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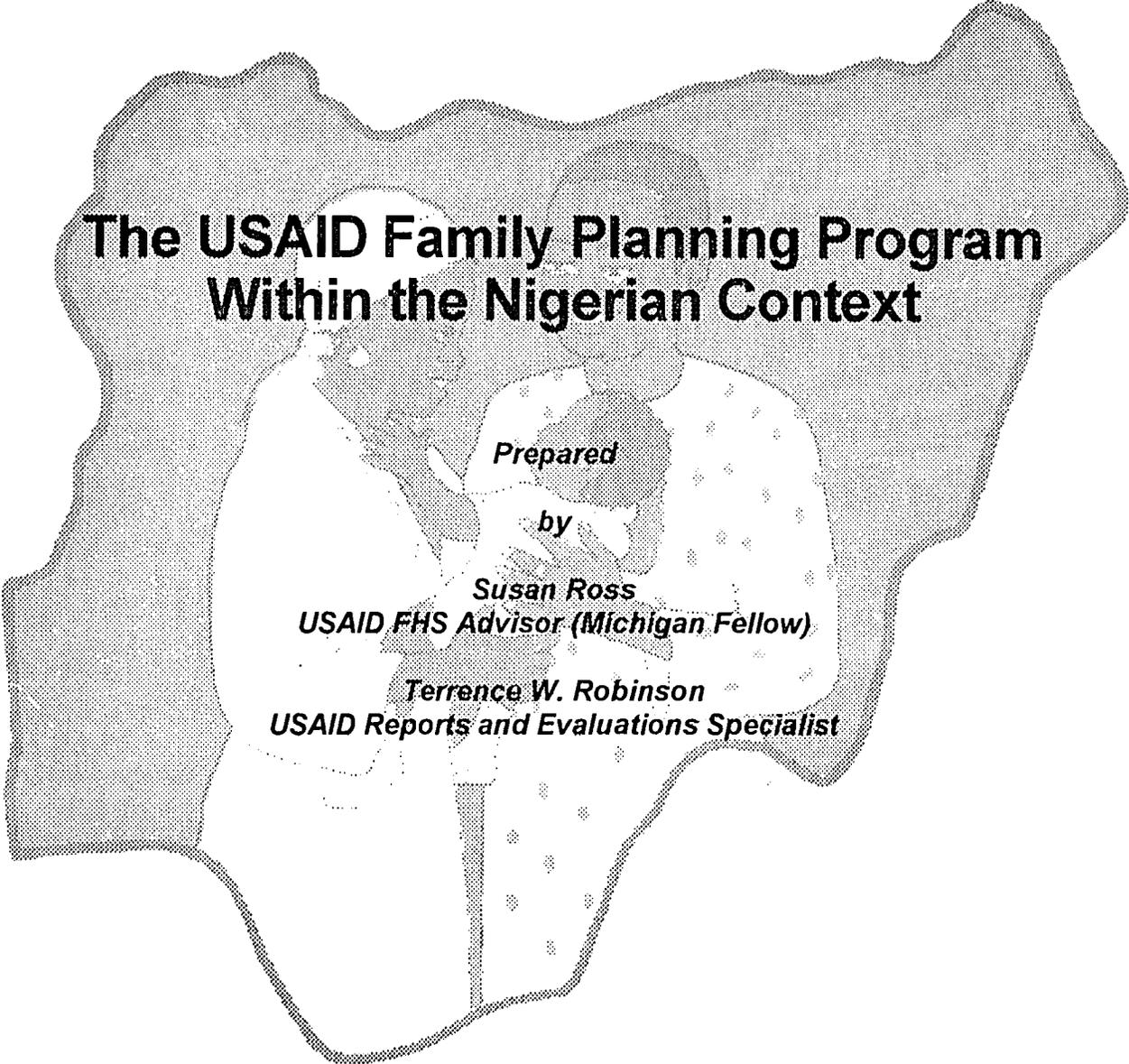
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The USAID Family Planning Program Within the Nigerian Context



Family Health Services
November 1994

FHS Project Funded by United States Agency for International Development



The USAID Family Planning Program Within the Nigerian Context

Prepared

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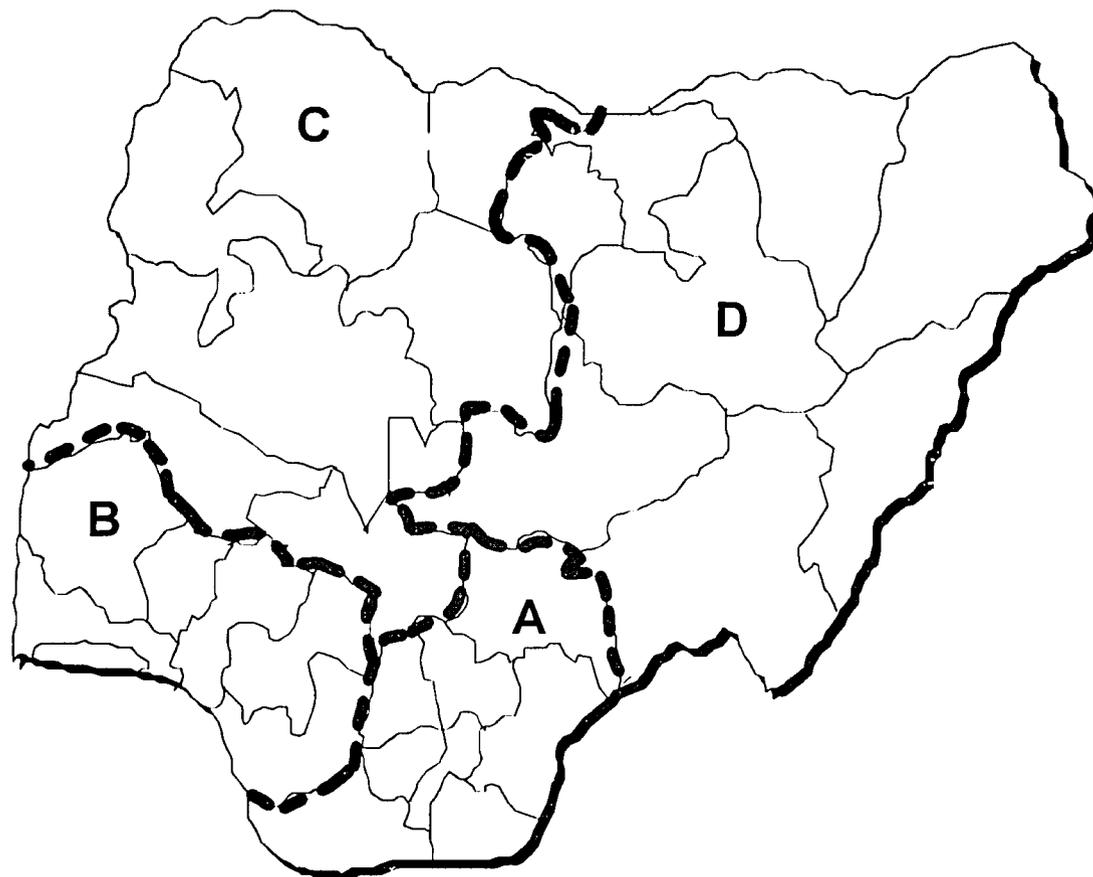
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Nigeria

| NORTHWEST | |
|--------------|------|
| CPR | 1.2 |
| FP Knowledge | 27.7 |

| NORTHEAST | |
|--------------|------|
| CPR | 2.0 |
| FP Knowledge | 21.9 |



| SOUTHWEST | |
|--------------|------|
| CPR | 15.0 |
| FP Knowledge | 73.6 |

| SOUTHEAST | |
|--------------|------|
| CPR | 8.8 |
| FP Knowledge | 53.9 |

■ ■ ■ Primary Health Care Zones

Source: 1990 NDHS Note: CPR any method, National 6.0

Health and Demographic Indicators

| | 1963 | 1993 (est) | | 1963 | 1993 (est) |
|-----------------------|------------|------------|--|------|------------|
| Population | 55,700,000 | 94,270,068 | Urban Population (%) | 19 | 35 |
| Births | 3,676,200 | 4,619,233 | Total Fertility Rate | n/a | 6.0 |
| Crude Birth Rate | 66 | 49 | Mean Number of Children Ever Born to Women 15-49 | n/a | 6.8 |
| Infant Deaths | n/a | 402,797 | Maternal Mortality Rate | n/a | 15 |
| Infant Mortality | n/a | 87.2 | | | |
| <5 Deaths | n/a | 887,816 | | | |
| >5 Mortality Rate | n/a | 192.4 | | | |
| Life Expectancy (yrs) | 36 | 51 | | | |

Sources: 1963 Census/Federal Office of Statistics; 1990 NDHS; 1991 Census and growth rate of 3.2%; U.N. World Population Chart, 1990; FGN/UNICEF Situation Analysis of Women and Children, 1990
Note: Rate per 1,000

I. THE USAID FAMILY PLANNING PROGRAM: THE NIGERIAN CONTEXT

Nigeria is the fourteenth largest African country in terms of area, with a land mass of 356,669 square miles equal to that of Texas, Louisiana, and Mississippi combined. Nigeria is also the most populous nation on the African continent, with 20 percent of all sub-Saharan Africans living in Nigeria. The 1991 census reported a provisional estimate of 88.5 million, which is regarded by some as low. Currently, the population is estimated at 95 million with an annual growth rate of 3.1 percent, resulting in a doubling of the population by the year 2014 – in only 20 years. This makes Nigeria the third most-densely populated country in sub-Saharan Africa, following Rwanda and Burundi.

A. ECONOMY

Nigeria's dynamic, enterprising population and unusual endowments of arable land, minerals, petroleum and natural gas give it high potential for diversified economic develop-

MAJOR ISSUES TO OVERCOME

- Political Commitment and Contribution
- Inadequate Knowledge of Providers and Consumers
- Unequipped Facilities
- Inadequate Commodities Supply and Distribution
- Low Demand for Services
- Deficient Systems for Data Collection and Analysis
- Religious/Cultural and Traditional Beliefs

ment. However, the current economic picture is bleak. Although Nigeria was one of the wealthiest African countries in the 1980s, by 1993 it was considered the 13th poorest country in the world. The oil boom of the 1970s provided the impetus for a shift from an agricultural economy to an export economy relying on oil for more than 95% of its export earnings and 80% of federal budget resources. The oil boom also triggered a massive rural to urban migration devastating the agriculture production. The decline in demand and drop in price of oil, which began in the early 1980s, resulted in high levels of unemployment and recession. Historically a net food exporter, by 1985 Nigeria imported more than \$500 million in foodstuffs annually. The Nigerian government reacted by banning most food imports in 1987. As a result of the worsening economic crises, declining earnings, scarce food supplies and high unemployment, the government launched a Structural Adjustment Program (SAP) in July 1986.

Despite Nigeria being the world's sixth-largest supplier of crude oil, its economy has been plagued with increasing inflation and an accelerated currency devaluation – from N16 (naira) to \$1 U.S. on January 16, 1992 to N97.5 to \$1 U.S. on November 4, 1994. Rising prices have eroded real-wage gains, leading to significant economic distress among all classes of the population with an associated decline in the standard of living. A growing class of poor emerged whose needs have not yet been recognized by the Nigerian leadership in allocating public resources. Additionally, the difficulties in transition from military to civilian leadership have challenged the sustainability of Nigeria's economic policy reforms.

Implementation of the "naira re-valuation policy" in January 1994, which fixed the exchange rate at 22 Naira to \$1US and required that all foreign exchange (FX) be channeled through the Central Bank, crippled the economy. The Nigerian market relied heavily on importation of both raw and finished goods for manufacturing products. Nigerian businesses have not been able to acquire adequate amounts of foreign exchange or secure commercial loans for operations, severely hampered their importation ability and reduced production. Additionally, in July 1994 most banks closed for approximately six weeks as a result of strikes and fuel shortages causing a scarcity of naira as well as foreign exchange.

B. POLITICAL STRUCTURES

Since gaining independence in 1960, Nigeria has been plagued by military coups in its efforts to govern itself. The First Republic ended in a series of military coups in 1966. The Second Republic fell to a military coup in 1983 after elections that were characterized by widespread claims of vote rigging, corruption and economic mismanagement.

Nigeria still has not been able to finalize its political transition from a military government to civilian rule. After successfully holding elections for local, state and national assembly officials, the transition came to a halt with the postponement of presidential elections, originally scheduled for November, 1992. A joint military/civilian transition government installed for this period was largely ineffective. The subsequent presidential election of June 12, 1994, believed by most Nigerians and external observers to be the freest and fairest in Nigeria's history, was annulled by the military leaders.

As a response to the election annulment, the United States imposed sanctions that precluded the transfer of funds to the Government of Nigeria (GON). In July 1993, USAID suspended, and later terminated, \$11-million in non-project assistance (NPA/ESF) under a health policy program. The local currency generated from this assistance was to support the Primary Health Care program. In addition, although the Nigerian Combatting Communicable and Childhood Disease (NCCCD) Project was authorized, no Grant Agreement was signed with Government of Nigeria.

On August 25, 1993, an interim government, comprised of a both of civilian and military representatives, was appointed for six months and new elections scheduled for February 1994, but even that plan was negated. On November 18, 1993, the military again assumed power; all elected bodies and officials were dissolved and replaced by military administrators.

In December 1993, the military government planned a national constitutional convention to be held in March 1994. The purpose of this convention was to ratify a new constitution and lead to a democratically elected government. Although the convention began in July 1994 and is still taking place, it has little creditability because the elections for conference participants were canceled. In addition, the Abacha Regime has committed actions that negate its avowed intention to hand-over to a democratically elected president (see box next page).

