Recommendation. If the INTRAH team training approach is repeated in other states, the time and expense of the training should be reduced by selecting only individuals who are already experienced family planning clinicians to be members of the TOT team and by utilizing curricula developed in the first states as a base for local curriculum development. Selecting experienced clinicians as trainers would obviate the need for an extensive clinical skills training component. This should, however, be replaced by a shorter course to update the team members' contraceptive technology information and skills.

Another approach to developing an institutionalized capacity for training is to develop training as part of a small number of centers of special competence in family planning services and training. Currently the University of Ibadan is the single most important family planning training institution in the country. Selected other university-based teaching hospitals could possibly be encouraged and assisted to develop in a similar direction. Ultimately such centers of special competence would need to be based on a well functioning, relatively large volume family planning service, so they can only be envisioned in places in which a substantial demand for services can be expected eventually to develop. They would also need to be accessible by good roads, and preferably also by air transportation; have good communications support; be located near schools of nursing, midwifery and medicine; and have excellent leadership interested in family planning.

Recommendation. One or two places with these basic attributes should be selected as sites for development of a longer course to train NMWs and CHOs in IUD insertion, clinic management, IEC and outreach. With additional time, local commitment and considerable external assistance, these programs could be developed into comprehensive centers of training and service excellence which would have the flexibility to meet new training needs as the national family planning program evolves. Once the short-term need to provide initial in-service family planning training for the people who had none during their basic professional education is met, the country will still need some capacity for continuing education, to support and improve the system.

As conceptualized, the centers of special competence would be developed to provide:

- longer courses for selected NMWs, CHOs and others in IUD insertion, management/supervision, IEC and outreach through training and working with TBAs,
- MD training in minilaparotomy with local anesthesia,
- administration and management training for physicians and other appropriate health personnel,
- courses to prepare physicians for providing medical backup for the extended service delivery system,
- courses for the people who will provide continuing education in the field, including occasional technical updates,
- other training oriented to management of the family planning system, such as management at various levels of the statistics and commodity supports systems,
- training health educators and others for IEC,
- training tutors for the schools of midwifery, nursing and health technology,
- training tutors for the shorter hormonal contraceptive courses offered in all the states, and
- courses in supervision for public health nurses (PHN).

Contact with the universities would allow enhanced evaluation of training and should facilitate two-way communication between the elites of the system and the realities of the field, thereby improving the research and education conducted at the university as well as the services provided in the field. In addition, university-based training centers can be partially supported by education rather than FMOH funds.

Some other technical suggestions are:

- All courses need to be based on a clear statement of the actual roles, functions and tasks the trainees will be expected to perform after training, the curricula must be expressly designed to create and lead to the development of the knowledge, attitudes and skills necessary for the trainees to fill the identified roles.
- In addition to travel, the cost of per diem is one of the largest components of the cost of training. It is suggested that training contractors might consider either approaching PPFN, the YWCA and/or church or women's organizations to see if they might be interested in organizing local arrangements or using the dormitories at local institutions thereby avoiding the high costs of hotels and restaurants.
- Recognizing the importance of increased communication between the public and private sector, selected private sector trainers and trainees should be invited to participate in public sector courses. This potentially can reduce the cost of training if private sector trainees are requested to pay their own tuition. This will be particularly effective where earning capacity will be enhanced by the training.
- The emphasis of sterilization training should be shifted toward minilaporotomy with use of local anesthesia and away from the laparoscopic technique.
- All personnel trained must immediately be supported with the equipment and commodities necessary to start providing services. If this need cannot be adequately attended to by the existing system, then the training programs must assume responsibility to see that this occurs.
- Some child health objectives should be included in most of the family planning but it is currently overwhelming some courses. A single unit comprising essential information regarding the interrelation among family planning, ORT, breast-feeding/infant nutrition and EPI should be developed jointly by experts in each of these fields to be used both in family planning courses supported by AID and in EPI or ORT courses supported by UNICEF. Special attention is called to the phrase "the interrelation" of these subjects. Too often even in so-called integrated services or training, they are dealt with so separately that one does not appreciate how intimately they can be interrelated in the campaign for child survival.

Information, Education and Communication

Information dissemination, education and communication concerning family planning is a reasonably new phenomenon in Nigeria. Previously health and personal aspects had been the major emphasis in the limited IEC efforts; however, the door was opened by the present government to discuss the positive aspects of slowing population growth as well. The need for family planning information was recognized as early as 1964 when the private National Family Planning Council of Nigeria called upon Pathfinder to support the development of Planned Parenthood Federation of Nigeria (PPFN). This organization, whose motto is "children by choice not by chance," has as its main activity the dissemination of family planning information through printed materials, mass media, and person-to-person field work. They encourage people to accept and practice family planning because it (1) is a preferable alternative to abortion, (2) ensures proper upbringing of children, (3) helps in solving the high rate of infant deaths, (4) helps in solving the problem of "child dumping," and (5) promotes maternal health. PPFN workers reach as many as one-half million individuals annually, using a set of approved operational guidelines to facilitate planning of these efforts.

Over the ensuing years a variety of AID CAs have been called upon to support family planning IEC as a part of service programs. Pathfinder has continued its efforts in support of PPFN, which is now an affiliate of the International Planned Parenthood Federation (IPPF), in their development of print materials and other promotional campaigns. During the last few years, Population Communication Services (PCS) has developed eight projects in collaboration with PPFN, University College Hospital Ibadan (UCH), the Nigerian Television Authority (NTA), and a variety of state ministries. Materials developed under this project, including method-specific picture booklets in four major languages, have been extremely well received by service personnel. Distribution of these booklets has lagged somewhat, encouraging hoarding at the various branch offices and service points; however, PPFN is presently taking actions to overcome this problem. Working with the Futures Group, PCS is supporting the televising of the RAPID presentation concerned with the potential social and economic impact of Nigeria's rapid rate of population growth. The UNFPA is presently supporting the Nigerian Educational Research Council in the development of suggested secondary school curricula changes to include the population message within the standard subject matter and within various non-formal educational programs.

This varied approach has contributed to the development of enthusiasm for family planning in many small groups within the Nigerian society. However, AID supported IEC efforts in Nigeria have three major constraints that must be considered:

1. Access to the Population. Nigeria is a large country, which makes transportation expensive and time consuming. Mass media reach a limited number of the 100 million population; there are about one-half million televisions, and newspapers reach only about one million readers. Radio transmission covers about 85 percent of the country, but listenership is not known. This situation is compounded by the use of five major languages (Yoruba, Hausa, Ibo, English and Pidgin English) plus many other local dialects, and limited literacy.
2. Limited Resources. At present, PCS is the only major CA involved with IEC activities. Pathfinder has also contributed in this area. Both CAs have an African emphasis; however, their resources for Nigeria are probably limited to present levels. PPFN is presently constrained by the recent limitation of IPPF resources and has turned to AID its CAs for program support.
3. Cultural Reticence. Even trained nurse-midwives and family planning professionals admit reticence to discuss family planning openly. Sterilization (VSC) is virtually omitted from the clinic-and hospital-based IEC efforts at present. Unfortunately, the team was unable to attend a promotional presentation, but there may be additional cultural biases which decrease information flow to potential users.

Operating within these constraints, there are four areas that may be considered: Coordination, target, choice of materials and campaigns, and evaluation. At present, the efforts that exist are somewhat fragmented. This is a result of the very nature of the rapid upsurge in interest in family planning; small entrepreneurial groups have each sought IEC support to complement their own efforts. All communications and learning theory supports simplicity and repetition of messages in order to achieve transfer of ideas. Therefore, simple and appropriate messages should be developed and should be repeated in all materials and campaigns. There is a need for increased coordination, with the development of a key message for each target group. The messages should include family planning benefits and should promote service utilization. They should include information about the location of service sites and services offered.

The development of these messages must take the audience into account. Since AID support in general is oriented towards reducing maternal and infant mortality through fertility reduction, there are several subgroups within the population who are the appropriate targets of family planning IEC programs. The primary group is women in the high fertility age group (18-30 years). These are the women who most often make use of MCH facilities

Evaluation of all IEC efforts is mandatory to allow management decisions, including cost implications. To date there has been no quantitative evaluation of the IEC efforts in Nigeria; however, PCS plans a major evaluation of its efforts this year and Pathfinder may have such an effort in progress also. PPFN expressed a strong need for evaluation and cost-efficiency analysis of its outreach efforts due to present funding constraints.

Given the above, the following five recommendations are proposed:

Recommendation. The CAs presently involved in IEC should be utilized and coordinated to the fullest extent possible. Their IEC campaign development should take into consideration the targets and content areas noted above and their campaign and message development should be coordinated for consistency by one selected CA or Nigerian institution, e.g., PCS or PPFN. This unit should serve as a clearinghouse for all IEC materials, receiving and retaining at least one copy of any item produced, to serve as a reference center for all CA efforts.

Recommendation. Other CAs not previously involved in IEC should be included in this coordinated effort. This should include CAs which support private sector training and CBD efforts with women's groups, unions, professional associations, and others.

Recommendation. The population section of the Five Year Plan should be used as a springboard for political support and solicitation of other major donor support for IEC efforts. Ministerial initiatives should be promoted at both the federal and state levels in the Ministries of Education (including curriculum modifications at all levels), Information (responsible for massive social changes, e.g., the "War Against Indiscipline"), and Youth and Sports (adolescents and men).

Recommendation. Due to limited resources, cost containment efforts must be made. These might include economies of scale, increased use of free media time, and simplification of client-oriented materials. Reassessment of the decision concerning in-country printing should be carried out in light of other recommendations that costs of shipment and in-country logistics be picked up by the appropriate CA.

Recommendation. Evaluation, especially quantitative measures such as numbers reached, comprehension of messages and comparative cost, is needed for AID and CA management decisions. Each CA should be required to carry out internal evaluations at regular intervals. In addition, an independent CA should be called upon to provide an impact evaluation for the IEC effort as a whole with specific recommendations for the coordinating unit (see the first recommendation above) and for additional cost savings.

Previous Page Blank

Service Delivery

Vice President George Bush made the statement that "sensible family planning" must be a part of the African effort to stem the increase in food shortages (United Nations International Conference on the Emergency Situation in Africa, March ^, 1985). In this spirit, the AAO in Lagos has stimulated and encouraged appropriate parties to join in the effort to provide family planning services within the constraints presented by the lack of a bilateral program in Nigeria. AID does not encourage use of its funds for major capital expenditure or for recurring costs of national programs. However, the AAO has provided resources to relevant support functions (training, IEC, commodities, complementary equipment), as well as to entrepreneurial comprehensive efforts, primarily in the private sector. This section, therefore, addresses the issue of service delivery as it relates to the impact of these support functions on services rendered and also with regard to private sector participation.

In the public sector, family planning is perceived as a policy issue for demographic/economic reasons but operationally it is assigned primarily to the health sector. While the structure of the Federal and State MOH administration is discussed elsewhere in this paper, it is important to note aspects related to service potential here. At present, the public health sector employs a significant percentage of all trained nurses and nurse-midwives, of whom there are about 1/1,700 population. The annual output of nurses is about 5,000 and that of midwives is about 3,000. The physician-population ratio is about 1/8,500, 20 percent of whom are expatriates and as in most countries, most of these professionals are concentrated in urban areas. Creating the planned health infrastructure has been delayed due to economic conditions; however, over 6,000 health facilities are known to exist nationwide. In all, this yields a situation in which only about 35 percent of the population has access to the modern health system, and, in spite of training large numbers of health professionals, economic pressures may limit their hiring.

Prior to the present interest expressed by the public sector, family planning was provided in Nigeria by four routes: PPFN and other private organizations; some mission programs; training programs based in universities; and the commercial sector. These services include the entire range of program possibilities: voluntary sterilization, clinical and non-clinical family planning methods, community based distribution and commercial sales. When requested, PPFN has provided services in MOH facilities according to a suggested fee schedule that approximates one naira (₦) per one month supply of pills, condoms or foam, ₦ 1-5 for an IUD, and ₦ 5 for a diaphragm. At present their distribution system may be reaching as many as 80,000 clients annually. Their pilot CBD program provided services

equivalent to about eight couple years of protection (CYP) per worker each year in the earliest project data. PPFN was clearly a major element of the early family planning services effort.

Some mission hospitals and some training institutions have independently introduced family planning services. Although there is no present inventory, it is clear from conversations throughout Nigeria that many people received didactic, clinical or in-service training in this area even when it did not appear officially in curricula. In addition, FPIA has sponsored two mission-based clinic and outreach projects providing a broad spectrum of services in which CBD aspects bring services to the household or to the individual in the community. This sort of service delivery serves an important IEC function, emphasizing the social acceptability of family planning through person-to-person discussion. Training institutions have also developed service delivery activities to provide practical experience as part of training programs. FPIA has supported a project at the University of Ife which provides clinical and non-clinical services as well as female sterilization. Columbia University and Pathfinder have joined forces to provide a primary health care-family planning CBD program with the University of Ibadan. AVS has established service sites in at least three major teaching centers and with the Kaduna Military Health Facility.

