PD-AAW-850

DEPARTMENT OF STATE

AGENCY FOR INTERNATIONAL DEVELOPMENT

SUB-PROJECT PAPER

FAMILY HEALTH INITIATIVES II - NIGERIA
698-0462.20

UNCLASSIFIED

AUTHORIZED: $67,000,000
July 9, 1987

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A = Add, C = Change, D = Delete — Amendment Number

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: Nigeria

3. PROJECT NUMBER: 698-0462.20

4. BUREAU/OFFICE: AFR — 06

5. PROJECT TITLE (maximum 40 characters): Family Health Initiatives II - Nigeria

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 12 DD 31 YY 92

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 87 B. Quarter 4 C. Final FY 91

8. COSTS ($000 OR EQUIVALENT $1 = 4)

A. FUNDING SOURCE	FIRST FY 87 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	18,000		18,000	67,000		67,000
(Grant)	(18,000)	( )	(18,000)	(67,000)	( )	(67,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country		2,500	2,500		33,500	33,500
Other Donor(s)						
TOTALS	18,000	2,500	20,500	67,000	33,500	100,500

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. 2. Loan	D. OBLIGATIONS TO DATE 1. Grant	D. 2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	E. 2. Loan	F. LIFE OF PROJECT 1. Grant	F. 2. Loan
(1) PN	400					67,000		67,000	
(2)									
(3)									
(4)									
TOTALS						67,000		67,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	DEL	TNG					
B. Amount	32,000	35,000					

13. PROJECT PURPOSE (maximum 480 characters)

to increase the acceptability and availability of family planning information and services throughout Nigeria in both the public and private sectors.

14. SCHEDULED EVALUATIONS

Interim MM 11 YY 89 MM 07 YY 91 Final MM 11 YY 92

15. SOURCE/ORIGIN OF GOODS AND SERVICES

[XXX] 000 [ ] 941 [ ] Local [XXX] Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

17. APPROVED BY

Signature: Kay MacManus

Title: Kay MacManus, AAO/Lagos

Date Signed: MM DD YY

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (8-79)

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20523

ASSISTANT
ADMINISTRATOR

JUL 1 1987

ACTION MEMORANDUM FOR THE ADMINISTRATOR

THROUGH : AA/PPC, Richard Bissell

FROM : A/AA/AFR, Alexander R. Love

SUBJECT : Family Health Initiatives II - Nigeria Sub-project (698-0462.20)

I. Problem: Your approval is requested for a grant of $67,000,000 from FAA Section 104, Population Planning Appropriation to the Federal Military Government of Nigeria (FMG) for the Family Health Initiatives II - Nigeria sub-project (698-0462.20), as described below. The planned obligation for FY 1987 is $20,000,000.

II. Discussion:

A. Project Description

As contained in the attached Project Paper, the Family Health Initiatives II (FHI-II) - Nigeria sub-project (698-0462.20) seeks to increase the acceptability and availability of integrated family planning services in both the public and private sectors throughout Nigeria.

The project supports the rapid expansion of family planning through the coordinated activities of four key functional areas:

Private sector service delivery to develop, refine, implement and expand large-scale, private sector networks which provide family planning and other basic services through a variety of commercial, work place and community outlets, and private maternity homes and medical facilities.

Public sector service delivery to strengthen management systems and service delivery capacities in order to provide clinic-based services in all levels of government facilities, from large teaching hospitals to basic village dispensaries with initial programming in capital cities and other model primary health care/local government areas (LGAs).

Information, education and communication to enhance the acceptability of smaller family norms and family planning as well as to provide information on available family planning options and services.

Policy implementation to strengthen the process of policy implementation and strategic planning for efficient

mobilization of an effective and self-sustaining national family planning program.

Through the provision of technical assistance, training and commodity support, mutually reinforcing activities under these four components have been carefully coordinated to comprise an integrated Nigerian family planning project.

By the end of this five-year project, it is expected that there will be a broad political and social constituency supportive of family planning policies and programs. Family planning information and services will be widely available at reasonable cost through both the private and public sectors. This will be reflected in a nationwide contraceptive prevalence rate of 12 percent or approximately 2.5 million users. Seventy percent of the users will be served by the private sector, receiving information and contraceptives through more than 12,000 commercial, community level or private outlets. In the public sector, information and services will reach thirty percent of the contraceptive users through 3,600 government hospitals, maternities, health centers, and dispensaries.

The project will ensure that a cadre of administrative, clinical and educational personnel exists to plan, execute, supervise, and evaluate clinic-based family planning services in public facilities from teaching hospitals to basic LGA grass-root dispensaries. Trained physicians, nurses, midwives, and pharmaceutical personnel as well as vendors in the private sector will be providing basic contraceptive information and products. Trained community leaders will be actively promoting smaller family norms and the use of modern contraceptive methods. Finally, teachers will be trained to include family life education in teacher colleges and urban secondary schools. More than 12,000 individuals in both the private and public sectors will be trained under this project. All trainees will be trained in other primary health care skills, e.g. immunization and oral rehydration therapy (ORT) as well as family planning and management.

An innovative, broad-based information, education and communication (IEC) program will be in place to build social support, encourage smaller family norms, and explain the availability and use of modern family planning methods. Consequently, 80 percent of the population aged 15-44 will be aware of modern contraception and its benefits by 1992.

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B. Financial Summary

The life-of-project funding will be $100.5 million, with AID providing 67 percent of the funding and FMG providing 33 percent of the funds. The approximate project cost breakdown is as follows (in $ millions):

	AID	FMG	Total
Technical assistance	$ 32.2	$ 10.0	$ 42.2
Training	11.2	15.0	26.2
Commodities	23.6	3.5	27.1
Income generated	0.0	5.0	5.0
Total	67.0	33.5	100.5

Note that the FMG contribution is valued at an estimated $33.5 million, $5.0 million of which will be generated by the sale of contraceptives through the private sector and reinvested in the project.

C. Committee Action and Findings

The ECPR was held on May 29, 1987 and approved the project. Based on the ECPR discussions, the Project Committee concluded the following:

1. Appropriate and adequate measures were taken to assure socio-economic acceptability and technical soundness of the project;

2. FY 1987 funding of $20,000,000 for the project will be provided;

3. There is a likelihood of continued long-term AID involvement in Nigeria, which will be examined during periodic project evaluations, because of the importance of Nigeria in the scheme of African development and the urgency of its population problem;

4. Considerable other donor involvement is essential if Nigeria is to adequately deal with its population problem, and AID should be instrumental in orchestrating that support;

5. Appropriate management of the project will depend on REDSO/WCA resources in areas such as Project Development, Contract Management, Legal Counsel, Commodity Support and

Population Technical Assistance. REDSO/WCA's capability to provide such support will be assessed after the first year as part of the planned initial evaluation;

6. The technical resources for training provided in the public sector component by The Pathfinder Fund must be strengthened prior to award of an implementation contract to include a broader range of training skills including physician, clinical and contraceptive logistics training;

7. Institutional support to Nigerian population and family planning organizations is critical in achieving project objectives and will be defined in detail in contracts to be negotiated with implementing U.S. organizations where appropriate;

8. No human rights clearance is required for this project;

9. An environmental exclusion statement signed by the Bureau Environmental Officer was included in the Project Paper;

10. Appropriate payment verification measures have been included;

11. The implementation plan is realistic and establishes a reasonable timeframe for carrying out the project; and,

12. Requirements of FAA Section 611(a) have been satisfactorily met.

D. Special Concerns

1. S&T/POP Collaboration: S&T/POP will continue to provide support to Nigeria through centrally-funded projects in complementary areas not included under this project such as biomedical and demographic research, operations research, voluntary surgical contraception. Any activities proposed for S&T/POP funding in other areas will be mutually agreed upon by the appropriate representatives of the Africa and S&T Bureaus.

2. Impact of AIDS - Attention was given to the possible effects of the AIDS problem on this project, particularly in terms of supply and distribution of condoms. Although it is important to distinguish between disease prevention and family planning, the project should be seen for its potential, though secondary, contribution to AIDS prevention. If AIDS-related use of condoms increases by more than five percent annually over the life of the project, additional resources may be required.

3. Collaborative Assistance Mode - Subsequent to the decision to implement the subject project through the collaborative assistance mode, a modification to the AIDAR (HB 14) was issued which restricts the use of the collaborative assistance mode to Title XII institutions. Nonetheless, it was recommended that the evaluation include an assessment of the effectiveness of the collaborative assistance mode for this project.

4. Implementing Agencies: The project will be implemented by four organizations through the collaborative assistance mode. The organizations selected for the design were: a) Family Planning International Assistance (Private Sector Development); b) The Pathfinder Fund (Public Sector); c) Johns Hopkins Population Communication Services (Information, Education and Communication); and d) University of North Carolina Population Center (Policy Implementation). All contracting actions under the project will be AID Direct undertaken by AAO/Lagos and REDSO/WCA.

5. Training: This project supports the training of over 12,000 people in various aspects of family planning. Virtually all training will be implemented by Nigerians in Nigerian institutions.

6. Local Cost Financing: Pursuant to HB1 Supplement B, Chapter 18A(1)(c), the detailed cost analyses done for each of the procurements were performed in consultation with local businesses and reflect work done by the implementing organizations under earlier contracts in Nigeria.

7. Gray Amendment Entities: Two Gray Amendment entities, Africare and the Center for Development and Population Activities (CEDPA), were among the subcontractors of the successful bidders for the design phase for this project. It is anticipated that these subcontractors will continue through the implementation phase. For other procurement actions, Gray Amendment entities will be encouraged and specifically invited to submit bids for activities open to free competition.

8. Designated Officer: The USAID/Lagos officer responsible for the project is Keys MacManus or her designee; the AID/W project officer for the project is the appropriate AFR/TR/HPN officer.

III. Waivers: Based upon the justifications contained in Annex F of the Project Paper, two waivers are requested. They are as follows:

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A. Source/origin and 636(i) waiver for project commodities: to permit the procurement of approximately 12 vehicles at an approximate cost of $180,000 and of electronic equipment at an approximate cost of $300,000 from countries included in Geographic Code 899; and,

B. Source/origin waiver for local cost financing: to approve local cost financing of commodities from countries included in Geographic Code 899 in an amount not to exceed $2,000,000;

IV. Justification to the Congress: The Family Health Initiatives II Project was included in the FY 87 Congressional Presentation, Annex 1, page 551. A Congressional Notification was submitted on June 8, 1987. The waiting period will expire on June 23, 1987.

V. Recommendation: That you sign the attached sub-project Authorization and thereby approve life-of-project funding of $67,000,000 and the requested waivers.

Attachments:
1. Project Authorization
2. Project Paper
3. Issues Paper

Clearances:

GC, Howard Fry:		Date 7/1/87
AFR/PD/CCWAP:JHradsky		Date 6/18/87
AFR/TR, Keith Sherper		Date 6-12-87
AFR/CCWA, Julius Coles		Date 6/16/87
AFR/DP, Jim Govan		Date 6 26 87
M/AAA/SER, John Owens	(draft)	Date 6/8/87
AFR/PD, Carol Peasley		Date 6/18
AFR/CONT, Ray King		Date 6-18-87
S&T/POP, Duff Gillespie	(draft)	Date 6/11/87
AAO/Lagos, Keys MacManus	(draft)	Date 6/3/87

AFR/PD/CCWAP:AGetson/DRobertson:647-9069:6/03/87:3310K

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C 20523

SUBPROJECT AUTHORIZATION

Name of Country: Nigeria

Name of Project: Family Health Initiatives II Sub-project for Nigeria

Number of Project: 698-0462
Number of Subproject: 698.0462.20

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, (the "Act") I hereby authorize the Family Health Initiatives II Sub-project for Nigeria (the "Cooperating Country") involving planned obligations of not to exceed Sixty-seven Million United States Dollars (U.S.$67,000,000) in grant funds (the "Grant") over a five-year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs of the sub-project. The planned life of the sub-project is five years and four months from the date of initial obligation.

2. The project ("Project") consists of the provision of technical assistance, training and commodities to assist the Cooperating Country in making family planning services and commodities acceptable and available throughout Nigeria in both the public and private sectors.

3. The Project Agreement(s) which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Commodities, Nationality of Services.

Commodities financed by A.I.D. under the Project shall have their source and origin in the Cooperating Country or in the United States except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Cooperating Country or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

b. Conditions Precedent

The Project Agreement shall contain conditions precedent in substance as follows:

Prior to the disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, for any Project costs other than that of the Project Coordinator, the Cooperating Country will, except as the Parties may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that the Cooperating Country has officially named the Project Director and the Project Managers to be assigned to each component of the Project to represent the Cooperating Country.

c. Covenants

The Project Agreement shall contain covenants in substance as follows:

(1) Prohibition on Abortion Related Activities. None of the funds made available under this Grant may be used to finance any costs relating to (a) performance of abortion as a method of family planning; (b) performance of involuntary sterilization as a method of family planning; (c) motivation or coercion of any person to undergo abortion or involuntary sterilization; (d) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning; or (d) active promotion of abortion as a method of family planning.

(2) Voluntary Family Planning. The Cooperating Country agrees that all family planning under this Project will be voluntary and that no coercion will be used.

(3) National Population Policy. The Cooperating Country agrees to implement the National Population Policy in such a manner as to promote the activities under this Project.

(4) Office Establishment. The Cooperating Country agrees that within the first year of this Project, the Federal Ministry of Health (FMOH) will establish, staff and fund its Office for Planning and Coordination for the Population Program (OPCPP), which office will be the primary contact for this Project.

(5) Provision of Family Planning. The Cooperating Country agrees that family planning services and commodities are to be provided at all levels of health care delivery and other appropriate places.

(6) Training. The Cooperating Country agrees that all government personnel trained under this Project in special clinical skills will be posted in facilities and assigned duties where the skills acquired will be used.

(7) Use of Materials. The Cooperating Country agrees that all materials produced under the Project may be used by A.I.D. in its other population activities.

(8) Visas. The Cooperating Country will ensure the timely provision of visas to Project personnel and shall provide multiple entry visas on a yearly basis to those personnel from both the contractors and A.I.D. specified on a list provided by the Federal Ministry of Health to the Ministry of Foreign Affairs.

d. Waivers. Based upon the justifications in Annex F of the Project Paper and based upon my authority under IDCA Delegation of Authority 1, I hereby:

(1) Approve a waiver to permit the procurement of approximately 12 motor vehicles at an approximate cost of U.S.$180,000 and of electronic equipment at an approximate cost of U.S.$300,000 from countries included in Geographic Code 899;

(2) Approve local cost financing of commodities from countries included in Geographic Code 899 in an amount not to exceed U.S.$2,000,000;

(3) Certify that exclusion of procurement from Free World countries other than the cooperating country and countries included in Code 941 would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program; and

(4) Certify that circumstances exist to waive and do hereby waive the requirements of Section 636(i) of the Act.

M. Peter McPherson
Administrator

Date: JUL 9 1987

Clearances:
GC:Howard Fry _____ Date 6/1/87
AFR/TR:Keith Sherper _____ Date 6-12-87
AFR/CCWA:Julius Coles _____ Date 6/18/87
AFR/DP:Jim Govan _____ Date 6/22/87
M/AAA/SER:John Owens DRAFT Date 6-9-87
AFR/PD/CCWAP:JHradsky _____ Date 6/18/87
AFR/PD:Carol Peasley _____ Date 6/18
AFR/CONT:Ray King _____ Date 6/18/87

Drafted:GC/AFR:PGJohnson:gw 2184H/6/9/87

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FAMILY HEALTH INITIATIVES II - NIGERIA
(698-0462.20)

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ACRONYMS

AAO	AID Affairs Officer
AED	Academy for Educational Development
AVSC	Association for Voluntary Surgical Contraception
CBD	Commerce Business Daily
CBD	Community Based Distribution
CCCD	Combatting Communicable Childhood Diseases
CDC	Center for Disease Control
CEDPA	Center for Development and Population Activities
CPC	Carolina Population Center
DOA	Delegation of Authority
ECOWAS	Economic Community of West African States
FAR	Federal Acquisition Regulations
FHI	Family Health Initiatives
FMG	Federal Military Government (of Nigeria)
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FMOI	Federal Ministry of Information
FPMT	Family Planning Management Training
FOS	Federal Office of Statistics
FP	Family Planning
FPIA	Family Planning International Assistance
HB	Handbook
IEC	Information, Education and Communication
IHPS	Institute for Health Policy Studies
IITA	International Institute for Tropical Agriculture
ILO	International Labor Organization
INTRAH	(Program for) International Training in Health
IPPF	International Planned Parenthood Federation
IQC	Indefinite Quantity Contract
IBRD	International Bank for Reconstruction and Development
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU/PCS	Johns Hopkins University/Population Communication Service
JSI	John Snow, Inc.
KAP	Knowledge, Attitude and Practice
LGA	Local Government Area
MCH/FP	Maternal Child Health/Family Planning
MIS	Management Information Systems
MSH	Management Sciences for Health

NCPA	National Council on Population Activities
NERC	National Education Research Centre
NETC	National Education Technology Centre
NGO	Non-governmental Organization
NITEL	Nigerian Telephone
NPB	National Population Bureau
NYSC	National Youth Service Corps
OPCPP	Office for Planning and Coordination for the Population Program
ORT	Oral Rehydration Therapy
PACD	Project Activity Completion Date
PASA	Participating Agency Service Agreement
PC	Project Coordinator
PHC	Primary Health Care
PIACT	Program for the Introduction and Adaption of Contraceptive Technology
PID	Project Identification Document
PID	Pelvic Inflammatory Disease
PIL	Project Implementation Letter
PPFN	Planned Parenthood Federation of Nigeria
PSC	Personal Services Contractor
RAPID	Resources for the Awareness of Population Impact on Development
REDSO/WCA	Regional Economic Development Services Office/West and Central Africa
RIG	Regional Inspector General
SFEM	Second Tier Financial Exchange Market
SMOH	State Ministry of Health
SMOI	State Ministry of Information
SMLG	State Ministry of Local Government
SOW	Statement of Work
STD	Sexually Transmitted Diseases
S&T/POP	Science and Technology Bureau/Population
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
UNESCO	United Nations Education, Science and Culture Organization
UNICEF	United Nations Children's Fund
USDH	United States Direct Hire
WHO	World Health Organization

EXECUTIVE SUMMARY

I. Project Purpose and Description

The Nigeria Family Health Initiatives II (FHI-II) sub-project (698-0462.20) seeks to enhance the quality of life of Nigerian citizens. To this end, the purpose of the project is to increase the acceptability and availability of integrated family planning services in both the public and private sectors throughout Nigeria.

At the request of the Federal Military Government of Nigeria (FMG), the project, which was designed jointly by a team of Nigerian/American experts, will address the rapid expansion of family planning through the coordinated activities of four key functional areas:

- Private sector service delivery to develop, refine, implement and expand large-scale, private sector networks which provide family planning and other basic services through a variety of commercial, work place and community outlets, and private maternity homes and medical facilities.

- Public sector service delivery to strengthen management systems and service delivery capacities in order to provide clinic-based services in all levels of government facilities, from large teaching hospitals to basic village dispensaries, with initial programming in capital cities and other model local government areas.

- Information, education and communication to enhance the acceptability of smaller family norms and family planning as well as to provide information on available family planning options and services.

- Policy implementation to strengthen the process of policy implementation and strategic planning for efficient mobilization of an effective and self-sustaining national family planning program.

Through the provision of technical assistance, training and commodity support, mutually reinforcing activities under these four components have been carefully coordinated to comprise an integrated Nigerian family planning project.

II. Expected Achievements and Accomplishments

By the end of this five-year project, it is expected that there will be a broad political and social constituency supportive of family planning policies and programs. Family planning information and services will be widely available at reasonable cost through both the private and public sectors. This will be reflected in a nationwide contraceptive prevalence rate of 12 percent or approximately 2.5 million users. Seventy percent of the users will be served by the private sector, receiving information and contraceptives through more than 12,000 commercial, community level

or private outlets. In the public sector, information and services will reach thirty percent of the contraceptive users through 3,600 government hospitals, maternities, health centers, and dispensaries.

The project will ensure that a cadre of administrative, clinical and educational personnel exists to plan, execute, supervise, and evaluate clinic-based family planning services in public facilities from teaching hospitals to basic LGA and grass-root dispensaries. Trained physicians, nurses, midwives, and pharmaceutical personnel aswell as vendors in the private sector will be providing basic contraceptive information and products. Trained community leaders will be actively promoting smaller family norms and the use of contraceptive methods. Finally, teachers will have been trained to include family life education in teacher colleges and urban secondary schools. More than 12,000 individuals in both the private and public sectors will be trained under this project. All trainees will be trained in other primary health care, e.g. immunization and oral rehydration therapy (ORT) as well as family planning.

An innovative, broad-based information, education and communication (IEC) program will be in place to build social support, encourage smaller family norms, and explain the availability and use of modern family planning methods. Consequently, 80 percent of adults aged 15-44 will be aware of modern contraception and its benefits by 1992.

The objectives for this project are both ambitious and achieveable. Data from the World Fertility Survey, along with more recent surveys, demonstrate that increases in contraceptive prevalence more rapid than changes in socio-economic variables have occurred in other countries with national family planning programs. Bangladesh, Colombia, Thailand, Mexico, and the Republic of Korea have all shown increases of over 20 percent in prevalence in as little as 5 to 10 years. While these accomplishments are attributed to numerous factors, the most important are a strong political will, institutional and infrastructural capacity, and a popular readiness. These conditions exist in Nigeria, and FHI-II is in an optimum position to expand the program rapidly.

III. Implementing Agencies

FHI-II will be implemented through the collaborative assistance mode to permit closer involvement with the Federal Military Government of Nigeria (FMG) and USAID/Lagos. Four organizations were selected for the design phase who will be eligible for implementation. They are as follows: Family Planning International Assistance (Private Sector); The Pathfinder Fund (Public Sector); Johns Hopkins University Population Communication Service (IEC); and University of North Carolina (Policy Implementation). The implementing agencies will subcontract with a variety of U.S.-based and local private organizations as well as appropriate national, state and LGA agencies.

IV. Financial Plan

The life-of-project funding will be $100.5 million, with AID providing 67 percent of the funding and FMG providing 33 percent of the funds. The approximate project cost breakdown (in millions) is as follows:

	AID	FGN	Total
Technical assistance	$ 32.2	$ 10.0	$ 42.2
Training	11.2	15.0	26.2
Commodities	23.6	3.5	27.1
Income generated	0.0	5.0	5.0
Total	67.0	33.5	100.5

Note that the FMG contribution is valued at an estimated $33.5 million, $5.0 million of which will be generated by the sale of contraceptives through the private sector and reinvested in the project as part of the host country contribution.

FHI-II differs from many AID projects in that it does not provide direct financial support to governmental and parastatal bodies. Instead, funds are directed toward transfer of skills/knowledge and development of supportive infrastructures. In addition, this project is unique in that, with the exception of contraceptives, it underwrites no recurrent costs such as government salaries and vehicles. As a result, there is an increased probability of ultimate self-reliance.

V. Term of the Project

Project Activity Completion Date (PACD) is December 31, 1992, with initial AID funding beginning in FY 1987.

VI. Project Issues

A. Management Capability

The FHI-II management system minimizes management burden on USAID/Lagos and takes full advantage of the management experience of the implementing organizations. To ensure manageability, the following measures are included: a full-time personal services contractor will be hired by USAID/Lagos; the entire administrative and logistical support component will be contracted; and, implementation responsibility will be reduced to four organizations with past proven records of managing family planning activities in Nigeria. REDSO/WCA will provide implementation support per an established schedule of services.

B. Other Donor Activities

Representatives from the World Bank and United Nations Fund for Population Activities (UNFPA) participated in the development of this project. Although the FHI-II project constitutes major support for Nigeria's national family planning program, significantly more resources will be needed over the next five years and beyond to build the foundation for sustaining an effective national population program. As outlined above, project efforts focus on major start-up activities in areas of integrated family planning service delivery, particularly in the urban areas, including a significant initiative in the private sector complemented by IEC and policy implementation activities. Shortfalls are envisioned with regard to: a) support for institutional development; b) cost of refurbishing and upgrading of public sector facilities,

particularly at the local government level; c) support for mass reproduction of IEC materials; d) intensive in-service training activities; e) family planning commodities and other related supplies; f) vehicles; and g) operating costs associated with sustaining the program in the long-term. Although it is envisioned that the federal and various state governments would absorb some of the costs associated with meeting these requirements, major financing gaps would still remain for which further external support would be required. Parallel discussions are currently underway between the Federal Government and other donors to support the national program. The UNFPA and the World Bank are expected to assume major costs associated with sustaining the program in the long run and beyond the FHI-II. USAID will pursue an aggressive strategy early on in the project to ensure other donor coordination and involvement.

C. Contraceptive Supplies

Without contraceptive supplies there can be no family planning. Therefore, the project has budgeted $17.0 million for contraceptives to cover 80 percent of the anticipated contraceptive needs for the expected 12 percent user prevalence by 1992. The remaining 20 percent necessary will be provided: a) through other donors for items such as injectables and Norplant; b) by other centrally funded programs (voluntary surgical contraception); or c) by commercial sources outside of the project from the non-subsidized market. Actual procurement will be based upon annual contraceptive projections. Throughout the life of the project alternative means of supplying contraceptives (e.g., cost recovery and purchase of supplies, other donor contributions, local manufacture and sale) will be explored and tested to ensure adequate supplies of contraceptives over the life of the project and at the end of the project. Contraceptives will be a major program costs as prevalence increases.

D. Use of Gray Amendment Entities

In the past, USAID/Lagos has successfully utilized Gray Amendment entities. The contracting mode utilized for this project, collaborative assistance, by definition may utilize this type of institution. In fact, two Gray Amendment entities, Africare and the Center for Development and Population Activities (CEDPA), were among the subcontractors of the successful bidders for the design phase for this project. It is anticipated that these subcontractors will continue through the implementation phase. For other procurement actions, Gray Amendment entities will be encouraged and specifically invited to submit bids for activities open to free competition.

E. Waivers

FHI-II requires three waivers: a) Source/Origin (Code 899) for vehicles; b) Source (Code 899) for shelf-item procurement; and c) Source/Origin (Code 899) for technical commodities (primarily electronic equipment). Justification for these waivers is contained in Annex F of this document.

F. Voluntary Population Planning

All family planning services offered under this project will be voluntary, and no one will be coerced into using a family planning method. A wide range of contraceptives will be provided including hormonal methods, barrier methods, intrauterine devices as well as

natural family planning methods. No funds will be used for abortion or abortion-related activities. Throughout implementation, these underlying principles will be discussed with the program participants and monitored accordingly.

VII. Summary

The scope of the FHI-II Project is comprehensive and extensive covering key areas which have proven to be essential to the rapid acceptance and use of contraceptive services. The depth of the project extends from the federal level to the LGA level transcending both the public and private sectors. The technical approach, particularly through the private sector, is innovative yet culturally appropriate and will, if successful, establish a service delivery model for all of Africa. The magnitude of project is unprecedented in Africa yet the cost per user will be one of the lowest in the continent.

Moreover, the project base is sound. There is a strong political will to deliver family planning services as an integrated health service. The project builds on the strengths of the Nigerian public and private systems and takes advantage of the many lessons learned from earlier AID-support population projects. It ensures the involvement of a variety of host country leadership institutions, both governmental and non-governmental. It logically channels and encourages donor coordination within a coherent, flexible framework. Further, the project maximizes the U.S. comparative advantage and relies on technically proven agencies to implement the program activities.

I. PROJECT BACKGROUND AND RATIONALE

A. Background

1. Demographic and Economic Considerations

Nigeria, with its population of 105 million people and an annual growth rate 3.3 percent, has the largest population of any country in Africa and is also one of the fastest growing countries in the world. At this annual rate of growth, Nigeria's population will double in twenty-three years. In fact, if the population continues to grow at the current rate, Nigeria, in about 50 years, will have the same number of people (454 million) that currently inhabit all of sub-Saharan Africa.

The fertility of the Nigerian population is high. The Population Reference Bureau estimates the total fertility rate (TFR) of Nigeria to be 6.5 (the TFR measures live births per woman over the course of her lifetime). There is evidence that this rate is rising in Nigeria, in large measure due to modernization, urbanization and shifts away from the traditional practices of breastfeeding and postpartum abstinence which historically have served as natural constraints on fertility.

Although Nigeria often is characterized as a medium income country, per capita income of $680 obscures the fact that Nigeria, like most developing countries, has extremes in wealth and poverty. The most recent Government Household Survey (1983-84) reveals that 61 percent of rural and 31 percent of urban households earn less than $300 per year.

Recently, Nigeria has experienced an enormous and rapid economic reversal. Five years ago, annual oil revenues were $25 billion and Nigeria could afford to import food. By 1986, oil revenues had dropped to $5 billion, and Nigeria now struggles to grow its own food. Millions of Nigerians are unemployed or underemployed. The oil boom accelerated the move to urban centers which now are crowded with rural migrants who lack jobs and the resources to return to the countryside. The unemployed are mainly young people. According to a recent Federal Military Government of Nigeria (FMG) survey, almost 80 percent of the urban unemployed and 70 percent of the rural unemployed were younger than 25 years.

In October 1986, the FMG imposed essential but severe foreign exchange restrictions which have exerted further pressure on Nigerians by increasing the cost for fuel, water, food and shelter. Now, neither government nor individuals can meet the costs of health, education, and other social services. Recent declines as high as 30 percent in school enrollment and in the use of medical facilities bear witness to the fact that many Nigerians can no longer afford to send their children to school or pay for health care. Recent comparative worldwide studies indicate an alarmingly high rate of malnutrition among Nigerian children, even as compared to other African countries.

2. Social Considerations

Nigeria is culturally rich, but also diverse and complex. The country has three major ethnic groups (Igbo, Yoruba, and Hausa) and hundreds of ethnic subgroups. There is no single language that can be understood by the masses. There are two major religious groups (Christian and Muslim), each competing for converts and seeking to add to their numbers by encouraging large families.

Nigeria's social and health conditions are similar to those of the poorest countries in the world. The literacy rate is low (45 percent) especially among females (30 percent), and is perhaps declining. Life expectancy is 50 years. National rates of infant mortality (100-127/1000) and maternal mortality (80-90/10,000) are extremely high.

Traditionally, children are highly valued in Nigeria. The 1981-82 Nigerian Fertility Survey indicated that Nigerian women, on an average, desire family size was 8.5 children. This desire for many children is reinforced by the high infant and child mortality. Nigerian women marry young (average 16.9 years) and start childbearing early. Teenage childbearing accounts for 14 percent of all births in Nigeria. This Fertility Survey was completed before the economic decline. Recent surveys among urban males indicate a preference for approximately 5 children. There is no data to show whether female attitudes have also changed in the past five years.

In Nigeria, as in all societies, health risks of pregnancy are greater to women under 18 or over 35 years of age, those with parity of four and above, those with a pregnancy within the last two years and those with previously complicated pregnancies or deliveries. Moreover, too close a succession of births predispose children to numerous health and development problems, including protein calorie malnutrition. In Nigeria, such malnutrition is commonly suffered by the older child who is replaced at the mother's breast by a too closely spaced younger sibling.

The Nigerian Fertility Survey and other studies have found that the level of knowledge about modern family planning is extremely low -- about 33 percent. The same studies indicate that approximately 6 percent in the reproductive age group currently practice some form of contraception, including traditional methods, but only 2.6 percent use modern methods. Unfortunately the practices of breastfeeding and postpartum abstinence are in decline, especially in urban areas and among the less traditional and better educated women.

Again, it should be noted that the above studies were conducted during the oil boom years and attitudes and practices have probably changed with couples having greater knowledge and access to modern family planning in the last two years. Recent attitudinal studies suggest no entrenched negative attitudes toward modern contraception by Nigerians. Receptivity to the use of modern contraceptives for birth spacing is reported. However, some concerns about "morality" and fears about side-effects are commonly encountered. The main obstacles to use of modern contraceptives appear to be lack of widespread knowledge about and availability of contraceptives. As Nigerians are open to new ideas, these obstacles will likely fade once an effective family planning

program with a strong information component is underway supported by the FMG, the medical establishment, and other community leaders.

3. Political Structure and Policy Considerations

Like the U.S., Nigeria is a federation of states and a Federal capital. Within the 19 states there are over 300 LGAs. The Federal Government is responsible for setting overall priorities and policies and providing technical guidance and direction for quality standards. Within parameters established by the Federal Government, the state governments are autonomous in the planning, development, and execution of their various social, health and educational programs. The LGAs are responsible for program planning and execution at the grassroots level.

Regarding population/family planning, Nigeria's policy has evolved over the past twelve years from a stance of "development first", taken at the International Conference on Population at Bucharest in 1974, to the present concern over the country's rapid population growth. Beginning in 1981, when Nigeria's economy began a downward spiral, the FMG no longer had the capacity to fund its ambitious development plans. Thoughtful Nigerians were further shocked by the 1984 World Bank Development Report which projected Nigeria's population would increase from its then current rank of number ten in the world to number three (after India and China) unless steps were taken in the near future to reduce the birth rate. In the past two years, Nigeria has moved from Number 10 to Number 8. As a result, the policy climate in Nigeria has rapidly become supportive of a strong nationwide family planning program, not only as a preventive health measure, but also as a socio-economic necessity.

Over the past two years, the government has made remarkable progress in developing a comprehensive, multi-sectoral national population policy. The policy, adopted unanimously in mid-1986 by the Government's Executive Council Cabinet, has since been endorsed by the National Council of Health (comprised of the Federal Minister of Health and his directors plus Commissioners of Health from all the 19 states). The policy, endorsed by the President, is expected to be promulgated by executive order this year.

This far-reaching policy sets out ambitious targets for four major policy goals: improved living standards; preventing premature deaths among high risk groups of mothers and children; reducing population growth rates through voluntary family planning; and a more even distribution of population between urban and rural areas. A primary aim of the policy is to make family planning services available to "all persons voluntarily wishing to use them but to give priority attention to the high risk groups such as women under 18 or over 35, those with previous complications of pregnancies or childbirth or those with chronic illnesses which increase the health risks of getting pregnant."

The delivery of "easily affordable, safe and culturally acceptable family planning services" is singled out as one of the most important strategies of the population policy. To this end, the Federal Ministry of Health (FMOH) drafted, in 1985, a Five-Year (1986-1990) Action Plan for a National Family Planning Program. The plan outlined the rationale, premises, goals, objectives and program elements of expanding the access

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of the Nigerian population to voluntary family planning services. All 19 states and the Federal capital have formulated corresponding action plans. Many LGAs are beginning to develop similar plans to systematically expand services to the community level in keeping with the overall FMG strategy of decentralizing integrated Primary Health Care (PHC) activities to the LGA level.

The FMG has consistently reaffirmed its commitment to the development of family planning services as a part of integrated health services. The 5th National Development Plan (1986-1991) identifies family planning as a major component of PHC. The corresponding FMG 1986 National Health Policy and Strategy indicates that national health services, based on PHC, should include Maternal and Child Health (MCH) which encompasses family planning. Family planning in this context is defined as "services offered to couples to educate them about family life and to encourage them to achieve their wishes with regard to i) preventing unwanted pregnancies; ii) securing desired pregnancies; iii) spacing of pregnancies; and iv) limiting the size of the family in the interest of family health and socio-economic status. The methods prescribed shall be compatible with their culture and religious beliefs." In March 1987 the FMOH published a Health Program Development Plan (1987-1991) to implement this policy strategy, which reiterates the desire to develop a comprehensive family planning program within the context of integrated health care.

The FMG and all state governments have requested U.S. government assistance in developing and implementing these policies and programs so that family planning can be well-integrated into the primary health care system, initially via the 52 model LGAs.

B. Rationale

Nigeria is committed to the task of development, including a health care system which will enable all Nigerians to achieve socially and economically productive lives. The FMG has placed a high priority on primary health care, including family planning, as indicated by its comprehensive, multi-sectoral national population policy and the national health strategy. Of the development interventions which Nigeria can make, family planning, with its potential for birth spacing, can prove to be extremely beneficial because birth spacing is directly related to the improved health of both the mother and child.

Much infant and maternal mortality can be averted through preventive measures such as immunization, birth spacing and improved hygiene and nutrition programs. Additionally, birth spacing helps to reduce the malnutrition suffered by an older child weaned too early because of the birth of another child. It is well known that many infant deaths can be avoided if births are spaced more than two years apart. Calculations from fertility survey data suggest that at least 20 percent of infant deaths and 15 percent of maternal deaths -- and probably more -- could be avoided if no births occurred to women before 18, after 35, after the fourth child or less than two years apart.

In addition to the health rationale for birth spacing, the economic squeeze is being felt by most Nigerians. A recent survey of young urban males in Nigeria found that 91 percent cited economic need as a justification for family planning. As a result, the desire for family planning is increasing. Average monthly income in rural households is less than $25; in urban households, the average is $57 per month. Moreover, in urban areas, the average Nigerian spends 54 percent of his or her income on food, leaving 46 percent for all other expenditures.

Nigerians place a high value on educating their children and education is a priority with the FMG. A recent FMG household survey indicates that in the rural areas for persons between the ages of 15-29, the literacy rate is 53 percent for males and 33 percent for females. In urban areas the rates are 81 percent and 52 percent, respectively. However, recent declines in school enrollment, especially for young girls, are certain to have a serious deleterious effect on Nigeria's development plans. It is also known that female educational levels can markedly influence infant mortality and the acceptability of family planning.

As the foregoing suggests, there is a great need for a comprehensive family planning service program including a very strong informational component. Fortunately, the FMG is firmly committed to the initiation of this program. This FHI-II Project, designed in collaboration with FMG counterparts, alleviates many of the above health, economic and social problems which are recognized by the FMG.

The project rationale is based on geographic, economic, social, and programmatic considerations:

- Geographically, Nigeria is the most populous country in Africa with the potential to serve as a model for many other African countries. However, its political stability and capacity to achieve its full potential as a leader in Africa depend on continued social and economic stability and progress. This could be undermined by continued extraordinarily high fertility rates which have produced a population growth rate higher than those ever experienced by currently industrialized nations.

- Economically, Nigeria's resources can provide a higher per capita income in the foreseeable future if total population size increases more slowly. With less population and improved productivity, Nigeria could invest greater resources in development and in the improvement of social, health and education services.

- Socially, Nigeria already has the strong health infrastructure necessary to provide extensive, integrated family planning services. Its internationally recognized health training institutions form a sound foundation for carefully designed training and technical assistance inputs.

  Technically, family planning is an appropriate public health measure to enhance the quality of life by preventing high risk pregnancies and illegal abortions, and by encouraging proper birth spacing.

- Programmatically, innovative and cost-effective approaches can be used to enhance service delivery capability in both the public and private sectors to increase the acceptability and accessibility of integrated family planning information and services throughout Nigeria.

Moreover, the project is designed to provide a coordinated program for U.S. population assistance inputs into Nigeria which:

- ensures coordination with a variety of Nigeria institutions under the leadership of the Federal Ministry of Health and involving all other ministries, state governments, LGAs, and influential organizations and individuals at all levels;

- maximizes limited U.S. resources by developing a streamlined system of field operations and administration;

- encourages supporting assistance from other national and international donors within a coherent, well-planned, yet flexible framework; and, above all,

- builds upon the important strengths of the Nigerian system so that opportunities for short-term effectiveness and long-term institutionalization of the project activities are maximized.

The design of the project builds on AID's 20 years experience in population assistance. Under the project, AID undertakes the role it can play best: overall project design, selection of institutions with the greatest technical expertise, and policy supervision of limited number of large contracts. Competent technical organizations will be selected to perform roles for which they have already demonstrated great competence in development and implementation of a large number of small, diverse subcontracts or other activities. The span of control for both AID and the collaborating agencies will be at the level where both AID and its contractors can perform most efficiently. This structure ensures that substantive and management responsibilities are divided according to past experience and skills.

The Project Description and the materials which follow spell out in detail the overall strategy and the goals, purposes, outputs, and expected end of project status to be achieved through this project.

II. PROJECT DESCRIPTION

The five-year FHI-II Nigeria sub-project is a major, innovative, and far-reaching endeavor. It is designed to increase the acceptability and the practice of family planning by approximately four fold in the most populous country of Africa - to a level of about 2.5 million users of modern contraception or 12 percent of the eligible population by 1992. To achieve this ambitious objective, the project strategy builds on existing strengths These include:

- a vigorous and enterprising private sector in Nigeria which already sells contraceptives in the urban areas of the 19 states;

- well-staffed decentralized state and local government health facilities throughout Nigeria which include many health personnel working in an integrated setting;

- multiple, lively and open channels for information, education, and communication about family planning through both traditional and modern media;

- informed and interested policy-makers and other leaders ready to facilitate the implementation and management of the project; and

- on the part of USAID, a collaborative mode of assistance that links AID policy and planning with the technical skills and management expertise of specialized organizations which have worked successfully in Nigeria.

Building on these strengths, the project will assist the FMG in incorporating family planning into the public and private sector health delivery systems. The result will be a nationwide program in family planning reaching all of the major ethnic groups in Nigeria. It will rely heavily on initial market and audience research, an inventory of health resources, clinic service statistics, and selective surveys to develop culturally acceptable approaches that are feasible through existing or potential service delivery channels. The project is designed not only to meet current demand but also to create new awareness and interest in the benefits of family planning and, most importantly to move toward a self-sustaining effort that can depend increasingly on Nigeria's own institutions and resources.

A. Project Purpose

The project purpose is to increase the acceptability and availability of family planning information and services throughout Nigeria. The overall objective to be achieved, which will be assessed by surveys and service statistics in 1992, is to increase the prevalence of modern contraceptive methods from 2.6 percent of eligible couples, as measured by the Nigerian Fertility Survey in 1981-82, to 12 percent in 1992. Such an increase in contraceptive prevalence would be large but not unprecedented. Other countries, which like Nigeria are highly rural, low income, and with low literacy levels, have increased contraceptive use dramatically over short time periods as a result of various programs; for example, Zimbabwe, from 5 percent prevalence in 1976 to 14 percent in 1979; Botswana, from 8 percent prevalence in 1976 to 29 percent in 1984; and Bangladesh, from 8

percent in 1976 to 19 percent in 1983. The overall objective can be achieved in Nigeria by utilizing existing institutions and health programs at a time when FMG support has been assured and when economic pressures have made family planning an acceptable individual choice as well as a demonstrated health benefit.

B. Four-Pronged Strategy

The project links together four distinct but inter-related components:

- Private sector service delivery to develop, refine, implement and expand large-scale, private sector initiatives in family planning that provide services through a variety of commercial, workplace and community outlets, and private maternity homes and medical facilities.

- Public sector service delivery to strengthen management systems and service delivery capacities in order to provide clinic-based services in all levels of government facilities, from large teaching hospitals to LGA clinics and dispensaries.

- Information, education and communication to enhance the acceptability of smaller family norms and family planning as well as to provide information on available family planning options and services.

- Policy implementation to strengthen the process of policy implementation and strategic planning for efficient mobilization of an effective and self-sustaining national family planning program.

The project strategy, the outputs, and the indicators of project achievement are all designed around the Nigerian institutions and capabilities that can best achieve the project purpose of increase acceptability and availability of integrated family planning information and services. Service delivery, the main emphasis of the project, utilizes both the private and the public sector. To enhance service delivery, IEC and policy activities will extend from the national level to state and LGAs and will be linked to service delivery needs and capacities.

1. Private Sector

Nigeria's robust and enterprising private health and commercial sectors will be tapped to provide family planning information and services with major emphasis on urban areas. Existing distribution networks will be expanded and new ones created to provide private interests with contraceptive commodities.

Specifically, the private sector component of this project will contribute to achieving FHI-II's overall prevelance goal by serving 1.2 million family planning users in 1992. This will be accomplished by providing services and/or commodities through three program networks; large distributors, medical and service delivery sites, and associations and factories.

Large-scale distributors. Sterling Products (Nigeria) Ltd. and W.C. Clark are examples of large-scale distributors. Sterling Products, a U.S./Nigeria owned manufacturer and distributor of over-the-counter drugs, will reach 4,000 outlets by 1992. W.C. Clark, or a similar trading company, will be selected to reach other commercial outlets such as supermarkets, department stores, and market women.

Medical and Service Delivery Sites Nurses, midwives, doctors, maternities, clinics, religious missions, and hospitals will be supplied and trained to provide family planning services.

Associations and Factories. A variety of activities will be initiated with vendors, community people, employers, and others. Vendor activities will be organized by large units for efficiency, for example, under the Union Transport Workers or the Market Women's Association.

Together, these private sector networks will service a total of approximately 12,000 outlets in 12 states, initially. These outlets will be located primarily in cities of 100,000 or more population.

In addition, an estimated 500,000 users will be served outside this project, primarily through private sector providers, with various methods, such as voluntary surgical contraception, implants, injectables, and other contraceptive products or brands not directly provided under the auspices of the project. As a result, it is estimated that, by 1992 approximately 70 percent of the 2.5 million family planning users in Nigeria will be served by the private sector (1.7 million) and 30 percent by the public sector (800,000). This is a reversal of the current ratio, in which 70 percent of users are served by the public sector, 30 percent by the private. Yet it reflects more closely the current overall pattern of utilization for other established health services which is approximately 60 percent private and 40 percent public.

In order to serve 1.2 million users through the private sector, over 7,000 persons will be trained. These will include pharmaceutical personnel who will be trained in family planning methods and counseling; vendors who will be taught more about specific family planning methods and sales; and private nurses and doctors who will be trained to insert IUDs as well as counsel and provide other methods.

Contraceptive supplies will be purchased by AID through a separate contract, and delivered to Sterling Products and other distributors. Storage, distribution, and monitoring of use will be managed by the private sector component under service subcontracts.

The achievement of these private sector outputs is dependent on the following premises:

- the private sector is willing to make an investment in family planning services;

- the private infrastructure can accommodate increased family planning activities;

- private sector personnel trained under the project will utilize their newly acquired skills to attract and serve family planning clients; and

- an increasing number of Nigerians will be willing to purchase contraceptives as prices become affordable.

These premises have been demonstrated, although on a much smaller scale, in previous AID-funded activities in Nigeria, such as the commercial marketing project with Sterling. This experimental project sold over six million condoms and 600,000 cycles of pills to retailers in the first nine months of operation. With a first year budget of only $47,000 plus commodities, this project generated income equivalent, before devaluation, to $1.0 million. It also supported the first nationwide television, radio, and newspaper advertising campaign for family planning products in sub-Saharan Africa.

2. Public Sector

Nigeria's extensive public sector health services operate in all the nineteen states and in the Federal capital of Nigeria. Unlike many public health services, Nigeria's health services are generally well-staffed and provide integrated services in all urban and many rural areas for those who cannot afford to pay for private health care. These facilities will be upgraded by training present staff and providing the equipment and supplies needed to make comprehensive family planning information and services available. In essence, family planning will be added to an infrastucture which is mostly in place.

Specifically, the public sector component will contribute to achieving FHI-II's prevalence goal by serving approximately 800,000 of the expected 2.5 million family planning users through 3,600 service delivery points which will provide family planning and health related information and services by 1992. These service points will be linked with the primary health care delivery systems with priority given to the urban areas and the 52 model LGAs. Initially the project will serve urban and semi-urban areas but will gradually extend to rural areas.

In support of this output, health personnel at all levels will be trained in family planning service delivery, including communication skills. Approximately 4,500 individuals serving in the public sector will be trained to provide family planning information and services. In addition, approximately 3,000 will receive family planning instruction during pre-service courses, the curricula for which will be developed or revised with technical assistance provided by the project. Family planning program management and service systems including service statistics, supervision and clinical protocols will be revised or developed by the project. Approximately 700 government employees at local, state and federal levels will be trained to use these management systems. Contraceptive supplies, including pills, condoms and foam, will be provided to all public service points. Equipment will be provided to cover a total of 1,000 full service clinics, offering IUD insertion, and 2,600 partial service points, offering non-clinical methods (condoms, pills, foam).

The achievement of these public sector outputs depends on the following premises:

- state and local government authorities will continue to expand family planning services to existing facilities as necessary;

- state and local government authorities are willing to release individual nurses and other providers for in-service training as required; and

- state and local government authorities are willing to maintain service statistics and record systems to monitor levels and quality of service.

Evidence to date suggests that these premises are reasonable. The number of public sector state health clinics reporting family planning use has increased from virtually none in 1983 to about 300 in 1985 and then to more than 600 by the end of 1986. While reporting of service statistics is not uniform, 19 states and the Federal capital reported at least 146,223 new accepters in 1986 and 385,866 total contraceptive visits in 1986 compared with 17 states reporting 87,218 new accepters and 182,727 total contraceptive visits in 1985, increases of about two fold. In addition, over 2,000 state health personnel have already been trained. Estimated commodity usage by public health clinics increased by almost 200 percent between 1985 and 1986. The Planned Parenthood Federation of Nigeria (PPFN) provided services to 42,631 accepters in 1984 and increased that number to 62,253 by 1986.

3. Information, Education, and Communication (IEC)

IEC activities will draw on Nigeria's substantial communication resources to bring potential users into service facilities. Nigeria has 22 television stations, 35 radio stations, 19 dailies and 18 weekly newspapers. These media can all encourage acceptance and countinued use of family planning by (a) increasing public awareness of family planning, (b) strengthening personal interest in the benefits of family planning, and (c) reinforcing correct and consistent practice of freely selected methods. IEC will support service delivery by both the public and private sector at the national, state and LGA level. It will also stimulate the informed and open debate which is characteristic of Nigerian society. In this way, the small family norm with its resulting health, social, and economic benefits can be increasingly recognized and accepted by men and women of all ages, cultural backgrounds, and socio-economic status.

Specifically, the IEC component will contribute to achieving FHI-II's contraceptive prevalence goal by increasing awareness of family planning to 80 percent of the population aged 15-45 by 1992 compared with a 33 percent level in 1981-1982. This will be accomplished by measures ranging from the creation of a national family planning logo (to be developed by a nationwide contest and used wherever private or public services and supplies are available) to culturally appropriate local activities planned and implemented through IEC action programs developed by all 19 states and designated LGAs.

In support of this goal, four major types of output will include print materials for health workers, training and social mobilization, mass media and family life education training for teachers of secondary schools and post-secondary schools.

Print Materials. Over 6 million copies of promotional and educational posters, methods charts, reference cards and pictorial motivational booklets will be made available to health providers to ensure a free and informed choice and so advise on safe and correct usage of family planning methods.

Training and Social Mobilization. Because the contact between service provider and client is a key factor in family planning acceptance, over 10,000 service providers, sales agents and motivational officers will be trained in IEC concepts as part of regular training programs conducted in the public and private sectors. One result of these efforts will be family planning campaigns conducted at the state level and by designated LGAs.

Mass Media. Over 3,000 television, radio programs, folk-drama, spots and films will be produced in five major languages and disseminated through modern (broadcasts), traditional (theater) and alternative (rural festivals, songs and dances, and television viewing) channels to reinforce inter-personal communication. Testimonials from traditional leaders will also be widely utilized to muster community support.

Family Life Education. Over 30,000 copies of audio/visual and print materials for use by teachers and students will be developed and provided for inclusion into the family life education curricula in teachers colleges and selected secondary schools. The materials will be introduced through a series of state-level training sessions for teachers. Dramas, contests, and quiz shows will stress active student participation.

The achievement of these IEC outlets depends on the following premises:

- state and local health facilities will integrate the print materials provided into regular counselling, group health lectures, and other in-clinic and outreach activities;

- national and state radio and television facilities will provide free or affordable time for various types of family planning related information; and

- state health, local government and private sector personnel will collaborate in local activities such as program launchings, festivals, contests and other forms of publicity and mobilization relating to family planning.

Evidence to date suggests that these premises are reasonable. About 325,000 print and pictorial booklets on three modern methods in four different languages were printed and distributed by PPFN to their own and to state health clinics. Over 85 percent of the Yoruba-speaking clients said the health motivators explained the booklets carefully and gave them

to clients, most of whom referred to the booklets later and showed them to their husbands. A pilot television show produced by the Nigeria Television Authority in Enugu cited by 57 percent of new accepters at the clinic mentioned in the broadcast as their "source of referral." State officials in at least 16 states have already requested specialized IEC assistance in carrying out local mobilization-type activities.

4. Policy Implementation

Nigeria's federal system, which places great responsibilities for health, education and community welfare at the state and local levels, has permitted family planning services to advance rapidly. The policy implementation component will develop coordinating mechanisms to support family planning activities more effectively at all levels. Recognizing the diversity of the Nigerian people and the value Nigerians place on discussion, consensus and rule by recognized community norms rather than by administrative fiat, the policy component will expand opportunities both within the government and among other Nigerian leaders to analyze population needs and implications and to plan for an appropriate response. Specifically, the policy implementation component will contribute to FHI-II's goals by focussing on strategic planning and fiscal support, by enhancing leadership and institutional support, and by institutionalizing means for long-term data analysis and evaluation. The project plans to implement activities along the following lines:

Strategic Planning. Five year plans will be developed with the 95 percent of LGAs which do not yet have plans. Annual strategy planning seminars will be held for senior federal and state planners. In addition, there will be an annual workshop for state Family Planning Coordinators. Different ministries, such as Information, Local Government, Education and Agriculture, will join with the Ministry of Health in promoting family planning. Emphasis will be on developing skills at the LGA level to plan and manage programs through a series of about 30 training courses.

Fiscal Support. Focus will be on improved fiscal management including the preparation and justification of family planning budgets; cost recovery in various types of health services; and cost-benefit analysis, using RAPID models of family planning programs to demonstrate the very heavy real costs to development goals of excessively high fertility.

Leadership and Community Support. Ethnic, religious, traditional, business and other leaders will be invited to participate in some 25 workshops and 150 seminars to discuss the health and social benefits of smaller families. The National Council on Population Activities (NCPA) will develop these sessions to gain participation and support, such as testimonials from various non-governmental groups, including professional business and women's organizations.

Institutional Development. Strong leadership in key institutions is considered essential for the rapid expansion and efficient performance of the national family planning effort. To this end, the project will strengthen the institutional capacity of leadership organizations (federal and state line ministries such as education, agriculture, and rural development), consultative groups (advisory councils), and non-governmental organizations (PPFN and NCPA).

Data Analysis and Evaluation. Baseline survey data, a pilot sentinel system, and household surveys will include selected questions relating to fertility and family planning. They will be collected in part by the Federal Bureau of Statistics and analyzed with technical support from the National Population Bureau (NPB).

The achievement of these policy outputs depends on the following premises:

- national and state officials will continue to support the development and implementation of population and family planning policies; and

- other leaders will participate in seminars on population issues.

Evidence to date suggests that these premises are reasonable. Since 1983 Nigeria has made impressive progress in developing policy support for family planning service delivery and information, including a National Population Policy, a Federal Family Planning Action Plan, 19 state plans and 10 local government plans. Earlier meetings were held with all federal ministries, all state governments, including ministries and influential leaders with all four zones have issuing communiques endorsing the National Population Policy. Services now exist in every state. The Federal Bureau of Statistics conducts monthly household serveys that provide valuable data. The federal budget and most state governments include line item budgets for family planning. It is clear that at the federal and state levels, political leaders recognize that family planning is a major component in primary health care. In addition, knowledgeable planners are beginning to recognize the benefits of a reduced population growth rate for Nigeria, and non-government leaders are expressing support for policies of responsible parenthood. Recognizing that Nigeria's rapid progress in population policy development can be a model for other African countries, policy development teams from Zaire and Zambia have already visited Nigeria.

C. Linkages Among Components

Each of these four institutional approaches - private sector, public sector, IEC, and policy implementation - will function together not as four separate projects but as one unified project operating through four complementary channels. In every phase of the project as in every part of Nigeria, there will be close linkages among the four activities.

Initially in the research and analysis phase, for example, the public sector project will develop a baseline survey with relevant questions on communication, marketing and policy issues as well as on knowledge, attitude, and practice of family planning and service availability. Market research by the private sector and a proposal developed jointly by the private and IEC sectors will lead to joint selection of an advertising agency to prepare materials in support of private sector products and public sector services for all appropriate levels.

Training will be coordinated. The well-qualified public health sector will offer training which, on the one hand, includes an IEC module and IEC trainers and on the other hand is open to private sector

practitioners who can earn appropriate certification. IEC materials will be available for different types of training and will continue to be provided to private and public services delivery centers.

Constituency-building seminars and workshops by the policy sector will draw on experts in service delivery and use materials developed by the IEC sector. For example, a film illustrating the RAPID demographic projections in pictures and stories that all can understand will be available for these meetings. Radio and television coverage stimulated by the IEC component will highlight policy conclusions of important groups.

Monitoring and evaluation of each aspect of the project will depend on shared resources: the baseline survey, service statistics, audience analysis, market research, focus group discussions, the private sector management information system, and various sentinel and household surveys.

Finally, the technical assistance staff of the specialized U.S. organizations implementing the project will be located in a single office in Lagos with smaller representational units in the four health zones where representatives will work in close contact and share many administrative and information resources with federal, state and LGA counterparts.

D. Project Management

The design of the management approach through the collaborative assistance mode with four selected prime contractors takes into account the experience of previous AID-funded activities in Nigeria as well as the scope and complexity of the planned project. It reduces the administrative burden on AID, and complements the existing management resources of the AID structure and of the other parties to the project - the FMG and the implementing agencies. In the past, the diversity of centrally funded activities in Nigeria and the involvement of a large number of implementing agencies inhibited the development of an overall program strategy or a coordinated management approach to the expenditure of AID population funds. Developed in response to this situation, the FHI-II management plan consolidates resources so that project implementation can ultimately become a local management responsibility for the national population program.

The management plan, described in detail in Section IV, places complete responsibility for the project in the field with USAID/Lagos. A Project Coordinator will be contracted to serve as the Cognizant Technical Officer with planning, administration, monitoring and coordination of all project activities. REDSO/WCA will provide services to USAID/Lagos in the support of project implementation. Overall administrative and logistic support for the project will be contracted externally.

The FMG will provide counterparts for the Project Coordinator and for each technical component contractor in Lagos. In addition, various government agencies at state and local levels will take responsibility for the planning, management and implementation of various project activities.

The four implementing organizations have prepared individual work plans (Annexes H, I, J, and K) which include plans for the integrated management of component activities. These work plans will serve as a basis to coordinate and unify the project's technical activities as well as its administrative and logistical services. These four experienced and technically qualified prime contractors will consolidate their activities by working through a number of subcontracts with U.S.-based organizations, the FMG and public and private Nigerian institutions. On-site management teams based in Lagos and in each of the four regional health zones will be established to provide closer supervision and monitoring as well as technical assistance to project activities.

The Project Management Committee will include AID, FMG and the project contractors. The committee's primary function will be to review work plans on an annual basis and to provide guidelines for any strategy redirection. This committee will meet quarterly for the purpose of project review and will include visiting technicians and other donor agency representatives, as appropriate. This body will also act in an advisory capacity to the Project Coordinator and FMG counterparts.

E. Collateral A.I.D. Centrally Funded Activities

Many of the current S&T/POP centrally funded activities in Nigeria will be incorporated within this project and therefore the individual subprojects will be phased out according to the plan in Annex G. However, certain selected research and program-specific activities will not be financed by this project and will continue to be financed by S&T/POP through existing agreements and contracts with U.S. based organizations and cooperating agencies. Specifically, the following activities will be centrally funded for the duration of this project:

- Survey Research, such as the demographic and health surveys conducted by Westinghouse;

- Biomedical Research, such as the Norplant contraceptive field trials conducted by Family Health International (FHI);

- Operations Research, such as specialized research on family planning service delivery approaches developed by Columbia University;

- Voluntary Surgical Contraception, such as projects financed through the Association for Voluntary Surgical Contraception (AVSC) and the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO); and

- Other Special Activities as determined and agreed upon by USAID/Lagos and S&T/POP.

These activities will be coordinated by USAID/Lagos and be complementary to the work of the four project contractors.

F. Project Beneficiaries

Those who benefit from this project can be categorized as direct and indirect beneficiaries. Direct beneficiaries are those groups or individuals who actually participate in the design and implementation of activities. These include policymakers, opinion leaders, health and other ministry officials, trainers and media representatives, as well as Nigerian consultants and program staff. They will have an improved understanding of development planning, program management, and the design, implementation, production and evaluation of activities, materials and workshops. They will be better able to appreciate the importance of a holistic approach to development, especially in the context of child spacing and maternal and child health programs. These benefits may well go beyond Nigeria's borders as neighboring countries adopt all or part of the Nigerian approach.

Those individuals and groups trained through the program will also benefit directly through improved clinical, communication and management skills. It should be noted that most of the service providers and state family planning coordinators are women, and therefore this project will benefit women by leadership development in a major way.

Those individuals served by the project are the ultimate beneficiaries. The accessibility and availability of family planning information and services to eligible couples will ultimately improve the health of mothers and children and the general quality of life for all Nigerians. Without question, family planning is an effective and inexpensive means to save lives. By helping women bear their children during the healthiest times for both mothers and children, family planning helps prevent the deaths of infants, children and mothers. Family planning also enables couples to decide for themselves the spacing of births and number of births. Effective use of family planning allows women to avoid unwanted pregnancies, the dangers of illegal abortion, and childbearing under circumstances that will be a threat to their infants or their own health.

G. Institutionalization

Institutionalization means that eventually the activities supported will become self-sustaining through cost-recovery, or income generation, and that the necessary technical skills and supportive infrastructure will remain to carry on the services initiated. The ultimate success of this project will be measured by movement along a continuum from dependence on external resources to self-reliance. The major activities and outputs of the FHI-II project described above should be well enough established during the project, particularly through special studies and training, to remain in place long past the life of the project itself with diminishing need for any external support.

Cost-recovery or income generation. Self-sufficiency through cost recovery, or income generation, has been an elusive objective in most family planning programs. However, innovative private sector and IEC activities being introduced through this project have the potential to change this experience. Contraceptive sales through the private sector are expected to generate approximately $5.0 million over five years which

will be reinvested in the project as part of the host country contribution. IEC materials - whether print or broadcast - will be sold to users or funded by private sponsors to recover production costs. In addition, the extensive use of existing private sector networks like the missions and private maternity homes to provide family planning services, and the support of the Union of Transport Workers and the Market Women's Association to distribute information and sell non-prescriptive contraceptives will add an exciting new dimension that will reduce the burden on government resources.