ACTIONS BY THE ABACHA-LED REGIME

- Arrested many pro-democracy supporters, most notably Chief Abiola
- Proscribed the labor unions, who held a 10 week strike (7/94)
- Closed several newspapers including the well-balanced *Guardian*
- Signed a decree that places the government above the judiciary

From January 1993 to date, there have been three Heads of State and four Ministers of Health, making program implementation extremely problematic. The annulment of the elections, frequent demonstrations, strikes, fuel shortages and replacement of the civilian officials with military administrators have taken a deep toll on the Primary Health Care system.

C. ADMINISTRATIVE STRUCTURES

Administratively, Nigeria consisted of 19 states in 1967, expanding in 1981 to 21 states with 350 LGAs. In 1991, 10 new states were created, including the Federal Capital Territory (FCT), Abuja, for a total of 31. Each state is composed of local government areas (LGAs) – currently 589 LGAs nationwide.

The proliferation of political units significantly affected implementation of the Primary Health Care program. The authority for PHC shifted in 1991 to the LGAs, which are responsible for providing PHC services, maintaining health infrastructure and mobilizing community support. State Ministries of Health (SMOH) plan and render services at the state level, as well as provide training and a range of technical support services, including supervision, to LGAs. Although creation of new States and LGAs has broadened participation of communities in the government process, the reality is that they have smaller health budgets, little organizational capability to implement the PHC program and inadequate health care infrastructures with inadequate redistribution of equipment and lack of secretariat buildings/offices.

D. DEMOGRAPHY

Nigeria is experiencing marked changes in the size, distribution, and composition of its population as the result of persistently high growth rates driven by high rates of fertility, declining mortality rates and urban migration. While two-thirds of the population still live in rural areas, almost half the population will be urban residents by the year 2020. With an average total fertility rate (TFR) in excess of six children and a projected growth rate of 3.1 percent, Nigeria's population will double in 20 years. In addition, 48 percent of the population is below the age of 15 and the number of women of reproductive age (WRA, 15-49) constitute 24 percent.

Based on the 1990 NDHS data, the birth rate for adolescents 15 to 19 years of age was estimated to be 152 per 1,000, or 905,000 births per year. This large number of births has implications for Nigeria's health care system as well as for the future of

the adolescent and her child. Most births to teens are first births and women having their first child are at higher risk of serious medical complications.

This rapid rate of population growth compromises national development by outstripping Nigeria's ability to maintain the environment, provide jobs, infrastructures and social services. This suggests an urgent need for altering fertility rates and child spacing patterns

E. SOCIOCULTURAL CONTEXT

Nigeria's significant economic and cultural differences tend to split the country into two distinct areas. In general, the North is largely agrarian and less developed economically, primarily Muslim with lower literacy and educational levels, particularly among females. The South is relatively more economically developed with a commercial/industrial base, predominantly Christian with higher educational levels among females. The population is almost evenly divided between Christians and Muslims with a small number adhering exclusively to traditional religions. Literacy is estimated at 54 percent for males and 35 percent for females, with large regional disparities.

The pressure to bear many children beginning at an early age often leads to disastrous results, contributing to Nigeria's high maternal mortality rate of

CULTURAL FACTORS PROMOTING HIGH FERTILITY

- large families are highly valued in Nigerian society
- children remain the means of support for the elderly
- ethnicity/religion influence childbearing decisions
- marriage is early and universal
- children elevate a woman's status within the family
- regulation of fertility is not a woman's own decision

15 per 1,000 live births and related high level of infant mortality of 87.2 per 1,000 live births. Widespread polygamy and limited economic opportunities for women lead to frequent and extended childbearing, which also contributes to the high rates of pregnancy-related death and disability.

F. RATIONALE FOR FAMILY PLANNING PROGRAM

In 1981-82, the Nigerian National Demographic Sample Survey (NNDSS), designed along the lines of the World Fertility Survey, was conducted. Results indicated high fertility (TFR 8.2) and low contraceptive use (about one percent). The government began to see population growth as a problem, which was addressed in its 1988 population policy (see below). The situation had slightly improved by 1990 when the NDHS indicated that fertility dropped from TFR of 8.2 to six, and use of family planning rose to six percent for all methods and 3.8 percent for modern methods. Regional prevalence rates differ considerably; use in southwest region was 11 percent, the southeast four percent, while in the northern regions only about one percent. Although use was low, the NDHS also indicated a substantial unmet demand for family planning services (22 percent); 10 percent for limiters and 12 percent for

spacers. This was consistent with 26 percent of women with at least four children indicating their future intention to use family planning.

G. POPULATION POLICY

In 1988 the Government of Nigeria adopted the *National Policy on Population for Development, Unity, Progress and Self-Reliance* (NPP). Before this point in time, family planning could not be discussed in public and was seen universally as taboo. Presently it is possible to have radio and television spots about family planning. The Policy was designed to utilize a multi-sectorial approach that fosters active involvement of the public sector, communities, non-governmental organizations (NGOs) and the private commercial sector to effectively deliver safe family planning services. Service delivery is supported by a vigorous, national program of (IEC) focused on critical target groups such as males and youths. The policy is quite comprehensive but contains ambitious targets for fertility reduction.

POPULATION POLICY TARGETS FOR FERTILITY REDUCTION

- Reduce the TFR from 6 to 4
- Reduce growth rate from 3.3% to 2.5% by 1995 and 2.0% by 2000
- Make FP information available to adolescents by the year 2000
- Reduce high risk pregnancies by 50% by 1995 and by 80% by 2000
- Extend availability of FP services to users by 50% by 1995 and 80% by 2000
- Reduce IMR to 30 per 1000 live births by the year 2000
- Reduce the proportion of WRA who get married before age 18 by 50% by 1995 and by 80% by the year 2000

These targets are probably unattainable within the target time frames, even with a greatly accelerated national effort to expand family planning information and services.

H. NIGERIA'S HEALTH SECTOR PROFILE

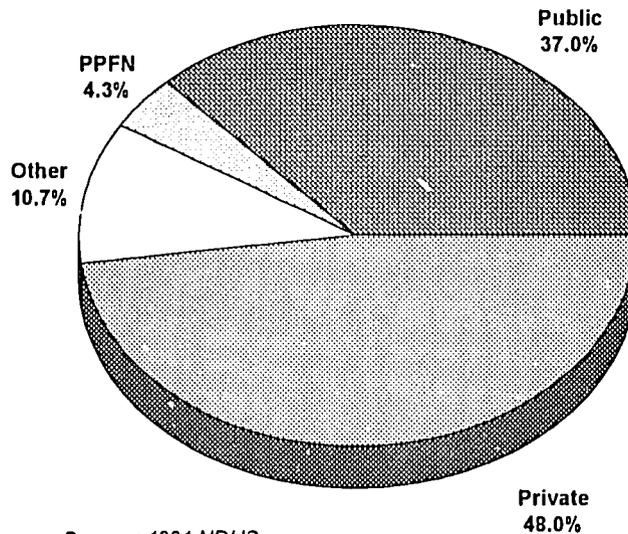
The current health care status of the majority of Nigerians, especially women and children, is marginal at best. It has been estimated that avoidance of high risk births alone could avert up to 20 percent of the infant mortality and 25-40 percent of maternal mortality. Basic health care is delivered in the public sector through an extensive system of 7,700 hospitals and clinics linked together to form a nationwide Primary Health Care system.

Family planning information and services are delivered through a wide variety of sources, both public and private. According to the 1990 NDHS, 37 percent of family planning acceptors receive their services from government facilities, 48 percent from private sources, 4.3 percent from Planned Parenthood Federation of Nigeria (PPFN) with the remaining receiving methods from religious organizations.

Despite the fact that all government facilities are *suppose* to offer family planning services, only 2,400 government facilities provide these services — 1,500 outlets provide temporary methods and 900 sites offer all methods including voluntary surgical sterilization (VSC). Although physical access doesn't appear to be a problem for health facilities — with NDHS reported only 37 percent of respondents having to travel more 10 miles to the nearest center — this is not the case for family planning. Acceptors may have to travel substantial distances to obtain services because not all facilities offer family planning. This is particularly important because the public sector is the major supplier of long-acting methods. Sixty percent of intrauterine contraceptive device (IUCD) users and almost half of injectable users receive services through government facilities

The private sector is dynamic and diverse; it includes private for profit, NGOs, professional organizations and private hospitals and maternities to name a few. Planned Parenthood Federation of Nigeria (PPFN) is the largest family planning NGO in Nigeria with 15 full-time and 55 seasonal service sites. The private sector with its thousands of outlets has a great e:

Fig. 1 Source of Contraceptive Supply



Source: 1991 NDHS

ii. FAMILY HEALTH SERVICES PROJECT, 1988-1992

A. BACKGROUND

USAID/Nigeria, after withdrawing in 1979, was reestablished in 1983 when economic and health indicators fell to record low levels. Prior to 1987, about 20 organizations implemented their own family planning efforts without coordination or cohesive direction. Funds for these activities were obtained from the regional Family Health Initiatives-II (FHI-II) Project (number 698-0426).

In 1987, the design of the Family Health Services (FHS) project was completed and authorized for five years – PACD December 31, 1992 – with funding at \$67 million and a matching contribution from the Nigerian Government of \$33 million. This project built on the groundwork laid under FHI-II while fostering collaboration between contractors and providing general direction. To date, a total of \$53.5 million has been obligated – \$21 million from FHI-II and \$32.5 million from FHS. In the Smith & Crocker report (1992) the actual government contribution, both cash and in-kind, toward the USAID/Nigeria portfolio was estimated at \$52 million with \$33.1 million directed to the FHS project.

Family Health Services Time Line

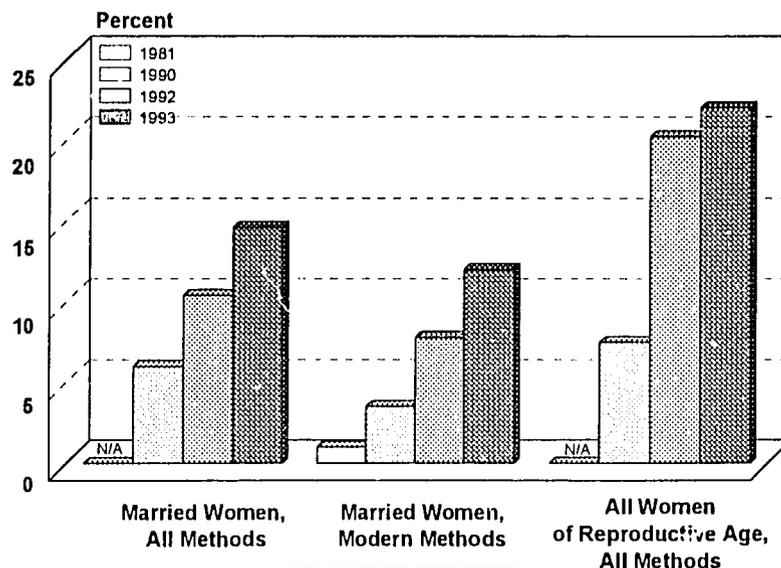
- 1983-1986 ■ Family Health Initiatives — II
- 1987 ■ Family Health Services Project Design and Authorization
 - Contracts Awarded to Prime Implementation Contractors
- 1988 ■ National Population Policy Ratified
- 1989 ■ Regional Inspector General's Audit Report
 - Evaluation by Population Technical Assistance Project
- 1990 ■ Nigeria Demographic and Health Survey
 - *Gold Circle* Social Marketing Began
- 1991 ■ Health Sector Assessment
 - Management Reviews by Price Waterhouse and Pop Tech
 - National Logo Campaign
 - *Right Time* Social Marketing Began
- 1992 ■ Nigeria Integrated Household Surveys (NISH)
- 1993 ■ Family Health Services "Transition"
 - RAPID, AVSC, CEDPA, SEATS, FPMD
 - Financial Management Review
- 1994 ■ Nigerian Family Health Services Project Authorization
 - Decertification
 - International Council on Population and Development (ICPD)

As a result of various political events both within and external to Nigeria, FHS has been extended twice without any increase in the funding levels. (Details will be discussed below.) The first extension changed the PACD from December 1992 to June 30, 1994. Delays in the project design of the follow-on Nigerian Family Health Services project (NFHS) resulted again in the extension of the project until June 30, 1995, which is the current PACD.

FHS has been very successful in meeting its expected project outputs (EOPS). The contra-

ceptive prevalence rate rose from six percent – 3.8 percent modern methods – in 1990 to 21 percent – 11% modern methods – in December 1994. Awareness of family planning as a concept has greatly increased while knowledge generally remains low.