Other private groups have developed service delivery programs. FPIA has aided the "Trim Family" project of the Commercial Medical Foundation to develop clinical family planning services. The National Nigeria Port Authority has also practiced entrepreneurship and has developed clinical services with FPIA for its 30,000 port workers. In some areas private practitioners have also contributed significantly to family planning service delivery efforts. The commercial sector, e.g., pharmacies, patent medicine stores, may be contributing a significant, if not the major, portion of all contraceptive services. FPIA, in collaboration with Sterling Pharmaceuticals, is planning a commercial retail sales project of major significance. This project should assure availability of pills, condoms, and foaming tablets in about 7,000 commercial outlets nationwide.

Service delivery efforts, aimed primarily at married women of high parity, had yielded a total CPR of less than 3 percent modern method use as recorded by the National Fertility Survey (1981-82). Recent efforts have probably increased prevalence significantly in isolated pockets nationwide; however, with the apparent declines in breast-feeding and traditional postpartum abstinence and with the continuation of early marriage practices, it is likely that this increase would have had little impact on total fertility or the national growth rate.

An additional major concern is the economic and personal cost of abortion. Abortion in Nigeria is illegal and is an act of desperation and the personal costs are high. The abortion mortality and morbidity rates are excessive causing a strain on the already limited health resources of the nation. Abortion occurs with alarming frequency among adolescents, a group which has traditionally had little access to family planning services or information. Clearly this group would benefit from services. It was suggested to the team by an official of the FMOH that informing men about family planning and providing them with family planning methods could have a major impact on this problem. In sum, service delivery in family planning has a cost-saving potential for the health system, in addition to its direct health and demographic impact.

With these factors in mind, the FMOH is presently developing a family planning action plan for the public sector. This plan is being developed with AID and other major donor input. This plan will provide the framework for AID support in service delivery. The strategy recommends interministerial work at the federal and state level, with emphasis on LGAs for service delivery (LGAs average over 300,000 population but vary greatly) following in the footsteps of EPI efforts.

This approach has major strengths and weaknesses. Strengths lie in supporting both interministerial efforts and state level initiatives. Also, tying the effort to EPI may allow increased contact with married women. LGAs, however, may be too small to allow for economies of scale. EPI efforts have not been shown to strengthen LGA management and the program appears to be quite separate from the MCH services, using separate staff, logistics, and line authority. Furthermore, although this may increase access to high fertility women, it gives limited attention to the problems of adolescents, men, and those who lie beyond the health system. Nonetheless, it will provide a much needed framework upon which to build a significant family planning program.

Three specific areas within this definition of service delivery may deserve increased effort and attention by AID. These are service outreach, service skills, and service management/logistics. A major area of CA service effort consists of the development of pilot projects supporting the entrepreneurial efforts of private sector organizations and individuals. The PPFN efforts based in government facilities may diminish as governmental family planning efforts increase, allowing PPFN to place more emphasis on outreach to the underserved sectors. Much work remains to be done in the private sector. Although FPIA and Pathfinder have developed some significant small projects in this area, this sector has great potential. Possibly as much as 65 percent of the population would have access only to these alternative service systems. At present these projects are free-standing; they are not designed to be bases of massive efforts. However, service outreach also serves a vital role in IEC in that

it creates a person-to-person communication network of significant proportions, therefore growth in this area would reinforce mass communication efforts and provide a basis of social acceptability for potential family planning acceptors. Intensive outreach of this nature is needed in urban as well as rural areas. Finally the commercial sector with its infinite number of outlets, from the pharmacies to market women are potential agents of change through person-to-person contact. The concentration of urban populations may simplify start-up planning and costs of these projects, with a view to expansion and, perhaps, institutionalization.

Service skills are of major importance. Although this area is addressed extensively in the section on training, there may remain the need for AID to emphasize the service-orientation aspects of these skills to those CAs who provide training. Aspects which perhaps have not received adequate coverage include public health orientation, the concept of coverage, the development of objectives and/or targets, and handling of supplies. Furthermore, the skills supported by AID must be appropriate to the needs of the population, the ability of the service infrastructure to support them, and must be of a nature to assure that their primary use leads to family planning delivery. Furthermore, some family planning skills must be institutionalized within every MOH service unit.

Examples where service skills development may not be appropriately oriented are few in number, but may have significant implications. For example, to date, the major thrust of services has been IUD insertion in the hands of highly educated nurse-midwives. Whereas this remains an extremely appropriate entry path to service delivery, it is important to assure a "cafeteria" approach, in terms of both commodities and service personnel. Many health facilities do not have adequate personnel, space, equipment, or funds to support IUD services. A second example that has significant cost implications has been a relative emphasis on laparoscopic training, rather than mini-laparotomy, for tubal ligation. Although the program was originally instituted to stimulate interest in reproductive health, and may have been very successful in that objective, the present climate and needs suggest a shift to more appropriate technologies. Nearly 40 laparoscopes/laprocators have been provided by JHPIEGO over the past four years; however, there have been requests for resupply of Falope bands from only eight users. Interviews with a few of the physicians who have this equipment reinforce the impression that it has not been used primarily for family planning. Estimates indicate that family planning use accounts for about 5 percent of actual use. Laparoscopy necessitates an expensive piece of equipment, high maintenance costs, and special training while also promoting a technique which is neither replicable nor feasible outside major medical centers in Nigeria. Furthermore, the majority of physicians trained in laparoscopy did not receive other appropriate technological training, e.g., IUD

training or minilaparotomy training. Unfortunately, JHPIEGO has eliminated minilap from its sterilization training program, albeit on request by the Nigerians. Minilap is a relatively simple method to learn, it can be performed with local anesthesia and no special equipment (although certain instruments simplify matters), and the skill can be shared between colleagues allowing rapid dissemination.

Another direction for reinforcing service skills might be the development of service guidelines. Guidelines for method prescription would assure that services are appropriate for both the care provider and the client. These guidelines would also assure consistency in training carried out by the various CAs. These guidelines facilitate rather than limit activities and could be developed for all levels of personnel, including physicians and market women. The guidelines for physicians may take the form of a pamphlet addressing issues in family planning, such as working with auxiliaries, and public health concepts. Guidelines for other levels of personnel would take the place of standing orders, emphasizing flexibility and service availability. They should be appropriate to absorption capability, and the available methods.

Service management is the third major area for consideration. Although management issues are addressed elsewhere in this document, a few technical areas are highlighted below.

Service data versus Surveillance: It is not necessary at this stage of development to burden the entire system with a complex data collection form. A statement of total visits and commodity records which includes inventory, receipts, distribution and balance to be analyzed centrally with a "push" mentality would be adequate. With such a system, one could assess progress, re-supply, and make the majority of management decisions. Each clinic already maintains a daily roster of clients and service rendered. Any additional information needed could be occasionally gleaned from this. The only piece of information lacking in this system is continuation rates; however, that piece of information can be obtained through simple surveillance at selected sites as needed for strategic management. The client data form, which was instituted at the same time as the record system, has been widely accepted and approved. However, certain problems have been noted in the field. The nurses who work with the forms have complained about their large size and a question regarding breast-feeding, which is vital to prescription choice has been left out. In addition, the question of smoking may be culturally irrelevant in Nigeria, but appropriate questions concerning snuff and chewing tobacco, are not included.

Commodity prescription: Based on a precedent set by PPFN, oral contraceptives are generally dispensed one cycle at the first visit, and three cycles per visit from then on, regardless of the distances the client must travel and modified only by her ability to pay. The vast majority of side effects occur during the first months of use, hence there is no medical reason to

limit the number of cycles distributed after the second visit if the client has adapted to the method. Concerning number of pill formulations available, there are reasons that justify limiting the AID program to one formulation. At present, there is insufficient emphasis on counseling the client to utilize the same dosage for three months, rather than immediate method switching if minor side effects are encountered. Such switching may increase the negative rumors about oral contraceptives. Assurance and continuation resolve the vast majority of minor side effects. Other formulations will remain available in the private sector if absolutely needed. A second justification for only one formulation is the presently weak logistics system. Commodities that are similar are often confused at all levels, leading to poor distribution and stock outs. The schedule of visits for IUD follow-up may also be excessive, but it is largely ignored by the clients.

Costs: At present, the cost of family planning services in the public sector varies but in most areas the PPFN cost guidelines serve as a base. This means a minimum of ₦ 3-5, in addition to any travelling expense, is necessary for a client to receive family planning services. Where a family's income average ₦ 100-200 a month and an average of 50 percent of this goes to housing, an outlay of ₦ 5 or more for preventive health may well be prohibitive. A recent study by Africare of clinic utilization reflects decreased usage as fees have been introduced. Furthermore clinic personnel state that the reason EPI increased clinic use was because it was free. Conversely, charging for commodities and services is supposed to convey a certain value upon them, decreasing wastage. Certain programs rely on these fees for partial reimbursement of operating costs. It should be noted, however, in terms of entire program costs, the savings from reducing the incidence of septic abortions and complications of high risk pregnancies will more than make up for any losses from decreasing the cost of family planning service provision.

Commodity Logistics and Supply: AID will continue to play a major role in commodity supply to Nigeria and, therefore, has some responsibility to assure the best possible logistics to supply provider units. In addition to improved management through training, the cost implications of developing a national logistic system must be considered. Supply of equipment can be very costly; efforts should be directed towards supplying those trained rather than towards supplying standing units. At present, Africare is carrying out an assessment of equipment needs in several states. It is not clear that this survey is oriented to the objective of assuring family planning service capability. Minimally, it will be necessary to correlate Africare data with training data to assure that the equipment that is available will be most appropriately placed. The CA performing the training may be most appropriate supplier for IUD or minilap equipment.

Based on the above, the team recommends the following:

Recommendation. CAs which support private sector efforts, especially those that reach populations unserved by the MOH system (i.e. adolescents, men, and populations who do not attend clinics), should be encouraged to increase their efforts which are complementary to the public sector strategy. This will serve both IEC and service delivery objectives. However, each CA should be asked to submit a strategy for expansion with proposals in this area. These CAs should be encouraged to reach out to new organizations, including women's groups, religious missions, and unions. PPFN may wish to reorganize to be more complementary to the MOH efforts and should be given technical assistance in this effort.

Recommendation. CAs should offer technology appropriate to the family planning effort of Nigeria.

Recommendation. The development of service guidelines, which could be undertaken by a series of workshops sponsored by a CA affiliated with a respected health institution, may also serve as an aid to CAs in assessing the appropriateness of their training objectives.

Recommendation. The cost of family planning to the client should be reassessed in light of the present economic situation, personal disposable income, and cost savings of family planning. A CA or an individual consultant selected by ISTI could perform this task.

Research/Evaluation

The AID population program in Nigeria has undergone tremendous growth in concert with the positive policy changes of the current government. Research is attractive in the early stages of a dynamic service-oriented program such as this in that results can serve (1) as a management aid, (2) to promote acceptance of new methodologies, and (3) to enhance positive policy development. The present group of CAs can provide support in these areas through funding appropriate biomedical, sociodemographic, and operational research. Policy research, per se, is provided through the UNFPA and World Bank efforts, but if a specific need should arise, Columbia University Population and Law Center would be an appropriate CA to use.

At present, AID is supporting biomedical research through the Family Health International (FHI). Their projects, planned and in progress, include two IUD studies, two comparative studies of high- and low-dose progestogen pills, a study of the use of minipills during lactation, a six-center study of Norplant, and a comparative study of spermicides. In addition they are carrying out five survey/surveillance types of studies and are continuing maternity care monitoring (MCM) in these sites. Workshops on contraceptive technology, MCM, and female sterilization have been held for dissemination of research findings. The in-country budgets for these projects are minimal, but the outcomes have been great in terms of good will among high level medical decision-makers and potential for improved service delivery.

Sociodemographic studies have included work by the World Fertility Survey and the Futures Group. The Nigerian Fertility Survey yielded invaluable information for policy and planning. The RAPID presentation has been warmly received and is presently being redesigned for national television presentation. The Futures Group is involved in aiding the FMOH and all Ministries in development of a National Strategy and Five Year Plan in population and family planning. Westinghouse Health Systems is also developing the first state (Ondo) contraceptive prevalence survey to assess progress and to allow for planning improved services. At present Africare is carrying out a survey of equipment which has been expanded to include attitudinal questions. The D.D.D. project is actively involved in analyzing the 1982 Household Health Survey, highlighting fertility parameters. This survey was carried out by the National Population Bureau.

Operational research (OR) can serve two major functions: (1) to introduce a new program element in a carefully controlled manner and (2) to allow for improved management decision making in on-going projects. The cost-effectiveness assessment which are a part of most OR can be of major importance in planning the efficient use of limited resources; however, OR is not meant to

substitute for program development. At present there is one major family planning OR project in Nigeria carried out by Columbia University. This six year old project has not yielded cost-effectiveness data nor quantitative guidelines for future programming. At present, there are 155 volunteer workers providing at least five times more primary health care services than family planning services. It should be noted, however, that this project was seminal in introducing the concept of CBD in Nigeria, a major programmatic breakthrough.

Following the recent period of rapid growth and increased interest in family planning, it is important to evaluate all program activities. As the program expands, it becomes increasingly more important to establish objectives and coordinated strategies based on evaluative findings. Therefore, data are needed now as a basis for those decisions. Sociodemographic data is a vital tool in this process. Assessment of evaluative data frequently leads to the development of alternative ways to proceed. OR projects then may serve as alternatives in terms of efficiency, ability to expand, and cost-effectiveness. A major constraint in this area is the minimal orientation of present CAs to utilize the outcome of their research for making management decisions. However, at this stage in development of the family planning program in Nigeria, it is precisely this aspect of OR that is needed.