Cost-recovery in the public sector is more difficult. Costs can be diminished when family planning services are fully integrated, when education is provided through pre-service training and when supplies are procured from the most competitive sources. Also government institutions can charge private practitioners and sellers for training and licensing .

It is clear that contraceptives will have to be subsidized for the life of the project and probably beyond. Income generated, however, will support critical activities to support the overall family planning movement. This effort to recover costs will set an important precedent for future activities. The real emphasis on institutionalization will focus on the transfer of skills and development of strong executing infrastructures.

Transfer of skills and supportive infrastructure. All four components involve substantial training in valuable skills. The public sector efforts directed towards the establishment of comprehensive family planning training as part of the pre-service curricula for the training of medical personnel represent a major institutionalizing activity. Furthermore the clinic equipment and instrument provided to both the public and private sector components will ensure the continuation of services through these channels for years beyond the life of the project.

Transfer of knowledge. The policy component will concentrate on building a solid, lasting Nigerian foundation of political will, leadership commitment, and legal support for all aspects of the national population program. The institutionalization of IEC efforts will be measured by the creation of a lasting and universal understanding of family planning among Nigerians of the means and availability of services to achieve desired family size and approval of the concept of a smaller, planned family. IEC materials development and social mobilization techniques will be firmly embodied in the responsibilities and activities of family planning managers and service providers by the end of the program.

H. Project Inputs

1. Primary Contributors

Total project inputs in the form of cash and in-kind contributions amount to $67.0 million (including $17.0 million in contraceptives) from the U.S. government through the U.S. Agency for International Development (USAID). A total of $33.5 million, or 33 percent of the total amount of $100.5 million required for the project, is provided by the FMG.

The USAID cash contribution of $50.0 million, provided largely through the prime contractors responsible for the four project components, will pay for technical assistance, equipment and commodities, training and production activities. An additional $17.0 million will be necessary for contraceptives.

The FMG inputs will be in the form of staff and facilities made available for the delivery of family planning services, free or discounted airtime for family planning programs and spots on television and radio, vehicles to be used by the program, as well as staff and space for training activities.

2. Complementary Donor Activities

Interactions with other international donors will continue throughout the five-year program to ensure complementary and supplementary financial, technical and material resources. The World Bank, United Nations Fund for Population Activities (UNFPA), United Nations Children's Fund (UNICEF), and United Nations Education, Scientific and Cultural Organization (UNESCO), among others, have been instrumental in helping create a momentum which has brought the health delivery system to its present level. In addition to AID, the other significant donor supporting population activities in Nigeria has been the UNFPA. Over the past ten years UNFPA, working with UNICEF and WHO, has provided population assistance to specific state governments in a variety of program areas including Maternal Child Health/Family Planning (MCH/FP), service development, population planning, fertility research, demographic/economic training and research, law and population studies, and rural migration. There has been some WHO support for strengthening basic research skills and research on specific contraceptive methods such as oral and injectable contraceptives. Current and planned donor assistance is described below.

UNFPA. UNFPA is currently providing population assistance to the FMG in the areas of MCH/FP, contraceptives, population, education and census support. UNFPA MCH/FP support focuses on state and LGA levels and emphasizes MCH/FP as a component of the Nigeria primary health care program. In this context, UNFPA will assist the 52 LGAs designated for more intensive primary health care program development. UNFPA will be working with both the FMOH and the FMOE to improve and expand population education programs. Assistance also will be provided to the National Population Bureau (NPB) for census and vital statistics activities.

Currently, UNFPA is planning to assist the newly created Office of Planning and Coordination of Population Programs in the Directorate for Health Planning in the FMOH through provision of training, technical assistance, vehicles and equipment.

The five year authorization (1987-1992) for UNFPA is $10.0 million. Of this amount approximately $6.0 million has been programmed for activities described above. Approximately $4.0 million remains to be programmed. UNFPA has been working closely with USAID/Lagos and the design team to identify areas of assistance which will complement the proposed FHI-II program.

World Bank. The World Bank is currently providing assistance to Sokoto State and plans to provide assistance to Imo State in the form of a structural adjustment loan designed to expand and improve health and family planning activities in these states.

The World Bank has recently completed an assessment visit to Nigeria in preparation for a major national population project loan. Although the specific project activities to be financed are still being planned, the general project components are known. At the present time the Bank plans a "hard" loan to the FMG to support the development of population and family planning programs at the national, state and LGA level through a variety of activities including:

- institutional development;
- family planning service development (LGA level);
- training and training institution support;
- health facility renovations;
- transport assistance;
- medical equipment, supplies and contraceptives;
- health education (including IEC programs);
- population program planning; and
- population monitoring, research and evaluation.

The funding level for the proposed Bank program has not yet been determined, but is expected to be about $60.0 million. As a consequence of the strong Bank participation in the FHI-II design, there is a high degree of willingness to cooperate with both USAID and UNFPA in developing programs which complement rather than duplicate activities planned by each organization, particularly in areas such as facility renovation, transport and other recurrent cost support, which are not covered by FHI-II.

3. Long-term Funding Implications

This project intends to support discrete activities which will assist the FMG and private sector institutions to develop a longer-term management capability, and which will put broad programmatic systems into place. Although AID has made no future commitments to Nigeria, it is clear that Nigeria's population needs extend far beyond this five-year project period. Therefore, in recognition of both the long-term need for population assistance and the desire to develop a sustainable program, AID will be prepared to plan for post-project activities. In addition, AID will take aggressive measures to ensure that the FMG and other institutions are capable of continuing the effort, independently or with the assistance of other international donors or lenders.

As is described above, the World Bank and UNFPA have long-range interests in Nigeria. Continued coordination of this project's activities with these and other donor programs is essential to provide the support necessary for the FMG to sustain the population program. The evaluation plan provides for integrating these efforts in monitoring of project progress.

III. IMPLEMENTATION PLAN

The Implementation Plan is presented according to three stages: Stage I (Pre-Project and Start-up) covers the period from the processing of the Project Paper through Authorization, the signing of the Grant Agreement with the FMG, negotiating and signing subcontracts with the implementing agencies, recruitment for the Project Coordinator and the Administrative/Logistics firm including mobilization of the project office. This stage will be completed about six months after project authorization. Phase-out of ongoing AID-supported activities funded through other mechanisms is also included in this section to demonstrate the transition from current activities to the project.

Stage II (Implementation Cycle) covers approximately one year of actual project implementation, including the cycle of quarterly planning meetings, preparation, discussion and approval of the second year workplans and budgets and AID reporting. Stage II ends in December, 1988. Benchmark activities are provided in some detail in this section, based on the detailed component workplans. Also included are the baseline surveys, studies, assessments and planning activities scheduled during this period.

Finally, Stage III is more abbreviated and covers out-years and certain planned activities such as mid-term and final evaluations, final surveys and phase-out. Other activities will be spelled out annually at the time of workplan submission. The cycle of collaboration meetings and reporting is given by month.

STAGE I: PRE-PROJECT AND START-UP

MONTH	ACTIVITY	RESPONSIBILITY
1987		
APRIL	STATE PERSONNEL/EQUIPMENT SURVEYS (CONTINUES THROUGH STAGE I)*	(PUBLIC SECTOR)
	DELIVERY OF EQUIPMENT SETS TO CLINICS -(CONTINUES THROUGH MARCH 1988)*	(PUBLIC SECTOR)
	-CONTINUE CLINICAL TRAINING PER PHASE OUT PLAN (THROUGH MARCH 1988)*	(PUBLIC SECTOR)
MAY	-PROJECT PAPER REVIEW	(AID/W)
JUNE	-PROJECT PAPER AUTHORIZED	(AID/W)
	-NPB PILOT SENTINEL SURVEY*	(POLICY)
	-POPULARIZED VIDEO OF RAPID COMPUTER CONTRACT SIGNED WITH PRIME TV/FMOH)*	(IEC)
JULY	-PIO/TS FOR PSC, ADMIN/LOG AND IMPLEMENTING ORGANIZATIONS SUBMITTED	(REDSO/USAID)
	-ADVERTISEMENT FOR PSC COORDINATOR BEGINS	(REDSO/USAID)
	-ADVERTISEMENT FOR ADMIN/LOG FIRM BEGINS	(REDSO/USAID)
	-IEC CONTRACTS SIGNED WITH OGUN AND BORNO STATES*	(IEC)
	-OGUN STATE LGA WORKSHOP*	(PUBLIC SECTOR)
AUGUST	-GRANT AGREEMENT SIGNED	(USAID/FMG/REDSO)
	-PIL NUMBER ONE ISSUED (DISCUSSION OF CPS)	(REDSO/AAO)
SEPTEMBER	-FP LOGO DEVELOPMENT CAMPAIGN BEGINS*	(IEC)
	-ISLAMIC LEADERS CONFERENCE*	(POLICY)

*ALREADY FUNDED UNDER CURRENT PROJECTS

OCTOBER	-BUSINESS LEADERS WORKSHOP (NCPA)*	(POLICY)
	-CONDITIONS PRECEDENT SATISFIED, COUNTER-PARTS IDENTIFIED FOR ALL COMPONENTS	(FMG/USAID/REDSO)
	-PROJECT COORDINATOR INTERVIEWS	(USAID/REDSO)
	-ANNUAL MEETING OF STATE/LGA FP COORDINATORS AND DEPUTIES (PORT HARCOURT)	(PUBLIC SECTOR)
	-REVIEW ALL AND ADOPT BEST ELEMENTS OF CLINICAL TRAINING MODELS FOR STANDARDIZED MODEL IN NIGERIA*	(PUBLIC SECTOR)
	-INITIAL PLANNING/DESIGN OF BASELINE SURVEY*	(PUBLIC/ POLICY)
NOVEMBER	-PROJECT COORDINATOR HIRED	(USAID/REDSO)
	-ADMIN/LOG CONTRACT SIGNED	(REDSO)
	-OBSERVATION VISIT TO BRAZIL	(FMG/PUBLIC SECTOR)
DECEMBER	-PROJECT COORDINATOR ON BOARD	(USAID/REDSO)
	-IMPLEMENTING CONTRACTS SIGNED (IEC, PUBLIC, PRIVATE, POLICY)	(REDSO)
	-PROJECT OFFICE ESTABLISHED (LEASED SPACE)	(ADMIN/LOG)
	-PROJECT IMPLEMENTATION REPORT (PIR)	(USAID)
	-RAPID VIDEO/FILM AVAILABLE*	(IEC)

STAGE II: IMPLEMENTATION

1988 JANUARY	-QUARTERLY PROJECT COMMITTEE MEETING	(USAID)
	-COUNTRY PROGRAM STAFF HIRED	(ALL IMPLEMENTING ORGANIZATIONS)
	-STAFF ORIENTATION	(ENTIRE PROJECT)
	-SUBCONTRACTS SIGNED	(IEC, POLICY)
	-NATIONAL LOGO CHOSEN	(IEC)
	-INITIATE CONSTITUENCY SUPPORT ACTIVITY	(POLICY)
	-ASSESS OGUN AND BENUE MIS PRETEST	(PUBLIC SECTOR)

FEBRUARY	-LOCAL STAFF HIRED	(PRIVATE/PUBLIC AND IEC)
	-PHASE-OUT COUNTRY OFFICE	(PUBLIC SECTOR)
	-SIGN LGA STUDY SUBCONTRACT W/ ARMTI	(POLICY)
	-COST RECOVERY STUDY INITIATED	(POLICY)
	-INITIATE MARKET RESEARCH	(PRIVATE SECTOR)
	-PPFN MALE MOTIVATION TRAINING COURSES BEGIN	(PRIVATE SECTOR)
	-ESTABLISH COUNTERPARTS WITH FEDERAL LEVEL MINISTRIES OTHER THAN FMOH	(IEC)
	-COMPLETE AND ANALYZE STATE PERSONNEL AND EQUIPMENT INVENTORY	(PUBLIC SECTOR)
	-NEGOTIATE IN-SERVICE CLINICAL TRAINING PLANS FOR YEAR ONE	(PUBLIC SECTOR)
MARCH	-INITIATE DEVELOPMENT OF NATIONAL IEC PROGRAM WITH COUNTERPARTS	(IEC)
	-INITIATE BASELINE SURVEY	(PUBLIC SECTOR)
	-INITIATE NKST MISSION PROGRAM NETWORK	(PRIVATE SECTOR)
	-PLAN STATE PUBLIC SECTOR INTERVENTIONS BASED ON INVENTORIES	(PUBLIC SECTOR)
	-REVIEW, EVALUATE CONTENTS AND USE OF CLINIC EQUIPMENT AND IUD KITS	(PUBLIC/PRIVATE)
	-WORKSHOP FOR FMOH STAFF IN USE OF REVISED MIS	(PUBLIC SECTOR)
	-LAUNCH ADVERTISING CAMPAIGN FOR PRIVATE SECTOR	(IEC/PRIVATE)
APRIL	-QUARTERLY PROJECT COMMITTEE MEETING	(USAID)
	-REVIEW, REVISE AND DEVELOP CLINICAL PROCEDURES AND PROTOCOLS FOR ALL SERVICE LEVELS	(PUBLIC SECTOR)
	-NATIONAL "SUMMIT" MEETING OF STATES AND FEDERAL HEALTH LEADERS	(POLICY/PUBLIC)
	-FOS BEGINS HOUSEHOLD SURVEY WITH FP QUESTIONS	(POLICY)
	-ASSUME RESPONSIBILITY FOR ONDO COUNTRY WOMEN SALES PROJECT	(PRIVATE SECTOR)

	-IN-SERVICE TRAINING BEGINS (CONTINUES THROUGHOUT YEAR)	(PUBLIC SECTOR)
	-IEC CAMPAIGNS INITIATED IN 5 STATES	(IEC)
	-INITIATE NCPA MASS MEDIA ADVOCACY AND IEC PACKAGES DEVELOPMENT	(IEC)
	-ASSESSMENT OF COMMODITY NEEDS COMPLETED	(PRIVATE SECTOR)
	-INITIATE TOT IEC CURRICULA DEVELOPMENT	(IEC)
	-INITIATE DISTRIBUTOR PROGRAM NETWORKS	(PRIVATE SECTOR)
	-INITIATE VENDORS/ASSOCIATIONS PROGRAM	(PRIVATE SECTOR)
	-NEGOTIATE ESTABLISHMENT OF NEW IN-SERVICE CLINICAL COURSES	(PUBLIC SECTOR)
	-ASSESS PRE-SERVICE CURRICULA PROGRESS	(PUBLIC SECTOR)
MAY	-REGIONAL CONFERENCE FOR BUSINESS LEADERS	(POLICY)
	-POSTERS, STICKERS, BANNERS, OF LOGO AVAILABLE	(IEC)
	-INITIATE SECOND ROUND OF VENDOR/ ASSOCIATION PROGRAM	(PRIVATE SECTOR)
	-INITIATE PRIVATE SERVICE PROVIDERS NETWORK	(PRIVATE SECTOR)
	-COMMENCE IN-SERVICE TRAINING IN NEW STATES/INSTITUTIONS	(PUBLIC SECTOR)
	-ASSESSMENT OF PRIVATE SECTOR CLINICAL NEEDS	(PRIVATE SECTOR
	-ZONAL WORKSHOPS FOR STATE STAFF ON REVISED MIS	(PUBLIC SECTOR)
	-LAUNCH ADVERTISING CAMPAIGN FOR PRIVATE SECTOR	(PRIVATE SECTOR)
JUNE	-PROJECT IMPLEMENTATION REPORT	(USAID)
	-IMPLEMENTING CONTRACTOR REPORTS DUE	(PUBLIC/PRIVATE IEC/POLICY)
	-COMMENCE STATE ROUNDS FOR EQUIPMENT REVIEW	(PUBLIC SECTOR)

	-REGIONAL CONFERENCE FOR ISLAMIC LEADERS (NCPA)	(POLICY)
	-COMMODITIES ORDER PLACED	(PRIVATE SECTOR)
	-INITIATE PRIVATE SECTOR PRACTITIONER PROGRAM	(PRIVATE SECTOR)
	-INITIATE LGA CONSULTATION/STUDY (INSTITUTE FOR LOCAL GOVERNMENT)	(POLICY)
	-INITIATE SUBCONTRACTS WITH FEDERAL LEVEL MINISTRIES FOR IEC PRODUCTION AND WORKSHOPS	(IEC)
	-INITIATE CONTRACT WITH PPFN FOR IEC MATERIALS DEVELOPMENT	(IEC)
JULY	-QUARTERLY PROJECT COMMITTEE MEETING	(USAID)
	-STATE FP COORDINATORS NATIONAL WORKSHOP	(POLICY/PUBLIC IEC)
	-PRIVATE SECTOR N/NM TRAINING	(PRIVATE SECTOR)
	-NCPA MASS MEDIA ADVOCACY CAMPAIGN BEGINS	(IEC)
	-REVISED MIS INSTALLED, ALL STATES	(PUBLIC SECTOR)
AUGUST	-REGIONAL CONFERENCE FOR ISLAMIC LEADERS (NCPA)	(POLICY)
	-ASSIST NPB IN FINALIZING BASELINE STUDY	(PUBLIC SECTOR)
	-ASSESS MICROCOMPUTER NEEDS OF SELECTED STATES	(PUBLIC SECTOR)
	-FIRST DRAFT OF FY '89 BUDGET, WORKPLANS SUBMITTED BY ALL CAS/SUBCONTRACTORS	(USAID)
	-REVIEW, REVISE AND DEVELOP CLINICAL PROCEDURES AND PROTOCOLS FOR ALL SERVICE LEVELS	(PUBLIC SECTOR)
	-CONDUCT IEC CURRICULA WORKSHOP	(IEC)
SEPTEMBER	-REGIONAL CONFERENCE FOR BUSINESS LEADERS (NCPA)	(POLICY)
	-DESIGN/PRE-TEST ADDITIONAL MIS COMPONENTS	(PUBLIC SECTOR)
OCTOBER	-QUARTERLY PROJECT COMMITTEE MEETING/REVIEW AND APPROVE FINAL 1989 WORKPLANS AND BUDGETS	(USAID)

	-NATIONAL WORKSHOP FOR TRADITIONAL RULERS (NCPA)	(POLICY)
	-CONDUCT NATIONAL FAMILY LIFE EDUCATION TOT WORKSHOP	(IEC)
NOVEMBER	-REGIONAL CONFERENCE FOR BUSINESS LEADERS (NCPA)	(POLICY)
DECEMBER	-REGIONAL CONFERENCE FOR ISLAMIC LEADERS (NCPA)	(POLICY)
	-PROJECT IMPLEMENTATION REPORT	(USAID)
	-IMPLEMENTING CONTRACTOR REPORTS DUE	(PRIVATE/PUBLIC IEC/POLICY)

STAGE III: PERIODIC EVALUATION, PHASE-OUT (IMPLEMENTATION BENCHMARKS AFTER DECEMBER, 1988 WILL BE BASED ON APPROVED ANNUAL WORKPLANS)

ANNUALLY

JANUARY	-CONTRACEPTIVE PROJECTIONS AND COMMODITIES PLANNING	(USAID/PRIVATE/ PUBLIC)
	-QUARTERLY PROJECT COMMITTEE MEETING	(USAID)
	-STATE-BY-STATE PROGESS EVALUATION	(POLICY)
MARCH	-ANNUAL COMMODITIES ORDER	(USAID)
APRIL	-NATIONAL "SUMMIT" MEETING OF NIGERIAN LEADERS	(ENTIRE PROJECT)
	-QUARTERLY PROJECT COMMITTEE MEETING	(USAID)
JUNE	-PROJECT IMPLEMENTATION REPORTS	(USAID)
	-IMPLEMENTING CONTRACTOR REPORTS DUE	(PUBLIC/PRIVATE IEC/POLICY)
JULY	-QUARTERLY PROJECT COMMITTEE MEETING	(USAID)
	-STATE FP COORDINATOR MEETING	(ALL)
	-ANNUAL WORKPLAN DRAFTS DUE	(ALL)

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OCTOBER	-QUARTERLY PROJECT COMMITTEE MEETING	(USAID)
	-ANNUAL WORKPLANS AND BUDGETS REVIEWED AND APPROVED - FORWARD FUNDING	
DECEMBER	-PROJECT IMPLEMENTATION REPORTS	(USAID)
	-IMPLEMENTING CONTRACTOR REPORTS DUE	(ALL)
NOV. 1989	-FIRST PROCESS EVALUATION	(REDSO/USAID/FMG)
JULY 1991	-SECOND PROCESS EVALUATION	(REDSO/USAID/FMG)
NOV. 1992	-END OF PROJECT EVALUATION	(REDSO/USAID/FMG)
NOV. 1992	-END OF PROJECT PREVALENCE SURVEY	(EXTERNAL CONTRACT)
DEC 1992	-PACD	

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IV. MANAGEMENT PLAN

A. Introduction

Management of FHI-II integrates the activities of the four project components (private sector, public sector, policy implementation and IEC) with on-going FMG family planning activities at the national, state and LGA level. These linkages will be strengthened through an innovative system which takes advantage of the management experience of the implementing organizations, and the successes of the FMG, while minimizing the administrative burden on USAID/Lagos.

The development of the project's management scheme considers the previous program management experience under the centrally funded projects, and proposes a simplified administrative structure for FHI-II activities. The management structure assures manageability through the addition of a project-funded coordinator, the external contracting for all project administrative and logistical support, reducing the implementing organizations to only four with established track records in Nigeria, and systematic support from REDSO/WCA to USAID/Lagos.

B. USAID/Lagos Management Experience

When the USAID/Lagos was reopened in 1983, development activities were limited to less than a dozen population activities at a level of approximately $2.5 million/year. In recent years, the level of activity has steadily increased. This has been in response to the growing awareness by the FMG of the detrimental impact of the rapid population growth rate, other maternal and child health care problems and the worsening economic conditions facing Nigeria

USAID/Lagos welcomed increased interest and support from centrally funded projects through S&T/POP and Health. These activities, however, suffered from limitations as follows:

1. Insufficient and Fluctuating Funding Levels

Virtually all funding for population and health activities in Nigeria has come from centrally funded resources supplemented by occasional Africa Bureau fallout. In spite of the relative importance of Nigeria in the economic and demographic context of Africa and indeed in the world, funding levels have been small ($.06 per person per year). Furthermore, there have been wide fluctuations in funding levels from one year to the next as a consequence of central funding availability and programming decisions. Only in FY86 did USAID receive a fully African Bureau Health Project Combatting Communicable Childhood Diseases (CCCD). Population funding remained problematic.

2. Diverse Activities with Multiple Actors

The range of activities under central funding has included well over 200 subgrants with dozens of implementing organizations. However, despite the numerous activities, adequate resources are not available to respond to Nigeria's needs. For example, adequate funds have not been made available for basic training, with the result that six states have yet to receive formal clinical training in family planning skills.

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3. Short-term Strategy

While significant achievements in programming centrally funded population activities have been made, USAID/Lagos has been limited to a short-term strategy in population activities due to the uncertainty of funding levels. Lacking a bilateral agreement, USAID/Lagos has accepted funds and adapted its programming to the Nigerian context, but has been unable to sustain a long-term strategy. With the steady growth of demand for family planning in Nigeria, S&T/POP advised USAID/Lagos in 1985 that its resources could not cover an expanded program and strongly urged USAID to develop a bilateral or quasi-bilateral to assure long-term, adequate funding for the program. AFR/DAA and AFR/TR strongly seconded S&T/POP's recommendation.

C. Proposed Management Strucuture

As discussed in the feasibility analyses, there has been a marked increase in interest in family planning on the part of the FMG. This situation has given rise to a revised program management philosophy for USAID/Lagos, which can be summarized as follows: Assured funding; redirecting management from Washington to the field; focussing of resources and activities through fewer channels; and, support for a stronger role of Nigerian organizations in family planning activities.

1. Redirection of Program Management

As opportunities for major achievements in family planning arise, the decisions concerning ways to exploit these opportunities must be seized. USAID/Lagos has gone to great lengths to sensitize a constituency in family planning and now requires the latitude of more direct control of resources. Sound relationships have been forged with key health and population leaders, both inside the FMG and out. Moreover, in order to recognize the key role Nigeria plays in Africa's future, program goals and resources must be apportioned with this role in mind.

2. Focussing of Assured Levels of Resources

A collaborative mode project permits more careful focussing of resources to those areas which have the greatest potential for success. In this project, these include private sector development, the documented need for training of family planning service providers and health care managers, supported by a well-planned, targeted IEC campaign including educational efforts aimed at influentials and policymakers. While acknowledging that a host of other family planning activities exist alongside these selected areas, and should be allowed to continue, the essential objective of rapidly increasing availability and acceptability of family planning information and services must be addressed through the longer term, strategically planned program presented in this project.

3. Stronger Role for Nigerian Organizations

It is the aim of this project to foster a strong indigenous capability to influence the policy climate in Nigeria and to administer

family planning programs. The PPFN has been active in many areas and has benefited from donor support by IPPF, USAID and UNFPA. The World Bank and UNFPA are developing programs to strengthen federal level family planning activities which closely parallel this project's focus of private/public sector service delivery supported by IEC/policy programs.

USAID/Lagos has identified the NCPA as a potentially important policy advocacy body. As described in the Administrative Analysis, the NCPA is a new organization with a mandate to provide a forum for the coordination of various private sector and voluntary organizations' activities, and to undertake programs of public enlightenment concerning problems of population growth throughout Nigeria. This project proposes to underwrite certain activities of the NCPA to bolster its development.

Project management must consider the institutional capability of the host country to continue a family planning program in the absence of direct AID involvement. USAID/Lagos believes its efforts along with those of other donor programs will ease this eventual transition.

D. Management Resources

As a precursor to presentation of this management structure, inventory of the project management resources available and the limitations associated with these resources will be presented. These include USAID/Lagos, REDSO/WCA, the four implementing organizations and the FMG.

1. USAID/Lagos

USAID/Lagos is staffed by two Direct Hire employees in the Embassy (the AID Affairs Officer and Health/Population Development Officer), one PASA Agricultural Officer at the Institute of International Tropical Agriculture (IITA) in Ibadan; two PASA employees from the Centers for Disease Control (CDC) to manage USAID's CCCD Project. USAID/Lagos is also supported by two Direct Hire Foreign Service Nationals as program assistants and a contract staff of 13. Both American Direct Hires are due for rotation within the next 18 months. Thus, the availability of adequate personnel resources must be addressed by any management plan for this project.

2. REDSO/WCA

REDSO/WCA in Abidjan gives priority support to USAID/Lagos, a "Schedule B" post. As such, REDSO/WCA provides a full complement of mission services on a periodic basis, including project development, technical support (population, agriculture, health, etc.), legal guidance, contract and commodity management, and financial management.

In accordance with its usual support to "Schedule B" posts, REDSO/WCA agrees to make available whatever resources are required to support implementation of this project. This is evidenced by the nearly two-person years of staff time directed to the development of the project. REDSO services are not, however, available for actual project management.

3. Implementing Organizations

Selected under the collaborative assistance mode, each of the four implementing organizations will manage its own component. These organizations were selected competitively based on Expressions of Interest prepared especially for this project. A key criterion for selection was the institutional capability and committment to manage projects, with an emphasis on prior Nigerian experience.

4. Federal Military Government of Nigeria

As described in the Administrative Analysis, FHI-II seeks to work closely with numerous entities in the FMG. Although the host government will not manage project funds directly, they will be instrumental in the review and approval of annual work plans. In addition, the role of the FMOH may be considerably strengthened by UNFPA and World Bank plans to support the development of an Office of Planning and Coordination to the Population Programs.

Owing to the high degree of autonomy of the states under the federal system, the project will focus on the state and LGA level for most implementation activities. Accordingly, State Family Planning Coordinators are the likely counterparts to work with the project at the state level.

E. Project Management Plan

The FHI-II management will be enhanced through the incorporation of several innovations which build on past experience and adapt to local conditions. Most importantly, USAID proposes to recruit a senior, full-time project-funded coordinator, who will be supported by a full complement of REDSO/WCA services. To reduce the administrative burden, all administrative and logistical support will be provided externally through a contract. This structure is illustrated in Table 1 of this Chapter.

Project activities will begin in accordance with a mutually agreed upon phase-out/phase-in plan for projects currently supported by centrally-funded cooperating agencies (AID/W-REDSO-USAID), attached as Annex G. Based on the agreement reached through this plan, the four implementing organizations have developed detailed annual work plans with FMG/USAID inputs. These workplans complement four key activities described in the Phase-in/Phase-out Plan which are outside the scope of the project.

The project contemplates no additional Americans employed to work in Nigeria by the implementing organizations, although one PSC will be hired for the position of Project Coordinator. Due to the importance and magnitude of this project, and the nature of the collaborative mode with its periodic re-assessment of direction, this one full-time U.S. professional was deemed essential by the design team.

1. Project Coordinator

The role of the Project Coordinator is to act as Cognizant Technical Officer and manage all project implementation actions under the direction of the USDH Project Manager. In general, the Project Coordinator will be responsible for the planning, administration, monitoring and coordination of all project activities. The roles/responsibilities of this senior level position are presented in a detailed SOW attached as Annex L.

While it is not essential that this position be filled by an American, it should be advertised and competed to include the U.S. as a source (possible Nationality waiver required). This individual will report directly to the USDH Health/Population Development Officer under the general supervision of the AID Affairs Officer (AAO).

Recruitment for this position will begin immediately upon project authorization with advertisement in the Commerce Business Daily, leading professional journals and a cabled announcement worldwide. Based on the response, a short list will be assembled for telephone and in-country interviews including FMG participation. These actions are reflected in the Implementation Plan. The Project Coordinator should be on board by December 1987.

2. REDSO/WCA Support

As described earlier, REDSO/WCA will provide continued support to USAID/Lagos in project implementation. The expected level of support is estimated at one person year annually. This support is apportioned as follows:

a. Regional Population Officer: 2-3 person months/year;
b. Project Development Officer: 2 person months/year;
c. Regional Contracts Officer: 1-2 person months/year;
d. Regional Legal Advisor: 1 person month/year;
e. Regional Controller: 2 person months/year; and
f. Regional Supply Management Officer: 1 person month/year.

These services have been tentatively established in Annex N of this paper and have been agreed to by REDSO/WCA management.

3. External Administrative/Logistics Support

In recognition of the burden to USAID/Lagos of providing support to non-USDH employees, FHI-II includes a contract for centrally provided administrative and logistical support to project personnel. The purpose of this contract is to establish, staff and maintain an office for all project personnel, and to monitor equipment/commodity utilization which will permit a reduction in the current level of PSC contract staff funded by USAID/Lagos. In will also maximize cost-effectiveness by centralizing many similar functions (communications, office space, office equipment, etc.), and will promote collaboration among implementing agencies.

A detailed draft Statement of Work for the Administrative and Logistics Support Unit is included as Annex M.

4. Implementing Organizations

It is important to note that the selection of the implementing organizations under the collaborative assistance mode considered management capability as a central criterion. Building on this established track record, each of the four implementing organizations has prepared a management plan for inclusion into its respective workplan. As evidenced in these workplans, management at the implementation level is characterized as follows:

a. integration of project activities with one another and with FMG, where appropriate;
b. fully developed relationships with FMG designated counterparts;
c. strengthening of Nigerian organizations to manage and administer family planning activities; and
d. close coordination of activities and resources through careful advance planning;
e. in-country, local hire programs managers with home office support;
f. coordinated, regionally-based oversight, where possible; and
g. periodic review of activities and annual assessment, re-programming.

These provide the arrangements for well coordinated application of project resources and are fully discussed in the individual workplans,.

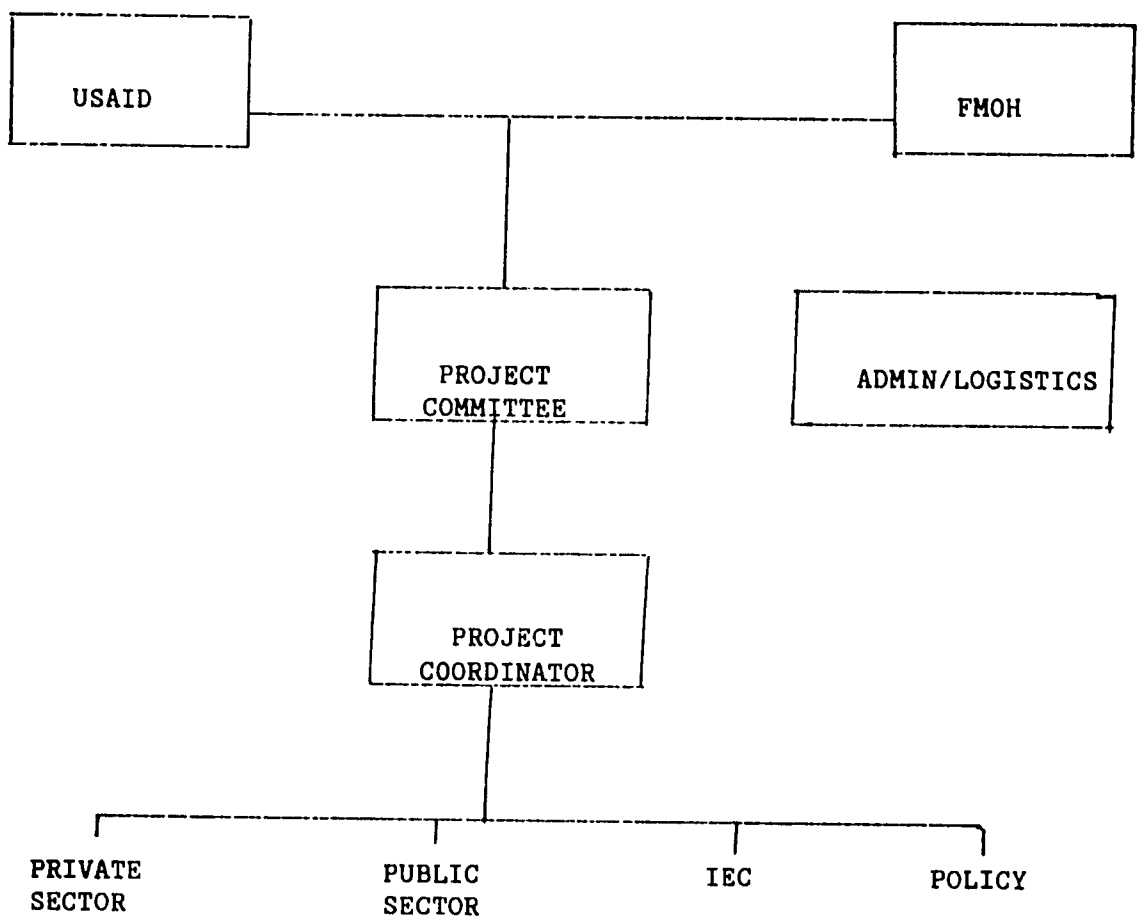
F. Annual Workplans

Essential to the collaborative assistance mode of implementation, the project will make use of annual workplans for improved management. Each component workplan (a project planning, organizing, and scheduling tool developed with designated Nigerian counterparts and institutions) will serve as the basis to coordinate and unify the project's technical activities and will serve as the basis for determining the type, quantity and timing of the administrative/logistical services needed to implement the project. The overall implementation activities of the project will be spelled out in an annual implementation plan and will be monitored and updated during quarterly reviews of the workplans. The implementing contractors, FMG, and USAID will be parties to the preparation of the plans and contractors will be obligated to the contents of the work plans in their performance under their contracts as approved and monitored by AID.

G. Project Management Committee

Representatives from the above-listed organizations will participate in periodic reviews as a Project Management Committee, which is co-chaired by the AID Project Manager and the FMG counterpart. The primary function of the committee will be to review work plans on an annual basis and provide guidelines for any redirection of strategy. At a minimum, this committee will convene quarterly for the purpose of project review, including the participation of visiting technicians, as appropriate. In addition, S&T/POP and REDSO/WCA will participate fully in the annual reviews and, to the extent possible, in the quarterly reviews. To aid management of the project, this body should act in an advisory capacity to the Project Manager and his FMG counterpart.

TABLE 1: FAMILY HEALTH INITIATIVES II
PROJECT MANAGEMENT
STRUCTURE



H. Summary

The individually-tailored management structure proposed for FHI-II, particularly as a function of the collaborative assistance mode, will assure coordinated planning, management and oversight of numerous project activities, with ample opportunities for review by the four implementing organizations, the FMG and AID.

V. PROCUREMENT PLAN

A. Introduction

Procurement under this project is planned in four areas: implementing organizations, project management, evaluation/audit services, and contraceptives. Where possible, commodity procurement has been included in the responsibility of the implementing organizations. This is done to improve the responsiveness of the commodity procurement process to the technical performance and to ease the administrative burden of the AID Project Coordinator. This section provides a summary of each procurement area and refers to appropriate annexes for further details.

B. Implementing Organizations

AID has chosen the collaborative assistance mode for this project. Primary program conditions which allow for use of the collaborative assistance approach are where the project involves: problem-solving type activity, the requirement to develop institutions, the need to devise operating systems and policies to execute the project, and where the implementation of the project involves research and development and testing of alternative methods of project implementation as the project proceeds through its life. The collaborative approach also lends itself to projects where in the beginning it is difficult to define precisely, in advance, what contractor inputs will be. Further, the collaborative assistance approach invites and enables a high degree of participation in project planning among AID, host country, and private agency recipients of services and the contractor(s). The program conditions for which the collaborative assistance approach was designed were determined to be the dominant conditions of the FHI-II Project.

The four implementing components are described below:

1. Private Sector

   a. Description. The Private Sector Component, as described in annexed work plan (Annex H), will expand and improve the distribution of contraceptives through private outlets and private service providers through training and commodity distribution activities.

   b. Estimated Cost. $10.0 million.

   c. Probable Source. U.S. and Nigeria for services; U.S. and Nigeria for all commodities.

   d. Waiver Required. No.

   e. Method of Procurement. Collaborative Assistance Mode. Competed in January 1987. Design contract awarded to Family Planning International Assistance (FPIA) and subcontractors John Snow International and Margaret Sanger Center.

   f. Method of Financing. Federal Reserve Letter of Credit.

g. Delivery Schedule. Sign contract by December 1987. REDSO/WCA Regional Contracts Officer.

h. Procurement Schedule. Submit PIO/T by September 1987.

i. Notes. This contract will include provisions for subcontracting technical assistance, training and commodity procurement. The contractor will be required to comply with AIDAR and FAR procedures.

2. Public Sector

a. Description. The Public Sector Component as described in annexed work plan (Annex I) will ensure that family planning services and information are extended through to at least 3,600 public sector service points.

b. Estimated Cost. $11.0 million.

c. Probable Source. U.S. and Nigeria for services; U.S. and Nigeria for commodities.

d. Waiver Required. No.

e. Method of Procurement. Collaborative Assistance Mode. Competed in January 1987. Design contract awarded to The Pathfinder Fund and its subcontractors Management Sciences for Health, Institute of Health Policy Studies, Africare, John Short & Associates, and Family Health International.

f. Method of Financing: Federal Reserve Letter of Credit.

g. Delivery Schedule. Sign contract by December 1987. REDSO/WCA Regional Contracts Officer.

h. Procurement Schedule. Submit PIO/T by September 1987.

i. Notes. This contract will include provisions for subcontracting of technical assistance, training and commodity procurement. The contractor will be required to comply with AIDAR and FAR procedures.

3. Information, Education and Communication

a. Description. The Information, Education and Communication Component, as described in the annexed work plan (Annex J), will develop and implement a broad IEC campaign at national, state and LGA levels based on the use of mass media, print materials and training.and directed to a variety of audiences.

b. Estimated Cost. $15.0 million.

c. Probable Source. U.S. and Nigeria for all services. U.S., Nigeria and Code 899 Source/Origin for commodities (see below).

d. Waiver Required. Waiver request for electronic equipment (Code 899) estimated at $300,000. Specifications are contained in work plan.

e. Method of Procurement. Collaborative Assistance Mode. Competed in January 1987. Design contract awarded to the Population Communication Services (PCS) of Johns Hopkins University, School of Hygiene and Public Health.

f. Method of Financing. Federal Reserve Letter of Credit.

g. Delivery Schedule. Sign contract by December 1987. REDSO/WCA Regional Contract Officer.

h. Procurement Schedule. Submit PIO/T by September 1987.

i. Notes: This contract will include provisions for subcontracting technical assistance, training and commodity procurement. PCS will be required to comply with AIDAR and FAR procedures.

4. Policy Implementation

a. Description. The Policy Implementation Component, as described in the annexed work plan (Annex K), aims to strengthen the process of policy implementation and strategic planning for efficient mobilization of an effective and self-sustaining national family planning program.

b. Estimated Cost. $3.0 million.

c. Probable Source. U.S. and Nigeria for all services and commodities.

d. Waiver Required. No.

e. Method of Procurement. Collaborative Assistance Mode. Competed in January 1987. Design contract awarded to Carolina Population Center (CPC) of University of North Carolina at Chapel Hill.

f. Method of Financing. Federal Reserve Letter of Credit.

g. Delivery Schedule. Sign contract by December 1987. REDSO/WCA Regional Contracts Officer.

h. Procurement Schedule. Submit PIO/T by September 1987.

i. Notes. This contract will include provisions for subcontracting technical assistance, training and limited commodities. The contractor will be required to comply with AIDAR and FAR procedures.

C. Project Management

Project management actions are divided into two procurements: Project Coordinator and Administrative/Logistics Support. These are described in detail with illustrative scopes of work and budgets as annexes.

1. Project Coordinator

   a. Description. The services of a Project Coordinator will be required to assist AID Direct Hire Project Manager. A detailed position description and budget are contained in Annex L.

   b. Estimated Cost. $1.0 million for five years.

   c. Probable Source. U.S.

   d. Waiver Required. No.

   e. Method of Procurement. AID direct competition.

   f. Method of Financing. Cost reimbursement.

   g. Delivery Schedule. Sign contract by November 1987. REDSO/WCA Regional Contracts Officer.

   h. Procurement Schedule. Submit PIO/T by July 1987.

   i. Notes. To expedite hiring of coordinator, this procurement will be advertised prior to the availability of funds. However, the advertisement will contain a proviso that the execution of a contract is contingent upon the availability of funds and a signed agreement with the FMG.

2. Administrative/Logistics Support Unit

   a. Description. An Administrative/Logistics Support Unit will be contracted to establish and staff an office facility to take full administrative and logistical responsibilities for the four project implementing organizations. The Scope of Work and budget are described in Annex M.

   b. Estimated Cost. $5.0 million for five years.

   c. Probable Source. U.S. or Nigeria for services. U.S., Nigeria and Code 899 for commodities (see below).

   d. Waiver Required. Waiver justifications for vehicle procurement and shelf item procurement (Code 899) contained as Annex F.

   e. Method of Procurement. Competitive (AID Direct) for services and commodities.

   f. Method of Financing. Cost reimbursable and fixed fee for prime contract.

   g. Delivery Schedule. Sign contract by November 1987. REDSO/WCA Contracts Officer.

   h. Procurement Schedule. Submit PIO/T by July 1987.

i. Notes. This procurement will be advertised prior to the signature of the Grant Agreement with the proviso that funds are available. This contract will include provisions for subcontracting technical assistance and commodity procurement. The contractor will be required to comply with AIDAR and FAR procedures.

D. Evaluation and Audit Services

The Evaluation Plan makes provisions for two process evaluations and an end-of-project evaluation including an end-of-project national prevalence survey. In addition, provisions are made for an end-of-project audit.

1. Evaluation

a. Description. As described in Section VI, Evaluation Plan, two process evaluations and one final impact evaluation including an end-of-project prevalence survey will be funded during project implementation.

b. Estimated Cost. $1.2 million.

c. Probable Source. U.S. and Nigeria.

d. Waiver Required. No.

e. Method of Procurement. AID Direct Indefinite Quantity Contract (IQC); REDSO/WCA Regional Contracts Officer.

f. Method of Financing. Cost reimbursement plus fixed fee.

g. Delivery Schedule. Various per Implementation and Evaluation Plans.

h. Procurement Schedule. Submit PIO/Ts three months prior to desired evaluation date, except for end-of-project national prevalence survey which will require approximately 10 months lead time for planning, questionnaire design, pre-testing, and interviewer training.

2. Financial Audit

a. Description. A final audit to review expenditures is planned with provision of an interim audit and/or technical guidance in financial systems, if warranted.

b. Estimated Cost. $0.3 million.

c. Probable Source. U.S. and Nigeria.

d. Waiver Required. No.

e. Method of Procurement. AID Direct Indefinite Quantity Contract (IQC) - REDSO/WCA.

f. Method of Financing. Cost reimbursement plus fixed fee.

g. Delivery Schedule. End of project - December 1992.

h. Procurement Schedule. Submit PIO/T 3 months prior to desired start-up date.

E. Contraceptives

Detailed contraceptive projections were developed pursuant to the technical objectives of the service delivery components of the project. For the strong of heart, discussion of the calculations of these projections is contained in the Technical Analysis (Annex Q). A summary of the requirements is presented below.

a. Description. Contraceptives as described in the annexed Technical Analysis (Annex Q).

b. Estimated Cost. $17.0 million. (See attached Table for annual estimates).

c. Probable Source. U.S. (Code 000).

d. Waiver Required. No.

e. Method of Procurement. AID Direct S&T/POP Contraceptive Procurement Project (936-3018), with handling and freight forwarding handled through an existing contract.

f. Method of Financing. Competitive - U.S. Government centrally competed.

g. Delivery Schedule. Annual shipments. Orders placed in January by S&T/POP/Commodities.

h. Procurement Schedule. Submit PIO/C in January each year. USAID/Lagos.

i. Notes. Annual contraceptive requirement estimates will be made according to S&T/POP "Guidelines for Contraceptive Procurement," and will follow procurement schedules established under the Central Contraceptive Procurement System. Procurements will be made annually based on previous consumption.

Not factored into this budget amount is a possible increase in use of condom and spermicides due to the impact of the FMG Anti-AIDS educational program. It is estimated that possibility 500,000 condoms will be required for AIDS prevention in the first project year, increasing annually at a minimum rate of 5 percent. It is expected that by 1992 approximately $1.0 million will be required for condoms for AIDS prevention alone.

F. Participation by Gray Amendment Entities

Various Gray Amendment entities have been involved in the population program in Nigeria in the past with success. Of the organizations contracted under the collaborative assistance mode for the design phase, The Pathfinder Fund and Johns Hopkins University subcontracted with Gray Amendment entitites, Africare and CEDPA. During the implementation phase, the four primes will be encouraged to involved other such interests.

VI. EVALUATION PLAN

A. Scope

The project evaluation will involve two types of assessments: 1) internal management reviews and 2) independent external evaluations.

1. Internal Management Reviews

Semi-annual program reports and quarterly service statistics reports will be prepared regularly by the project contractors and reviewed by AID management. At formal quarterly and annual meetings, FMG representatives, AID management and project contractors will meet for internal programmatic and management reviews. The purpose of these reports and reviews will be to monitor key performance indicators, assess program progress and make mid-course corrections on the basis of identified accomplishments or constraints.

2. External Evaluations

Three external evaluations will be conducted by evaluators independent of AID or the project contractors. During the first three and one-half years, there will be two process evaluations which will focus on program management and performance. The first evaluation will provide the basis for any major adjustments in program management or direction. The second evaluation will be to review overall project achievement and to prepare for a follow-on project if warranted or to explore alternative directions for future involvement of external funding agencies (AID, World Bank, UNFPA, etc.). A final impact evaluation will focus on the project's achievements towards reaching the stated purpose and outputs as detailed in the Logical Framework and will include a national population survey to determine changes in contraceptive knowledge, attitudes and practices.

The above monitoring mechanisms will be particularly important given the intensity and innovativeness of the various program approaches. Constant and systematic tracking, over time, of key performance variables (e.g. contraceptive prevalence, shift to private sector service delivery institutionalization) will be critical to: a) insuring appropriate and timely project implementation; b) identifying possible shortcomings in project design; c) making necessary course adjustments; and d) preparing for future population/family planning activities whether funded by AID or other agencies, or absorbed by the FMG.

B. Measurable Indicators of Project Goals, Purpose, Outputs Targets

The following are the major objectives of this project, and the means whereby data will be obtained to measure the achievement of these objectives.

1. Goal

The project ultimately aims to reduce the infant mortality rate; reduce the maternal mortality rate; reduce high risk pregnancies; and reduce the total fertility rate. Baseline measures will be obtained from

a sample survey of the population conducted in the first year covering four states representative of the four regions of Nigeria. This survey will provide direct estimates of the infant mortality rate, the total fertility rate and, high risk pregnancies (as related to age, parity and birth interval) through a pregnancy history questionnaire. A final national population survey of the four original states plus four new states (with oversampling of the baseline states) will estimate these same parameters, and permit direct estimates of the changes that have occurred. In addition, FMG, World Bank, WHO, and UNICEF reports should provide data for progress verification. Close donor coordination and maximum use of resource will be important to optimum goal achievement.

2. Purpose

The project purpose is to increase the acceptability and availability of family planning aservices in both the public and private sectors. It encompasses four major objectives:

- to increase contraceptive prevalence to 12 percent (approximately 2.5 million users) with 70 percent served through the private sector and 30 percent through the public sector;

- to establish family planning service outlets nationwide (12,000 private sector and 3,600 public sector);

- to bring knowledge of family planning concepts to 80 percent of the population aged 15-44 and to bring attitudinal changes toward smaller family norms;

- to strengthen the policy implementation process to allow the rapid expansion of family planning services.

The following enumerates the specific performance indicators and the means, over time, to verify progress.

Contraceptive prevalence. By the end of the project it is expected that at least 12 percent of eligible couples will be using a modern contraceptive method compared to the current use of about three percent. The project purpose is to increase the acceptability and availability of family planning services in both the public and private sectors. It encompasses four major objectives: to produce a favorable policy climate for a rapid family planning program expansion; to bring the knowledge of family planning concepts to 80 percent of the eligible population; to establish family planning information and service outlets nationwide (12,000 private sector and 3,600 public sector); and to increase contraceptive prevalence to 10-12 percent (approximately 2,500,000 users).

Indirect estimates of contraceptive prevalence rates during the course of the project will be derived from public sector service statistics and private sector commodity distribution figures in combination with the findings of client follow-up surveys to measure continuation rates. Annual contraceptive commodities projections will assess, on a yearly basis, the previous year's contraceptive use. The baseline population survey will provide contraceptive prevalence rates for selected states in the four regions of the country. The National

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Integrated Survey of Households will indicate, annually, national and state level estimates of contraceptive prevalence. A pilot sentinel survey in four urban areas will seek to measure attitudual and practice changes at points in which project resources have been concentrated. The definitive measurement of the prevalence reached by the end of the project will come from the final national population survey. All of the population surveys will be designed to distinguish contraceptive users according to whether they obtain their supplies from the public or private sector as well as their source of referral. Of particular interest will be the shift in percentage of users served by the private sector.

Service Delivery. By the end of the project it is anticipated that family planning information, services and commodities will be provided through approximately 12,000 private sector outlets and 3,600 public service delivery points. Service points will be considered "established" when information and/or services are available regularly and on demand; when trained staff is in place; when there is a constant and adequate supply of contraceptive supplies; and when service provided or commodities sold are regularly reported through the overall management information system.

To identify service delivery progress, a state-by-state baseline inventory of all public sector family planning facilities and trained staff will be undertaken in the pre-project period. During the first project year, a management information system will be developed by the public sector component which will provide service statistics data to document the expansion of services through new service delivery sites as well as the level of service performance of all other service sites. Private sector service performance will be documented through annual sales/commodity distribution figures. Both the public sector and private sector service outlet performance will be subject to independent verification by outside evaluation teams.

Knowledge and attitudinal changes. Knowledge of family planning by the adult population is expected to increase to 80 percent comparedwith the 33 percent level observed during the 1981-82 Fertility Survey. The 1982-82 recorded "desired family size" of 8.5 children should also be lowered. Knowledge of family planning concepts will be measured in the baseline and final population surveys. Additionally, questions on family planning knowledge will be incorporated into the annual National Integrated Survey of Households to be conducted by the Federal Office of Statistics. From time to time throughout the project, the contractors will obtain spot surveys on this topic from various population sub-groups as a part of ongoing monitoring of program performance.

Policy implementation. By the end of the project, it is anticipated that the FMG, all 19 states and the Federal Capital governments will have the capability to conduct strategic planning for a minimum of five years and will be able to budget resources to implement strategic planning. Indicators of the degree of policy implementation success will come from FMG policy statements, fiscal support, legislation or regulations supportive of family planning, and the content of national state and LGA long-term strategic planning documents.

Institutionalization. The project supports the institutionalization of a capability to manage a population program of the magnitude required in a country as large as Nigeria. While total self-reliance in five years is probably not a realistic objective, success in this domain will be indicated by the movement along the continuum of dependence on external resources. The degree of institutionalization will be measured by the ability of the public sector at the federal, state and LGA levels: a) to continue family planning services, once established; b) to sustain training of personnel either through preservice or inservice training; c) to maintain capabilities to plan, execute and evaluate service, training and educational programs; and, d) to allocate necessary budgetary resources for service, training and IEC activities. In the private sector, institutionalization will be measured by the ability to continue expansion of service networks and to assume and maintain a greater proportion of clients who pay for services and commodities. The clearest indication of private sector institutionalization will be when the sale of commodities equals the AID purchase and distribution price. These indicators will be carefully measured over the life of the project.

3. Outputs

A summary listing of the expected outputs for each project component is provided in the Logical Framework. Annual work plans will detail the inputs required and the schedule of outputs expected. Measurement of these outputs will come from such sources as the management information system, records of commodity distribution and sales, reports of training courses, workshops and seminars, compilations of IEC materials, progress reports, planning documents, and consultation reports. These will be routinely obtained by the contractors and be available for review and evaluation. Progress will be assessed at quarterly management reviews.

C. Benchmark Evaluation Activities

The benchmark activities in the evaluation process are the following:

1. Ongoing Component Evaluations

Each component contractor will routinely monitor its program outputs against its annual workplan. In addition, the contractors will undertake a number of discrete diagnostic surveys from time to time to identify problems in project implementation, to provide information for management decisions regarding project implementation and to assess program performance. Examples are listener surveys and focus group discussions to assess IEC activities, client follow-up studies to assess the quality of service delivery, and trainee follow-up observations to evaluate retention of information and skills.

2. Quarterly AID/Contractor Management Meetings

At quarterly project committee meetings, overall project progress will be assessed and activities coordinated to assure that the project is on track, that the management and logistical support are meeting the project requirements and that the commodity pipeline is adequate. These ongoing reviews will provide the empirical basis for preparing future work plans, and to permit activity restructuring, if necessary, on sound management decision-making.

3. Annual AID Management Reviews

The fourth quarterly meeting each year will be an Annual AID Management Review involving the project committee including FMG representatives and counterparts, component contractors, AID management officials from USAID, REDSO and S&T/POP, and the AID Project Coordinator. Other donor agencies will be invited as observers. The contractors will prepare an annual report of work performed in the previous year and a proposed work plan for the following year detailing the inputs required, the outputs expected and the justification. Particular emphasis will be placed on monitoring technical assistance inputs to guarantee effectiveness and efficiency. Work plans will be subject to critical review by AID management and FMG counterparts and substantial revisions in the projected program of work may be recommended. Financial support for the subsequent year's work will be subject to AID approval of the annual work plan. The requirements for logistical support and project commodities for the next year will also be determined at this time. Work plans will also be shared with other donor agencies to insure coordination and maximum use of resources.

4. First External Evaluation

The first external evaluation will be a review at the end of the second year of the project (tentatively November 1989). In collaboration with the USAID/Lagos and the AID Project Coordinator, REDSO/WCA will organize this evaluation. The team will consist of at least four technical experts with skills in family planning service delivery, manpower development and training, management information systems, and information, education and communication programming. In addition, the team will include at least one management expert with skills in evaluating overall project management capabilities and systems. An FMG counterpart will also be requested to participate as a team member. As a process evaluation, this effort will evaluate progress toward attainment of project objectives with a particular emphasis on the identification and evaluation of problem areas or constraints which may inhibit project achievement.

This evaluation will focus on the performance of the contractors in terms of how effective they are in producing the outputs required by the project. Attention will concentrate on management issues such as coordination of inputs (technical assistance, training, logistics, commodities) with program activities; quality of the training and service delivery; effectiveness of program planning and management systems being established; coverage of the population being achieved by contraceptive services; operational utility of information systems; effectiveness of IEC activities; and degree of participation being enlisted from the private sector. Also, the degree of collaboration among the contractors and any efficiencies that are being achieved in this collaborative assistance approach will be assessed. Major mid-course changes in the project approach, operations and/or process may be recommended as a result of this evaluation. An evaluation report summarizing major observations, conclusions and recommendations will be due within six weeks of the evaluation. On receipt, the evaluation report will be scheduled as the major agenda item for discussion between the FMG, contractors, and AID at the next scheduled quarterly management review. A copy will be distributed to other appropriate donor organizations.

5. Second External Evaluation

This second external evaluation will take place approximately eighteen months before the termination of the project (tentatively set for July 1991). As with the initial evaluation, REDSO/WCA will organize the evaluation in consultation with USAID/Lagos and the AID Project Coordinator. Again, four or five technical and management experts and representatives from the FMG and other donor organizations will be required to execute the evaluation. For continuity, at least one of the evaluators should have participated in the initial evaluation. As future programming is involved, a REDSO/WCA project design officer and technical officer will participate in the evaluation.

The purpose of this evaluation will be: a) to assess to what degree the project has or will achieve its purpose; b) to determine initial impact of the project; and, c) to prepare appropriate documentation, if warranted, for a follow-on project or to explore alternative funding for necessary activities. The evaluation team will review project sites, interview training participants, gather information on all aspects of the program results and make an independent assessment as to whether the project should continue and establish clear parameters for future programming. Should AID elect not provide additional support, measures must be taken to ensure that the FMG is capable of continuing the program independently, or with the assistance of other international lenders or donors.

6. The End-of-Project Evaluation

The end-of-project evaluation will take place just prior to the PACD (tentatively November 1992). In consultation with AAO/Lagos and the AID Project Coordinator, REDSO/WCA will organize the evaluation. Four to six technical and management experts as well as FMG representatives will participate in the evaluation, expected to take one month.

The objective of this evaluation will be: a) to assess the overall management of the project and the degree to which the project has achieved its purpose and reached the goals that were set forth at the outset; and, b) to evaluate, to the degree feasible, the overall development impact of the project. Attention will be concentrated on evaluating those measurable indicators of the goals and purpose as given above. In particular, if there is to be a follow-on project funded by AID, the FMG or other donors, special emphasis will be placed on "lessons learned" to enhance and improve future programming. The evaluation team will review all records of program activities and accomplishments and the results of the various population surveys as well as make independent assessments of actual program performance through field visits.

A component of this final evaluation will be a national population survey to determine contraceptive knowledge and prevalence and to determine current fertility rates and maternal and infant mortality rates. This survey will cover a nationally representative sample of at least 10,000 households, with attention to oversampling in the selected states included in the baseline survey. The purpose of the survey will be to accurately measure changes that have occurred since the inception of the project. Planning and design of this national survey will begin

in early 1992, but as many of the project activities and project momentum will not occur until 1992, the survey will not be carried out until the last quarter of 1992.

7. Audit

The project will make provision for an end-of-project audit. Through an Indefinite Quantity Contract, the Regional Inspector General (RIG) in Dakar will arrange for an independent audit firm to carry out a comprehensive examination of the project costs. If warranted, during the course of the project, RIG/Dakar may invite an independent audit firm to examine the contractor procedures and internal financial controls relating to project expenditures.

VII. FINANCIAL PLAN

A. Introduction

The Financial Plan for the Nigeria FHI-II Project is presented below, together with a commentary on the bases of calculation of the cost estimates. Detailed Year One budgets and five-year costings for each of the project components are provided in Annexes H to K.

The financial values presented in this Section have been adjusted as appropriate to take account of the effects over the five-year project period of both inflation and the fluctuations in the U.S. Dollar : Naira exchange rate. The assumptions made in respect of these two elements are discussed later in this Section.

B. Summary

The total costs of the project over the five-year period are estimated at $100.5 million, $67.0 million (66.6 percent) of which will be provided by USAID. The overall contribution of the FMG (33.3 percent) has been calculated on the basis of the identifiable costs borne by and income generated in the country; it is expected that the Nigerian contribution will actually be greater on account of those costs that cannot be readily quantified at the project design stage.

Table 1, below, indicates the estimated total costs of the project over the five-year time-span, separated by both US and Nigeria contributions between technical assistance and training components and the provision of commodities and other equipment and materials.

TABLE 1 - TOTAL PROJECT COSTS

($ million)

	U.S.	Host Country	Totals
Technical Assistance	32.2	10	42.2
Training	11.2	15	26.2
Commodities	23.6	3.5	27.1
Income generated		5.0	5.0
TOTALS	67.0	33.5	100.5

The contributions of the host country to the project relate primarily to the provision of service clinics, staff time and training, and appropriate air-time on television and radio for advertising purposes.

A more detailed analysis of the estimated host country contribution over the life of the project is given below in Table 3.

The projected costs of the four collaborative contracts and the related administrative, logistical and procurement elements of the project will be funded by AID; these costs are summarized in Table 2. Detailed descriptions of the activities and expenditures under each project component are provided in the respective work plans. Year 1 budget analyses are also provided in the Annexes, together with full five-year spreads of the anticipated costs.

A commentary on some of the broader assumptions made in calculating these estimated costs follows.

C. U.S.-funded Costs

1. Collaborative Contracts

The cost estimates for the four major elements of the project, the collaborative contracts, have been computed using the same broad assumptions (for example, for inflation and exchange rates - discussed below), although some bases of calculation differ between the various contracting organizations. These bases, however, are in accordance with each organization's normal practice, and subject to future negotiation. Standard rates have been used for computing per diems, other personnel allowances and travel costs, and staff remuneration packages are broadly comparable, depending on the grades of personnel required under each workplan.

Differences arise, however, in the calculation of each organization's overhead (or indirect cost) element. For example, whereas Johns Hopkins University charges 32 percent overhead on all personnel, consultants, travel and per diem, stationery supplies and other direct costs, FPIA calculates its overhead at a rate of 29.18 percent on the above costs plus the first $600,000 of subcontract values in each year. Similarly, the University of North Carolina charges overhead of 25 percent on all costs except equipment purchases and only the first $25,000 of each contract (in total, as opposed to each year), while the Pathfinder Fund's overhead is based at 28.75 percent on all costs (excluding expenditure on bulk materials and related freight charges).