Fig. 2 Contraceptive Prevalence Rates (%) by year, by marital status



Sources:

¹Nigeria Fertility Study 1981

²Nigeria Demographic and Health Survey 1990

³Nigeria Integrated Survey of Households Sept. 1992

Table 1. Knowledge, Approval and Use of Family Planning among women age 15-49, by year

| Method | 1981 | 1990 ¹ | 1992 (%) | 1993 |
|---|-------------------|-------------------|-------------------|-------------------|
| Approve of Family Planning | | 70.8 ⁵ | 75.0 ⁴ | |
| Aware of One Modern Method | 34.0 ⁶ | 45.7 ⁶ | 83.1 ² | 61.9 ³ |
| Heard Family Planning Messages ⁶ | | 24.6 | | |
| Approve of Messages ⁶ | | 56.1 | | |

Sources:
¹1990 Nigeria Demographic and Health Survey
²Nigeria Integrated Survey of Households Sept. 1992
³Nigeria Integrated Survey of Households Dec. 1993
⁴1992 Nigerbus Survey

Notes:
⁵Among Currently Married Women
⁶Among All Women of Reproductive Age

Table 2. FHS Structure, 1988-1992

| Component | Implementor | Subcontract |
|-----------------------------------|---|--|
| Public (\$11 million) | Pathfinder (620-0001-8018) | Mgm't Sciences for Health (MSH) International Health Programs Africare |
| Private (\$8.3 million) | Family Planning International International Assistance (620-0001-8015) | John Snow Institute (JSI) Margret Sanger Center (MSC) |
| IEC (\$15 million) | Johns Hopkins University Population Communication Services (PCS) (620-0001-8013) | Center for Development and Population Activities (CEDPA) Program for Appropriate Technology in Health (PATH) Saffitz, Alpert and Assoc. (SAAI) |
| Policy (\$2.5 million) | Johns Hopkins University Institute for International Programs (620-0001-9001) | |
| Administration (\$5.0 million) | African-American Institute (620-0001-8008) | Sweethill |

Source: FHS Project

B. PROGRESS TOWARD OUTPUTS

Initially, FHS was designed in a collaborative mode with four technical components and one support contract. This approach was selected in order to:

- Streamline technical efforts
- Avoid duplication
- Foster collaboration among components
- Contribute to an overall programmatic goal
- Provide a manageable work load for the AID Affairs Office

Management of the project was implemented through two different mechanisms: (1) **1988-1991**, the Mission hired a Project Coordinator, as a personal services contractor, to coordinate the efforts of the different contractors; and (2) **1991-1993**, through a OYB transfer to Family Health International's International Science and Technology Institute (ISTI) provided a Project Administrator and some technical support. Although FHS has made great strides, this administrative position has been plagued by the lack of "real authority." Neither approach had contractual authority over the other organizations, creating many conflicts.

OUTPUT #1: Increase Contraceptive Prevalence Rate to 12 Percent

Over the past five years, the population program, with FHS assistance, has taken off. The aim of FHS was to achieve a national CPR of 12 percent by 1992. In December 1992, Federal Office of Statistics (FOS) household survey estimated CPR at 14.4 percent with 7.4 percent for modern methods which is a significant increase from the 1990 NDHS of six percent with 3.8 percent modern methods. The dissemination of the National Population Policy in 1988 is partly responsible for this surge, however, the worsening economic situation is generally credited with being the key motivating factor in increasing contraceptive use.

| | 1981 ¹ | 1990 ² | 1992 ³ |
|---|-------------------|---|-------------------|
| Married Women, Modern Methods | 1.0 | 3.5 | 7.8 |
| Married Women, Any Method | 5.0 | 6.0 | 10.4 |
| All Women of Reproductive Age ⁴ | | 7.5 | 20.2 |
| FHS Target ⁵ | | | 12.0 |
| Sources: | | Notes: | |
| ¹ Nigeria Fertility Study 1981 | | ⁴ Any Method, traditional and modern | |
| ² Nigeria Demographic and Health Survey 1990 | | ⁵ Target does not distinguish between modern and traditional methods, and does not specify all or married women. | |
| ³ Nigeria Integrated Survey of Households Sept. 1992 | | | |

OUTPUT #2: Family Planning Information, Commodities, and Services Provided Through 12,000 Private Sector Outlets and 3,600 Public Sites

1. Information

FHS was tasked to disseminate FP information through 12,000 private sector outlets and 3,600 public service delivery sites. FHS was also expected to increase FP knowledge to 85 percent of the population. Awareness regarding the general concept of FP has increased from approximately 35 percent in 1988 to 76 percent in 1992. However, knowledge regarding specific types of methods still remains low at 43 percent. In 1992, the National FP Logo was launched. Identification was made of 40,069 sites offering family planning services. IEC materials, such as posters and stickers with the message "Child Spacing Services Available Here," were given to each facility. In addition, television, radio spots were aired on a frequent basis. In June 1992, three months after the start of the logo, 30 percent of survey respondents had seen the symbol, of which six percent could describe it accurately. By the end of the campaign in December 1992, 33 percent of those interviewed had heard of the campaign, and 66 percent of these could describe it accurately.

2. Commodities

Although importation of contraceptive supplies increased, the system was plagued by stock-outs and mal-distribution. Eighty-two percent of the logo sites identified indicated difficulty in obtaining family planning products.

Family Planning International Assistance (FPIA) procured \$9.6 million in contraceptives, which were initially distributed in both the public and private sectors by a subcontractor, Sterling Products, Nigeria Ltd. From early in 1992, Population Services International (PSI) assumed responsibility for distribution using FHS staff and its social marketing program. A portion of the commodities procured by FPIA were not distributed until 1993. In addition to the procurement of contraceptives through FPIA, USAID/Nigeria initiated procurement through USAID's Central Contraceptive Procurement Project. An initial fund (OYB) transfer of \$2.4 million took place in FY91.

**Table 4. Project Commodity Shipments
from AID/W to Nigeria, 1988-1992**

| Commodity | 1988 | 1989 | 1990 | 1991 | 1992 | Total |
|-------------------|-----------|-----------|------------|------------|------------|------------|
| Condom | | | | | | |
| Private | 2,778,000 | 222,000 | 14,988,000 | 11,772,000 | 11,952,000 | 41,712,000 |
| Public | 3,402,000 | 6,228,000 | 4,386,000 | 5,100,000 | 5,172,000 | 24,288,000 |
| Copper-T | | | | | | |
| Private | 16,200 | 3,200 | 52,000 | 60,000 | 50,000 | 181,400 |
| Public | 110,600 | 94,200 | 34,600 | 108,000 | 203,000 | 550,400 |
| Oral Pills | | | | | | |
| Private | 504,000 | 93,500 | 1,218,000 | 2,150,600 | 2,811,600 | 6,685,136 |
| Public | 753,600 | 1,178,400 | 753,600 | 1,473,600 | 1,644,000 | 2,864,736 |
| VFTs | | | | | | |
| Private | 62,400 | 153,600 | 936,000 | 456,000 | 1,406,000 | 3,014,000 |
| Public | 768,000 | 1,536,000 | 1,344,000 | 1,704,000 | 3,096,000 | 8,448,000 |

Source: FHS/USAID Commodity Listing, received under contract 620-0001-C-00-8015

3. Services

Between 1988-92, FHS has equipped 1,200 clinics to provide IUCDs and VSC services as well as training approximately 12,000 health care workers from the public and private sector in the following areas include:

- Clinical Services
- Interpersonal communication
- Supervision
- Management
- MIS
- Financial management
- Community-Based Distributions
- Counselling

| Table 5. CYP Generated through Public and Private Facilities by year 1988-1992 | | | | | |
|---|---------------|---------------|----------------|----------------|----------------|
| | 1988 | 1989 | 1990 | 1991 | 1992 |
| Private | 14,752 | 64,317 | 128,332 | 214,328 | 217,516 |
| Public | n/a | n/a | 433,710 | 337,848 | 365,868 |
| Total | 14,752 | 64,317 | 562,042 | 552,176 | 583,384 |

Source: FHS Project

C. PROJECT ACCOMPLISHMENTS

1. Public Sector Component

Designed to strengthen the government family planning delivery system, Public Sector component activities included:

- Developing training curricula for various cadres of health providers, both in-service and pre-service
- Facilitating the establishment of a training network in the areas of clinical service delivery and management
- Developing and implemented the Nicare Primary Health Care Management Information software in collaboration with the USAID-funded Combatting Childhood Communicable Diseases Project
- Developing standards of practice to improve the quality of family planning service delivery

| ACCOMPLISHMENTS |
|---|
| <ul style="list-style-type: none"> • 5,000 public sector staff trained in service delivery • 500 facilities equipped to provide full range FP services • Standards of Practice developed and disseminated • In-service and pre-service curricula developed • Training network developed |

2. Private Sector Component

This component was designed to develop and expand private sector family planning initiatives through a variety of channels including commercial, work place, and private medical facilities and maintain a logistics system. Activities included:

- Shipping, clearing and distributing all commodities for both the public and private sectors
- Training of private sector providers
- Social marketing of condoms
- Providing clinical services through private health facilities
- Providing community-based services through women's groups

ACCOMPLISHMENTS

- 2,384 providers trained in clinical services
- 1,400 market-based vendors trained to provide FP methods
- 3,400 community distributors trained to offer FP methods
- 3.2 million *Right Time* condoms sold
- 10.5 million *Gold Circle* condoms sold
- ??0 million "naked" no-brand condoms sold

3. Information, Education and Communication Unit

Designed to increase awareness and acceptability of family planning options and services, component activities included:

- National multimedia campaigns
- Developing various IEC materials in local languages
- Promoting award-winning rock video by Nigerian artists
- Facilitating development of training curricula for counselling and interpersonal communication
- Providing orientation for journalists
- Liaising with political and traditional groups promoting support for family planning

ACCOMPLISHMENTS

- National Logo identified 40,069 outlets that offer FP
- Six Million IE&C materials produced/distributed to 40,000 outlets
- Produce 1,000 radio, TV spots and dramas
- Established IEC network

4. Policy Component

This component was designed to assist in the implementation of the NPP by obtaining support from influential persons, opinion leaders and constituency groups to mobilize community resources for the family planning program.

ACCOMPLISHMENTS

- Translated and disseminated the Policy into three local languages
- Policy analysis of DHS data
- Oriented 1,300 government officials and religious and traditional leaders to the population policy

5. Administration and Logistics Component

This component was designed to support all the technical contractors.

ACCOMPLISHMENTS

- Leased and maintained FHS building
- Facilitated logistics and travel arrangements
- Assisted in overseas procurement and clearance

D. LESSONS LEARNED

1. Coordination

There were many instances where inputs were not coordinated. For example, IEC efforts were undertaken in areas experiencing product stock-outs. As the number of Cooperating Agencies increased, so did the importance of collaboration of project implementation efforts. There was no coordination with other organizations working in Nigeria, such as the Association for Voluntary Surgical Contraception (AVSC).

2. Currency Exchange

With the rapid fluctuation of currency exchange, it was necessary to maximize transactions by negotiating the best possible rates to provide resources for the projects.

3. Administration and Decentralization of Resources

Technical personnel spent nearly half of their time completing administrative and contracting paperwork, greatly reducing their time for program implementation. Additionally, a great deal of time was wasted because the majority of decisions were made by headquarters staff in Lagos, not by field staff.

4. *Special Technical Assistance Required*

When FHS began, there was much groundwork needing development and implementors needed “tunnel vision” to focus attention toward workable areas. As the program matured, more areas of technical assistance were required and could not be filled by the current contractor’s expertise.

5. *Geographic Focus*

To have impact in a vast country like Nigeria, inputs must be technically sequenced and resources harnessed. In the early days of FHS, inputs were scattered, uncoordinated and had questionable impact. For example, IEC campaigns would take place in one state while training occurred in another state. It was also very inefficient to implement all field programs from Lagos.

6. *Institutionalization*

FHS concentrated efforts on developing a large group of family planning acceptors. Hence, institutionalization was not the primary focus. Additionally, most of the Nigerian NGOs require a long-term, sustained focus directed specifically toward institution building.

7. *Project Management*

For effective management, successful coordination and to achieve project outputs, the Project Administrator needs authority and control over resources within the project.

E. OTHER AGENCIES

To respond to increasing Nigerians’ needs, in 1992 the Mission encouraged participation of cooperating agencies to fill gaps in assistance coverage. FHS coordinated with various agencies on the following activities, as articulated in a memorandum of understanding between the Mission and R&D/POP.

- Transferred \$125,000 to the Bureau of Census to assist the National Population Commission in disseminating the census data.
- Transferred two million dollars to the Family Planning Development Project to strengthen the management capability of Planned Parenthood Federation of Nigeria. This project has been very problematic from the onset, and continues to be plagued by low performance.
- Completed a buy-in to the RAPID Project for \$700,000 to develop and institutionalize the “RAPID Model.”
- Transferred \$400,000 over a three-year period – 1992, 1993, and 1994 for a total of \$1.2 million – to Association for Voluntary Surgical Contraception (AVSC). AVSC has worked in Nigeria since 1978. Prior to 1993, despite AVSC being well established in Nigeria, there was little collaboration between it and FHS. From 1993, AVSC located a person in FHS. Also, the AVSC Regional Representative served as the Director of the Programs Department. While still useful, the representative’s

time was limited. AVSC greatly expanded its program and the Mission anticipates this will continue in the future.

- Family Planning Logistics Management Project assisted the government in assuming responsibility for the operation of the commodities system. All assistance was financed with core funds.
- The Evaluation Project, with core funds, assisted FHS in the analysis of FOS and NICARE data. Additionally, it assisted in Mission in monitoring its impact.

III. FAMILY HEALTH SERVICES IN TRANSITION, 1993-94

A. BACKGROUND

The FHS project was originally scheduled to terminate on December 31, 1992. For several reasons, it was extended for eighteen months until June 30, 1994, at no additional increase in life of project (LOP) funding. First, Nigeria's transition to democracy was to have been concluded by December 1992. USAID/Nigeria felt that the newly elected administration should be involved in the development of the follow-on family planning project, Nigerian Family Health Services (NFHS), and that an eighteen-month extension would give it that opportunity. Unfortunately, the military did not relinquish power as scheduled.

Second, based on the results of the 1991 Health Sector Assessment, 1991 FHS Management Review and previously mentioned "Lessons Learned," project implementation required significant modifications in direction. However, a new project design and procurement would have created a huge gap in service provision. An agreement was reached to refocus and extend the project to June 30, 1994, during the NFHS design – later extended to June 30, 1995. The Mission wanted a period to test its new approaches before embarking on the new project. New emphasis included:

- Reorganizing FHS roles/responsibilities
- Strengthening zonal offices
- Coordinating technical inputs and resources
- Increasing focus toward private sector
- Utilizing organizations outside the FHS umbrella
- Consolidating office administration, transportation and financial management functions under one contractor

Disharmony among Project contractors made collaboration extremely difficult. In 1991, to improve coordination, all personnel were placed under one payroll system – under African-American Institute. Standard salaries and benefits were developed in an attempt to foster loyalty to one organization, Family Health Services. In early 1993, the contracts of FPIA, JHU/IIP and Pathfinder expired. The JHU/PCS contract was extended without funding increase because of its large, unexpended pipeline and will be extended again to coincide with the current FHS completion date (PACD). The AAI contract also has been extended and its funding increased to provide comprehensive personnel, administrative and financial services in support of the entire USAID/Nigeria program.