Biomedical research should continue to serve as a stimulus for high level medical decision makers to remain interested in family planning. In addition, projects which introduce new methodologies, improve program safety and efficacy, and provide feedback on health outcomes in related reproductive health areas should continue to be encouraged.

In the area of research and evaluation, the team recommends the following actions:

Recommendation. Evaluation, concentrating on program impact as the major goal of improved family planning service outcomes, must be demanded of all CAs, no matter what their mandate. This will aid in their own strategy development for coordination and improved program outcome in Nigeria, and will aid AAO/Lagos to select those CAs which can best contribute to achieving this goal. Project objectives, which must be set in the context of the entire picture of family planning in Nigeria, must be produced by each CA for project approval.

Recommendation. Operations research should be oriented to answering specific management or policy questions of interest to future program thrust. Controversial issues and management concerns as well as cost-effectiveness assessments should be addressed.

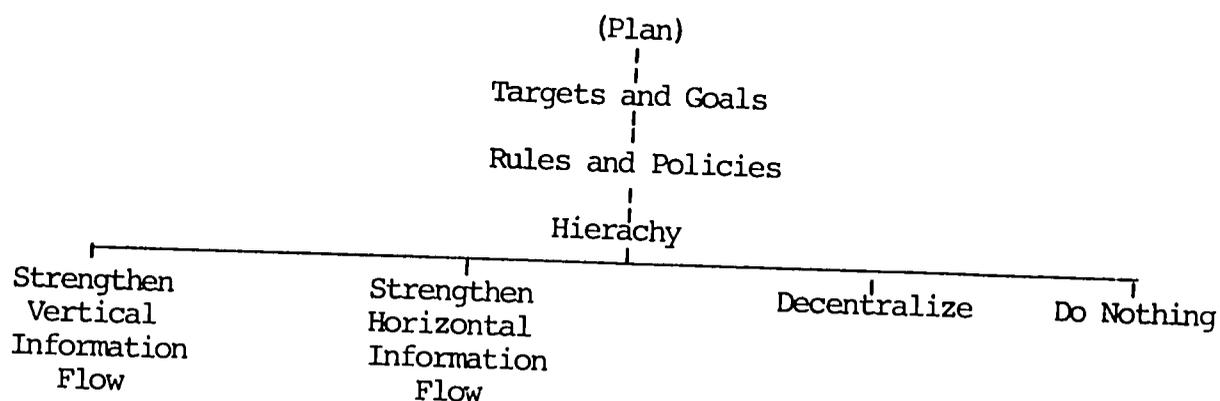
Recommendation. Biomedical research projects should be continued and should be selected for their potential positive impact on quality and quantity of services delivered in Nigeria. Data produced should be shared with all interested parties in Nigeria through publication and seminars.

Recommendation. Projects should be encouraged to stay within their particular area of research expertise or to seek out the aid of other CAs with that expertise. For example, Columbia University may benefit from collaboration with a social marketing CA while Africare may benefit by allowing a group with sociological survey expertise to aid in their questionnaire development.

VII CHANGES IN MANAGEMENT APPROACH

Theory of organizational coordination is virtually unique for the degree of consensus on a single model which was dubbed at its introduction as the information processing model. It postulates seven organizational responses or activities that coordinate the operations of different components of an organization or program. Preceding these seven is the development of a comprehensive plan of action which the theoreticians have taken as a given but which is often absent in practice.

Schematically, the model appears as follows:



The strategies at the top of the chart are to be undertaken first and in the order depicted: Organizational coordination is impossible without a plan; targets for each of the units or activities help those units keep in step with one another; when targets are not met there should be unambiguous rules or policies for how to handle the situation; if the breakdown in coordination is not covered by a rule, there must be a point in the hierarchy where a decision can be taken to redirect efforts to restore the equilibrium of the system. After those few steps have been taken an organization may invest in three other strategies to improve coordination, or it may do nothing--the seventh option--as the chaos may be better than the cure. An expanded description of this theory, especially as it applies to the situation being examined in Nigeria, is attached as Appendix J.

It may be noted that this scheme describes much of which is already being done by AID in Nigeria. While it is reassuring to find that the AAO's practice is supported by theory, the reason for this presentation is to indicate the priorities that must be established in addressing coordination issues. When observers note that two units are not operating in perfect harmony, the usual response is to propose a committee or other horizontal structure to link the two. The above theory indicates that such a step is one of the last actions that should be considered.

The following reviews the activities of steps in the scheme as they relate to the situation examined in Nigeria.

1. Plan. The starting place is the basic plan of action or strategy of the program. (Here strategy is used in the business policy sense and not as applied in AID.) The plan relates and sequences the activities of the program to achieve objectives, fixes deadlines, and provides contingency plans to respond to the most likely deviations from the basic plan. As the FMOH develops its own National plan of action, this can serve as a basic framework for the development of plans by AID and the CAs.

Recommendation. A consultant should assist the AAO in developing a strategic plan for the next two years. It would be most useful if the consultant had broad experience in U.S. private industry planning and fully understood the methodology of strategic planning. This individual would work with the AAO for at least four weeks in Nigeria collecting the basic data required and putting the activities together into a cohesive program. The timing of this exercise depends upon the availability of the AAO as she will be the primary resource. Ideally, it should be started early in 1986.

2. Targets. In an ideal world, the targets fall easily out of the planning process. Here they do not, due in large measure to the relative independence of the CAs. Consequently, each CA will have to buy into the plan and negotiate the targets they plan to achieve. Clearly there will be modifications to the plan and, ecologically balanced as it is, changes in one aspect will affect other elements. Our suggestion is to be prepared for this and go about the plan modification with as much good humor as possible.

Recommendation. Each CA should be given a copy of the completed basic plan and invited to "bid" on those elements of the plan that are within its presumed sphere of competence. CAs need to be informed that once the bidding is over, any new directions not included in their agreed program must be justified in light of changing circumstances; after all, the purpose of this exercise is coordination. Furthermore, each CA should also develop their agency's plan of action for Nigeria, to be updated annually and submitted to AID.

3. Rules and Policies. Rules and policies are automatically invoked when targets cannot be met. The rules are of two varieties:

- a. Those internal to an operating unit--the idea being the unit should first commit its own resources to get the program back on track before spreading the alarm and demanding that others put things right, and
- b. Program wide rules and policies--acknowledging that unit X's failure to come through will affect other units in the system and that those units must be mobilized to adapt to the new situation.

Recommendation. Each CA must present, in its workplan for each and every project, at least some contingency plans for coping with the most likely problems; we have enough experience to anticipate most of those. The AAO faces the cheerless task of developing fallback positions on a program-wide basis when individual CAs cannot resolve their own problems.

4. Hierarchy. The hierarchy is given -- this is AID.
5. Vertical Information. Here there is much that can be added to what has already been done. The AAO, who is in the best position to exercise on-the-spot management, needs immediate access to indicators of program progress. Primarily she needs access to lack of progress in specific areas that threaten to spill over and impede other activities. At present the CAs file reports at the conclusion of certain activities and events. These often unilluminating tomes may arrive too late to take corrective measures and the drop rate is so high that problems, hinted at amidst the verbiage, often go unnoticed by the reader.

Recommendation. Each CA must file an exception report within five days of the conclusion of an activity or deadline to meet a target, if the target has not been met. It would be earnestly appreciated, of course, if the CA would notify the AAO as soon as it becomes evident that a future target cannot be met. Also, CAs should provide AID with a brief written report (focusing on progress achieved and problems encountered) before leaving Nigeria at the end of each visit. These reports should be available for other CAs to review. Formal trip reports should be provided to AID on a more timely basis, i.e., within 30 days of travel, and be circulated, as appropriate, to other CAs working Nigeria.

A promising initiative will soon be undertaken by the newly arrived Health Development Officer who will load existing information on population projects into a computerized data system.

Recommendation. The information on project activities, deadlines, start-up dates, budgets, etc. that are contained in the plan should be entered. Presumably the data can be addressed by any column or key word.

6. Horizontal Information. Surprisingly the team has little to recommend in this area. Past efforts have been energetic and successful and better lateral coordination may be in the offing as additional CAs establish offices in Nigeria.

The following are some additional recommendation for the on-going day-to-day requirements for coordination in the Nigerian program:

Recommendation. AID/W should continue its coordination of the Nigeria Working Group. This group should be convened regularly. Although information sharing on various program activities will continue to be important, a greater focus on problem solving in particular program areas may be more fruitful.

Recommendation. AID/Lagos should support the FMOH in its continued efforts toward coordination of the donor community. Regular meetings will provide the opportunity of focusing on donor input on family planning in the national plan, and should ameliorate the problems of duplication or gaps in support.

Additional issues explored by the team which may reduce the management burden of AID include the following

a. Contracting Private Organization for Specific Management Tasks. The team explored with Sterling Pharmaceuticals the possibility of their being contracted for an expanded role in the management information system, particularly in the area of contraceptive distribution. Sterling was ambivalent but indicated that as the commercial retail sales expand, they may be in a better position to assume additional responsibilities in this area.

Recommendation. The team recommends that AID explore this potential opportunity at a later date.

b. Utilizing CA Administrative/Logistic Capability. Some of the cooperating agencies are establishing their own offices or hiring representatives in Lagos (Pathfinder, PCS and AVS) or in the region (INTRAH and Columbia).

Recommendation. The team recommends that AID explore ways to encourage these CAs in taking over some, if not most, of the administrative/logistical support for their projects, currently handled by the AAO.

c. Networking With In-Country Agencies. Although the federal government plans to be more involved and will aid with the coordination of state activities there appear to be some of these activities which could be done on a more regional basis. The earlier recommendation regarding quarterly meetings for SFPCs could assist in public sector networking. As discussed in the training section, the development of training curricula for separate state programs may not be necessary, training of trainers might be done at regional or zonal centers of special competence. In addition, with a stronger population policy, it may be possible to develop a national IEC program, rather than programs on a state-by-state basis. An example in the private sector is the support the PPFN is giving to various cooperatives, market-women or women in development organizations or its approach to private physicians and nurse-midwives. Institutional development support to PPFN could enable them to expand this effort.

In this concern for networking, however, AID needs to recognize the pluralistic nature of the Nigerian society, special influence of local leaders and the inherent nature of the bureaucratic system, all of which frequently limit the effectiveness and efficiency of nationwide organizations. In other words, management-intensive as it may be, AID and its CAs will continue to find it necessary to deal with small organizations, particularly in the private sector, for some time to come. Thus, some program "retailing" may continue to be necessary.

Recommendation. In conclusion, the team recommends that AID explore all opportunities for in-country networking. Particularly in the private sector, special efforts must be made in institutional development to enhance the capacity for this networking. Small management-intensive experimental efforts will still be justified, especially to support outreach and coverage objectives.

VIII TYPE AND LEVEL OF ASSISTANCE FOR FUTURE ACTIVITIES

In the absence of bilateral funding, current AID programming in Nigeria is excessively complex involving seventeen CAs, each having different and often narrowly defined mandates. Due to these narrow mandate and the limited funds available, no one organization can be requested to assume major program responsibility, especially in a country as large as Nigeria. The requirement to use such a large number of CAs to piece together a comprehensive program has resulted in an inordinate management burden on the AAO/Lagos. For example, in July, some 50 consultants and representatives of CAs passed through Lagos with specific program tasks to perform. July was an unusual month with a backlog of visits which had awaited the AAO's return from home leave. Several teams were expected to complement each others efforts, such as the policy review teams from Futures and the World Bank and this strategy team. Clearly it was useful for the strategy team to have the contact with the representatives of various CAs. Special efforts have been made by AID/W, the CAs and the AAO to coordinate cooperating agency activity. On the other hand, the potential for waste and duplication and lost opportunities for in-depth treatment of a particular program is rather clear.

The team cannot address the issues of whether a bilateral program per se is an appropriate relationship with Nigeria at this time. However, the team can only conclude that a different funding mechanism, either bilateral or regional, must be found to make larger blocks of money available on a multi-year basis under the management of the AAO. The mechanism should include the provision for contracting technical and management assistance, for supporting local PVO and public sector activity and for buying into the projects of selected CAs as necessary.

With the recent doubling of the AAO/Lagos direct hire staff, from one to two persons, and the probable addition of local contract personnel, the AAO should be able to manage a high level of resources if a more efficient programming and funding mechanism is available.

The recently developed Plan of Action for a National Family Planning Program being presented by the FMOH as part of the Fifth National Development Plan (1986-1990) calls for approximately \$130 million, exclusive of personnel and facilities, to be allocated for family planning program activities in both the public and private sector. It should be noted that these expenditures cover only the family planning component even though the services may be provided in the context of maternal and child health. Of the \$140 million, the Nigerian contribution is projected to be \$40-50 million with external requirements of \$90-100 million. If AID maintains its role as principal donor, at least in the first two or three years of this plan, requests to AID may total \$50-60 million over that period, largely for

contraceptives, surgical equipment, IEC, training, technical assistance and private sector support. Clearly this will require a substantial increase over the \$4-5 million currently being disbursed annually by AID through its CAs.