Indirect costs have also been calculated for individual subcontracts under each project component, the bases for these calculations being in accordance with the subcontractors' normal procedures. A comparison of the four prime organizations' own indirect costs as a percentage of their total project budget is as follows:

IEC	7.38%
Private	17.91%
Public	20.20%
Policy	12.65%

2. Support Services

The activities carried out under the administration and logistics budget include providing support to the four collaborative contractors in the form of office facilities and staffing, both in Lagos and in four regional offices, local transport, general equipment procurement services and up-country logistical surveillance.

The procurement of contraceptives will be carried out under the auspices of fixed price contracts negotiated by S&T/POP, expected to amount to $17.0 million over the project duration. The project design has also made provision for evaluations and audits of the activities and expenditures during the life of the project, and a contingency sum of $3.5 million has been included. Details of these activities and anticipated expenditures are provided in the relevant work plan sections of this report.

TABLE 2 - ANALYZED COST BUDGET

($ million)

	FY87	FY88	FY89	FY90	FY91	Totals
COLLABORATIVE CONTRACTS						
IEC	2.2	3.4	3.4	3.3	2.7	15.0
Private	2.3	2.8	2.2	1.5	1.2	10.0
Public	3.1	2.3	2.0	2.1	1.5	11.0
Policy	0.7	0.6	0.6	0.5	0.6	3.0
SUBTOTALS	8.3	9.1	8.2	7.4	6.0	39.0
SUPPORT SERVICES						
Admin./Logistics	1.4	1.0	1.1	1.3	1.2	6.0
Evaluation/Audit	0.0	0.2	0.1	0.2	1.0	1.5
Contraceptives	1.0	1.9	3.0	4.8	6.3	17.0
Contingency	0.5	0.7	0.8	0.7	0.8	3.5
TOTALS	11.2	12.9	13.2	14.4	15.3	67.0

D. Host Country Contributions

Table 3 analyzes the estimated contributions to the project of the host country. These amounts comprise not only the contributions (mostly in-kind) from the federal, state and LGA level governments, but also the anticipated income generated in the private sector from the sales of contraceptives and training services.

It will be noted that by far the largest element is the contribution from the public sector in connection with the provision of full and partial service family health clinics, together with the related staffing and facilities. The calculation of the estimated annual contribution takes into account the salaries of the FMOH (and other government) employees attending training courses provided by the program, and a proportion of the rehabilitation of facilities and personnel costs of the service clinics made available for the project. The estimates have assumed that in full service clinics 25 percent of the annual staffing costs will be related specifically to project-related family planning activities; in partial service clinics, 50 percent of the relevant salary costs have been included.

The host country contribution from the private sector is expected to arise from reinvestment of the income generated through the distribution and sale of contraceptives and through the fees charged in later years for some training programs. The income generated is expected to rise in direct proportion to the increasing volumes of contraceptives distributed under the program, reaching approximately $5.0 million by year five of the project. This would suggest that, by that time, the private sector will have achieved a high degree of self-sufficiency in the distribution and sale of contraceptives.

TABLE 3 - HOST COUNTRY CONTRIBUTION

($ million)

	FY87	FY88	FY89	FY90	FY91	Totals
IEC	0.7	0.8	0.8	0.8	0.9	4.0
Private	0.4	0.6	0.9	1.5	1.9	5.3
Public	1.3	2.8	5.2	7.4	6.8	23.5
Policy	0.1	0.1	0.1	0.2	0.2	0.7
TOTALS	2.5	4.3	7.0	9.9	9.8	33.5

E. Method of Financing

Table 4 presents a summary of the methods of financing for the major project actions envisioned. These are described by type of procurement, contracting method, type of contract, financing method, contractor advances and the estimated value of the action.

The four contracts with the collaborating agencies will be AID direct, cost reimbursement contracts, as the participating agencies are all non-profit organizations. Their preferred method of financing for these contracts is a Federal Letter of Credit, which is permissible for U.S. organizations under certain conditions. This determination will be made by the Controller in conjunction with the Contracts Officer. While these organizations may be able to qualify for advances, further negotiations will be required. The estimated value of these contracts is $39.0 million.

The administrative/logistics support unit will be procured competitively as an AID Direct Contract. There are several local organizations tentatively interested in bidding on this type of procurement. A Cost Reimbursement Plus Fixed Fee contract is envisioned for a "for profit" organization, which would be financed by direct reimbursement, with vouchers paid through the Regional Controller in Abidjan. Advances are not permitted under for profit arrangements. The cost estimate for this action is detailed in the attached Statement of Work (Annex M). However, qualified non-profit organizations will be allowed to compete.

Evaluation and Audit provisions have been made, as described in the Evaluation Plan. These actions would be executed through IQCs in Washington or Abidjan, and are thus, AID Direct Cost Reimbursement contracts. The Audit, if required, would be at the direction of the Regional Inspector General (RIG) in Dakar. Evaluations will be directed by the Project Coordinator. No advances are envisioned under any of the available $1.5 million.

Contraceptives will be procured centrally through S&T/POP, as described in Procurement Plan. These are purchased directly at a fixed price negotiated centrally. The figure of $17.0 was developed by a CDC/JSI specialist in contraceptive projections, and background calculations are included in Technical Analysis.

Finally, the Project Coordinator will be a personal services contractor, identified competitively through advertising in the Commerce Business Daily, technical journals and an AID worldwide cable. This cost reimbursement contract will be financed by direct reimbursement, with vouchers paid by the Regional Controller in Abidjan.

F. Obligation Schedule

The obligation schedule is set forth as in Table 2 - Analyzed Cost Budget. This demonstrates the desired annual obligations. They are as follows:

FY 87 - $11.2 million
FY 88 - $12.9 million
FY 89 - $13.2 million
FY 90 - $14.4 million
FY 91 - $15.3 million

G. Assumptions

The budgeted costs of the four main project components (public and private sectors, policy and IEC), together with the estimates for the Administration and Logistics support, Procurement Services Agreement, Project Coordinator and Evaluation and Audit elements, have been calculated with the use of standard assumptions for treating inflation and the changing U.S. Dollar:Naira exchange rate. These assumptions are stated in detail below.

The budget for procuring, clearing from the U.S. and shipping the contraceptives over the five year project has been computed on the basis of estimates of fixed price contracts with US suppliers. Thus, the total cost of $17.0 million is considered to be already quoted in inflated terms, and no further adjustment required for this figure.

All costs for the full five years of the project have been estimated initially in current (April 1987) prices and then have been adjusted to account for inflation and changing exchange rates (except for the procurement budget of contraceptives, per above). It has been assumed that the costs will not differ significantly between the project design stage (March - April 1987) and the anticipated commencement of the project implementation; consequently no account has been taken of the possible effects of inflation and changing exchange rates on the estimated Year 1 costs.

The current cost calculations include both local and foreign exchange amounts and a total "Dollar equivalent" value for each year, computed by converting the Naira costs by the prevailing exchange rate of N4:$1.

While all attempts have been made to identify specifically which costs will be payable in Naira and which in U.S. Dollars, it is clear that much of the U.S. Dollar expenditure will actually be incurred in Nigeria. Thus, although the detailed costings for the USAID-funded element of the project indicate that Naira 86.2 million ($17.1 million at average exchange rates for the five years, or 25.5 percent of total inflated costs) will be expended directly in Naira, it is anticipated that a far greater amount will actually be spent in Nigeria.

1. Inflation

The recent economic climate in Nigeria has seen wide fluctuations in the annual rate of inflation, reportedly varying from approximately 10 percent in 1984/5 to around 40 percent in 1985/6. Following the introduction of the Second Tier Financial Exchange Market (SFEM) in October 1986, it is generally thought that these wide fluctuations may level out, resulting in a more steady rate of inflation for the next few years.

The rates assumed for the purposes of computing the budgeted Naira costs over the five-year period are 20 percent per annum for the second and third years, falling to 10 percent per annum for the remaining two years. This results in a compound rate of 74.24 percent over the five years, assuming no inflation between the present time and the first year of the project.

For U.S. costs, a standard rate of annual inflation of five percent has been adopted for the five year period, commencing with the Year Two estimates. The comparative compound rate for the five years works out at 21.55 percent.

2. Exchange rates

For the purposes of converting Naira costs, after accounting for inflation in Nigeria, into US$ equivalents, it has been necessary to provide for the possible fluctuation in exchange rates over the five years of the project. It has been assumed that the Naira will weaken against the Dollar by 15 percent between years two and three, this decline reducing to 10 percent per annum thereafter. Thus, by Year Five the Naira:dollar exchange rate is expected to be N6.12:$1; the average rate for all costs estimated over the five years works out at N5.05:$1.

H. Recurrent Costs

It should be noted that this project differs from most other major AID projects in that it does not provide direct financial support to governmental and parastatal bodies. This project is also unique in that it is intentionally designed to not assist in the payment of government salaries or fund other operating costs; nor is there any specific provision for the procurement of vehicles to be used by the FMG; these costs will be funded by the FMG. Shortfalls will be financed through a loan to be provided by the World Bank and other donor activities (UNFPA).

The most significant recurrent cost which will continue beyond the end of the FHI-II Project is related to the procurement, shipping and distribution of contraceptives, the volume of which is expected to total 285 tons by 1991/2, at a landed value of approximately $17.0 million (in current cost terms). On the assumption that the present selling price structure continues, and after taking into account the income that will be generated in the private sector from sales of contraceptives, substantial subsidies will be required to meet the shortfall between increasing recurrent costs and revenues. The project paper therefore assumes that this activity will continue to be financed largely from other donor grants.

The public sector activities identified as forming the largest element of the host country contributions to the project, namely the provision of full and partial service clinics and training programs, will have become fully institutionalized by the end of the five years. Pre-service and on-the-job training will have become part of the standard curriculum for FMOH employees involved in the family health sector, and the new facilities introduced under the project for family planning will be incorporated into the existing structure of hospitals and clinics. In consequence, the project paper assumes that practically all recurrent costs in this area will be absorbed in the normal activities of the public sector. The World Bank has expressed a strong interest in lending funds to Nigeria to support the health/population sector.

The IEC and policy components of the project seek to develop and enhance the country's capabilities in the areas of health education, information dissemination and policy determination and implementation. It is envisaged that these goals will have been achieved to a large extent by the end of the five years, and the direction to be pursued after completion of the project will be related to the maintenance of those capabilities and the continuation of effective programs and policies for family planning. The recurrent costs related to these activities are not expected to be substantial. Moreover, the World Bank is also interested in making loans to the FMG for IEC support.

I. Local Cost Financing

Pursuant to HB1 Supplement B, Chapter 18A(1)(c), the Mission Director is required to make a determination based upon a reasonable analysis of the supply and prices of indigenous and shelf-item goods and services expected to be required, that such prices are reasonable, taking into account comparable delivery terms and prices from eligible sources, and the implementation schedule of the project.

The detailed cost analyses done for each of the procurements were performed in consultation with local businesses and reflects work done by the implementing organizations under earlier contracts in Nigeria. It warrants repeating that the effects of the SFEM on local prices still remains to be settled and local price fluctuations will continue for the foreseeable future. For this reason, estimates are perhaps more conservative than under more stable conditions. Nonetheless, costs are shown to be significantly lower than could be obtained from the authorized source/origin of this project.

TABLE 4 - METHOD OF FINANCING
($ MILLIONS)

PROCUREMENT	HC/DIRECT	CONTRACTING METHOD	TYPE OF CONTRACT	FINANCING METHOD	ADVANCE	EST VALUE
PRIVATE SECTOR	DIRECT	COLLABORATIVE MODE	COST REIMBURSEMENT	FEDERAL RESERVE LETTER OF CREDIT	NO	$10.0
PUBLIC SECTOR	DIRECT	COLLABORATIVE MODE	COST REIMBURSEMENT	FRLC	NO	$11.0
IEC	DIRECT	COLLABORATIVE MODE	COST REIMBURSEMENT	FRLC	NO	$15.0
POLICY	DIRECT	COLLABORATIVE MODE	COST REIMBURSEMENT	FRLC	NO	$ 3.0
ADMIN/LOGISTICS SUPPORT	DIRECT	COMPETITIVE	COST + FIXED FEE	DIRECT REIMBURSEMENT	NO	$ 5.0
PROJECT COORDINATOR	DIRECT	COMPETITIVE	COST REIMBURSEMENT	DIRECT REIMBURSEMENT	NO	$ 1.0
CONTRACEPTIVES	DIRECT	COMPETITIVE (CENTRALLY)	FIXED PRICE	DIRECT REIMBURSEMENT	NO	$17.0
EVAL/AUDIT	DIRECT	COMPETITIVE (IQC)	COST + FIXED FEE	DIRECT REIMBURSEMENT	NO	$ 1.5
CONTINGENCY	--	--	--	--	--	$ 3.0
					TOTAL	$67.0

DGET WORKINGS PROJECT Totals PROJECT

(Inflated prices)	Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
C	3,331,239	1,411,868	2,244,678	9,053,903	1,398,773	3,367,013	9,891,054	1,465,327	3,420,081	11,124,621	1,324,944	3,323,619	7,183,531	1,469,827	2,643,109	40,584,348	7,070,738	14,998,497
IVATE	2,262,564	1,790,845	2,356,486	3,444,089	2,014,715	2,763,430	2,773,575	1,664,644	2,212,782	1,608,123	1,174,218	1,463,137	1,061,198	1,030,838	1,204,163	11,149,549	7,675,260	9,999,997
BLIC	464,350	2,973,346	3,089,433	557,220	2,134,093	2,755,277	668,664	1,910,724	2,042,871	735,530	2,000,953	2,133,100	809,083	1,346,979	1,479,126	3,234,848	10,366,095	10,999,758
LICY	1,143,000	396,518	682,268	1,518,600	287,050	617,181	1,498,320	284,865	580,976	1,426,392	299,109	555,377	1,499,335	314,064	558,949	7,085,647	1,581,606	2,994,751
MIN./LOGISTICS	4,307,688	73,500	1,150,422	3,843,706	0	835,588	4,612,447	0	911,551	5,789,134	60,775	1,100,864	5,636,239	0	920,563	24,189,213	174,275	4,918,988
OJECT COORDINATOR	0	260,820	260,820	0	193,526	193,526	0	203,422	203,422	0	213,362	213,362	0	246,833	246,833	0	1,117,962	1,117,962
ALUATION/AUDIT	0	50,000	50,000	0	200,000	200,000	0	50,000	50,000	0	200,000	200,000	0	1,000,000	1,000,000	0	1,500,000	1,500,000
OCUREMENT SERVICES	0	973,000	973,000	0	1,849,000	1,849,000	0	2,977,000	2,977,000	0	4,832,000	4,832,000	0	6,293,000	6,293,000	0	16,924,000	16,924,000
NTINGENCY	0	500,000	500,000	0	750,000	750,000	0	750,000	750,000	0	750,000	750,000	0	750,000	750,000	0	3,500,000	3,500,000
T O T A L S	11,508,841	8,429,897	11,307,107	18,417,518	8,827,156	12,830,964	19,444,060	9,305,983	13,148,682	20,683,809	10,855,361	14,571,459	16,189,387	12,451,540	15,095,742	86,243,605	49,869,937	66,953,954
Annual Inflation rate	0%	0%		20%	5%		20%	5%		10%	5%		10%	5%				
Dollar : Naira rate			4.00			4.60			5.06			5.57			6.12			

BUDGET WORKINGS HOST COUNTRY CONTRIBTIONS HCCONT

(Inflated prices)	Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
IEC	2,940,000	0	735,000	3,528,000	0	766,957	4,233,600	0	836,680	4,656,960	0	836,680	5,122,656	0	836,680	20,481,216	0	4,011,996
PRIVATE	1,520,000	0	380,000	2,736,000	0	594,783	4,821,120	0	952,791	8,268,480	0	1,485,534	11,639,232	0	1,901,028	29,984,832	0	5,314,134
PUBLIC	5,191,000	0	1,297,750	12,822,000	0	2,787,391	26,125,920	0	5,163,225	40,966,992	0	7,360,221	41,864,645	0	6,837,723	126,970,557	0	23,446,311
POLICY	560,000	0	140,000	672,000	0	146,087	806,400	0	159,368	887,040	0	159,368	975,744	0	159,368	3,901,184	0	764,190
T O T A L S	10,211,000	0	2,552,750	19,758,000	0	4,295,217	35,987,040	0	7,112,063	54,779,472	0	9,841,802	59,602,277	0	9,734,798	180,337,789	0	33,536,631
Annual Inflation rate	0%	0%		20%	5%		20%	5%		10%	5%		10%	5%				
Dollar : Naira rate			4.00			4.60			5.06			5.57			6.12			

VIII. SUMMARY OF ANALYSES

A. Economic Analysis (Annex O)

Changes in economic conditions in Nigeria over the past few years have altered the views of both government and individuals about population and desired family size.

The fall in oil prices, beginning in 1980, had immediate and drastic effects on the economic structure and development strategies in Nigeria. Nigeria is currently attempting to restore internal and external economic balances and move toward economic recovery. Population policies and demographics, which seemed of little importance at the federal level during the boom years, have come to the forefront in the government's economic thinking. This change has come about, in part, because of on-going requirements for massive resource inputs in the education and health sectors and a corresponding diminishing national budget. At the individual family level, it appears that the depreciating Naira and resulting shrinkage in household disposable income are causing familieis to consider having fewer children, or at least postponing the birth of their child.

It is clear that reductions in fertility cannot come about immediately. Therefore, there will be a lag time between reductions in fertility and any corresponding reductions in demand for public social, health, and educational services. At the same time, it is clear that investments in productivity require concomitant reductions in fertility to maximize their marginal return. The positive economy-wide impacts of reduced fertility can reinforce both the steps being taken for economic recovery and should become an integral part of the longer-run structural adjustments which are taking place.

In countries like Nigeria, which are still "catching up" in their provision of social, health and education services, reduced fertility does not necessarily imply reductions in budgetary and capital outlays for social service infrastructure. However, reduced fertility does suggest that such outlays will go toward increasing the percentage of the population being served, rather than just holding the line. So, too, the struggle to become food self-reliant is made easier by having fewer mouths to feed. By ensuring a healthier workforce through reduced infant and maternal mortality, there is greater potential for making productivity gains which can offset the relative loss of cheap agricultural labor caused by smaller families. Consequently, development goals may be more attainable when fertility reductions begin to reduce the number of job seekers.

Further, this project will have substantial institutional impacts for family planning/health program planning, implementation and service delivery at the federal, state and local government levels. For example, it reinforces FMG policy to seek greater involvement by the private sector and to begin to address cost recovery in both private and public service delivery systems through the sale of contraceptives and IEC materials, charging tuition for training, and charging for clinic equipment.

B. Social Soundness Analysis (Annex P)

Complex social and cultural considerations play an important role in the design and outcome of family planning programs in Nigeria. Childspacing is an established tradition in Nigerian families. Nigerian women have customarily practiced both extended postpartum abstinence and prolonged breastfeeding. As these practices decline and disappear, however, shorter birth intervals and higher fertility are resulting. Modern family planning, then, supports the tradition of childspacing and enables families to achieve it.

Experts believe a subtle change in values may be occurring in Nigerian households: prestige traditionally associated with family size, may now be achieved through the relative economic success of one's children. Thus, pronatalist values still pervading most Nigerian cultures are being modified by equally pervasive desires to succeed in the social, cultural, and economic communities. Fewer but better educated children add to the father's prestige. Since the current economic crunch and the associated costs of schools (in terms both of lost labor as income production and of school fees) suggests to many families that fewer children might actually be better for the household.

Nigeria is culturally heterogeneous and requires different regional approaches to the introduction of family planning. Sensitivity to different languages, marital patterns, and values is essential. The project provides for the development of materials and information tailored to meet specific cultural norms. IEC content will reflect people's attitudes and customs and will be in their own language. Thus, family planning will be introduced in ways that are culturally appropriate and can be presented as a logical extension of traditional values.

Traditional leaders can be either thorny opponents or staunch allies of family planning efforts. Treated with respect and given the opportunity themselves to learn about modern family planning methods, many leaders will see that it can be in their interest to join and even lead their people in family planning programs. This is already occurring in some areas, as evidenced in recent Muslim leadership leadership meetings where family planning and child spacing were endorsed.

While women seem often ready for family planning, men have not always been so. The project's approach to male attitudes and practices posits that men can be natural allies in the expansion of family planning programs if given the opportunity to see how their self-interests and values can be enhanced, i.e., men do want healthy wives and successful children. Encouragement from their wives will help, as will public commitment to family planning by traditional, religious, government and business leaders, all of whom are seen as partners in the program.

All religions - Muslim, Christian, and traditional groups - place high values on human welfare and good health for women and children, though not all religious groups endorse all family planning methods. However, it appears that family life education and responsible parenthood can be supported by all groups. Therefore, it is quite evident that approaches must be culturally sensitive and appropriate.

As elsewhere, young people in Nigeria, are becoming more sexually active. Unplanned pregnancies are on the increase, and illegal abortions, and deaths caused by these are very serious problems. Clearly, an effective family life education and family planning effort can help reduce the causes of these serious problems.

The economic and socio-cultural factors noted have encouraged national political leaders to take note of the population situation. Their support for family planning has shifted in the past decade from non-concern and even some opposition to support from the very highest government officials. The Head of Government at the time of the Mexico City Conference sent a strong statement of support to the conference, and this message continues to guide the FMG today. A national population policy is currently in the final stages of government approval and, when issued, will provide excellent support for and coverage of this project.

C. Technical Feasibility (Annex Q)

Given the economic, social, cultural and political context of the project, there are issues of technical feasibility to be addressed. Are adequate contraceptive supplied and support facilities available? Are there sufficient trained people to carry out the program? Will people learn enough about family planning methods to choose and use them effectively? Finally, are these contraceptive technologies suitable in the Nigerian context?

The answers to these questions range from a qualified to strongly endorsed "yes". Nigeria has a strong medical and health infra-structure. Nigeria has over 12,000 medical practitioners, 41,000 nurses, 35,000 midwives, 3,000 pharmacists, 25,000 health workers in the public sector alone. Added to this are the private sector medical practitioners, 4,000 maternal clinics, 5,000 drug stores, 20,000 patent medicine shops and many traditional birth attendants. There are also market women, agriculture extension workers, taxi drivers, and many others with a demonstrated potential for commodity distribution. The government estimates that the service base includes over 11,622 government-counted public and private health facilities, a great number of which are yet untapped for family planning. Expansion to and through these people and establishments, through training and extended contraceptive delivery networks, is a cornerstone of the project. Access to and availability of sources from most rural hamlets to the center of Lagos seems assurable.

Raising public demands for such services will also be essential. For this purpose, intensive IEC and market research efforts are proposed, using indigenous consulting firms and advertising agencies. Nigeria has good media coverage, through radio and television (35 radio and 22 TV stations), and the press (19 dailies and weeklies). Production of printed material, films, etc. is possible in-country, and there is a substantial and growing body of communications skills and resources.

Nigeria has not experienced significant problems with contraceptive methodologies or practices, and evidence of established use of all methods of family planning, from "natural family planning" and coitus interruptus to pills, injectables and voluntary surgical techniques can

be found in different parts of the country. New technologies such as Norplant are being tested in-country and will be incorporated into the project when appropriate.

The rates of maternal and child mortality and morbidity in Nigeria are still extremely high, and are caused in large part by excess fertility: births to women too young or old, and at very short intervals. Family planning is essential for major improvement in maternal and child health. Urgent attention will be given to these problems initially in the model LGAs.

In summary, rapid expansion of family planning services thus seem very feasible and consistent with converging economic, social, political, cultural and other considerations. The stage is set for rapid growth, with addition of the essential assistance now proposed. Rapid growth in contraceptive prevalence has occurred in other countries with comparable economic levels. In these cases, political will, technical capability, infrastructure and popular readiness have been key factors, and all seem present to impressive degrees in Nigeria in 1987. Contraceptive prevalence is already on the increase and accelerating, and the start-up period phase is established, thus, the timing and content of this project offer promise of extraordinary effectiveness.

D. Administrative Analysis (Annex R)

The Administrative Analysis presents a descriptive narrative of the organizations participating in the FHI-II project. USAID/Lagos and the FMG will implement the project through the collaborative assistance mode with four carefully selected U.S.-based organizations with extensive experience in managing population activities in Africa. The FMG will provide counterparts at the national, state and LGA levels integrating activities between several ministries and encompassing both the private and public sector.

The Primary Implementing Organizations selected for the design are all well-established and experienced in developing and implementing population/family planning programs in Africa in general and in Nigeria in particular. All have demonstrated sound and practical administrative and financial systems which have proven in the past to be responsive to management constraints in Nigeria.

USAID/Lagos will be responsible for overall management of the project. To assist USAID, a full-time Project Coordinator will bd hired to direct the various components of the project and chair the Project Committee with representatives of the FMG and the implementing organizations. The resulting management structure is presented in the Management Plan.

Finally, a wide range of Nigerian organizations will be directly involved in implementing the project with the prime contractors. They include, for example, several federal and state ministries (Health, Information and Education), major teaching hospitals (UCH/Ibadan), various Nigerian media organizations (FRCN, NAN, etc.), private and non-governmental organizations (PPFN and NCPA), and large and small commercial enterprises (Sterling and Clarke). All of these organizations were involved in the design of this project. One of the major objectives of this project is to utilize Nigerian organizations to the maximum extent possible. It is anticipated that by the end of the project many activities will be totally planned and executed by host country organizations.

IX. CONDITIONS AND COVENANTS

A. Introduction

In order to assure that critical assumptions made during the design are addressed by the implementing parties, a series of conditions and covenants has been prepared for inclusion in the Project Grant Agreement. These are presented below with an accompanying explansion where warranted.

B. Conditions Precedent (CP)

There are three issues set forth for inclusion as conditions precedent to disbursements. These initial actions are considered essential to project success and preclude issuance of any obligating documents pending their satisfactory resolution. They are as follows:

1. An opinion of counsel acceptable to AID that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms.

Owing to the federal/state structure of the Nigerian Government and this project's activities over various ministries at all levels, AID wishes to be assured that the signatory for the FMG in this instance can commit these parties to the terms and conditions of the Agreement. The REDSO/WCA legal advisor has discussed this with Federal officials.

2. A statement of the name of the person holding or acting in the office of the Grantee specified in Section 8.2, and of any additional representatives, together with a specimen signature of each person specified in such statement.

This is a standard CP for all projects and names the FMG-designated individual with the authority to take action in project-related matters. This may include more than one individual to provide a back-up.

3. Evidence that the Grantee has officially named the Project Director, and the Project Managers to be assigned to each component of the project to represent the Grantee.

Continued FMG participation in the project requires the provision of named-counterparts for the Project Manager and each of the four technical components. It is expected that the FMOH will name some of the individuals from within its ranks and second appropriate officials from other ministries where appropriate (Private Sector, IEC). In the event that the UNFPA/World Bank-sponsored Office for Planning and Coordination for the Population Program (OPCPP) is established in the FMOH, natural counterpart relationships would result for this project.

C. Covenants

Covenants imply a more continuous action by the Grantee in project implementation and constitute mutual agreement of specific issues

affecting the project. Ten covenants have been identified for the Agreement; they are as follows:

1. Project Evaluation. Evaluation of progress toward attainment of the objectives of the Project.

This is a standard covenant and ensures that the FMG agrees to take an active role in the evaluation process as a means to improve project performance.

2. Prohibition on Abortion Related Activities. None of the funds made available under this Grant may be used to finance any costs relating to (a) performance of abortion as a method of family planning, (b) motivation or coercion of any person to undergo abortion, (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning, or (d) active promotion of abortion as a method of family planning.

This is a required covenant in family planning projects. Section 104(f) of the FAA (Section 525 of the 1982 Appropriations Act) expressly prohibits the activities listed above.

3. Voluntary Family Planning. The Grantee agrees that all family planning under this project will be voluntary and no coercion will be used.

Because of the possible sensitivities on the part of the FMG to a rapid expansion of family planning program, AID wishes to assure the FMG in this covenant that all AID-funded population activities are offered on a strictly voluntary basis.

4. National Population Policy. The Grantee agrees to implement the National Population Policy in such a manner as to promote the activities under this Project.

This covenant reinforces the key role AID believes a favorable policy climate, particularly at the national level, plays in the implementation of a successful family planning program.

5. Office Establishment. The Grantee agrees that within the first year of this Project, the Federal Ministry of Health (FMOH) will establish, staff and fund its Office for Planning and Coordination for the Population Program (OPCPP), or an equivalent office, which office will be the primary contact for this Project.

The World Bank and UNFPA have expressed interest in assisting the FMOH in the establishment of the OPCPP. AID strongly supports this action and agrees to integrate the project activities with this office when it is created.

6. Provision of Family Planning. The Grantee agrees that family planning services and commodities are to be provided at all levels of health care delivery and at other appropriate places.

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This covenant reinforces the objective of the private sector's activities to explore new distribution and marketing outlets, such as taxi drivers associations and market women, for sale of certain contraceptives, and that family planning services are not restricted to any one element of the public health care system.

7. Training. The Grantee agrees that all government personnel trained under this project in special clinical skills will be posted in facilities and assigned duties where the skills acquired will be used.

Where project training is involved, AID wishes to emphasize the need to make appropriate use of trained personnel in their areas of expertise.

8. Use of Materials. The Grantee agrees that all materials produced under the Project may be used by AID in its other population activities.

This project will fund the development of new materials in training and IEC, including mass media. This covenant points out that AID-funded materials which may be beneficial in other AID-funded population activities may be borrowed for this purpose.

9. Visas. The Grantee will ensure the timely provision of visas to Project personnel and shall provide multiple entry visas on a yearly basis to those personnel from both the contractors and AID specified on a list provided by the FMOH.

Due to the frequency of visits envisioned by AID and implementing contractors during project implementation, the FMG agrees to advise its embassies in Washington, Abidjan and Nairobi that multiple entry visas may be issued pursuant to a mutually agreed upon list.

(3) ACTION: REDSO INFO: WAAC ECON/POL

VZCZCAB0361
OO RUEHAB
DE RUEHC #0182 1120120
ZNR UUUUU ZZH
O 220119Z APR 87
FM SECSTATE WASHDC
TO RUEHOS/AMEMBASSY LAGOS IMMEDIATE 2260
INFO RUEHAB/AMEMBASSY ABIDJAN IMMEDIATE 3399
BT
UNCLAS STATE 120182

LOC: 182 544
22 APR 87 0123
CN: 55051
CHRG: AID
DIST: AIDL

Action TOAD 3
Info PDTR.1
Due Date 4/23
Action Taken

AIDAC ABIDJAN FOR REDSO/WCA

E.O. 12356: N/A

SUBJECT: FAMILY HEALTH INITIATIVES II - NIGERIA
SUB-PROJECT PID - ECPR GUIDANCE (698-0462.20)

1. FOR THE RECORD, ECPR MEETINGS FOR SUBJECT PROJECT WERE HELD ON AUGUST 11, 1986, CHAIRED BY DAA/AFR LOVE, AND NOVEMBER 18, 1986, CHAIRED BY DAA/AFR RICHARDS. THE PID WAS APPROVED. THE ECPR CONCLUDED THAT THERE SHOULD BE AN INCREASED EFFORT IN THIS SECTOR WITHIN NIGERIA, AND A FIVE-YEAR PROJECT WOULD ESTABLISH THE BASIS FOR EFFECTIVE MANAGEMENT OF ADDITIONAL FAMILY PLANNING ASSISTANCE AS WELL AS GIVE GREATER COHERENCE TO THE ALREADY SUBSTANTIAL CENTRAL AND REGIONAL SUPPORT BEING PROVIDED. THE DESIGN OF A MANAGEMENT SYSTEM WHICH WOULD REDUCE THE NUMBER OF INTERMEDIARIES, LESSEN OVERSIGHT BURDEN ON THE MISSION, AND FACILITATE IMPLEMENTATION OF PROGRAM ELEMENTS WAS WELCOMED. IN THIS REGARD, THE ECPR CONCURRED IN THE MISSION'S RECOMMENDATION TO USE COLLABORATIVE MODE FOR DESIGN AND IMPLEMENTATION.

2. OTHER DONORS: THE ANTICIPATED ROLE OF OTHER DONORS IN THIS SECTOR WILL DIRECTLY INFLUENCE THE NATURE OF U.S.A.I.D. PROJECT DESIGN. THE PP TEAM SHOULD CAREFULLY EXAMINE OTHER DONOR PLANS, PARTICULARLY THOSE OF THE WORLD BANK. GIVEN THE STRONG POTENTIAL ROLE TO BE PLAYED BY THE IBRD, THE TEAM SHOULD MAKE A REALISTIC ASSESSMENT OF WHAT THE NIGERIAN GOVERNMENT WILL ACCEPT ON A LOAN BASIS. FINALLY, BECAUSE AGENCY EFFORTS IN THIS SECTOR CAN BE EXPECTED TO BE GREATLY CONSTRAINED BY LIMITED RESOURCES, IT WILL BE IMPORTANT FOR THE TEAM TO REFLECT UPON OTHER SOURCES OF LONG TERM FUNDING SHOULD THE PROJECT GENERATE A PROGRESSIVELY GROWING DEMAND FOR RESOURCES.

3. THE ECPR'S CONCLUSION, REINFORCED BY SUBSEQUENT DISCUSSIONS, WAS THAT SUBJECT PROJECT FUNDING WILL PROVIDE UP TO DOLS 50 MILLION LOP FOR TECHNICAL SERVICES, TRAINING, ETC., ALONG LINES OF THE PID PLUS DOLS 13 MILLION FOR CONTRACEPTIVES.

4. REGRET DELAYS IN ISSUING THIS GUIDANCE. ANY

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J UNCLASSIFIED STATE 120182

PRELIMINARY FIELD INFORMATION ON PROMISING FUNDING OPTIONS WHICH COULD BE PROVIDED TO AID/W WOULD BE HIGHLY APPRECIATED. SHULTZ
BT
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ANNEX B

NIGERIA FAMILY HEALTH INITIATIVES II PROJECT

LOGICAL FRAMEWORK
(698-0462.20)

LOP Funding: $67 million
PACD: 12/31/92

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program Goal:			
To improve the quality of life in Nigeria by strengthening integrated health care services available through private and public facilities.	1. Reduced infant mortality rate 2. Reduced maternal mortality rate 3. Reduced high risk pregnancies 4. Reduced total fertility rate	1. FGN Health and Economic Statistics 2. World Bank Reports 3. WHO/UNICEF and Other 4. Specially Commissioned Surveys	1. FGN provides political and financial support for private and public sector health care delivery, including family planning. 2. Smaller family size norms will result from improved MCH/FP information and services.
Project Purpose	EOPS:		
To increase the acceptability and availability of integrated family planning information and services throughout Nigeria in both the private and public sectors.	1. A national contraceptive prevalence rate of approximately 12 percent or 2,500,000 users, with 70 percent served through the private sector, 30 percent through the public sector. a. Family planning information, services and/or commodities provided through approximately 12,000 private sector outlets. (b) Family planning and health-related information and services provided through at least 3,600 public service delivery points. 2. Eighty percent of the population aged 15-45 having knowledge of family planning concepts. 3. Attitudinal changes favoring smaller family norms. 4. A capability for policy implementation and strategic planning for the national family planning effort.	1. FGN Policy Statements and National, State and LGA Planning Documents 2. Service Statistics 3. Contraceptive Supply Records 4. State Personnel and Facility Data Base Information 5. Commercial Sales Reports 6. Implementing Organizations 7. Periodic KAP Studies/Spot Surveys 8. Demographic and Health Surveys 9. Mid-Course and End-of-Project Evaluations 10. End-of-Project Prevalence Survey	1. There is a growing demand for family planning. 2. Most contraceptive users users are willing and able to pay for commodities. 3. Private entrepreneurs can realize a profit through contraceptive marketing/distribution/sales. 4. Sufficient commodities are available to support the project.

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs:			
A. Private Sector			
1. Distribution network established to provide private interests with family planning commodities. 2. Private sector trained in providing family planning information, services and/or commodities.	1. Family planning commodities available to at least: (a) 5,650 private medical providers and service delivery sites; (b) 4,375 large-scale commercial distributors; and (c) 2,100 association and factory outlets. 2. Training completed as follows: (a) 4,000 pharmaceutical personnel trained in FP methods and counseling; (b) 1,000 vendors trained in family planning methods and sales; and (c) 2,100 nurses and doctors trained to level of IUD insertion.	1. Implementing Organization Reports 2. Project Evaluations 3. On-Site Verification 4. Progress Reports 5. Commercial Sales Records 6. Distributor Reports 7. Training Reports 8. Baseline and End-of-Project Surveys	1. Private interests are willing to make an investment in family planning services. 2. Private infrastructure can accommodate increased activities in family planning. 3. Trained people can utilize skills to attract family users.
B. Public Sector			
1. Public sector health personnel trained to provide improved infor-tion, services and program management. 2. Clinical service delivery points equipped. 3. Management systems for family planning programs developed and/or improved.	1. Training completed as follows: (a) 4,500 family planning service providers trained in improved clinical/communication skills (b) 700 federal, state and LGA staff trained in management of family planning programs; and (c) pre-service training curricula for all categories of personnel to incorporate family planning. 2. 1,000 service delivery points staffed and equipped for full service (including IUD insertion) and 2,600 others for non-clinical services. 3. Management and service systems developed/revised including: (a) service statistics; (b) supervisory systems; (c) strategic and financial planning; (d) other MIS components; and (e) clinical service procedures and protocols.	1. Contractor Reports 2. Project Evaluations 3. On-site Verification and Supervisory Reports 4. Training Records 5. State Personnel/Facility Data Base Information 6. Clinic Reports and Service Statistics 7. Baseline and End-of-Project Surveys	1. Sufficient case load is available for clinical training. 2. Institutions are willing to: (a) select trainees based on established criteria; (b) release trainees from daily responsibilities to attend courses; and (c) provide work assignments and use of new skills. 3. Additional outlets providing family planning services are established by states and LGAs.

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
C. Information, Education and Communication (IEC)			
1. Approved national, state and LGA level IEC action programs targeted to private and public sectors. 2. IEC activities/materials developed to support private and public family planning services. 3. Trainer training conducted and materials developed to strengthen family life education (FLE) in secondary schools and post-secondary schools.	1. Project sponsored IEC initiatives including: (a) Approved and executed national IEC program which supports private as well as public sector activities; (b) Approved and executed IEC action programs in 19 states and Federal Capital Territory; and (c) IEC action programs developed and executed in at least one priority LGA of each state. 2. IEC activities conducted and materials produced to include: (a) a national logo designed for use in identifying at least 10,000 service and sale outlets in public/private sector; (b) 6,000,000 copies of various print materials available at all service, sales and outreach outlets; (c) 10,000 service/sales/motivational agents trained in IEC concepts as part of regular training conducted in the public/private sectors; (d) 40 orientation symposia, campaigns and supporting IEC materials to promote FP awareness among private/public interest groups and leaders; (e) 3,000 TV, radio programs and spots, films, newspaper and magazine inserts produced in at least 5 languages; and (f) 20 specialized IEC training workshops conducted. 3. 40 trainers of teachers deployed, 200 secondary or post-secondary teachers trained, and a total of 30,000 copies of 5 types of support FLE materials produced and distributed.	1. Implementing Organization Reports 2. Project Evaluations 3. FLE and IEC Materials 4. Training Reports 5. Published Programs and Strategies 6. KAP Studies 7. Clinic Referral Data and Reports 8. On-site Verification 9. Focus Group/Audience Research Results 10. Baseline and End-of-Project Surveys	1. Nigerian leaders will support IEC for family planning. 2. Mass media available and willing to promote family planning messages. 3. Appropriate broadcasting stations are willing to provide free air time. 4. In-country capability exists to design and produce cost effective IEC materials. 5. Other international donor agencies are willing to provide complementary resources in the area of FLE institution building, materials development and production, training and equipment.

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
D. Policy Development			
1. National, state and selected LGA family planning program policies, strategies, and action plan established. 2. Processes for expansion, coordination, and improvement of private and public sector activities established. 3. Positive support from influential and constiuency groups and NGOs for family planning expansion nationwide.	1. The following at national level and in all 19 states and priority LGAs: (a) family planning strategies for public and private sectors which include advisory bodies, strong leadership, budgetary support; (b) Participation in annual cycle of collaborative evaluations; national conference to review experiences and coordinate inputs; and re-planning for program improvements. 2. Strong constituency support established among leadership of at least five main national influence groups. 3. Two major national NGOs effectively support policy implementation. 4. Capacities to observe changes in fertility and family planning and to identify and clarify special policy and program needs.	1. Implementing Organization Reports 2. Published Strategy/Action Plans 3. State Program Assessments 4. Reports of Consultation/ Advisory Committees 5. Reports of NGOs and Institutional Support Activities 6. Reports on Pronouncements and Action Steps by Key Leaders 7. Reports on Seminars and Activities of Constituent Groups 8. Reports of Annual State Reviews, National Meetings, and Annual State Plans 9. Reports from Data Systems 10. Special Study Reports	1. Nigerian leaders are willing to support the development of family planning programs. 2. There is recognition of common concerns and needs for policy and program support by official agencies, NGOs, and key private groups. 3. Population policy values are consistent with various concerns of special interest groups. 4. Regular cooperation re-assessments of progress can raise general commitment and capacities for improvement. 5. Sensitive indicators of effects are obtainable and essential to guide policy and program implementation.
Inputs			
USAID - $50,000,000 FRN - $33,500,000 Contraceptives - $17,000,000	See Financial Plan	1. Progress Reports 2. Mid-Course and Final Evaluations 3. Financial Reports	1. Inputs are available in timely fashion. 2. CPs are satisfied. 3. Contracts are signed with implementing organizations.

ANNEX C

FEDERAL MINISTRY OF HEALTH

NATIONAL HEALTH PLANNING DIVISION

FED. SECRETARIAT, IKOYI - LAGOS

P.M.B. No. .....

Telegrams PERMHEALTH

Telephone 684491

Ref. No. MH. 1810/Vol. V/762

Date 23rd April, 1987

Dr. Keys MacManus,
The Agency for International Development,
U.S. Embassy,
2 Eleke Crescent,
Victoria Island,
Lagos.

Dear Dr. MacManus,

Further to my letter of June 30, 1986, which outlined prospective areas of joint collaboration under the Technical Co-operation Agreement between the Federal Government of Nigeria and USAID, I request support in the further planning and execution of the "National Health Policy and Strategy" and the "Action Plan for a National Family Planning Effort." As detailed in these documents, the Government proposes to increase the availability of health related and voluntary family planning information and services in both the public and private sectors throughout Nigeria.

To this end, the Government requests technical and material assistance in expanding service capacities, management and clinical training of all levels of personnel, medical equipment and contraceptive supplies, and management systems development as well as information, education and communication support. As you well know, the lines of these programmes, projects and activities have been the subject of continuing dialogue between the concerned Federal, State and Local Governments and USAID.

We look forward to further collaboration with USAID in developing strategies and programs to enhance the health and welfare of all Nigerian citizens, particularly mothers and children.

With grateful appreciation,

Yours faithfully,

Dr. A. B. Sulaiman
Director, National Health Planning,
for: Permanent Secretary.

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5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1987 Continuing Resolution Sec. 526. Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? NO

2. FAA Sec. 481(h). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government), has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without NO

Congressional enactment, within 30 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, and to prevent and punish drug profit laundering in the country, or that (b) the vital national interests of the United States require the provision of such assistance? N/A

3. Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress listing such country as one (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country? N/A

4. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? NO

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? NO

6. FAA Secs. 620(a), 620(f), 620D; FY 1987 Continuing Resolution Secs. 512, 560. Is recipient country a Communist country? If so, has the President determined that assistance to the country is important to the national interests of the United States? Will assistance be provided to Angola, Cambodia, Cuba, Iraq, Syria, Vietnam, Libya, or South Yemen? Will assistance be provided to Afghanistan without a certification? NO

7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? NO

8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC? NO

9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? NO

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10. FAA Sec. 620(q); FY 1987 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1987 Continuing Resolution appropriates funds?

(a) yes, and payments have been made to correct this status
(b) no

11. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percent of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

Yes, taken into account by the Administrator at the time of approval

12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

NO

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operating Year Budget? (Reference may be made to the Taking into Consideration memo.)

Payment status taken into account

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism?

NO

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15. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? NO

16. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? NO

17. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) NO

18. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? NO

19. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.) Taken into consideration

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20. FY 1987 Continuing Resolution Sec. 528. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? NO

21. FY 1987 Continuing Resolution Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? NO

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? NO

2. Economic Support Fund Country Criteria

FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest? N/A

CP

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded from Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1987 Continuing Resolution Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project. — CN will be prepared

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? — (a) yes (b) yes

3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? — N/A

4. FAA Sec. 611(b); FY 1987 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) — N/A

5. **FAA Sec. 611(e).** If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	N/A
6. **FAA Sec. 209.** Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	FHI-II Nigeria is a subproject of a regional project, executed as a bilateral activity.
7. **FAA Sec. 601(a).** Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices, (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	(a) N/A (b) Project activities have large private sector component (c) N/A (d) N/A (e) N/A (f) N/A
8. **FAA Sec. 601(b).** Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	$17.0 million contraceptive procurement will be US-manufacture and provides opportunity for US firms to expand
9. **FAA Secs. 612(b), 636(h).** Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	Evaluation Plan establishes benchmarks for all project inputs.
10. **FAA Sec. 612(d).** Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	NO

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11. FY 1987 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

12. FY 1987 Continuing Resolution Sec. 558 (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers? N/A

13. FY 1987 Continuing Resolution Sec. 559. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? NO

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14. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded, by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of

N/A

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U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

15. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? N/A

16. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate sysem for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A

17. FY 1987 Continuing Resolution Sec. 532. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution? N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and

(a) Population activities will include the poor through public sector component;
(b) N/A
(c) By reducing populatic growth rate, the FMG will be better able meet economic develo ment goals;

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insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

(d) Support to the Federal Ministry of Health will primarily benefit 20 State Family Health Coordinators, all of whom are women.

(e) N/A

b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the source of funds (functional account) being used? — YES

c. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? — N/A

d. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to whch the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? — YES

e. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? — YES

f.	FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	Nigeria's most serious constraint to development is probably the rapidly growing population. This project directly addresses this constraint by increasing the acceptability and availability of family planning information and services.
g.	FY 1987 Continuing Resolution Sec. 540 Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	NO
	Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	NO
	Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	NO
h.	FY 1987 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?	NO
	If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?	NO
i.	FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	YES

j. FY 1987 Continuing Resolution. How much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

All procurement will be advertised competitive; However, CEDPA and Africare are subcontractors to the primes for implementation.

k. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

l. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

NO

m. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water

NO

ANNEX E

INITIAL ENVIRONMENTAL EXAMINATION

OR

CATEGORICAL EXCLUSION

Project Country: Nigeria

Project Title: Family Health Initiatives II Nigeria (698-0462)

Funding: FY(s) 1987-1992 $ 50,000,000

IEE Prepared By: Jeffrey W. Goodson
Regional Environmental Officer,
REDSO/WCA

Environmental Action Recommended: Categorical Exclusion

Positive Determination _____
Negative Determination _____

Categorical Exclusion:

This activity meets the criteria for Categorical Exclusion in accordance with 22 CFR 216.2(c)(2)(viii) and is excluded from further review because it is an activity involving population and family planning services and includes no components directly affecting the environment.

APPROVED X

DISAPPROVED _____

DATE OCT 10 1986

DATE 10/14/86

Concurrence:
Bureau Environmental Officer
Bessie L. Boyd, AFR/TR/SDP

Clearance: GC/AFR _____

ANNEX F

PROCUREMENT WAIVERS

In order to implement the Nigeria Family Health Initiatives Project (FHI-II), three procurement waivers are required, as described below. This section sets forth the justification for these waivers as presented in the project authorization.

A. Vehicle Waiver

1. Waiver Type - A source/origin waiver from AID Geographic Code 000 (U.S. only) to Code 899 (Special Free World) and from Section 636(i) of the Foreign Assistance Act (FAA) for the purchase of vehicles.

2. Background

a. Cooperating Country:	Nigeria
b. Authorizing Document:	Project Paper
c. Project Number:	(698-0462.20)
d. Project Title:	Nigeria Family Health Initiatives
e. Description of goods:	Twelve station wagons
f. Approximate value:	$180,000
g. Probable Origin:	U.K., France, W. Germany
h. Probable Source:	Nigeria

3. Discussion Implementation of the FHI-II Project includes the provision of all administrative and logistical support through an independent contract. The contractor will be required to provide vehicles for in-country transportation needs of the technicians for a period of five years. In addition, the contractor will be responsible for vehicle maintenance and repair.

4. Justification

a. Source Origin. In accordance with AID Handbook 1B, procurement of commodities from AID Geographical Code 899 under a grant financial project requires a waiver. Pursuant to Chapter 5B4a(2), a source/origin waiver may be granted if the commodity is not available from countries or areas included in the authorized geographical code.

As described above, an independent local contract will provide all logistical support for implementation of this project, including procurement, maintenance and repair of vehicles. There are no U.S. vehicle distributors represented in Nigeria for either purchasing or repair of U.S. vehicles. Furthermore, use of these vehicles will most often be in the interior of the country and must be able to make use of local repair facilities and spare parts.

The likely sources of vehicles purchased in Nigeria with a dependable repair and spare parts network are the United Kingdom, West Germany or France. Peugeot has an assembly plant in Nigeria, parts for which are imported largely from France.

b. Section 636(i). Section 636(i) of the Foreign Assistance Act prohibits the purchase of non-U.S. manufactured vehicles "except when special circumstances" exist. Pursuant to Handbook IB, Chapter 4C2d(1), special circumstances exist if there is an:

i. inability of U.S. manufacturers to provide a particular type of needed vehicle; or,

ii. present or projected lack of adequate service facilities and supply of spare parts for U.S. manufactured vehicles.

As described above, there are no service facilities or spare parts suppliers for U.S. manufactured vehicles; accordingly, special circumstances exist which waive the requirements of Section 636(i).

B. Shelf Item Procurement Waiver

1. Waiver Type - A source waiver from AID Geographic Code 000 (U.S. only) to Code 899 (Special Free World) to increase the off-shelf procurement limit from $250,000 to $2,000,000.

2. Background

a. Cooperating Country:	Nigeria
b. Project Title:	Family Health Initiatives
c. Project Number:	(698-0462.20)
d. Authorization Document:	Project Paper
e. Description of Goods:	Shelf Items
f. Approximate Value:	$2,000,000
g. Probable Origin:	EEC and Japan
h. Probable Source:	Nigeria

3. Discussion

Implementation of the FHI-II Project provides for an independent contract for all administrative and logistic support over the five-year life of the project. The contractor will establish a project office in Lagos to support a professional staff of 10-15 Nigerians and frequent short-term visits, as described in Annex M (SOW for Administrative Logistic Support), including equipping and furnishing the office. In addition, the contractor may be called upon to procure limited technical commodities for the implementing organizations on an emergency basis. Moreover, implementing contractors will be making certain off-shelf purchases. While certain of these items will have their origin in countries included in AID Geographic Code 941, many will not but will have their origin in countries included in Code 899. However, the total estimated amount of off-shelf procurement is approximately $2,000,000. At this time it is not possible to determine the total value of such Code 899 items. Therefore, the request is being made to increase the imported shelf-item procurement limit of Code 899 items from $250,000 to $2,000,000.

4. Justification

Handbook 1, Supplement B, Chapter 18, provides that the total amount of imported shelf items purchased from countries included in Code 899 but not Code 941 may not exceed $250,000 without first obtaining a specific geographic source waiver. Pursuant to Handbook 1B, Chapter 5B4 a(2), a source waiver may be granted when it can be demonstrated that the commodities are not available from countries or areas included in the authorized code.

This project will provide an estimated $20.0 million in commodities over five years most of which will be from the U.S., primarily contraceptives. Shelf item procurement, including office furniture, equipment and limited technical supplies, is not expected to exceed 10% of the total commodity requirements. In Nigeria, many of these shelf items are of U.S. origin and fall within the $5,000 per transaction limit. Accordingly, a waiver permitting the increase of the $250,000 limit is required.

C. Technical Commodity Source/Origin Waiver

1. Waiver Type - A source/origin waiver from AID Geographical Code 000 (U.S. only) to Code 899 (Special Free World) for equipment required to implement the project.

2. Background

a. Cooperating Country:	Nigeria
b. Project Title:	Family Health Initiatives
c. Project Title:	(698-0462.20)
d. Authorization Document:	Project Paper
e. Description of goods:	Video, electronic equipment
f. Approximate Value:	$300,000
g. Probable Origin:	EEC, Japan
h. Probable Source:	EEC, Japan

3. Discussion

An ambitious IEC campaign will be implemented under the project which promotes family planning and contraceptive use. A variety of equipment will be procured for use in developing radio and television messages which include video equipment, tape recorders, cameras and service equipment, all of which will be turned over to the FMG at the end of the project.

4. Justification

Pursuant to AID Handbook IB, Chapter 5B2b(4), a waiver of source and origin may be granted if it can be demonstrated that the commodities are not available from countries or areas included in the authorized geographical code. Through experience of implementing similar programs in Nigeria, Johns Hopkins representatives advise that U.S. manufactured video and sound equipment are not compatible with the equipment used by

the FMG Ministry of Information. The video format for Nigeria is PAL and no like equipment is manufactured in the U.S., which can be used for project purposes in Nigeria. As a consequence of the non-availability of U.S. manufactured goods compatible with Nigerian specifications, the probable source and origin of compatible equipment is either the United Kingdom, West Germany or Japan.

DEPARTMENT OF STATE

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

FAMILY HEALTH INITIATIVES II - NIGERIA

SUB-PROJECT PAPER

VOLUME TWO

ANNEXES

UNCLASSIFIED

FAMILY HEALTH INITIATIVES II - NIGERIA
(698-0462.20)

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ANNEX G

TRANSITION PHASE-OUT PLAN

NIGERIA FAMILY HEALTH INITIATIVE PROJECT (698-0642.20)

I. BACKGROUND

In large part, through the support of many of the AID centrally funded projects, Nigeria has begun seriously to focus its attention on the importance of family planning as a preventive health measure as well as a development necessity. USAID/Lagos and the Federal Military Government of Nigeria (FMG) have perceived the need for a directed and focussed family planning effort. As a result, a comprehensive five-year family planning project in Nigeria is being designed. A major result of this project will be the reduction of the number of organizations with primary responsibility for implementing AID's family planning program in Nigeria. As currently planned, up to five contractors will have primary responsibility for family planning project development and implementation under the Nigeria Family Health Initiatives II Project (698-0642.20).

This new focus requires that the activities of those organizations currently operating in Nigeria either be incorporated into the new project or be programmed to phase-out as the new project phases in. However, this process will be done in an orderly manner in accordance with the following conditions:

- Current momentum in family planning in Nigeria is not lost. Therefore every effort will be made to allow no gap between the current efforts and the establishment of the new project.

- Strict adherence to this plan so that all organizations are treated fairly and on an equal basis.

- Phase-out will provide enough flexibility so that should the proposed project not be authorized, or not be authorized on schedule, current family planning activities could continue.

On November 18, 1986, representatives of S&T/POP, USAID/Lagos, REDSO/WCA and AFR/TR/HPN met to review and mutually develop a plan for the phase-out of current centrally funded activities which will be incorporated into the overall family planning project in Nigeria. The following outlines the basic premises for transition to the new project.

II. PREMISES OF THE PHASE-OUT PLAN

A. Timing

A reasonable and appropriate landmark date for phase-out has been established as March 31, 1988, given that the project contracts should be executed in the last quarter of FY 87 and in-country start-up is expected to require about six months.

B. Terms of the Planned Project Phase-Out

1. Current sub-projects already approved by S&T/POP and USAID/Lagos and now on-going will end at their current termination date.

2. Current sub-projects already approved by S&T/POP and USAID/Lagos to continue must be completed by March 31, 1988.

3. All new sub-projects approved by S&T/POP and USAID/Lagos will have a mandatory completion date of no later than March 31, 1988. Approval for new sub-projects will be given based on the following criteria: (a) sub-project proposals must be of high technical quality; (b) sub-project proposals to be considered must contain or directly lead to activities which will be incorporated into those of the new Nigeria project or fall into the category described in 4. below; (c) it must be ascertained that any new sub-project activity could not be delayed until the new Nigeria project begins.

4. Certain S&T/POP activities considered outside but complementary to the proposed project may continue subject to the availability of funds and with approval of S&T/POP and USAID/Lagos. These activities consist of biomedical/social research through the Family Health International Project (936-3041); voluntary surgical contraception through the Program for Voluntary Sterilization (932-0968) and the Training in Reproductive Health Project (936-3045); operations research through the Strategies for Improvement of Service Delivery Project (936-3030); and the demographic/health survey work through the Family Health and Demographic Surveys Project (936-3025).

III. EXCEPTIONS

Any exceptions to the above stated terms must be mutually agreed to by USAID/Lagos and S&T/POP, and by REDSO/WCA, as appropriate.

IV. EFFECTIVE DATE

This plan will go into effect December 27, 1986.

V. COMMUNICATIONS

S&T/POP cognizant technical officers will be responsible for communicating the terms of this plan to their respective cooperating agencies.

References:

1. Nigeria Family Health Initiatives Project (698-0642) dated November 24, 1986.
2. State 384760, December 12, 1986.
3. Lagos 13618, December 27, 1986.
4. State 11684, January 14, 1987.
5. Lagos 719, January 21, 1987.

ANNEX H

PRIVATE SECTOR COMPONENT

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ANNEX H

PRIVATE SECTOR COMPONENT

I. EXECUTIVE SUMMARY

The private sector component of FHI-II intends to tap Nigeria's robust and enterprising private and commercial sectors for the widespread provision of family planning information and services. It will contribute to achieving the project's overall 12 percent prevalence goal by serving 1.2 million, of the proposed 2.5 million, family planning users by the fifth year of the project. Services and/or commodities will be provided through approximately 12,000 private sector outlets. In support of this output, training will be provided to a total of 7,100 persons including pharmaceutical personnel, vendors, midwives and doctors.

By applying a series of demographic, economic and social considerations, twelve first-year emphasis states were selected, according to the Federal Military Government of Nigeria's (FMG) health zones, as follows: Southwest: - Oyo, Lagos, and Bendel; Southeast: Imo, Rivers and Benue; Northwest: Kaduna, Kwara and Abuja, and Northeast: Kano, Plateau and Borno. In subsequent years, additional states will be selected, based on a strategic assessment and need. All states will participate prior to the close of the project.

The tactics to be used to meet the project's objectives are as follows: 1) initiate family planning services with associations not currently involved in service provision; 2) expand distribution of contraceptive products through commercial outlets, medical personnel and other private groups; 3) provide services which parallel or complement those of the FMG and the public sector program; 4) utilize local resources; 5) extend family planning to new populations, especially in the urban areas, and 6) work with hard-to-reach populations, i.e., those who do not utilize the public sector facilities and "high risk" groups.

Key activities will include supplying contraceptives and equipment for three program networks, i.e., large-scale distributors, health and service delivery sites, and vendors and associations.

Large-scale Distributors. Sterling Products (Nigeria) Ltd. and W.C. Clarke (Nigeria) are examples of large-scale distributors who will participate in the project. Sterling Products is a U.S./Nigerian (60/40) owned manufacturer and distributor of over-the-counter drugs. By 1992, it will reach 4,000 outlets and generate an estimated $4.5 million. A trading company such as W.C. Clarke also will be selected to distribute contraceptives. Trading companies differ from Sterling in that they distribute a wide variety of products through supermarkets, department stores and indigenous market women. Using a trading company will allow the private sector to reach a broader spectrum of the population in need, particularly rural and poor people.

Health and Service Delivery Sites. Included in this network will be nurses, midwives and doctors, maternities, clinics, religious missions and hospitals. Distributing contraceptives through this network will allow the private sector to maximize the use of local resources.

Experienced personnel in specialty hospitals will be selected, trained to a higher standard, and their efforts will be organized. Existing curricula and public institutions will be used for training.

Vendors and Associations. A variety of activities will be initiated with vendors, community people, and others with no prior medical training. Factories which provide employee based family planning services also will be included. Vendor activities will be organized by large units for efficiency, i.e., under the Union of Transport Workers or the Market Women's Association. Commodities will be channeled to a central location and thereafter to "chapter" offices responsible for delivering contraceptive supplies directly to vendors.

A series of key support activities also will be undertaken: training, IEC, advertising, market research and technical assistance. As a major element of the component training will receive direct funding. However, emphasis will be placed on cost recovery (through direct reimbursement or sale of goods and services) and on utilizing existing training facilities, State Training of Trainees (TOT) teams and Planned Parenthood Federation of Nigeria (PPFN). Emphasis also will be placed on developing a strong commercial marketing component. Working with consultants and the IEC component, a mass media campaign will be developed including television, radio, newspaper and magazine advertising and point of purchase materials.

The prime contractor, Family Planning International Assistance (FPIA), will have overall responsibility for managing the private sector component. In conjunction with the other components, a suboffice will be opened in Lagos, Nigeria, which will house professional staff responsible for the immediate performance of all program networks and subcontractors.

II. COMPONENT OBJECTIVES

A. Rationale

The population of Nigeria is by far the largest in Africa and one of the largest in the world. A combination of population growth and brief periods of prosperity have led to a major migration to urban centers. Every aspect of the human services infrastructure is already strained with greater stress to come. In the November 1986 issue of POPLINE, Nigerian Minister of Health, Ransome Kuti, states that "There is a very big unmet need for family planning and with the right policies we can do something about it." Through the Family Health Initiatives II (FHI-II) Project, the Nigerian public and private sectors will work together to strengthen family planning programs that work and to initiate new approaches to service delivery. Nigeria's new national population plan gives priority to urban areas and states that a proportion of the population will receive service through "community based distribution and commercial programs". For a number of reasons, Nigeria is well suited for the private sector expansion called for in the plan:

1. The private sector always has played an important role in Nigerian health care. Trained medical practitioners in the private sector form a large pool of expertise which can be organized to deliver services at clinical intra-uterine contraceptive device (IUCD) and partial (pills and barrier methods only) family planning delivery levels.

2. Nigerians are a dynamic people with a long history of success in commerce. In Lagos alone, there are currently over 250 factories. Throughout the country large markets abound which can serve as service points.