B. STRUCTURE

Because many of the contractual mechanisms changed in 1993, the structure and responsibilities of FHS changed as well. Instead of four technical contractors the project was divided into two departments, Policy and Program Coordination (PPC) and Technical Services and Support (TSS) with project management being implemented in the Project Administrator's office.

The Policy and Program Coordination department had oversight responsibility for the four zonal and five RIS offices. In addition, this department ensured that all strategies and activities were implemented in accordance with the FHS project design and the NPP. Specific responsibilities included strategic planning, program prioritization and integration and overall project performance.

Each zonal office — Ibadan, Enugu, Bauchi, and Kaduna — had a staff of two to four Program Officers responsible for the following: identifying priorities; developing workplans and budgets; monitoring ongoing programs; liaise with officials/institutions on emerging FP obstacles and opportunities; and identifying technical requirements and assuring their available assistance.

The Technical Services and Support department provided technical assistance to the federal, state and local levels as well as the private sector in project design and strategy formulation. Four divisions were established within this department. They were training, commodities and logistics management (CLM), IEC, and monitoring and evaluation (M&E). Specific functions included developing technical strategies, managing the operational research activities, and establishing a technical-resource data base.

In March 1993, to streamline efforts, all personnel, administration and financial management functions were consolidated under the logistics contractor — the African-American Institute (AAI). AAI created a Personnel, Administration and Finance unit (PAF) to be responsive to the needs of the technical projects with out programmatic input or authority. PAF's responsibilities included:

- Personnel Management (Employee Payroll and Benefits)
- Procurement of Commodities
- Infrastructure Acquisition & Maintenance,
- Transport and General Logistical Support
- Standard procedures for motor pool operations;
- Communication Management.
- Organization of project-related conferences
- Travel arrangements
- Comprehensive Financial Services

C. COUNTRY PROGRAM STRATEGIC PLAN

The “*Nigeria Country Program Strategic Plan*” (CPSP), approved by USAID/W in 1992, provided the framework for the family planning program. The goal of the USAID/Nigeria portfolio is to promote “a healthier and more productive society” with a sub-goal to “reduce fertility, morbidity and mortality.” Strategic Objective #1, increased voluntary use of family planning, directly relates to FHS. The project was designed with targets providing the steps necessary to achieve this objective — increased demand for, availability and utilization of, and enhanced quality of family planning services.

TARGET #1.1: Increased Demand for Modern Contraceptive Methods

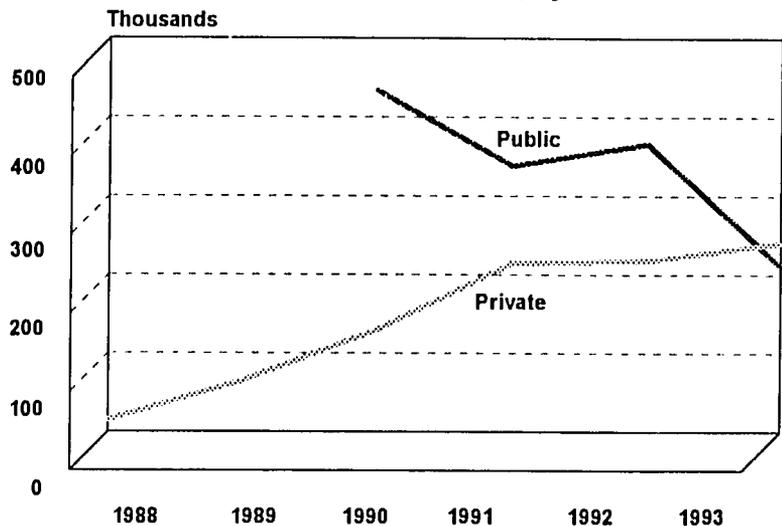
Among the 46 percent of the April 1993 Nigerbus respondents aware of specific family planning/child spacing methods, over 87 percent approved of couples who use these methods. This is an important measure of how attitudes toward family planning are changing in Nigeria.

TARGET #1.2: Increased Availability of Modern Contraceptive Methods

One of the innovative strategies tested under this transition phase was called the Resource Intensification Strategy (RIS). This was the first family planning attempt to look holistically at the needs of a specific community, both public and private. Five states were selected to participate in this pilot. The strategy was intended to maximize the benefits to the community by orchestrating the timing of required technical inputs, e.g., IEC, training, while closely monitoring progress and impact of activities. Detailed implementation plans were developed jointly by public and private providers.

From 1993 -1994, FHS equipped 70 clinics to provide a full range of family planning services including voluntary surgical contraception (VSC), 187 clinics to provide other methods and trained 3,000 service providers.

Fig. 3 CYP Generated Public and Private Facilities, by Year



Source: FHS Project

Note: 1993 reflects January to August only

Social marketing, the main avenue of increased availability of contraceptives to consumers, greatly increased the market for FP products. USAID/Nigeria awarded Population Services International (PSI) an eighteen-month grant for \$2.3 million in March, 1993 – extended through September 1996 with an FY94 obligation of an additional \$2.3 million. Condoms received a lot of attention through mass media as well as other forms of advertising, e.g., billboards. In 1993, 23 million condoms were sold, up from 7.05 million in 1992. Although Nigeria was beset with strikes and demonstrates in 1994, preliminary figures reflect sales figures at 30 million as of October 1994, with projections of 40 million by the end of 1994. Intrauterine contraceptive device (IUCD) sales more than tripled from the 13,000 sold in 1993 to 44,000 by October 1994. Oral contraceptives (OCs) have been more difficult to market as a result of a change in the brands received as well as the inability within Nigeria to advertise pills by brand. Sales reached 3.2 million in 1993 and 3.4 million as of October 1994. Sales of vaginal foaming tablets (VFTs), the lowest seller, rose from 800,000 in 1993 to 1.9 million by October 1994. The total value of contraceptives delivered to Nigeria from 1988 through 1994 is estimated at \$15.3 million. Procurement of family planning commodities by FPIA totalled \$9.6 million. Fund (OYB) transfers of \$13.2 million were as follows: FY91, \$2.4 million; FY93, \$4.8 million; FY94, \$6 million; and ther repaning \$7.5 milioon is available for FY95/96 deliveries.

TARGET # 1.3: Enhanced Quality of Family Planning Services

There are many reasons that woman who intend to, do not use family planning. Among these reasons are distance to services, rude providers, client waiting time, no available supply, side effects religion and husband's disapproval. In recent surveys, it was reported that client continuation of family planning methods is very low. After the first month of use, 30 percent of the clients did not return. After one year, 70 percent of the clients had stopped using contraceptives. The 1992 Situational Analysis (SA) reflected some interesting aspects of service delivery that may have lead to high discontinuation rates. Of clients surveyed, 62 percent were not told what to do if they had problems with their method and 43 percent were not told where to go for resupply. In addition, clients did not always get what they asked for when they entered the clinic. Approximately 50 percent of clients who would have preferred another method received IUCD, 15 percent received injectable and 14 percent received combined pill. Not getting one's preferred method may lead to discontinuation, showing client satisfaction many not be as high as clients' initial verbal response, and that there may be provider bias in choice of method.

FHS has trained over 1,000 providers in interpersonal-communications skills to improve providers' ability to counsel clients. FHS has ensured that during training of clinical service providers, the Standards of Practice are utilized and disseminated to trainees. In addition, in 1993, the Mission began a quality assurance initiative to address issues of quality of care.

D. PROJECT ACCOMPLISHMENTS

1. *Training Division*

This division was designed to coordinate training efforts previously scattered throughout the public and private sectors. A training plan was developed that included all types of training as well as different sectors. The major thrust of the training was to institutionalize this capability within Nigerian institutions family planning service-delivery system. Four universities were selected to conduct the training courses with FHS assistance.

ACCOMPLISHMENTS

- Established of the Training NGO Network
- Institutionalized training through Nigerian universities
- Trained 3,000 providers

2. Monitoring and Evaluation Division

The Monitoring and Evaluation (M&E) division was designed to continue systematic data collection and analysis and train personnel in the program how to utilize NICARE, the data-entry computer software.

ACCOMPLISHMENTS

- Established NICARE system at the zonal offices
- Evaluated 29 private sector USAID-supported subprojects
- Assisted FOS with two Quarterly Household Surveys/State Profiles
- Developed monitoring tools

3. Information, Education and Communication Division

The Information, Education and Communication Division, embodied by JHU/PCS staff, was design increase acceptability and knowledge of family planning through the logo, mass media campaigns, drama productions, and print material.

ACCOMPLISHMENTS

- Produced and distributed six million IEC materials to 40,000 outlets
- Produced 1,000 radio and TV spots and dramas
- Distributed 1,200 press kits to journalists

4. Commodity and Logistics Management Division

This division was created for several reasons: (1) for closer monitoring of commodity procurement because the program had experienced product stock-outs and overstocking situations; (2) the procurement system changed from the one implemented by FPIA (1988 to February 1993) to central procurement through USAID/Washington created many challenges in terms of procedures and clearance; and (3) to assist the Government of Nigeria in its capacity to manage the public sector commodities and logistics system. Initial staffing was two persons in Lagos, then an additional person placed in each of the four zonal offices, for a total of six persons.

ACCOMPLISHMENTS

- Trained master trainers and federal and state personnel on commodities management
- Operated the public sector commodities logistics system
- Participated in the preparation of contraceptive procurement tables
- Prepared and implemented phase-out plan for commodities distribution

E. OTHER AGENCIES

FHS continued its participation with cooperating agencies to fill gaps in assistance coverage as follows:

- Transferred \$1,760,000 to Pathfinder to assist PPFN enhance clinical services and expand sites. Pathfinder was designated to coordinate inputs of MSH, JHU, and Pathfinder to PPFN.
- Transferred \$4.8 million to the Central contraceptive Procurement Project for family planning and HIV/AIDS prevention and control commodities for distribution in the private and public sectors.
- Transferred \$400,000 to the Association for Voluntary Surgical Contraception (AVSC) to continue the organization's activities in Nigeria.
- Transferred \$700,00 to Demographic and Health Surveys (DHS) data collection.
- CEDPA reentered Nigeria. CEDPA has a widespread community of alumni in Nigeria through its use of central funds that supported nine projects with Nigerian women's organizations.

V. THE NIGERIAN FAMILY HEALTH SERVICES PROJECT

Nigeria's political crises, which began June 1993, not only delayed implementation efforts of FHS but also the design of FHS's follow-on, the Nigeria Family Health Services Project (NFHS). In February 1994, under PIL 10, FHS was extended until June 30, 1995, without increased funding. This was to allow for completion of project activities, submission and approval of the NFHS Project Paper and authorization of the project.

Nigerian participation in the design of NFHS was very important to the Mission. Long-term sustainability is dependent upon a sense of ownership among Nigerian leaders and implementors. To assist in the preparation of the NFHS Project Paper, a Nigerian Technical Advisory Committee (TAC) composed of senior policy-makers, influential people and program implementors, was convened. This assured that the new project reflected Nigerian directions. The group met twice during the Project Paper preparation, providing a forum for key Nigerian family planning and primary health care experts to discuss and reach consensus on major issues related to the design and implementation of NFHS. The Committee identified a Core Writing Group (CWG) that was instrumental in writing the Project Paper.

Several cooperating agencies (CAs) also participated in partnership with USAID in the development of NFHS. Much of the technical assistance required for the effort was provided by these CAs. The role of the CAs in recurrent project design, strategic planning and the development of workplans will continue.

Design of the NFHS project lasted for almost two years, beginning with the approval of the Project Identification Document (PID) in 1992. Relevant cable traffic included:

| CABLE | NO. | DATE | TITLE |
|---------|--------|---------|---------------------------------|
| Abidjan | 005686 | 4/27/92 | PID-REDSO |
| State | 199717 | 0/04/92 | PID-ERCP |
| Lagos | 009752 | 6/30/93 | The Participatory process |
| Abidjan | 002243 | 2/16/94 | PP-REDSO |
| State | 062940 | 3/15/94 | PP-ERCP-ARF/BUR |
| State | 105263 | 4/21/94 | CN-NFHS (Expired April 8, 1994) |

Source: USAID/Nigeria

Although the Project Paper was approved in March 1994, NFHS authorization was delayed until July 21, 1994 – a result of program issues arising from the narcotics decertification of Nigeria on April 1, 1994.

NFHS was designed to have a management and administrative structure that would provide optimum opportunity for: (1) long-term sustainability with project management responsibilities in the hands of Nigerians; (2) satisfaction of USAID/Nigeria

program implementation and monitoring responsibilities; and (3) effective participation of key partners.

A Technical Advisory Group (TAG), composed of key Nigerians and Americans, was included in the design. The TAG was scheduled to meet twice a year to review the overall situation and the status of project implementation and provide guidance to ensure the achievement of project objectives.

The Technical Coordination Unit (TCU) was proposed as an expansion of the FHS Project Administrator's office. It would be staffed with a Project Director (Nigerian), two Technical Advisors (Americans) and a Senior Program Officer (Nigerian). It would provide overall direction and technical coordination of the project. The TCU would supervise the two departments – Policy and Program Coordination and Technical Services and Support – created during the FHS transition. These units would maintain their previously described roles and responsibilities. In addition, while the PAF unit was designed to continue, a competitive procurement would take place among Grey Amendment entities.