Substantial AID funding of local costs is never too attractive; it will be even less so in Nigeria as the unfavorable exchange rate makes these costs especially high in dollar terms. Thus policy dialogue is particularly important at this time in supporting Ministry of Health efforts to increase the financial participation of the Federal and State governments. Although the support is already significant in salaries of health personnel and in facilities made available in both the public and private sector programs, it must be matched in line item budgetary allocations.

It will also be important for AID to continue to encourage the local currency generating potential of commercial retail sales activities and that of distribution through private physicians and nurse-midwives, as long as income generation does not interfere with access of the population to contraception at an affordable rate.

An attractive possibility for local funding appears to exist with American based firms holding large amounts of Naira in blocked accounts. These cannot be repatriated in dollars at present. Several groups are exploring ways of accessing these funds for local costs of family planning programs. A favorable decision by the U.S. Internal Revenue Service that these donations, if made through a U.S. institution, were tax deductible would facilitate this use. This would be particularly helpful for projects in the private sector.

Recommendation. AID should lend whatever encouragement and legal advice available to facilitate access by family planning programs to U.S.-held blocked naira accounts.

Recommendation. AID should develop a different funding mechanism, either bilateral or regional to make available larger blocks of money (\$50-60 million over 5 years) on a multiyear basis under the management of the AAO.

NIGERIA STRATEGY REVIEW TEAMSCOPE OF WORKJuly 8 - 26, 1985

Given the size and complexity of the country and the shortage of management and financial resources in AID, what can be done to prioritize activities and improve efficiency of management?

1. Can or should programs be more focused, e.g. on urban centers or on states more effective or more ready as evaluated by specific criteria?
2. Should AID use its manpower and resources to place more emphasis on the private sector? What kinds of organizations and types of activities will most likely fill a key gap or bring more efficiency to the program?
3. Is it still necessary or appropriate to put as much emphasis on child survival interventions other than family planning?
4. Should there be any shift in relative emphasis among the following activity areas?

Policy Development
 Information, Education and Communication
 Training
 Commodity Supply and Management
 Clinical Equipment
 Records and Statistical Management
 Service Delivery (Clinical, Community Based and Commercial Distribution)
 Research (Biomedical, Operations and Socio-demographic)

5. What can be done to improve productivity and cost-effectiveness of the following major program activities examined by the team?

Support Functions

Training
 Management and Evaluation
 Logistics
 Statistics and Record Keeping Systems
 Commodities and Equipment
 Information, Education and Communication
 Research

Service Delivery

Clinical
 Contraceptive Retail Sales
 Community Based Distribution

6. What changes in the management approach of AID and its CAs can enhance efficiency and effectiveness?
For example:
 - What are the pros and cons of national level coordination; is it time to strengthen the role of any Nigerian national unit in program planning, monitoring or implementation?
 - Can more networking be stimulated among Nigerian institutions; what institution building activities will be required?
 - Can any more actions of a program management nature be contracted to private sector institutions?
 - Are there adequate coordinating mechanisms among CAs to produce coherent programming in any particular area?
 - Can CA and AID direct supported activities be made broad enough or sufficiently comprehensive to have regional, state or national impact?
 - Would a bilateral program or other means to place long-range funding under AAO control enhance management and coordination?
7. Given the importance of Nigeria's 100 million inhabitants to the continent, the rapidly improving policy climate for effective population programs, and Nigeria's present economic condition--what can be said about the adequacy of AID support for the population program?

APPENDIX B

CONTACTS AND SITES VISITED

Nigeria Strategy Review Team
July 8-27, 1985

LAGOS STATE

American Embassy/Lagos

Mr. Thomas W.M. Smith, Ambassador
Dr. Keys MacManus, AID Affairs Officer
Mr. Lawrence R. Eicher, Health Development Officer
Mrs. H.O. Shitta-Bey, Program Specialist
Mr. Bayo Iginla, Logistics Specialist
Mr. Peter Osayamwen, Training Officer

Federal Ministry of Health

Dr. A. B. Sulaiman, Director, National Health Planning
Mrs. A. Desalu, Planning Officer

Others: LAGOS CONTACTS

Dr. I.S. Salami, Chief Medical Officer, Lagos Local Government
Authority and Director of the IFPORT Project
Mr. Adami, West African College of Nurses
Mr. Udenze, Executive Officer, Nigerian Nurse-Midwives Council
Mr. M.A. Olabode, Executive General Secretary, Midwives
Association of Nigeria
Mr. George Nsia, Program Representative, United Nations Fund
for Population Activities
Ms. Olabise Olatokumo, Country Representative, Pathfinder Fund
Mr. Yomi Daramola, IEC Specialist, Pathfinder Fund
Mr. A. Fajobi, Executive Director, Planned Parenthood
Federation of Nigeria
Mr. Marc Okunna, Program Officer, Planned Parenthood Federa-
tion of Nigeria
Mr. William Price, Vice President, Sterling Products (Nigeria)
Ltd.

OYO STATE

Mrs. Grace E. Delano, University College Hospital, Ibadan
Mrs. A. Williams, Chief Health Sister, MOH
Mrs. C.A. Faoye, Program Officer (CBD Program), MOH
Mrs. Tonode, Nursing Sister, Center for Fertility, Jericho
Hospital
Ilora MCH Center/CBD Project Zonal Unit

OGUN STATE

Mr. A.A. Odulana, Permanent Secretary, MOH
Dr. S.A. Onadeko, Director Medical Services, MOH
Mrs. I.V. Mako, Director Nursing Services, MOH
Mr. J.A. Olabode, Planning Officer, MOH
Dr. A. Aina, Chief Health Officer, Family Planning Coordi-
nator, MOH

Ogun State con't

Dr. Ayodele Oni, Zonal Medical Officer for Abeokuta
Family Planning Store
Planned Parenthood Branch Office
Iberekood Comprehensive Health Center
Abeokuta Comprehensive Health Center
Abeokuta Maternity Hospital

PLATEAU STATE

Dr. S.Z. Jebwi, Chief Medical Officer, MOH
Mrs. S. O. Dung, Basic Health Coordinator, MOH
Mrs. Zipporah G. Mafuayi, Assistant Basic Health Coordinator
Family Planning Coordinator, MOH
Dr. J.A.M. Otubo, Jos University Teaching Hospital
Plateau School of Nursing
Plateau School of Midwifery
Seventh Day Adventist Hospital, Jinju
School of Health Technology Clinic
Family Planning Store
Government Store
University of Jos Family Planning Clinic
PPFN Branch Office
Jos, General Hospital Family Planning Clinic
Bukuru Dispensary and MCH Center

ONDO STATE

Dr. A.A. Adentunji, Principal School of Health Technology
State Family Planning Coordinator
Mrs. Olowo, Asst. Chief Health, School of Health Technology,
Mrs. J.E. Akerele, Principal Health Tutor, I/C Family
Planning Statistics, School of Health Technology, Akure
Mrs. Ogunlowo, Principal Health Sister, Aramoko
Mr. S.A. Orisasono, Health Educator/Nursing Superintendent
School of Health Technology
Ms. Bisi Ogunleye, Country Women Association
Family Planning Store
Akure District Hospital
Planned Parenthood Branch Office
Akure District Health Clinic

BAUCHI STATE

Mrs. Paulina Dogo, Senior Nursing Sister, MOH
Dr. Iliasu Mohammed, Chairman Health Management Board, MOH
Dr. Joshua Maina, Director Medical Services, MOH
Dr. M.O. Mahdi, Director, Health Services, MOH
Dr. (Ms.) Aisha V. Kwanashie, Medical Officer of Health, MOH
Mrs. Ahmed, Chief Health Sister, MOH

BENUE STATE

Dr. Alesc Kadin, Hon. Commissioner for Health

Benue State con't

Dr. (Mrs.) R.A. Abdullahi, Consultant Health, MOH
Dr. (Mrs.) Mary Ogebe, Chief Medical Officer, MOH
Mr. Ali Abu, CNO, Health Management Board
Dr. N.I. Bur, Chief Medical Officer, MOH
Mrs. S.O. Attah, Chief Health Sister, MOH
Mrs. M.K. Dalhatu, Chief Nursing Sister
Mrs. Esther. Onaguluchi, Chairman, PPFN
Mrs. J.S. Abeda, Principal Community Health Officer

IMO STATE

Dr. (Mrs.) Bridget Nwakwo, Honorable Commissioner of Health
Mr. Izuwa, Permanent Secretary, Health
Mrs. Grace Ogbonna, Chief of Family Planning, ORT, and EPI, MOH
Mrs. Josephine Madumke, Director of LGAS
Mrs. Nwangiro, Nurse Tutor
Dr. Emenalom, Acting Director Health Management Board
Sr. Rose Nzeakor, PPFN Branch Director
Private Maternity, Mercy's Maternity
Rural Health Clinic
MOH Family Planning Clinic

INTERNATIONAL AGENCIES CONTACTS

Mr. Tim Barton, Population Services International
Mr. Terrence Jezowski, Association for Voluntary Sterilization
Mr. Joseph Dywer, Association for Voluntary Sterilization
Mrs. Peggy Curlin, Center for Development and Population
Activities
Mr. Philander Claxton, Futures Group, RAPID II
Mr. Alan Alemian, Africare
Ms. Susan Rich, Population Crisis Committee
Dr. Moye Freyman, University of North Carolina
Dr. Linda Lacey, University of North Carolina
Dr. Tom McDivitt, University of North Carolina
Ms. Israt Hussain, World Bank/Washington
Mr. David Radel, World Bank
Dr. Gary Gleason, UNICEF
Mr. Alan Brody, UNICEF

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
AFRICARE	SMOHS in eight States: Plateau Niger Kwara Kano Kaduna Ogun Ondo Imo	Family Health Initiatives Project \$312,000 9/84 - 8/85 (completed)	Survey of sites to be equipped; U.S. purchase of equipment and supplies for 63 clinics: local purchase of equipment; distribution of supplies/equipment and follow-up of in-country distribution.
	SMOHS in remaining States in Nigeria	Sub-contract from AVS \$600,000 6/85 - 12/86	Survey of sites to be equipped; purchase of equipment/supplies for 200 clinics, follow-up with equipment distribution.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
American College of Nurse-Mid- wives.		Regional Family Health Initiatives Project with project in Nigeria \$174,000	Nurse-midwife and traditional birth attendant training in 5 States in Nigeria.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Association for Voluntary Sterilization	University of Ife (Oyo State)	NIF-03-TR-2A \$66,000 9/01/82 - 9/30/83 (completed)	Training of physicians in minilaparotomy; conduct I+E activities for professionals and general public.
		NIR-03-TR-3A \$41,000 10/01/83 - 12/31/84 (completed)	Continuation of above activities, plus one day workshop orientating health professionals to VSC.
Apex Medical Center		NIR-04-SV-1A \$18,000 8/01/83 - 12/31/84 (completed)	Equipping of dedicated space for minilaparotomy procedures; conduct of a health week with VSC/FP as theme.
University College Hospital (Ibadan, Oyo State)		NIR-05-EQ-1A \$36,000 12/01/83 - 11/30/84 (completed)	Equipping of dedicated space for VSC services at U.C.H.
University of Benin Teaching Hospital (Bendel State)		NIR-06-TR-1A \$58,000 3/01/84 - 8/31/85	Equipping of dedicated space for VSC at the Teaching Hospital; training of 15 physicians in VSC; establishing counselling for VSC services

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
AVS (continued)	Military Hospital	NIR-07-SV-1A \$43,000 3/01/84 - 8/31/85	Equipping of dedicated space for VSC; conduct workshop on VSC for medical personnel and counsellors; data collection on clinic visitors and VSC requestors.
	Specialist Hospital (Benin City, Bendel State)	NIR-08-SV-1A \$38,000 7/01/84 - 12/31/85	Equipping of dedicated space for VSC, conduct workshop for VSC for medical personnel and counsellors, training for residents in minilaparotomy.
	Iyi Enu Hospital	NIR-09-SV-1A \$34,000 7/01/84 - 12/31/85	Equipped of dedicated space for VSC, conduct workshop of medical personnel and counsellors; data collection on clinic visitors and VSC requestors.
	Jos University Teaching Hospital (Plateau State)	NIR-10-SV-1A \$40,000 9/01/84 - 2/28/86	Equipping of dedicated space for VSC; conduct counselling for VSC requestors, conduct workshop on VSC for medical personnel and counsellors.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
AVS (continued)	Lagos University Teaching Hospital (LUTH) (Lagos State)	NIR-11-SV-1A \$60,000 9/01/84 - 2/28/85	Equipping of dedicated space at LUTH; development of model VSC, IEC and counselling/referral program; conduct of comparative study of outreach efforts directed to community health centers.
	University College Hospital, Ibadan (Oyo State)	NIR-12-TR-1A \$20,000 3/1/85 - 2/28/86	Training of 20 nurse-midwives in VSC education and counselling at U.C.H.
	Ondo State Specialist Hospital (Ondo State)	NIR-13-SV-1A \$35,000 3/85 - 9/30/86	Equipping of VSC dedicated space; development of IEC/counselling and referral service for VSC.
	AFRICARE (Nationwide)	NIR- -EQ-1A \$600,000 6/85 - 7/85	Provision of basic equipment for family health/planning at 230 sites.
	Nigeria Army Reference Hospital	NIR- -SV-1A \$35,000 5/01/85 - 11/30/86	Equipping of VSC dedicated space.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Centers for Disease Control (CDC)	AID Affairs Office and SMOHs	<p>Technical assistance visits.</p> <p>December 1-22, 1983</p> <p>February 22 - March 9, 1984.</p> <p>August 4-30, 1984</p> <p>January 3-30, 1985</p>	<p>Identification and examination of options for establishing a reliable and efficient commodity management system to serve the various states in Nigeria.</p> <p>Technical assistance to SMOH officials in Niger and Ondo States, to design contraceptive supply/user reporting systems.</p> <p>Technical assistance to SMOH in Niger, Ondo, Plateau, Kano and Ogun to modify commodity management and service statistic forms and to train Family Planning directors/supervisors in their use.</p> <p>Participation in Pathfinder supported project to provide management training for Family Planning directors/supervisors from 19 states.</p>