3. The pharmaceutical industry is particularly strong and well organized, with sales networks reaching outlets on a national level. Sterling Products (Nigeria) Ltd. currently is distributing contraceptives to over 2,000 outlets nationwide under the auspices of a USAID Cooperative Agreement with a U.S.-based private voluntary organization (FPIA).

4. All cities over 100,000 in population have maternities and private specialty hospitals, plus private practice doctors or nurse midwives. Thus, economy of scale dictates that the private sector component work in these large cities.

5. There are 540 mission health facilities in Nigeria. In Benue State alone, eighty-eight mission facilities already have been organized under the NKST Mission to form a family planning network. Again the private sector will build on these existing networks.

6. Market women, transport workers, barbers and other vendor groups form a largely untapped pool which can be trained, certified and mobilized to sell condoms and foaming tablets.

7. Private associations such as PPFN, with proven track records, are ready to lend their broad experience and support to involving the rest of the private sector.

In many other countries as Colombia, Bangladesh and Thailand, the private sector successfully spearheaded the case, if appropriate management, training and logistical support were provided.

B. Host Country Involvement in Program Development

During the development of this program design, there was active participation from a variety of public and private sector entities, including the Federal Ministries of Health and Information, representatives of selected state ministries of health, the Executive Director of the PPFN, Sterling Products, (Nigeria) Ltd. and other commercial firms. Throughout the project, close and continued involvement with host country counterparts both in government and the private sector will be maintained.

The FMG already has made a significant contribution to the private sector effort in subsidized contraceptive sales by facilitating duty-free entry and movement of products. Permission from the Ministries of Commerce and Health was secured so that the Sterling sales program could move forward. The maintenance of this component depends on continual support

from the FMG. Further, in the last half of the project, a decision will need to be made by the FMG as to whether to maintain subsidized commercial sector supplies either through direct purchase or World Bank lending.

This project will utilize and strengthen a variety of Nigerian-owned commercial firms, plus local non-governmental organizations, including the PPFN. This project will greatly expand sales and service networks at all levels but particularly in the urban area. To do so efficiently will require coordination among a variety of commercial and non-governmental entities. This is expected to take place through a Private Sector Committee as per the Management Section of the FHI-II project paper. The National Council on Population Activities (NCPA) also is expected to contribute to this effort by reviewing ongoing activities and making suggestions as to periodic adjustments to program strategies. They also will have substantive involvement in the development of annual work plans and evaluation.

In sum, the host country will have significant and substantive involvement at every stage of program development and implementation.

C. Discussion of Principal Objectives and Life-of-Project Design

The purpose of the Nigeria FHI-II Project is to increase the acceptability and availability of family planning information and services throughout NIgeria in both the private and public sectors. To achieve this end, the policy, IEC, public and private sector contractors will work collaboratively and in concert with the FMG.

The private sector component will contribute to achieving FHI-II's overall 12 percent prevalence goal by directly serving 1.2 million, of the 2.5 million, family planning users. This will be accomplished by providing services and/or commodities through approximately 12,000 private sector outlets, as follows: 5,650 private medical providers and service delivery sites; 4,375 large-scale commercial distribution outlets and 2,100 association and factory outlets.

In support of the aforementioned, training will be provided to a total of 7,100 persons: 4,000 pharmacy and medicine store personnel will be trained in family planning methods and counseling, 1,000 vendors in family planning methods and sales, and 2,100 midwives and doctors to the level of IUD insertion competency.

The success of the private sector component relies heavily on several critical factors.

1. FMG continues to provide political and financial support for private and public sector health care delivery, especially family planning.

The FMG has consistently recognized the role of private medical firms in their planning for provision of family planning. The current subsidized program depends on government support. Many states have gone further by including training of private medical practitioners and deployment of traditional practitioners, market women, community leaders,

patent medicine shops and other groups in their state plans. The private sector component of the FHI-II project will depend heavily on continued government support, especially as distribution networks expand in the non-medical sector.

2. Commodities will be available to support project activities.

Considerable effort already has gone into calculating life-of-project commodity needs. It is crucial that timely attention be paid to making such future calculations and also to procuring sufficient supplies and arranging for their timely shipment and distribution.

3. Contraceptive users are willing and able to pay for commodities.

Pre-SFEM FMG household surveys show that approximately 66 percent of the urban Nigerian population only earns a cash income of 100 to 299 naira per household, per month. This figure admittedly is low. However, given the fact that contraceptives will be sold at very low prices and that poorer countries such as Bangladesh have successfully implemented subsidized contraceptive sales programs, it is anticipated that Nigerians also will rise to this challenge. Their willingness to pay will depend, in part, on the success of IEC and advertising campaigns which will inform Nigerians of the economic and health benefits of spacing their children and on establishing of appropriate price levels.

4. Private interests are willing to make an investment in family planning services and trained people will utilize skills to attract family planning users.

Doctors, nurses and nurse-midwives, currently maintain small to medium sized private practices and operate maternities. It is assumed that a proportion of this group will be willing to pay for IUCD insertion kits and IUCDs. Moreover, commercial outlets such as pharmacies and patent shops also must be willing to purchase the contraceptives offered through the project. There already is significant participation from this group, but it must be maintained and strengthened.

5. Private infrastructures in Nigeria can accommodate increased activities in family planning.

During more prosperous times, tremendous expansion took place in both commercial production and distribution networks, and in manpower and capital development in private medical facilities. These infrastructures still are not fully utilized. Moreover, the Nigerian business and professional community has demonstrated a high degree of adaptability to changing markets, products, and technology such as family planning.

6. Other interests (government and/or private) can be stimulated to respond to the increased public demand for contraceptives.

Reaching the goal of 12 percent prevalence requires that commodities supplied increase each year. In 1992, 140,000 IUCDs, 4,550,000 orals, 45,500,000 condoms, and 5,000,000 foaming tablets will be required to supply Nigeria's contraceptive needs. If income is generated, as anticipated, the private sector will acquire $5.0 million through the

sale of contraceptives, over the life of the project. The price of contraceptives donated through the private sector will have been $14,049,025. Thus, 32-35 percent of the value of the contraceptives will have been recovered.

Options for continuing the supply of contraceptives include, but are not limited to the following:

a. AID continues to supply subsidized contraceptives and a new (higher) prevalence goal is reached.

b. Contraceptive manufacturers (U.S.-based or other) take on the task of supplying other contraceptives, at a profit. Experimenting with pricing can support this option. For example, the private sector can slowly raise the price of contraceptives. Nigerian or other contraceptive suppliers, must be convinced to lower their prices, the goal being to reach a point where it is profitable for other suppliers to step in.

c. Given the anticipated volume of condoms (45,500,000 in Year Five), Nigerian-based firms may be interested in the local manufacture of condoms. The possibility of distributing contraceptives to other ECOWAS countries enhances the feasibility of this option. Local production of orals is not probable after only five years, since the cost involved in tableting is very high.

The private sector plans to explore these, and other options, throughout the life of the project so that the full potential of the investment in FHI-II can be realized.

III. TECHNICAL APPROACH

A. Introduction

The key activities required to achieve this component's goals and objectives have been organized into three groups. The first set of activities involves the supply of contraceptives and equipment and includes the warehousing, channeling and distribution of commodities to public institutions and vendors. The second set of activities focusess on establishing or strengthening large scale program networks for the sale of contraceptives and the private provision of family planning services. The third set of activities is result-contributing and, as such, provides support to the other two. Among these activities are: training, IEC and advertising, management information system (MIS) and evaluation, technical assistance, market research, and monitoring of commodities and quality of care.

B. Strategic Considerations and Tactics

The following series of strategic considerations have been developed in order to select priority areas in which the private sector program will function:

1. Demographic. By state: total population, population density, cities over 100,000, percent urban, percent female (urban and rural), and number of children per household (urban and rural).

2. Socio-Economic and Cultural. By state: adult literacy (urban and rural), monthly income (urban and rural), cultural, and government leadership and policies, particularly level of implementation of state family planning plans and policies vis-a-vis the private health delivery system (e.g., licensing, training, professional interchange).

3. Commercial. By state: number of factories and employees, number of large-scale distributor outlets, and number of sales by distributor.

4. Other Providers. By state: number of FMG health and family planning service providers, number of private maternity homes, hospitals and health centers, number of teaching hospitals, number of corporate, mission and private hospitals, and number of family planning related personnel.

The data base for the strategic considerations includes 1984 statistical tables and 1983-84 household surveys provided by the FMG, MOH, Statistical Division. Also utilized were the Nigeria Country Study, U.S. Area Handbook (1982); Who Makes What in Nigeria, Manufacturers Association of Nigeria (1984), plus reports, statistics and surveys from various project and collaborating agencies, and the records of Sterling Products, Ltd., a Nigerian distributor. An additional and important contribution to the pool of information is the combined Nigeria experience of team members acquired on previous trips and during this design phase. It is significant to note, however, that the FMG statistical tables are not complete (i.e., not all institutions or groups submitted survey returns).

In terms of applying the strategic considerations, the private sector is in the fortunate position of already having a national presence through FPIA's ongoing project with Sterling Products (Nigeria) Ltd. This project sells contraceptives in all Nigerian states and will continue to do so under this contract. Therefore, the strategic considerations have been used in terms of strengthening the Sterling project as well as to select priority states in which new program efforts will be initiated.

As a result of applying the considerations, by FMG health zones, twelve first-year priority states were selected: Southwest: Oyo, Lagos, and Bendel; Southeast: Imo, Rivers and Benue; Northwest: Kaduna, Kwara and Abuja, and Northeast: Kano, Plateau and Borno. In subsequent years, additional states will be added, based on an assessment of the strategic considerations and need. All states will participate prior to the close of the project.

A series of tactic statements also have been developed. They describe the basic strategy which will be used to meet the project objectives, as follows:

1. Initiate family planning services with associations not currently involved in service provision;

2. Expand distribution of contraceptive products through commercial outlets, medical personnel and other private groups;

3. Provide services which parallel or complement those of the FMG and the public sector program;

4. Utilize local resources;

5. Extend family planning to new populations, especially in the urban areas; and

6. Work with hard-to-reach populations, i.e., those who do not utilize the public sector facilities and "high risk" groups.

C. Eligible Activities

The eligible activities have been organized according to the three groups mentioned in the introduction to this section.

1. Contraceptive and Equipment Supply

In order to supply commodities in a manner which is both timely and effective, the private sector will carry out the following activities:

- Determine, on an ongoing basis, the quantities of contraceptive commodities required for the implementation of the project. This task will be completed with input from USAID, Centers for Disease Control (CDC), designated officials and through the review/analysis of data to be provided by the project's management information system.

- Refine U.S. and overseas systems in order to ensure adequate storage, inventory control and monitoring procedures. The procedures established will facilitate recording and tracking and make it possible to identify and trace a request or shipment at any stage in the process.

- Procure commodities and warehouse space according to established procedure.

- Review commodity requests and ensure adequate justification/calculation of commodities ordered.

- Arrange for freight forwarding/shipment and distribution of all contraceptive supplies.

- Provide technical assistance to subcontractors regarding the correct storage of commodities, inventory control and drawdown.

- Meet with FMG, World Bank, other donors and AID/Washington to ensure availability of subsidized or low cost contraceptives.

- Adjust the price of contraceptives according to the economic situation in Nigeria and monitor commercial pricing of commodities.

2. Program Network

The program network has been divided into three major components: large-scale distributors, health and service delivery sites, and vendors and associations. These networks are organized so that contraceptives can be channeled from their source to point of sale with facility. The use of networks is also expected to ease USAID/Lagos program management as private sector Nigerian staff will be assigned to monitor and provide technical assistance to each network.

Large-scale Distributors. This component covers activities with large distributors such as Sterling Products (Nigeria) Ltd. Sterling is a U.S./Nigerian (60/40) owned manufacturer and distributor of over-the-counter drugs. In November 1985, it began the distribution and sale of contraceptive products throughout Nigeria under a grant with FPIA. Sterling was selected, because it:

- is a well respected, U.S.-based, Fortune 500 company, with an established Nigeria division;

- has no previous history of distributing contraceptive products. Thus, no ties to maintain - or to break - with any U.S. or overseas contraceptive manufacturers;

- runs efficiently and effectively a distribution network consisting of warehouses, distributors, retailers, drivers and trucks;

- distributes pharmaceutical products (nationally) through over 4,000 outlets;

- is committed at its highest corporate levels (New York and Africa) to involvement in services which benefit the countries and communities in which it works; and

- is willing and able to take on the distribution of contraceptives. This activity fits into Sterling's business strategy of expanding its product line and making full use of its distribution capability. For example, Sterling had room on its trucks and could take contraceptives "up country" along with their regular product line thus accruing large-scale transport savings.

Sterling's performance has surpassed the expectations of even its most optimistic observers. With a first-year grant budget of only $47,000 plus contraceptives, Sterling accomplished the following:

- sold 6,000,000 condoms and over 600,000 cycles of pills, after only nine months of operation. No other AID sponsored project ever has sold 6,000,000 condoms within the same initial time frame;

- generated income of N941,658. (Pre SFEM this was equivalent to approximately one million U.S. dollars);

- trained 63 educators and 30 nurses and initiated family planning service delivery in 36 factories. It also oriented personnel managers from 24 companies to the benefits of family planning; and

- initiated, for the first time in sub-Saharan Africa, a nationwide television, radio and newspaper advertising of family planning products.

The income earned from its first funding period has been programmed for second period operations, further training with the private sector, and product promotion. Moreover, during period two, all Sterling activities will be paid for out of income generated. This, too, is a hallmark. No other project has ever been submitted to AID requiring only commodity support.

For all the reasons enumerated above, Sterling will continue its contraceptive distribution and training activities under the FHI-II private sector component.

Sterling will be strengthened through this contract by the addition of a new marketing approach, an MIS system and the ongoing review and refurbishing of distribution networks. In the first FHI-II project year, funds will be provided to initiate these activities. In subsequent years, Sterling is expected to generate enough income to cover these costs, the costs of its factory and training program and the costs of other program efforts.

Sterling's current clients are men and women who frequent urban pharmacies. These people tend to be from upper and middle income groups. At this time, however, it is estimated that they only comprise two and one half percent of all Nigerians. The new marketing program to be initiated in program Year One, is intended to make Nigerians at all income levels aware that low price contraceptives ("government subsidized") are available through local pharmaceutical outlets.

The private sector also will work with trading companies such as Clarke, Holt and UAC. They differ from Sterling in distributing a wide variety of products. Clarke, for example, distributes food products, cosmetics, alcoholic beverages, baby and paper products and pharmaceutical products. Clarke reaches supermarkets, department stores and indigenous market women throughout Nigeria and has depots in eight major cities. The private sector project will select one of the aforementioned companies to distribute contraceptives through this expanded system. Subsequently, other trading companies may be added. By using trading companies, a broader spectrum of the population in need will be reached, particularly rural and poor people. These trading companies will secure their contraceptives through Sterling.

In order to maintain high standards of quality of care and informed choice in the large-scale distribution system, emphasis will be placed on ensuring that the client receives adequate information at the point of purchase.

Health and Service Delivery Sites. This component covers activities with medical practitioners, nurses and nurse-midwives, with service delivery sites, (maternities, clinics, hospitals and missions). During the first year, five hundred practitioners will be trained to practice in small to medium sized medical facilities, maternities and hospitals. Three hundred sites also will be selected which already have trained and experienced medical personnel. These sites will be specialty hospitals and missions. A total of eight hundred sites will be covered under this component. The national logo developed by the IEC component will identify these eight hundred certified family planning sites to the general public.

This approach will allow the private sector to:

- maximize the use of local resources by using experienced personnel in specialty hospitals and missions;

- optimize the use of already trained personnel by training them to a higher standard and organizing their efforts;

- test the feasibility of training practitioners only in pill and barrier methods. (Preliminary data indicate that practitioners prefer to be trained to IUCD level);

- use existing training curricula and public institutions to train practitioners to IUCD level; and

- test the feasibility of having the most prosperous practitioners pay for training and IUCD insertion kits.

Three hundred medical practitioners will receive update training. The practitioners' activities will be organized and managed by professional groups such as the Nigerian Association of Nurses and Nurse Midwives, the Nigerian Medical Association or the Association of Obstetrics and Gynecology. Because of their large populations and well organized medical professional groups, Lagos, Aba (or Enugu), Jos and Ibadan have been selected as first year sites for training these groups of practitioners.

Since Nigeria already has a pool of practitioners trained to IUCD insertion level, the first step will be to identify individuals in this pool. This will be done by polling lists of trainees maintained by public institutions and, if necessary, by placing advertisements in local newspapers. The practitioners who are selected for update training and certification already must have skills which are equal to, or higher than, those which currently are accepted in the public sector in order to ensure the quality of service in the private sector.

Depending on skill level, three to five day training courses will cover topics such as clinical update, motivation, sales and record-keeping. standardized, already existing, training curricula can be adapted to meet the needs of this group. Six to ten training courses will be provided during the first year in existing training facilities, i.e., PPFN, universities and state training teams.

Because of the high cost of training, emphasis will be placed on cost recovery. At least 35 percent of practitioners are expected to pay for their IUD insertion kits. This is feasible since medical equipment sold through Nigerian commercial channels is expensive or unavailable and the project will sell them at a reduced cost. During the first year, a proportion of trainees also will be expected to pay for training. This will be done on an experimental basis.

Two hundred additional medical practitioners will be trained as follows:

> 100 will receive partial training, i.e., to pill and barrier level. This training will be delivered through public institutions, using existing curricula and will take approximately five days; and
>
> 100 will receive full service training, i.e., to IUCD insertion level. This training will take four to six weeks and also will be delivered through public institutions using existing curricula.

Again, attention will be given to cost recovery, and a percentage of the 200 medical practitioners will be expected to pay for training and medical supplies. This group will be organized and managed as previously described.

The specialty hospitals activity will be managed by a Nigerian management consultant firm. The firm will be selected early in the first contract year. It will be responsible for selecting participating hospitals, based on predetermined criteria, managing the distribution of contraceptives to the hospitals, providing technical assistance in commodity management and record-keeping, and for overseeing the promotion of the network in the community. This network will operate in a selected number of priority states, in cities with a population of 100,000 or over.

Nigerian religious missions tend to serve populations which are otherwise underserved, and often have health facilities for people living in rural, difficult-to-reach areas. According to the FMOH Medical Statistics Division, there are 540 mission health facilities in Nigeria. (They represent 4.6 percent of all Nigerian health facilities.) Over half of the mission facilities are located in four states: Benue (140), Plateau (64), Kaduna (57), and Kwara (54)).

One group of 88 health facilities in Benue state (a teaching hospital for nurses and midwives, 3 cottage hospitals, 5 comprehensive health centers, 13 primary health centers, 42 health clinics and 24 health centers) currently is operating under a FPIA grant with the NKST Mission (Nongo M Kristu V Ken Sudan Hen Tiv: Church of Christ on the Sudan among the Tiv.) This project will be incorporated into the Family Health Initiatives contract in 1988. Commodities will be supplied to this network through the nearest Sterling warehouse. Technical assistance in client counselling, record-keeping storehouse management and other support activities will be provided by the private sector Nigerian staff based in Lagos. IEC materials will be translated into local languages by mission staff. Commodities will be distributed through this mission network.

In the second year, the mission network will be expanded and special emphasis given to primary health care LGAs, as designated by the FMOH for working with mission groups.

Vendors and Associations. A variety of activities will be initiated with groups of vendors, community people, and others with no prior medical training. These include market women and men, taxi drivers, community leaders, members of the National Youth Service Corp (NYSC), (a one year service program for university graduates), and PPFN. The component also will cover factories which will provide employee-based family planning services.

Vendor networks will be organized by large units for efficiency, i.e., under the Union of Transport Workers or the Market Womens' Association. Commodities will be channeled to a central location in each city and thereafter to "chapter" offices responsible for distributing supplies directly to the vendors. Training, technical assistance and the IEC materials will be required to support this activity. Current models for training, certifying and deploying market women as pill distribution agents will be studied and adapted to meet special needs. In Ibadan, for example, market women now sell malaria medicine, oral rehydration salts and first aid supplies, together with contraceptives, and must travel out of the market to get supplies (some of which must be refrigerated). This FHI project will test the feasibility of training market women only in family planning counselling, sales, and a limited range of health delivery skills. It also will test the practicability of distributing commodities from a central point in each market so that the vendors have easier access to supplies. Methods of promoting or advertising the availability of contraceptives in the market will be explored.

During the first contract year, the factory employee-based program currently managed by Sterling Products Limited will be continued. Approximately, 250 factories located primarily in the Lagos area will be reached through this network. Experience has shown that to be cost efficient, employee-based projects must operate in factories which employ over two hundred workers. Additionally, the responsibility for the distribution of contraceptive commodities must be housed with one group which acts as an "umbrella" organization. Demonstration projects with two multinational firms (Lever Brothers (Nigeria) Ltd. and Mobil Oil (Nigeria) Ltd.) and one parastatal, Nigeria Telephone (NITEL), will be continued.

As the manufacturing center of Nigeria, Lagos is well suited as the site for this network. There are 255 factories in the Lagos area, fifty-nine of which employ 500 or more people, and sixty-nine employing between 200 and 499 people. The second greatest number of factories is located in Kano which has about sixty-three factories, with only twenty-three employing 200, or more, workers. Factories generally will receive their first supply of contraceptives at no cost, i.e., 100 condoms, 25 cycles of pills and 100 foaming tablets. These commodities will be sold at the established price and the income used to purchase the next supply.

3. Support Activities

Over the life of the private sector contract, a series of activities will be required primarily to provide support to the program network. Among these activities are: training, IEC and advertising, MIS and evaluation, technical assistance, market research and monitoring of commodities and quality of care. It is anticipated that the level of support will decrease over time and, ultimately, will be absorbed by local institutions.

Training. Training will be a major component of this project. Appendix 1 of Annex I illustrates the types of training required by category of vendor/service provider. Clearly, the magnitude of training requirements requires direct funding. From the outset, however, emphasis will be placed on cost recovery (through direct reimbursement or sale of goods and services) and on utilizing existing training facilities such as universities, state training teams, and associations such as PPFN. These public facilities will provide training and lend their broad experience to the program. PPFN has been providing Nigerians with family planning information and service for twenty-two years. It pioneered factory-based male motivation training and has trained all the medical personnel who work in the factories managed under the Sterling project. Under the FHI-II private sector component, PPFN will continue to provide training for Sterling. It also will train vendors and pharmaceutical personnel. Margaret Sanger (a U.S.-based subcontractor) will work with PPFN to develop model curricula for new categories of vendors.

It also will be important to utilize existing training materials and curricula such as 2-4 day courses in IEC or counselling, adapted for various literacy and experience levels, "mini" courses on inventory management and reorder points and other management related activities. Training will be provided for doctors, nurses, midwives, pharmacists, traditional practitioners, vendors, community development groups and others with no prior medical training (see Table 1).

Ongoing monitoring of the end results of training will be accomplished throughout the life of the project. Some degree of institutionalization of training needs to take place for long-range viability. Activities in support of this are envisaged.

MIS (Management Information System). The collection and analysis of data are essential to the success of this project, particularly in view of the rapidly changing Nigerian environment and market forces. The private and public sectors will work collaboratively to ensure that data collected in the private sector feed into the government's MIS system. Careful consideration will be given to determining the type and quantity of data required to facilitate ongoing decision-making, project operation and evaluation. This is significant because experience has shown that an inordinate demand for data can easily overload private sector enterprises, leading to confusion and incomplete returns. Given these factors, the types of activities and features to be included in the MIS system will be carefully determined prior to the design of the system.

IEC and Advertising. The majority of the private sector IEC efforts, apart from face-to-face encounters at service sites and points of

TABLE 1: ANALYSIS OF TRAINING NEEDS (PRIVATE SECTOR)

Characteristics of Vendor/Provider	Characteristics of the "target group" and/or type of method	Appropriate Type of Training: Technical (FP)	Appropriate Type of Training: Sales IEC and Counselling	Appropriate Type of Training: Record-Keeping and/or Inventory Management
Nurses + Nurse-Midwives				
o With pre - or inservice training in FP o Without pre - or inservice training in FP	o Full service* o Partial service* (no IUD's) (Women of child bearing age)	o Clinical update (3) days 4-6 wks; with 20 IUD insertions to certify o 3-5 days, without IUD insertion s	o 3 days	o 1 day
Doctors				
o OB/Gyns, or doctors trained in FP o General practice doctors	o Full service Mini lap (AVSC) N/A o partial service (no IUDs) (women of child bearing age)	o Clinical update (1 day) o 2 weeks, 20 IUD insertions o 3 days, with no IUD insertion	o ½ - 1 day	o 1 day
Pharmacist				
o Pharmacist (Registered) o Pharmacists' assistance/sales staff (no formal training at all)	o partial service (pills, barrier methods) o Injections (men, women and teens)	o 1 day contraceptive update/review o 3 days (field worker FW level knowledge of methods) -	o No sales training o 2 days IEC training	
Patent Medicine				
o Shopkeepers	o partial service** (pills, barrier) (men and women)	o 3 days (or 6 evenings)		
Traditional Practitioners				
o TBAs (Trained by Gov't or Untrained) o Traditional healers	o partial service ** (men and women)	o 3 days o 2 weeks (to include hygiene, ORT, etc.)		
Vendors/Community Development People, Others with no prior Medical training				
o Market people (women mainly) o transportation workers (men) o PPFN male motivation agents	o patial service (where approved) o barrier methods (women) barrier, pills o barrier (men, general public) o IEC barrier (men in factories)	o 5 days (and bi-annual 3 days update)		o 3 days (4 days, if pills)
o Vendors	o pill, barrier barrier	o 1 day skills update o 5 - 9 days		o 1 day sales o 3 days
o NYSC (non medically trained,*** but (all university graduates) o Other, as identified	barrier, IEC	o 2 days during orientation		o 1 day

* Full service - including IUD and diaphragms all methods except sterilization.
Partial service - includes no IUD insertion.

** Within existing Nigerian laws and policies.

*** Medically trained NYSC are included in their professional category.

purchase, will be managed by the IEC contract in close collaboration with the private sector. The IEC component work plan also describes in detail the anticipated advertising and IEC inputs. They are expected to be financed by the IEC contract.

Market Research. As noted earlier, Sterling Products (Nigeria) Ltd. was responsible for the first family planning advertising (television, radio and newspapers) in sub-Saharan Africa, under a grant with FPIA. This advertising was paid for with income generated by the sale of contraceptives. Thus, a relatively small sum was invested.

Realizing the neccessity for a strong, well mounted IEC effort, the FHI-II Project is investing a considerable amount of time and money in this critical area. The FHI-II/IEC component will include a wide range of mass media activities at the national, state and local levels. As a result of its efforts, 80 percent of the eligible population will become knowledgeable about family planning concepts. The private sector component has therefore tailored and timed its commercial sales marketing research efforts to coincide with, and not to duplicate inputs to be provided by the IEC component. For example:

- In month two, a U.S.-based consultant (a former Vice President of a major U.S. advertising company) will be hired to conduct marketing research. Since the scope of work is large, he will be assisted in data collection and analysis by one or more U.S. or Nigerian consultants. The team will provide information intended to guide initial planning regarding the sale of contraceptives.

- Such information will include, but not be limited to, the following: data regarding the current contraceptive mix (project supplied and other), contraceptives, sales quotas and profitability. Methods to be used to acquire the data include: interviews, surveys, retail audits and qualitative research with focus groups.

- In month four, the consultant will present his findings to the private sector component.

- In month five, the private sector component working with Sterling Products and the IEC component, will solicit bids from at least three Nigerian advertising agencies. The agency selected will work with Sterling and the IEC component to develop an appropriate mass media campaign which will include television, radio, newspaper and magazine advertisements and point of purchase material.

- The consultants will receive contracts in subsequent years to carry out new research, monitor progress and conduct evaluations.

Technical Assistance. Successful technical assistance (TA) includes at least two elements: (1) it "follows the data" by pursuing observable characteristics of program operations; and (2) it involves relevant personnel in the process. Technical assistance always should result both in specific improvement of a program's performance and in enhancement of the ability to solve problems.

FPIA/Nigeria field staff will make periodic monitoring visits to all Nigerian subcontractors. During the course of the visits, the subcontractors' needs will be assessed and TA provided, or scheduled, as required. Field staff will use FPIA's current technical assistance practices (which are documented in a staff TA Handbook). The handbook provides a framework for technical assistance and includes: analysis and design of record systems; assessment of the family planning environment; staff performance and organization; and commodity management.

D. Detailed Year One Activities

A work plan has been developed which lists the major tasks required during the first year. Due dates for each task are assigned by quarter. The plan is organized under major activities, i.e., I. Set-up, II. Implementation (Contraceptive Equipment and Suppliers, Program Networks and Support), III. Management, and IV. Monitoring and Evaluation.

During the first year of the program, the following activities will be accomplished:

- set-up FPIA on-site office (recruit, hire, deploy and orient staff);

- sign subcontracts with U.S.-based organizations: e.g., Johns Snow, Inc. and Margaret Sanger Center;

- conduct market research to provide information on method mix, contraceptive sales trends, segments of the population served/unserved, pricing of contraceptives, sales quotas and profitability; and

- sign subcontracts with Nigerian organizations to accomplish the following:

- NKST Mission: to manage contraceptive distribution to mission health facilities in Benue State;

- Medical Association(s): to manage medical practitioners' training, service and contraceptive sales in Lagos, Aba (or Enugu), Jos and Ibadan, and to train practitioner networks;

- Sterling Products (Nigeria) Ltd.: to continue to supply national contraceptive distribution networks reaching over 2,000 pharmaceutical outlets, to continue its employee-based and medical practitioner training programs and to expand its marketing efforts;

- Vendor Groups/Taxi Associations, Market Women and Others: to initiate contraceptive sales at community level in two or more cities;

- Lever Brothers, NITEL and Mobil Oil: to continue, at reduced funding levels, factory-based contraceptive distribution and family planning promotion demonstration projects; and

- W.F. Clarke (Nigeria) Ltd. (or comparable trading firm): to initiate and maintain contraceptive distribution networks reaching supermarkets, department stores and indigenous market women in eight major Nigerian cities.

- sign subcontracts for provision of training with PPFN (male motivators and vendors) and with local institutions for medical practitioners;

- design and implement MIS system;

- monitor project inputs and outputs and develop evaluation plan;

- provide technical assistance to Nigeria-based subcontractors in commodity management, finance, etc.; and

- develop new subcontracts with Nigerian agencies.

The following tables are the private sector Year One Detailed Work Plan by quarter.

NIGERIA PRIVATE SECTOR WORKPLAN YEAR ONE

	Quarter 1	2	3	4
1. Recruit, hire, deploy, orient staff and provide logistical support.	x			
2. Develop detailed work-plan, identity MIS needs and draft year one travel schedule.	x			
3. Sign subcontracts.	x			
4. Set-up MIS for general project management.		x		
5. Set-up MIS For monitoring and evaluation in collaboration with public sector.		x		
6. Procure commodities for year one operations.				
7. Establish coordination procedures with Government, private sector agencies, other contractors and USAID Project Coordinator.		x		

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NIGERIA PRIVATE SECTOR WORKPLAN YEAR ONE

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1. Recruit, hire, deploy, orient staff and provide logistical support.	x			
2. Develop detailed work-plan, identity MIS needs and draft year one travel schedule.	x			
3. Sign subcontracts.	x			
4. Set-up MIS for general project management.		x		
5. Set-up MIS For monitoring and evaluation in collaboration with public sector.		x		
6. Procure commodities for year one operations.				
7. Establish coordination procedures with Government, private sector agencies, other contractors and USAID Project Coordinator.		x		

	Quarter 1	2	3	4
II IMPLEMENTATION				
A. CONTRACEPTIVE EQUIPMENT AND SUPPLIES				
1. Establish draw down rates.	x			
2. Assess current commodity supply needs and review, revaluate contents and use of clinic equipment and IUD kits.	x			
3. Incorporate commodity system data into Nigeria MIS (re Set-up No 4)		x		
4. Ensure adequacy of F.P. contraceptive and equipment delivery systems from procurement to distribution points.	x			
5. Provide technical assistance to distribution subcontacts in the implementation and extension of the commodity management systems.	x	x	x	x
6. Monitor system and refine as required.	x	x	x	x

	Quarter 1	2	3	4
B. PROGRAM NETWORKS (Large Scale Distributors, Medical and Service Deliveries and Associations and Factories)				
1. Identify Nigeria sub-contract groups.	x	x	x	x
2. Determine quantities to be sold by each network.	x			
3. Identify training needs.	x	x		
4. Establish method to channel supplies.	x			
5. Establish uniform reporting systems.	x			
6. Sign contracts with selected organisations:				
- Initiate PPFN Male Motivation Training Courses	x			
- Initiate NKST Mission Program Network	x			
- Initiate Distributor Program Networks	x			
- Initiate Associations/Factories Program	x			
- Initiate Second Round Association Factories Program	x			
- Initiate Private Service Providers Network	x			
- Initiate Private /sector Nurse/Nurse Midwife Training	x			
7. Monitor contract performance including cost benefits.	x	x	x	x
8. Provide technical assistance as needed.		x	x	x

	Quarter 1	2	3	4
C. SUPPORT				
TRAINING				
1. Identify medical professionals working in the private sector who have prior training.	x			
2. Assesss network sites and determine training needs.	x			
3. Identify and assess in-country training resources according to government zones.	x			
4. Expand PPFN infrastructure for field and vendor training.	x			
5. Develop, field test and reproduce one to three day training modules for field workers, vendors, etc, in sales, IEC, counselling, record-keeping, and monetary management.	x	x		
6. Monitor and follow-up training Assesses results.	x	x	x	

	Quarter			
	1	2	3	4
D. MARKETING/ADVERTISING				
1. Sign consultant contract and initiate market research.	x			
2. Review research findings with IEC Component		x		
Solicit bids from Nigerian Advertising Agencies.			x	
4. Review agency briefs with IEC component and major distributior and sign sub-contract.			x	
5. Distribute IEC materials to networks.				x

		Quarter			
		1	2	3	4
III.	MANAGEMENT				
1.	Prepare MIS objectives and scope of work.	x			
2.	Participate in collaborative Agency Planning Meeting.	x	x	x	
3.	Finalize reporting formats and other requirements				
4.	Establish financial systems for paying subcontractors staff expenses (in US and Nigeria).	x			
5.	Prepare detailed second year plans of work.			x	
6.	Prepare second year sub-contracts as needed.				x

IV. MONITORING AND EVALUATION	Quarter 1	2	3	4
1. Receive baseline survey results				
2. Monitor sub-contractor performance (U.S. and Nigeria)	x	x	x	x
3. Develop protocol for first internal evaluation.				x

IV. COMPONENT MANAGEMENT

The prime contractor, FPIA, has overall responsibility for managing the private sector service component. In selecting its management approach FPIA has considered:

- the size and diversity of the FMG's administrative units, i.e., federal, 19 states and 304 local governments;
- its own organizational and administrative structure;
- the organizational structure and special skills of U.S.-based subcontractors;
- the proposed organization of the private sector's work, i.e., program networks and eligible activities;
- the varying skill levels of Nigerian subcontractors and their technical assistance needs; and
- the need to work closely with other collaborating agencies.

A. Management Approach

FPIA currently administers its AID-funded overseas activities through a three tier organizational structure: New York (headquarters), regional office and, as required, regional suboffice. This structure has proven both efficient and effective in terms of span of supervisory control and in the delegation of authority, decision-making and responsibility. FPIA believes that a manager's job should have the broadest possible scope; however, staff responsible for immediate performance, i.e., Associate Regional Directors, should not also be responsible for strategic planning.

Given these factors, FPIA intends to use its current organizational structure and procedures to manage the private sector component. It also intends to open a regional suboffice in Lagos, Nigeria.

New York. Personnel from five New York departments (Administration, Grants Management, Special Projects, Project Management and Logistical Management) will contribute to the overall management of the project. Major responsibilities of New York staff are to:

- negotiate and write contracts with U.S.-based consultants and major subcontractors, e.g., Johns Snow, Inc., and Margaret Sanger Center;
- review and approve Nigerian subcontracts;
- procure commodities and manage their shipping and distribution and conduct periodic TA visits to Nigeria;
- disburse funds to consultants and subcontractors in the U.S. and Nigeria;
- disburse funds to cover operations of Nigerian field office;

- analyze project's MIS data;

- review and provide input to field staff on reports submitted by subcontractors and consultants;

- oversee the monitoring of the private sector work plan; and

- provide overall administrative and financial guidance and arrange for the conduct of periodic evaluations.

Africa Regional Office (ARO). FPIA's Africa Regional Director will supervise the activities of the Associate Regional Director (ARD) who will be based in Lagos. He will be assisted by one regional office senior staff member (at 50 percent time) and a secretary (full time). Major responsibilities are to:

- recruit, hire, deploy and orient Lagos suboffice staff with assistance from New York, as may be required;

- develop detailed plan of work for Lagos, private sector component, assisted by Lagos ARD and New York, as required. Monitor planned versus actual performance;

- monitor the management of project activities through periodic visits to Lagos and review of office and program systems;

- provide technical assistance to Nigerian subcontractors in overall management of program networks and contraceptive distribution, as needed;

- conduct spot audits regarding adequacy of contraceptive inventory control and storage practices of large-scale distributors;

- supervise Lagos MIS system and participate in data analysis;

- review finance requirements and ensure adequate bookkeeping and inventory control; and

- manage year-to-year planning to better achieve objectives and respond to problems.

Lagos Regional Suboffice. The Lagos private sector staff will consist of an Associate Regional Director (ARD) and three program officers. Secretarial and administrative support will be provided through the FHI-II administrative component. The ARD will be responsible for the immediate performance of the private sector component. Under his/her direction, program officers will each be responsible for a program network: large-scale distributors, medical and service delivery sites and associations and factories.

The ARD also will be responsible for managing and providing support to U.S. subcontractors and consultants when they are working in Nigeria.

Major activities of the Lagos suboffice are as follows:

- prepare Nigerian subcontracts for activities as may be required under each program network;

- monitor subcontracts as per work plan schedule;

- ensure that family planning services are voluntary, informed and of a high quality per project work plan and FPIA procedures;

- ensure coordination of all network activities;

- develop new networks, coordinating with Africa Regional Director and other collaborating agencies;

- provide technical assistance, as required, to networks and associations;

- supervise MIS data collection and tabulation;

- work with market research/survey teams to translate results into program actions, at network levels;

- ensure compliance with FMOH family planning regulations and procedures and FMG laws;

- liaise with other organizations: USAID, IBRD, UNFPA, UNICEF, etc.;

- attend quarterly, full team (public, IEC, policy, private) meetings; and

- ensure efficient management of suboffice budget.

U.S.-based Subcontractors/Consultants. FPIA will negotiate and prepare subcontracts in New York for all U.S.-based subcontractors and consultants. All subcontracts will specify deliverables and due dates. The Lagos suboffice will provide overall management support to subcontractors and consultants while they are in Nigeria.

B. Component Linkages

1. With the FMG

This component of the FHI-II Project focusess on the private sector and as such does not anticipate direct day-to-day linkages with government. However, linkages with government officials at (principally the Federal Ministry of Health) state and LGA levels are extremely important for ongoing implementation. The policy sector's activities will also need to be closely coordinated with the private service sector to ensure ongoing support at these levels. Most importantly, the cooperation of the Federal Ministry of Health and the Federal Ministry of Commerce is essential for maintenance of a subsidized sales program utilizing AID-supplied, duty-free contraceptives.

2. With Other Collaborators and Implementors

The four "component" agencies, the Pathfinder Fund, JHU/PCS, the University of North Carolina and FPIA, have worked collaboratively in the design of the implementation plan.

Pathfinder/Public. Since both the public and private sectors are involved in service delivery, it will be important to ensure that service delivery points are parallel and complementary. Since public sites are stationary, the onus is on the private sector to accurately select its catchment areas. The private sector also must ensure that vendor distributors are aware of the nearest public family planning facility and are trained to make referrals.

Since the greater percentage of private sector training will take place in public institutions, using already prepared public sector curricula (which may be modified to meet private sector needs), the two sectors must establish communication channels and formulate plans which will facilitate the:

- sharing of public sector training calendars;
- sharing of lists of previously trained medical practitioners;
- scheduling of training courses;
- pricing of training;
- collecting and monitoring of income generated; and
- certification and follow-up of trainees.

The public sector will conduct a baseline survey which will estimate the prevalence rate, as the project begins, together with data on contraceptive method mix, sources of supply, attitudes and knowledge and other related matters. The private sector will provide a share of the costs for the survey through a subcontract with the public sector. The data collected will be used by the private sector to make required work plans and management decisions.

The private sector's MIS also must be designed so that private sector data can be channeled to the FMG.

Finally, ongoing communication between Lagos-based, public and private sector project coordinators will be essential.

JHU/PCS-IEC. The IEC component is responsible for developing the "messages" which will inform and motivate the public to use family planning. Media messages (radio and television) will be national as well as on a state level. Written materials will be developed for a variety of language groups and for trainers. The IEC and private sector must, therefore, establish communication channels and formulate plans which will facilitate the:

- distribution of IEC material to the various private sector networks, i.e., large-scale distributors, medical and service delivery sites and associations and factories. It is anticipated that the private sector will assist in the shipping, warehousing and distribution of IEC material;

- sharing of curricula developed by the IEC component for use in motivating groups, counselling, improving face-to-face interaction and in using IEC materials;

- sharing of curricula for training special interest groups such as taxi drivers and market women;

- sharing of ideas re contests, etc., which can be used to motivate groups on the local and state levels;

- distribution of materials to special interest groups (e.g., Islam and Family Planning, Cost Effectiveness of Family Planning Programs in Industry); and

- sharing of calendars for special training events such as traditional leader training and training of medical practitioners.

Finally, the IEC sector will work together with a primary private sector distributor (via a subcontract) to assist in the development of a brief which will be submitted to three advertising agencies. The IEC component will then review agency proposals and select the advertising agency. The distributor will subcontract with the agency selected.

University of North Carolina - Policy. The policy implementation component is responsible for issues such as LGA leadership in family planning program development and the linkage of family planning to EPI and other categorical programs. Strategic planning also is a major responsibility of the policy component. This will involve annual reviews of state family planning program performance and annual planning exercises conducted with the FMOH. The policy and private sector components must establish communication channels and formulate plans which will facilitate:

- the sharing of data regarding state fee schedules for health service. This information is important to the private sector as it implements its own pricing schedules;

- the participation of the private sector component in interstate evaluations proposed by the policy sector;

- the participation of the private sector in annual meetings of state family planning coordinators;

- the sharing of survey data collected by the policy component. Specifically, the private sector will periodically prepare questions which can be added to the monthly Federal Bureau of Statistics (FOS) surveys. Data collected from sentinel surveys regarding pricing of contraceptives and choice of method also will be valuable to the private sector;

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- the sharing of information regarding policy data on the roles and responsibilities of traditional birth attendants and traditional healers also will assist the private sector as it develops its plans to provide training for these groups; and

- the sharing of information regarding universities with the capacity to do "quick" demographic research.

Finally, the private sector also expects to benefit from ongoing interaction between its Lagos-based Director and the Lagos-based senior demographer which the policy component will provide.

Other Implementors. The private sector will work with other implementing agencies as follows:

- Association for Voluntary Surgical Contraception (AVSC). Mission hospitals currently provide voluntary sterilization. FPIA intends to maintain linkages with AVSC in order to facilitate expansion of such programs and to ensure that high quality service is provided.

- UNFPA, The World Bank and UNICEF provide technical expertise and services to Nigeria. The private sector will establish relationships with field representatives of these organizations, through its Lagos suboffice, in order to encourage exchange of information and complementary service provision.

3. With AID

The private sector will provide AID with all required progress reports. It also will liaise with AID regarding project assessment and evaluation.

In Lagos, the private sector will relate to the AID Program Coordinator per FHI-II Project requirements. The project paper provides more detail in this regard.

V. MONITORING AND EVALUATION PLAN

Major "benchmark" activities in the monitoring and evaluation of the private sector component of the FHI-II Project include:

- baseline survey results;

- annual sales/commodity distribution figures and next year projections (produced in January of each year);

- first internal component assessment (in the second quarter of FY 89);

- mid-term AID (external) evaluation (in June 1989);

- second internal component assessment (in the sector or third quarter of FY 91);

- AID (external) evaluation (in early 1991); and

- final survey results (in September 1992);

- final contraceptive sales/distribution and program report (end of 1992).

- final AID external evaluation late 1992.

Some of the "benchmark" activities are AID-managed external events, and some are collaborative efforts with other components. A third group of activities will focus on internal monitoring and evaluation by the private sector team.

Mid-term and final project evaluations are mandated and managed by AID. The private sector team will facilitate external evaluators' activities, as required, and expect to participate with other collaborators and AID, in review of mid-term evaluation results and any necessary restructuring of the program, based on findings.

A baseline and final survey is planned to provide data necessary to look at the effects of the entire FHI-II Project in all sectors. These surveys are described more fully in the Public Sector Component Work Plan. The surveys will contain a number of questions important to the private sector, particularly regarding source of supply (by method), source of information (including advertisements) and method or brand preference. These surveys will help document the mutually supportive roles of the various components.

Internal evaluation, ongoing monitoring and programmatic decision-making will be based on data collected in various ways. Data on contraceptive sales and distribution is currently available to the level of about 500 wholesale distributors. The system for collection, processing and analyzing this data will be refined, and cost efficient ways to collect point of purchase data will be explored (e.g., periodic sampling of point of purchase outlets). Other sources of information will include market research studies, small surveys, assessments of individual activities and site visit reports. Emphasis will be placed on maximizing usefulness, accuracy and consistency among indicators measured in various parts of this program.

AID mandates the production of periodic progress reports on each component (including figures on sales/commodity distribution) and submission of annual work plans, which will be preceded by data collection and planning process. Routine monitoring will take place on a predetermined schedule and on an as needed basis, covering financial, programmatic and logistical aspects of project activities. In addition, two major internal assessments are planned. The first assessment will take place in the third quarter of FY 89 after the first full year of implementation (six months, roughly of "set-up" time). The second major internal assessment will take place in the second or third quarters of 1991.

Assessments are expected to focus on the following key programmatic areas:

- patterns in movement and sale of contraceptives;

- effectiveness of marketing strategies;

- status of commercial (non-subsidized) contraceptive sales;
- pricing of contraceptives;
- cost-benefits of various approaches and vendor/sales networks;
- validity of strategic considerations;
- success in reaching "target" groups;
- quality of care (through monitoring selected quality of care indicators; and
- achievement of program targets.

Assessments will be used to make adjustments in the program.

VI. FINANCIAL PLAN

A. Introduction

The prime contractor (FPIA) has a well established financial management system and operational procedures. FHI-II private sector funds will be held and managed at FPIA's New York headquarters and fund transfers to U.S. and Nigerian subcontractors will be made from New York.

B. Method of Financing

USAID/REDSO/WCA shall make available to FPIA such amounts as necessary to carry out the work plan through a Federal Reserve Letter of Credit. This system has proven efficient and effective throughout FPIA's history of managing over one hundred million dollars of AID funds.

FPIA has established operational procedures for the management of subcontracts. All subcontracts will be legally binding documents set forth in writing and based on previous negotiations and understandings. Subcontracts may include negotiated "Advance Agreements" to avoid later cost allowability disputes. Advance payments may be made to provide operating funds for the subcontractor to draw on to support contract performance. Requests for future payments will be accompanied by documents adequately substantiating the right to payment. All Nigerian subcontracts will be in local currency, not U.S. dollars. All subcontractors must maintain appropriate accounting records, per established FPIA procedures.

Subcontractors will be required to submit reports (per agreed upon schedule) and performance will be monitored through regular, on site, monitoring and technical assistance visits. Audits required will be performed by external audit firms. FPIA reserves the right to examine and audit the records of any subcontractor, notwithstanding the audit process.

C. Host Country Contribution

It is anticipated, based on very positive results from FPIA's Sterling Contraceptive Marketing program, that revenues will be generated through the sale of contraceptives. These resources, coming from Nigerian customers and clients, will be rechanneled into the growth and expansion of private sector activities and will be a major source of host country financing. The private sector component will generate an estimated $5.0 million through the sale of IUCDs, orals, condoms and foaming tablets under the Sterling subcontract. Per FPIA procedures, these funds will be held in a separate bank account not to be spent without FPIA authorization and USAID review. The income generated by Sterling in the first year will be budgeted in the second year of FHI-II private sector operations. The same procedure will be followed in subsequent years. A variety of cost recovery mechanisms will be initiated through the sale of family planning services and equipment by trained Nigerian medical practitioners. This also is expected to contribute to the financing of the FHI project. Additional contributions in the form of staff time, health facilities and office space will be provided by participants in the various private sector networks.

The FMG also is making a major and significant contribution to the project by eliminating duties on imported contraceptives and family planning equipment.

D. Budgets

A detailed Year One budget and an overall five year budget follow this section. Of the total budget of ten million dollars available for the private sector component, $2.3 is in local currency and $7.7 million is in dollars. Importantly, $1 million (out of the $7.7 million) is for equipment and materials to be distributed and utilized in Nigeria. Additionally, $3.0 million (or 60 percent) of the consultant and subcontract line items ultimately will be disburged in local currency.

BUDGET WORKINGS — PRIVATE SECTOR Totals — PRIVATE

(Inflated prices)	Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
PERSONNEL	126,164	231,410	262,951	151,397	242,981	275,893	181,676	255,130	291,034	199,844	267,886	303,790	219,828	281,280	317,185	878,909	1,278,686	1,450,853
CONSULTANTS	293,600	162,500	235,900	352,500	126,765	203,396	141,898	129,257	157,300	123,108	65,147	87,264	150,160	40,796	65,322	1,061,266	524,465	749,182
TRAVEL & PER DIEM	123,000	83,200	113,950	137,196	72,801	102,626	113,004	48,004	70,337	95,333	32,827	49,955	154,272	36,871	62,068	622,805	273,703	398,936
EQUIPMENT & MATERIALS	0	200,190	200,190	0	572,985	572,985	0	201,835	201,835	0	78,151	78,151	0	45,246	45,246	0	1,098,407	1,098,407
SUBCONTRACTS	1,719,800	697,750	1,127,700	2,802,996	592,589	1,201,935	2,336,998	638,493	1,100,350	1,189,837	354,053	567,822	534,938	241,801	329,498	8,586,569	2,524,685	4,327,306
OTHER DIRECT COSTS	0	43,400	43,400	0	39,811	39,811	0	36,559	36,559	0	33,629	33,629	0	30,777	30,777	0	184,175	184,175
OFFICES / FACILITIES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INDIRECT COSTS	0	372,395	372,395	0	366,784	366,784	0	355,367	355,367	0	342,526	342,526	0	354,067	354,067	0	1,791,139	1,791,139
TOTALS	2,262,564	1,790,845	2,356,486	3,444,089	2,014,715	2,763,430	2,773,575	1,664,644	2,212,782	1,608,123	1,174,218	1,463,137	1,061,198	1,030,838	1,204,163	11,149,549	7,675,260	9,999,997
Annual Inflation rate	0%	0%		20%	5%		20%	5%		10%	5%		10%	5%				
Dollar : Naira rate			4.00			4.60			5.06			5.57			6.12			

Indirect costs % rate 29.18% - Applied to Personnel, Consultants, Travel, Equipment supplied direct, Other Direct Costs & first $600,000 of Subcontracts

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DRAFT PRIVATE SECTOR BUDGET, NIGERIA FHI II
BUDGET 6
4 April 1987

PROGRAM AND FISCAL YEARS

	1988	1989	1990	1991	1992	TOTAL	Percent of Total
PERSONNEL AND BENEFITS							
FPIA Headquarters							
Admin @ 5%	7,561	7,939	8,336	8,753	9,190	41,779	
Grants Manag Div	29,440	30,912	32,458	34,080	35,785	162,675	
Spec Proj Div	19,838	20,830	21,871	22,965	24,113	109,617	
P + D	16,963	17,811	18,702	19,637	20,619	93,731	
Commodity & Equipment Purchase/Distr	46,000	48,300	50,715	53,251	55,913	254,179	
FPIA Af Reg Off							
Admin @ 20%	16,330	17,147	18,004	18,904	19,849	90,234	
Assoc Dir @ 50%	29,958	31,456	33,029	34,680	36,414	165,537	
Support @ 120%	13,340	14,007	14,707	15,443	16,215	73,712	
Nigeria Staff							
Assoc Reg Dir @ 100%	51,980	54,579	57,308	60,173	63,182	287,222	
Program Officers x3 @ 100%	29,756	31,244	32,806	34,446	36,169	164,421	
Driver @ 100%	1,785	1,874	1,968	2,066	2,170	9,863	
SUB TOTAL: PERSONNEL AND BENEFITS	262,951	276,099	289,903	304,399	319,619	1,452,970	
Take out 5% increase pa - NEW SUB TOTAL :	262,951	262,951	262,951	262,951	262,951	1,314,755	14.21%
CONSULTANTS							
TA: Marketing/Commodities/Economic Analysi	100,000	90,000	53,800	54,560	35,736	334,096	
Advertising/Promotion	(This is included in Sterling, below)					0	
Reviews - Monitoring: Dist Points	5,000	7,250	2,500	2,500	500	17,750	
Evaluation	(See Baseline)		7,500		12,500	20,000	
Management	5,000	10,000	5,000	5,000	1,000	26,000	
Cost-Benefit Analysis	2,500	10,000	3,000	5,000	1,500	22,000	
MIS Design Management	60,000	30,000	20,000	10,000	20,000	140,000	
New Network Development	50,000	62,500	88,900	37,060	23,236	261,696	
Audits of Sub Contractors	2,000	4,000	10,000	5,000	13,000	34,000	
Audit and Bookkeeping Firm	3,400	3,500	3,600	3,700	3,800	18,000	
Other	5,000	7,750	5,000	5,000	1,000	23,750	
Nigeria TA Consultants	3,000	8,000	5,000	3,000	2,000	21,000	
CONSULTANTS SUB TOTAL	235,900	233,000	204,300	130,820	114,272	918,292	
Take out 20% increase pa - NEW SUB TOTAL :	235,900	194,167	141,875	75,706	55,108	702,756	7.60%
TRAVEL AND PER DIEM							
Travel: FPIA NYC and US-Based Consultants	27,500	27,500	20,000	15,000	20,000	110,000	
Travel: Af Reg Off and Africa Based	8,200	8,200	8,200	8,000	8,400	41,000	
Travel: Nigeria Local	14,000	17,000	15,000	15,000	17,200	78,200	
Per Diem: International	47,500	47,500	34,500	26,000	34,500	190,000	
Per Diem: Nigeria Local	16,750	17,300	13,250	11,000	28,700	87,000	
SUB TOTAL: TRAVEL AND PER DIEM	113,950	117,500	90,950	75,000	108,800	506,200	
Take out 20% increase pa - NEW SUB TOTAL :	113,950	97,917	63,160	43,403	52,469	370,898	4.01%
EQUIPMENT AND MATERIALS							
Other	20,000	5,000	5,000	5,000	5,000	40,000	
SUB TOTAL: EQUIPMENT AND MATERIALS	20,000	5,000	5,000	5,000	5,000	40,000	
Take out 20% increase pa - NEW SUB TOTAL :	20,000	4,167	3,472	2,894	2,411	32,944	0.36%

ODC							
ODC: FPIA Headquarters						0	
ODC: Af Reg Off	21,700	22,750	23,875	25,100	26,250	119,675	
SUB TOTAL: ODC	21,700	22,750	23,875	25,100	26,250	119,675	
	43,400	45,500	47,750	50,200	52,500	239,350	
Take out 20% increase pa - NEW SUB TOTAL	43,400	37,917	33,160	29,051	25,318	168,846	1.82%
SUB CONTRACTS							
NKST Mission						0	
First Foundation	20,000	40,000	40,000			100,000	
Baseline Survey	10,700	21,500	25,000			57,200	
Trad Healers (Path+Fut)	50,000					50,000	
Vol Health Workers	20,000	20,000				40,000	
Market Women (CU)						0	
Other						0	
Sterling Pharmaceuticals (Nigeria) LTD	325,000	475,000	375,000	225,000	75,000	1,475,000	
Clear/Deliver Public Sector Commodities	1,000	4,000	15,000	32,000	52,000	104,000	
PPFN	Included with Educators & Margaret Sanger Training as Sub Co					0	
Associations (See Also JSI)	10,000	25,000	20,000	15,000	7,500	77,500	
Vendor Training	3,500	10,000	3,000	2,000	250	18,750	
Pharmacist Training	5,000	12,500	3,000	3,000	1,500	25,000	
Educators: Male & Female Motivators	5,000	15,000	3,000	1,000	1,000	25,000	
John Snow, Inc. (JSI)							
Sals, Frin, Cons, Trav, PD, Equip	228,000	224,000	272,000	198,000	158,000	1,080,000	
Sub Contracts							
Associations	107,000	136,000	138,000	117,000	127,000	625,000	
Medical Practicioners Networks	175,000	150,000	250,000	170,000	100,000	845,000	
Factory/Work Based	60,000	50,000	20,000	10,000	10,000	150,000	
Margaret Sanger Center: Clinical Traini	102,500	175,000	204,200	50,000	25,000	556,700	
Other Networks	5,000	20,000	50,000	30,000	15,000	120,000	
SUB TOTAL: SUB CONTRACTS	1,127,700	1,378,000	1,418,200	853,000	572,250	5,349,150	
Take out 20% increase pa - NEW SUB TOTAL :	1,127,700	1,148,328	984,861	493,634	275,969	4,030,493	43.56%
SPECIAL EQUIPMENT PURCHASES							
IUCD Kits	115,000	402,500	149,500	51,750	28,750		
Sphygmamometers	8,000	50,000	4,000	2,000	1,500		
Stethoscopes	6,000	37,500	11,250	3,000	1,350		
Pelvic Models	690	1,035	345	115	115		
Gloves	46,500	46,500	12,400	7,750	3,100		
IEC	4,000	42000	2,100				
SUB TOTAL: SPECIAL EQUIPMENT PURCHASES	180,190	541,535	179,595	64,615	34,815	1,000,750	
No 20% increase to take out - NEW SUB TOTAL	180,190	541,535	179,595	64,615	34,815	1,000,750	10.82%
INDIRECT	372,395	349,319	322,327	295,886	291,292	1,631,220	17.63%
TOTAL	2,356,486	2,636,300	1,991,401	1,268,140	1,000,334	9,252,661	100.00%

********** YEAR 1 BUDGET **********

BUDGET WORKINGS
(DETAILED)

PRIVATE SECTOR
==========

PRIVDTL

(Current - 1987 - prices)

	<------- N	Year 1 $	-------> Total $ Equiv.
PERSONNEL AND BENEFITS			
FPIA Headquarters			
Admin @ 5%		7,561	
Grants Manag Div		29,440	
Spec Proj Div		19,838	
P + D		16,963	
Commodity & Equip. Purchase/Distrib.		46,000	
FPIA Af Reg Off			
Admin @ 20%		16,330	
Assoc Dir @ 50%		29,958	
Support @ 120%		13,340	
Nigeria Staff			
Assoc Reg Dir @ 100%		51,980	
Program Officers x3 @ 100%	119,024	0	
Driver @ 100%	7,140	0	
SUB TOTAL :	126,164	231,410	262,951
CONSULTANTS			
TA: Marktg/Commodities/Econ. Analysis	150,000	62,500	
Advertising/Promotion			
Reviews - Monitoring: Dist Points	15,000	1,250	
Evaluation			
Management	15,000	1,250	
Cost-Benefit Analysis		2,500	
MIS Design Management	60,000	45,000	
New Network Development	20,000	45,000	
Audits of Sub Contractors	8,000		
Audit and Bookkeeping Firm	13,600		
Other		5,000	
Nigeria TA Consultants	12,000		
SUB TOTAL :	293,600	162,500	235,900
TRAVEL AND PER DIEM			
Travel: US-based FPIA & Consultants		27,500	
Travel: Af Reg Off and Africa Based		8,200	
Travel: Nigeria Local	56,000		
Per Diem: International		47,500	
Per Diem: Nigeria Local	67,000		
SUB TOTAL :	123,000	83,200	113,950

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********** YEAR 1 BUDGET **********

EQUIPMENT AND MATERIALS			
Special equipment purchases - IUCD Kits		115,000	
Sphygmamometers		8,000	
Stethoscopes		6,000	
Pelvic Models		690	
Gloves		46,500	
IEC		4,000	
Other		20,000	
SUB TOTAL	0	200,190	200,190
OTHER DIRECT COSTS (ODC)			
ODC: FPIA Headquarters		21,700	
ODC: Af Reg Off		21,700	
SUB TOTAL :	0	43,400	43,400
SUB CONTRACTS			
NKST Mission	80,000		
First Foundation	42,800		
Baseline Survey		50,000	
Trad Healers (Path+Fut)	80,000		
Vol Health Workers			
Market Women (CU)			
Other			
Sterling Pharm. (Nigeria)	1,300,000		
Clear/Deliver Public Sector Comm.	4,000		
PPFN			
Associations (See Also JSI)	40,000		
Vendor Training	14,000		
Pharmacist Training	20,000		
Educators: Male & Female Motivators	20,000		
John Snow, Inc. (JSI)			
Sals, Frin, Cons, Trav, PD, Equip		228,000	
Sub Contracts			
Associations		107,000	
Medical Practicioners Networks		175,000	
Factory/Work Based		60,000	
Margaret Sanger : Clinical Train.	99,000	77,750	
Other Networks	20,000		
SUB TOTAL :	1,719,800	697,750	1,127,700
INDIRECT COSTS			
Overheads		372,395	
SUB TOTAL :	0	372,395	372,395
TOTAL	2,262,564	1,790,845	2,356,486

ANNEX I

PUBLIC SECTOR COMPONENT WORK PLAN

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ANNEX I

PUBLIC SECTOR COMPONENT WORK PLAN

I. EXECUTIVE SUMMARY

The heart of Nigeria's family planning program is the provision of services through the public sector. Public health personnel and facilities will be the principal means by which federal, state and local government area (LGA) governments fulfill their family planning goals.

A strong policy framework guides the public sector program. The Federal Ministry of Health (FMOH) has adopted a Five Year Action Plan for a National Family Planning Program, and all state governments and some LGAs have followed the federal model with their own specific plans.

Recognizing the importance of family planning for maternal and child health, the public sector program is firmly integrated within the existing health system. It includes the provision of information and services for voluntary spacing methods, usually in conjunction with primary health care measures such as oral rehydration therapy (ORT) and immunization.