Although many of the general directions of NFHS were consistent with its predecessor (FHS), some new areas of emphasis were identified. These were, for example: greater involvement of the private sector; programs targeted at youths; male motivation; a northern strategy to address the attitudes existing within the Muslim culture; an urban thrust to reach large populations; and integration among services.

Many cooperating agencies (CAs) participated in partnership with USAID to develop NFHS, as well as providing the bulk of U.S. technical assistance (TA). In the past, CAs were involved in project design, strategic planning, development of workplans and project implementation. Under NFHS, it was anticipated this relationship would continue. USAID/Nigeria's Health Population and Nutrition Office was to be responsible party for USAID/Nigeria contacts with CA managers. PAF was charged to facilitate communication, arrange support for TA visits and handle routine logistical requests.

As in the past, a memorandum of understanding (MOU) was to be negotiated with Office of Population for the CAs participating in NFHS. A contribution by G/R&D/POP to the NFHS Project was expected to total \$22 million.

VI. DECERTIFICATION

On April 1, 1994, in PD-94-22, President Clinton determined that Nigeria was one of the four major narcotics producing and/or transiting countries not meeting the standards set forth in Foreign Assistance Act Section 490(b), thus “decertifying” Nigeria for narcotics purposes. Decertification subjected Nigeria to the provisions of Foreign Assistance Act Section 490(e), which denies all United States assistance to Nigeria unless specific exceptions exists. Under authority of FAA Section 617, funds were authorized, but only for closeout purposes. This was a precedent-setting scenario because no other decertified country had a USAID program – in addition to Nigeria, decertification in 1994 included Syria, Burma and Iran.

In May 1994, the Mission examined its portfolio and prepared a plan for the orderly windup of its program. For FHS, the Project Assistance Completion Date (PACD) of June 30, 1994 became a critical date; virtually all contract, including those of project staff as well as institutional grants and contracts with Cooperating Agencies were scheduled to terminate on that date. Several activities ceased immediately, while others were continued through December 1, 1994, which was the statutory date for phase-out mandated by decertification. Implementation ceased from April through August. Since then, field efforts have been limited to preparing for new activities exclusively within the private sector. To ensure an orderly closeout and avoid abandonment of the program, several contracts and grants were extended through December 1, 1994, as follows:

- No-cost extension of JHU/PCS’s PACD
- No-cost extension of PSI
- No-cost extension of Africare
- Added \$690,000 to the AAI contract for closeout costs
- Extension of about 100 individual contracts with project staff

On June 14, 1994, the USAID Deputy Administrator signed a memo stating that with provisional congressional notification (CN), USAID could continue its program in the private sector. Furthermore, USAID was restricted from giving support to the government at any level. This memo was approved by the USAID administration based on the argument that maintaining the USAID/Nigeria program was in the best interest of the United States. The CNs expired on July 15, 1994 for the FHS and NFHS Projects, and August 17, 1994 for the CAs.

Restrictions imposed by decertification required major readjustments in the program and provided new impetus for expansion into the private sector. The situation also fostered an environment where donor coordination was increased and enhanced. In May 1994, USAID began discussions with UNFPA and ODA to identify activities that could be financed through other mechanisms. This was extremely important for the public sector commodities logistics system (See Annex B).

VII. FAMILY PLANNING AFTER DECERTIFICATION

NFHS was finally authorized on July 21, 1994, for \$65.5 million. The Project Paper was not modified as a result of decertification requirements. Rather, the Authorization Memorandum outlined new implementation modalities in accordance with statutory requirements.

In FY 1994, \$4,492,733 was obligated under NFHS as follows:

- \$2,200,000 to extend African-American Institute's contract through June 30, 1995
- \$2,292,733 to the Population Services International grant to continue its social marketing activities.

In addition, the following funds were transferred to Washington for family planning activities in Nigeria:

- \$6.0 million for contraceptives, including HIV/AIDS condoms
- \$0.7 million for RAPID
- \$0.03 million to Pathfinder
- \$0.5 million to JHU/PCS

As a result of decertification, USAID/Nigeria began to redesign its portfolio and its component projects according to the new operating procedures. This included clarifying roles and responsibilities within USAID/Nigeria and those of its various "Implementing Partners" (IPs), many of which are USAID Cooperating Agencies. The results of this process produced the following documents:

- USAID/Nigeria Program Update
- Statement of Work: Logistics Support Unit (LSU) revision of PAF
- Statement of Work: Task Team (interim PCU)
- Statement of Work : Program Coordination Unit (PCU)
- Concept Paper: Nigerian SAG

The present program mandate applied to family planning states that "a truly NGO program can continue in Nigeria without direct benefit to the government." Responsibility for program direction and implementation shifts, to a great extent, to the U.S.-based Implementing Partners. The Logistics Support Unit (LSU), formed from AAIs PAF, will support the needs of the NGOs and remain strictly a service organization with no technical responsibility. Major administrative changes within the FHS project:

- Personnel shifted from employment by FHS to that of U.S.-based NGOs
- Technical direction no longer the responsibility of the projects, but that of NGOs in partnership with USAID
- Creation of a Program Coordination Unit (PCU) to assist coordination efforts among IPs, across program sectors but without implementation responsibilities
- Withdrawal of assistance to, and procurement of contraceptives for, the public sector

The shift from public to exclusively private sector is not without problems. Nevertheless, activities such as social marketing that have excelled in the private sector dem-

onstrate successful implementation. The need to maintain a policy dialogue with the government remains critical. Areas for such dialogue include policy and standards development, commodities clearance and access to public sector management information system (MIS) data.

Although many of the new directions of the project are not entirely new, implementation modalities differ from those originally designed. Major strategic thrusts include:

- Expanding the private sector
- Accounting for cultural and religious differences present in Northern Nigeria
- Urban-area emphasis
- Special groups (e.g., adolescents and men)
- Women's empowerment

VIII. CONCERNS FOR THE FUTURE

- ***Geographical Focus of Inputs:*** A balance needs to be drawn between addressing national family planning requirements and those of discrete geographic areas.
- ***CA Coordination:*** To achieve impact, technical inputs must be coordinated. A variety of uncoordinated CAs working in the same geographic area can be problematic. If a single CA can provide all required inputs in that area, so much the better.
- ***Social Marketing Product Expansion:*** It is necessary to utilize the Population Services International's social marketing plan for ICUD and injectables to expand the market for these contraceptives.
- ***Integration of Norplant®:*** A plan is needed for Norplant® that identifies market strategy for use, procurement mechanisms, budget, anticipated method mix, number of outlets to be opened, and a training plan.
- ***Partnering with Local NGOs:*** Popular NGOs must not be overloaded and overutilized the result of too many CAs attempting to work with one local NGO will be crippling.
- ***Role of the PCU:*** It must be recognized that the PCU has no authority. All issues and decisions on coordination of CAs will be the responsibility of the Mission, particularly the HPN office.
- ***Data Collection:*** Plans should continue for another DHS to take place as soon as possible.
- ***Public Sector Commodity Requirements:*** Work with donor agencies should continue for monitoring the public sector commodities logistics system.

APPENDIX A

| Target | Responsible Division | Achievements | FHS I Institution Building | FHS II Collaboration |
|---|--|--|---|--|
| A national contraceptive prevalence rate of approximately 12% | All divisions and cooperating agencies | The 1992 FOS Contraceptive Prevalence Survey indicates a total CPR of 14.6% with 7.8% of this attributed to modern-method use | | |
| 80% of the population aged 15-49 will have a knowledge of family planning concepts Attitudinal changes favoring smaller family norms IEC activities materials developed to support private and public family planning services National-, State-, and LGA-level action programs developed for private and public sectors | FHS IEC (JHU/PCS and subprojects) | <p><i>General</i> The 1992 FOS contraceptive prevalence survey indicates that 77% of the population of reproductive age is aware of family planning a a concept</p> <p>The RMS 1992 Nigerbus data indicates that of respondents who know about family planning, over three quarters approve of it.</p> <p><i>Specific</i> Two national multimedia campaigns implemented in collaboration with PPFN and the FMOH.</p> <p>Over 6,000,000 motivational and information materials produced and distributed to more than 30,000 public and private sector health facilities and outlets.</p> <p>Produced over 1,000 television, radio, newspaper, and magazine advertisements, feature programs and live dramas.</p> <p>Standard curricula developed and used for training in counselling, FLE, materials development and formative research, training video produced to complement counselling training.</p> <p>1,200 press kits for journalists produced and ready for distribution. Public relations and other activities with journalists supported.</p> <p>Over 30 workshops for journalists, traditional and religious leaders and other special target groups executed.</p> <p>Audiovisual equipment provided to over 30 institutions.</p> | <p>During FHS I, the IEC Division worked with both public and private institutions at the state and federal government levels as noted below.</p> <ul style="list-style-type: none"> • Federal Ministry of Health, Education Branch — print materials production • Federal Ministry of Health, Department of Population Activities — national multimedia campaign, Lagos • State Ministries of Health — multimedia campaigns, inclusive of counselling and social mobilization • Federal and State media houses — television and radio scripting and production • Planned Parenthood Federation of Nigeria — national multimedia campaign: sexual-responsibility songs and print materials production • National Council for Population activities — advocacy support materials for journalists and other influentials • Advertising Agencies — national and state multimedia campaigns • Research Firms — qualitative and quantitative research studies • Distribution Companies — materials distribution and media placement • Production Houses — scripting and production • IEC Consultant Network — materials development, counselling training, research and evaluation, IEC training, project management <p>Personnel in the above institutions received formal training in IEC, as well as on-the-job training through provision of technical assistance from FHS.</p> | <p>In general, FHS II should expand its use of the private sector to meet the high demand for IEC interventions. Institution building in IEC should be continued within the public sector. However, it should be done with the recognition that the outputs and capabilities will be more relevant to long-term technical sustainability rather than addressing immediate IEC need.</p> <p>Key institutions to work with IEC during FHS II include:</p> <ul style="list-style-type: none"> • Planned Parenthood Federation of Nigeria — multimedia campaigns, development of PPFN as an IEC resource agency for others in Nigeria, print and mass media materials development, piloting new and innovative IEC initiatives. • National Council for Population Activities — advocacy support for policy makers, journalists, and other influential people. • FMOH-Health Education Branch — Large scale print materials production and distribution. • State Ministries of Health and Media Houses — mobilization campaigns to provide complementary localized and grass roots orientation for larger, umbrella mass media campaigns • Advertising Agencies, Public Relations Firms, Production Houses, Distribution Companies, Research Agencies, and Consultants — planning and implementation of multimedia campaigns at national, regional and state levels. Management linkages between these agencies and public and private sector service delivery entities will be critical. <p>Consideration should also be given to how agencies, such as those listed above, can best be supported to contribute to the IEC efforts.</p> |

Appendix A

| Target | Responsible Division | Achievements | FHS I Institution Building | FHS II Collaboration |
|--|---|--|--|--|
| <p>Family Planning information services and or commodities provided through approximately 2,000 private sector outlets.</p> <p>70% of contraceptive users served through the private sector.</p> <p>Distribution network established to provide private interests with commodities.</p> <p>Private sector trained in providing family planning information, services and or commodities.</p> | <p>Private Sector (FPIA and sub-contractors)</p> | <p><u>General</u></p> <p>Over 6,600 private sector health facilities and outlets have been provided commodities and training for personnel.</p> <p><u>Specific</u></p> <p>More than 4,500 distributors and trading companies are selling family planning commodities.</p> <p>Nearly 30 trainers equipped to train private sector providers.</p> <p>2,250 nurses from private sector trained in clinical services including IUCD insertion.</p> <p>4,395 pharmacy personnel trained in family planning methods and counseling.</p> <p>Over 1,400 vendors trained to provide family planning counseling and services.</p> <p>Advertising campaign executed for Right Time Condom. OCs advertised through trade journals.</p> | <p>The private sector during FHSI collaborated with both for-profit and non-profit private sector groups. Emphasis was placed on training providers, equipping sites, providing of commodities and conducting outreach activities.</p> <p>Collaborating agencies included NKST and other hospital networks; state branches of National Association of Nigerian Nurses/Midwives; Women's NGOs such as COWAN and NCWS; parastatal organizations such as NITEL.</p> <p>Other more retail-oriented operations were supported through training of pharmaceuticals personnel and the social marketing effort of the Right Time condom through Sterling Pharmaceutical.</p> <p>Through its projects which encompassed different types of service delivery and support models, FHS has learned a great deal about the efficiencies and inefficiencies of these systems in the Nigerian context. FHS II can draw on this experience in expanding the market and build on the foundation already laid with numerous private sector entities.</p> | <p>FHS II should continue working with the private sector entities supported during FHS I. Opportunities should also be sought to expand services through similar groups in other states.</p> <p>In building on the gains made during FHS I, attention should be focused on:</p> <ul style="list-style-type: none"> • Strengthening support systems for existing service delivery projects such as referrals, IEC, supervision and management. • Expanding the social marketing program to marketing program to include multiple products with a broader geographical coverage. • Implementing service delivery projects where other supporting FHS structures are in place. |
| <p>Family planning and health-related information and services provided through at least 3,600 public service delivery points.</p> <p>30% contraceptive users served through the public sector.</p> <p>Clinical service delivery points equipped.</p> <p>Public sector health personnel trained to provide improved information services and program management.</p> | <p>Public Sector (Pathfinder and Sub-contractors)</p> | <p><u>General:</u></p> <p>Over 3,000 public sector staff trained in service delivery and 500 facilities equipped for family planning services including IUCD insertion.</p> <p><u>Specific:</u></p> <p>Standards of practice for family planning developed and distributed in collaboration with Federal Ministry of Health.</p> <p>Standard family planning curricula developed, pretested, and finalized for pre-service training in Schools of Midwifery and Schools of Health Technology. Curriculum development underway for Schools of Nursing and Medical Schools.</p> <p>Standard curricula developed for CSPs, CHEWs, VHWs and physicians.</p> | <p>Work in the public sector focused on developing adequate standards and structures from the national level for family planning service delivery, as well as increasing service availability through public sector SDPs.</p> <p>Key counterparts for the public sector included the federal Ministry of Health, Department of Primary Health Care; the Schools of Health Technology, Midwifery and Nursing; and state family planning units operating under the auspices of Primary Health Care.</p> <p>At the national level the public sector division was instrumental in:</p> <ul style="list-style-type: none"> • Establishing standard in-service curricula for all levels of public sector personnel; • Developing and publishing a Standards of Practice manual for family planning; | <p>In the public sector, FHS should continue its institution building with both the Federal Ministry and the State MOHs. Greater emphasis should be placed on working with selected LGAs and service delivery points, however, to improve quality of care, increase availability of longterm contraceptive methods and to address management and systems related issues.</p> <p>Work should also continue with pre-service training institutions to monitor progress and to establish a similar program within the medical institutions.</p> <p>In line with the directions taken during the FHS I transition period, training, commodities support, monitoring and evaluation, general IEC interventions, and other cross cutting technical supports should be provided for both public and private service delivery groups through central entities where appropriate.</p> |