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Center for Development and Population Activities (CEDPA)	Ministry of Education in all 19 states.	Family Health Initiatives Project \$497,557 8/84 - 9/86	Training of MOE staff, teachers and women's organizations to encourage family life education in school curricula in all 19 states.
	Individual Nigerian Leaders	Course \$6,000 per trainee 3/83 - ongoing	Training course scholarship awards to approximately 112 Nigerians for participation in the various CEDPA courses.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Columbia University	University of Ibadan (Oyo State)	Nigeria - 02 \$478,000 7/01/79 - 12/31/84 In collaboration with Pathfinder.	Operations research to test safe, effective low-cost model for door-to-door delivery of MCH/FP in rural Nigeria.
	Oyo State MOH	Nigeria - XX (proposal)	Continuation of above activities with expansion to state system throughout state.
	University of Ibadan	Nigeria - XX \$50,000	Operations research utilizing market women for community based distribution of contraceptives.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Family Health International	Catholic Hospital Ibadan (Oyo State)	Study 903 \$1,000 2/84 - 8/84 (completed)	Study on maternity care monitoring.
	Amadu Bello Hospital (Kaduna State)	Study 902 Center 042 \$1,000 1/84 - 6/84	Maternity care monitoring
		Study 5538 \$3,300 12/84 - 12/86	Straight Study of Lippes Loop
		Study 5538 \$3,125 12/83 - 12/86	Lippes Loop vs. CuT 200
	University Medical Center Ile-Ife (Oyo State)	Study 8825 \$3,950 12/84 - 3/86	Comparison of low dose pills Norinyl 1/35 vs. Lo Ovrall.
	University of Port Harcourt	Special Study \$2,500 7/84 - 7/85	Zaria Maternity Survey data analysis.
	FHI - In house Study	Special Study \$14,319 2/83 - 9/84	Secondary analysis of adolescent sexuality data

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Family Health International (continued)	Jos University Teaching Hospital (Plateau State)	Special Study 8875 \$4,700 10/84 - 1/87	Study of progestogen only oral contraceptives in breast feeding women.
		Workshop \$10,000 FY86	Workshop on contraceptive technology and biomedical research needs in Nigeria.
	Teaching Hospitals in Ibadan (Oyo State), Zaria (Kaduna State), Jos (Plateau State), and Benin City (Bendel State).	\$20,000 12/86 - 12/87	Norplant implant training and trials.
Ibadan University (Oyo State)		Study 8825 \$8,220 2/82 - 3/86	Comparison of oral contraceptives: Norinyl 1/35 vs. Lo Ovral
		Study 903 \$1,000 10/83 - 2/84	Maternity Care Monitoring
		C-403 \$16,830 4/84 - 3/85	Survey of Physician attitudes and knowledge.
		\$25,000 Late FY85	Workshop on Nigerian Maternity Monitory Studies

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Family Planning International Assistance	University of Ife (Oyo State)	Nigeria - 04 \$336,000 6/83 - 4/30/86	Training of nurse-midwives; outreach for family planning, and delivery of services.
	Baptist Hospital	Nigeria 10 \$104,000 5/1/84 - 8/31/85	Training of staff on outreach and clinical services; information/education activities; delivery of FP services.
	Nigerian Association of Sports Medicine (Ibadan, Oyo State)	Nigeria 12 \$154,000 12/1/83 - 11/30/84 (completed)	Family life education for youths; peer group meetings and support services.
	Seventh Day Adventist Health Services Project (nationwide)	Nigeria 13 \$60,000 1/1/85 - 4/30/86	Outreach services to rural clinics, information/education, training of health service staff in clinical and outreach skills.
	First Foundation Medical Center	Nigeria \$71,000 9/30/86	
	Federal Ministry of Health	\$825,000 - FY84 \$1,750,000 - FY85	Contraceptive commodities for statewide FP program.
	Margaret Sanger Center (sub-contract)	Sub-contract \$61,000 1/31/86	Assistance to the Ministry of Health, Cross River State to plan, conduct, assess and to manage service projects

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
FPIA (Continued)	Sterling Pharmaceutical Company	NIG 18 \$4,465 8/85 - 7/86	Contraceptive retail marketing in approxi- mately 9,000 outlets. Training of 60 nurses and educators in 20 pharmaceutical company staff clinics.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Futures Group/ RAPID II	National Population Bureau	Nigeria 1 \$95,000 8/01/80 - 6/30/83 (completed)	Preparation of RAPID socio-economic model for Nigeria, Presentation to high level policy makers; training of local participants to use computer in spin off RAPID presentations.
	Various Subcontracts	Nigeria 2 \$200,000 1/01/84 - 1/01/88	Through various contracts to support studies and activities for population policy development and awareness.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
International Planned Parenthood Federation	Planned Parenthood Federation of Nigeria (nationwide)	Nigeria \$5,659,000 1984 - 1985 (completed)	Institutional support to PPFN for initiating information/education activities and the support of family planning services in 158 clinics throughout the country. Also provision of contraceptive commodities.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Johns Hopkins University Population Communication Services	Kwara State MOH (Kwara)	AG-NGA-01 \$87,000 4/01/84 - 3/31/86	Development of IEC informational program using various means of mass media and printed material.
	Planned Parenthood Federation of Nigeria (nationwide)	AF-NGA-02 \$74,290 11/1/84 - 10/31/85	Printing and distribution of method specific (IUD, Pill, Condom) booklets in four languages (Hausa, Ibo, Yoruba and Pidgin English).
	Planned Parenthood Federation of Nigeria (nationwide)	AF-NGA-03 \$203,229 1/1/85 - 12/31/86	Advertising and communication campaign with several mass media and interpersonal communication components.
	University of Ibadan (Oyo State)	AF-NGA-04 \$42,374 7/1/85 - 1/31/86	Development and printing of a pictorial booklet for use in counselling for VSC.
	Planned Parenthood Federation of Nigeria (nationwide)	AF-NGA-05 \$66,895 7/1/85 - 12/31/86	Workshop to increase the awareness of health/FP officials and radio/television broadcasting experts in use of media for promoting FP in Nigeria

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER, AMOUNT AND DURATION	PROJECT DESCRIPTION
Johns Hopkins University Population Communicat. Services (continued)	Nigerian Television Authority/ Enugu (Anambra State)	AF-NGA-06 \$12,012 8/85 - 7/86	Development and production of a 13 part weekly T.V. series for broadcast in Anambra State
	School of Health Technology Ondo, MHO (Ondo State)	AF-NGA-07 \$14,880 8/85 - 7/86	Development and production of a weekly radio program on health and family planning. The 26-part series is to be produced by the School of Health Technology and the Ondo State Radiovision Corporation
	Imo MOH and Imo Broadcasting Corporation (Imo State)	AF-NGA-08 \$51,600 8/1/85 - 7/31/86	Organization of two state-wide workshops to bring together 200 women's organizations, traditional leaders, production of 26 weekly radio drama programs, and a development of a booklet on natural FP.
	Nigerian Television Authority (nationwide)	AF-NGA-09 \$12,000 8/85 - 1/86	Production and broadcast in Nigeria through NTA system, a television program on the Future's Group/ RAPID analysis.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Johns Hopkins University Program for Internation. Education (JHPIEGO)	University of Benin Teaching Hospital (Bendel State)	NCA-65 \$92,848 7/1/84 - 8/31/85	Six 3-week didactic and clinical training courses for nurse-midwives. 150 students and 26 graduate nurses participating.
	University College Hospital Ibadan School of Midwifery (nationwide)	NCA-69 \$49,878 5/1/84 - 7/31/85 (completed)	Workshop of 41 tutors of schools of nursing, midwifery, and health technology, to develop a pre-service curriculum in reproductive health.
	University College Hospital, Ibadan (Oyo State with other state impact)	NCA - 70 \$232,080 6/1/85 - 5/31/86	Six 4-week family planning clinical training sessions for 90 tutors from schools of nursing, midwifery, and health technology.
	University of Ibadan (Oyo State with other state impact)	NCA-11 \$181,064 2/1/85 - 2/28/86	Three 2-week didactic/clinical courses in laparoscopy for 24 physicians. Three 1-week didactic/clinical courses for 24 OR nurses; one 5-day course for 8 anesthesiologists.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER, AMOUNT AND DURATION	PROJECT DESCRIPTION
JHPIEGO (continued)	Institute of Health, Ahmadu Bello University (Regional - Impact)	NCA-48 \$80,239 11/1/84 - 10/31/85	Three 2-week courses in reproductive health for a total of 60 participants (medical officers, nurse-midwives) from Kaduna, Niger, Sokoto and Kwara States.
	Kaduna MOH (regional impact)	NCA-78 \$113,623 1/1/85 - 12/31/85	Clinical training in reproductive health skills for 81 health professionals, primarily nurse-midwives from Kaduna, Kwara, Niger and Sokoto.
	University of Benin (Bendel State with regional impact)	NCA-72 \$92,750 1/1/85 - 1/31/86	Two didactic/clinical courses in reproductive health for a total of 48 medical officers from southern and eastern Nigeria.
	Kano MOH	NCA-79 \$138,974 1/1/85 - 12/31/85	Three 4-week courses for 45 physicians and nurse-midwives for update and clinical practicum. 60 medical students will also attend the courses.
	Army Medical Corps	NCA-81 \$52,540 11/1/84 - 10/31/85	Two courses in reproductive health for 85 physicians and 85 nurses from 85 military outposts in Nigeria.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
JHPIEGO (continued)	College of Medicine, University of Lagos (Lagos and Ogun States)	NCA-84 \$63,769 2/1/85 - 1/31/86	Three 2-week courses for 60 physicians, nurse- midwives, and community health officers from Lagos and Ogun States.
	University of Jos, Department of Ob./Gyn. (Plateau State)	NCA-85 \$53,713 8/1/85 - 7/31/86	Three 2-week didactic/ clinical courses for 24 medical officers from MCH/FP clinics in Plateau State.
	University of Ibadan, College of Medicine	NCA-89 \$93,888 7/1/85 - 6/30/86	Two 2-week courses on Sexually Transmitted Diseases for 40 physicians midwives throughout the country.
	University of Ibadan, Department of Nursing (nationwide impact)	NCA-93 \$153,000 8/1/85 - 7/31/85	Two-week training course for trainers comprised of didactic/practical experience for 40 nurse/ midwifery tutors; four 2-week courses at state level for 98 tutors.
	Baltimore Courses (nationwide impact)	NSP-17 \$134,000 September 16-27, 1985	One 2-week course in Baltimore for two top level MHO officials from 15 states and the FMOH.
	FEMOPE Marketing Company	NCA-18 63,494 9/1/84 - 8/31/85	Preventive maintenance and repair of AID donated laparoscopic equipment in Nigeria.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
JHPIEGO (continued)	Baltimore Courses (national impact)	Course scholarship \$6,000/trainee 1975 - on-going	Award of scholarships to date 32 physicians in advance techniques and 24 physicians/other professionals in JHPIEGO sponsored courses.
	Institutions with JHPIEGO graduates (nationwide)	Laparoscopes at \$7,000/each	40 laparoscopes provided to JHPIEGO graduates.
	Anambra MHO (Anambra State)	NCA-proposal \$89,757 11/1/85 - 12/31/86	Didactic and clinical training of physicians and nurse-midwives from MCH/FP services.
	Institute of Health Ahmadu Bello University, Zaria	NCA-proposal \$40,000 11/1/85 - 12/31/85	Four-day regional conference for tutors of Northern states to review curriculum changes and update ORT/FP.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
PATHFINDER FUND	Nigerian Institute of Advanced Legal Studies, University of Lagos	Project # 6498 \$29,000 4/01/82 - 9/30/83 (completed)	Establishment of a legal advisory panel to coordinate a series of studies on key law and population issues.
	University of Ibadan (Oyo State)	Project 7110 \$486,000 1/01/83 - 3/31/85	Extension of community based FP/health services in 3 zones in Oyo State, coordinated with Columbia University operations research project.
	University of Maiduguri Hospital	Project 7225 \$3,000 FY 1983	Training of three nurses in FP delivery at UCH, Ibadan.
	University of Ife (Oyo State)	NIG-001-1 \$205,000 10/01/83 - 3/31/85	Organization of a family planning unit at the University; training of community health assistants for outreach; periodical in-service training for physicians and nurse-midwives.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
PATHFINDER FUND (continued)	Univeristy of Calabar Teaching Hospital	NIG-002-2 5/01/83 - 3/31/86	Training of 100 nurse/midwives from Oyo and Imo States. Provision of follow-up technical assistance to graduates in setting up service.
	Iyi-Enu Hospital (Anambra State)	NIG-004-1 \$104,000 3/01/85 - 5/31/86	Expansion of services at Iyi-Enu Hospital; establishing service delivery capabilities in 2 hospitals and 4 community health centers in the urban, rural and riverine areas of Anambra State. Initiation of IEC/ outreach program.
	University of Ilorin Teaching Hospital	NIG-005-3 \$334,000 4/01/84 - 03/31/86	Provision of FP services at the teaching hospital; training of clinic staff in outreach and community education development of IEC materials; upgrading of clinical skills of nurse/midwives in 3 training sites.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
PATHFINDER FUND (continued)	University of Benin Teaching Hospital (Bendel-State)	NIG-006-3 \$177,000 7/01/84 - 6/30/85	Establishment of UBTH as a training center for nurse midwives in central and eastern Nigeria. Two 6-week training programs for 2 groups of 10 nurse-midwives from Bendel and surrounding states. Provision of concurrent services.
	Jos University Teaching Hospital (Plateau State)	NIG-007-2 \$102,000 7/01/84 - 6/30/85	Establishment of FP clinical service; development of IEC program, and development of FP training program for physicians.
	Akure Local Government Authority	NIG-008-1 \$21,000 1/01/84 - 8/31/85	Establishment of FP services at 14 sites in the Akure LGA with out-reach program serving 2,100 new users.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
PATHFINDER FUND (continued)	Ahamdu Bello Univeristy Teaching - Hospital	NIG-009-2 \$102,000 10/01/84 - 9/30/85	Training of 3 nurse-midwives in clinical services; expansion of clinical services, organization of an IEC program, orientation of medical students to family planning.
	Youth Advisory Center University of Benin (Bendel State)	NIG-011-2 \$177,000 8/01/83 - 6/30/86	Implementation of a mass media campaign to educate public on adolescent fertility problems; organization of clinic for special adolescent services and counselling.
Several Contracts (nationwide)		Family Health Initiatives Project \$1,200,000 9/1/84 - 8/31/86	Two programs on planning and development; community based distribution project, two rural, one urban. Nurse midwife training at UCH for 120 nurses, development of IEC program and provision of TA to visit states. Printing and distribution of Medical Forms and Client Records; work-shop for key pharmacists.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
PATHFINDER FUND (continued)	University of Benin Teaching Hospital (Bendel- State)	NIG-006-3 \$177,000 7/01/84 - 6/30/85	Establishment of UBTH as a training center for nurse midwives in central and eastern Nigeria. Two 6-week training programs for 2 groups of 10 nurse-midwives from Bendel and surrounding states. Provision of concurrent services.
	Jos University Teaching Hospital (Plateau State)	NIG-007-2 \$102,000 7/01/84 - 6/30/85	Establishment of FP clinical service; development of IEC program, and development of FP training program for physicians.
	Akure Local Government Authority	NIG-008-1 \$21,000 1/01/84 - 8/31/85	Establishment of FP services at 14 sites in the Akure LGA with out-reach program serving 2,100 new users.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Population Council	University of Ife (Oyo State)	CP 83.46A/84.01A \$219,976 8/1/83 - 12/31/85	Study of sub-ethnic variations in breast- feeding, marital sexuality and fertility in Yoruba land.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Research Triangle Institute	University of Benin (nationwide impact)	1920-76 \$50,000 10/01/83 - 9/30/84 (completed)	Conference to disseminate results on studies regarding urbanization in Nigeria. Participants included state planning officials from throughout Nigeria.
	University of Benin	1920 - 8 \$31,000 7/21/82 - 5/31/84	Information/dissemination on employment and living conditions of three Nigerian cities.
	National Population Bureau	\$168,000 1/01/84 - 9/30/84	Provision of micro-computers to 7 ministries to aid in the integration of population variables into planning, especially for the Fifth National Development Plan. Seminar held to train key operators and planners.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
University of North Carolina, Program for International Training in Health (INTRAH)	Federal Ministry of Health	Project 35610 \$20,000 5/85 - 9/85	Workshop on contraceptive update for key nursing staff.
	FMOH and SMOHs in Imo, Ondo, Plateau, Benue and Anambra States.	Project 35610 \$150,000 (approximately) 1985	Two 5-day contraceptive update workshops per state with approximate 30 participants for a total of 300 nurse-midwives.
	Health Management Board, Bauchi State	Project 35609 \$175,353 6/85 -	Establishment and training of a 15 member state level training team for future FP training; clinical training of 15 health providers, and training of 15 health educators.
	Imo State MOH	Project 35608 \$224,461 3/85 - 8/86	Development of training team of 15 persons in family planning service delivery (clinical and educational skills). Development of training curriculum for in-service and pre-service training. Family Planning policy seminar for 69 senior state officials, training of 20 nurse-sisters in clinical skills. Follow-up workshop.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
INTRAH (continued)	Kwara MOH	Project 35607 \$264,207 2/85 - 7/86	Training of 15 member state training team; training of 60 nurse-midwives in clinical skills; workshop for follow-up and evaluation.
	Individual Nigerian Participants	\$124,564 FY 85 - on going	Training of 24 health professionals out-of-country, including courses offered in the Phillipines, Chapel Hill, Mauritius, Zimbabwe and Tanzania.
	SMOHs in Ondo, Plateau, and Ogun States.	FY-84 No information available estimated: \$120,000 per state	Development of 15 member training teams, clinical/education development; follow-up seminar.