The progress of the family planning program over the past four years has been dramatic:

- The number of public facilities offering family planning services increased from two in 1983 to more than 600 by late 1986.

- The number of personnel trained to provide family planning services increased from some 250 in 1983 to over 2,000 in 1987.

- Communication and outreach efforts, which have begun in nine states, have increased families' understanding and acceptance of family planning.

As a result of these efforts, the number of clients receiving family planning services through the public sector nearly doubled in the past year.

Much needs to be done, however, to meet the rapidly increasing need for services and to build a strong foundation for the continuation and future expansion of the program. The public sector component of this project is therefore designed with the two broad objectives of (1) expanding and improving family planning services, and (2) strengthening the capability of Nigerian institutions and personnel to conduct the program. To meet these objectives, component activities will help to expand service facilities and trained personnel, assure the quality and consistency of the program and establish the necessary program management and monitoring systems.

By the end of the project, family planning information and services will be provided to 800,000 people through 3,600 public sector service delivery points which will have received project-funded equipment and

supplies. A total of 4,500 health workers will have been trained to provide both clinical and non-clinical family planning services, and 700 personnel will have received training to improve basic management skills. Uniform training curricula, protocols and standing orders will assure a consistently high quality of program services. A refined management information system and a revised national service statistics system will further improve program management and responsiveness to public needs.

Component activities will be directed primarily to the state level, with full participation by the FMOH. They will focus first on expanding services in urban and semi-urban areas, until adequate coverage is reached. Services will be extended to rural areas as there is an increase in understanding and interest in modern family planning methods. Throughout the project, special attention, particularly in management training, will be given to the 80 LGAs that have been designated as priorities under the primary health care program.

This project component will be carried out by the Pathfinder Fund, the prime contractor, in close collaboration with Nigerian institutions and government officials at all levels. To assist in these efforts, the Pathfinder Fund will also subcontract with U.S.-based organizations which have specialized skills and extensive experience in Nigeria. Recognizing the interdependence of the four major project components, the Pathfinder Fund will collaborate closely with the policy, IEC, and public sector components throughout the life of the project.

II. COMPONENT OBJECTIVES

A. Background and Setting

During the past three years, the federal and state governments of Nigeria have initiated a public sector family planning program designed to provide safe, affordable and culturally acceptable family planning services to the Nigerian people. Remarkable progress has been made in this short time to establish the program's foundation. Official government recognition at all levels of the importance of family planning, and decisive actions by federal and state governments have gone far to meet growing public needs for information and services. A.I.D., among other donors, has worked closely with the federal and state governments during this period to provide substantial assistance, particularly in the areas of policy development, strategic planning, motivation, training of personnel, and provision of commodities and basic clinic equipment.

By early 1987, the family planning program in Nigeria is building on a solid policy framework: the Five Year Action Plan for a National Family Planning Program, drafted by the FMOH in 1985, and the action plans that have been developed in all 19 states, the Federal Capital and some LGAs. These plans underscore the fact that family planning is not a vertical, free-standing effort, but is fully integrated into the primary health care system as an essential factor in ensuring the health of mothers and children.

The integrated nature of the family planning program also greatly simplifies the task of carrying out federal and state action plans. In Nigeria, in contrast to other countries, family planning is an addition to an infrastructure that is mostly in place, rather than the creation of a whole new system. The strong health infrastructure includes a large number of health training institutions: 13 medical schools, 58 nursing schools, 66 schools of midwifery, and 27 schools of health technology, as well as a number of specialized institutions. There are currently an estimated 6,000 LGA and 3,000 state health facilities nationwide.

The FMOH has also defined a systematic approach to the introduction of family planning into public sector programs. This approach emphasizes seven essential activity areas for a strong, well-functioning system that responds to public needs. These areas include:

- training in clinical, communication and management skills;
- family planning service delivery in clinics and through outreach activities;
- information, education and communication (IEC) to increase clients' awareness and knowledge of family planning;
- facility improvements;
- llogistics and supplies;
- monitoring and evaluation; and
- development and use of management information systems.

Pre-project programs have achieved impressive gains in the key areas of expanding numbers of service points, training personnel, and IEC.

The expansion of family planning service points in the public sector is a remarkable achievement. In 1983, only two public facilities in Nigeria offered family planning services; by April 1987, more than 600 service points were in operation. The rate of expansion of service points nationwide is increasing. For example, in the last three months of 1986, 50 new clinics nationwide began providing family planning along with other health services.

The number of health personnel trained to deliver family planning services through the public sector has also risen dramatically, from some 250 in 1983 to over 2,000, located in all states, in 1987. This has been accomplished through a wide range of training efforts most of which were assisted by AID-funded cooperating agencies. These training efforts, although varied from state to state, have covered topics such as clinical and non-clinical methods, training of trainers, commodities, logistics and management. In addition, pre-service curriculum revision has already been completed, or is well underway, to incorporate family planning for most categories of health personnel.

Family planning IEC activities have further strengthened the service program. IEC activities, which have taken place in nine states so far, involve training service providers in how to educate the community and counsel clients in the benefits of family planning for family health, what methods are available, how to use them, and what to do if questions or problems occur. In turn, the increased understanding of family planning that has resulted from IEC activities has reinforced the other major program efforts in training and establishment of facilities.
The efforts described above have produced a rapid increase in contraceptive use. In 1980, modern contraceptive prevalence nationwide, from all sources, was estimated at 2.6 percent. While more recent nationwide data are lacking, prevalence is believed to have risen to 5 or 6 percent in 1987. Moreover, increases in the number of users served by the public sector are striking: reports from the states show a nearly 100 percent increase in users, overall, in the past year. (This figure is confirmed by matching clinic records with inventory drawdowns.) In Ogun state, for example, the number of users served by the public sector increased from 3670 in 1984, to 9,000 in 1985, to 15,000 in 1986. The intensive training, IEC and community outreach efforts undertaken in this state typify what the FMOH and other state governments intend to do to carry out their family planning action plans.

It should also be noted that these nationwide contraceptive use figures do not take into account the serious under-reporting that probably exists. In Bauchi state, for example, only six of the 14 family planning clinics submitted reports. No data are available on the number of users served by the military and local clinics.

Despite these accomplishments, much remains to be done to enable the FMG to establish a national family planning program, and to expand to the scale required to achieve its health and demographic goals. There are three broad program needs:

- Expand services, by providing more service points and trained personnel to staff them.

- Assure program quality and consistency. At present, there are several variations in how personnel are trained, what services are provided, how well facilities are staffed and equipped, and how consistently adequate supplies are available. No protocol or standing orders have yet been developed to cover these areas. Existing management and information systems cannot accommodate the program's needs, even at its current level; some management systems (e.g. equipment maintenance) do not yet exist because of the government's initial concentration on clinical service provision.

- Build a strong foundation for the continuation and future expansion of the program. An adequate number of well-equipped facilities is required, along with the institutional capacity to train personnel, direct and manage service delivery for both rural and urban populations, and ensure high quality and consistency.

To meet these needs, the FMG will require substantial continued assistance from AID and other donors. This assistance will need to

follow a systematic, coordinated approach toward program expansion, standardization and institutionalization.

B. Principal Objectives

The public sector component of this project has two principal objectives:

1. Expansion and improvement of family planning services, especially in urban areas and in the 80 model LGAs.

2. Strengthening of the capability of Nigerian institutions and personnel to conduct the public sector family planning program.

Thus this project component will help the FMG, first, to meet the immediate need for high quality services. At the same time, it will help to strengthen the government's capability to continue and to expand the program further after this project is completed.

Achieving the objectives of this component will mean that:

- high quality, culturally appropriate family planning services will be widely available at all levels of government facilities, from large teaching hospitals to basic village dispensaries;

- by Year Five of the project, approximately 800,000 people will be receiving contraceptive services through these facilities;

- a cadre of administrative, clinical and educational personnel will be in place to plan, carry out, manage and evaluate public family planning services; and

- organizational, management and information/evaluation systems will be in operation at all levels.

The strategy and specific activities that will be employed to achieve these objectives are described in Section III, Technical Approach.

The objectives of this component conform closely to the FMOH's plans to increase the availability and acceptability of family planning information and services in the public sector. The component will also contribute to achieving the goal of the overall Family Health Initiatives II (FHI-II) project by helping to improve the quality of life in Nigeria by strengthening integrated health care services.

Achieving the objectives of the public sector component involves coordination and mutual assistance relationships with the other three components of this project.

Federal and state governments depend on the public sector as the principal means of implementing family planning policies and plans. This component therefore relates closely to the policy component, which will assist in establishing the family planning policy framework and plans for rapid expansion of the program. The success of government strategy depends on how well the public sector program carries them out. In turn,

the success of public sector service delivery efforts will depend to a major degree on the support and leadership of policy makers.

The success of the public sector component is also linked to the IEC component, since mass media and family life education activities supported through this component will create broad public awareness and interest in family planning. The usefulness of IEC efforts, similarly, depends on having family planning services available for clients who have been motivated to seek them.

Additionally the objectives of the public and private sector components complement each other in their focus on populations that differ geographically and by income level. While both public and private sector components will concentrate initially on urban areas, the public sector will gradually extend services to rural areas which lack commercial networks. Initial attention in the rural expansion will be through the model primary health care LGAs. Public sector programs will also serve families with incomes too low to afford family planning services that are offered commercially. It is also important to note that private sector services will be legitimized through public sector certification. Further, the public sector will assist the expansion of private sector services by providing family planning training and certification to private sector service providers.

C. Host Country Involvement in Program Development

The work plan for the public sector component was developed with the advice and assistance of representatives of the Federal Ministries of Health and Information, the National Population Bureau (NPB) and the Nigerian private sector, most importantly the Executive Director of Planned Parenthood Federation of Nigeria (PPFN). As noted above, the work plan is based on federal and state plans and strategies for family planning. During the design process the public sector team also interviewed various federal and state leaders, governors, commissioners, traditional leaders, rural and urban community leaders and family planning clients. All of the above individuals played an important role in guiding the direction of the discussions and decisions to ensure that these plans are both culturally acceptable and practically implementable within the Nigerian context. Over the next five years, the activities of the public sector component will depend heavily on the continued participation of individuals from both public and private sector.

III. TECHNICAL APPROACH

A. Strategy

This project will provide key technical assistance, training, equipment and supplies to achieve the two overall objectives of the public sector component. The assistance will be provided through a contract with the Pathfinder Fund, which will have over all responsibility for carrying out this strategy. To support these efforts, Pathfinder will subcontract with other U.S.-based organizations with specialized skills in the major activity areas involved, as well as extensive experience in Nigeria.

An important part of the strategy is to direct activities at the state level, giving particular attention to the 80 LGAs that have been designated for emphasis in the primary health care program.

1. Expanding and Improving Family Planning Services

To achieve the first component objective -- expanding and improving family planning services -- the public sector component will pursue a two-pronged strategy:

a. Provide services to 800,000 people through 3,600 service points and community outreach; and

b. Improve services by training 5,200 personnel, and standardizing curricula, service protocols and procedures.

a. Provide Services. The public sector component strategy follows the Nigerian Government's definition of service provision. Under this definition, clients have received services when they have been provided with either contraceptive methods, or counseling and advice on family planning, or both. The range of voluntary clinical and non-clinical spacing methods offered will include IUDs, orals, condoms, vaginal foaming tablets and natural family planning.

Public sector service points include clinics, maternities and dispensaries. There are currently some 6,000 LGA and 3,000 state health facilities nationwide. For a service point to be "established" to supply services means that a process somewhat like the following will have occurred:

- The component staff will work with state and local officials to identify potential service points.

- The specific needs of each service point for equipment, supplies and training will be inventoried and met if feasible.

- Family planning information and services will be available regularly and on demand utilizing standardized service protocols.

- Record keeping systems will be introduced and in full operation at these points.

- Re-supply and follow-up technical assistance and maintenance systems will operate smoothly to continue support for each service point.

Of the 3,600 service points to be established under this component, 1,000 will be staffed and equipped to provide comprehensive information and services including IUD insertions. The remaining 2,600 will provide information and non clinical methods only, making referrals to the other service points for clients desiring clinical methods. All service points will incorporate active community outreach efforts. Approximately 3,000 staff will be providing both clinical and non-clinical services, along with a full staff of non-clinical service providers.

b. Improve Services. Equally importantly this project component will provide in-service training to improve the skills of all categories of public sector health personnel: doctors, nurses, midwives and community health workers. Others, such as traditional birth attendants, may also receive training.

Training for all personnel will cover the skills essential for providing high quality, culturally appropriate services: contraceptive methods (clinical or non-clinical, depending on the category of personnel); IEC and community outreach; and management and supervision. Training in contraceptive methods will be provided in conjunction with training in oral rehydration therapy (ORT) and immunization.

Of the 5,200 trainees planned under this project, 1,000 will receive full clinical training. This strategy is based on the fact that approximately 2,000 clinicians have already been trained to date, of the 3,000 clinicians needed to supply clinical family planning services. An additional 3,500 health personnel will receive sufficient training to provide family planning information and non-clinical methods.

This strategy also takes into account the pre-service and on-the-job training that will take place in the next five years, but that is not directly attributed to this project. It is estimated that 3,000 new health personnel will gain family planning skills in pre-service training institutions. These new service providers will benefit from work done before this project to train tutors in family planning didactic and practicum skills to incorporate family planning into pre-service curricula. Approximately 2,000 personnel will also receive on-the-job training in clinical and non-clinical skills. However, it is impossible to specify this latter category precisely.

Strengthening program management skills is essential to improving family planning services. To accommodate the rapid expansion of the program to date and the expansion planned in the next five years, management staff must acquire the skills essential for directing a large, complex programs.

Management personnel at the federal, state and LGA levels will play appropriate roles in the program's success by:

- defining program plans and budgets;
- guiding program implementation, including securing adequate staff, space, logistic and fiscal support;
- testing new service delivery models and procedures; and
- assessing progress and correcting deficiencies.

They will take the lead in resolving a wide range of problems, from deciding how best to carry out government policies, to handling political sensitivities, to dealing with operational problems such as supervision, logistics and transportation. Their management effectiveness is therefore essential to achieving consistent, high quality services and linking public sector activities to policy developments.

Specifically, the management training strategy calls for training some 700 personnel. This number includes 100 at the federal level, three in each state government, and two in each LGA.

Another important part of the strategy to improve services is standardization. This is critical to maintain consistent availability and quality of public sector services, to respond to public needs, to serve as service models for the private sector, and to ensure coordination of program inputs.

Standardization refers specifically to the revision and implementation of uniform training curricula as appropriate for various categories of personnel, establishment of uniform clinical protocols and procedures, introduction of a revised national service statistics system, and refinement of the national management information system (MIS). Most of these systems exist or are emerging in Nigeria. However, there is much variation in their application. Further, they need to be extended to cover the five levels in the management and supervision scheme of the FMOH's recently introduced National Health Plan:

- clinic management at the point of service;
- local government health office, which is responsible for oversight of LGA-based primary health care services;
- State Ministry of Local Government, which will rely on PHC program coordinators to advise, supervise and assist in management of LGA-based services;
- State Ministry of Health which is the center of planning and coordination of all health services provided in each state; and
- Federal Ministry of Health, where central health policy and planning as well as unified program statistics are managed.

This project component will therefore assist in developing the standards needed in each area and establishing systems to meet them. In doing so, it will consider the different models used in each program area in the past few years, and will incorporate the features that have proven most effective. These include, for example, on-the-job training and maintenance skills emphasized by Africare, and INTRAH's approach toward training of trainers and community health education.

2. Strengthening the Capability of Nigerian Institutions and Personnel

The project will achieve the second overall component objective -- strengthening the capability of Nigerian institutions and personnel over the long term - through a strategy that involves many of the same activities as those that will be undertaken to reach the first component objective. These include establishing ongoing training programs, equipping service sites and strengthening management systems.

When this project ends in 1992, the public sector will have in place systems, facilities and trained personnel to enable the continuation and expansion of family planning services throughout the Federation. These accomplishments, as well as the increased credibility that derives from performance, will provide a basis for extending the program in the future to meet the growing need for services. Finally, this strategy will

strengthen the Nigerian government's ability to sustain the program with decreasing levels of assistance.

Specifically, this project component will increase institutional capability in family planning by:

- providing an infrastructure of facilities equipped to offer family planning services;

- providing adequate numbers of trained personnel to staff those facilities;

- providing adequate numbers of tutors and trainers who have received training in family planning;

- ensuring that family planning is incorporated into both pre service and in-service training curricula for all levels of personnel; and

- establishing management and logistics systems, protocols and procedures to assure program continuity and quality.

Follow-on activities may require training of additional staff and continuing education of trained staff.

B. Outputs

1. Assistance to Training Programs

The project will provide technical assistance and other resources to support in-service training for different categories of personnel, and technical assistance for curriculum development for pre-service training institutions. As noted above, training will cover ORT, immunization and voluntary spacing methods, including natural family planning. In-service training will be the major thrust of project training activities in the first few years, until the incorporation of family planing into pre-service curricula reduces the need for it.

All training supported through this project component will rely heavily on the excellent core of trainers, tutors and curricula that already exists in Nigeria. The project will supplement this as needed when additional resources, specialized skills, new technologies, etc. are required.

Most training, for both state and LGA personnel, will be conducted at the state level. However, regional training programs may also be organized, taking advantage of strong on-going programs and/or groups of trainers in the following states: Imo, Kwara, Lagos, Ogun, Oyo and Plateau. These regional training interventions will be designed to train service personnel and trainers from states which have no in-service training capacity. Some training, e.g. for FMOH staff, or for physicians receiving specialist training will also be undertaken at regional levels.

The public sector will also provide training and certification for private sector personnel. This however, is budgeted for in the private sector component of the project, so is not reflected in the public sector budget.

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Specifically, the component will provide six types of training assistance.

a. Training of Tutors and Trainers

Project assistance will include training in didactic and practicum skills for tutors, especially in schools of nursing and midwifery, and trainers in in-service training institutions.

As noted previously, much has already been accomplished in this area. Family planning training teams have been developed in nine states with assistance from the INTRAH project. However, training teams may need to be developed in other states as well. Tutors from all schools of nursing, midwifery and health technology have also received family planning training. However, additional tutors need to be trained so that there will be two or three trained tutors in each school.

This project will therefore focus on (1) training for tutors and trainers who have had no family planning training so far; and (2) refresher training as new curricula, new technologies, etc. are introduced.

b. Curriculum Development

The project will monitor the progress that has already been made in incorporating family planning into pre-service curricula at all levels. Technical assistance will be provided as needed to coordinate and assist in this process.

The curriculum development process is already well underway. As a result of prior AID-funded technical assistance, the midwifery curriculum has been revised by the Nigerian Nursing Council and is expected to be ratified and piloted in one state shortly. However, it may be necessary to add a three-week practicum in family planning to this curriculum. The family planning components of the several community health worker curricula are undergoing revision and the nursing curriculum is to be revised within the current year, both with AID-funded technical assistance. Revision of the medical school curriculum on a national scale must await reconstitution of the currently suspended Nigerian Medical Council. In the meantime, a number of medical schools have proceeded to implement teaching family planning in their reproductive and community health curricula. Therefore, curriculum development will not play a prominent role in this project, since it has been largely covered in previous activities

Curriculum development efforts will follow several principles:

- develop comprehensive curricula for the different training institutions, that ensure high quality care and a unified approach to family planning;

- omit training on topics that are irrelevant to Nigerian families (e.g. diaphragm);

- emphasize modern pedagogical methods;

- increase counseling of patients by all levels of personnel, especially high risk patients (over 35 and under 18); and

- incorporate the most successful features of training and curriculum development experiences over the past few years, such as the work of INTRAH, Africare, JHPIEGO, Pathfinder, and the American College of Nurse Midwives in areas such as training of trainers, community health education, clinic management, logistics, requisitioning, maintenance and on the job training.

The following are also important subjects that are likely to be covered in curricula being revised and/or updated:

- Norplant and other potential new methods,

- sexually transmitted diseases (STD) and the use of barrier methods for prevention and

- infertility, especially related to cases resulting from STDs and induced abortion.

Assistance from AID centrally-funded projects (e.g., JHPIEGO) will be sought for curriculum development in areas not covered by this project.

Curricula for in-service training in IEC will be developed by the IEC component of this project. Efforts are already underway to include IEC in in-service training in Ogun State and University College Hospital-Ibadan.

c. Clinical and Non-clinical Training

As noted earlier, 1,000 health personnel (physicians, nurses and midwives) will receive theoretical and skills training in both clinical and non-clinical spacing methods. Another 2,600 health personnel (principally community health workers) will receive training in non-clinical methods.

The success of clinical training efforts will depend to some extent on whether a sufficient caseload is available to the trainees. In this regard, experience to date with clinical training has been varied. The availability of patients will be an important factor in choosing clinical training sites.

Since physicians play an important role in the areas of program leadership, management and supervision, this project component will increase emphasis on physicians' training. Two types of training will be provided: (1) training for specialists, to include surgical aspects of family planning (e.g. NORPLANT, if approved); and (2) general training for non-specialists in both clinical and non-clinical methods. All physicians will also receive training in person-to-person communication (including discussion of side effects), and, as appropriate, management, supervision, and the management information system.

d. Specialized Training

Funds will be set aside for support of specialized training activities which may be required during the course of the project. For example, these might include:

- training of traditional birth attendants (TBAs);
- short-term U.S. or third-country training;
- training for women councillors at the LGA level; and
- training for community-based distribution (CBD).

No long-term or degree training will be funded, given other priorities. The public sector team will, however, work with the FMG to identify other sources of funding for long-term training.

e. Training in Communication and Outreach

IEC will be an important part of training of doctors, nurses, midwives and community health workers. The contractor for the IEC component of the project will assist in this training activity by developing the curriculum (as noted in section 1.b. above), and teaching public sector trainers how to use it.

Models and case studies of particularly successful outreach efforts will be identified for use in training of community health educators as well as clinical service providers.

Although IEC is vitally important to the understanding and use of family planning, IEC training has received little attention For this reason, it will receive special emphasis in Years I and II. In addition to traditional IEC subjects, training efforts in this area will emphasize:

- training health personnel to plan, conduct and evaluate community health education efforts to increase clinic enrollment;

- involving traditional rulers and other community leaders;

- making special efforts to inform and motivate males;

- making clinicians educators and advocates of the FP program; and

- relating counseling and informed consent to service delivery practices and giving consistent information in clinics and in communities.

f. Management Training

Management training activities supported by this project will expand on the interventions begun in 1986 by the AID-funded Family Planning Management Training (FPMT) project. They will focus on state and LGA-level training needs, although some training will also take place at the federal level. Special emphasis will be given to management training in the 80 model LGAs, in cooperation with the CCCD project.

A number of Nigerian program staff have participated in management training courses both in-country and in the U.S. These individuals will form an important resource pool of trainers for future in-country management training endeavors. External consultants will also be required in this area during the early years of the project.

Specific types of management training activities are likely to include:

- Workshops for state coordinators at least once each year, to assist in planning for management improvement interventions. The first such meeting took place in Bauchi State in July 1986. Through USAID/Lagos' Cooperative Agreement with the Pathfinder Fund, a pre-project state coordinators' workshop will be held in October 1987 in Port Harcourt. MSH staff will be requested to participate.

- Training and other activities for administrative and supervisory staff at both state and federal levels in areas related to the revision and use of the management information system (MIS) (See Table 2 for management training projections and Section III. B.4. for more on the MIS).

- Development of LGA action plans. During the pre-project period, FPMT will work with Ogun and perhaps three additional states to develop LGA action plans for family planning, following the lead of the Lagos State workshop held in early 1987. These LGA activities then will become models for similar interventions to take place during the project.

- Regular program planning exercises to update and/or revise local, state and federal action plans as in the Bauchi, Ogun and Lagos examples presented above.

- Supervision and monitoring. The state family planning action plans provide for the deployment of supervisory personnel at the SMOH and LGA levels. These personnel are expected to provide consultation and on-the- job training in the course of supervisory visits, and will be instrumental in implementing the linkages between the various levels of care for consultation and referrals. To facilitate an effective supervisory support system for all service projects, management training activities will give attention to the design, testing and implementation of models for supervision and monitoring and to the development of training modules, including case studies, on this subject. This will be coordinated with policy implementation component activities.

- Financial planning and cost recovery. As more state and local governments allocate funds for family planning, influenced by activities planned by the policy component, the need for management training in financial planning, budgeting and cost recovery will increase. FPMT held a successful workshop on this subject in Imo state in 1987. This activity will be refined and repeated. The training materials resulting from the Imo workshop will be standardized and shared in later training interventions in the fiscal area.

- Contraceptive logistics management. In-service training for all nurses and midwives will include basic skills for understanding requisitioning and warehouse management. Complementary to that effort, warehouse managers (pharmacists and pharmacist assistants) will be given a one week course in contraceptive supply and storage management. State family planning coordinators will be provided special training in supervision of supply management systems.

Other common management problems or issues are likely to arise during rapid program expansion in Nigeria. These will be explored for technical assistance or training intervention over the life of the project. They include human resource management; the development of systems for internal evaluation and personnel feedback; and coordination of various service elements in an integrated program.

2. Development of Protocols and Standing Orders

Simple and readily understood protocols and standing orders for use at each clinical service delivery point will be developed during the early implementation phase of the project. They will cover all aspects of service delivery, including standards of clinical practice and service delivery, counseling and advice on family planning, maintenance, requisitioning and utilization.

The protocols and standing orders will be developed utilizing consultants from leading training institutions for the various cadres of personnel, with technical assistance provided by the public sector consortium. These protocols and standing orders will become an essential part of all standardized training curricula and will be provided to all service delivery sites in printed form for ready reference by clinicians and management staff.

To provide additional assurance that family planning services adhere to high standards of clinical practice, efforts will be made to link service sites with trained doctors as points of referral for complicated cases. Also, ways to enlist local level medical advisory committees will be explored on a pilot basis, to encourage support for the family planning program as well as communication and cooperation among the involved health professionals.

3. Provision of Equipment and Supplies

a. Equipment

Limited provision of sets of basic clinical equipment and IUD insertion kits will be undertaken to allow new full-service clinics to begin operation. (It is not anticipated that project resources will be used to provide equipment and supplies to training institutions. Assistance for this purpose is expected to be provided by the World Bank or UNFPA.)

Provision of necessary equipment will be carried out by Africare under a sub-contract with the Pathfinder Fund. Africare has been working with the FMOH, SMOHs and other service providers over the past few years to deliver A.I.D.-funded sets of basic medical equipment and supplies to

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assist in preparing clinic and hospital facilities for service delivery. By early 1988, some 680 of these equipment kits will have been delivered through the Africare channel.

Under this project, Africare will continue to follow the methodology routine it has used to date. This calls for Africare staff or consultants to visit and inspect facilities recommended by state governments to receive equipment sets. Site visits and the completion of a detailed questionnaire on physical plan, clinical equipment and supplies, commodities, clinic personnel and consumer characteristics are used to determine the required inputs. Africare then purchases equipment for selected new and expanding service sites. Africare and regional project staff also follows-up at the state level to ensure delivery to the designated clinics and to provide technical assistance on the appropriate use and maintenance of the equipment.

Each kit consists of a sufficient supply of items to equip a full operational family planning clinic (exclusive of contraceptives and IUD insertion kits). Under the new project, Africare will also procure and distribute IUD kits through state channels to service sites. The use of each item in equipment sets and IUD kits will be reviewed early in Year I to determine whether changes are needed in composition of the sets and kits prior to ordering additional equipment. This assessment will be based on cost, maintenance and durability of items, and considerations of maximizing staff and patient time in the clinics.

b. Contraceptive Commodities

Preliminary estimates have determined that most of the contraceptives used by the public sector program over the life of the project will be provided by USAID. In conjunction with technical assistance provided by the U.S. Centers for Disease Control (CDC) and other centrally-funded contractors, the public and private sectors will jointly determine the national commodity needs each year. The private sector will then take responsibility for ordering, shipping, storing and distributing these contraceptives within Nigeria. Other non-AID-supplied contraceptives, e.g. injectables, will be furnished by UNFPA, PPFN and the FMG. In the event that new technologies, such as the NORPLANT contraceptive implant, are adopted by the FMG prior to their approval by the U.S. Food and Drug Administration, special arrangements will be required for their procurement, possibly through UNFPA or other donors.

4. Development and Establishment of a Management Information System for Monitoring and Evaluation

The first task in refining and expanding the national MIS will be to identify management decisions at the local, state and federal levels which the system can support. This process, which began during the design phase of the project, will be continued during the pre-project period through the state inventory and planned pretest of a revised service statistics system in Ogun State, the results of which will be presented at the next annual meeting of the state family planning coordinators.

The eight components proposed for a revised and expanded MIS include:

- individual record system to support optimal method selection and the provision of high quality service;

- service statistics and contraceptive logistics systems;

- service personnel, facility and equipment resources - local, state, and national data bases;

- feedback from users and non-users - attitudes and suggestions regarding service, knowledge, and practice from diagnostic spot surveys and focus groups;

- program personnel suggestions for service improvement;

- supervisory checklist and reporting system;

- multi-region household surveys; and

- regular evaluation of the MIS and its costs.

Within the past year the FMOH, with technical assistance from AID-funded organizations, introduced a nationwide family planning service statistics system, one element of the MIS proposed above. Although there are major problems in the implementation of the system, the information the system intends to collect is of highest priority. The project will assist in refining the existing system, to preserve the best of the system and to avoid disruption of clinic operations as improvements are introduced.

The existing service statistics and logistics system component will be examined and revised to ensure that it can assist in management and planning decisions such as:

- forecasts of commodity needs by state, zone, and service point;

- identification of service points requiring supervision because of irregular method mix, e.g. only pill accepters;

- identification of areas requiring supervision and perhaps expanded IEC efforts because of relatively low recruitment of new accepters;

- identification of service points requiring supervision because of failure to report, or changes in performance compared to that of the previous year; and

- estimation of impact based on couple years of protection.

Another MIS component, the individual record card, already exists in part but requires revision and expansion to truly serve its purpose of assisting in the provision of quality clinical services to reach individual family planning user. The addition of several elements to this component such as appointment and referral cards will be explored.

CDC, which has in the past provided technical assistance on several components, the service statistics and client record systems as well as contraceptive forecasting, will be involved in revision exercises at no cost to the project.

The remaining six components in the above list will be developed over the life of the project. The personnel and equipment database will be started during the pre-project period with the state inventories. In addition to the importance of this tool to the overall public sector and other component plans, the database will be computerized at the federal level and updated regularly for use in monitoring the progress of the nationwide program. The other five components of the MIS will be developed over the course of the project in collaboration with the FMG and program officials as well as with the other project contractors, to ensure that the entire system is responsive to and supportive of the management needs of the overall program.

To be useful throughout the program the MIS must be simple enough to operate without extensive and costly training. Every effort will be made to design the components to be self-explanatory and/or in such a way that on-the-job training can be achieved. Instructions for using the system must be clearly stated and printed on all forms. Although it is recognized that all such systems function more efficiently if automated, the revised MIS must be primarily manually operated. All of these issues will be considered in revising and developing elements of the planned MIS over the course of the project.

Most of the components of the MIS will used at different levels of the program for routine internal evaluation of the public sector program, e.g. the individual record system for clinic-based monitoring and the personnel and facility data base for federal and state monitoring of progress. All components of the MIS will be designed for ready use in program monitoring and evaluation. Management training activities will also stress the importance of understanding and using the MIS components for monitoring purposes.

One particular component of the MIS, the initial baseline household survey, will establish the baseline measure of contraceptive prevalence, including source of contraceptive service, knowledge, and attitudes about family planning among women of reproductive age and among men. The survey will also measure breastfeeding, postpartum abstinence, and fertility. All contractors will collaborate with one another and with Nigerian counterparts in the design of the survey, which will be subcontracted to the National Population Bureau for implementation. A full description of the monitoring and evaluation plan for the activities of this public sector work plan, which goes beyond the above-mentioned program monitoring elements, is presented in Section V of this Annex.

5. Critical Assumptions

Several factors will impact on the achievement of these public sector outputs. The FMG, the individual states and LGAs must remain committed to the program and to following the policies and action plans they have adopted. They must be willing to upgrade existing facilities to incorporate family planning services. Furthermore, the personnel required to staff these facilities must be released for project-funded

training, and then assigned to designated family planning facilities in order to practice skills acquired in training. Since some 2,000 government personnel have been trained in prior in-service courses and most have been assigned to facilities providing family planning services, there is reason to believe these assumptions will hold true.

C. Component Approach

The approach of this project component to the activities outlined above will parallel the political and geographical strategies outlined in the FMG's Five Year Action Plan for a National Family Planning Program.

The Action Plan describes a three-tiered approach, with responsibilities for action at the national, state and local levels. Principal responsibility for service provision, community outreach, training and management of state and local programs rests with the states and LGAs. The FMG will take the lead in developing program management systems and standards.

Project activities will be concentrated at the state level, in accordance with state action plans and with the full participation of the FMOH.

An important activity during the pre-project period will be a state-by-state inventory to determine precisely the personnel, training and equipment needs and resources in each state. While much information is already available, the inventory will provide the consolidated, standardized data needed to prepare detailed state-based plans for the additional funding and technical assistance required to attain the component objectives.

The Pathfinder Fund will work closely with state officials and the FMOH to complete the inventory, to examine state plans, and to plan and implement state and local level activities. The State Family Planning Coordinators and Deputy Coordinators will be key counterparts throughout the project.

While specific needs may vary in each state, in general the states will be encouraged to follow the geographic strategy of the FMOH Action Plan. This implies concentrating efforts on providing family planning services in urban and semi-urban areas until adequate coverage is achieved. The aim is to meet the needs of urban and semi-urban people for contraceptives and information, while increasing community health education efforts in rural area. Provision of contraceptives to the rural population will expand gradually as interest grows in modern family planning. This approach takes into account the demographic situation in rural areas, where infant mortality is high and traditional birth spacing practices (breastfeeding and postpartum abstinence) are still in place. From the start of the project, special attention will be given to conducting project activities, especially management training, in the 80 LGAs which are implementing model primary health care activities.

Finally, public sector activities supported by this project will be closely coordinated with activities of the other three project components. As indicated in Section III. B. above, the effectiveness of each component depends on support and collaboration with the others.

D. Detailed Year One Activities

Stage I: Pre-project and Set-up

1987	Activity
April	State personnel/equipment inventories* (continues through Stage I)
	Delivery of clinic equipment sets* (continues through March 1988)
	Continue clinical training per Phase-out Plan* (continues through March 1988)
April-December	Pre-service curricula review by FMOH and Nursing Council* (to be completed during 1987)
June	Ogun State LGA Planning Workshop*
July-October	Ogun State pre test of revised MIS components*
October	Family Planning Coordinators' Workshop in Port Harcourt*
	Initiate planning/design of baseline survey.*
Last quarter	Review, revise and standardize in-service clinical curricula developed for Nigeria*
	Management/technical training of staff of 4 pilot special emphasis PHC LGAs (CCCD)*

Stage II: Implementation

1988	Activity
January	Country Representative/staff hired locally
	Assess Ogun State MIS pre-test
February	Pathfinder Country Office phased out
	Negotiate in-service clinical training plans for Year 1 with existing training institutions
	Complete/analyze state personnel/equipment inventories, plan specific interventions

* Funded already.

1988	Activity
March	Country staff orientation
	Begin baseline Household Survey with NPB
	Review/evaluate contents/use of clinic equipment and IUD kits
	Orientation on revised MIS for FMOH and project staff
	Plan specific state by state subcontract interventions based on analysis of state inventories, e.g., clinical and management training plans, equipment distribution plan
April	Assess institutionalization of pre-service curricula (quarterly)
	Participate in national "summit" meeting.
	Negotiate for establishment of in-service clinical training courses for remainder of Year 1 in additional states/institutions
	Commence in-service training in existing institutions**
	Assess, review, revise clinic procedures and protocols for all service levels
May	Commence in-service training additional states/institutions**
	Zonal workshops for state staff on revised MIS
	Commence state rounds for equipment review (continues throughout Year 1)
July	State FP Coordinators National Strategic Planning Workshop
	Install revised MIS - all states
August	Assist NPB in finalizing Baseline Household Survey
	Assess microcomputer needs -- selected states
	Planning for Year 2 commences, first draft 1989 work plan prepared.

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* Funded already.

** See Table 2 for Year 1 Training Plan.

1988	Activity
September-December	Design/pre-test additional MIS components - 4 states
	In service training continues as per Table 2

VI. COMPONENT MANAGEMENT

A. Management Approach

The Pathfinder Fund (Pathfinder), as prime contractor for the public sector component of the FHI-II project, will retain overall responsibility for the management of this contract. All activities carried out under the prime contract and its several subcontracts will be supervised by U.S.-based and in-country staff who are directly responsible to Pathfinder. All contract-related communications with AID (AAO/Lagos, REDSO/WCA, and/or AID/Washington) will flow through Pathfinder staff.

Based on past experience in Nigeria and available staff and consultant expertise, Pathfinder has identified three U.S.-based organizations to carry out the major subcontract activities under this contract. They are as follows:

Africare - Equipment and commodity logistics; maintenance training and support; participation in curricula review; in-service clinical training; and coordination of the clinical training aspects of family life education (ORT, EPI, responsible parenthood, anti-AIDS and anti-drug education).

Institute for Health Policy Studies (IHPS) - In-service clinical training, monitoring the establishment of pre service training, and development of clinic protocols and procedures; and

Management Sciences for Health (MSH) - Management training, management information systems and survey research.

Several small subcontracts are also planned with Nigerian organizations, primarily for survey research and data collection.

Pathfinder's FHI-II Project Manager, who will be based in Boston, will be assisted in overall contract and subcontract management by other Boston-based professional/technical staff and by the Lagos-based Country Representative. The Project Manager will be expected to work with Pathfinder and subcontractor staff involved in the project to develop annual work plans and ensure compliance with them; take an active role in ensuring that each person and organization understands the tasks required to implement the planned activities; review draft plans for work assignments when appropriate; and be responsible for representing Pathfinder with USAID and the FMOH, for attending any joint meetings of the representatives of the four components, and for coordinating closely with representatives of the other prime contractors, as appropriate.

In addition, Pathfinder will require that each subcontractor appoint a coordinator responsible for managing the organization's technical inputs and administrative support to the FHI-II Project. To ensure the quality of the technical assistance provided to the project, Pathfinder will require that subcontractors clear with Pathfinder any changes in key personnel before implementing them.

The collaborative assistance mode requires that annual work plans will be developed for each major component; the work plan for the public sector component will detail the expected inputs and outputs for Pathfinder and its subcontractors. Pathfinder's Project Manager will use this work plan to monitor project implementation by Pathfinder and the subcontractors.

Pathfinder and its subcontractors will meet regularly in the U.S. to review work plan progress and share information and ideas. Likewise, the Lagos-based project staff will have similar regular meetings as well as specially called meetings in connection with technical assistance visits and other significant project events.

The subcontracts will be administered by Pathfinder using established procedures. Subcontractors will be required to submit periodic management and fiscal reports. In addition to the development of annual work plans and the coordinating activities mentioned, minimum reporting requirements include:

> Semi-annual progress reports describing the work accomplished and its relation to the annual work plan for the period preceding the report. These reports will identify gaps in performance and the reasons for them, steps taken to address any problems, and recommended actions The reports will contain a summary of expenditures by line item for the subcontract and by project activity. They will also contain forecasted expenditures for the remainder of the funding period. The specific format of these reports will be mutually agreed upon by Pathfinder and its subcontractors.
>
> Periodic requests for reimbursement will be submitted to the Pathfinder Director of Accounting. Each request voucher will itemize the expenditures made during the period since last payment and on a cumulative basis for comparison to the subcontract budget. The vouchers will be itemized by budgeted line items and will be analyzed and approved by the Director of Accounting prior to payment.

The Pathfinder component staff in Nigeria, with assistance from the logistics contractor, will coordinate all travel and field activity in Nigeria by Pathfinder staff, subcontractors and consultants, and will be the primary point of contact for all in-country logistical and support services. All subcontractor staff and consultants visiting Nigeria will be requested to contact Pathfinder's Country Representative on arrival and, if requested, to debrief in-country staff prior to departure. Contacts by subcontractors and consultants with the USAID/Lagos will be arranged through Pathfinder's Lagos staff.

B. Component Linkages

1. With the FMG, Other Implementors and Donors

During the implementation stage, as during the design phase of the FHI-II, Pathfinder and its proposed subcontractors will make every effort to collaborate and cooperate with all relevant units of the FMG. The design team had excellent cooperation from its FMG counterparts from the Federal Ministries of Health and Information as well as from the National Population Bureau. This interaction during the design phase has created important linkages which will be strengthened during project implementation. The public sector component looks forward to developing a close and collaborative working relationship with one or more counterparts to be appointed by the FMG prior to the project start-up. Section IV of the Project Paper describes the overall project linkages with the FMG at the federal level in greater detail.

Most of the public sector activities will be carried out at the state and local levels. Linkages will be created with government officials at these levels as the program dictates. Close ties to the State Family Planning Coordinators will be required for the implementation of state-level training and clinic site visits for determination of equipment needs and placement. Cooperation of local government officials is crucial for selection and placement of training candidates. Staff and faculty of local training institutes will be co-opted for the important role they will play in the successful achievement of training objectives.

Throughout the life of the project, the public sector component will be alert to opportunities to forge closer links with all levels of government as well as to other donors and implementors also involved in the national program. Every effort will be made to cooperate with others' activities and to build on the foundations they have created. Other implementors and/or donors will be consulted and invited to participate in future project planning exercises as they were in the design phase so that costly duplication of efforts or other confusion will be avoided throughout the program.

2. With Other Collaborators

The project design phase demonstrated the ability of the four components to work together in creating a unified action plan. This collaboration will be even more essential during project implementation. Various mechanisms describing the specific plans and processes for this collaboration are detailed throughout the four component work plans as well as in Section II of the Project Paper. It is important to note here that the public sector component is aware of the vital contributions to be made by each of the other technical contracts. None of the activities planned by this or the other components can stand alone or succeed in a vacuum. Therefore, every effort will be made by the public sector component to see that the collaborative mode is maintained throughout project implementation. This is an absolutely essential requirement for overall project success.

3. With AID

Specific means of managing the public sector component linkages with AID are set out in Management Appraisal, Section A. above. Specific public sector contract communications will flow through Pathfinder project staff in Boston and/or Lagos. Overall FHI-II linkages with AID will take place through the AID Project Coordinator based in Lagos by means of joint planning exercises and periodic Project Advisory Committee meetings.

One planned linkage between the FHI-II public sector component and AID's other Nigeria-based health activity - CCCD - has been identified. This involves joint training in management and technical skills for health staff of the 80 LGAs which have been designated by the FMG for special PHC activities. This will be further explored by Pathfinder during the pre-project phase.

V. MONITORING/EVALUATION PLAN

A. Identification of Benchmarks

Since the project is to cover all states of the Federation as opposed to targeting activities in only a few selected states and because the states have developed their programs at different rates and with varied emphasis, the first step in the implementation plan will be to complete baseline inventories of family planning manpower, facilities, and equipment for each state. The resulting information base will become the first project benchmark against which state-by-state program plans are made and against which subsequent progress is measured. For the outputs noted in the public sector Technical Approach (Section III), benchmarks and the timeframe for their achievement are noted in the sectoral component implementation plan and in Tables 1 and 2. The methodology and schedule of monitoring output achievements are noted below.

B. Methodology

To the extent possible, the state baseline inventory will be carried out by Pathfinder and Africare country staff presently in Nigeria during the pre-project period. This will be done during state visits undertaken in connection with ongoing project activities. This review should be completed within the first quarter of the project implementation by planning state visits to all outstanding states (those not covered during the pre-project period) for data collection. Project field staff will undertake the latter activity.

A second baseline measure, to be funded and used by all four project components, is the baseline Household Survey, to be carried out during Year One in all regions of Nigeria by the National Population Bureau. Technical assistance will be provided by the public sector MIS subcontractor. This survey will provide measures of current fertility, contraceptive prevalence (by method and source), family planning knowledge and attitudes, as well as media and purchasing habits. Results will be used by all four components for program planning, implementation and evaluation.

The accomplishments of most public sector component objectives will be measured periodically through analysis of FMOH service statistics; regular project activity reports from subcontractors on training, provision of equipment and commodities, development of the MIS, and other efforts; and survey data. When adjustments in the timeframe and/or specific output objectives are required, these will be discussed at the time of regular component planning and review sessions. Any changes or revisions in component plans will be presented and explained during the annual meeting of the four collaborating contractors so that full coordination of these changes can be reflected in the overall project work plan.

C. Specific Monitoring Plans

As outlined in the section on Component Management (Section IV), each subcontractor will be responsible for monitoring the specific project outputs for which it is given responsibility in the terms of its subcontract. Throughout the life of the project, brief narrative reports will be submitted monthly to the prime contractor by each subcontractor, along with the submission of detailed financial reports. These narratives will include statements of progress in the achievement of specific project objectives as set out in the component Detailed Year One Activities, such as the numbers of each clinical and management cadre trained, the number of courses taught or funded, numbers of clinic sites equipped, specific MIS component activities, numbers of workshops held, and results of surveys completed. Technical assistance interventions will also be described.

Regular planned monitoring visits will be undertaken by component staff in Nigeria. The four regional project officers will move throughout their designated regions on a regular schedule. Lagos-based staff will make field visits in connection with special activities, e.g., training sessions and MIS interventions, which fall within their particular responsibilities. U.S.-based staff will undertake scheduled monitoring visits to Nigeria several times each year. Trip reports will be prepared following all the above visits.

Information gathered through monthly subcontractor reports and the monitoring trip reports will be compiled for quarterly submission to the USAID Project Manager. All reports submitted in connection with the public sector activities each year will be utilized in planning future sectoral activities in keeping with the rolling design methodology of project planning.

TABLE 1 - PUBLIC SECTOR FAMILY PLANNING

SERVICE SITES AND STAFF PROJECTIONS

Year	Number of Service Sites				Number of Staff			
	Full Service	To be Added	Partial Service	To be Added	Full Service	To be Trained	Partial Service	To be Trained*
End 1986 (Base)	600(?)		(?)		2,000+		2,000(?)	
		100		(?)		(?)		
Enc 1987	700		200		2,000+		2,000(?)	
		100		550		250	2,500	500
End 1988	800		750		2,250			1,000
		100		750		250		
End 1989	900		1,500		2,500		3,500	
		150		1,000		250		1,000
End 1990	1,050		2.500		2,750		4,500	
		200		1,000		250		1,500
End 1991	1,250		3,500		3,000		6,000	
Total to be added**		550		3,300		1,000		4,000

* Half of these are to be trained in pre-service courses and half in project support in-service courses.

** Totals allow for attrition over the life of the project.

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TABLE 2 - PUBLIC SECTOR 5-YEAR IN-SERVICE TRAINING PLAN

Area of Training	Trainees	No. to be Trained by Year I	II	III	IV	V	Total	Length of Course (Weeks)	Total Number Trainee-Weeks
1. Training of Trainers - full service clinical skills	Nursing/Midwifery tutors and state trainers (selected states)	75	75	50	50	0	250	4	1000
2. Training of SHT Tutors in revised FP curriculum	SHT Tutors	40	0	0	0	0	40	1	40
3. Physicians/Nurses/ Midwives - full services clinical skills	Physicians, Nurses and Midwives	250	250	250	250	0	1000	2-6	5024
4. As 3. above - Refresher course	As 3. above - (previously trained)	0	0	0	100	200	300	1	300
5. Non-clinical Service Delivery, Outreach and Communication	Community Health Workers and Nurses	250	500	500	750	0	2000	2	4,000
6. As 5. above - Refresher course	As 5. above - (previously trained)	0	0	0	500	300	800	1	800
7. As 1. above - Refresher Course	As 1. above - (previously trained)	-	-	-	20	40	60	1	60
8. Management Training - various skills	Federal and state program managers	150	150	150	150	168	768	2	1536
TOTALS		765	975	950	1820	708	5218		12000

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VI. FINANCIAL PLAN

A. Budgets

The attached tables present the life-of-project and detailed first year budgets, respectively, for the public sector component. The total five year budget of $11 million includes three major subcontracts with U.S.-based organizations for technical assistance in the following critical public sector activity areas:

- training in clinical and communication skills;
- training in management skills and the development of a management information system; and
- equipment and commodity logistics and maintenance.

The additional subcontracts will be negotiated with Nigerian organizations, the National Population Bureau and the Federal Office of Statistics, for carrying out surveys. The data to be collected by these activities are essential for establishing the project's baseline measure of contraceptive prevalence and other related information as well as measuring ongoing progress over the life of the project. These information collection activities will be co-funded by the other project contractors.

B. Host Country Contribution

The FMG contribution under this particular project component represents more than twice the external (USAID) contribution. An estimated in-kind contribution of N127 million (equivalent to $25 million at the average exchange rate for the project period) will be provided by the FMG. This contribution will be in the form of clinic space and staff provided by state and local governments as well as the staff time contributed by trainers and trainees during the numerous training courses to be funded by the project. Space will also be provided by state and local government bodies for training women.

C. Local Currency Financing

Several major items noted in the budgets include local currency components. A major portion of the in-service training costs will be provided in naira as will all of the in-country travel costs. Locally produced equipment will also be evaluated for possible purchase under the clinic equipment line items. Furthermore, eight professionals and a number of support staff will be hired locally and paid in naira. A conservative estimate of local currency financing under the public sector component totals approximately N16.0 million (or more than $4 million) over the five years of the project.

UDGET WORKINGS — PUBLIC SECTOR Totals — PUBLIC

(Inflated prices)

	Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
ISONNEL	215,350	115,900	169,738	258,420	121,695	177,873	310,104	127,780	189,065	341,114	134,169	195,454	375,226	140,877	202,163	1,500,214	640,421	934,293
ISULTANTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VEL & PER DIEM	249,000	26,300	89,050	298,800	22,428	87,385	358,560	23,009	93,871	394,416	23,592	94,454	433,858	27,154	98,016	1,734,634	122,984	462,775
IPMENT & MATERIALS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CONTRACTS	0	2,085,695	2,085,695	0	1,347,376	1,347,376	0	1,136,009	1,136,009	0	1,169,255	1,169,255	0	721,463	721,463	0	6,479,797	6,479,797
R DIRECT COSTS	0	215,000	215,000	0	173,250	173,250	0	181,913	181,913	0	191,008	191,008	0	139,783	139,783	0	900,954	900,954
CES / FACILITIES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RECT COSTS	0	529,951	529,951	0	469,344	469,344	0	442,013	442,013	0	462,929	462,929	0	317,702	317,702	0	2,221,939	2,221,939
O T A L S	464,350	2,973,346	3,089,433	557,220	2,134,093	2,255,227	668,664	1,910,724	2,042,871	735,530	2,000,953	2,133,100	809,083	1,346,979	1,479,126	3,234,848	10,366,095	10,999,758
nual Inflation rate	0%	0%		20%	5%		20%	5%		10%	5%		10%	5%				
llar : Naira rate			4.00			4.60			5.06			5.57			6.12			

Direct costs % rate 28.75% - Applied to all costs (incl. Subcontracts), excluding bulk materials & related freight charges

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BUDGET WORKINGS (DETAILED) PUBLIC SECTOR PUBDTL

(Current - 1987 - prices)		Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
PERSONNEL																			
US-based Salaries																			
- Project Director			30,000			30,000			30,000			30,000			30,000		0	150,000	
- Admin. Assistant			25,000			25,000			25,000			25,000			25,000		0	125,000	
- Secretary			10,000			10,000			10,000			10,000			10,000		0	50,000	
- Dir. Tech. Services			6,800			6,800			6,800			6,800			6,800		0	34,000	
- Reg. Dir. (Africa)			5,700			5,700			5,700			5,700			5,700		0	28,500	
US Fringe benefits	24.00%		11,400			11,400			11,400			11,400			11,400		0	57,000	
Nigeria-based Salaries																			
- Country Representative			27,000			27,000			27,000			27,000			27,000		0	135,000	
- Training Officer		17,000			17,000			17,000			17,000			17,000			85,000	
- MIS/Logistics Officer		17,000			17,000			17,000			17,000			17,000			85,000	
- Admin/Finance Officer		17,000			17,000			17,000			17,000			17,000			85,000	
- 4 Program Officers		64,000			64,000			64,000			64,000			64,000			320,000	
Nigeria Fringe benefit	45.00%	100,350			100,350			100,350			100,350			100,350			501,750	
Subtotal		215,350	115,900	169,738	215,350	115,900	169,738	215,350	115,900	169,738	215,350	115,900	169,738	215,350	115,900	169,738	1,076,750	579,500	848,688
CONSULTANTS																			
Subtotal			0	0		0	0		0	0		0			0	0	0	0	0
TRAVEL & PER DIEM																			
International travel																			
- US/Lagos trips : 6 in yr 1; 5 in yrs 2-5																			
- Trips @	$2,500		15,000			12,500			12,500			12,500			12,500			65,000	
US local travel	$2,000		2,000			2,000			2,000			2,000			2,000			10,000	
Local travel - Air																			
- 100 trips @	N 250	25,000			25,000			25,000			25,000			25,000			125,000		
Local travel - Road		64,000			64,000			64,000			64,000			64,000			320,000		
Per diem																			
US-based staff																			
- 100 days in yr 1, reducing in later years @	$98		9,800			6,860			6,370			5,880			7,840			36,750	
Lagos-based staff																			
- 200 days @	N 200	40,000			40,000			40,000			40,000			40,000			200,000		
Field staff																			
- 600 days @	N 200	120,000			120,000			120,000			120,000			120,000			600,000		
Subtotal		249,000	26,800	89,050	249,000	21,360	93,610	249,000	20,870	83,120	249,000	20,380	82,630	249,000	22,340	84,590	1,245,000	111,750	423,000

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EQUIPMENT & MATERIALS																			
Subtotal		0	0		0	0		0	0		0	0		0	0		0	0	0
SUBCONTRACTS																			
1. Africare		872,107			172,336			136,248			136,248			136,248			1,453,187		
2. IHPS		737,035			728,583			586,440			599,753			174,944			2,826,755		
3. MSH		359,553			357,296			282,706			266,322			257,357			1,523,234		
4. Baseline survey		117,000			0			0			0			0			117,000		
5. National HH survey		0			25,000			25,000			25,000			25,000			100,000		
Subtotal	0	2,085,695	2,085,695	0	1,283,215	1,283,215	0	1,030,394	1,030,394	0	1,027,323	1,027,323	0	593,549	593,549	0	6,020,176	6,020,176	
OTHER DIRECT COSTS																			
Direct costs		15,000			15,000			15,000			15,000			15,000			75,000		
Special Projects		200,000			150,000			150,000			150,000			100,000			750,000		
Subtotal	0	215,000	215,000	0	165,000	165,000	0	165,000	165,000	0	165,000	165,000	0	115,000	115,000	0	825,000	825,000	
INDIRECT COSTS		529,951	529,951		446,994	446,994		400,919	400,919		399,895	399,895		261,374	261,374	0	2,039,134	2,039,134	
T O T A L S	464,350	2,773,346	3,089,433	464,350	1,882,469	2,148,557	464,350	1,583,083	1,849,171	464,350	1,578,496	1,844,586	464,350	1,008,163	1,224,250	2,321,750	9,575,560	10,155,997	

Dollar : Naira rate

	4.00	4.00	4.00	4.00	4.00

Indirect costs % rate 28.75% - Applied to all costs (incl. Subcontracts), excluding bulk materials & related freight charges

********** YEAR 1 BUDGET **********

BUDGET WORKINGS (DETAILED)

PUBLIC SECTOR

PUBDTL

(Current - 1987 - prices)			<------- N	Year $	-------> Total $ Equiv.
PERSONNEL					
US-based Salaries					
- Project Director				30,000	
- Admin. Assistant				25,000	
- Secretary				10,000	
- Dir. Tech. Services				6,800	
- Reg. Dir. (Africa)				5,700	
US Fringe benefits	24.00%			11,400	
Nigeria-based Salaries					
- Country Representative				27,000	
- Training Officer			17,000		
- MIS/Logistics Officer			17,000		
- Admin/Finance Officer			17,000		
- 4 Program Officers			64,000		
Nigeria Fringe benefit	45.00%		100,350		
Subtotal			215,350	115,900	169,738
CONSULTANTS					
Subtotal					
TRAVEL & PER DIEM					
International travel					
- US/Lagos trips : 6 in yr 1; 5 in yrs 2-5					
= Trips @	$2,500			15,000	
US local travel	$2,000			2,000	
Local travel - Air					
- 100 trips @	N	250	25,000		
Local travel - Road			64,000		
Per diem					
US-based staff					
- 100 days in yr 1, reducing in later years @	$98			9,800	
Lagos-based staff					
- 200 days @	N	200	40,000		
Field staff					
- 600 days @	N	200	120,000		
Subtotal			249,000	26,800	89,050

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********** YEAR 1 BUDGET **********

EQUIPMENT & MATERIALS			
Subtotal		0	0
SUBCONTRACTS			
1. Africare		872,107	
2. IHPS		737,035	
3. MSH		359,553	
4. Baseline survey		117,000	
5. National HH survey		0	
Subtotal	0	2,085,695	2,085,695
OTHER DIRECT COSTS			
Direct costs		15,000	
Special Projects		200,000	
Subtotal	0	215,000	215,000
INDIRECT COSTS		529,951	529,951
T O T A L S	464,350	2,777,346	3,089,433

IEC COMPONENT WORK PLAN

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ANNEX J

IEC COMPONENT WORK PLAN

I. EXECUTIVE SUMMARY

A. Principal Objectives

The overall purpose of this project is to increase the awareness, acceptability and availability of family planning information and services throughout Nigeria both in the public and private sectors. At the end of the five-year project, 80 percent of the population aged 15-45 will be informed of family planning concepts. Hopefully, smaller family norms will result. To achieve this objective, there is a need for a strong, well-designed and managed information, education and communication (IEC) component to support activities of the public sector, private sector and policy implementation components.

IEC helps empower people to make informed decisions about their family's future. A good IEC program is vital in linking health and family planning needs to existing services. By making available culturally appropriate and easily understood information about family planning services, IEC also helps refute misconceptions and ameliorate anxieties toward the concepts of family planning and the use of modern contraceptives. In areas where latent demand for family planning already has been met, demand creation activities can increase the number of family planning accepters.

B. Technical Approach

The IEC approach proposed in this project is based on the principle that knowledge, attitude and practice of individuals can best be influenced by exposure to consistent, reinforcing and culturally appropriate messages coming from familiar, credible and multiple channels of communication. The message must be focussed, clear and frequent in its exposure. It must be communicate through the most creative and effective media available and must initiate an action by the viewer, reader or listener.

Based on this principle and Johns Hopkins University/Population Communication Services (JHU/PCS) experience in Nigeria over the past three years, a "concentric circle" approach to design and implement IEC activities is proposed on the national, state and local government area (LGA) levels in both the public and private sectors. These "circles" are significant by themselves and create a greater influence when combined:

- clinic-based face-to-face contact between the individuals and the health provider;
- clinic-based person-to-group communication;
- clinic-based outreach activities;
- support from influentials; and
- support from traditional and modern mass media.

C. Programs of Action

The following activities will be undertaken over a five-year period to produce, disseminate and effectively use IEC materials at each of the "circles" or levels of intervention:

- Mass Media. Production of 3,000 television, radio, film and folk media programs and spots, and newspaper and magazine inserts in at least five languages;

- Influentials. Organization of 40 orientation symposia and campaigns as well as IEC packages to promote family planning awareness among selected opinion leaders (e.g., traditional and religious leaders, political and business figures) and their constituents;

- Clinic-based and Outreach Activities. Development of a national logo designed for use in identifying at least 15,000 service and sales outlets in the public and private sectors; 6 million copies of various print materials available at all service, sales and outreach points; 10,000 service, sales and motivational agents trained in IEC concepts as part of regular training conducted in the public and private sectors; and 20 specialized workshops conducted to improve public and private sector IEC capability; and

- Family Life Education. Production and distribution of a total of 30,000 copies of five types of Nigeria-specific teacher and student materials produced and distributed through a series of workshops for secondary school and post-secondary teachers.

D. Program Management

In order to control the range and variety of activities proposed , it is essential that they are consolidated into manageable groups. All national and regional activities will be consolidated into seven major implementing Nigeria-based networks: the National Council on Population Activities (NCPA); the Federal Ministries of Health, Information and Education; the Planned Parenthood Federation of Nigeria (PPFN); and advertising firm; and a technical assistance resource agency. At the state level, similar consolidation will take place, especially when working with primary health care-designated LGAs.

To improve on-site monitoring and timely technical assistance, JHU/PCS will field a country representative supported by five Nigerian program officers and financial and administrative staff. Four of the program officers will be responsible for activities occurring at the regional, state and LGA levels in each of the four regional health zones. The fifth program officer will be responsible for activities occurring in Lagos at the national level. Their efforts will be supplemented by U.S.-based consultants and staff from JHU/PCS and its subcontractors, Program for the Introduction and Adoption of Contraceptive Technology (PIACT), Center for Development and Population Activities (CEDPA), and Academy of Educational Development (AED).

Counterparts in appropriate departments of the Federal Ministries of Health, Information and Education will be designed in order to involve the respective ministries in the design and implementation of activities. An ad hoc expanded IEC coordinating/planning committee to be composed of all major private and public sector agencies involved in IEC will also be established.

II. IEC COMPONENT OBJECTIVES

A. Primary Goal

The overall purpose of this project is to increase the awareness, acceptability and availability of family planning information and services throughout Nigeria both in the public and private sectors. It is expected that a prevalence rate of 12 percent will be achieved with 60 percent of total users served by the private sector and 40 percent served by the public sector. Hopefully, smaller family norms will result from knowledge about and use of family planning. To help achieve this objective, there is a need for a strong, well-designed and managed IEC component to support activities of the public sector, private sector and policy components.

B. Rationale

Information, education and communication helps people make informed decisions about their family's future. A good IEC program is vital in linking existing health and family planning (family planning) needs of the populace to existing health and family planning (family planning) services. By making available culturally appropriate and easily understood information about family planning services, IEC also helps to refute misconceptions and ameliorate anxieties toward the concepts of family planning and the use of modern contraceptives. In areas where latent demand for family planning already has been met, demand creation activities can increase the number of family planning accepters.