Appendix A

| Target | Responsible Division | Achievements | FHS I Institution Building | FHS II Collaboration |
|---|---|---|---|---|
| <p>Management systems for family planning programs developed and or improved.</p> | <p>Public Sector <i>(continued)</i></p> | <p>National MIS system for family planning developed and operational under primary health care system. Training provided in public sector for 1,623 midwives; 84 physicians; 1,415 CHEWs; 1,062 VHVs. Refresher training provided for 219 midwives and 50 physicians.</p> <p>Management, supervisory, MIS, organizational development and commodities management training provided for over 1,500 public sector employees.</p> | <ul style="list-style-type: none"> • Integrating family planning into pre-service curricula for midwives, health technology and nursing; • Assisting with the development and institutionalization of an MIS system for family planning; <p>Developing technical expertise through the consultant network system to support ongoing projects and service delivery efforts.</p> <p>All of these interventions have been key in strengthening the family planning program within the primary health care system.</p> <p>At the state level, the division was key in:</p> <ul style="list-style-type: none"> • Developing state training teams to support state level expansion of services. • Expanding service availability through training additional personnel. • Equipping and upgrading facilities • Strengthening management and other support systems to facilitate provision of family planning services through the public sector. <p>With many of these critical basic tasks achieved, FHS II can now look towards upgrading of services, improving quality of care, and management support systems to enhance the overall effectiveness of the public sector program.</p> | |
| <p>A capability for policy implementation and strategic planning for the national family planning effort.</p> <p>National, state and LGA family planning program policies, strategies and action plans established.</p> | <p>Policy and Evaluation (JHU/IIP)</p> | <p><u>General</u> Over strategic planning and constituency building workshops executed with government officials, religious and traditional leaders and non-governmental organizations.</p> <p>Numerous studies undertaken to assess cost recovery, leadership opinion and contraceptive requirement trends.</p> <p><u>Specific:</u> Further Analysis Group convened and supported to produce and publish Policy Analysis of the Nigeria Demographic and Health Survey.</p> | <p>The Policy and Evaluation Division worked with NGOs, public sector institutions and opinion leaders to create a supportive environment for the family planning. Specific areas of concentration included strategic planning and information dissemination through publications and symposia.</p> <p>Key groups with which the Policy Division collaborated included:</p> <p>Federal Ministry of Health, Department of Population Activities — Publications: Population Policy and Pop Talks; Symposium.</p> | <p>NCPA and the FMOH/DPA should remain the two key institutions through which advocacy efforts are carried out during FHS II. Other institutions with which FHS I collaborated should be considered along with others in the context of the following:</p> <ul style="list-style-type: none"> • Reaching greater numbers of top level policy makers • Broader and more frequent dissemination of information to policy and opinion leaders; • Implementing of constituency-building activities in geographical areas where other program interventions are underway. |

Appendix A

| Target | Responsible Division | Achievements | FHS I Institution Building | FHS II Collaboration |
|---|---|--|---|---|
| <p>Positive support from influential and constituency groups and NGOs for family planning expansion.</p> <p>Establishment of processes for evaluation policy and program acceptability.</p> | <p>Policy and Evaluation <i>(continued)</i></p> | <p>Over 1,300 representatives of government, non-governmental religious and traditional groups oriented on family planning and the population policy.</p> <p>Strategic planning workshops conducted in ten states; Fact Finding missions conducted in eight states.</p> <p>Publications of "Pop Talk" and "Family Health" developed and distributed to over 5,000 constituency groups and opinion leaders.</p> <p>Population policy translated and printed in three vernacular languages.</p> <p>Public sector cost recovery survey conducted.</p> | <p>Planned Parenthood Federation of Nigeria —Symposium for traditional and religious leaders.</p> <p>MAMSER — Symposium and orientation for MAMSER personnel.</p> <p>Women's NGOs such as NCWS, University Women, Better Life for Rural Women, Nigeria Labor Congress/ Women's Branch — Symposium for members.</p> <p>Traditional and Religious Entities — Symposium.</p> <p>Further Analysis Group — Publications.</p> <p>Nigerian Institute for Policy and Strategic Planning; Centre for Democratic Studies — Symposium.</p> <p>The activities of this division were key to sensitizing many politically powerful and influential groups in the country to the intent of the population policy and the need for their support.</p> | <p>In addition, FHS II should consider supporting prominent Nigerian academicians and researchers to carry out special studies. The results should be presented for deliberation and debate by opinion leaders, political figures and other scholars.</p> <p>FHS II should furthermore work closely with its advisory group. These individuals represent a powerful joint body, as well as being prominent and influential figures within their own areas of expertise. They should be called on to help shape and guide the structure of advocacy work and to contribute to implementation of advocacy activities.</p> |

APPENDIX B

History of Commodities and Logistics in Nigeria

A. Overview — 1988-1992

Since 1988, USAID has been involved in the distribution of contraceptives for both the public and private sectors. Family Planning Assistance International (FPIA) was awarded a contract to expand private sector involvement, train private providers and provide contraceptives. All private sector outlets developed a revolving fund to enable procurement of contraceptives on a continuing basis. This was not established in the public sector.

FPIA was responsible for forecasting all contraceptive needs, procuring supplies through funds available in its contract, shipping and arranging for clearance at the port and delivery to the Sterling warehouse. Sterling Products, a sub-contractor to FPIA was responsible for the distribution of contraceptives throughout the country, utilizing its zonal warehouse system. Although the logistics system improved over time, it was plagued by frequent stock-outs and maldistribution at the service delivery points (SDPs). One site would have a year's supply of contraceptives while a neighboring SDP would not have any supplies. There was little transfer among administrative units. As a result many acceptors could not obtain desired services due to stock-outs and contraceptives were wasted as a result of expiration.

Contraceptive Supplies Distributed by Sterling, 1988-February 1993

- PILLS 4,557,309
- CONDOMS 31,128,792
- VFTS 1,394,595
- IUCDS 43,958

The Society for Family Health (SFH), incorporated in 1985, immediately began testing the concept of social marketing through support from the Population Crisis Committee. In 1990, with assistance from Population Services International (PSI) and USAID/Nigeria, SFH began social marketing Gold Circle (No-Color) condoms in three states (Lagos, Osun and Oyo).

Since SFH was basically a one-man show and restricted to only three states, it had a rather slow start, in 1990 1.13 million condoms were sold. In 1991, the memo of understanding between USAID/Nigeria and SFH was renegotiated and allowed expansion of its geographic area. SFH began to use two Nigerian organizations, Pharco and Togaphram, to distribute contraceptives throughout the country.

Within two years, SFH had a distribution system throughout the country — in 1992 7.05 million were sold. While it was felt that a great demand existed for this product, frequent stock-outs of supply limited a larger market share. Gold Circle was targeted at C and D population with its recommended price at N1.00 for a package of four condoms. As a result of inflation and devaluation of the naira, the price has

increased steadily over time. The 1994 recommended price is N3 for a four-pack – still affordable to the target population.

In April 1991, Sterling Products, Ltd., launched its social marketing campaign for Right Time condoms (Panther). The product was originally designed to reach A, B, and C urban and semi-urban populations. This product was rather expensive - N4.50 for a package of three condoms. It was questioned whether this price was really affordable for the target population. Despite extensive advertising campaigns and widespread distribution, Right Time did not produce the magnitude of sales predicted – in 1992 only three million were sold.

B. Transfer of Responsibilities — 1993

The FPIA contract was scheduled to end on December 31, 1992. Concurrently, USAID/W made it mandatory for all Missions to procure their contraceptives from the central contraceptive project. Therefore, the FPIA contract was only extended until February 28, 1993 in order to provide a smooth transition to this new system.

Sterling, as a worldwide corporation, decided it no longer wanted to be involved with FP products. Therefore, PSI/SFH was awarded an eighteen-month grant (March 31, 1993 to June 30, 1994) to supply contraceptives for both AIDS prevention and FP to USAID's private sector partners. Additionally, PSI/SFH would market condoms as well as other FP products, such as pills.

FPIA had high expectations for the Right Time product line. It was anticipated that a Right Time pill might be the next product marketed. Unfortunately, Right Time did not perform as well as expected, creating a huge surplus of condoms (11 million). The Mission decided to have these condoms tested prior to shipping. Although they were stored in the United States under good conditions, all failed the quality indicator tests. Lot A, approximately six million condoms registered 31 CQI out of 100, indicating immediate destruction, which the Mission authorized. Lot B, approximately five million, received 52 CQI indicating use within one year. Many attempts were made to find other countries to utilize these products, but Panther condoms were being phased out as part of USAID/W's standardization process, so no other country was interested in this product. As a result of delays in shipping and distribution, the Mission decided it was better to destroy these condoms (Lot B) instead of having a situation with expired condoms being distributed to consumers. (Note: All 11 million condoms were destroyed in the US prior to being shipped.)

On March 1, 1993, the Mission authorized the transfer of all contraceptives from Sterling and FPIA to PSI as presented below.

Transferred from Sterling to PSI (Nigerian warehouse)

| | |
|----------------------|-----------|
| Panther condoms..... | 5,000,000 |
| Noriday | 727,000 |
| Norquest..... | 1,087,200 |

Transferred from FPIA to PSI (US Warehouse)

| | |
|-------------------|-----------|
| Conteptrol | 638,000 |
| Flower Logo | 705,600 |
| IUCDs | 30,000 |
| Lo-Femenal | 445,200 |
| Noriday | 1,033,200 |
| Noriquet | 321,600 |
| Overette | 270,000 |

In addition to the transfer of these products, USAID/Nigeria reimbursed Sterling for products that it bought out-right from FPIA. This sum of \$38,260 was for 504,000 packaged Blue Panthers, 783,000 unpackaged Blue Panthers and various packaging materials.

Also at this time, USAID/W was in the process of trying to standardize its procurement of contraceptive products. Shifting from one brand to another in a huge market like Nigeria is a big challenge and requires a lot of communication and planning.

Gold Circle condoms changed from No-Logo, No-color to Blue and Gold condoms, which were distributed in the private sector while the public sector continued to receive No-Logo No-Color. Oral contraceptives (OCs) were standardized on Lo-Femenal for the public sector and a private sector pill was suppose to be available. The transition for condoms went very smoothly but was more problematic for OCs. Due to contracting difficulties, the private sector pill has been slow to come on board forcing USAID to supply Lo-Femenal to both sectors for the last year. In late 1994, the contract was finally signed (for Duofem) and it is anticipated that by late 1995 Duofem will be distributed as the private sector pill in Nigeria.

C. PSI — Private Sector

PSI/SFH has greatly enhanced availability and use of FP products in Nigeria; couple year of protection (CYP) has risen from 47,000 in 1992 when they were only marketing condoms to 425,553 CYP in 1993 by diversifying their methods, outlets and employing the services of a different distributor, WAD. Preliminary results for 1994 — from January through October — indicate a similar upward trend to 598,787 CYP.

PSI has been able to achieve these results by greatly enhancing its sales force and marketing team, securing its own warehouse and utilizing more efficient distributors. From 1990-92, PSI/SFH's main distributors were Togopharm and Pharco, two Nigerian companies. As a result of various weaknesses in these organizations, PSI/SFH began, in 1993, seeking new, more efficient distributors. PSI developed a close partnership with West African Drug (WAD), which has a mobilized sales force and eight regional offices. This arrangement allowed PSI to effectively distribute stock throughout the country with minimal investment in warehouses, vehicles and personnel.

Under the FHS project, there were 30 private sector sub-project that required contraceptives. PSI worked with these organizations to estimate contraceptive needs and then provide a six-month supply free of charge as "seed stock" to establish a contra-

ceptive revolving fund. After the initial stock was depleted, the organizations would procure their contraceptives from one of WAD's regional offices. The PSI sales force provided TA to these organizations to enhance the efficiency of the system.

These sub-projects required varying amounts of contraceptives depending on the structure, personnel, clientele and size. As a group, the sub-projects constitute 2% of all condoms distributed by PSI, 20% of VFTS, 13% of OCs and 12% of IUCDs.