INVENTORY OF COOPERATING
AGENCY PROJECTS

COOPERATING AGENCY	HOST INSTITUTION	PROJECT NUMBER AMOUNT AND DURATION	PROJECT DESCRIPTION
Westinghouse Health Systems	Population Bureau	\$100,000 (approx.) Ongoing	Processing and analysis of household survey; publication of relevant reports.
	Ondo MOH	\$150,000 9/85 - 9/86	Fertility and Health Survey in Ondo State to determine fertility patterns and contraceptive prevalence.

BREAST-FEEDING AND INFANT NUTRITION
INTERVENTIONS

The child survival intervention which has the closest direct effect on both child health and child spacing is the promotion of appropriately prolonged breast-feeding. Breast-feeding and family planning are inherently interrelated and mutually supportive. The suppression of ovulation associated with breast-feeding is presently the major influence on the interval between births in Nigeria. If breast-feeding practices continue to decline faster than the prevalence of modern contraceptive use increases, the fertility rate will rise instead of fall. Traditional practices included postpartum abstinence and breast-feeding until the third year of life. The breakdown of these practices has contributed to the increase of fertility rates, especially under urban pressures of modernization. According to three recent studies, the average duration of full breast-feeding in urban populations may be less than one month with the average duration of any breast-feeding as short as 7 to 10 months. The average return of menses, an indication of fertility return, is generally 2-3 months sooner. Hence the average breast-feeding women in these Nigerian studies was able to become pregnant as early as 4-7 months postpartum. Because most Nigerian women who become pregnant while breast-feeding wean their babies immediately, family planning also helps to make extended breast-feeding possible.

Breast-feeding/infant nutrition education is not complex and should be paired with family planning education, both for purposes of training health workers and for IEC efforts. Both family planning and breast-feeding/infant nutrition education are preventive health services, and they can be provided at a single IEC or service contact. Breastfeeding/infant nutrition education involves simple messages to encourage mothers (1) to delay introduction of other foods and fluids until their infants are at least 4-6 months of age, (2) to give appropriate foods and appropriate time feedings after a breast-feed, (3) to give fluids by cup and avoid all use of bottle feeding, (4) to allow frequent suckling, including at night, and (5) to avoid the use of "pacifiers" which partially meet the infant's need to suck and therefore reduce natural suckling and nipple stimulation which is necessary to prolong amenorrhea and natural birth spacing, (6) to use an effective method of contraception to avoid becoming pregnant before it is appropriate to wean their babies, and (7) to continue breast-feeding until the child is at least two years of age.

In sum, the complementarity and symbiosis of these two preventive health interventions makes a perfect combination in support of child survival without significant additional cost to the family planning community.

STATE FAMILY PLANNING CHECKLIST

ORGANIZATION

1. Has a family planning advisory/coordinating committee been formed?
2. Does the membership include representatives of appropriate support groups and the principle service providers in the state?
3. Are the members placed in their respective organizations so that they can influence their organization's level of support for family planning?
4. Have the members of the committee been trained?
5. Does the committee meet regularly?
6. Has a state family planning coordinator been appointed and trained?
7. Does the state coordinator have the authority and resources to plan and monitor program activities?

PLANNING

1. Has a state plan for family planning been developed?
2. Does the plan include objectives/targets; strategy; program elements; plan of action and budget?
3. Was state planning based on sound data including survey of existing facilities and trained personnel?
4. Has the state allocated its resources to the Program?
 - office, clinic and warehouse space?
 - administrative, supervisory and clinic personnel?
 - vehicles and other material resources?

SERVICE DELIVERY

1. Facilities:
 - Have facilities been renovated?
 - Have facilities been adequately equipped?
2. Personnel:
 - Have clinical personnel been appointed and trained?
 - Is staff trained for delivery of high quality services?

3. Supervision:
 - Is supervision system in place?
 - Have supervisors been appointed and trained?
 - Does supervision occur monthly or better?
 - Are vehicles available for supervision?
4. Outreach:
 - Have outreach systems to backup and feed service delivery points been established?
 - Have outreach staff been appointed and trained?
5. Information/Education:
 - Are media channels used to inform potential users of available services?
 - Are family planning service sites marked appropriately?
 - Are educational materials available for educational presentations at clinic and in community?
6. Commodity Management:
 - Have commodity logistic systems been established and are they in place?
 - Has the commodity logistic team been appointed and trained?
 - Have warehouses for family planning equipment and supplies been established?
 - Are commodities ordered?
 - Have commodities been received?
7. Record Keeping and Analysis:
 - Are record keeping systems in place?
 - Are record keeping supervisors appointed and trained?
 - Have clinic personnel been trained to use the record system?
 - Are records kept and regularly reported?
 - Is statistical data analyzed by clinic and supervisory personnel, used for management decision and fed up and back to appropriate levels?

PROGRAM PERFORMANCE

1. How widespread are existing service sites having adequate equipment and trained staff?
2. What is the level of service performance?
 - Active users?
 - Continuation rate?
 - Trends in performance?
3. What is the general political climate and community acceptance of program activities?

CONTRACEPTIVE
REORDER QUANTITIES

In estimating the mix and quantity of supplies for reorder, we looked at the rate of drawdown on supplies at PPFN facilities for the first or second quarter of 1985. Data were not included for a facility if there had been a stock out or near stock out of an item as this would obviously bias the consumption of that item. In comparing the PPFN experience with the CDC estimates in Table 7 of the 5 October 1984 report, we note some significant differences: Condom use rate is one-third as great in PPFN clinics, OC use is three times as great, injectables are six times as popular, and so on. Below are the CDC estimates and the PPFN stock use rates projected for a national program.

	<u>OC</u>	<u>IUCD</u>	<u>INJECT.</u>	<u>CONDOM</u>	<u>FOAM</u>
CDC	1,079,100	157,000	84,290	4,521,000	57,260
PPFN	3,200,000	355,000	530,000	1,480,000	300,000
		<u>JELLY</u>	<u>DIAPHRAGM</u>		
CDC		16,308	1,714		
PPFN		29,600	*		

* lack of stock made use rate estimates impossible

One hesitates to accept the PPFN numbers without question as the mix of methods is influenced by the clientele, provider biases, and policies of that institution. Further, the CDC estimates were based on some field research and data so cannot be ignored. Given the disparities between the two sets of estimates, however, we cannot comfortably ignore either set, nor can we be very secure in any recommendation.

The estimates that follow were arrived at by first simply averaging the two other estimates. Admittedly this is an unsophisticated response, but it is the best available at the moment; the reader is warned these projections could be well off the mark. Second, the MOH and PPFN systems were compared to determine whether their characteristics would influence consumption patterns. It is expected, for example, that there will be spontaneous "commercialization" of MOH commodities; AID supplied products are already in evidence in some pharmacies. Consequently we increased the number of pills and condoms to respond to this demand (the purpose is not to enrich pharmacists but rather to guarantee adequate supplies for the clinics.) Finally, we have allowed for a 30 percent growth in effective demand.

ESTIMATED CONTRACEPTIVE NEEDS
JUNE 1986 - JUNE 1987

OC Cycles	IUDs			Injectables
	Lippes		CuT	
	C	D		
2,200,000	30,000	200,000	30,000	300,000
	Foam Tablets		Diaphragms	
		Jelly	75 mm	85 mm
	180,000	23,000	700	1,200

Adjustments

The impact of proposed IEC campaigns may upset these calculations. Ogun is the bellwether state; any pronounced increase over the following estimated monthly rates of commodity usage will signal the need to submit an additional order. Note that if the IEC campaign produces no effect, Nigeria may have as much as three years of commodity supply on hand by mid-1986.