In the past three years, there has been a rapid increase in the number of family planning activities throughout Nigeria. This is nationwide through both public and private sector outlets and steady progress has been made in introducing states and organizations to the importance of IEC support for family planning programs.

JHU/PCS has visited 15 of the 19 states of Nigeria during the past three years, working closely with federal and state health and information officials in designing and implementing family planning IEC projects. Print materials are being produced and properly used. IEC campaigns and activities involving mass media, interpersonal communication and social mobilization have been launched in seven states of the major ethnic areas of Nigeria, all with positive results.

For example, a very popular television program in Anambra was sponsored to incorporate family planning/health messages into its format. An urban clinic was advertised during the broadcasts. In the first three months of airing, the number of new accepters more than tripled and 57 percent of new accepters at this clinic stated that they heard about the clinic's services from the television.

In Kwara state, the impact of a year-long multimedia campaign on new accepters was equally impressive. During the year, as television and radio spots and programs were aired and a field worker conducted outreach, attendance at the urban clinics almost quadrupled, with a growing percentage of new accepters indicating television and the field worker as major sources of referral.

Finally, a study on the use of PPFN's methods booklets by clinics staff to counsel potential users and subsequently by potential accepters to share with husbands revealed that 85 percent of health workers did indeed use the booklet in counseling clients. And of the 88 percent of clients who kept the booklet, 78 percent shared it with their husband.

A momentum now exists in all regions of Nigeria for establishing family planning services with trained staff and for developing IEC activities to inform and motivate the eligible population. Other state-level IEC projects are in various stages of planning and development. Private Nigerian voluntary organizations like PPFN and the NCPA now have taken the initiative to organize media seminars and male motivation projects. But despite this level of activity, the magnitude of need in Nigeria dwarfs present IEC efforts.

C. Host Country Involvement in the Program Design

JHU/PCS has continued to benefit from close collaboration with Nigerian government officials and private sector organizations in the design of the FHI-II program.

Leading Nigerian authorities on communications teamed with representatives from the FMOH and JHU/PCS in shaping the strategy and implementation plan of the program. Working sessions with representatives from the Federal Ministry of Information (FMOI) were complemented by visits to the National Institute of Public Information (NIPI) and state level ministries of information.

Meetings with the National Education Research Council (NERC), the National Education Technology Center (NETC) and state ministries of education firmed the strategy for supporting family life education for teachers of secondary and post-secondary school levels.

Directors of the PPFN and NCPA, the management of Sterling Products (Nigeria) Ltd., and representatives of advertising agencies provided insight into developing private sector elements of the design.

This quality of collaboration will continue to be sought during the next five years to help ensure the successful implementation of the project.

D. Principal Objectives

At the end of the project, 1) IEC action program incorporating a range of mass media activities, mobilization campaigns, print materials and skills training at the national, state and LGA level (at least one LGA per state in accordance with the LGAs designated by the FMOH's Primary Health Care Strategy) will have been approved and executed: 2) 80 percent of the eligible population aged 15-45 will be knowledgeable about family

planning concepts; 3) information on the benefits of child spacing and modern methods of contraceptives in the form of wall charts, posters, picture booklets and promotional displays will have been made available to 12,000 private sector outlets and 3,600 public sector delivery points; and 4) trainers of teachers will be trained and 30,000 copies of materials for trained teachers and students in family life education will have been developed, produced and made available for use by secondary and post-secondary schools.

III. TECHNICAL APPROACH

A. Underlying Principle

The IEC approach proposed for this project is based on the principle that knowledge, attitude and practice of individuals can best be influenced by exposure to consistent, reinforcing and culturally appropriate messages coming from familiar, credible and multiple channels of communication. The message must be focussed, clear and frequent in its exposure. It must be communicated through the most creative and effective media available and must initiate an action by the viewer, reader or listener.

For example, a person hears a message on the radio describing the health benefits of family planning and extolling the listener to visit the nearest family planning clinic. A similar visual message is aired on television and is supported by those the viewer respects. When the same message is repeated by a health worker in a clinic setting, that message has a higher probability of being absorbed than a message coming only from a single source. Based on this principle, and JHU/PCS experience in Nigeria in the past three years, a "concentric circle" approach to designing and implementing IEC activities is proposed.

There are six major "circles" to this approach (see Figure 1):

- clinic-based face-to-face contact between the individual and the health provider, motivator or seller;
- clinic-based person-to-group communication;
- clinic-based outreach activities;
- non-health community outreach;
- support from influentials; and
- support from traditional and modern mass media.

"Clinic-based" includes government clinics, hospitals and maternal/child health centers, private practitioners' maternity clinics, and employment-based clinics. Service providers, motivators and sellers include nurses, midwives, doctors, traditional birth attendants, healers, herbalists, pharmacists, and market vendors, all of whom could be trained and encouraged to conduct outreach activities to further create a demand for their services and commodities.

B. The "Concentric Circle"

1. Clinic-based IEC: Groups and Individuals

The face-to-face encounters between potential clients and the service provider are crucial events that have a lasting impact on the

ultimate behavior of the client. These events are the inner two "concentric circles." Motivating groups of mothers who are already in the clinic for maternal and child health services constitutes the most immediate and practical way of reaching out to and recruiting new accepters. This approach is especially effective in Nigeria where it is not unusual to see hundreds of mothers waiting in a common area for services in many clinics.

More importantly, the quality of the transaction between the service provider or the motivator and a potential client offers the best opportunity to turn an accepter from a passive recipient into an active promoter of family planning in his or her own community.

The types of IEC interventions that help improve the quality of these encounters are varied:

- integrating appropriate IEC curricula into the training of service providers/motivators with an emphasis on techniques of counseling individuals, improving face-to-face interaction, motivating groups, countering rumors and misconceptions, and using low-cost, simply produced IEC materials to support their efforts;

- providing service providers/motivators with reference materials (e.g., simple visual methods-specific cue cards) to improve their knowledge of family planning methods and increase their level of confidence;

- providing low-literate client groups with pictorial leaflets and booklets on how to use different methods of contraception;

- providing appropriate visual aids (e.g., wall charts depicting modern and traditional methods) to health workers or sellers in explaining the different methods available;

- providing attractive posters to clinics with motivational messages with which potential clients could identify;

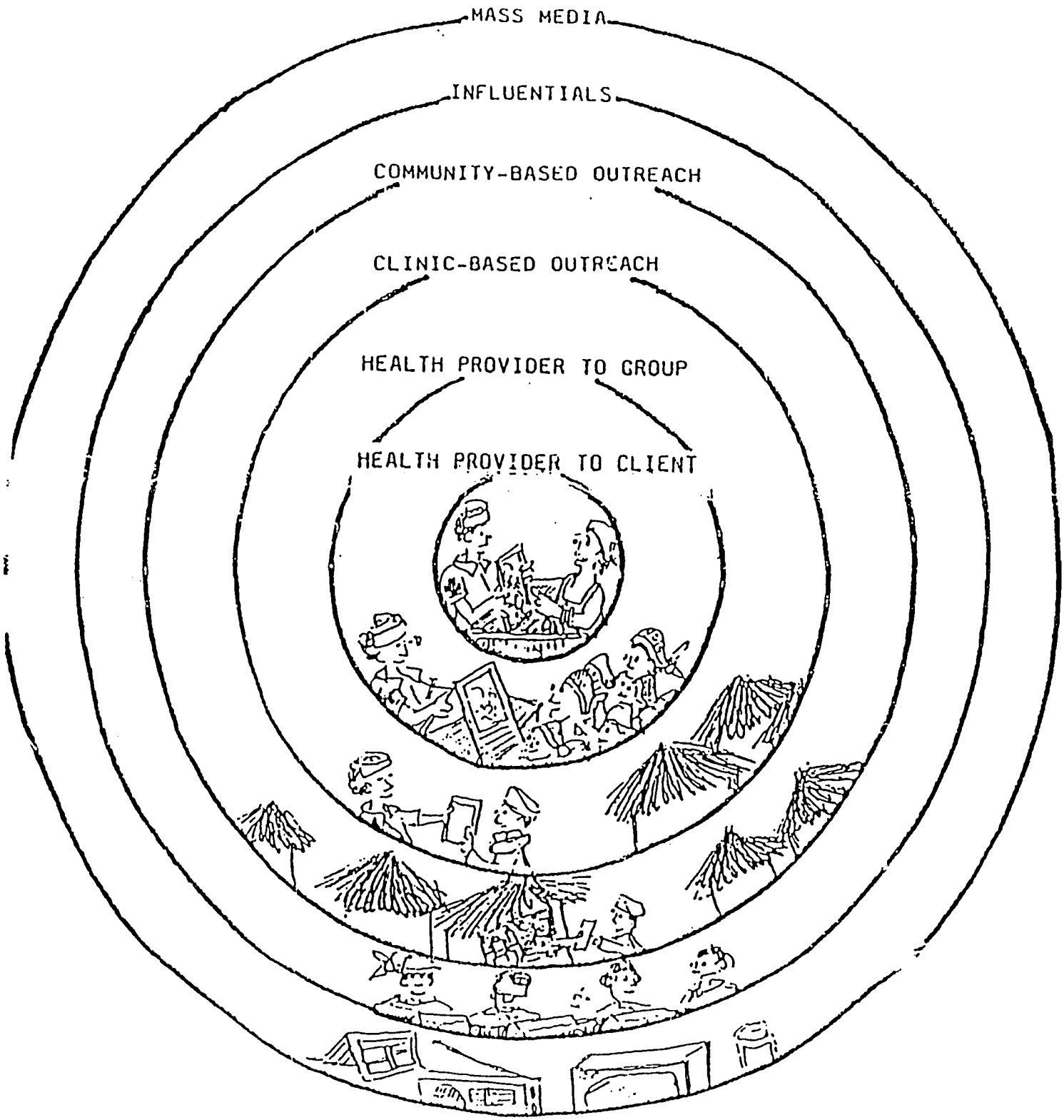
- providing practical person-to-group motivation-enhancing equipment (e.g., megaphones);

- encouraging new clients to become motivators and to bring their friends and relatives when they make their next visit;

- identifying the location of the clinic with an attractive logo displayed on a poster, banner or other signs; and

- providing low-cost portable audio-visual equipment to enhance counseling activities and to provide information and motivation when a service provider is not readily available (e.g., sound-slides).

FIGURE 1: THE "CONCENTRIC CIRCLE" APPROACH



2. Clinic-based Outreach

Clinics in general are patronized by clients who live within their immediate proximity. It is therefore necessary to devise ways of reaching potential clients in the catchment area beyond the immediate periphery of the clinic walls. One effective way of doing this is to encourage clinic-based personnel to do outreach work. These types of activities include:

- encouraging service or sales providers to visit markets where women usually congregate, or mechanic villages (large vehicle repair depots) where men work and live;

- conducting specialized campaigns directed at one particular sector of the populace (e.g., male motivation);

- equipping health workers with appropriate posters, samples of contraceptives, displays depicting traditional and modern methods, and megaphones to attract more people;

- exposing service providers from other parts of Nigeria to activities in areas where clinic-based outreach is taking place; and

- distributing simple mimeographed flyers indicating when and where family planning services are available in a given locale.

3. Non-health Community Outreach

The number of groups promoting family planning can be multiplied when other non-health sectors are mobilized to motivate their constituents. Types of activities include:

- training agricultural extension workers, home agents, and literacy workers as part of their routine to promote family planning and refer people to service outlets;

- training information officers in community mobilization techniques and the use of FMOI mobile vans to show films and disseminate other IEC materials;

- orienting taxi drivers, market women and other business associations and unions to sell non-prescriptive methods and refer potential clients to appropriate public or private service points;

- holding contests for the best orators on family planning topics from among the ranks of town criers, market women, taxi drivers and other groups; and

- supporting members of community service organizations and voluntary organizations with user leaflets, stickers and other promotional print materials.

4. Influentials

For the family planning movement to acquire greater legitimacy and acceptance, it is crucial that influential groups, elders and opinion leaders are mobilized and, in turn, supported in their motivational efforts.

IEC addressed to influentials is an important building block for the population program, especially in a multi-ethnic society like Nigeria. Influentials should be elicited to help motivate their own constituents to support the program. Types of activities involve:

- organizing traditional and religious leaders' symposia and meetings at the national, regional, state and LGA levels (the Policy Implementation Component will be jointly involved with these activities);

- organizing workshops for producers and managers of television and radio, and editors and journalists of newspapers and magazines;

- transforming the Nigerian RAPID computer presentation into more easily understood radio, television or print formats for general public consumption;

- organizing orientation workshops and initiating activities with organizations having potential outreach roles among their vast networks, affiliates or branches (e.g., Union of Transport Workers, National Council of Women's Societies, Association of Wives of Military Officers);

- supporting the National Council on Population Activities to develop IEC packages for its constituency-building activities addressed to influential groups, professional associations and opinion leaders; and

- providing special motivation sessions for elders who could, in turn, influence younger generations;

- publishing special works addressed to specific groups (e.g., Islam and family planning, cost-effectiveness of family planning/IEC activities in industries) (Again, the Policy Development Component would be jointly involved.)

5. Mass Media

While "concentric circles" mentioned thus far are significant by themselves and create greater influence when combined, both traditional and modern mass media offer a better opportunity to reach greater audiences in shorter time periods. When used effectively, the mass media not only brings about wider awareness about family planning but also can tap the emotions of viewers and listeners to more effectively persuade potential users to change behaviors.

This is especially true when the creativity at the LGA level is tapped to yield Nigeria's rich history of traditional media: town criers, talking drums, dance and songs, drama troupes, puppet shows. These media involve audience participation and offer the emotional spark needed to excite awareness and stimulate action among its followers.

Modern mass media is supported by over 22 television and 35 radio stations that relay national programs and produce local broadcasts in local languages. Nineteen daily and 18 weekly newspapers and nine major magazines circulate throughout Nigeria. Radio has the widest reach, particularly in the rural areas. Access to television in many urban areas is estimated to be between 60 and 80 percent of the population. Newspapers are believed to be primary medium for reaching opinion leaders.

When used in combination, traditional and modern mass media will not only inform but also stimulate, educate and help to convince the greatest number of people. As a reinforcement for personal communication and counseling by health care providers, mass media are invaluable.

The creative use of the mass media is essential for inspiring and maintaining a positive public atmosphere for the population program. Types of activities include:

- integrating family planning messages into existing popular radio and television series (variety shows and soap operas) or newspaper/magazine sections;

- developing interactive traditional media with family planning/health themes;

- recording traditional media with family planning messages in modern media for broadcasting;

- developing and producing 5-minute television and radio fillers with family planning messages, including recorded testimonials from traditional and religious leaders;

- developing and producing television and radio specials and serials;

- developing and producing television and radio spots, jingles and newspaper ads;

- organizing media events such as state and LGA family planning launchings;

- organizing workshops for media practitioners;

- training selected MOI/MOH personnel in radio and television production techniques and print material development;

- providing observation study tours for selected media practitioners;

- providing limited radio recording and editing equipment to selected radio stations on a pilot basis;

- providing video equipment to selected MOI offices on a pilot basis to develop and produce motivational and technical video programs for broadcast or transfer onto 16 mm film and shown through mobile vans; and

- promoting the national family planning logo whenever possible.

There will be three major thusts of the mass media. The first involves a centralized generic and "brand" specific campaign to support private sector programs. Viewers, listeners or readers will be informed that family planning information and services are available in outlets identified with a prominently displayed national logo. Although national in scope, the materials produced will also be available in five major languages. Mass media and point-of-purchase messages and images will be mutually reinforcing. The generic campaign is also expected to have a significant impact on the promotion of public sector programs.

The second involves state-level use of mass media to establish public sector capabilities in IEC. This allows for "ownership" of programs and products at the state level and the development of capability in IEC among state and ultimately LGA personnel. This state-specific media component would also allow for development and placement of messages uniquely appealing to the particular state. This is especially true for traditional media, "testimonials", and for giving prominence to outstanding personnel in the field. States then could actively plan to exchange their materials on a regional level on the basis of "competitive advantages," thus achieving economies of scale.

The third thrust focusses on using mass media to support the policy sector. This involves transforming the RAPID computer presentation into easily understood formats and using media coverage of family planning events and special broadcasts on population issues to enlighten decision-makers.

C. Message Development

1. Research

It is essential to use only select high quality and appropriate messages in a variety of creative ways. To be able to identify these key messages in the cultural context of Nigeria, a practical audience research activity is necessary.

Three research tracks will be followed closely. The first, market research, will be conducted by the private sector. The results will be used to develop messages to be used in an advertising campaign, especially those aimed at the buying client.

Second, for general reference, but particularly in IEC support of public sector and policy component activities, "rapid anthropological research" (e.g., mini-studies combined with focus group discussions) will be conducted in the four major health zones involving the major ethnic

groups of Nigeria early in the life of the project. This will help provide a dimension to IEC planning necessary for producing regionally-distributed materials.

Third, the IEC component will actively participate in and closely monitor the research activities conducted under the policy implementation and public and private sector components. The findings of these research efforts will feed into developing message and channel strategies including specific design of materials. They also will be useful for establishing benchmark data needed for evaluation. Close interaction with health care providers through visits, observation, focus groups, discussions, workshops and other participating mechanisms will increase the feedback necessary for effective IEC.

2. Design

It is important to underscore, particularly in the context of Nigeria, that messages should be designed for specific audiences segmented by sex, age, ethnic group and particularly urban/rural.

For example, a large percentage of rural women practice post-partum abstinence for an average of 14 months and breastfeeding for an average of 18 months. Messages that promote modern methods may dissuade mothers in the rural areas from using traditionally effective methods; and if the modern methods are not readily available nor fully understood by the user, the net effect is an increase in fertility. Hence, messages also should reinforce effective traditional methods currently being practiced, especially in the rural areas. The message of modern methods should be directed more to people already in the process of breaking away from tradition - the urban population - who also have greater access to services and commodities.

Similar care needs to be taken in designing messages for women as opposed to men. The experience of JHU/PCS has shown that men tend to care more about the economic implications of child spacing, whereas women are more concerned about the health aspects.

Messages for men also have to be directed toward different locales at different times. For instance, men work and congregate in areas that are sometimes distinct from where women work and live. A good example is the mechanic village, a depot of vehicular repair on the outskirts of towns which is mostly inhabited by men. Outreach activities to these places must specialize in motivating males to be concerned about child spacing, and radio programs must be aired during times when men congregate around their radios during morning or afternoon breaks.

A very different and more creative entertaining media strategy should be created for youth. Issues of teenage pregnancy, early marriage and other concerns need to be addressed through familiar and stimulating channels like music, drama and dance.

3. Audiences

The following table highlights some of the major target audiences, media and messages for family planning IEC over the next five years.

Each of these audiences can be further seqregated by urban/rural residence, language and ethnic groups, literacy, age, and parity:

Audience	Media	Message
Married Women (Age 20 - 35)	- clinic visits and counseling by health workers; - conversations with friends and relatives; - community group meetings; - traditional and modern mass media. - influential's support	- FP is for the health of the children; - FP is for the health of the mother; - FP adds to the quality of life; - FP helps parents control their own future.
Older Married Women (Age 35 and above)	- clinic visits and counseling by health workers; - peer counseling; - community group meetings; - traditional and mass media.	- Above messages, and, - Limit family size; - Advise the younger generations to space their children and limit their family size.
Married Men (Age 20 - 45)	- work place - groups and associations; - traditional and modern mass media; - father's clubs.	- Above messages, and, - Responsibility includes FP; - FP allows for educating children.
Adolescents (Male and Female, Age 15 - 24)	- school curricula; - extra curricula activities (e.g. drama); - modern mass media (e.g. music); - peer groups and clubs; - contests/quiz shows.	- Be a woman before becoming a mother; - Plan the future through FP; - Become an adult before having children; be wise and responsible about FP; - Limit partners for health and well-being.
Influentials (includes elders, Age 45 and above)	- groups meetings with peers and leaders; - mass media.	- FP is good for the community; - FP is mostly a modern method for a traditional practice; - FP adds to the quality of life and thus the power of a community.

Influentials can be further segmented by religious and ethnic affiliation, professional associations and unions (including teachers), leaders of community groups, etc.

As is evident, this segmentation is necessary to identify audiences in order to design accurate, meaningful and convincing messages. The " concentric circle" approach offers the mechanism, cost-effectiveness and timeliness of introducing IEC activities without losing sight of the characteristics of the people to be affected. This is why the importance of audience research cannot be over-emphasized.

D. Life-of-Project Design

To achieve the principal IEC objectives identified under this FHI-II Project, financial, technical and material resources will be made available at the national, state, and local government area levels in collaboration with the policy, public and private sector components.

1. Programs of Action

A national IEC program of action to support both the public and private sectors' IEC activities will be formulated and implemented. This action program also will lend support to similar state IEC action programs to be designed and implemented in each of the 19 states and the Federal Capital Territory. IEC action programs also will be developed and activated in at least one local government area of each state. Priority will be given to LGAs identified as priority by the FMOH's Primary Health Care Delivery System. These IEC action programs will be the framework, at different levels, within which materials will be developed and disseminated, and where appropriate service and sales providers will be trained in the development and use of the materials.

2. Outputs

The following IEC activities will be undertaken over a five-year period to produce, disseminate and effectively use IEC materials at the national, state and LGA levels:

- Mass Media. Production of 3000 television, radio, film, and folk media programs and spots, and newspaper and magazine inserts in at least five languages;

- Influentials. Organization of 40 orientation symposia and campaigns as well as IEC packages for selected influential groups to promote family planning awareness among private and public leaders and interest groups;

- Clinic-based and Outreach Activities. Development of a national logo designed for use in identifying at least 15,000 service and sales outlets in the public and private sectors; 6,000,000 copies of various print materials available at all service, sales and outreach outlets; 10,000 service, sales and motivational agents trained in IEC concepts as part of regular training conducted in the public and private sectors; and 20 specialized workshops conducted to improve public and private sector IEC capability; and

Family Life Education. A total of 30,000 copies of five types of Nigeria-specific teacher and student materials produced and distributed to at least 15 of 19 states through a series of workshops for 200 teachers of urban secondary and post-secondary schools.

3. Five-year Planned Activities

The gamut of materials to be produced, the activities to be conducted and the ways in which the outputs will be made public is indeed a great task.

Mass Media. Television and radio drama programs and variety shows that have a proven viewership or listenership will incorporate family planning messages and socially significant health themes. This is an entertaining method of providing educational materials through a channel familiar and acceptable to the desired audience. Traditional media, including songs, dance, mobile folk drama troups, puppet shows and other culturally familiar and respected means of communication will be developed to disseminate valuable family planning information. A special music project will be developed nationally and by region to involve local popular musicians to record and distribute popular songs which contain family planning themes.

Print Materials. Print materials such as methods reference cards for service providers to use in explaining the benefits, risks and application of various available methods of contraception, and supporting wall charts depicting traditional and modern methods of contraception will be produced. A national logo will be designed through a widely publicized contest. The winning logo will be reprinted on posters, decals, banners, displays and markings to indicate locations of service points and sales outlets.

Specialized IEC Workshops. To support the production, dissemination and effective use of the IEC materials and activities, 20 specialized IEC training workshops will be held throughout the life of the project. These workshops include audience research, community analysis, message development and creative ways for playwriters, and television and radio scriptwriters to incorporate family planning messages into traditional and broadcast programs; low-cost audio-visual material production for service providers; illustrative and low-cost printing techniques for artists involved in print material production; video and radio pre- and post-production techniques in developing higher quality and more creative programs. Advanced overseas IEC training for a limited number of local staff will be provided, especially in cases where the best returns can be obtained in terms of increasing IEC products.

Motivational Skills Training. Counseling and motivational skills also will be provided to a network of trainers involved in teaching family planning at selected regional training institutions. These skills will be taught to health workers attending in-service training on family planning. Print materials will be used as part of the training, and trainees can take samples back to their locale for use. Relevant IEC equipment such as videos, sound slides and tape recorders will be

provided to regional training sites to improve training techniques. UNFPA and World Bank resources will provide support similar to pre-service institutions.

Mobilization/Materials Development Skills Training. Workshops for selected state and local government workers involved in materials development and social mobilization will be held to supplement their skills in conducting orientation symposia and public campaigns to increase the awareness of local leaders and community groups in the importance and availability of family planning.

Family Life Education. Sets of print and audio-visual materials for teachers and students will be produced and introduced through a series of workshops for teachers. These workshops will assist teachers to creatively implement a family life education secondary and post-secondary school curricula as approved by the FMG.

These family life education activities have naturally evolved out of the extensive training programs conducted by CEDPA over the last three years. CEDPA (a U.S.-based subcontractor to JHU/PCS for this program) has assisted state ministries of education to incorporate an expanded range of primary health and population education concepts into existing secondary and post-secondary school curricula. The objectives of these workshops were to strengthen the inclusion of family life education. population, responsible parenthood as part of primary health care into these schools and technical colleges. Over 180 participants have been trained under these programs and now are developing state-level activities of their own.

Building on the momentum that CEDPA has created, the IEC component will concentrate its efforts on introducing Nigeria-specific print and audio-visual materials for use by teachers and as reference for students at the secondary and post-secondary school levels. This will be accomplished through a national workshop for CEDPA alumni trainers held to design a standard training curriculum for training teachers. Trainers' and teachers' guides and audio-visual materials, and students' reference materials specific to Nigeria will be designed and produced to be introduced to teachers during the workshops and implemented into the existing family life education curricula during the course of the five-year program. Family life education activities will continue to be encouraged and supported in LGAs identified as priority under the FMOH's Primary Health Care Delivery System. The public sector component also will be involved, as they have had substantial experience in developing family life education curricula.

As a special stimulant to further family life education, drama contests and debates will be promoted, and a national population quiz show will be developed and broadcast to involve competition from at least 300 secondary schools throughout Nigeria.

E. Critical Assumptions

The aforementioned activities can best be conducted in an environment supportive of family planning. It is expected that Nigerian leaders will increasingly support IEC activities for family planning. Mass media

channels and production facilities will be available and willing to promote family planning messages. Optimal support will come from appropriate government ministries in requesting broadcasting stations to provide free or substantially discounted airtime. The capability in Nigeria to design and produce large quantities of quality materials in a cost-effective way will continue. Since the IEC financial resources provided under this project are limited, other local and international donor agencies are expected to provide complementary financial, technical and material resources in institution building, materials development, skills training, equipment and supplies, and family life education at the secondary and collegiate levels.

F. Cost Recovery

Due to the high costs which will be incurred in developing, producing and airing or distributing IEC materials, it is proposed that several experiments in cost-recovery be explored:

- producing high quality "enterteach" radio and television specials and selling them to commercial sponsors;
- producing high quality recorded music tapes with educational messages and selling them in the commercial market;
- selling wall charts, user booklets, reference materials and posters to private sector health service providers;
- exploring possibilities with advertising agencies in combining "brand" specific materials with other appropriate products to share production and advertising costs; and
- exploring the possibility of buying radio and television block time and seeking several sponsorships for commercially viable family planning programs aired at that time.

The most promising cost-recovery opportunities will be undertaken on a pilot basis. Clear financial accountability will be set up to ensure that funds generated are accounted for and placed back into the family planning program.

G. Year One Work Plan

During the first year of the program, the following activities will be conducted:

- start-up of on-site JHU/PCS program office;
- participation with the other components in a nationwide baseline survey;
- analysis of results of rapid anthropological research conducted in the four major health zones of Nigeria by an identified technical resource agency;

- promotion of a national family planning logo, under the auspices of FMOH, which will identify sources of family planning commodities and services in both the public and private sectors;

- the development of clinical posters, reference cards and motivational materials under the direction of the Health Education Division of FMOH;

- the planning of a series of IEC packages, including video testimonials from traditional and religious leaders, based on workshops for opinion leaders conducted by the NCPA;

- the mass production of family planning methods-specific pictorial leaflets by PPFN;

- a national workshop under the auspices of the Ministry of Education and its appropriate agencies for teacher trainers to develop teacher and student materials for use in the family life education curricula in secondary and post-secondary schools;

- the adaptation of the RAPID presentation to video and film and the distribution of copies through the FMOI network and other outlets;

- a training of trainers workshop to design an IEC curricula for use in regional family planning training sites;

- the planning of an IEC materials development/social mobilization workshop for state and capital LGA officials;

- two on-going state level multi-media campaigns in Ogun and Borno states; and

- the development of IEC activities in five states with collaboration from the public and private sector components.

To effectively administer the subcontracts to be signed and the activities to be managed, an orientation workshop will be conducted for the on-site JHU/PCS program staff during the first two months of Year One.

Following is a detailed work plan for Year One.

	PRE	1	2	3	4	5	6	7	8	9	10	11	12
I. PRE-PROJECT ACTIVITIES													
1. Develop scope of work and identify and secure commitment from country representative	X												
2. Negotiate draft sub-contracts with U.S.-based agencies	X												
-CEDPA													
-PIACT													
-AED													
3. Develop scope of work and criteria for selection of on-site staff		X											
-5 program officers													
-1 fiscal analyst													
-1 administrative assistant													
4. Collect and shortlist program officer candidates	X												
5. Review and establish logistics of financial flow system from JHU/PCS to Nigeria	X												
II. START-UP ACTIVITIES IN-NIGERIA (ADMIN.)													
1. Place in-country representative		X											
2. Interview and final selection of staff		X	X										
3. Conduct orientation for in-country team			X										
-Fiscal													
-Administrative													
-Programmatic													
-5 year implmentation tasks													
4. Finalize sub-contracts with US-Based agencies		X											
-CEDPA													
-PIACT													
-AED													
5. Identify and establish counterpart at FMOH		X	X	X									
6. Discuss/review work plan Year 1 in context of 5 year program with FMOH counterpart and reps of key IEC agencies			X										
7. Participate in baseline survey conducted by Public Sector			X										
8. Identify and secure commitments from major national-level subcontractors:				X	X								
-NCPA													
-FMOH (HEU)													
-FMOI													
-PPFN													
-Resources Group													
-NERC/NETC/M. of Ed.													
9. FMOH establishes Organizing Committee to conduct national logo competition	X												
10. Logo competition conducted	X												
11. Five finalists chosen;National logo picked	X												
12. Logo printed on posters, flags, stickers		X	X	X	X								

	PRE	1	2	3	4	5	6	7	8	9	10	11	12
III. ADVERTISING AGENCY													
1. Develop sub-agreement with a primary private sector distributor					X	X							
2. Assist distributor to develop a brief for at least 3 advertising agencies; interface with market research						X	X	X	X				
3. Review advertising agency proposals										X			
4. Select advertising agency											X		
5. Contract with advertising agency signed											X		
6. JHU/PCS and major distributor reviews and approves detailed media plan												X	X
7. Ad. agency develops point of purchase materials (P.O.P) Process continues through Yr. 2													X
IV. NCPA													
1. Discuss and finalize contract to provide IEC support for series of national workshops and promotional campaigns for: -Traditional and Religious leaders -NGO'S and PVO's -Media -Business -Medical Personnel -other Interest Groups		X	X	X									
2. Prepare active media campaign about population issues					X	X							
3. Conduct campaign for mass media coverage of population issues							X	X	X	X	X	X	
4. Establish IEC committee for organizing design of IEC packages: -Business leaders -Traditional leaders -Islamic leaders			X	X									
5. Develop IEC Packages IEC packages available beginning of Year 2.						X	X	X	X	X	X	X	
V. FMOH/HEALTH EDUCATION UNIT													
1. Develop and finalize sub-contract with HEU of FMOH to design, develop and distribute 3 types of print materials -Family planning methods clinical wall chart -Motivation posters,(to be designed by region) -Method specific cue cards					X	X							
2. Determine technical assistance and support from appropriate agency in developing materials					X	X							
Design of family planning Methods Clinical Wall Chart -English -Split poster to include traditional methods and modern methods.							X	X	X	X			
3. Design of Motivational Posters -2 distinct messages -each poster in 4 major languages							X	X	X	X	X		
4. Design of Methods - specific cue cards -4 methods -English -includes risks, benefits, application							X	X	X	X			
Print materials materials produced and distributed in Year 2.													

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	PRE	1	2	3	4	5	6	7	8	9	10	11	12
VI. PPFN													
1. Discuss and finalize subcontract with PPFN to revise format of existing family planning methods booklets and agree on distribution plan						X	X						
2. Revise format of booklets to a folded leaflet or small pocket-size booklet								X	X	X			
-Condom													
-IUCD													
-Pill													
-VSC													
-Injectable													
-In Hausa, Yoruba, Ibo, Pidgin English													
3. Approval of camera-ready art											X		
4. Bidding and selection of printer											X	X	
5. Printing of first batch of 3 million copies total												X	X
Materials available Year 2													
VII. FAMILY LIFE EDUCATION													
1. Develop and finalize with appropriate Ministry of Education institutions a strategy to (a) implement family life education training of trainers workshop; (b) develop teachers/student materials, and (c) conduct state workshops for teachers			X	X	X								
2. Interface with World Bank, UNFPA and Public Sector Component on strategy						X							
3. Finalize program with appropriate MOED institutions					X	X							
4. Establish Executive Committee responsible for implementing action plan						X	X						
5. Plan National workshop							X	X	X	X			
6. Conduct National workshop and augument Executive Committee with 4 regional representatives										X			
7. First Executive Committee meeting to review workshop and submit ideas and drafts										X	X		
8. Commission drafting of materials											X	X	
-Trainer materials													
-Teaching materials													
-Student materials													
Process continues through Year 2													
VIII. RAPID/TV													
1. Final script approved in writing and submitted to Prime television for production	X												
2. Fixed Price Contract signed by Prime television	X												
-Production of Video													
-Pre-test													
-Revision													
-Duplication													
3. Letter of Agreement with FMOH to organize Committee to pre-test, revise and approve video	X												
-FMOH													
-FMOI													
-NTA													
-Prime television													
4. Production of Video	X												
5. Pretest and revision of video	X												
6. Final copy of video available	v												

	PRE	1	2	3	4	5	6	7	8	9	10	11	12
7. Committee designs distribution/airing strategy through NTA channels and FMOI	X												
-Sets schedule													
-Number of copies of video and film													
8. Preview of video by appropriate officials	X												
9. television/radio/newspaper publicity of airtime of program	X	X											
10. Program aired	X	X											
11. Video duplicated		X											
12. Video transferred to film and duplicated		X	X	X									
13. Distribution of films and video through all possible outlets			X	X	X	X							
14. Showing of films				X	X	X	X	X	X	X	X	X	X
IX. TECHNICAL RESOURCE AGENCY													
1. Review and approve plan for conducting rapid anthropological research in 4 major ethnic areas:	X												
-Methodology													
-Personnel													
-Timetable													
-Budget													
2. Execute audience research work plan	X												
3. Compilation and analysis of results	X												
4. Research results available		X											
5. Identify technical resource agency to provide Nigerian-based technical assistance:		X	X										
-Audience research in four major ethnic areas													
-Materials development and pretesting													
-IEC training													
-Planning													
-Project design and development													
6. Finalize subcontract with agency			X										
7. Agency provides T.A. in further research, materials development, training, workshops, planning, project design, monitoring and evaluation.				X	X	X	X	X	X	X	X	X	X
X. TRAINING OF TRAINERS: IEC CURRICULA (To be held for 4 trainers each from UCH, OGUN, OWERRI, ZARIA)													
- 2 week workshop to learn IEC concepts and design 5 day IEC curricula													
1. Discuss and finalize workshop with appropriate agency.		X	X	X									
2. Interface with Public and Private Sector team.		X	X										
3. Sign subcontract which includes:			X										
- organizing committee made up of representatives from 4 regions													
- development with committee of training curricular for workshop													
- availability of training materials for trainers' use back home													
4. Plan workshop				X	X	X	X						
5. Conduct 2 week workshop and design curricula to be used in regional training centers									X				
6. Monitor inclusion of curricula into family planning school curricula										X	X	X	X

	PRE	1	2	3	4	5	6	7	8	9	10	11	12
XI. MOBILIZATION/IEC WORKSHOP													
1. Identify appropriate resource agencies to conduct workshops				X	X	X							
2. Discuss and finalize subcontract with selected agency						X	X						
3. Develop strategy of series of workshops to cover major zones, 19 states and at least 20 LGAs								X	X				
4. Plan first workshop to include five-six states									X	X	X	X	
interface with appropriate agencies to provide planning equipment and materials													
Process continues through Year 2. Workshop to be held Year 2.													
XII. STATE AND SPECIAL ACTIVITIES*													
A. Activities already in place and continued through March 1988													
1. Ogun State multi-media campaign													
-Subagreement to be signed June 1987	X												
-Major activities to be implemented implemented	X	X	X	X	X	X	X	X	X	X	X	X	X
2. Borno State IEC campaign													
-Subagreement to be signed June 1987 June 1987	X												
-Major activities to be implemented	X	X	X	X	X	X	X	X	X	X	X	X	X
B. New state activities to be developed and finalized													
1. Rivers State IEC action program	X	X	X	X									
2. Kaduna State IEC action program	X	X	X	X									
3. Niger/Abuja State IEC action program	X	X	X	X									
4. Benue State IEC action program	X	X	X	X									
5. Lagos State IEC action program	X	X	X	X									
C. New state activities implemented				X	X	X	X	X	X	X	X	X	
XIII. MONITORING		X	X	X	X	X	X	X	X	X	X	X	X

*Note: All of the above activities will be funded by all remaining Nigeria Buy-in monies before expending monies from the 5 year program budget for above activities.

IV. COMPONENT MANAGEMENT

In order to effectively manage the range and variety of activities proposed in the IEC component throughout the 19 states and the Federal Capital Territory, it is essential that the activities are consolidated into manageable groups.

It is expected that all the activities could be consolidated and managed at an average yearly rate of 20 contracts. This consolidation reflects the complex characteristic of managing an IEC program in a multi-ethnic society within a federal system of autonomous states. It demonstrates that a national program has to be operated at the national (sometimes regional), state and LGA levels simultaneously if one is to be effective in communicating and reinforcing messages on family planning.

The management approach proposed for the IEC component is to consolidate all national and regional activities into seven major networks. The most promising organizations representative of these networks include:

- the National Council on Population Activities for IEC packages addressed to influentials;
- the Federal Ministry of Health, Health Education Division, for clinic-related print and audio-visual materials;
- an advertising agency to support the private sector program;
- the Planned Parenthood Federation of Nigeria for development and production of user-oriented materials for both the public and private sector outlets, as well as organizing regional IEC workshops;
- the National Education Technology Center and the National Educational Research Center under the Federal Ministry of Education for the family life education program;
- the Federal Ministry of Information for developing video and 16 mm films for mobile vans and for training of information officers at the LGA level; and
- a technical resource agency to provide local expertise in IEC research, design, planning, materials development, training and workshop management.

At the state level, similar consolidation will take place as this has proven successful in previous JHU/PCS projects. Instead of directly contracting the development of print materials to a printer, the production of drama programs to a television or radio station, the training of health workers in motivation skills to an education institution, and the distribution of materials to one of the state ministries, one sub-agreement was initiated, usually with the state ministry of health, to coordinate and manage all the activities. Technical support was provided as needed. But on-site monitoring and timely technical assistance is key to the success of this management

approach. Flexibility also must be retained depending on the unique strengths and resources in each state.

To manage the range of IEC activities proposed in the next five years and to provide timely technical assistance support, JHU/PCS will field a country representative supported by five Nigerian program officers and a financial and administrative staff. Four of the five program officers will be responsible for activities occurring at the regional, state and LGA in each of the four regional health zones. They will be recruited from and positioned in the northern, eastern, central and southwestern zones of Nigeria. The fifth program officer will be responsible for activities occurring in Lagos at the national level. The program officers will be responsible for designing, implementing, monitoring and evaluating activities in their regions. They also will be expected to provide timely technical assistance visits and will be supplemented by U.S.-based consultants and staff from JHU/PCS and its subcontractors (PIACT, CEDPA and AED). A fiscal analyst and administrative assistance will provide fiscal and administrative support.

To further strengthen the management approach, a Nigerian technical resources agency will be identified to provide technical assistance to a majority of activities throughout Nigeria. These services include research, project design, the management of workshops, materials development, monitoring and evaluation support and other technical expertise as the occasion arises. In some instances, U.S.-based consultants may be teamed up with local consultants to perform joint assignments, hence ensuring better follow-up in the field.

The country representative will be the paramount responsible party accountable for all activities in Nigeria. The representative will act as a liaison with JHU/PCS in the United States, as well as with federal ministry level officials and counterparts and USAID/Lagos. Much of the country representative's work resides in supervising the work of the program officers and providing a link with available technical resources.

A senior program officer and support staff will be situated in the U.S. to provide administrative and programmatic support. JHU/PCS Principal Investigator, Project Director and Deputy Project Director will also provide programmatic and technical expertise. The country representative will be accountable to the management of JHU/PCS. All subcontracts will be cleared in the home office (Baltimore) and entered into agreement between the Johns Hopkins University and the subcontractors.

A. Collaboration with the Federal Government of Nigeria

Counterparts in appropriate departments of the Federal Ministries of Health, of Information, and of Education will be established in order to involve the respective ministries in the design and implementation of activities. An *ad hoc* expanded IEC coordinating/planning committee to be composed of all major private and public sector agencies involved in IEC will be established jointly by FMOH and USAID. A similar relationship will be encouraged at the state and LGA levels, whenever possible, by the regional program officers.

B. Collaboration with Other Implementors

The IEC country representative, the five program officers and supporting staff will work closely with the public sector, private sector and policy implementing component representatives and the AID project coordinator. This collaboration will be manifested in regular and ad hoc meetings, joint planning, joint field visits and joint accountability for certain program outputs. The sharing of some support staff, office space, equipment and supplies will enhance the collaborative nature of the project. This could be made more meaningful if a financial system is set up whereby the major contractors only use one bank. This would increase project leverage to ensure that funds wired from the U.S. are available on a timely basis. Similar collaboration is expected in the U.S. among prime and subcontractors: sharing of information, coordination of field visits, and general program support.

C. Collaboration with Other Donor and Lending Agencies

The activities planned under this five year program are substantial in number and content. But considering the size of Nigeria, they are insufficient. Moreover, the continual technical and material resources needed to maintain if not improve the status of IEC activities in Nigeria will demand substantial resources that cannot be covered by the financial resources allocated in this project. Many of the activities proposed also can be supported, expanded or deepened with material, equipment, and technical expertise from international agencies like UNFPA, the World Bank, UNICEF and UNESCO. UNFPA is particularly strong in family life education through its project with NERC executed by UNESCO. Complementing and coordinating activities in this area will be most important. Use of existing UNICEF facilities like printing presses also will be explored. The World Bank currently is supporting a maternal and child health project in Sokoto and is finalizing one in Imo. One area in which major agencies like UNFPA and the World Bank could focus is on institution and infrastructure development at the national, state and LGA levels. Continuous dialogue will be conducted with these international donor agencies to exchange information on how best their resources and expertise could complement this program. The JHU/PCS representative will also work closely with UNICEF officials in Nigeria to assure the inclusion of child spacing messages in their IEC efforts.

D. Collaboration with USAID

A major program supported by USAID in Nigeria is HealthCom under the CCCD project. HealthCom has recently begun planning and designing its activities in the aspects of IEC activities to promote the immunization program, the use of oral rehydration salts, child spacing, and the prevention of malaria. JHU/PCS will work closely with HealthCom in identifying opportunities for a) joint IEC training workshops, b) co-sponsorship of regular radio or television programs, c) sharing of research findings needed for IEC planning and materials development.

V. MONITORING AND EVALUATION PLAN

A. Monitoring

Based on JHU/PCS experience, the key to successful projects in Nigeria is close monitoring and supervision of the project. The establishment of an on-site JHU/PCS team with regional program officers to monitor and provide technical assistance in the field will greatly enhance the quality and speed of project implementation. It is planned that for every activity implemented, an average of six monitoring/technical assistance visits will be conducted for every 12-month period.

Other sources also will be used to collect benchmark information for monitoring purposes:

- a compilation of all IEC materials and final reports of activities undertaken in Nigeria, classified by state;
- quarterly progress and financial reports from on-going activities;
- participation and access to data collection under the policy, public and private sectors' research projects (surveys, market research, service statistics);
- processed clinic-referral data in states prior to and following state and LGA IEC campaigns and activities;
- rapid anthropological types of audience research at the regional and state levels; and
- built-in project-specific monitoring and evaluation components as terms of agreement in contracts (e.g., simple recall surveys, pre and post knowledge tests, coupon turnovers, focus group discussions, content analysis, etc.).

B. Evaluation

The JHU/PCS project proposal format requires that all primary objectives are accompanied by evaluation criteria. This ensures that every project has evaluation plans prior to the onset of the activity.

The on-site JHU/PCS team can draw upon the following resources for technical assistance in developing and implementing evaluation plans:

- U.S.-based JHU/PCS staff and consultants;
- JHU School of Hygiene and Public Health faculty; and
- Nigeria-based technical resource agency.

Large-scale evaluation will be integrated into formative and summative research conducted by the public sector component and into market research activities undertaken by the private sector component. Close collaboration with the components' plans for data collection will be actively sought to identify opportunities to insert IEC-specific questions and concerns.

VI. FINANCIAL PLAN

A. Proposed Financial System

USAID/REDSO/WCA shall make available to Johns Hopkins University such amounts as necessary to carry out the yearly work plan through a Federal Reserve Letter of Credit. Of the total budget available for the IEC component, $7.1 million is in foreign exchange and $7.9 million is in local currency costs. A quarterly financial report will be submitted by JHU/PCS to USAID and REDSO.

B. Method of Financing

1. U.S.-based Subcontracts

For U.S.-based subcontractors of JHU/PCS, an established operational procedure is currently in place with AED and PIACT. This system will also be used with CEDPA. JHU/PCS enters into a five-year subcontract with the above organizations and provides a ceiling on the budget. An annual work plan and budget are negotiated each year to implement that year's activities. Individual written requests entitled "Request for Services" are submitted to the subcontractors by JHU for each major activity. Monthly progress and financial reports are submitted to and received by JHU/PCS staff.

2. Nigeria-based Subcontracts

JHU/PCS has also developed a system of disbursing funds and building accountability in implementing projects in Nigeria. Most projects are executed through a sub-agreement format or a fixed-price contract. The contractors are required to open a separate non-interest bearing account in the name of the project, and not comingled with any other project funds.

The contractors submit quarterly progress and financial reports in formats provided by JHU/PCS. Reporting formats contain built-in indicators to determine the amount needed for the next disbursement of funds to the project. JHU/PCS reserves the right to conduct audits of the project when deemed appropriate.

The sub-agreement format is normally used in projects which require a series of activities and services that are not easily defined in units. Fixed-price contracts are normally used for projects under $25,000 in which the unit of output and price is well-defined and fixed. Payment is rendered only after an acceptable product is delivered.

JHU/PCS will introduce established operational procedures used with U.S. based subcontractors to one of its subcontractors in Nigeria - the chosen technical resource agency. This subcontract, however, will be in local currency, not in U.S. dollars.

Based on previous experience with state-level sub-agreements with the ministries of health, JHU/PCS provides resources for agreed upon inputs and outputs and allows the MOH to subcontract some of the IEC activities to outside agencies (e.g., printers, radio and television stations).

The use of established financial management systems currently in place within JHU/PCS, and its relations with both U.S. and Nigeria-based subcontracts will allow for both flexibility and accountability in the management of the funds. To ensure that the financial systems are understood, JHU/PCS will brief all its subcontractors on financial and administrative procedures early in the life of the five-year program.

C. Host Country Contributions

The host country government is expected to complement the IEC component budget of $15 million with an estimated in-kind and indirect cost of about $3.7 million, or roughly 25 percent of the USAID contribution. This amount is calculated by assigning cost values to (1) the amount of time all federal, state and LGA personnel who are expected to be involved in various IEC activities (20 percent of salaries of about 212 personnel at all levels; (2) office space contribution computed at 10 percent of total estimated salaries; (3) use of government vehicles estimated at $125 per person per year, and (4) 40 percent of free radio and television production and airtime. The budget estimate for the life of the project follow:

Salaries	$1,433,000
Office space	$ 703,300
Vehicles	$ 580,000
Airtime/Production	$ 957,569
Total	$3,673,869

Following is a detailed Year One budget and an overall five-year budget projection.

BUDGET WORKINGS (SHEET) IEC Final Totals IECBTOT

(Inflated prices)	Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
PERSONNEL	221,400	342,396	397,746	265,680	357,267	415,023	318,816	412,355	475,363	463,478	240,635	323,904	509,826	277,030	360,300	1,779,201	1,629,683	1,972,336
CONSULTANTS	0	28,350	28,350	0	29,768	29,768	0	31,256	31,256	0	32,819	32,819	0	34,460	34,460	0	156,652	156,652
TRAVEL & PER DIEM	373,648	100,409	193,821	448,378	105,429	202,903	538,053	110,701	217,036	557,644	116,236	216,424	613,408	122,048	222,235	2,531,131	554,823	1,052,419
EQUIPMENT & MATERIALS	0	203,085	203,085	0	98,892	98,892	0	16,474	16,474	0	17,298	17,298	0	18,163	18,163	0	353,913	353,913
SUBCONTRACTS	2,545,776	528,944	1,165,388	8,111,347	585,554	2,348,890	8,759,987	649,671	2,380,894	9,776,739	722,393	2,478,904	5,700,861	804,987	1,736,105	34,894,710	3,291,549	10,110,180
OTHER DIRECT COSTS	0	42,420	42,420	0	47,166	47,166	0	49,524	49,524	0	52,001	52,001	0	54,601	54,601	0	245,711	245,711
OFFICES / FACILITIES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INDIRECT COSTS	190,415	166,264	213,868	228,498	174,698	224,371	274,198	195,345	249,534	326,759	143,563	202,270	359,435	158,538	217,244	1,379,306	838,407	1,107,287
T O T A L S	3,331,239	1,411,868	2,244,678	9,053,903	1,398,773	3,367,013	9,691,054	1,465,327	3,420,081	11,124,621	1,324,944	3,323,619	7,183,531	1,469,827	2,643,108	40,584,348	7,070,738	14,996,497
Annual Inflation rate	0%	0%		20%	5%		20%	5%		10%	5%		10%	5%				
Dollar : Naira rate			4.00			4.60			5.06			5.57			6.12			

Indirect costs % rate 32.00% - Applied to Personnel, Consultants, Travel, Equipment (only $6000 pa supplies) & Other Direct Costs

********** YEAR 1 BUDGET **********

BUDGET WORKINGS (DETAILED SHIFT)

JHU - US based

IEC1BDTL

(Current - 1987 - prices)

		<------- N	Year 1 $	-------> Total $ Equiv.
PERSONNEL				
Salaries				
- Prin. Investigator			6,000	
- Project Director			2,915	
- Dep. Proj. Director			9,900	
- Sr. Prog. Officer			30,800	
- Prog. Asst./Officer			19,360	
- Secretary			15,400	
- Contract Spec.			9,240	
- Financial Spec.			16,500	
- Administrator			5,775	
- 3 SPO/PO support			11,550	
Fringe benefits	24.00%		30,586	
Subtotal			158,026	158,026
CONSULTANTS				
6 TA's/year, av.21 days (18 in country) @	$225		28,350	
Subtotal			28,350	28,350
TRAVEL & PER DIEM				
International travel				
- 4 trips/year x 3 staff				
- 6 consultant trips/year				
= 18 trips @	$2,500		45,000	
Local travel				
- 21 days x 4 x 3 staff				
- 21 days x 6 consultants				
= 378 days @	$20		7,560	
Travel in US				
- 6 trips/year from Baltimore @	$140		840	
- 24 trips/year Baltimore - DC @	$30		720	
Per diem				
- 21 days x 4 x 3 staff				
- 21 days x 6 consultants				
= 378 days @	$98		37,044	
- 6 US 2 day-trips @	$75		900	
- 24 US 1 day-trips @	$30		720	
Subtotal			92,784	92,784

********** YEAR 1 BUDGET **********

EQUIPMENT & MATERIALS				
IBM PC & printer			2,600	
Typewriter			800	
Supplies			6,000	
IEC equip. for Nigeria			193,685	
Subtotal			203,085	203,085
SUBCONTRACTS				
1. On-site workshop		3,400		
2. Production of logo		200,000		
3. Ad. agency PDP materials		40,000		
4. NCPA mass media		198,000		
5. FMOH devt. print materials		28,000		
6. PPFN prod. methods leaflets		772,000		
7. CEDPA FLE		145,300		
8. FMOH rapid video/film		64,000		
9. Tech. resource agency		221,540		
10. TOT IEC curricula		63,296		
11. IEC mobil. workshop		98,240		
12. State-level activities		580,000	**	
13. Ad. agency media campaign		0	**	
14. Admin./mgmt. workshops		0		
15. Specialised IEC workshops		0		
16. Music Industry		0	**	
17. Baseline survey		132,000		
18. AED			120,504	
19. PIACT			163,773	
20. CEDPA			244,667	
Subtotal		2,545,776	528,944	1,165,388
OTHER DIRECT COSTS				
Communications				
- Postage ($150/m)			1,800	
- Courier (4/m @ $50)			2,400	
- Telephone (4/m @ $40)			1,920	
- Telex (4/m @ $75)			3,600	
Overseas training				
- 4 courses/year				
Travel	$2,500		10,000	
21 days per diem	$75		7,500	
21 days travel	$20		2,000	
Materials/course	$125		500	
Tuition fees	$2,500		10,000	
Bank charges			2,700	
Audit fees (yrs 2-5)			0	
Subtotal			42,420	42,420

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********** YEAR 1 BUDGET **********

INDIRECT COSTS		104,825	104,825
T O T A L S	2,545,776	1,158,434	1,794,878

Dollar : Naira rate 4.00

Indirect costs % rate 32.00% - Applied to Personnel, Consultants, Tra

********** YEAR 1 BUDGET **********

BUDGET WORKINGS (SHIFT)

JHU - Nigeria based

IEC2BDTL

(Current - 1987 - prices)		<------- N	Year 1 $	-------> Total $ Equiv.
PERSONNEL				
Salaries & benefits				
- Country representative			184,370	
- 5 Program officers		105,000		
- Fiscal Analyst		18,000		
- Administrator		15,000		
Fringe benefits	30.00%	41,400		
Housing		42,000		
Subtotal		221,400	184,370	239,720
TRAVEL & PER DIEM				
International travel				
- Country Rep : 1 trip/year				
- 5 POs : 1 trip each / 5 years				
= 2 trips pa @	$2,500		5,000	
Local travel				
- Country Rep : 180 days pa				
- 5 POs : 180 days each pa				
- Fiscal Analyst : 60 days pa				
- Admin Assist : 28 days pa				
= 1168 days @	$20	93,440		
- 72 local flights @ N	250	18,000		
- Country Rep : Lagos travel/month	$50	2,400		
Per diem				
International travel				
- Country Rep : 14 days/trip				
- 5 POs : 21 days/trip				
= 35 days pa @	$75		2,625	
Local travel				
- Country Rep :				
180 days - Expat @	$80	57,600		
180 days - Local @	$50			
- Local staff : 988 days @	$50	197,600		
- Lagos meetings 12 people/month @	$8	4,608		
Subtotal		373,648	7,625	101,037
INDIRECT COSTS	32.00%	190,415	61,438	109,042
T O T A L S		785,463	253,433	449,799

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ANNEX K

POLICY IMPLEMENTATION COMPONENT WORK PLAN

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ANNEX K

POLICY IMPLEMENTATION WORK PLAN

I. EXECUTIVE SUMMARY

The purpose of this component is to strengthen processes of policy implementation and strategic planning needed in Nigeria for efficient mobilization of public and private sector resources into a dynamic, effective and self-sustaining national family planning program. This component builds on the solid policy development accomplishments of the Federal Military Government of Nigeria (FMG) over the past few years. These include the development of a national population strategy, a federal family planning action plan, 19 state action plans, and 10 local government action plans.

Activities under this component are grouped under five general functional categories. The proposed activities have been identified on the basis of previous experience and joint assessments with key Nigerian leaders as to their importance for immediately advancing the national program, building the framework for solid future growth, and feasibility. The proposed activities are interdependent and link with the three other components.

The general categories of project activity are as follows: (1) strengthening strategic planning functions; (2) building a sound financial basis; (3) enlisting key constituencies for the national program; (4) developing institutional capacities for effective programs among administrative leaders, policy advisory groups, and non-governmental organizations (NGOs); and (5) establishing systems for monitoring and evaluation that can quickly capture experience, help guide program improvements and enhance policy support. Under these subject areas, the particular activities to be undertaken in the first year will concentrate on promising action lines already underway such as the development of detailed plans at the state and local government area (LGA) levels, work with Moslem groups, and certain other pressing policy needs. The program of activities each year will be adjusted as needed to respond to emerging program issues and opportunities.

The conditions now in Nigeria for this project assistance are unusually receptive, in terms of readiness for action, availability of human resources, magnitude of host country contribution, crucial need, and potential for impact.

This policy component will work through the Federal Ministry of Health, (FMOH) Office for Planning and Coordination of the Population Program (OPCPP); the Federal Office of Statistics (FOS), National Population Board (NPB), and the National Council of Population Activities (NCPA), a non-governmental organization. Contract management of this project component will be carried out by the UNC, which has effectively worked over 20 years with many AID population program contracts overseas, especially in Nigeria. The Project Director at UNC will maintain close contact with USAID, with component subcontractors and with concerned U.S. agencies. He will stress working directly with colleagues in Nigeria. A senior Nigerian staff representative in Lagos will be engaged to assure

continuing attention to this program component. In the development of project activities, special efforts will be made to identify and enlist Nigerian expertise, and to work with and through Nigerian institutions (especially NCPA), in order to gain the advantages thereof and also to help build institutional capacities.

II. BACKGROUND

Population policy and program implementation have evolved to a marked degree in Nigeria in the past two years. Indeed other African countries are borrowing the Nigerian model of how to build a system to sustain a comprehensive program for changing demographic patterns. Nigeria's pioneering role in involving the private sector, which has been adopted at federal, state and local levels, is being carefully studied by Brazil and Colombia for possible replication within their systems.

After a systematic presentation of national demographic and policy issues through the RAPID presentations at the national level and to various state leadership groups, a consensus supportive of family planning emerged in various constituencies. Nigerian experts, in collaboration with U.S. and World Bank technical assistance, developed:

- a National Population Policy and Strategy;
- a Federal Family Planning Action Plan;
- 20 state plans; and
- 10 LGA action plans (out of 304).

Nigeria has instituted:

- family planning services in every state and about two-thirds of its LGAs;

- family planning IEC programs to promote small family norms in 50 percent of the states; and

- a line item in the federal budget and most state budgets for family planning.

Nigeria has actively encouraged and supported the involvement of:

- ministries in addition to health at the federal and state levels;
- the for-profit commercial sector; and
- the voluntary and religious communities.

In spite of these great strides, this current policy "umbrella" is only a beginning on the long road to institutionalizing population policy implementation, through decisions and actions in the three levels of government and more importantly within individual families.

The public and private sector components will work with Nigerian counterparts to assure that voluntary, quality family planning services are available at reasonable costs to the majority of the populace. The IEC component will support the Nigerian media and appropriate voluntary and governmental entities in informing couples of the dangers of high risk pregnancies and the benefits of smaller families. The policy implementation component will support the three other components by

working closely with key ministries/organizations, voluntary associations and leadership groups to institutionalize population planning and implementation as an integral part of Nigeria's development process and to assure a supportive climate for family planning programs.

Policy development actions are important at all levels; the more so because of Nigeria's federated system of government which delegates most responsibilities to the states and because of recent governmental decisions which have further delegated responsibilities to the LGA level. This is particularly true in the health and education areas where most of the action for a successful population program must take place.

III. TECHNICAL APPROACH

A. Introduction

The main objective of this component is to enhance population policy development and implementation and to strengthen program planning, coordination, monitoring and evaluation, at federal, state and local levels. For these purposes, more specific objectives are: (1) enhancing strategic planning functions, through developing related skills, procedures and systems at all levels, in order to mobilize resources, coordinate inputs, and use feedback to adjust program systems for maximum effect; (2) building a broader and stable financial base as needed for program activities; (3) strengthening basic support of key constituencies for the national population program; (4) developing institutional capacities for policy and program planning support as needed at national, state and LGA levels; and (5) establishing mechanisms to monitor and evaluate progress toward particular policy and program goals, and establishing mechanisms for corrections in ways that reflect evolving policy and program needs and provide rapid feedback into planning decisions.

The development of the policy implementation component will involve the five areas just enumerated above. These activities will take place over the life of the project. After the first year, the emphasis will be adjusted to reflect changing conditions. The policy component activities will especially help to link all the FHI project components effectively into a total national program.

These activities will be carried out principally through the NCPA, a non-governmental organization; FMOH/OPCPP; the NPB; and other Federal Government agencies. The UNC or its collaborating agencies will provide technical and financial support in the implementation of this program.

Policy development and implementation is a long-term process that requires intensive and sustained efforts including technical assistance, data collection and analysis, training, etc. It is necessary to reach the diverse groups that influence policy decisions and that can facilitate or impede program development. Over the life of the project, activities of this component will reach over 1,500 policy level personnel at the federal, state, and LGA levels, as well as over 2,000 members of key constituency groups outside of the government.

Under each of the five functional categories below are summarized the program approach and the specific activities necessary to carry out the population policy implementation component.

1. Strategic Planning Processes

Given the magnitude of the family planning effort currently underway in Nigeria, strategic planning will be of paramount importance. The expanded family planning program will require vastly enlarged capacities for strategic planning (as well as execution) at federal, state and LGA levels. The strategic planning process is already underway. So far, development of simple, prototypical planning frameworks for application at state and more recently at LGA level, has been well received by concerned officials and extremely helpful in initiation of further planning steps. Thus the support in this regard from AID-supported contractors (RAPID, Options, Management Training/MSH and Pathfinder) has already been instrumental in the significant progress made to date in the development of planning skills and in leadership support.

State family planning coordinators and their supervisors at all levels need to develop skills in problem analysis and problem solving as well as in designing realistic operational strategies. Ninety-five percent of the LGAs need to develop five-year plans similar to those prepared in Lagos State with support from AID's Options project. An annual review of the federal and state plans plus those of the Lagos LGAs must be undertaken. The project will assist the 52 model primary health care (PHC) LGAs in their plan development, as well as another 150 over the life of the project covering approximately two-thirds of the LGAs. For these LGAs, priority attention will be given to developing local planning and management skills. This PHC emphasis will start as a pre-project activity with support from USAID's CCCD Project and the Management Training/MSH Project.