In addition to these sub-projects, PSI, through its affiliation with WAD, distributed contraceptives to patent medicine shops, pharmacies, private hospitals and clinics and other outlets. Progress in this area is reflected below.

| | 1993 | | 1994 ¹ | |
|--------------------|------------|---|-------------------|----------------|
| | Sales | CYP | Sales | CYP |
| Gold Circle | 20,752,210 | 138,348 | 28,661,653 | 191,078 |
| Right Time | 3,032,463 | 20,216 | 1,815,595 | 12,104 |
| OCs | 3,250,000 | 216,679 | 3,425,300 | 228,353 |
| VFTs | 867,500 | 5,783 | 1,918,000 | 12,786 |
| IUCD | 12,727 | 44,527 | 44,133 | 154,466 |
| Total CYP | | 425,553 | | 598,787 |
| <i>Source: PSI</i> | | <i>¹January through October only</i> | | |

D. PSI — Social Marketing

Social marketing has been the main avenue of increased availability of contraceptives to consumers. Gold Circle condoms have received a lot of attention through mass media, e.g. radio and TV, as well as other forms of advertising, e.g. billboards. In 1993, 23 million condoms were sold, up from 7.05 million in 1992. Although 1994 has been beset with strikes and demonstrations, preliminary figures reflect sales figures at 26 million as of August 31, 1994.

OCs have been more difficult to market as a result of changing brands received and the inability within Nigeria to advertise pills by brand. Vaginal foaming tablets (VFTs) have also been sold. However, quantities are not as high as the other products — 1.9 Million in 1994.

E. PSI — HIV/AIDS Prevention and Control

PSI worked with AIDSCAP to provide condoms to the AIDS sub-projects — three to date, which constitutes less than 1% of all the Gold Circle condoms marketed throughout the country. Gold Circle is marketed as prevention against AIDS as well as for family planning purposes. PSI has worked with the National AIDS Surveil-

lance and Control Programme to launch Gold Circle television commercials and involve traditional and local leaders by listening to their views on condoms.

PSI plans to expand condom distribution to more untraditional outlets, such as brothels, bars, universities etc. It also plans to increase its enter-educate advertising through such forums as dances for youths.

F. FHS Assistance to the Public Sector

FHS has been working with the FMOH to ensure an adequate in-country commodity supply with timely distribution. In October 1992, the Nigeria government expressed a great desire to be responsible for its commodities and logistics system. Therefore, with FPIA leaving the country, a division was created in FHS to provide TA to the government. It was first composed of two persons based in Lagos and then an additional person placed in each zonal office for a total of six persons tasked with monitoring the public sector commodities system.

When the FMOH requested this responsibility, it had no capacity in terms of resources or trained personnel to implement the system. Therefore, FHS continued operating the commodities logistics system while the FMOH personnel were being trained to assume this responsibility. Although the FMOH expressed its desire to implement this system, it was an arduous task to get them to follow through on any aspect of the system that had been agreed to. As a result, FHS basically had to run the whole system to ensure that commodities were delivered to the end users. From October 1992 until November 30, 1994, FHS financed the following:

- Refurbishment and upgrading security of the central (oshdi) warehouse
- Twenty-four-hour security of the oshdi warehouse
- Salary of storekeeper at oshdi warehouse
- Commercial transportation of the supplies to state warehouses, quarterly
- Refurbishment and upgrading security for four zonal warehouses
- Physical inventories of state and zonal warehouses
- Collection and analysis data from state FPC, quarterly
- Preparation of CPTs
- clearance of contraceptives from port

FHS also provided external TA to increase the institutional capacity of the FMOH in implementing this system. One person from FMOH was trained in the United States by the Family Planning Logistics Management (FPLM) project. In June 1993, FPLM trainers conducted a training for federal and zonal personnel on commodities management. Unfortunately, this course was not well-attended because of the riots in the country.

In November 1993, FHS, in conjunction with FMOH staff, trained 15 master trainers, who in turn trained four persons from each state, countrywide, in commodities logistics management. A training for LGA personnel has been planned by the Population Activities Funding Agency (PAFA-World Bank) for nearly two years. USAID/Nigeria was going to collaborate by financing the trainers. However, difficulties accessing PAFA funds were encountered and the training has never taken place.

G. Decertification

As a result of decertification and subsequent restrictions placed on USAID/Nigeria, the program can no longer directly support the GON. This policy required that all assistance to the Government be terminated as of December 1, 1994. Therefore, USAID has implemented a three-fold strategy: (1) to ensure continuation of the contraceptive supply until another mechanism is in place; (2) greater involvement of the private sector; and (3) identify other contraceptive sources.

1. Phase-out from the Public Sector

Close-out activities for the public sector commodities system, to be completed by November 30, 1994, included:

- Physical inventories of all state warehouse inventories to assess the status of supply
- Development of a re-distribution plan to rationalize the allocation of supplies
- Facilitating a forecasting workshop for FMOH personnel
- Provision of six month "seed stock," based on previously six months consumption data, to allow services to continue on an uninterrupted basis

USAID/Seed Stock to be Delivered by November 30, 1994

- CONDOMS 1,008,000
- IUCDS 20,400
- LO-FEMENAL 239,600
- VFTS 510,000

2. Expansion of the Private Sector

As a result of decertification all shipments ordered by USAID/Nigeria were halted. The Mission obtained special authorization from US/GC to continue shipments for the private sector. In June 1994, the Mission also obtain authorization to re-program shipments previously ordered for the public sector to the private sector. These shipments included 3,354,000 condoms, 750,000 VFTs and 93,600 IUCDs.

PSI/SFH will play an even larger role in the program in the future. USAID/Nigeria awarded PSI/SFH another two-year grant – September 1994 to October 1996 – to

continue its activities and begin social marketing of Depo-provera, IUCDs and possibly ORS solution. Although the public sector can not receive any more contraceptives from USAID, the mission is still importing the same amount of contraceptives in the 1995 forecast, based on overall consumption. The only change is that distribution will only be conducted through one sector.

3. Donor Coordination

The third strategy was to actively seek out other donors to coordinate USAID/Nigeria's efforts. Results of this have been very fruitful. UNFPA has agreed to finance the operational costs of maintaining the commodities logistics system for one year, ending December 1995. This includes payment of security guards at the central warehouse, transportation between administrative levels, and hiring five field commodities and logistics officers who will provide assistance to the government personnel.

ODA has also agreed to collaborate in this effort. It will provide overseas training for governmental personnel in the area of commodities and logistics management. UNFPA has a signed document with the National Primary Health Care Agency to implement this program beginning December 1, 1995.

The USAID-donated "seed stock" is suppose to provide a buffer so that UNFPA has some time to get involved in the system before distribution is necessary. Once this stock runs out (approximately in March 1995), UNFPA will be in a position to fulfill requirements from its own supplies. One area where there may be a shortfall is IUCDs. This has been discussed with ODA and it is exploring the possibility of undertaking a one-time procurement to fill this gap, approximately 72,000 IUCDs for March to December 1995.

Regarding contraceptive supplies, UNFPA will procure one million cycles of Microgyn, 750,000 vials of Depo-Provera and 750,000 vials of Noriestrat.

I. Future Actions

USAID, UNFPA and ODA have also worked very closely with the government and the World Bank (PAFA) to develop a three-year proposal (1996-1999). This would cover operational costs of the commodities logistics system until the government can establish a procurement system for contraceptives and allocate funds to this effort, i.e. budgetary line item.

A draft proposal has been developed. However, there has been difficulty clarifying roles and responsibilities of the various implementors. This is particularly true regrading the central warehouse. **TIME IS RUNNING OUT.** If this proposal is not submitted to Washington by January 31, 1995, it is highly unlikely that the government will be able to procure contraceptives or maintain a functioning commodities logistics system in 1996 and susbequent years.

USAID/Nigeria's colleagues in both the World Bank Nigeria and Washington are excited about assisting the government to establish these systems. However, this **must** be followed up by all the donors to see it through to fruition.

APPENDIX C

NIGERBUS Family Planning Monitor in Nigeria — October and December 1992

| | Oct '92 | | Dec '92 | |
|---|---------|----|---------|----|
| | # | % | # | % |
| 1. Have you heard of any family planning method, child spacing, or other methods that can be used to prevent pregnancy? | 4002 | 47 | 4000 | 55 |
| 2. Which family planning methods have you heard of? (for those who have heard of FP) | 1874 | | 2212 | |
| Oral pills | | 64 | | 70 |
| Condom | | 55 | | 55 |
| Foaming tablets | | 23 | | 18 |
| Diaphragm | | 7 | | 8 |
| Norplant | | 4 | | 5 |
| Injectable | | 45 | | 46 |
| IUD/Coil | | 18 | | 21 |
| Male Sterilization | | 5 | | 4 |
| Female Sterilization | | 5 | | 4 |
| Thermomer/rhythm/billing | | | | |
| Calendar/safe period | | 18 | | 18 |
| Withdrawal | | 8 | | 9 |
| Traditional | | 8 | | 8 |
| Periodic abstinence | | 4 | | 5 |
| Others | | 1 | | 3 |
| 3. From what source have you heard about family planning/child spacing? | 1874 | | 2212 | |
| Husband/wife/partner | | 5 | | 5 |
| Other relatives | | 7 | | 6 |
| Friends | | 23 | | 28 |
| Doctor/Nurse/FP provider/ other health worker | | 63 | | 55 |
| Public meetings/forum | | 6 | | 3 |
| Trad. opinion leader | | 2 | | 2 |
| Religious opinion leader | | 2 | | 1 |
| Schools/teachers/others | | 8 | | 12 |
| Radio | | 24 | | 24 |
| TV | | 19 | | 20 |
| Newspapers/magazines | | 13 | | 13 |
| Other print media | | 3 | | 4 |
| Other sources | | 1 | | 3 |

Appendix C

| | Oct '92 | | Dec '92 | |
|---|---------|----|---------|----|
| | # | % | # | % |
| 4. Do you approve of couples that use family planning and child spacing methods? | 1874 | 82 | 2212 | 82 |
| 5. Can you tell me why you don't approve of family planning? | 320 | | 375 | |
| Against religion | | 53 | | 57 |
| Harmful/side effects | | 16 | | 15 |
| It is not natural | | 9 | | 13 |
| I am in need of children | | 8 | | 8 |
| Spoils woman's womb | | 1 | | 2 |
| Others | | 3 | | 7 |
| It is a sort of community | | | | |
| Abortion | | 1 | | 1 |
| Against culture | | 1 | | 1 |
| Causes death of women | | 3 | | 1 |
| Increases corruption | | 2 | | 1 |
| 6. Have you or your spouse used any family planning or child spacing methods in the last two months? | 564 | 61 | 733 | 64 |
| 7. Have you or your spouse ever used any family planning or child spacing methods to prevent pregnancy? | 1538 | 37 | 2212 | 33 |
| 8. How long have you been using your current method? | 346 | | 471 | |
| Under 1 month | | 3 | | 3 |
| 1 - 2 months | | 7 | | 3 |
| 3 - 6 months | | 12 | | 10 |
| 7 - 12 months | | 22 | | 21 |
| 13 - 24 months | | 20 | | 20 |
| 25 - 36 months | | 13 | | 15 |
| 37 - 48 months | | 4 | | 6 |
| 49 - 60 months | | 5 | | 5 |
| 61 - 72 months | | 2 | | 3 |
| 73 + | | 12 | | 13 |

Appendix C

| | Oct '92 | | Dec '92 | |
|---|---------|----|---------|----|
| | # | % | # | % |
| 9. Where did you get the method you are currently using? | 346 | | 471 | |
| Government Hospital | | 18 | | 19 |
| Government health center/ maternity.FP clinic | | 16 | | 16 |
| Government Doctor | | 7 | | 5 |
| Private Doctor | | 11 | | 4 |
| Private health center/ maternity center/family planning clinic | | 11 | | 8 |
| PPFN | | 5 | | 4 |
| Pharmacy shops | | 3 | | 1 |
| Chemist/patent medicine store | | 9 | | 9 |
| Spouse/partner | | 5 | | 4 |
| Place of work | | 1 | | 1 |
| Church | | 1 | | - |
| Friends | | 6 | | 9 |
| Others | | 3 | | 4 |
| Respondents' use non-supply method | | - | | 6 |

Appendix C

NIGERBUS Family Planning Monitor in Nigeria October 1993 - April, 1994

| | 1993 Oct. (n=4,000) | Dec (n=4,042) | 1994 Feb (n=3,948) | Apr (n=4,024) |
|--|---------------------------|------------------|--------------------------|------------------|
| 1. Have you heard of any family planning method, child spacing, or other methods that can be used to prevent pregnancy? (QFP4) | 52% | 54% | 56% | 50% |
| | Oct (n=2,093) | Dec (n=2,174) | Feb (n=2,2203) | Apr (n=1,998) |
| 2. Which family planning methods have you heard of? (QFP5) | | | | |
| Oral pills | 76 | 75 | 74 | 74 |
| Condom | 65 | 61 | 70 | 78 |
| Foaming tablets | 14 | 14 | 16 | 19 |
| Diaphragm | 8 | 5 | 10 | 10 |
| Norplant | 3 | 4 | 6 | 5 |
| Injectable | 54 | 51 | 55 | 52 |
| IUD/Coil | 24 | 25 | 24 | 22 |
| Male Sterilization | 10 | 7 | 10 | 14 |
| Female Sterilization | 12 | 13 | 17 | 17 |
| Thermomer/rhythm/billing calendar/safe period | 25 | 19 | 28 | 28 |
| Withdrawal | 16 | 9 | 12 | 19 |
| Traditional | 11 | 12 | 13 | 18 |
| Periodic abstinence | 8 | 7 | 6 | 8 |
| Others | 1 | 1 | 2 | 1 |
| | Oct (n=2,093) | Dec (n=2,174) | Feb (n=2,203) | Apr (n=1,998) |
| 3. From what source have you heard about family planning/child spacing? (QFP9) | | | | |
| Husband/wife/partner | 5 | 8 | 5 | 11 |
| Other relatives | 5 | 7 | 6 | 10 |
| Friends | 23 | 25 | 26 | 30 |
| Doctor/Nurse/FP provider/ other health worker | 59 | 59 | 58 | 56 |
| Public meetings/forum | 6 | 6 | 6 | 8 |
| Trad. opinion leader | 2 | 2 | 2 | 2 |
| Religious opinion leader | 3 | 3 | 4 | 4 |
| Schools/teachers/others | 14 | 12 | 15 | 15 |