PROJECTED MONTHLY USE RATE, OGUN

<u>OCs</u>	<u>IUDS</u>	<u>Injectables</u>	<u>Condoms</u>	<u>Foam Tablets</u>
23,000	3,250	2,500	57,300	1,340

These numbers, when viewed on a monthly basis seem high--particularly viewed against total visits of 2,700 in Ogun for the first quarter of 1985. Thus, the IEC campaign will have to have a considerable impact to precipitate early reordering.

INVENTORY, ASSESSMENT AND FUTURE PLANS FOR
AID-SUPPORTED TRAINING ACTIVITIES IN NIGERIA

A. Training Support for Sterilization

Since 1983 JHPIEGO has spent approximately \$570,000 to train 112 physicians in laparoscopic sterilization and other aspects of reproductive health. Half of these physicians were trained in the United States and half in Nigeria. The average cost of the U.S.-based training was \$7,321 per trained physician, whereas, the average per-trainee cost of in-country training was \$2,857. In addition, the Association for Voluntary Sterilization has spent between \$15,000 - \$20,000 to train an unknown number of physicians in minilap sterilization techniques, and JHPIEGO has spent \$150,000 to train 42 nurses as members of the operating team necessary to perform laparoscopic sterilization procedures. This training costs an average of \$8,000 for each of 11 nurses trained in the United States and \$2,000 for each of 31 nurses trained in Nigeria. In 1986-1987 JHPIEGO plans to train 12 additional physicians in sterilization techniques and to do this training in Nigeria.

B. Training Physicians to Manage Medical Complications
Associated with IUDs and Hormonal Contraception

Aside from performing sterilizations, the major clinical family planning role for physicians in Nigeria is to provide the medical backup for contraceptive services provided by nurse-midwives. Training for this role should lead the physician to understand and support the nurse-midwife's role in direct provision of family planning service, to have a solid theoretical knowledge of the physiological action, contraindications and medical risks of IUDs and hormonal contraception, and to be able to diagnose, manage and treat both minor and serious complications of IUDs, hormonal injections and pills. JHPIEGO and INTRAH have supported some joint training of physicians (MD) and nurse-midwives (NMW) and JHPIEGO has also provided two week didactic courses for 72 medical officers from state and local ministries of health. The JHPIEGO physician-only training costs approximately \$2,000 per trainee. The training supported by INTRAH was to prepare physicians as members of multidisciplinary state family planning "training of trainers" (TOT) teams. The joint MD/NMW training supported by JHPIEGO has trained 20 individuals (9 physicians and 11 nurse-midwives) in immunization, family planning and ORT. The program, called "IFORT" (for Immunization, Family Planning, and ORT) plans to train two more groups, or a total of approximately 30 MDs and 30 NMWs for a total cost of \$65,000--approximately \$1,000 per trainee. The content of this two-week course covers a wide range of subjects including population and health reasons for family planning, high-risk pregnancies, infertility, immunization, childhood diseases, sexually transmitted diseases,

childhood nutrition, program administration, ORT, and counseling and education techniques, but includes only 10-11 hours of content on actual family planning methods including sterilization. Although undoubtedly useful for developing an understanding of the need for family planning and support for the program, this course could neither prepare nurse-midwives to provide clinical family planning services nor physicians to diagnose and treat the complications of IUDs and hormonal contraception.

Although it may be necessary to provide some content in other areas of obstetrics, gynecology or child health within courses intended for physicians and nurse-midwives who are in positions of leadership and responsibility in government health service, it should now be possible to train such individuals in courses which are primarily about family planning. The course described above included only 4-4.5 content hours per day, and only approximately one-fourth of that time was devoted to the clinical aspects of family planning. Such courses could be strengthened by increasing the training time to at least 5.5 hours per day and devoting at least half of that time to clinical family planning. In addition, although there are some important advantages to training physicians and nurse-midwives together in the same course, because doctors and midwives fill different roles in the health care system, combined training will necessarily reduce the ability of the course to give the members of either discipline the training inputs required to prepare them for their specific roles. Perhaps it would be useful to experiment with a course in which midwives and physicians were trained separately in the mornings (each with inputs designed to meet their specific needs), and then come together for the afternoon session to cover content which must be assimilated by both. It is essential that the persons responsible for the course clearly define the roles and functions which the trainees will be expected to perform at the end of the course and design the curriculum to provide inputs to prepare the trainees for their specific roles. The training of physicians should include some emphasis on diagnosis and management of contraceptive complications.

JHPIEGO is planning expanded activities in the joint training of nurse-midwives and physicians during the remainder of 1985 and in 1986. The plans include training 85 MD/NMW pairs to start family planning services in 85 Army outposts and training 45 midwives and physicians from Kano and an unknown number from Anambra. In addition JHPIEGO is planning a course in sexually transmitted diseases to be given for both physicians and nurse-midwives at the University of Ibadan. Costs for these courses are projected at about \$300,000. The cost per trainee of these proposed courses range from \$3,088 for a 4-week combined clinical and didactic course in Kano to only \$309 per trainee for the training proposed for the Army, the difference probably being due to the Army's ability to provide room and board.

C. Training Nurse-Midwives to Provide Clinical Family Planning Services

The largest amount of AID's training support has gone to prepare nurse-midwives to provide clinical family planning services, including the insertion of IUDs. Since the early 1970s, both Pathfinder and the University of North Carolina, through INTRAH during the past 6 or 7 years and through a similar program before that, have supported varied efforts directed towards training Nigerian nurse-midwives in family planning. As with all AID-supported family planning inputs to Nigeria, these efforts began to ripen to fruition during the past two years. Major NMW training efforts in the past several years are summarized below. INTRAH, JHPIEGO and Pathfinder have played the major roles.

1. INTRAH Training Supports

INTRAH's contractual agreement with AID allows their participation in a wide variety of types of training for nurses, midwives, and paramedical, auxiliary and community health and family planning personnel. To date most of their efforts in Nigeria have been focused towards nurse-midwives and especially towards institutionalization through training of trainers. In addition, INTRAH has contributed, but to a lesser degree, to training nurse-midwives and other for management, supervisory, and IEC roles.

a. Creation of Multidisciplinary Family Planning Training Teams for Specific States

INTRAH's major strategy in the past several years has been to develop within several selected states intensively trained multidisciplinary teams. These individuals are prepared both in family planning and in training methodology. Given a sufficiently large "training of trainers" (TOT) input, INTRAH believes that these teams will be able on their own to assess the varied and ongoing family planning training needs in their respective states, and to plan, implement and evaluate training programs to meet those needs. Each state training team consists of 15-16 people, usually including 3-4 physicians, 1-2 health educators, and 8-10 nurse-midwives and public health nurses (who supervise local MCH/FP services). Because of the multidisciplinary makeup of the team, it should contain the flexibility to train various categories of health workers.

The training inputs for complete TOT are extensive, comprising separate courses spread over a 9-month period, including the following:

-- Training of Trainers (2 weeks)

childhood nutrition, program administration, ORT, and counseling and education techniques, but includes only 10-11 hours of content on actual family planning methods including sterilization. Although undoubtedly useful for developing an understanding of the need for family planning and support for the program, this course could neither prepare nurse-midwives to provide clinical family planning services nor physicians to diagnose and treat the complications of IUDs and hormonal contraception.

Although it may be necessary to provide some content in other areas of obstetrics, gynecology or child health within courses intended for physicians and nurse-midwives who are in positions of leadership and responsibility in government health service, it should now be possible to train such individuals in courses which are primarily about family planning. The course described above included only 4-4.5 content hours per day, and only approximately one-fourth of that time was devoted to the clinical aspects of family planning. Such courses could be strengthened by increasing the training time to at least 5.5 hours per day and devoting at least half of that time to clinical family planning. In addition, although there are some important advantages to training physicians and nurse-midwives together in the same course, because doctors and midwives fill different roles in the health care system, combined training will necessarily reduce the ability of the course to give the members of either discipline the training inputs required to prepare them for their specific roles. Perhaps it would be useful to experiment with a course in which midwives and physicians were trained separately in the mornings (each with inputs designed to meet their specific needs), and then come together for the afternoon session to cover content which must be assimilated by both. It is essential that the persons responsible for the course clearly define the roles and functions which the trainees will be expected to perform at the end of the course and design the curriculum to provide inputs to prepare the trainees for their specific roles. The training of physicians should include some emphasis on diagnosis and management of contraceptive complications.

JHPIEGO is planning expanded activities in the joint training of nurse-midwives and physicians during the remainder of 1985 and in 1986. The plans include training 85 MD/NMW pairs to start family planning services in 85 Army outposts and training 45 midwives and physicians from Kano and an unknown number from Anambra. In addition JHPIEGO is planning a course in sexually transmitted diseases to be given for both physicians and nurse-midwives at the University of Ibadan. Costs for these courses are projected at about \$300,000. The cost per trainee of these proposed courses range from \$3,088 for a 4-week combined clinical and didactic course in Kano to only \$309 per trainee for the training proposed for the Army, the difference probably being due to the Army's ability to provide room and board.

C. Training Nurse-Midwives to Provide Clinical Family Planning Services

The largest amount of AID's training support has gone to prepare nurse-midwives to provide clinical family planning services, including the insertion of IUDs. Since the early 1970s, both Pathfinder and the University of North Carolina, through INTRAH during the past 6 or 7 years and through a similar program before that, have supported varied efforts directed towards training Nigerian nurse-midwives in family planning. As with all AID-supported family planning inputs to Nigeria, these efforts began to ripen to fruition during the past two years. Major NMW training efforts in the past several years are summarized below. INTRAH, JHPIEGO and Pathfinder have played the major roles.

1. INTRAH Training Supports

INTRAH's contractual agreement with AID allows their participation in a wide variety of types of training for nurses, midwives, and paramedical, auxiliary and community health and family planning personnel. To date most of their efforts in Nigeria have been focused towards nurse-midwives and especially towards institutionalization through training of trainers. In addition, INTRAH has contributed, but to a lesser degree, to training nurse-midwives and other for management, supervisory, and IEC roles.

a. Creation of Multidisciplinary Family Planning Training Teams for Specific States

INTRAH's major strategy in the past several years has been to develop within several selected states intensively trained multidisciplinary teams. These individuals are prepared both in family planning and in training methodology. Given a sufficiently large "training of trainers" (TOT) input, INTRAH believes that these teams will be able on their own to assess the varied and ongoing family planning training needs in their respective states, and to plan, implement and evaluate training programs to meet those needs. Each state training team consists of 15-16 people, usually including 3-4 physicians, 1-2 health educators, and 8-10 nurse-midwives and public health nurses (who supervise local MCH/FP services). Because of the multidisciplinary makeup of the team, it should contain the flexibility to train various categories of health workers.

The training inputs for complete TOT are extensive, comprising separate courses spread over a 9-month period, including the following:

-- Training of Trainers (2 weeks)

- Community Health Education (2 weeks),
- Family Planning Curriculum Development (4 weeks),
- Family Planning Clinical Service Delivery Skills (4 weeks),
- Management/Supervision/Evaluation of Family Planning Programs (4 weeks), and
- Education Materials Development (2-3 weeks).

In addition to all of these courses, which total 18-19 weeks, the training team is expected to conduct one clinical training course with technical assistance from one INTRAH trainer as part of the overall program. This is followed by a two-week workshop devoted to review and evaluation of the entire project. The entire sequence of training inputs involved in creating a state Family Planning Training Team costs approximately \$120,000.

To date, INTRAH has completed this training in three states--Niger, Ondo and Plateau. Training is ongoing in Imo and Kwara, and is planned to commence in Bauchi in September 1985. The Strategy Team visited two of the states with completed INTRAH team training. In Ondo the training team concept seems to have been successful. The local team has already developed and implemented two second-generation training programs--one to train NMWs in both clinical and management skills, and one on family planning IEC which focused on developing a family planning curriculum and materials for use by the State Ministry of Education. The course for nurse-midwives was used to train a NMW for the military health services, as well as NMWs for the state system, and trained 8 NMWs to serve as family planning supervisors for the 8 health service zones within the state. Another outcome of the INTRAH training was the development, during the TOT course, of clinical guidelines for IUD insertion and ORT. Members of the state training team also plan in September to conduct a one-week didactic family planning course to teach 60 nurse-midwives to provide family planning services restricted to the use of hormonal and barrier contraceptives. Thus it appears that in Ondo the rather massive training inputs involved in creating a state training team did create the momentum necessary to generate an on-going, locally motivated and powered training capability.

To date, the same large dose of training inputs does not appear to have paid off in Plateau where second

generation training has not been implemented due to lack of funds. Although the Plateau training team has developed several curricula--a six week clinical skills course for NMWs, a one week course for public health sisters (supervisors) and Community Health Officers (who supervise health facilities), and a two week workshop for physicians--none of these courses have been implemented yet. INTRAH is planning to support the one week course for health supervisors and Community Health Officers (CHOs) later this year, and this course will make first use of Plateau's expensively generated family planning training team.