The policy implementation component will foster enhanced planning capability through:

a. intensifying and expanding capabilitiy at the LGA level; and
b. developing and applying new planning methodologies.

a. Extension of current activities. Current activities to develop state and LGA plans will be enhanced and intensified under the current project. Mechanisms will be put into place to bring about their systematic review, evaluation and coordination at the state or national level. An initial step in this institution building will be the commissioning of a study, probably by the Institute of Local Government or Nigerian Institute for Social and Economic Research (NISER) to assess a sample of LGAs in terms of their organization structures and their capacity to plan and manage programs. The study would also make recommendations for strengthening LGA leadership. Assuming the successful conclusion of this effort, the Institute or NISER would be further contracted to assist LGAs, initially the 52 model LGAs, to develop their five-year family planning plans as an integral part of their primary health care system.

The policy implementation component also support an annual strategy planning seminar for all senior federal and state planners and representatives of cooperating agencies to update their five year plans, as first developed at the JHPIEGO 1986 planners workshop. A total of four seminars will be held over the life of the project, with approximately 30 high-level participants in attendance. They will be held in the United States in alternate years. These seminars will include technical updates on such matters as AIDS, ORT, drug abuse, as well as fertility technology. But they will concentrate on the results of an annual independent state-by-state work plan evaluation, carried out with the public sector component, two months prior to the senior annual workshop. The policy component will also participate with the three other components in the annual workshop for all state FP coordinators and deputies. (This is a follow on to the Bauchi workshop in 1986 and Port Harcourt workshop scheduled for October 1987.) The policy implementation component will support the preparation of case studies and other materials for utilization at the Planners' Seminar and the Coordinators' Workshop. From the Planners' Seminar will come a broad annual strategy to be refined and finalized at the Coordinators' Workshop.

To summarize these steps, an illustrative annual calendar is shown below:

January	-	State level program evaluations
February	-	Evaluation data available (NPB, FOS, etc.)
March	-	"Summit meeting" for national program review
April	-	National Health Council Meeting
June	-	State Family Planning Coordinators' meeting (except in 1987 when it meets in October)
July	-	State and LGA program annual plans
August	-	AID collaborator planning; possible other assistance
October	-	(Special national/regional/state seminars)
December	-	Preparations for state level evaluations

b. Development and use of policy and planning tools. At the federal level especially, there is demonstrated need to develop a simple management information system (MIS) for general information, control, and planning purposes. This should help to summarize current information about policy and program developments in the states and to track and coordinate various inputs and project activities in different activity areas. This system will be developed by the FMOH and the NCPA with technical assistance through the policy implementation component. This mechanism can also serve to track the inputs to the policy component. Topics include: state and LGA family planning organization development and delivery system data; constituency group activities and program support being provided to them; the stage of development of and findings from monitoring systems; activities in the private sector; IEC activities and plans; related policy developments (e.g., regarding women's status and marriage age), etc. Such a system can be developed in very simple form in the near term, and then grow. It will eventually be a component part of the overall project MIS. The policy implementation component will provide technical assistance to these efforts.

2. Financial Support

The policy implementation component of the FHI project recognizes the critical need for continued financial commitment to family planning programs if accepted policy goals are to be reached. :This is manifest in two ways:

a. commitment of ordinary budgetary resources to family planning; and
b. recovery of costs at the local level so as to eventually phase down the reliance on external donors.

Steps toward achieving these financial goals will take place at different rates as programs evolve throughout the country.

The expansion of family planning programs in Nigeria is predicated on the ability to use existing personnel in the public sector health system at various levels, without large requirements for additional recurring costs or other new budgetary arrangements.

Nevertheless, there still will be continuing need to ensure that governmental budgets at every level include provisions to meet specific needs of expanding family planning program activities not otherwise covered. These may include, for example, costs of strengthened supervisory activities (including travel, staff training, supplies, outreach activities and IEC, etc.). States and LGAs will eventually need to budget for purchase of contraceptive supplies. Some states have already shown their political commitment to population programs by including budget line items for the family planning program.

a. Activities to bring about financial committment to family planning programs at all levels of the governmental system emphasize the importance of investments in family planning and the essential soundness of such investments. Specific activities include:

1) development and presentation of RAPID-type cost/benefit models of family planning for budget decision-makers. These models will be adapted by the NPB from the many already available technologies (through the Options Project, for example). UNC and its collaborating agencies will provide necessary financial and technical assistance. A series of presentations/ discussions/seminars will be carried out by the NPB over the life of the project;

2) analysis of family planning programs needs at the implementation level. During the first project year, a policy diagnostic study of existing famiy planning programs operations in various states will be carried out. The aim of this study is to show LGAs how to make the case for budgetary support through:

- application of sound fiscal management techniques to existing budgets; and
- techniques of advanced budgetary and program planning.

LGAs will thereby be able to convince political leaders at various levels of the soundness of investment in family planning.

This study will be carried out by the widely respected Agricultural and Rural Management Training Institute (ARMTI) headquartered in Ilorin. This institution, which has been greatly strengthened by World Bank support, will analyze existing family planning operations in several states and LGAs in order to recommend fiscal management procedures including timely and proper use of funds. Findings and recommendations will be presented and discussed at the third annual Family Planning Coordinators' workshop in June 1988. In future years, coordinators will be trained in how to present budget analyses and how to do advanced budget planning. This exercise will be encouraged through the management training of the public sector component.

b. Activities designed to bring about the eventual phase-down of subsidies, particularly those of international donors, focus on cost-recovery in family planning programs. A strong policy of cost recovery will not be instituted right away given the nascent state of family planning programs in Nigeria. However, it is important now to learn from experience so far and to undertake simple pilot studies as needed to see how possible cost recovery systems may eventually be installed and how they affect family planning acceptance and continuation rates as well as choice of methods.

On-going experience in Nigeria in the health care field for cost recovery is particularly relevant. A number of models are currently being tested in Nigeria, most notably, the Ogun State revolving drug fund. The CCCD project, through Johns Hopkins University, is also involved with the FMOH in exploring cost recovery options. In order to capitalize on these existing studies, a short-term sub-contract is scheduled with consultation from Johns Hopkins through a local institution to examine how cost recovery programs in family planning may impact upon program performance. In future years, additional studies will be carried out, and up to 20 innovative approaches will be adopted in on-going programming.

3. Constituency Building

There is need to broaden and deepen the extent of constituency support for the national program, with special attention to groups whose influence can have important impacts on program implementation and effectiveness. Activities in this area should aim not only at identifying potential obstacles and opposition groups to the expansion of family planning services, but at gaining group leaders' positive endorsement of program goals, and where possible, to enlist various interest groups into actively contributing to policy, planning and program implementation activities.

Although birth spacing has been and still is to a certain extent a traditional health practice among most Nigerians, the concept of small families is new and encounters opposition among several minority groups in the country. Misconceptions as to religious bans on family planning are widespread. Ironically these misconceptions are more prevalent among Moslem leaders despite Islam's historic openness to birth control. The Roman Catholic leadership of Nigeria has stated its support for natural family planning (which, incidentally, is taught in all AID-supported training programs in Nigeria). Both Islamic and Christian groups have expressed strong interest in having seminars on family planning.

Programs will also be explicitly directed to the Nigerian business community. This group, which has yet to express an organized interest in family planning, has been key in such countries as Mexico in reinforcing government committment to population policy.

In the course of developing this work plan in collaboration with Nigerian colleagues, key groups have been specifically identified at the national level. Types of groups for priority consideration should include those that have a large network of strong influence and those that might have particular positive or negative importance for policy and program development. These are:

- Islamic leaders and Islamic women's groups (with whom activities are already underway);

- business group leaders (initial steps will relate to major industry heads, chambers of commerce, and Rotary Club, etc.);

- traditional rulers (recent pilot experience provides the basis now for nationwide approach) and traditional medical practitioners;

- medical leaders, along with other professional and special interest groups (women, religious groups, legal profession) especially concerned with adolescent fertility problems;

- women's groups (working through established relationships with National Council of Women's Societies) and especially among women educators; and

- labor union groups (working through Industrial Training Fund, and with ILO Resident Advisor).

As indicated above, some activities have already begun. The number of groups and the extent of their activities will expand over the life of the project.

Initiatives along these lines have already greatly benefited from FMOH leadership and support, which will continue to be enlisted through participation in seminars, preparation of papers, and as resource persons in identifying key issues and traget groups. In addition, the policy implementation component will provide limited institution building support to the NCPA which has already successfully sponsored consciousness-raising activities with the media and among Lagos market women. To strengthen the Council's capacity, the policy component will provide the Council a full-time program officer and modest office equipment and clerical staff to use in carrying out the activities described above.

To reach any particular group, experience to date in Nigeria indicates a sequence of activities (rather than a single input) should be carefully pursued. This sequence will identify the group's particular characteristics, be guided at each step by group members, and provide means for key leaders themselves to discuss points of concern and move toward consensus and positive support. This process will then be

extended to members of the group at state and local levels. Development of activities will involve the following:

- planning sessions with key leaders;
- collection of relevant background information and materials as needed to relate population issues to particular group concerns;
- seminars or workshops with group leaders to achieve consensus and plan follow-up actions;
- development of appropriate interpretive materials (in collaboration with the IEC group) for wider use among similar groups; and
- follow-up as required to support related extension activities.

4. Institutional Support

The population policy implementation component will seek to strengthen the capacities of leaders of institutions which have or will serve in strategic planning positions for population programs. Strong leadership in key institutions is essential for rapid expansion and efficient performance of family planning programs. The more support mobilized, among varied units at different levels, the stronger the total program effort. The previous section has already described the support which will be provided to the NCPA to carry out constituency building. An obvious by-product will be the strengthening of the NCPA as an institution. This section will focus on additional institutional units that should be helped to play a leadership or supportive role.

There are three general classifications of leadership groups:

a. Administrative Leadership Groups which include key government constituencies in federal and state line ministries, such as Education, Agriculture, and Rural Development and local government authorities;

b. Consultative Groups which include federal-level consultative groups on population programs (and subsequent technical advisory groups that may also be formed), and state-level consultative groups; and

c. Non-governmental Organizations such as PPFN and NCPA, whose program has already been described.

To help strengthen capacities among the above groups, the following activities will be pursued over the life of the project:

a. Administrative Leaders Specialized technical assistance will be provided to the designated representatives of certain ministries and organizations (in addition to information and education, with which the IEC component is working closely) to assist in considering: 1) stronger

representation of population factors as affecting their own planning; and 2) identification of concrete steps on how their sectoral activities may contribute to the family planning program. The concerned groups include those dealing with agriculture, social welfare, justice, and planning, plus the President's new Office of Food, Roads and Rural Infrastructure.

Although UNFPA and the World Bank will provide the majority of the day-to-day operations costs of the FMOH/OPCPP, continuing specialized technical assistance will also be provided under this project. However, since it is the primary agency actively involved in implementing population policy, the program for its support is described in the first function, Strategic Planning.

In order to reach these critical audiences in federal and state line ministries, and in order to relate their program goals to population programming, activities will be built on the highly sucessful RAPID model. These will include:

- application of sector-specific models showing in greater detail the impact of rapid population growth on individual sectoral goals, and

- the costs/benefits of family planning which accrue by sector.

The results of the analyses are expected to show up in the forthcoming fifth National Development Plan.

After the first year, these models and associated seminars are expected to take place, as appropriate, at the state or zonal level. As with the previous RAPID project experience, project activities will be carried out by the NPB, with technical and financial assistance from UNC and its subcontractors.

b. Consultative Groups. Drawing upon further developments relating to the federal-level Consultative Committee on the Population Programme, a series of zonal seminars will be organized by the FMOH, with FHI project assistance, for members of counterpart consultative groups at state levels. These groups will be state and local level entities mirroring the federal level and thus will be comprised of representatives from various state ministries and NGOs involved in family planning program implementation. The initial aims will be to orient them to the wider policy and program context to their various special roles, and to the processes whereby such groups should support related state and local policy and program developments. The seminars will be repeated annually, and will increasingly deal with practical issues such as gaining financial support, enlisting constituencies, dealing with the private sector, etc. A limited number of international study tours will be provided to strengthen the orientation and commitment of consultative group members representing important sectoral areas.

c. Non-governmental Institutions. As described above, this project will focus on the organizational development and strengthening of the NCPA to assist in constituency building. As such, AID will be the primary source of funds for this organization.

NGOs such as PPFN with strong capacities to work in partnership with official program mechanisms have proved to be extremely useful in Nigeria. For example, NGOs have worked closely with Family Planning Coordinators in some states to build policy support and develop new program designs. There is need still to augment such resources to meet special program needs with flexibility, innovation and influential support. This project will provide small subgrants and technical assistance to assist the PPFN in carrying out its on-going policy development program.

5. Evaluation and Feedback Mechanisms for Correction

The project as a whole calls for before-and-after assessments of effect (as discussed in the Project Evaluation Section) based on a baseline survey. The project must also contribute strongly to the processes of continuing improvement of policy and program implementation, through helping develop efficient systems to collect, disseminate and ensure utilization of relevant data. Each program component has many needs for particular types of information at different places and times, relating to planning and monitoring its own special functions; these are best managed directly within the component activities. However, other broad needs may be best met through use of more general mechanisms; these are of special concern to the policy component. These needs relate especially to a) baseline measures that can help to update certain information relevant to program planning, b) periodic assessment and feedback of information regarding fertility trends and family planning use, especially in areas where program effects should be most expected and c) capacities to respond as required for special needs to clarify policy or program problems or guide implementation decisions.

Because of the complexity of the program, of Nigerian society in general, and a wide variety of program needs, it was decided not to rely solely on the baseline survey for project evaluation/feedback. The project will undertake a series of three complementary data collection activities.

In the baseline type measures, the ideal is to survey a representative sample of the nations' whole population, but problems of cost and time suggest the compromise of studying only an area from each of the country's four major zones. An acceptable supplemental approach is to collect less detailed data annually from a national household sample survey. For the practical purposes of giving quick concurrent feedback to guide policy implementation, the most practical system is a combination of methods derived from experience with "mini-surveys", sentinel observation areas, simple techniques for ensuring accurate data, and use of sensitive analytic methods.

a. Baseline Survey. Preliminary planning for this will be pursued during 1987. Full preparatory activities should start in project month No. 1 and the report would be ready in month No. 11. The survey will cover approximately 500 women in the urban and in the rural areas in each of four states. The information gathered will include retrospective fertility histories, use of modern contraception and traditional methods, source of supply for users, related knowledge and attitudes, contacts with health services and media, and consumer buying habits, especially of

health products. The information gathered from the baseline survey corresponds to the informational needs of the other three components which will contribute to the funding of the survey.

For the above activities, the NPB is especially qualified because of its demographic expertise, earlier experience with the Nigerian Fertility Survey, field offices and staff established in each state, and its responsibility for mapping and house-listing the basic "enumeration areas" nationwide. These "EAs" offer great advantage as sample observation units for the above purposes. Although the policy implementation will support the baseline data effort, major technical assistance to the NPB will also be provided by the public sector component.

b. Annual National Household Survey. A small number of questions regarding details of recent fertility, KAP-type data, and selected other program-relevant items will be added to the continuous national sample survey managed by the Federal Office of Statistics. This monthly survey deals with many topics and covers 1,200 households throughout Nigeria each month. The additional questions should provide national estimates of fertility and family planning patterns, and in due course may be adapted to focus on certain areas according to need. Because of the complexities of managing such data under difficult conditions, the NPB is expected also to participate in design, oversight and analysis of the information. After "tooling" up activities in Year 1, this will be in operation during years 2 - 5.

This activity will be carried out as a part of its regular programs by the FOS, but will receive additional financial resources and technical assistance on specific analytic/operational problems from the policy implementation component.

c. Sentinel Surveys. A pilot sentinel system of surveys will be funded through this component to provide information on vital events and practices (births, deaths and family planning) in four selected urban areas, covering approximately 500 women each in capital LGAs in four states. Initial experiences will confirm aspects of methodology such as how often revisits are needed for sensitive and meaningful assessments of changes, desirability of "rotating" observation areas, etc. Most importantly, the data should produce indicators of success or failure in those areas (urban) where project resources are concentrated and thus allow for rapid implementation modifications as needed.

After the first project year, if it seems feasible, the system will be extended to 10 states, and the second year to all states. Selected other areas can be included as feasible according to needs. Initial information produced from each area, within one month of initial survey, will include fertility indicators (especially open birth intervals and high risk births) and family planning use and associated factors. Depending on resurvey frequencies (6 months to one year), quick feedbacks will indicate changes occurring, plus data from special questions added for program purposes. Although on a small scale, these surveys provide sensitive, timely indicators which should capture or indicate necessary program changes.

This activity will also be developed with the NPB, with financial and technical assistance through the policy component.

B. Work Plan

The life-of-project aims, assumptions and activities have been summarized above, for each functional category in the policy component area. Below are summarized the expected pre-project activities and first year schedule of work.

Pre-project Activities - July-December 1987

1. Strategic Planning

a. Preparatory Planning with State Family Planning Coordinators

During the 1987 Port Harcourt Family Planning Coordinators' Conference, review with participants the current state level policy and planning status, analysis of current problems, and project plans for 1987.

b. NISER

Consultations with NISER to prepare study of organizational structure and capacity for program planning and management.

c. Information System

Consult with FMOH regarding strategy and plans for first steps toward strengthening the population/family planning program information system.

2. Financial Support

a. NPB

Consult regarding needed steps to obtain data and to apply cost-benefit models of governmental budget allocations for family planning (in consultation with RAPID/Options Projects).

b. ARMTI

Discuss and proceed with plans for activities during 1988 aimed at equipping administrators better to build and manage health and family planning program financing (in consultation with RAPID/Options, CCCD/JHU). August 1987.

c. FMOH, Johns Hopkins Group and World Bank

Consult on current work plans and possible further strategies to proceed efficiently with cost recovery issues with the aim of producing specific policy guidelines and operational applications. (Consultations to be linked with RAPID/Options Project country visits.)

3. Constituency Building

a. Islamic Population Policy

Meeting to be held with leaders and with Islamic women's groups (paired meetings in northern and southern regions) to produce proposals for set of follow-up activities during 1988. (Supported by RAPID/Pathfinder, with FMOH.)

b. Business Leaders' Conference

Conference to be held for national business leaders, to raise their own population awareness, to initiate plans for further action steps by business groups to support the national program, and also to help enlist selected leaders for continuing participation and support of NCPA (to be sponsored by NCPA with assistance by Options Project.).

c. Traditional Rulers

Planning will proceed to organize a systematic nationwide activity to enlist support of traditional rulers, to gain their participation in general promotional activities (e.g., films), and to encourage taking specific steps to support family planning in their own areas. Planning will include discussions with PPFN, NPB, JHU/PCS, and others concerned, closely involving representative rulers. (To be led by NCPA with further assistance from Pathfinder and RAPID/Options Projects.)

d. Traditional Medical Practitioners

Continue pilot studies in Lagos State and Sokoto (with RAPID and Pathfinder support) and seek relevant success experience for further reference from other areas, regarding possible patterns of more involvement with family planning/primary health care.

4. Institutional Support

a. Administrative Leadership Groups

Along with assistance to be provided through UNFPA in the process of developing the proposed new FMOH/OPCPP, consultation assistance will also be available as appropriate through the RAPID/Options Projects. June-December 1987.

b. Consultative Group Support

Discussions with members of national-level Interministerial Consultative Group, sponsored by other agencies and projects, will be developing guidelines for sectoral participation.

c. NGO Development

Discussions and planning will be pursued with NCPA regarding steps toward broadening membership, and toward specific project implementation capacities. Program support/technical assistance will be provided to PPFN.

5. Evaluation and Feedback

a. Baseline Survey

With NPB, also initiate discussions and plans regarding design and requirements for baseline survey activity expected in 1988.

b. National Household Survey

In consultation with NPB, pursue discussions with FOS on design and implementation plans for addition of selected fertility and family planning related questions to national integrated household survey in 1988.

c. Sentinel Surveys

Contract (under RAPID/Options Project) for the development of "sentinel" mini-surveys and observation system in four capital city LGAs.

The first year implementation schedule is as follows:

Activities	Pre	Quarters 1	2	3	4
0. General					
a. Review plans with FMOH, USAID and collaborating groups, and other components	X	X		X	
b. Confirm consultant needs and pre-scheduling	X	X		X	
c. Recruit Nigeria staff and establish office, roles, and relationships (technical, organizational, financial)	X	X			
1. Strategic Planning					
a. Contract FMOH to plan and implement state program evaluations			X	X	
b. FP Coordinator workshop; Policy planning			X		
c. State-level evaluations			X		
d. National "Summit" meeting				X	
e. LGA organizational structure studies	X		X		
f. Policy information systems with NCPA	X	X	X	X	X

Activities	Pre	Quarters 1	2	3	4
2. Financial Support					
a. Subcontract with NPB for RAPID-type FP cost-benefit models					
- Developmental steps			X		
- Use with health, finance planning groups				X	X
b. Subcontract with ARMTI on FP financial development					
- ARMTI consultations and report		X	X	X	
- ARMTI participation, FP coordinator meeting					X
- ARMTI curricula for the courses				X	
3. Constituency Building					
a. Finalize initial activity plans, and subcontracts to work with 4 groups: Islamic, business, traditional rulers, medical			X		
b. Organizational steps/workshops with constituency groups				X	X
4. Institutional Support					
a. Development of FMOH/OPCPP to carry out constituency development	X				
b. Identification/initial activities with administrative leadership groups		X		X	
c. Constitution of consultative groups				X	X
d. Support to NGOs, PPFN and NCPA	X	X	X	X	X
5. Evaluation and Feedback					
a. Negotiate contract with NPB for baseline survey	X				
b. Carry out baseline survey					X
c. National household survey			X		
d. Pilot test "sentinel system" by NPB	X				
e. Evaluate "sentinel system" by NPB			X		
f. Expand "sentinel system" by NPB					X

IV. COMPONENT MANAGEMENT

A. General Approach

1. Lagos Representative

This project component will be supported in Lagos by a senior Nigerian professional with the following characteristic: special knowledge of the population field; association with problems of policy development and interpretation in Nigeria; and experience with general problems and methods of planning (at national, state and LGA levels) in the development and health fields. An initial period of intensive orientation plus systematic attention to a continuing process of professional growth will aim to build both deeper competence in the various aspects of this role, and also broader knowledge of other sources of expertise, and capacities to draw upon these. Contact is now established with persons who could fill such requirements.

Functions of this position will include the following:

a. Maintenance of continuing contact at the local level with progress and problems of population policy implementation in Nigeria, as these evolve, with a view to identifying needs and opportunities for special assistance from this project component. This will require continuing close relationships with concerned Nigerian Government officials and key private sector groups concerned with these matters.

b. Maintenance of close communication with the representatives of other major project components to maximize points of collaboration and mutual reinforcement.

c. For the policy implementation component project activities now planned, participation in more detailed formulation of plans and specification of subcontract arrangements, assistance with development of project activities, and monitoring and evaluation of performance and follow-up.

d. For other future activities, continuing assessment of factors that may influence priorities, potentials, modes of pursuing these; provision of related direct technical consultation and assistance as needed; and participation in the appropriate cycle of project development and implementation.

e. Responsibilities also for reporting functions including regular communications regarding general developments, special needs, and project monitoring, to CPC and its subcontractors; and ensuring that administrative and financial reporting steps and requirements are met in full and timely manner.

f. Provision of assistance especially to the development of NCPA in its performance of specific policy and program support activities; its processes of future planning to meet particular national needs; and building its organizational and financial base and capacities for expanded future service.

g. Day-to-day representation of this project component in its planning, administrative, technical assistance, subcontract implementation, and coordinating functions.

h. The Lagos representative will benefit from immediate administrative supporting services from the general logistical support unit and will also be able to benefit from the field relationships and capacities of the FHI Project's proposed four zonal offices. Specific technical support will be provided on a strong and continuing basis through the Project Director and specialized services made available from the CPC project office. Orientation to matters of contracting and fiscal administration will also be assured from the UNC office. Direct supervision of these arrangements as provided from the UNC office will be supplemented by additional fiscal management and monitoring services as may be needed through arrangements with a Lagos-based accounting firm.

2. CPC Management

The CPC-based Project Director will work directly with the Lagos representative in developing the roles and relationships outlined above, and will especially help to mobilize and ensure the availability and orientation of technical support staff from CPC and subcontractor staff as needed to support the diverse project component activities. In this process, emphasis will be given, both to assisting in immediate task performance, and to building institutional capacities to continue such functions. For these purposes, as appropriate, other special services available through the CPC project office and other subcontractor staff will also be utilized, including help with building related technical information systems, project documentation and evaluation methods, in-service staff orientation, computer skills, means for tapping various other international supporting services, etc. The CPC project office will help ensure close contact with relevant sources of expert consultation and supporting sources from other agencies. The CPC will also provide continuing services of a financial management specialist who will supervise budget and contractual arrangements, working closely with the Lagos office and with subcontractors, and enlisting supplementary accounting services in Nigeria for special purposes as needed (with procedures as now applied to INTRAH project subcontract arrangements).

3. Technical Assistance, Project Subcontracts, and Institutional Capacity Development

Project activities should tend, over time, to move through phases of progress from more emphasis on technical assistance activities, and dependence on direct development of specific packages of work through subcontracts with Nigerian agencies, toward increasing the extent of indirect assistance, through general support to the Nigerian institutional entities which should have growing capacities themselves to carry the functions of planning, developing, and as needed, themselves subcontracting, for series of related program activities.

Some of the organizations receiving assistance are:

Federal Ministry of Health (FMOH). The FMOH will provide the organizational base for guiding such activities as: annual state program

reviews; annual family planning program general meeting; development of general population program planning and information systems (linked with general health planning systems); identification and use of demonstration and testing areas.

National Council for Population Activities (NCPA). The NCPA should provide a unifying base for development of the following functions: activities to organize the support of leadership of key influence groups, and to establish guidelines for enlisting such constituencies more widely; "policy monitoring" information services (including monitoring legal aspects); activities to strengthen salient themes supportive of family planning (adolescent fertility problems, older age at marriage, linkage with achieving educational goals, etc.); pilot activities aimed at demonstrating feasibility, methods and policies that can open wider avenues for family planning promotion (e.g., through traditional medical practitioners, etc.)

National Population Bureau (NPB). The NPB should provide a base for leadership in: developing "sentinel" systems for quick feedback of trends and effects; periodic surveys of general demographic/family planning patterns (directly or with other agencies like FOS); and other special problem-oriented studies.

B. Component Linkages

1. With Government of Nigeria

The Project Director and Country Representative will maintain very close contact with key officials in the Federal Ministry of Health, especially the Director of National Health Planning and the staff of the FMOH/OPCPP. This will involve regularly scheduled meetings, review of plans and progress, prior clearance and collaborative arrangements for specific project activities, and special consultation on current needs and issues. Close contacts will also be maintained, as appropriate, with other units in the Federal Ministry of Health and in other ministries concerned with aspects of population policy and strategic planning, and with concerned state officials.

2. With Other PHI Project Components

The policy component project director and country representative will maintain effective continuing relationships with the AID Project Coordinator and the IEC, public and private sector components on matters of project planning and execution. This will involve regularly scheduled meetings to review plans, progress, and areas of collaboration; jointly pursuing field explorations, supervisory visits, and project implementation and evaluations. There will also be common use of basic logistic and supporting services.

In the USA, a network of continuing communication and evaluation already existing among the collaborating agencies will be strengthened and regularized, to facilitate sharing of information, long-term planning, and such immediate efficiencies as are achievable through coordination of staff travel and of project support services.

With respect to particular project activities in Nigeria, numerous points of specific collaboration are referred to in descriptions of work plans. For example, the policy component will particularly collaborate with IEC activities relating to development of approaches to enlist policy and program support among important constituency groups, and development of NGO capacities for policy and program support. The policy component will reinforce the public sector efforts especially through helping to strengthen institutional support from official advisory groups and from NGOs, to build the base of financial support, to faciiitate LGA commitments to family planning services, and to help introduce family planning into the planning and execution of other health service program systems. The policy component will facilitate the private sector progress through concern with policies which, for example, may influence commodity pricing, or access to public sector support (e.g., through training) for private family planning services. The policy component will seek to serve all the other sectors through program monitoring, evaluation and problem solving functions responsive to current needs and issues. Importantly, it will help pull all sectors together in pursuing annual reviews of progress in each state and in a meeting each year to highlight lessons learned and ways to achieve best results through coordinated component efforts, that can provide guidelines for the states annual re-planning.

3. With Other Assistance Agencies

The policy implementation component includes as a main concern the optimization of support for national population program efforts from sources within Nigeria, and this requires keeping in view also the patterns of potential assistance from other external sources. All of the FHI Project components, along with their Nigerian agency counterparts, will be alert to needs to coordinate with other possible donors, to avoid overlaps and seek cumulative effects. The policy component, in maintaining an overview of the framework and processes of population program development, will especially watch for such opportunities to coordinate efforts and to be ready to assist, as possible and appropriate, in considering ways whereby different sources of assistance, including the project, may reinforce each other to best advantage. Prior to the present project preparations, and in the course of project design-phase planning, close consultation and discussions on this subject have taken place with concerned Nigerian Government officials and especially with representatives of the World Bank, UNFPA, and UNICEF. These general integrative consultations and planning activities are expected to continue and to increase.

In development of specific project activities relating to policy and planning, there will also be continuing attention to inter-agency collaboration and involvement. For example, work on issues of program financial support will be coordinated with World Bank concerns with this subject. Although not developed as a part of this component, potential for extension of family planning into EPI programs and monitoring activities will be pursued in close collaboration with UNICEF.

Also, assistance by UNFPA to strengthening of the FMOH leadership staffing for family planning, and to building capacities of the NPB, will be reinforced by FHI Project efforts.

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4. With USAID

The policy component activities will obviously be closely linked to the general USAID program leadership in Lagos through regular consultations on plans and activities, special reviews of new project initiatives, and concurrent discussions on evolving experience and special issues. The policy component should be especially concerned with maintaining international assistance activities in a low key, supportive mode that emphasizes support for enhancing Nigerian capacities and leadership.

V. MONITORING/EVALUATION PLAN

A. Identification of Benchmarks

The broad objectives of this component are:

- to create a favorable policy climate, overcome barriers to rapid program expansion, and gain endorsements from key constituencies;
- to build a body of knowledge for effective strategic planning and program implementation; and
- to build the professional capacity to identify, analyze and resolve policy issues.

The following are indicators of direct inputs and outputs during the life of the project relating to these objectives.

	No.	Participants
1. National Workshops (3-5 days)		
Constituency Groups		
Islamic leaders	1	40
Christian leaders	1	40
Traditional Rulers	1	150
Business leaders	1	40
Local government Ministry leaders	1	50
Women's Groups	1	50
Education leaders/planners	1	50
Traditional practitioners		
2. Annual "Summit" Conference	4	120
3. Regional Workshops (2-5 days)		
Religious leaders	8	240
Business leaders	10	200
Traditional leaders	6	120
LGA Councilors	6	180

4. State/LGA Seminars (1 day)	No.	Participants
Religious leaders	40	500
Business leaders	20	250
Traditional Rulers	20	500
Women's Groups	25	250
Consultative groups	20	250
LGA Councilors	20	250

5. State Program Evaluation Teams

Annually in 19 states for 4 years — 500

6. Development and Presentation of RAPID-type Cost-benefit Model

Model Development	1
Development Applications	20

7. Training Courses (1-2 weeks)

Executive leaders	5	100
Financial support	8	200
LGA support	8	200
Strategic planning (2 weeks)	8	160

8. Formal Reports of Conferences/Other Reports, Papers

a. Strategic Planning Process

- Annual Federal Plan update - 5 years
- Annual State Plans update - 20 states x 5 years
- Annual LGA with F.P. component description: 200 by 5 year
- Reports (series) of LGA implementation experiences
- Proceedings of workshop on LGA implementation
- Report on impact of cost recovery for FP services and MCH
- Report on pilot studies of public sector support of private sector (non-clinical) contraceptive distribution

b. Financial Support

- Report of financial analysis of FP program
- Case studies of financial management
- Curricula for 3 courses on financial management
- Cost-benefit study of health impact of FP
- Illustrated presentation materials from cost-benefit study

c. Constituency Building

- Reports, training materials and supporting documents from each constituency

d. Institutional Support

- Issues papers from consultative group seminars
- Reports of State Evaluation Teams
- Curricula for FP leadership training courses
- Reports on organizational growth and work of NCPA
- Line ministry plans

e. Evaluation and Feedback

- Reports on baseline survey
- Reports (series) of fertility and FP from integrated household survey (annually x 5)
- Reports of "Mini survey" results and trends from "sentinel surveys" (6 monthly x 5 years)

If these objectives are accomplished, the outcomes/impact should be:

- stronger social and political support for family planning;
- growing financial commitments to family planning programs at the federal and state levels;
- effective and operational strategic plans at the federal, state and (some) LGA levels; and
- favorable public attitudes and increasing prevalence of contraceptive practice.

B. Methodology

The activities to be undertaken to monitor program performance will be as follows:

- an annual work plan will be developed each year detailing the activities to be undertaken with a month by month timetable of expected accomplishments;

- quarterly activity reports will be required of all contractors and implementing agencies. These will be checked against the projected timetable of activities;

- trip reports which will be submitted relating to all technical assistance activities will be reviewed to assess the accomplishment of objectives; and

- documentation of benchmark outputs as listed above will be obtained, specifically by:

  - conference proceedings
  - workshop reports/evaluations
  - course curricula/trainee evaluations
  - plan documents
  - study reports.

The activities to be undertaken to evaluate the outcomes/impact of the program will be as follows:

- collection and analysis of formal policy documents and any related laws, edicts or regulations produced by the federal or state governments;

- collection and analysis of press reports to document statements and positions taken by leaders in the public sector and key private sector constituencies as well as to assess public reactions to family planning through letters, commentary, news articles, etc.

- documentation of follow-up actions taken by key constituent organizations, i.e., follow-up conferences, promotional activities and/or service provision to their membership or the general public;

- collection of public sector budget documents at the federal, state and LGA levels to analyze annual levels of financial support for family planning activities;

- quantitative assessments of the relationships between program objectives as set out in annual planning documents at the state and federal levels, and actual accomplishments; and

- population based surveys in selected areas to measure trends in fertility, family planning practices, and related factors.

VI. FINANCIAL PLAN

A. Proposed Financial Systems

Funds under this contract will be made available by USAID to the University of North Carolina at Chapel Hill, Carolina Population Center. The expected mode will be a cost reimbursement contract, with approved budget and cost elements, established indirect cost rates, and applicable conditions and reporting requirements. The Federal Reserve Bank Letter of Credit will be the mode of financing. Financial management and administration functions are the responsibility of the UNC-CH Office of Contracts and Grants, with support by the special administrative and accounting staff working within the CPC administrative structure.

B. Methods of Financing

Expenditures directly incurred by UNC for salary and consultant services, travel, and other costs will be governed by established university standards and procedures. In case of subcontractors for amounts usually under $25,000 and for tasks subject to clear prior definition and scheduling, a fixed cost subcontract system will normally be applied following the basic format and procedures approved by USAID and as utilized during the last several years by the UNC Carolina Population Center and The Futures Group in operation of the RAPID II Project. This requires from the subcontracting agency a detailed statement including background statement, objectives, plan of work and budget justification, which is subject to processes of review, adjustment and concurrence. The approved contract then stipulates a set of precisely defined deliverables due according to a specific time schedule with corresponding amounts of payment to be made against the total approved cost. Payments are

released on formal approval of each deliverable by check to the subcontractors' designated account. Experience with this type of arrangement indicates that it will be effective and efficient for supporting many of the functions to be performed under the FHI Project, on the part of either a U.S.-based or Nigerian agency subcontractor. In the case of subcontracts for larger amounts and to cover a series of activities over longer time periods, cost-reimbursable contract procedures would be utilized, of the form approved by AID and used in Nigeria by UNC during recent years for the INTRAH Project activities.

C. Host Country Contribution

Host government contributions will be made to the policy and planning component of project activities in the form of time and effort directly supporting development of project activities, participation in them, and other direct contributions of facilities, space, transport and staff support services. Minimum estimates of such contributions to project activities during the first year are illustrated for certain categories as follows.

1. Strategic Planning Processes

Intensive planning for these activities during the first year will entail official participation with time and travel costs valued at over $50,000. In the four subsequent years, the contributions of time, transport and facilities for the teams doing 19 state-level evaluations and for the national "summit" conference will exceeed $100,000 annually.

2. Financial Support

The production of analyses materials and training for strengthening financial support for family planning will involve contributions of time from key officials also, estimated at $50,000.

3. Constituency Building

Professional time contributed by top officials from federal and state ministries, and from federally supported institutions (e.g., Ibadan University's Department of Islamic Studies) to planning, making preparatory arrangements, and participation in seminars for constituent leaders' groups, based on experience up to now, will be at least 2 person months per group. Estimated value of this plus related facilities and services for sequences of work with three groups will be $50,000.

4. Institutional Support

It is estimated that activities for institutional support will use outside technical assistance extensively in the initial years, but that this will diminish and capacity is included at NPB, OFPPA, etc. The budget is approximately $75,000 per Years 1 and 2, and an average of $35,000 in out years.

5. Evaluation and Feedback

This will require contributions of time for intensive consultation and support from key officials of NPB and related federal agencies, and of officials at state levels, plus use of existing NPB space, office facilities, and transport, equivalent to over $100,000 during the first year.

Over the first five year period, estimated levels of contribution to these and similar activities lead to a minimum estimate of project total contrbution to this project component of over $700,000.

D. Life-of-Project Budget and Detailed Year One Budget

The summary estimate requirements for dollar and naira costs, by budget categories for five years, is presented in the following tables.

BUDGET WORKINGS

POLICY COMPONENT

POLICY

(Inflated prices)	Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
PERSONNEL	100,000	156,000	181,000	120,000	151,200	177,287	144,000	145,530	173,988	158,400	152,807	181,265	174,240	160,447	188,995	696,640	765,983	902,446
CONSULTANTS	0	15,080	15,080	0	15,834	15,834	0	16,626	16,626	0	17,457	17,457	0	18,330	18,330	0	83,327	83,327
TRAVEL & PER DIEM	63,000	79,984	95,734	60,600	49,455	62,629	72,720	51,928	66,299	79,992	54,524	68,896	87,991	57,250	71,622	364,303	293,141	365,[illegible]
EQUIPMENT & MATERIALS	0	23,750	23,750	0	0	0	0	0	0	0	0	0	0	0	0	0	23,750	23,750
SUBCONTRACTS	980,000	0	245,000	1,330,000	0	290,870	1,281,600	0	253,281	1,188,000	0	213,439	1,237,104	0	202,055	6,024,704	0	1,204,644
OTHER DIRECT COSTS	0	14,000	14,000	0	5,250	5,250	0	5,513	5,513	0	5,788	5,788	0	6,078	6,078	0	36,628	36,628
OFFICES / FACILITIES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INDIRECT COSTS	0	107,704	107,704	0	65,311	65,311	0	65,269	65,269	0	68,533	68,533	0	71,959	71,959	0	378,777	378,777
T O T A L S	1,143,000	396,518	682,268	1,518,600	287,050	617,181	1,498,320	284,865	580,976	1,426,392	299,109	555,377	1,499,335	314,064	558,949	7,085,647	1,581,606	2,994,751
Annual Inflation rate	0%	0%		20%	5%		20%	5%		10%	5%		10%	5%				
Dollar : Naira rate			4.00			4.60			5.06			5.57			6.12			

Indirect costs % rate 25.00% - Applied to all costs, except Equipment, and only the first $25,000 of each subcontract

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BUDGET WORKINGS (DETAILED) POLICY COMPONENT POLDTL

(Current - 1987 - prices)		Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
PERSONNEL																			
US-based Salaries																			
- Project Director			50,000			40,000			30,000			30,000			30,000		0	180,000	
- Admin. Assistant			20,000			20,000			20,000			20,000			20,000		0	100,000	
- Secretary			10,000			10,000			10,000			10,000			10,000		0	50,000	
- Finance specialist			20,000			20,000			20,000			20,000			20,000		0	100,000	
- Program specialists			30,000			30,000			30,000			30,000			30,000		0	150,000	
US Fringe benefits	20.00%		26,000			24,000			22,000			22,000			22,000		0	116,000	
Nigeria-based Salaries																			
- Country Representative		100,000	0		100,000	0		100,000	0		100,000	0		100,000	0		500,000	0	
Subtotal		100,000	156,000	181,000	100,000	144,000	169,000	100,000	132,000	157,000	100,000	132,000	157,000	100,000	132,000	157,000	500,000	696,000	821,000
CONSULTANTS																			
- 58 days @	$260		15,080			15,080			15,080			15,080			15,080				
Subtotal		0	15,080	15,080	0	15,080	15,080	0	15,080	15,080	0	15,080	15,080	0	15,080	15,080	0	75,400	75,400
TRAVEL & PER DIEM																			
International travel																			
- US/Lagos trips : 14 in yr 1; 9 in yrs 2-5																			
= Trips @	$2,500		35,000			22,500			22,500			22,500			22,500			125,000	
US local travel	$5,000		5,000			5,000			5,000			5,000			5,000			25,000	
Local travel - Air trips 100 in yr 1; 50 in yrs 2-5																			
= Trips @ N	250	25,000																	
Local travel - Road		18,000			12,500			12,500			12,500			12,500			75,000		
					18,000			18,000			18,000			18,000			90,000		
Per diem																			
US-based staff																			
- 408 days in yr 1, reducing in later years @	$98		39,984			19,600			19,600			19,600			19,600			118,384	
Lagos-based staff																			
- 100 days @ N	200	20,000			20,000			20,000			20,000			20,000			100,000		
Subtotal		63,000	79,984	95,734	50,500	47,100	59,725	50,500	47,100	59,725	50,500	47,100	59,725	50,500	47,100	59,725	265,000	268,384	334,634
EQUIPMENT & MATERIALS																			
- Computer etc			23,750														0	23,750	
Subtotal		0	23,750	23,750		0	0		0	0		0	0		0	0	0	23,750	23,750

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SUBCONTRACTS																		
1. FMWH/Strat.planning	140,000			240,000			140,000			140,000			140,000			800,000		
2. NCPA/Constituencies	200,000			175,000			150,000			50,000			50,000			625,000		
3. ARMTI/Fin.Devt.	80,000			100,000			40,000			20,000			0			240,000		
4. Local Govt. Instit.	80,000			100,000			60,000			40,000			20,000			300,000		
5. NPB/Consort.Eval.	480,000			500,000			500,000			500,000			500,000			2,480,000		
Subtotal	980,000	0	245,000	1,115,000	0	278,750	890,000	0	222,500	750,000	0	187,500	710,000	0	177,500	4,445,000	0	1,111,250
OTHER DIRECT COSTS																		
Direct costs		14,000			5,000			5,000			5,000			5,000			34,000	
Subtotal	0	14,000	14,000	0	5,000	5,000	0	5,000	5,000	0	5,000	5,000	0	5,000	5,000	0	34,000	34,000
INDIRECT COSTS		107,704	107,704		62,201	62,201		59,201	59,201		59,201	59,201		59,201	59,201	0	347,509	347,509
T O T A L S	1,143,000	396,518	682,268	1,265,500	273,381	589,756	1,040,500	258,381	518,506	900,500	258,381	483,506	860,500	258,381	473,506	5,210,000	1,445,043	2,747,543

Dollar : Naira rate 4.00 4.00 4.00 4.00 4.00

Indirect costs % rate 25.00% - Applied to all costs, except Equipment, and only the first $25,000 of each subcontract

********** YEAR 1 BUDGET **********

BUDGET WORKINGS (DETAILED) — POLICY COMPONENT — POLDTL

(Current - 1987 - prices)		N	Year 1 $	Total $ Equiv.
PERSONNEL				
US-based Salaries				
- Project Director			50,000	
- Admin. Assistant			20,000	
- Secretary			10,000	
- Finance specialist			20,000	
- Program specialists			30,000	
US Fringe benefits	20.00%		26,000	
Nigeria-based Salaries				
- Country Representative		100,000	0	
Subtotal		100,000	156,000	181,000
CONSULTANTS				
- 58 days @	$260		15,080	
Subtotal		0	15,080	15,080
TRAVEL & PER DIEM				
International travel				
- US/Lagos trips : 14 in yr 1; 9 in yrs 2-5				
= Trips @	$2.500		35,000	
US local travel	$5,000		5,000	
Local travel - Air trips 100 in yr 1; 50 in yrs 2-5				
= Trips @	N 250	25,000		
Local travel - Road		18,000		
Per diem				
US-based staff				
- 408 days in yr 1, reducing in later years @	$98		39,984	
Lagos-based staff				
- 100 days @	N 200	20,000		
Subtotal		63,000	79,984	95,734
EQUIPMENT & MATERIALS				
- Computer etc			23,750	
Subtotal		0	23,750	23,750

********** YEAR 1 BUDGET **********

SUBCONTRACTS			
1. FMQM/Strat.Planning	140,000		
2. NCFA/Constituencies	200,000		
3. ARMTI/Fin.Devt.	80,000		
4. Local Govt. Instit.	80,000		
5. NPB/Consort.Eval.	480,000		
Subtotal	980,000	0	245,000
OTHER DIRECT COSTS			
Direct costs		14,000	
Subtotal	0	14,000	14,000
INDIRECT COSTS		107,704	107,704
T O T A L S	1,143,000	396,518	682,268

ANNEX L

POSITION DESCRIPTION

PROJECT COORDINATOR
NIGERIA FAMILY HEALTH INITIATIVES PROJECT

A. Responsibility

The Project Coordinator will be responsible for the overall management, including planning, administration, monitoring and coordination of all activities related to the development and implementation of the Nigeria Family Health Initiatives Project. The Project Coordinator will report directly to the U.S. Direct Hire Health/Population Development Officer under the general supervision of the AAO/Lagos. The Coordinator will be named as Cognizant Technical Officer in the implementation contracts.

B. Duties

1. Planning

a. With project collaborators, provides management framework and direction for overall planning and development of project activities.

b. Directs development and review of contractor annual work plans, and combines individual work plans into one project work plan.

c. Convenes quarterly project review committee meetings.

d. Prepares for and participates in mid-term and final evaluations.

e. Provides direction and guidance to short-term and long-term technical advisors, including briefings and debriefings.

2. Administration

a. Provides overall direction and supervision to the collaborative contractors and administrative logistics contractor in the planning, execution, and monitoring of the project.

b. Oversees FMG and contractor compliance with AID policies, procedures and regulations.

c. Drafts AID documentation necessary for project implementation (e.g., PIO/T's, PIO/C's, PIO/P's, amendments, waivers, etc.).

d. Drafts AID documentation necessary for procurement of goods and services and assures compliance with AID procurement requirements.

e. Prepares required AID documentation for AAO/Lagos administrative review and approvals (e.g., delivery of performance certificates, voucher reviews, etc.).

f. Provides direction to the logistics contractor and oversees the project office organization and management.

g. Ensures the timely and coordinated provision of AID financing and/or inputs.

3. Monitoring

a. Develops and executes project management systems for overall monitoring of project achievements.

b. Conducts periodic site visits to monitor progress of project activities.

c. Regularly reviews contractor work plans and contractor progress in project activity achievement.

d. Identifies problems in project execution and assists in problem resolution.

e. Monitors effective utilization of resources and ensures accurate budgetary forecasting.

f. Directs data collection for subsequent AID project analysis/planning and develops an historical record of implementation for the official AID project file.

g. Provides timely progress reports or special briefings on project problems/achievement required by FMG, Mission, REDSO/WCA (e.g., Project Implementation Report, etc.).

4. Coordination

a. Coordinates, as appropriate, project activities with the FMG at all levels.

b. Coordinates project activities and requirements with REDSO/WCA technical, project, legal, financial and contracts offices.

c. Coordinates with all collaborating agencies involved in project execution.

d. Coordinates with other AID centrally or regionally funded contractors, as appropriate (e.g., AVSC, Columbia University, FHI, JHPIEGO, etc.).

e. Coordinates with other international organizations and donors (e.g., World Bank, UNFPA, UNICEF, IPPF, WHO, CDC, etc.).

C. Qualifications

Senior level technical administrator with the following qualifications:

1. Ten to fifteen (10-15) years of progressive experience in the management of large-scale health and/or population programs.

2. Extensive experience in LDCs, preferably Africa and Nigeria.

3. Graduate level training in health program management, family health/population dynamics or equivalent.

4. Knowledge of and experience with AID policies, procedures and regulations.

5. Demonstrated ability in project documentation and reporting.

6. Good interpersonal skills and experience in cross-cultural settings.

D. Period of Service

The contract is intended to be for a period of five years, but only the first two years will be funded. Accordingly, the contract will be set up to reflect a five-year period; two years definite with a three year option.

E. Administrative Support

This contract makes provisions for housing, shipment of POV, standard allowances, post differential, etc. Housing and logistical support will be provided through the FAS agreement with the Embassy. All other administrative support will be provided through the administrative support unit.

F. Medical

The contractor and dependents will be afforded medical unit privileges, with the presentation of appropriate medical clearance documentation.

BUDGET WORKINGS

PSC

PERSONAL SERVICES CONTRACTOR

Item	Allow.	Rate	Arrival Year 1	(---------- In Position Year 1	Year 2	Year 3	Year 4	Year 5	----------)Departure Year 5	Totals
SALARY		60,000		60,000	60,000	60,000	60,000	60,000		300,000
FRINGE BENEFITS		23.0%		13,800	13,800	13,800	13,800	13,800		69,000
TRAVEL & TRANSPORTATION										
- International travel		$2,500	10,000			10,000			10,000	30,000
- R & R		$2,500			10,000		10,000			20,000
- Excess baggage (kg)	40	$18.5	740						740	1,480
- Airfreight (kg)	320	$5.0	1,600						1,600	3,200
- Sea Freight (kg)	3,360	$2.0	6,720						6,720	13,440
- Shipping PVO vehicle	1	$2,500	2,500						2,500	5,000
- Storage (kg/pa)	4,820	$0.5		2,410	2,410	2,410	2,410	2,410		12,050
- In-country local travel (trips)	30	$50		1,500	1,500	1,500	1,500	1,500		7,500
ALLOWANCES										
- Post differential		25.0%		15,000	15,000	15,000	15,000	15,000		75,000
- Temporary lodging (days)	30	$60	7,200						7,200	14,400
- Supplemental post		$1,000	1,000							1,000
- Education		$6,300		12,600	12,600	12,600	12,600	12,600		63,000
- Quarters / house rental		$40,000		40,000	40,000	40,000	40,000	40,000		200,000
- Housing maintenance (Yr.1 120%)		$10,000		12,000	10,000	10,000	10,000	10,000		52,000
- Guards		$10,000		10,000	10,000	10,000	10,000	10,000		50,000
- Furniture & appliances		$50,000	50,000							50,000
- Per diem, Washington DC (days)	5	$90	450							450
- Per diem, in-country (days)	100	$80		8,000	8,000	8,000	8,000	8,000		40,000
OTHER COSTS										
- GBA insurance		$1,000		1,000	1,000	1,000	1,000	1,000		5,000
- Visa, passports, medicals		$300	300			200				500
- Invitational travel & per diem		$3,000	3,000							3,000
- Recruitment		$1,000	1,000							1,000
- Contingencies		0.0%	0	0	0	0	0	0	0	0
TOTAL COSTS			84,510	176,310	184,310	184,510	184,310	174,310	28,760	1,017,020

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ADMINISTRATIVE AND LOGISTIC SUPPORT

Statement of Work

A. Background

AID and the FMG are implementing an expanded family planning program intended to increase the availability and acceptability of family planning information and services throughout Nigeria. This five-year program will be implemented through a consortium of U.S. private voluntary organizations and universities contracted under the collaborative assistance mode. Four implementing organizations (Family Planning International Assistance, The Pathfinder Fund, Johns Hopkins University Population Communication Services and the Carolina Population Center of the University of North Carolina) seek to rapidly expand the use of modern family planning methods through a comprehensive approach which includes strengthening service delivery capabilities of the private and public sectors, extensive use of media and printed materials to increase awareness, and carefully planned programs aimed at fostering a receptive policy climate among influentials.

Each organization will employ local professional staff for in-country project implementation, to be supplemented by frequent short-term consultancies from their U.S. offices. The local staff will be based in Lagos with possible expansion to four regional locations. Their activities will focus on contraceptive distribution, training, and implementing media campaigns in support of family planning (refer to Detailed Year One proposals in component work plans, Annexes H - K).

B. Statement of Work

The purpose of this procurement is to provide the in-country administrative and logistical support for the above-described organizations over the five-year life-of-project. Services will be required to establish a fully functioning office to accommodate this effort, with staff for all aspects of project administration including expediting local procurement, accounting, office management, clerical and other support staff, and maintenance, including services for regional offices (for which FMG resources will provide primary support). These functions are described in greater detail below.

1. Office administration. Establish, manage and maintain a project office, in compliance with Nigerian law, which delivers a full range of business services.

2. Office space. Provide and furnish individual office space for permanent employees with provision for short-term consultancies, conference room, lounge, kitchen and bathroom facilities commensurate with the magnitude of the staff.

3. Local procurement capability. Serve as purchasing agent for all office and field support equipment and supplies to mobilize activities, and monitor distribution and storage.

4. Contraceptives management. Provide logistical support for the importation of contraceptive supplies as well as overall supervision for the warehousing, and distribution of contraceptive supplies. In addition, coordinate public and private sector management information systems to monitor contraceptive flow and to make forecasts for contraceptive needs. Design a simple computerized system to monitor contraceptive flow. Provide assistance, as appropriate, to public and private sector outlets in contraceptive logistics management.

5. Bookkeeping services. Maintain accounting systems for administrative and logistic support.

6. Secretarial support. Provide highly skilled secretarial support with an emphasis on word processing (60 wpm minimum).

7. Full business communication service. Provide telephone, telex, photocopy, express mail and other related business services with an international focus.

8. Transportation. Provide airport expediter services, travel arrangements, vehicle dispatching, drivers and other transportation support.

9. Security. Provide adequate staff for office and expatriate housing security.

10. Maintenance. Provide adequate office maintenance and housekeeping, and vehicle maintenance.

11. Regional Support. Provide regional support (to be defined during implementation) in four locations outside of Lagos (initial communications, transportation)

C. Period of Contract

This contract is intended to be for a period of five years, but only the first two years will be funded. Accordingly, the contract will be set up to reflect a five-year period; two years definite with a three year option.

D. Specific Personnel Requirements

AID estimates the following personnel will be required to perform the above-described services:

1. Office Director. Full-time office manager to coordinate secretarial, clerical and support staff; requires demonstrated experience in project administration and a familiarity with local laws and practices regarding employment; reports directly to AID Project Coordinator.

2. Deputy/Assistant Director. One full-time assistant manager is required to support manager in carrying out responsibilities; same qualifications as Office Director apply.

3. Secretaries. Four full-time secretaries for program and two for administration and a capability to access a pool of temporary secretaries will be required; secretaries must have demonstrated capability in word processing and be eligible under Nigerian law for employment; report directly to Office Director.

4. Accounting. Two full-time bookkeeper/accountants with certified skills in financial reporting to record project expenditures which are subject to periodic audit; reports directly to Office Director.

5. Purchasing agent. One full-time purchasing agent is required for project commodity processing (e.g., vehicles, furnishings, supplies, but excludes contraceptives), shipping and storing; demonstrated experience in local procurement, understanding of procurement regulations; reports directly to Office Director.

6. Contraceptive Logistics Specialists. Two full-time contraceptive logistics specialists are required to monitor the importation, storage, distribution and use of project-related contraceptives and to assist in forecasting of contraceptive requirements; reports to the Office Director.

7. Dispatcher. One full-time dispatcher is required to organize the transportation requirements under the project; reports to Deputy Director.

8. Drivers. Six full-time drivers are required with the capability to hire temporary drivers; drivers must have proven records of safety and possess valid permits; report to dispatcher.

9. Maintenance crew. A two-person chareforce/maintenance crew is required to support the project office, to clean and maintain office facilities; report to Deputy Director.

10. Guards. Two day and two night guards required for office and expatriate housing; report to Deputy Director.

E. Specific Commodity Requirements

The contractor will be required to purchase commodities, office equipment and other furnishing to adequately support the teams. An illustrative list is provided for estimating purposes. Local procurement will be permitted in accordance with AID source/origin rules, including the waivers authorized under the Project.

1. Non-expendable Equipment

a. Vehicles. Twelve six-passenger vehicles with heavy-duty specifications, air conditioning, and spare parts; require services agreements - to be purchased in two orders (Years 1 and 3).

b. Word processing/microcomputer equipment. Eight word processing/microcomputer systems including disc drive, printer (letter quality and dot matrix), monitor, keyboard, software, etc.; include services agreement - to be purchased at various intervals over project life.

c. Photocopiers. Four photocopy machines for heavy duty production with service agreements.

d. Typewriters. Eight typewriters (electric) and eight manual with service agreement.

e. Calculators. 25 calculators with printout option.

f. Air conditioners. 40 air conditioners over the life of the project with service agreements.

g. Refrigerators. Two standard size over the life of the project.

h. Stoves. Two standard size over the life of the project.

i. Chairs. Includes 12 executive chairs and 75 standard office chairs.

m. Conference tables.

o. Other. (lamps, lounge furniture, carpets, curtains, bulletin boards, safe, fans, etc.)

p. Generator. For project office.

2. Expendable Equipment

The contractor will be required to provide standard expendable supplies for office functioning including fuel for vehicles, repair and maintenance of facilities, etc. the contractor will provide for insurance of vehicles and facilities, as well.

F. Reporting Requirements

The Office Director will report directly to the Project Coordinator at AID, and will work cooperatively with the program offices in assuring that support is forthcoming in a timely manner and of high quality.

G. Regional Offices

The contractor will explore various alternatives to provide regional support to the four organizations. These may include shared schemes in coordination with the FMG or independent small-scale operations (one-room offices).