Appendix C

| | | | | |
|----------------------|----|----|----|----|
| Radio | 28 | 23 | 27 | 35 |
| TV | 20 | 17 | 24 | 31 |
| Newspapers/magazines | 12 | 10 | 14 | 17 |
| Other print media | 2 | 3 | 3 | 4 |
| Other sources | 1 | 1 | 1 | 1 |

*Calculations of 2 & 3 are based on only those that have heard of family planning/child spacing.

| | Oct (n=317) | Dec (n=300) | Feb (n=338) | Apr (n=195) |
|---|----------------|----------------|----------------|----------------|
| 7. Can you tell me why you don't approve of family planning (QFP16) | | | | |
| Against religion | 63 | 59 | 62 | 60 |
| Harmful/side effects | 20 | 13 | 17 | 14 |
| It is not natural | 9 | 11 | 9 | 12 |
| I am in need of children | 6 | 8 | 4 | 4 |
| Spoils woman's womb | 3 | 3 | 4 | 2 |
| Others | 3 | 5 | 3 | 6 |
| It is a sort of community abortion | 2 | 3 | 1 | 4 |
| Against culture | 2 | 3 | 2 | |
| Causes death of women | 1 | | | |
| Increases corruption | 1 | | 1 | |

*Calculations of 7 are based on only those that have heard of family planning/child spacing and did not approve of family planning or child spacing.

| | Oct (n=2,093) | Dec (n=2,174) | Feb (n=2,203) | Apr (n=1,998) |
|--|------------------|------------------|------------------|------------------|
| 8. Have you or your spouse used any family planning or child spacing methods in the last two months? (QFP17) | 22% | 26% | 24% | 27% |

*Calculations of 8 are based on only those that have heard of family planning/child spacing.

| | Oct (n=1,630) | Dec (n=1,600) | Feb (n=1,682) | Apr (n=1,456) |
|---|------------------|------------------|------------------|------------------|
| 9. Have you or your spouse ever used any family planning or child spacing methods to prevent pregnancy? (QFP19) | 17% | 17% | 20% | 23% |

*Calculations of 9 are based on only those that have heard of family planning/child spacing and have not used any family planning method within the past 2 months.

Appendix C

| | Oct (n=2,093) | Dec (n=2,174) | Feb (n=2,203) | Apr (n=1,998) |
|---|------------------|------------------|------------------|------------------|
| 10. How long have you been using your current method? (QFP21) | | | | |
| Under 1 month | 2 | 1 | | |
| 1-2 months | 3 | 2 | | 3 |
| 3 -6 months | 14 | 11 | | 11 |
| 7-12 months | 20 | 16 | | 19 |
| 13-24 months | 23 | 24 | | 23 |
| 25-36 months | 18 | 17 | | 17 |
| 37-48 months | 7 | 9 | | 9 |
| 49-60 months | 5 | 7 | 2 | |
| 61-72 months | 4 | 4 | 3 | |
| 73 + | 5 | 9 | 9 | |

*Calculations of 10 are based on only those that have heard of family planning/child spacing and used any family planning method within the past 2 months.

| | Oct (n=690) | Dec (n=777) | Feb (n=779) | Apr (n=542) |
|--|----------------|----------------|----------------|----------------|
| 11. Where did you get the method you are currently using? (QFP22) | | | | |
| Government Hospital | 18 | 18 | 18 | 21 |
| Government health center/ maternity.FP clinic | 15 | 12 | 13 | 11 |
| Government Doctor | 4 | 3 | 3 | 4 |
| Private Hospital | 10 | 6 | 8 | 9 |
| Private health center/ maternity center/family planning clinic | 16 | 19 | 4 | 9 |
| Private doctor | 2 | 1 | | |
| PPFN | 1 | 2 | 2 | 2 |
| Pharmacy shops | 2 | 2 | 3 | 7 |
| Chemist/patent medicine store | 10 | 7 | 11 | 20 |
| Market | | | | 1 |
| Spouse/partner | 4 | 5 | 3 | 1 |
| Place of work | 1 | 1 | 1 | 1 |
| Church | 1 | 1 | 1 | |
| Friends | 10 | 12 | 13 | 6 |
| Others | 2 | 3 | 2 | 1 |
| Respondents' use non-supply method | 3 | 7 | 8 | 4 |

*Calculations of 11 are based on only those that have heard of family planning/child spacing and used any family planning method within the past 2 months.

APPENDIX D

FHS NEWS UPDATE August 1993, Vol. 2 No. 1

APPENDIX E

FHS PUBLICATIONS

CONTRACEPTION (VSC QUALITY ASSURANCE)

Voluntary Surgical Contraception Quality Assurance and Management in Nigeria (Report of A Service Providers/Managers conference -Jos, Nigeria), AVSC (1987)

CONTRACEPTION (VSC SUSTAINABILITY)

AVSC (1989)

Sustainability of Voluntary Surgical Contraception Services in the National Family Planning Program of Nigeria (Report of a meeting held at the Central Hospital, Benin City, Aug. 13-16 1989)

SYNOPSIS: One of the major topics of discussion at that meeting was the identification of the need to make VSC services in Nigeria self-sustaining

CONTRACEPTIVE LOGISTICS

Jaramillo, M. and Ibe, I. 1992

Contraceptive Logistics Systems in Nigeria (Draft Report)

SYNOPSIS: Chapters include: The market for contraceptives, Strategic Planning for contraceptive logistics, Contraceptive logistics in Nigeria.

CONTRACEPTION (IUD)

A Comparative Study of the TCU 380A IUD and the Lippes Loop D IUD in Zaria, Nigeria. FHI 1993

SYNOPSIS: The major objective of this study is to evaluate the use of the TCU 380A among women in particular geographical locations in Nigeria.

CONTRACEPTIVE MARKETING

Market Vendor Distribution of Contraceptives in Nigeria: A Synthesis of Experience and Achievements (Preliminary Draft) Jinadu, M.K., Phillips, J.F. and Kane, T. 1993

SYNOPSIS: A background review of the market vendor initiative in Nigeria, the approaches used, and findings and experience from pilot projects and research.

CONTRACEPTION (NORPLANT)

Pre-Introductory Clinical Trial of Norplant Contraceptive Subdermal Implants: Report on the Five-Year Experience at Five Family Planning Clinics in Nigeria. FHI, Ladipo, O.A., Otolorin, E.O., Adekunle, A. et al (1993)

SYNOPSIS: The principal objective of this report is to evaluate safety, efficacy, and overall acceptability of the subdermal implants in different populations in Nigeria.

DHS

Policy Analysis of the Nigeria Demographic and Health Survey 1990 FHS, FOS Lagos, JHU/IIP and USAID 1992

FAMILY PLANNING ANALYSIS

Family Planning in Nigeria (An Analysis of Family Planning Needs, Uses and Supply) Options/
Futures Group 1993

FAMILY PLANNING EQUIPMENT

The Nigerian Armed Forces and Police Family Planning Equipment Requirements - A Family lanning
Project Proposal

SYNOPSIS: Project proposal by Africare requesting a grant of \$527,571 from USAID to carry out a
1.5 year FP Project in the Armed Forces and the Police locations throughout Nigeria in association
with the national FHS Program and the FMOH.

FAMILY PLANNING EVALUATION

Report of Final Evaluation and Review of Niger/Abuja FHS Family Planning Project (CON 166-1)
Mbibi, N., Maidawa, L., Ababukar, A., Baba, M.L., et al 1993

FAMILY PLANNING POLICY

Private and Public Service Systems for Family Planning: Policy Assessment in Nigeria Lacey, L. and
Torrey, B. 1993

FAMILY PLANNING PROGRAM (Zone A)

FHS Zonal Periodic Report on Family Planning Services Onyejekwe, C. 1993

FAMILY PLANNING PROGRAM ("B" ZONE)

Report of Program Activities in B - Zone of the FHS Project Omotosho, G. 1993

FAMILY PLANNING PROGRAM (ZONE D)

Report on Up-Date of Family Planning Program Activities in Zone D Sept. 1993 Dangana, M. 1993

FAMILY PLANNING PROJECTS

A Performance Assessment of Six Rural Community Based Health and Family Planning Projects in
Five States of Nigeria (April 1993) Delano, G.E., Billings, J., Odejimi, S., Onatunde, A. and Oyediran,
K. 1993

SYNOPSIS: The immediate objectives of this report are as follows: 1) To identify the factors contrib-
uting to the low level of contraceptive distribution by VHWs, 2) To determine the reasons contributing
to the low level continuation by contraceptive users, 3) To assess the reliability of record keeping by
VHWs and the accuracy of project service statistics.

FAMILY PLANNING SITUATION ANALYSIS

Using Situation Analysis as a Strategy to Strengthen Managerial Innovation in the Family Planning

Program of Nigeria, Adewuyi, A. 1991 Nigeria Family Planning Situation Analysis Study, Adewuyi, A.A. et al 1992

SYNOPSIS: This study provides a comprehensive information on the availability, functioning, and quality of family planning services in Nigeria so that needed improvements and expansion can be planned and implemented.

FAMILY PLANNING SITUATION ANALYSIS

Niger State Family Planning Situation Analysis Study, Kisseka, M. 1992

SYNOPSIS: Study provides comprehensive information on the availability, functioning and quality of FP services in Niger state so that needed improvements and expansion can be implemented.

FAMILY PLANNING SITUATION ANALYSIS

Kano State Family Planning Situation Analysis Study, Ayoola, G.B. 1992

Benue State Family Planning Situation Analysis Study, Ajaegbu, H. 1992

Lagos State Family Planning Situation Analysis Study, Babalola, S. 1992

Analysis of the Nigerian Beneficiaries of the FHS Project: 1988 - 1992, Babalola, S., Babalola, S.B., Adesina, N. and Arogbofa, Y. 1993

SYNOPSIS: The study examines the benefits accrued to Nigerian individuals and institutions through the FHS project. Chapters include: budget analysis for each of the major contractors, determination of the number of primary and secondary beneficiaries of the project and determination of the institution-building aspects of the project.

FAMILY PLANNING STANDARD OF PRACTICE

Implementation of the Nigeria Family Planning Provider's Guide: A National Standard of Practice (A proposal submitted to The Pathfinder fund), FMOH/PHC (1990)

FAMILY PLANNING SURVEY

Nigerbus Family Planning Monitor (August 1993): Summarized Key Findings, Wehmann, P.F. 1993

SYNOPSIS: The findings of this survey provide adequate feedback regarding the effectiveness of FHS/IEC communication campaign efforts to family planning knowledge, attitude, and practice. This report compares the findings of the August 1992 with August 1993 data.

FAMILY PLANNING SURVEY

Abia & Imo State Family Planning Distribution Survey (Preliminary Report Aug. 1992), FHS 1992

SYNOPSIS: This report reflects findings from the April - June 1992 distribution survey done of all facilities which could or do dispense/distribute FP products and services in Abia State and Imo States.

FERTILITY SURVEY (MALE)

Male Fertility Attitudes: A Neglected Dimension in Nigerian Fertility Research, Adamchak, D.J. and Adebayo, A. 1987

SYNOPSIS: This paper examines the fertility attitudes of a sample of 202 male Nigerian students

studying in the United States. Three areas were investigated: 1) perceptions of population problems in Nigeria; 2) attitudes towards FP, divorce, and male children; and 3) attitudes toward family size.

FHS/IEC

FHS/IEC At A Glance, IEC 1993

SYNOPSIS: The booklet contains the following: 1) Indicators of Impact of PCS Projects in Nigeria, 2) FHS/IEC Project Summaries, and reports such as: a) Mass Media Family Planning Promotion in Three Nigerian Cities, b) Improving the Quality of Service Delivery in Nigeria, c) The Impact of a Mobile Drama on Family Planning Behavior in Ogun State, Nigeria.

FHS PROJECT PERFORMANCE REPORT

Nigeria Family Health Services Project: Performance Report, January 1993, FHS 1993

FHS PERSONNEL POLICY

Personnel Policies Handbook, FHS/PAF 1993

SYNOPSIS: Handbook of the rules and regulations governing employment within the Nigeria FHS project.

FHS LESSONS LEARNED

Lessons Learned Under the Nigeria Family Health Services Project (Phase I)

SYNOPSIS: A compilation on Lessons learned under the FHS project made by various components in August 1992

FHS/PUBLIC SECTOR

FHS/Public Sector - Procedures Manual (1991), FHS 1992

HEALTH AND POPULATION EVALUATION

Nigeria Health and Population Sector Assessment, Gibb, D., Heiby, J., Pielemeier, N., Wolf, P., Long, D. and Woodfill, C. 1991

SYNOPSIS: Directions for the USAID/Nigeria Mission to explore in the immediate future as a basis for designing a program to meet Nigeria's needs in the health and population sectors in the 90's.

MIS

The Family Planning Management Information System LGA and State Manual, FMOH

PPFN

Institutional Assessment of the Planned Parenthood Federation of Nigeria (April 1992), Weiss, E., McGovern, M., Olatokunbo, O. and Petrich, E. 1992

SYNOPSIS: The report considers a number of possible PPFN development options as a basis for assessing current institutional strengths and weaknesses.

RIS

Reports of Abia State Resource Intensification Strategy Seminar for SMOH and LGA Policy Makers (Sept. 14 and 16 1993), Okochi, E., Onumonu, C., Ikpeme, B, Opuiyo, R. and Ntekpere, M.

Anambra State Resource Intensification Strategy Orientation Seminar (Sept. 22 and 24, 1993), Weiss, E., McGovern, M., Olatokunbo, O. and Petrich, E. 1992

SFH REPORT

Society for Family Health's June Monthly Report, Clancy, P.H. 1993