If the INTRAH team training approach is initiated in any other states, the amount of inputs needed to train the team could be reduced by selecting only individuals who are already experienced family planning clinicians to be members of the team and by utilizing curricula developed in the first states as a base for local curriculum development. Furthermore this expensive investment should not be made until other support systems are in place to implement services following the training.

b. Plans for a Five Day Course

Plans are being made to train 300 NMWs (60 each from the 5 states of Anambra, Benue, Imo, Ondo and Plateau) in a series of five day workshops (30 participants/workshop), beginning this fall. There seems to be some confusion regarding the purpose of this training. INTRAH's early planning documents described it as "Contraceptive Update" workshops "to update and refresh the nurse-midwives' informational base about the health benefits of family planning methods, and the indications/contraindications for each method including natural family planning." However, the stated goal of the course which has been developed and circulated here in Nigeria is "to prepare the health workers to offer efficient services in family planning including natural family planning and oral rehydration therapy in an integrated setting." More recent INTRAH documents describe the course as "intensive quality training in FP/ORT principles and practices (excluding IUD insertion) for a large number of nurse-midwives currently (or proposed to be) providing FP/ORT services." It appears that the purpose of the course has evolved from one of updating already trained people to one of providing initial family planning training for NMWs some of whom may be learning this material for the first time. Unfortunately, only 5.5 hours of the curriculum is devoted to training about the safe and effective use of family planning methods.

The expectation for this course in its target states appears to be that the training will prepare NMWs who are not now providing family planning services to begin to do so, and even to single-handedly establish family planning services in MCH facilities where no family planning services currently exist. The course will need to be extensively revised, and perhaps lengthened by 2-3 days, to meet these expectations.

c. Clinical Contraceptive Skills-Training at the Institute of Maternal and Child Health, Quezon City, Manila, for 5 MD/NMW Teams from Benue State

In April 1985 INTRAH supported 5 MD/NMW team from Benue, a state with limited family planning services and few staff trained in family planning to attend a six-week clinical contraceptive skills training course in Manila. The physicians to receive this training were selected with the assistance of an Africare physician who had spent considerable time assessing the availability of family planning services in Benue and who chose the physicians from places with the potential for services but no trained personnel. The nurse-midwife member of each team was selected by the physician, with input from others in his local situation. During the course each MD/NMW team developed a plan for implementing family planning services in their base institution and, in some cases, for second-generation training of others in clinical contraception skills. Two of the teams stayed in the Philippines for two additional weeks to be trained in minilap procedures. This latter activity was funded by AVS.

Although the teams returned from Manila only recently, and there have been delays in providing necessary equipment and commodities for them to begin family planning services, it appears that this approach will succeed in establishing services in MCH facilities where no family planning has been provided in the past. The training of the 5 MD/NMW teams from Benue cost \$65,100, or approximately \$13,020 per trained team, not including the cost of the additional minilap training. The three teams which did not have the minilap training expressed a need for it, and this is probably advisable in the future.

2. JHPIEGO-Supported Training for NMWs and Other Similar Cadres

a. Direct Clinical Training

JHPIEGO has assisted in the development and support of some direct clinical training, including a three week course (one week didactic and two weeks clinical) for 26 graduate nurse-midwives at the University of Benin Teaching Hospital. Approximately 150 undergraduate students also attended the one week didactic part of the course. The cost was \$93,000 or \$3,577 per graduate nurse-midwife trained not factoring in the benefit to the undergraduate students.

b. Efforts to Institutionalize Family Planning Training in the Pre-Service Curriculum for Nurse-Midwives

Most of JHPIEGO's efforts in NMW training have been directed toward training of nursing and NMW tutors and especially towards efforts to institutionalize family planning as an integral part of the pre-service nursing and midwifery curricula. Toward these ends, JHPIEGO sponsored a workshop at the UCH School of Midwifery in Ibadan to develop a family planning module as a model which could be used by schools and considered by the Nursing/Midwifery Council (the National body which establishes the standards and sets the curricula for all nursing and midwifery schools throughout Nigeria). The cost was \$50,000.

JHPIEGO has also supported training of 90 tutors from schools of nursing, midwifery and health technology throughout the country, which was also held at UCH Ibadan for a cost of \$232,000, and a 4-day regional conference to update nursing/midwifery tutors from the northern states in reproductive health, ORT and family planning which cost \$40,000.

3. Pathfinder

The UCH Midwifery School in Ibadan has been not only the pioneer but also the major workhorse in training nurse-midwives for family planning in Nigeria. This program has trained approximately 3,000 NMWs since its inception in 1973, with total Pathfinder support totaling about \$3 million. The cost per student is \$1,500 for a six-week course including the insertion and management of IUDs. The impact of the UCH training program has been widespread. Nurse-midwives in Ogun, which has almost 100 graduates of the UCH program plus about 25 NMW tutors trained by JHPIEGO, have developed their own family planning training center, using a curriculum they developed along the lines of the UCH curriculum. They did this

with no external stimulation or financial support, using space in a hard-to-reach and therefore underutilized primary health care center. They are now in their fourth training cycle, with 15 NMWs being trained in each course.

Like INTRAH, Pathfinder and the University of Ibadan are interested in developing a shorter course to train NMWs to deliver family planning services except for IUD insertion, but they believe that two weeks is the right length for such a course.

PROCESS OF PROGRAM EVOLUTION AND CORRESPONDING
MANAGEMENT REQUIREMENTS

Establishing Services

The management needs of any service program differ with its state of development. In their early stages, programs must focus on gaining a toehold, establishing services and gaining a small but loyal clientele. This they do by pursuing any and all opportunities and by mobilising whatever resources can be found even when those resources are not ideally suited to the task. The managerial attributes necessary are risk-taking, inventiveness, flexibility and a willingness to make personal sacrifices--all underwritten by an indestructible sense of optimism.

Goal Setting

As a program matures the need to get something going is met and the direction of the program becomes important. New partners enter with their own interests and agenda; the ill-adapted resources that were a life-saver earlier are now influencing program goals to make the goals suit the resources rather than the reverse, e.g., organizations that relied heavily on volunteers often have to deal with this problem; the multiple opportunities that were seized upon earlier now also threaten to pull the program in different directions to meet the needs of different client groups or different delivery modes. At this juncture, program management must respond by establishing and communicating clear goals. Each activity must be weighed against its contribution to achieving those goals. Furthermore, the control systems, which now emerge should focus primarily on progress toward goals.

Achieving Cost Effectiveness

Upon successfully meeting these last challenges, a new set arises to greet the maturing program. Clients and investors alike begin to clamor for cost-effectiveness. No one has expected the program to be cost-effective in its early days and the enthusiasm for providing or obtaining the services eclipsed concerns about efficiency. Indeed, many activities and delivery modes are revealed as patently inefficient. Management must now emphasize cost-effective activities and eliminate inefficient services. Since even inefficient operations will have developed a constituency and influence base, they will not be eliminated easily. The managers now need supervisory and control systems that accurately report on performance and resource utilization to determine where adjustments need to be made. They also require the political power to make those adjustments.

SUMMARY OF CONTRACEPTIVES ISSUED/DISPENSED

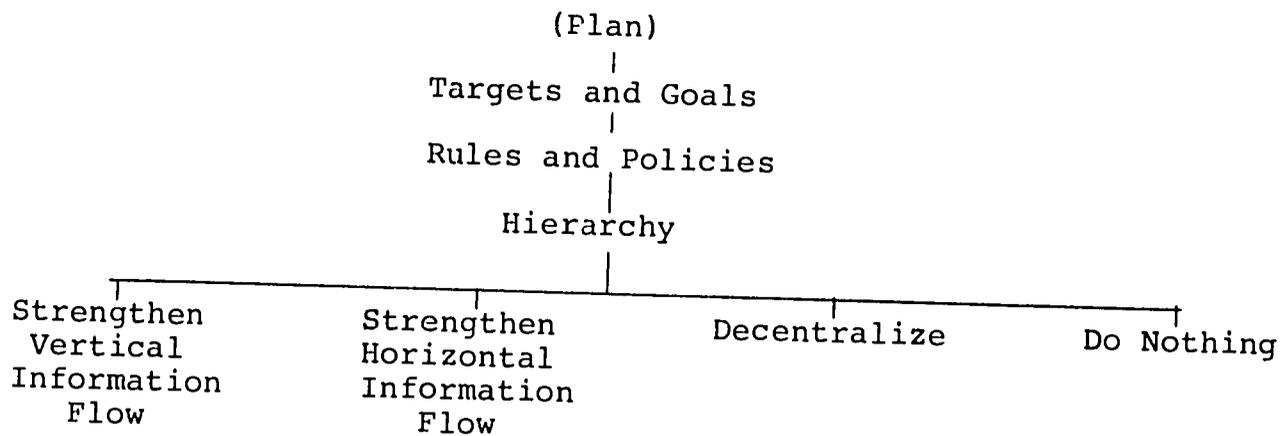
CLINIC _____ ZONE _____ STATE _____

REPORTING PERIOD: FROM (Month) _____ TO (Month) _____, 19 _____

COMMODITIES:	No. OF CLIENT VISITS	ORAL CONTRACEPTIVES					IUCD'S			CONDOMS	FOAMING TABLETS	INJECTION	CREAM, JELLY, FOAM	DIAPHRAGM(S) (Give Size)	NFP KITS	OTHER (Specify)	NONE (Specify Type of Visit)
		FEMENAL	NORIDAY	NEOGYNON	EUGYNON	OTHER	LIPPES C	LIPPES D	Cu T								
BEGINNING BALANCE																	
AMOUNT RECEIVED																	
AMOUNT DISPENSED/ISSUED																	
ENDING BALANCE																	

THEORY OF ORGANIZATIONAL COORDINATION
"INFORMATION PROCESSING MODEL"

The Information Processing Model of organization coordination postulates seven organizational activities that coordinate operations of different components of a program or organization. A comprehensive plan of action must be developed and in place to guide or direct program coordination. The following scheme depicts this model:



The strategies at the top of the chart are to be undertaken first and in the order depicted: coordination is impossible without a plan; targets for each of the activities help those units keep in step with one another; when targets are not met there should be unambiguous rules or policies for how to handle the situation; if the breakdown in coordination is not covered by a rule, there must be a point in the hierarchy where a decision can be taken to redirect efforts to restore the equilibrium of the system. After these steps have been taken an organization may invest in three other activities--vertical information, horizontal information and decentralization--to improve coordination, or it may choose to do nothing, which is the final activity.

To expand upon the activities of the Model:

1. Plan. The basis of any coordination effort is a strategy or plan which states objectives and the general activities that will be undertaken to achieve those objectives. Coordination, after all, has to be to achieve some end. And coordination becomes an issue when exceptions to the plan arise, e.g., training runs ahead of client motivation and we have a lot of clinical people sitting around letting their skills rust.

2. Targets. Part of a good plan is a set of targets, e.g., by January 1, 1986--20 trained clinical staff; 20 clinics equipped and supplied; administrative training for one coordinator and two field supervisors; TV spots to reach 20,000 people with three exposures each, radio spots to reach 20,000 people with three exposures each, etc. This example is incomplete but

illustrates the basic requirements for targets, which are:

- a. quantity necessary (if more than the necessary quantity is permissible, the target should so state),
 - b. formal date for completion; and
 - c. earliest date for completion as some activities must coincide exactly with others.
3. Rules and Policies. Targets are sufficient coordinating devices if
- a. they are reasonable,
 - b. they are met, and
 - c. the environment behaves as predicted.

When targets are not met or are inappropriate, the next thing an organization should do is have a set of rules or policies that respond to the most common deviations from targets; e.g., if local midwife training cannot keep pace with program development, send some trainees to UCH. These should be set policies so no appraisal decision making is necessary. There are a limited number of exceptions that can be foreseen but the policies or rules should cover automatic responses to the major reasons for failing to meet targets.

4. Hierarchy. To this point there is no call in the scheme for on-the-spot decision making; the program has been operating on auto-pilot. It is unrealistic to think that this will work indefinitely in social development, but organizational theoreticians argue forcefully that targets and rules will reduce coordination failures and do so at relatively low cost. Eventually, however, an unforeseen exception to the plan will arise and someone in the management hierarchy will have to resolve the problem. It is painfully obvious to every bureaucrat that the location of and process for arriving at that decision have to be known. Procedures for this decision making have to be established and provided for at critical junctures of a project's life.

5. Vertical Information. The next activity supports decision making within the hierarchy. It is simply an investment in better information for decision makers. The investment can be informal statistical systems, a supervisory network, or simply travel money for the manager her/himself to collect first hand data. Note that it only pays to produce information for people in the hierarchy who have responsibility and authority to handle the "exceptions". Frequent violations of this dictum occur in many bureaucracies.

111

6. Horizontal Information. Similar to the preceding is an investment in moving more and better information laterally. As before, the information is useful only if the units are empowered to take corrective action, e.g., cancel a redundant course, ship 500 IUDs. In the absence of that power, news that things are awry is only depressing. Common methods of lateral information transfer include site visits, coordinating committees, naming a full-time expeditor, and appointed liaison persons.

7. Decentralization. It happens sometimes that lateral coordination, performed by the complementing units, becomes so effective that the need for control from the top steadily decreases. Steps toward decentralization then make sense. Decentralization here means providing the resources and authority necessary to conduct program activities; this is commonly organized on a regional basis but other possibilities exist such as by service delivery mode or product

8. Do Nothing. A point is sometimes reached when further investments in reducing coordination problems do not produce adequate returns. Doing nothing means simply living with the discomfort.