H. Illustrative Budget (As attached)

BUDGET WORKINGS ADMIN./LOGISTICS Totals ADMIN

(Inflated prices)	Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Year 5 Total $ Equiv.	Years 1-5 N	Years 1-5 $	Years 1-5 Total $ Equiv.
PERSONNEL	364,000	0	91,000	436,800	0	94,957	524,160	0	103,589	576,576	0	103,589	634,234	0	103,589	2,535,770	0	496,723
CONSULTANTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TRAVEL & PER DIEM	80,000	0	20,000	96,000	0	20,870	115,200	0	22,767	126,720	0	22,767	139,392	0	22,767	557,312	0	109,170
EQUIPMENT & MATERIALS	1,072,000	70,000	338,000	24,000	0	5,217	28,800	0	5,692	665,280	57,881	177,407	34,848	0	5,692	1,824,928	127,881	532,008
SUBCONTRACTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	367,200	0	91,800	440,640	0	95,791	528,768	0	104,500	618,394	0	111,102	680,233	0	111,102	2,635,235	0	514,295
OFFICES / FACILITIES	1,520,000	0	380,000	1,824,000	0	396,522	2,188,800	0	432,569	2,407,680	0	432,569	2,648,448	0	432,569	10,588,928	0	2,074,229
INDIRECT COSTS	904,488	3,500	229,622	1,022,266	0	222,232	1,226,719	0	242,435	1,394,484	2,894	253,430	1,499,084	0	244,844	6,047,041	6,394	1,192,563
T O T A L S	4,307,688	73,500	1,150,422	3,843,706	0	835,588	4,612,447	0	911,551	5,789,134	60,775	1,100,844	5,636,239	0	920,563	24,189,213	134,275	4,916,986
Annual Inflation rate	0%	0%		20%	5%		20%	5%		10%	5%		10%	5%				
Dollar : Naira rate			4.00			4.60			5.06			5.57			6.12			

BUDGET WORKINGS (DETAILED) ADMIN./LOGISTICS ADMINDTL

(Current - 1987 - prices)	Year 1 N	Year 1 $	Year 1 Total $ Equiv.	Year 2 N	Year 2 $	Year 2 Total $ Equiv.	Year 3 N	Year 3 $	Year 3 Total $ Equiv.	Year 4 N	Year 4 $	Year 4 Total $ Equiv.	Year 5 N	Year 5 $	Total $ Equiv.	Years 1-5 N	Years 1-5 $	Total $ Equiv.
PERSONNEL																		
- Office Director	80,000			80,000			80,000			80,000			80,000			400,000		
- Deputy Director	32,000			32,000			32,000			32,000			32,000			160,000		
- Purchasing Agent	20,000			20,000			20,000			20,000			20,000			100,000		
- 2 Bookkeepers	40,000			40,000			40,000			40,000			40,000			200,000		
- 6 Secretaries	96,000			96,000			96,000			96,000			96,000			480,000		
- Dispatcher	8,000			8,000			8,000			8,000			8,000			40,000		
- 6 Drivers	48,000			48,000			48,000			48,000			48,000			240,000		
- 2 Expediters	16,000			16,000			16,000			16,000			16,000			80,000		
- 2 Janitors	8,000			8,000			8,000			8,000			8,000			40,000		
- 4 Security Guards	16,000			16,000			16,000			16,000			16,000			80,000		
Nigeria Fringe benefit 10.00%	(Included above)			(Included above)			(Included above)			(Included above)			(Included above)			0		
Subtotal	364,000	0	91,000	364,000	0	91,000	364,000	0	91,000	364,000	0	91,000	364,000	0	91,000	1,820,000	0	455,000
TRAVEL & PER DIEM (In country)																		
Subtotal	80,000	0	20,000	80,000	0	20,000	80,000	0	20,000	80,000	0	20,000	80,000	0	20,000	400,000	0	100,000
OFFICES / FACILITIES																		
- Lagos Office	720,000			720,000			720,000			720,000			720,000					
- Regional Offices	800,000			800,000			800,000			800,000			800,000					
Subtotal	1,520,000	0	380,000	1,520,000	0	380,000	1,520,000	0	380,000	1,520,000	0	380,000	1,520,000	0	380,000	7,600,000	0	1,900,000
VEHICLES / EQUIPMENT / FURNISHINGS																		
- 12 Vehicles	360,000									360,000						720,000		
- 8 Word processors		50,000									50,000						100,000	
- 4 Photocopiers		20,000															20,000	
- 16 Typewriters	32,000									32,000						64,000		
- 25 Calculators	12,000									8,000						20,000		
- Office furniture	200,000															200,000		
- Generator	400,000															400,000		
- 20pcs Lounge furniture	8,000															8,000		
- 2 Refrigerators	8,000															8,000		
- 2 Stoves	8,000															8,000		
- 20 Lamps	8,000															8,000		
- 10 Filing cabinets	8,000															8,000		
- 10 Bookshelves	8,000															8,000		
- Other furnishings	20,000			20,000			20,000			20,000			20,000			100,000		
Subtotal	1,072,000	70,000	338,000	20,000	0	5,000	20,000	0	5,000	420,000	50,000	155,000	20,000	0	5,000	1,552,000	120,000	508,000

OPERATING EXPENSES & OTHER DIRECT COSTS																		
- Communications	96,000			96,000			96,000			96,000			96,000			480,000		
- Fuel/POL	20,000			20,000			20,000			20,000			20,000			100,000		
- Premises repairs & maint.	20,000			20,000			20,000			20,000			20,000			100,000		
- Equipment serv. contracts	31,200			31,200			31,200			54,400			54,400			202,400		
- Expendable supplies	200,000			200,000			200,000			200,000			200,000			1,000,000		
Subtotal	367,200	0	91,800	367,200	0	91,800	367,200	0	91,800	390,400	0	97,600	390,400	0	97,600	1,882,400	0	470,600
INDIRECT COSTS																		
- Overhead	699,360	0		699,360	0		699,360	0		706,320	0		706,320	0		3,510,720	0	
- Profit	205,128	3,500	54,782	152,528	0	38,132	152,528	0	38,132	174,036	2,500	46,009	154,036	0	38,509	838,256	6,000	215,564
Subtotal	904,488	3,500	229,622	851,888	0	212,972	851,888	0	212,972	880,356	2,500	222,589	860,356	0	215,089	4,348,976	6,000	1,093,244
T O T A L S	4,307,688	73,500	1,150,422	3,203,088	0	800,772	3,203,088	0	800,772	3,654,756	52,500	966,189	3,234,756	0	808,689	17,603,376	126,000	4,526,844
Dollar : Naira rate			4.00			4.00			4.00			4.00			4.00			

Indirect costs % rate
- Overhead 30.00% - Applied to Personnel, Travel, Offices/facilities, Operating Expenses & Other Direct costs
- Profit 5.00% - Applied to all costs (including Overhead)

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********** YEAR 1 BUDGET **********

BUDGET WORKINGS (DETAILED) ADMIN./LOGISTICS ADMINDTL

(Current - 1987 - prices)	<------- Year 1		------->
	N	$	Total $ Equiv.
PERSONNEL			
- Office Director	80,000		
- Deputy Director	32,000		
- Purchasing Agent	20,000		
- 2 Bookkeepers	40,000		
- 6 Secretaries	96,000		
- Dispatcher	8,000		
- 6 Drivers	48,000		
- 2 Expediters	16,000		
- 2 Janitors	8,000		
- 4 Security Guards	16,000		
Nigeria Fringe benefit 10.00%	(Included above)		
Subtotal	364,000	0	91,000
TRAVEL & PER DIEM (In country)			
Subtotal	80,000	0	20,000
OFFICES / FACILITIES			
- Lagos Office	720,000		
- Regional Offices	800,000		
Subtotal	1,520,000	0	380,000
VEHICLES / EQUIPMENT / FURNISHINGS			
- 12 Vehicles	360,000		
- 8 Word processors		50,000	
- 4 Photocopiers		20,000	
- 16 Typewriters	32,000		
- 25 Calculators	12,000		
- Office furniture	200,000		
- Generator	400,000		
- 20pcs Lounge furniture	8,000		
- 2 Refrigerators	8,000		
- 2 Stoves	8,000		
- 20 Lamps	8,000		
- 10 Filing cabinets	8,000		
- 10 Bookshelves	8,000		
- Other furnishings	20,000		
Subtotal	1,072,000	70,000	338,000

********** YEAR 1 BUDGET **********

OPERATING EXPENSES & OTHER DIRECT COSTS			
- Communications	96,000		
- Fuel/POL	20,000		
- Premises repairs & maint.	20,000		
- Equipment serv. contracts	31,200		
- Expendable supplies	200,000		
Subtotal	367,200	0	91,800
INDIRECT COSTS			
- Overhead	699,360	0	
- Profit	205,128	3,500	54,782
Subtotal	904,488	3,500	229,622
T O T A L S	4,307,688	73,500	1,150,422

ANNEX N

REDSO/WCA SUPPORT TO USAID/LAGOS

REDSO/WCA will provide staffing support for the project as follows:

A. Regional Population Officer

1. Assists USAID/Lagos in project management duties until Project Coordinator is recruited;
2. Participates in quarterly project reviews;
3. Co-produces PIO/Ts with PDO

   - 4 collaborative contracts
   - 1 Project Coordinator PSC
   - 1 Administration/Logistics Firm;

4. Participates in selection and award committees;
5. Provides quarterly, at a minimum, circuit rides;
6. Participates in planning and review of annual work plan;
7. Participates in mid-project and final evaluations;
8. Acts as standing member of REDSO Project Committee; and
9. Assists in technical aspects of Grant Agreement negotiation.

Annually: 2-3 person months per year
Year One: 1/3 time of technician until contracts signed.

B. Project Development Officer

1. Advises AAO of implementation action under project (PILs, PIOs);
2. Co-produces the major PIO/Ts with technical offices and AAO:

   - 4 collaborative assistance contracts;
   - 1 Project Coordinator PSC
   - 1 Admin./Logistics firm contract;

3. Participates in review and award process;
4. Assists in negotiation of Grant Agreement;
5. Provides quarterly circuit rides;
6. Acts as evaluation officer, coordinating the necessary evaluations;
7. Chairs REDSO Project Committee;
8. Participates in annual work plan reviews; and
9. Backstops in accordance with DOA 551.

Annually: 2 person months/year
Year One: 1/3 time until contracts are signed (through 12/87)

C. Regional Contracts Officer

1. Prepares and negotiates four collaborative assistance contracts, estimated at $35-45 million;
2. Advertises, selects, and negotiates award of the administrative/logistics contract;
3. Advertises, selects and negotiates PSC for Project Coordinator;
4. Monitors contracts over five years;
5. Provides circuit rides, as required; and
6. Acts as standing member of REDSO Project Committee.

Annually: 1-2 person months/year
Year One: 1/2 time until contracts are signed (12/87).

D. Regional Legal Advisor

1) Prepares and negotiates, with USAID/Lagos, Project Grant Agreement with Government of Nigeria;
2. Reviews implementation actions in accordance with DOA 551;
3. Reviews periodic amendments to the Grant Agreement; and
4. Circuit rides in conjunction with other USAID/Lagos business.

Annually: One person month
July/August 87: 2-3 person weeks.

E. Regional Controller

1. Provides financial backstopping for all contracts:

   - establishing reporting procedures;
   - voucher examination;
   - payment provision; and
   - monitoring of expenditures;

2. Provides circuit rides for project financial monitoring;
3. Trains USAID/Lagos Budget Officer in financial monitoring procedures;
4. Acts as member of REDSO Project Committee;
5. Assists in project budget planning; and
6. Evaluates and establishes necessary financial systems.

Annually: 2 person months/year
Year One: 1/4 time until contracts are signed.

F. Regional Supply Management Officer

1. Provides circuit rides for monitoring procurement, as necessary.
2. Assists in establishing specifications for project commodities, and;
3. Assists in procurement of contraceptives and other equipment/commodities.

Annually: One person month.

ANNEX O

ECONOMIC ANALYSIS

A. Macro-Economic Overview

The 1973-80 oil boom period radically altered Nigeria's total resources position; it also facilitated economic policies of massive public sector spending, subsidization of consumption and production inputs, and expansion of parastatal activities. Rapidly rising public investments and especially the rise in urban construction distorted related prices and wages, thereby biasing the structure of the economy even further. Rising domestic costs and an explicit policy of allowing the naira to appreciate with increasing oil revenues resulted in deteriorated international competitiveness and a fall in non-oil exports. Administrative protection of domestic industry from foreign competition further distorted relative prices. Agriculture was the sector most adversely impacted by the oil boom. In 1970, agriculture accounted for slightly over 50 percent of non-oil GDP but its share fell to less than 30 percent by 1981.

By 1983 however, as oil revenues fell to one-half the 1980 level, external and fiscal imbalances became significant. Averages of foreign account trade payments rose; international reserves were drawn down; the current account deficit reached 6 percent of GDP by 1983. As early as 1984, Federal authorities initiated efforts to impose fiscal austerity. Across-the-board cuts in expenditures depressed private investment; administrative controls over imports caused shortages for production which resulted in extensive layoffs and sharp price increases. Real income per capita fell by one-third between 1980 and 1985. From 1982 to 1985, servicing of external debt requirements rose threefold, reaching a level of 34 percent of exports.

Serious efforts were begun in August 1985 to restore internal and external balances, a policy characterized as moving from "austerity alone to austerity with structural adjustment." The government's 1986 budget included key reforms of: 1) elimination of the financial subsidy on energy products, 2) commitment to phase out fertilizer subsidies, 3) a temporary 30 percent across-the-board import surcharge to serve as an implicit devaluation related to imports, and 4) a parastatal disinvestment program and commitment to relax and to simplify government controls over the private sector. In addition, the budget pledged restraint on the growth of the Federal government payroll, limitations on non-statutory transfers to parastatals to no more than 50 percent of the 1985 levels, and a moratorium on new projects not deemed to be essential to the recovery process. For the first time, the government budget was framed around policies and not projects. In effect, the 1986 budget represented most of the key reforms sought by the IMF except for an explicit devaluation of the naira.

During August-September 1986, the FMG intensified reform efforts in four fundamental areas:

- agriculture;
- industrial policy;
- devaluation; and
- debt rescheduling.

In August, the FMG announced an ambitious four-year Green Revolution policy. The sources of finance for this will come largely from revenues generated from the oil/energy subsidy cuts (estimated at 900 million Naira) and priority allocations of the 1987 investment budget (estimated at about 20 percent of non-debt allocations). The new industrial policy established the twin objectives of increased local value added content and employment as the basis for sectorial budget and capital allocations. The FMG also declared that it will control foreign exchange outlays on material inputs which are available locally.

Devaluation of the naira, the major remaining obstacle to debt renegotiation, was approved in principle in June 1986 by the creation of a second-tier foreign exchange market (SFEM). The second-tier opened on 29 September and a 66.3 percent devaluation was soon recorded. Soon thereafter, negotiations over debt rescheduling with the London Club and agreements with the IMF and World Bank intensified. Current debt rescheduling plus new credits of the IMF (reputed to be upwards of $900 million) and World Bank loans ($250 million) and continued fiscal austerity of the 1987 budget are expected to provide th the major stimulants for renewed economic growth in Nigeria.

B. Project Economic Impacts

The Nigerian Family Planning Project's four mutually reinforcing activities (policy development, IEC, public and private sector delivery systems) will develop an institutional framework to expand family planning services and information rapidly. The beneficiary group of this project is the Nigerian society at large via women of reproductive age. Consequently, quantitative projections of beneficiaries versus non-beneficiaries are not possible. On the other hand, adequate conceptual modeling, including RAPID analysis for Nigeria and actual cross-country LDC experience [1], exists to demonstrate significant positive net economic impacts of family planning programs. These net benefits can be categorized at three levels: economy-wide, macro-economic impacts; household or micro-economic impacts; and institutional impacts.

1/ Of the large body of literature, the World Development Report 1984 by the World Bank presents the most recent cross-country trends. The Committee on Population and Demography Report No. 16 (1982), Determinants of Fertility for Developing Countries, gives a good conceptual basis for impact assessments.

B. Economy-wide Impacts - Summary

Recent simulations and projections for Nigeria 2/ posit significant societal economic gains from reduced fertility. The following presents a selective summary:

- Gross Domestic Product (GDP) per capita - Conditions of low fertility (3 children per woman average by year 2000) compared to continued high fertility would yield a 50 percent higher GDP per capita in year 2010.

- Food Production versus Imports - Achievement of low fertility levels would transform macro-food deficits from 20 percent imports in 1980 to 30 percent surplus by 2010 given equivalent production/consumption per capita estimates.

- Social Service Demands - Education and Health

- Lower fertility would lead to an almost threefold drop in the annual increase in the projected primary school population allowing a reduction in the number of required teachers by half a million by 2010.

- Lower fertility would reduce the health at risk population by over one-third by 2010 and allow a 100 percent reduction in required clinics compared to continued high fertility.

These positive impacts will clearly not be achieved in the short-run and will not form the basis of economic recovery. They will, however, reinforce economic recovery and become an integral part of the longer run structural adjustment process. These impacts are most vivid and powerful on the demand side of structural adjustment. A rapid decline in fertility will require less budgetary and capital outlays for infrastructure and social services, thereby allowing an increasing proportion of capital to flow to more directly economic investment opportunities.

Declining fertility will also substantially impact key sector policies of the economic recovery and adjustment. As mentioned above, declining fertility will depress the demand for imported food, thereby allowing a green revolution food self-sufficiency goal to be achieved at a lower total volume of production/consumption and, consequently, lower total investment cost. The sectorial objectives of the new industrial policy

2/ Data drawn from various undated versions of RAPID. The Effects of Population Factors and Social and Economic Development - Nigeria. Reported orders of magnitude would be increased were the Nigerian economy to undergo appropriate structural adjustment.

will be greatly enhanced by a rapid decline in fertility. Using the RAPID simulations, a transition to lower fertility levels would result in a 10 percent lower total labor force in the year 2010. This trend would assist in the attainment of greater employment opportunities relative to total labor force/population.

The economy-wide benefits of reduced fertility culminate in higher incomes per capita. Combined with a lower total demand for public goods and services, higher incomes will support - and indeed generate - higher propensities to consume, save and invest. In effect, declining fertility will, in the long run, impact favorably on both the demand and supply side of structural adjustment and economic growth.

C. Household or Micro-Economic Impacts

Impacts of population growth to the macro-economy are relatively long-term and indirect. Those to the household are more immediate and direct. Each additional child is a mouth to feed, probably a child to educate. But each child also equates with an additional laborer for the family farm or a source of cash income via remittances. Children are usually a source of prestige and social security in later years. What can be calculated as costs to society may be perceived as benefits to individuals. These calculations, however, cannot be made to any real precision without a sophisticated data base.

In the current context of Nigeria, the weak economy and declining agricultural production point to reduced population growth as a beneficial strategy even at the household level. For resource poor rural families, smaller family size would decrease the proportion of agricultural production devoted to family consumption. A larger marketable surplus would increase total family income. Maternal and child mortality and morbidity would improve due to fewer complications of pregnancies. An important portion of farm labor productivity would improve, thereby raising crop yields.

Smaller families are an alternative survival strategy to those of increased land fragmentation, increased out-migration, and the resulting marginalization of the rural poor.

In essence, economic factors have altered the traditional tangible rewards of a large family. This trend is supported by the Social Soundness Analysis of this project.

The "oil-boom" era greatly changed the economic patterns and aspirations of large groups of Nigeria's population, with a rapid shift to urbanization (up to 30%), and decline from about 75% to 50% dependency on agriculture, and corresponding rise of employment in the service sector. The momentum of this dramatic transition was abruptly frustrated by the recent economic reversal. Without this rise and fall, strong effects on family aspirations and behavior might not have occurred. Now, however, improved health in urban areas means fewer infant deaths and a rise in the number of surviving children- a household level "population explosion" that directly frustrates the raised expectations and aspirations for greater employment and income. This combination of

factors corresponds to those which have occurred in other countries (with similar or lower economic levels) in the past that experienced very rapid declines in fertility. Based on historical demographic transitions (the classic Irish potato famine, for example) one can expect a movement toward declining fertility in Nigeria. The following suggests one mechanism for how such a transition may begin.

Micro-data to demonstrate the impact of lower fertility in Nigeria are almost non-existent and certainly grossly incomplete. It is widely acknowledged in the literature that multi-variant analysis is necessary to provide insights into the micro-relationships between socio-economic development and fertility. The only sub-sector in Nigeria for which there are partial data is for education and fertility.[4/] Increased education has been noted as a determinant factor of reduced fertility [5/] and the FMC has targeted educational campaigns towards women of high childbearing risks due to early marriage, high parity and/or short birth intervals. Unfortunately, the high cost of shcooling has reduced enrollment by as much as 30 per cent in the past two years.

Four variables were chosen for nine states to explore these relationships:

- number of children desired;
- mean age at first marriage;
- postpartum abstinence in months; and
- percentage of female population in primary school.

Even though these data are partial, three significant relationships emerged from multiple regression analysis. First, there was a significant - and negative - relationship between age at first marriage and desired completed fertility (correlation coefficient = -.725). Second, the relationship between age at first marriage and propensity to attend school (% female in primary school) was significant and positive, a coefficient of .924. Third, the three independent variables explained (adjusted R2) 78.3 percent of the variation in desired fertility levels. Specifically, the regression equation (see Technical Note attached) may be used to estimate the anticipated fertility response to changes in socio-economic determinants, the most powerful of which is age at first marriage. If this phenomenon was changed from a reported average of 16.4 to 18 years, then - all other things equal - desired fertility would fall from an average of 8.3 to 6.6 children. In proportionate terms, this represents a multiplier effect of over 2.5, e.g., increasing the age at first marriage by 1 percent decreases desired fertility by over 2.6 percent. A proactive IE&C program coupled with advanced opportunities for education into the secondary level will further reduce high birth parity risks and infant mortality.

D. Institutional Impacts

Although difficult to quantify, FHI-II will provide substantial institutional benefits in three specific areas:

4/ For an explanation of the data set and statistical results, see the Technical Analysis, Annex Q.

5/ See Economy-wide Impacts above and Social Soundness Analysis.

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- improved strategic planning capability at national, state and LGA levels;
- greater integration of program content with state and local government levels; and,
- more productive and efficient service providers, in both the public and private sectors.

The public sector component workplan presents specific proposals for technical assistance and training for the public sector (national, state and local governments) service providers and management personnel. The institutional impacts will be achieved through a wide range of training, including the development and implementation of a revised MIS.

In the area of pre-service technical training, the project objective is to achieve self-sufficiency in the capacity to provide family planning training at all levels in the health delivery service structure. If attained, this will result in a sufficient number of service providers with improved clinical and communication skills to staff 1,000 clinical service delivery stations and another 2,600 non-clinical points and a training system with a capacity to provide new service providers as required.

Some 3000 national and state level public sector employees will be trained in management skills relative to program implementation, cost recovery and monitoring. The management information system will provide necessary decentralized information on service statistics, logistics and costs. It will also incorporate an individual record system which will assist providers and users to select optional methods and yield feedback on service quality. Like the technical training strategy, the management skills training and information system should improve the institutional base for decentralized service delivery.

The longer term institutional impact will be a shift toward greater reliance on the private sector to deliver family planning commodities and basic IEC services. By providing training and initial commodities to over 12,000 private sector outlets, this project will attempt to serve 60 percent of the proposed family planning users via the private sector.

E. Cost Recovery

Federal, state and local governments are exploring cost recovery as a mechanism to finance, in part, provision of health services. This shift is due to the policy shift toward decentralization and simple economic necessity. The Fifth National Development Plan (1986-90) seeks to increase private sector and community involvement in financing health services via cost recovery (service fees, drug sales, contributions, retainer contracts). The longer run objective is to develop a national health insurance scheme.

The economic reality of seeking partial cost recovery is equally - if not more - compelling. Between 1975 and 1980 (the late boom years), only 1.2 percent of total Federal expenditures were devoted to health. State governments were highly dependent on statutory allocation from Federal accounts to finance state health boards and local facilities. As the economic crisis deepened, Federal grant financing dried up. Ogun State,

for example, derived up to two-thirds of its health budget from Federal accounts before 1984. Internally generated funds (state and local) as a percentage of total state budgets rose from 24.3 in 1983 to 48.4 in 1984 and stabilized at 48.0 in 1985. Even though the Ogun State health budget grew modertately during the 1981-1984 period, an increasing proportion of total recurrent costs went to fund personnel and by 1984, personnel accounted for over four-fifths of non-capital expenditures.

For the individual, the "out of stock" syndrome became pervasive. Hospitals and clinics, no longer financed by Federal funds, began to send patients into the private sector to find drugs and supplies. Devaluation associated with the Second Tier Foreign Exchange Market clearly increased this burden.

The project will support government policy and proposals to seek cost recovery. The Public Sector component will provide management training and information systems to implement specific cost recovery proposals from the Policy component research studies. Fees for private sector services, described in the Private Sector component, are a basic tenet of this project. This project will do much to establish the philosophy and practice of private sector and/or service for fee health care; current private sector family planning commodity distribution will be expanded. On the other hand, initial efforts at cost recovery for commodity inputs will not solve the health financing problem of fiscally starved state governments or workers earning less than the minimum wage of 125 N a month. As the family planning program expands and the macro-economic situation improves, the institutionalization of cost recovery should provide a slowly increasing base for financing family planning service delivery. Any attempt to quantify this would be full of gross assumptions and wild data guestimates.

F. Recurrent Costs

The recurrent cost calculations are described in the Financial Analysis Section. In terms of economic analysis, FHI-II recurrent costs are remarkably slight. Most of the public sector staff designated to service expanded family planning clinics are either FMG employees or in pre-service training. In the absence of an explicit program of staff reduction, the project will have no significant impact on the wage bill. New facilities to be used for family planning are, for the most part, to be incorporated into existing hospitals and clinics. Costs to refurbish and renovate family planning clinics will be borne by other donor programs, or will constitute a portion of the host country contribution. Transportation, normally an important recurrent cost in service delivery projects. is to be borne by other donors such as the World Bank under loan financing envisioned for the FMOH: FHI-II purchases no government vehicles. The most significant recurrent cost is that of contraceptives, which will increase to the extent that the project is successful in achieving its purpose. However, as in other developing countries with rapidly increasing family planning programs, this project assumes that donor support will extend well beyond the five years of this project and that contraceptive imports will continue to be largely donor financed.

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Appendix 1

Household Impacts of Fertility - Education Relationships

In an effort to create a data base to test the micro-relationship between socio-economic variables and fertility, data on female primary school attendance and three fertility variables were compiled or estimated for nine states in three regions:

Southeast: Anambra
Imo
Rivers

Southwest: Lagos
Ogun
Oyo

Northwest: Kaduna
Kano
Sokoto

The variables and data sources were as follows:

Variable	Date	Source
Mean age at first marriage	1981	Nigeria Fertility Survey (as reported in draft Social Soundness Report, Table 1)
Postpartum abstinence (months)	1981	Same as above
# children desired	1981	Same as above
# females in primary school	1983	State Ministries of Finance and Economic Planning (reported in Social Soundness)

State level estimates for female population (1963) were extrapolated to 1983 and age cohorts calculated using RAPID estimates of the national population. The percentage of females in primary school was then calculated for each state.

Multiple regression analysis (version SPSS) was employed using desired fertility as the dependent variable.[6] The resulting table of correlation coefficients was estimated as:

[6] Data on completed fertility were not used due to the unknown influence of mortality.

	F	A	M	E
Desired Fertility (F)	1.000			
Age at 1st marriage (a)	-.725	1.000		
Months of postpartum abstension (M)	-.206	.281	1.000	
% female enrollment in primary school (E)	-.490	.924	.121	1.000

The estimated equation takes the form of:

$$F = 22.016 + \underset{(2.43)^{**}}{4.24E} + \underset{(.91)}{.046M} - \underset{(-3.46)^{*}}{1.060A}$$

R2 = .783 F = 6.000

* Significant at the 95% level.
** Significant at the 90% level.

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ANNEX P

SOCIAL SOUNDNESS ANALYSIS

A. Summary of Key Socio-Cultural Issues

For the most part, activities to be under taken in this project have been tried on a small scale. As the project proposes to expand activities rapidly this analysis explores the various socio-cultural issues that might affect project success. The following narrative summarizes the key socio-cultural issues and how they will be adddressed by the project.

Traditional Values. Although pronatalist values pervade Nigerian culture, childspacing is also an integral part of the country's heritage. Nigerian women customarily practice both extended postpartum abstinence and prolonged breastfeeding. However, shorter birth intervals and higher fertility are occurring as these traditions break down. Modern family planning therefore constitutes not a revolution but a practical way of continuing the approved and established tradition of child spacing. Childspacing is an accepted concept. Therefore modern family planning is merely a new path to an old goal. As a result, the project will present family planning as a modern means for accomplishing what Nigerians have always practiced: childspacing for better health of mothers and children.

Cultural Heterogeneity. Nigeria is culturally heterogenous and requires different regional approaches. Different languages, marital patterns, and values require varied family planning communications and services. The autonomy of the state programs permits state programs to fashion specific approaches, but states may not know enough about their citizens' attitudes and preferences to develop appropriate strategies. By attentively listening in focus groups and structured interviews to users and non-users, community leaders, and project staff, the project will tailor communications and services to meet the specific conditions in the states and regions. Materials and information will use the major local language, and content will reflect people's attitudes and regional customs.

Traditional Leaders. Traditional leaders still exercise remarkable influence, particularly in rural areas. Eager to improve the health and economic welfare of their people and pleased to be the sources of enlightenment for their subjects, most leaders appreciate the opportunity to learn about modern family planning methods. Ignored or treated with disrespect, traditional leaders can be opponents, but involved and treated with due respect, they can be staunch and convincing allies. Consequently, the project will hold special seminars for traditional leaders prior to launching mass campaigns to provide forums for leaders to speak out in favor of family planning.

Male Involvement. Analysis of current newspaper obituaries shows male prestige derives not only from the number of surviving children but from his children's successful careers. Fewer, better educated children will increase a father's prestige. Thus Nigerian men, who face current

economic hardships in educating their children for success are already receptive to family planning. In addition, Nigerian women may also find it necessary to consult their husbands regarding the use of family planning methods. Men also want healthy wives and children. Therefore, it is important to teach a man family planning. Keep a husband ignorant, leave him out of the decision, and family planning has a raging opponent. As it is assumed that men can be natural allies of family planning if they understand it, the project will work toward involving men in family planning decisionmaking. The IEC campaign for family planning will include a component addressed to men of all ages. Moreover, involvement of men in training and outreach programs will also strengthen the program.

Religious Factors. Nigerians are deeply religious. Religious activities play an important part of their daily lives. The project cannot risk alienating any religious group. Ostensibly, Nigerian Muslims and Roman Catholics are family planning opponents. Yet Roman Catholics in the East are now promoting natural family planning methods, a far more positive approach than previous blanket opposition. Some Muslim leaders already support family planning, and have enthusiastically responded to seminars on the Koran and family planning. Protestant Christians have hosted family planning speakers in their churches and now provide family planning service in their hospitals. All three religions share a common concern for human welfare. All can espouse the goal of health for women and children. Differences do exist, but all in their own way can support the cause of family life education and responsible parenthood. The project will avoid polemics, stress the common cause of health for women and children, and educate the religious leaders. Like the traditional leaders, informed religious leaders can be staunch allies.

High Risk Pregnancies among Young Women. In Nigeria, as throughout the world, young unmarried women are increasingly sexually active and becoming pregnant at an alarming rate. One Nigerian study found that 89 percent of such women terminated their pregnancies through dangerous illegal abortions. To avoid abortion, the project will: a) train teachers and nurses to provide family life education and encourage the inclusion of family life education as a regular part of the secondary and post-secondary school curriculum; and b) train clinic staff to receive adolescents with care and respect.

The project will begin producing, testing and then introducing into the teachers colleges and secondary school curricula appropriate family life information and materials. Some family life education is a natural part of education for Nigerians of all ethnic groups and religions; appropriateness of content will be determined by pre-testing.

Contraceptive Social Marketing. The first 12 months of subsidized contraceptives sales through retail outlets has proved successful. Mass media advertising and the open sale of contraceptives have not provoked the negative reaction some detractors had imagined. With no point-of-sale advertising, and no special packaging, the project has captured about half the existing contraceptive market. It is assumed that expanded but culturally sensitive media advertising and point-of-sale advertising will increase consumer product awareness. An increased number of outlets, including market women, will augment

availability to all regions and socio-economic strata of the country. Traditional healers and birth attendants will be included in short-term training programs, and be taught at least the same information and procedures as market vendors: triage, provision of barrier methods and pills where appropriate.

Equity. Better informed and more open to western innovations, affluent urban residents are likely to to be early acceptors of family planning. In contrast, the rural poor, who have less access to mass media and who tend to live farther from existing clinics, pose a greater program challenge. Therefore IEC campaigns, based on careful research of media habits, will target radio times and programs preferred by the rural population. Lest cost inhibit acceptors, the public sector will provide all family planning services free or at nominal fees. Community outreach and village distributors will bring family planning to remote areas. Since family planning clinics have already opened in most urban areas, new public sector service points will be largely in small towns and areas more accessible to the rural poor. Advertising will make the public aware of commercial contraceptive products, and subsidized prices will make them affordable. IEC will also promote effective traditional methods for the rural populace.

B. Social-Cultural Context

Nothing is more rewarding to most Nigerian women than to bear and raise children. Nothing can give a Nigerian man more pride than to be surrounded by an admiring crowd of family and children. They are not just a sign of his wealth and power, they are his wealth and power. People themselves are the most highly valued resource in traditional society. Yet from all corners of Nigeria, the report is the same: family planning is an idea whose time has come. The sharp economic downturn in the last three years has aroused nationwide interest in birthspacing for economic and health advantages. Press coverage and official statements by government officials have switched in the last three years from suspicion of family planning to endorsement. The impossibility of raising the standard of living without a slower rate of population growth has become apparent to the majority of policymakers. The ideal of a large family has hardly changed. But that ideal does not have to change in order for people to change their attitude and behaviors regarding modern family planning methods.

1. Values and Beliefs

Pronatalist values are engrained in many rituals of life and even in daily greetings among Nigeria's ethnic groups and religions. The birth of a child is celebrated by a large and joyous gathering of family and friends. A woman is never the center of admiring attention so much as when she has just presented her husband and his family with a new baby. In the Mbisa district of Imo State there is even a special festival called the ewu to celebrate the birth of a woman's tenth child. It is the greatest honor a woman can earn, and relatives come from all over Nigeria to attend.

Marriage agreements and customs make it clear that a fundamental

purpose of marriage is to produce children. In traditional farming and craft economies, women and children were seen not as additional mouths to feed but as helping hands in the family. When a woman is given in marriage, her family loses her labor and her reproductive capacity, as well as her company. The husband's family compensates for these losses by giving gifts and paying a bride price to the bride's parents. The children she bears will belong to his family. If she is unable to bear children she is often returned to her family, who must refund the gifts and bride price.

Until a new bride has borne a child, she is expected to behave with great modesty and humility in her husband's family. In a polygamous or extended family, she should show her goodwill by voluntarily assuming a share of the other women's tasks as well as those falling to her. All previous wives are senior to her, and can give her orders. Only after she has begun to bear children does she take on status in the family. Her husband may reward her by providing her with capital to start trading in the market or further her education. Mothers customarily nurse their babies from one to two years during which time it was traditional to abstain from sexual intercourse. This allowed a natural birthspacing of two to three years. It also obliged men to seek sexual relations elsewhere, either in polygamous marriage or in extra-marital liaisons. It is considered shameful for a woman to get pregnant before she had finished nursing the child, and the health risks to both mother and baby are recognised. Post-partum abstinence is decreasing, however, in all parts of the country, and this is one reason for recent interest in modern family planning methods.

The rewards of a large family in the past were immediate and tangible. The woman had companionship and help in her work from her daughters. The sons joined their fathers in the fields or markets or workshop at a very early age.

The initial phases of urbanization and modern education in Nigeria reinforced pro-natalist values, and enhanced people's ability to support large families. In the first decade after independence modernization continued to favor large families. God (and the government) would provide, people believed. Education and social services were expected to be free, although they proved to have associated costs. The more children one had, the greater likelihood that one or more would succeed. One educated child meant help for siblings as well as for the parents. Even families having great difficulties feeding and educating their children would regard their problems as temporary, and their hope in the future. This situation has changed though with the current economic recession. Hope in the future has disappeared with the recent economic downturn. Jobs have not materialized, even for many of the educated sons. Some parents still have grown sons on their hands. Food costs are up and education now is increasingly costly. School fees are universal at the secondary level, and outlays for books, supplies, and periodic levies face the parents of primary school children. Enrollments are off 20 - 30% around the country. Malnutrition is reappearing as a major health problem in both infants and adults. Experience has shown that a salary is a divisible pie, in contrast to the expandable farms of the past when land was available to all for the asking. Farmland is scarce

in most rural areas, and totally unavailable in the close- settled zones around most state capitals. There is no prospect of sufficient land for the children already born, much less those to come. With these economic changes has come a gradual reduction in family size, a tendency away from extended family residence and toward looser nuclear units. Only in the North is large multigenerational extended family residence still common. The close relationship between completed fertility and average household size in each state is a statistical reflection of this trend. Where extended family residence is the rule, household size can average 12 or more. Women in many areas have had to take on greater economic responsibilities for child raising, and with this has come a greater role in family management. Separate male and female attitude surveys towards family planning have shown that economic strains on the family are the major motivation for both to seek modern family planning methods.

2. Geographic Variations

Family organization, economic roles, and residential patterns differ widely in different parts of the country. The approach of the family planning program should be tailored to such local variations to be socially acceptable and successful.

To illustrate local differences, this study chose three states for case study: Imo State in southeastern Nigeria, Kano State in the north, and Ogun State in the southwest. Imo State is predominantly Igbo ethnically and 90% Christian of whom 50% are Catholic. Kano is made up of the Hausa-Fulani groups, and is overwhelmingly Muslim. Ogun State is mainly Yoruba, with a nearly even split between adherents of Christian sects and Islam, plus a minority of perhaps 10 percent following traditional cults. Christians and Muslims in all areas retain customary beliefs to a certain degree, incorporating the ancestors and the spirit world, for example, into their world view.

C. Social Organization

The National Family Planning Program should be organized to use the full range of public and private sector institutions, modern and traditional. The existing program includes public and private sector training and assistance in equiping clinics. Contraceptive social marketing is being tried in several states. It is important that the different approaches be extended to the full geographic area, as they reach different audiences. A constant monitoring will be necessary to keep them coordinated. Extension of family life education is also planned for the educational system, but implementation has barely begun.

1. SOCIAL STRUCTURE

a. The Family

The 1981/82 Fertility Survey documented that marriage is nearly universal for both man and woman. Before the age of 30 nearly all women (96.8%) have been married, and even if they divorce they stay married over 95% of their adult lives. Despite this fact a fifth of all households in the survey did not have any married couples. Over half the households comprise nuclear families (56.1%), while 23.6% were extended

families. This reflects rapid change in residential patterns, as in the past the majority of family comprised several generations. This is important for the acceptability of family planning, as young couples living with their parents and inlaws are not free to decide independently about desired family size. Women in extended and polygamous households tend to compete for status by producing children. Grandparents and in-laws remind their children often of their desire for grandchildren.

Women marry far earlier in the north than in the south. Polygamy is also far more common in the north, although it is also common in the south. Completed fertility and household size are highest in the southeast.

Polygamous marriages are found among all faiths, and comprise 22.3% of households nationwide. An estimated 1/3 of women live in polygamous unions. Household heads are mostly adult males and the average difference in age between husband and his eldest wife is 12.6 years.

The roles of men, women and children in households varies from one ethnic group to the other. Among the Hausa and Fulani of the north a man is expected to support his wives and children. He provides for food, clothings, and education. Fewer northern women earn cash incomes than in the south, although economic necessity has led to increased interest in women's earning opportunities.

In the south, many Yoruba women, initially financed by their husbands, trade in the market. Igbo women also trade, and with a long tradition of education for women, many are able to find salaried jobs. Men generally take responsibility for children's school fees, although Igbo women often pay for their daughters' education to assure her equal opportunity. Because of these differing responsibilities, the response to economic strains varies. Women all over the country reported having to take on greater economic responsibility in the family recently.

b. Marital Stability.

The 1981/82 Fertility Survey showed that only 10% of ever-married women in the survey in Kano State had their first marriage dissolved, but among those 40 - 44 years of age, the rate was 17.4%. In urbanized states such as Lagos the rate of dissolution was higher, 24% over all and peaking at 46.7% for women aged 35 - 39. In Imo State 17% of first marriages had been dissolved by the time of the survey, and the peak rate was just over 21% in the 30 - 39 year old group. In most households, children are expected to begin helping at an early age, around five in rural areas and slightly later in the city. Sending children to school prolongs their dependency, and is costly for the family even when no tuition is charged.

c. School Enrollment.

In all three case study states school systems fees have been assessed since 1983 at the secondary level, ranging from N35 per term in Ogun State to N50 per term in Kano and Imo State. Primary school fees have been officially instituted only in some areas, but even where there are

not official, parents report increasing periodic levies. The impact on primary school enrollment has been immediate and universal. Secondary school enrollment have been affected only more recently, and the decrease is less.

Of the three case study states, Imo State is the only one to have calculated what percentage of the school aged population (5 - 14 years) was enrolled at school. It shows the percentage declining from 70.2% in 1981 to 45.3% in 1984. If one assumes the same rate of population growth since 1963 in all three states, Ogun State would seem to be sending a similar proportion of its school age population to primary school while Kano sends only about 2/3 of that proportion to primary schools. In the two southern states secondary school enrollments are about 1/3 of those in primary school, while in Kano the proportion drops to 1/10. These figures illustrate the well known reluctance of northerners to commit themselves to the modern educational system, which is seen as western and Christian oriented, a potential threat to traditional and Muslim values.

Education, employment of women, and urbanization have been widely hypothesized as factors likely to decrease fertility rates. The 1981/82 survey confirmed what local surveys had already suggested; the opposite may be true. Current fertility rates in urban areas are slightly below those in rural areas for the ages under 20, but they actually surpass rural areas in the prime child bearing ages of 20 - 35 years. Women with only a primary education have slightly higher completed fertility rate than women with no formal education. Only among women with secondary education does fertility began to decline. Women's employment is a factor only if it is also combined with secondary education.

In this light, the problem of women's education is particularly acute in the north. The northern women's association (Jamiyar Matan Arewa) and the State Ministry of Education have launched campaigns to improve women's education. Statistics suggest that they have a long way to go. The proportion of growth in primary school for girls has increased slowly from 26.3% in 1972 to 30.5% in 1986. In secondary schools, however, it has actually decreased slightly from 15.3% to 12.5%. Secondary education for girls is the best natural means of decreasing child marriages and high risk early teenage pregnancies, but because of the social sensitivity of Family Planning in the north, any campaign supporting female education should be separated from the family planning program per se.

d. Health Related Considerations. The health problems associated with uncontrolled fertility are very different in different parts of the country. There is very little knowledge or use of modern contraceptive methods nationwide. The women interviewed in the 1981/82 survey felt that they had little control over their fertility. Nearly half could not put a number to the ideal family size, and only 2.6 percent had ever used any modern contraceptive method. Another 12.5 percent had used traditional methods, mainly abstinence, while two thirds of the women interviewed had never heard of any contraceptive method.

There are four types of high-risk pregnancies, which the National Family Planning Action Plan targets: (1) births spaced less than two

years apart, (2) births to mothers aged less than 18 years, (3) high parity births (more than four), and (4) births to mothers over age 35. These occur with different frequency in different states. Infant and child mortality also varies greatly from one state to another.

In Imo State women enter marriage rather late at an average age of 17.5 years. Under the influence of Catholicism most marriages are monogamous. Only 18% of women live in polygamous unions. Completed fertility for women is high, however, at 6.6, and the intervals between births are the shortest in the nation. Breast feeding lasts an average of only 13.3 months and post-partum sexual abstinance 10.9 months. The short interval between births is dangerous to the health of both the children and their mothers. The high pregnancy rate among older women and high parity rate are also serious health problems.
In Kano State child marriage is customary and most girls are married before or immediately after puberty to ensure that the girl will be a virgin at marriage. It also fits in naturally with the custom of fostering children. Children are often raised by someone other than their natural parents. They are sometimes exchanged between siblings to solidify family ties, given to barren women, distributed to people who may be in need of their help, and often given to relatives who may be in a position to educate them.

These early pregnancies bring with them many health problems. The girls are frequently still growing themselves when the first pregnancy occurs. High rates of infant and maternal mortality are associated with complications such as eclampsia, vesico-vaginal fistula, obstructed delivery, and hemorrhage. Secondary infertility is also a serious problem, after the complications associated with a first early pregnancy.

Childbearing among northern women in their twenties, on the other hand, is relatively free of complications. Breastfeeding is relatively long, with an average of 21.1 months and post-partum abstinence from sexual relations lasts most of that time (mean 16.2 months). Completed fertility is relatively low at 4.1 children born to woman aged to 45 - 49 years.

A recent epidemiological study of childbirth in the north was done in the Teaching Hospital of Ahmadu Bello University in Zaria. Nearly 23,000 pregnances and deliveries were monitored between January 1, 1976 and June 30, 1979. There were 238 maternal deaths (10.5 per thousand deliveries). Perinatal mortality, normally only recorded if it occured during the 12 - 24 hour hospital stay, was 120 per thousand births. Important pregnancy complications included anemia (1,750 cases), disproportion (1,650), prolonged labor (1,249) pre-eclampsia (1,395), multiple pregnancy: twins (747), triplets (16), quadruplets (2), co-joined twins (3), ante-partum hemorrhage (780), eclampsia (525), sickle-cell disease (28), hepatitis (12), meningitis (13).

In Kano State, 94.9% women delivered their last child at home. The birth was attended by a traditional birth attendant (usually an older woman) in 68% of cases, by a family member in 16%, by no one in 11% and by a midwife or nurse in 4% of cases. Only 15% of the women had an

antenatal check up during their last pregnancy and only 20% of their children received any innoculation after birth. The above figures point to the need for training traditional birth attendants in the north as well as using contraceptive social marketing. Expansion of the modern health care facilities is important, but they reach too small a proportion of the population to have a significant impact in the family planning area in the five year span of this program.

In Ogun State the birth rate is one of the highest in the nation, at 237 per thousand women aged 15 - 49 years. Infant and child mortality are also high at 103 and 206 per a thousand live births respectively. Teenage pregnancies are less of a problem than elsewhere, as the average age at first marriage is 18.4 years. Traditional birth spacing through abstinence is widely practiced, with an average of 21.6 months ofabstinence following a pregnancy. High parity births are a problem particularly in older women. The proportion of women with more than four living children is 43% in the 35 - 39 year age groups and reaches 68% in the 45 - 49 year age groups. On the other hand, in Kano State less than two-thirds of that proportion of older women have had more than four children.

Ogun State has a thriving private health care system in addition to its public health care facilities, which is not true in Kano. Fifty-nine percent of women surveyed in Ogun State delivered their last child in a clinic and only 40% delivered at home. Nurse midwifes attended 55% of births, traditional birth attendants 19%, a family member 16%, no one 8% and a doctor 1.6%. There was a relatively high rate of pre-natal check up (67.5%) and innoculation of children (55%).

Studies of the use of health care facilities in Nigeria suggest that 60% of medical consultations are provided by traditional healers or chemist shops, and only 30% involve the modern health care system. Often a sick person makes use of both systems, by visiting first a chemist, then a traditional healer, then a modern clinic, and back to the traditional healer at different phases of an illness.

Traditional healers can also be important agents in the family planning program. A recent study interviewed 550 traditional healers in six states. It reported that a majority of them had little or no formal education, but they had long apprenticeships, lasting two to twenty years. Thirteen percent had secondary school education, and some of these were partially trained in modern medical care professions. There are also hawkers who carry a small number of medicines from chemist shops to sell in rural areas. Both healers and hawkers could be trained to distribute barrier methods and pills, in liaison with local clinicsas is being done for market-stall vendors.

The federal and state family planning plans in most cases call for such training, and the wide-spread use of traditional healers suggest that they should be a priority. In every state visited, State Ministries of Health reported that traditional healers are constantly applying to the Ministry for modern health training and recognition. There is good reason to believe that they could be effective agents in both urban and rural areas, particularly the latter where the modern health care system

is especially weak. Moreover, experience elsewhere has shown that traditional healers can undermine family planning programs if they are left out. Women who experience side effect of family planning methods or have other complaints take them to the healers, who may blame the contraceptive a woman is using for everything from irregular menses to venereal disease.

The leading commercial marketing of contraceptives has been organized by Sterling, through a nationwide network of pharmacies, chemist shops, and in some places market stalls, plus a program to work through large corporations' health clinics. Sterling provides training much like that organized through the State Health Ministries. USAID has subsidized the cost of contraceptives supplied; Sterling keeps a 20% handling charge and turns 80% of the cash proceeds of sales back into the information, education and communication program (IEC). Through an advertising contract, TV and radio spots and print and poster, advertisement have been published nationwide. A more elaborate TV soap-opera series with 180 - 200 episodes is being developed by Nigerian Television Authority. In its first year of operation the Sterling social marketing programs distributed 600,000 cycles of pills and almost 6,000,000 condoms, amounts equivalent to 143,846 couple years of protection. Suggestions have nevertheless been made for improvements, which should be considered in the immediate future. These include varying the advertisement campaign to provide a wider range of reasons for family planning, and using less elite model families (one current ad pictures a 2-child family celebrating their son's graduation day). A wider audience would be reached, marketing studies suggest, by advertisements with a simple message such as, "Ask yourself, can I feed another child? Can I cloth him? Where will I get the money for his school fees? Packaging of supplies and brand-names have also helped sales elsewhere. Sterling might also find that its distributors, who currently work on a flat salary basis, would be more competitive if they received productivity bonuses or commissions. An unavoidable constraint at all levels is that family planning supplies are low-profit items, marketed as a social service.

There needs to be a more deliberate effort to reach male audiences in both the public and private sector family planning programs. At present all of the training and administrative personnel encountered in the family planning program are women, and most of the outreach has been to women. Yet the response of men to corporate and military family planning programs suggests that they are interested in family planning. In their roles as heads of family they obviously have an interest, but this is usually assumed to mean a negative attitude toward family planning. In Kano State, for example, the program initially tried to motivate only women yet required a woman to have written approval from her husband to obtain contraception. The husband's approval is no longer required in Kano and more educational efforts are being directed to men.

2. Motivation

The primary motives of new family planning users all over the country are the same: economic stress. Every family clinic reported economic hardship as the major motivating factor. Men may be reluctant to admit

economic problems in public, particularly in the north where it is considered shameful, but women are quite frank about it. Because the downturn is a national event shared by everyone, there is greater willingness to admit it. The breakdown of post-partum abstinence also contributes to demand for modern FP methods, as the value of child spacing is still understood and modern methods are needed to maintain it. Educational campaigns stressing the high risks to mothers and children of early child bearing, high parity, short birth intervals, and births to older women are also persuasive.

The main disincentives stem from lack of use of the modern health care system, to which such services are largely confined, and the transportation, time, and embarrassment involved in obtaining them. In some areas cost is a factor in the market although low-cost supplies are available in most areas at public clinics. The commercial cost of pills ranges from N1 per month to N7 (US$0.25 to US$1.75), and condoms 50k - N2 (US$0.13 to US$0.50) for four. This is certainly less than the cost of feeding a child, but in rural areas where there is little cash flow, it still may be beyond the means of many families.

Motivational factors should also be considered for providers of health family planning services. Right now enthusiasm seems to be high, training programs are lively and imaginative, and humanitarian ideals seem to be an adequate reward. Dynamism is greatest however, during the organizational phases of the program and in training sessions. Once those are over the fact must be faced that public health care personnel are poorly funded and rarely have adequate medicines, equipment, or transportation to do their job. They receive the same low salaries regardless how many patients they see. Attendance at many clinics is low, perhaps because patients have so frequently found them lacking in medicine and equipment. Some good people leave the public health care system to set up private clinics. For market vendors likewise contraceptives are not a high profit item, and sales were highest in the initial months after the vendors' training and installation in their new roles. Brainstorming with them on how to improve sales might help, as might periodic reorganisation or retraining.

Political and community leaders are motivated additionally by the growing awareness that little progress can be made in other sectors until population growth slows down. It is not a popular stance to take, however. It has always been much more comfortable to say that ones strength is in numbers, as that strikes a responsive chord in listeners. The RAPID presentation regarding the negative social and economic consequences of continued high population growth has impressed community leaders, political leaders and the literate public. They do not, however, motivate many consumers to adopt family planning. Users' motivations are generally more immediate and personal.

D. Matching Project and Participants

The key to adapting state and local government family planning programs to local conditions is better knowledge about each area. In fact, substantial variations in approach are already noticeable. In the south where women's and men's voluntary groups are numerous and dynamic,

seminars for local leaders have been organized or are planned. In the north, on the other hand, program organizers believe that involving community leaders, particularly religious leaders, will be productive. Many public statements by Islamic authorities have concluded that family planning is acceptable in Islam if it does not involve abortion or sterilization for reasons other than the health of the mother. A minority of scholars have asserted that Islamic opposes modern family planning methods except for health reasons. Given the little-known, but serious health problems in the north discussed above, the northern IEC campaign should stress these. If and when the family planning organizers judge the possibility of cooperation by community and Islamic religious leaders to be better than at present, they should find common ground if they stress: 1) girls should stay in school, and 2) pregnancy in girls under 18 years has serious health risks for both the child and the mother.

What has not yet been adapted to local differences is the different times of life during which women need family planning aid, and the different reasons for it in different parts of the country. In most cases, information such as that gleaned from the fertility study in part two above, has not been available to local program specialists. The most serious problem is young mothers in the north, whereas in the south it is high parity shortened birth intervals may call for a different mix of methods offered in different areas, as well as different messages in the IEC program. The program is developing protocols to guide both providers and users to adopt the methods most appropriate to their circumstances. Written in a simple language, the guidelines will be widely published to curtail inappropriate use and allay public apprehension about side effects. The desirability of several methods varies also because of cultural factors. In the north, for example, most users are married women with children. These women prefer less easily detected methods such as the injection. Deep opposition to female promiscuity and the male belief that the availability of family planning will make woman promiscuous, makes it hard to reach the young women whose health is most at risk in pregnancy. Pills would be the method of choice for most of them, but women do not like to be seen taking them, even with their husband's permission.

In these sensitive circumstances, ironically, the condom may make an important contribution to family health. There is little concern about male promiscuity; it is a meaningless concept because men are assumed to have sexual freedom. Condoms are in the male domain. They are not considered to be "family planning," which is associated with women. Condoms are associated with sex, and in fact often used in extra-marital liaisons rather than in the family. Condom sales can therefore thrive in an atmosphere of opposition to family planning. Many wives may have to continue to rely primarily on post-partum abstinence, but at least this is subject to less pressure from the husband when his external liaisons are safe. In addition, both husbands and wives are better protected from sexually transmitted diseases, and the value of the condom as protection is becoming well known.

E. Obstacles and Opportunities

Many obstacles to the development of a family planning program have already been overcome in Nigeria in the last five years, but they may re-emerge from time to time in new guises. These can be grouped into political, religious, and cultural barriers.

1. Political

The political furor surrounding censuses in Nigeria reflect some of the political obstacles to family planning. Political groups, regions, and ethnic groups and religions vying for position all want to be numerous. The bottom line is that political power is measured in numbers, and allocations of federal funds are based on population.

Nevertheless, barring a major change in government, the political context is increasingly favorable. The tide has turned, and it will be difficult to turn back. There are no legal obstacles to the importation and distribution of contraceptives in Nigeria. The favorable public statements by government leaders should prove sufficient to facilitate family planning adoption. Political leaders do not have to undertake the whole IEC campaign. On the other hand, a top state health official who opposes family planning can effectively block a program in his state. Localized opposition should be expected to flare periodically, but diminish as acceptance becomes widespread.

2. Religious

Islamic. Some Islamic scholars oppose modern family planning methods, but they are a minority in Nigeria today. More important is the widespread fatalism, the belief by women that they have no control over their fertility. Children come from God, people say, and He will provide for them. But such fatalism, although common to Islamic women, is not inherent in Islam. There are two major puritanical Islamic movements (they reject the label fundamentalists) that count among their members. Some opponents of modern family planning are Jami atu Nasiil Islam and Izala. Fortunately, they have a social platform that coincides with the family planning program on larger social issues. They are campaigning hard to change the one factor that would do most to reduce high risk pregnancies and population growth: child marriage. They oppose child marriage and favor educating women. Completed fertility is low in the north. Moreover, one of the founders of both organizations, Sheik Abubakar Gumi, has twice come out in public saying that Islam does not oppose family planning. The fact that he did make such statements, and that they caused a stir in the press, reflects the widespread conservatism regarding family planning among northern Muslims. Those who have thought it through mostly accept the idea, but is is a new thing and some people are hesitant about such an intimate innovation.

Roman Catholics. The Roman Catholic Church is predominant in the southeastern states, and has many clinics throughout the country. It adheres to the Vatican stance against non-natural methods of family planning, but in most places actively encourages the principle of natural family planning abd responsible parenthood.

3. Cultural

When asked what factors inhibit the people from using family planning, a group of Nigerian nurse trainees came up with a list of "misconceptions" that reveals much about popular beliefs and fears. They mentioned the belief that family planning is designed to keep people from having children or make them limit their family size. They mentioned expense as a factor, where people cannot weigh the immediate requirement for a cash outlay against the much greater expense of child raising. They mentioned the opposition from parents and in-laws, and religious opposition which we have already discussed.

They believed that most men do not support family planning and that men feel that women using family planning methods would be promiscuous. And that men think that sexual satisfaction would be reduced by condoms and/or vasectomy.

Actually one study that looked at family decision making patterns in relation to fertility showed that fertility was lower when husband and wife made a decision on family size together than when no one made the decision. It was highest when the wife made the decision alone. A recent survey of male attitudes among Gulf Oil and Lever Brothers employees in Nigeria found that 63% agreed with both modern and traditional methods and an additional 23% agreed only with traditional methods. There was a strong desire for more information on birth spacing, with 73% wanting more information for themselves and 69% thinking that their wives needed more information. The ideal number of children averaged just over five, while the mode was four. Compare this to the ideal of over seven reported by women in the 1981/82 fertility survey.

In other studies, women reported fears for themselves if they used family planning. There is the taboo of becoming barren, and the fear and sometimes public humiliation of having a small number of children. They feared that they might become sterile while using family planning. Worries about side effects are also spreading. There was fear of migration of IUDs, or that menses would be irregular and one would feel run-down. Some believe that one could not breastfeed while using contraception, or that subsequent children would have a higher incidence of abnormalities. Women have also reported the fear that if one would die with an IUD in place, one might be reincarnated as a sterile woman. These rumours point to the need for press debate and public education about the use of appropriate methods at different times and for different circumstances, as well as how to manage minor side effects. The greater health risks from pregnancies are persuasive with statisticians and health professionals, but not to women themselves.

7. Spread Effects and Benefit Incidence

The initial target area of the family planning program is the urban population. This population is easier to reach with media messages, health care facilities, and marketing strategy.

Despite close rural/urban linkages in Nigeria, family planning will not "trickle down" spontaneously. Community based development needs to

be developed to carry outreach effectively into rural areas. The private sector program also needs to look into rural outreach, including perhaps greater use of chemists' hawkers and traditional healers.

All studies agree that highly educated women will be among the first to use family planning. They generally belong to the social economic elite. But clinics are already finding rising demand from poor and illiterate women. The social marketing strategy is successfully reaching the marketplace, where market women themselves constitute a socioeconomic middle class. The public health system is expected to provide free or minimal cost contraceptives to the poorest, but many of them have no access to clinics or to transport to get there.

The fact that a child survival campaign is reaching out to the same population in the same time period with oral rehydration therapy, immunization, and child nutrition education, will facilitate the adoption of family planning. As more children survive, better spacing will be needed. Family planning, in turn, reduces maternal and child morbidity and mortality.

G. Participation and Impact

Nigerian Participation. The Federal Government has committed itself to a national family program, with an action plan and dedicated resources. Every state has devised a family planning and deputy, action program, appointed a state family planning coordinator, and trained both outreach and service staff. LGAs have initiated hundreds of service sites. At the community level, village health committees, many developed for the Expanded Program of Immunization, have begun to incorporate family planning. In 1987, village health committees in 52 selected LGAs will begin to select community health volunteers to deliver primary health care services including family planning. This project will work through this existing system and build on and add to resources that currently exist.

Impact Potential -- Widespread and Effective Use of Methods. Ineffective use of contraceptives is a wasteful, disheartening, and even dangerous phenomenon. To avoid unwanted pregnancies among family planning users, the program will emphasize good education and counselling to help new users select the optimal contraceptive method for their circumstances. Already Nigerians have displayed preferences for a mix of effective methods, particularly the IUD. Additional training and facilities for IUD service will ensure that this effective method is available close to home and at free or nominal cost for even more women.

Impact Potential -- Spread and Continuity. Because many different organizations and groups of people in the public and private sector are incorporating family planning activities, the family planning program is not vulnerable to the collapse of any single institution. Private medical practitioners, pharmacists and retailers of many varieties, as well as public service providers, will all be increasingly involved. As the family planning movement develops, these people will continue to exercise their family planning skills wherever they are, and they will have a vested economic interest to see family planning continue and prosper.

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Measurement of Impact. Nigeria has excellent institutional capacity for measuring program impact, both through surveys and continuing monitoring. The National Population Bureau and the Federal Office of Statistics have offices in every state, with established sampling frames and teams of interviewers and supervisors experienced for collecting data. The program monitoring and evaluation schemes will collaborate with one or both of these institutions to obtain independent measures of program impact.

NB:
The full text of this social soundness analysis with bibliography, supporting tables and documentation is available from the USAID files.

TECHNICAL FEASIBILITY ANALYSIS

A. Introduction

The feasibility of the Nigerian Family Health Initiatives II Project is based on a demonstrated commitment to family planning on the part of the FMG. It is bolstered by growing popular awareness of the importance of family planning, both for improvement of maternal and child health and for the enhancement of national social and economic development. The recent increase in users of family planning services supports the feasibility of expanding these services and the apparent readiness of increasing numbers of Nigerians to utilize them. The rationale for rapid expansion is based on recognition of current public health and socio-economic realities, including persistent high fertility, high infant and maternal mortality, and a stagnating economy with serious unemployment and increasing poverty.

The technical feasibility of rapid service expansion depends on the project's mutually reinforcing elements acting in harmony, namely:

- a favorable policy framework for rapid nationwide acceptance of a national family planning effort;
- public and private sector delivery systems to extend affordable, safe and effective family planning services; and,
- an effective IEC program to inform the public of the benefits and availability of family planning services.

For this project, public sector expansion is to be achieved through integration of family planning services within the primary health care system which is already well underway. Expansion in the private sector will focus on existing networks of medical and traditional practitioners, pharmaceutical outlets, the expansion of existing and potential marketing networks, and the replication of successful pilot projects in community based outreach. By the end of the project a 12 percent contraceptive prevalence is expected -- a considerable increase over the current documented 1981 prevalence of 2.6 percent and currently estimated 5-6 percent.

Experience and critical analyses of a number of national family planning efforts worldwide have demonstrated the technical feasibility of rapid expansion of activities, in both vertical and integrated delivery systems and in a variety of marketing and community based distribution approaches. With the exception of Zimbabwe, no sub-Saharan African country has yet demonstrated substantial acceptance of modern family planning methods, let alone a rapid expansion of contraceptive prevalence. This fact underlines the importance of a careful examination of the socio-economic and cultural context in which the Nigerian project is placed. Data, however, from the World Fertility Survey, along with more recent surveys, demonstrate that increases in contraceptive prevalence more rapid than changes in socio economic variables have

occurred in other countries with national family planning programs. Bangladesh, Colombia, Thailand, Mexico, and the Republic of Korea have all shown increases of over 20 percent in prevalence in as little as 5 to 10 years. There are other countries however, in which contraceptive prevalence remains low despite national policy and organized family planning promotion, such as Kenya and Ghana. It should be noted, however that neither of these countries has allowed nationwide advertising or sale of contraceptives through the informal private sector. While numerous factors account for these divergent experiences, several conditions have been determined to significantly contribute to successful national programs. Among these are a strong political will, institutional and infrastructural capacity, and a popular readiness.

Nigeria's recent history and current socio-economic situation indicate that with appropriate government support and external assistance, these conditions exist. The realization by the country's leadership that national development is seriously constrained by Nigeria's rapid population growth, the commitment to support an integrated family planning program accompanied by substantial child survival initiatives, full involvement of the private sector, and an economic crisis in which high fertility is increasingly recognized as detrimental are all factors all augur well for the feasibility of the program in Nigeria. Moreover, the current accelerating pace of contraceptives acceptance tends to bolster this conclusion.

B. Technical Analysis

1. Service Delivery Issues

Worldwide experience has demonstrated that it is technically feasible for public and private institutions to provide safe, effective and reasonably-priced family planning services.

Family planning methods have been proven safe. Complications from the use of temporary contraceptive methods are rare and usually minor. Serious complications can be prevented or reduced with proper client screening, surveillance, early problem identification and proper management of the problem. Contraception also has been proven effective in preventing unwanted births when used properly. Failures (i.e., pregnancy) in use of pills and barrier methods are related mostly to improper uses. (For further details, see Table 1).

Experience in other developing countries which have educational and socio-economic levels similar to that the Nigeria shows that family planning programs are acceptable. Bangladesh, for example, has achieved a contraceptive prevalence rate of 30 percent; Colombia, 63 percent; Thailand, 65 percent; Indonesia 60 percent; and Tunisia, 42 percent. In Africa, family planning programs are a recent innovation. Nevertheless, a few African countries have achieved impressive contraceptive prevalence rates such as 56 percent in Mauritius, and 40 percent in Zimbabwe.

Successful family planning programs general depend less on technical feasibility than on the level of official policy support and the availability of high quality, low cost services. However, three technical elements are critical to the success of basic family planning services are:

- availability of adequately trained and supervised personnel;

- availability of a sufficient and constant supply of contraceptives and materials;

- availability of information for clients to make informed decisions.

The following narrative explores each of these elements as they apply in the Nigerian context.

a. Availability of Personnel

Nigeria has an extensive medical infrastructure and pool of trained personnel. In 1984 Nigeria had 12,412 registered medical practitioners (13.2 per 100,000 population), 41,370 nurses, 35,196 midwives, 2,360 pharmacists and approximately 25,000 other health workers in the public and private health care systems. The speed with which access to family planning expands will depend to a considerable extent on the degree to which these resources are mobilized and utilized for family planning.

The public sector component of the project will build enhanced family planning capability on an already well developed primary health care delivery system which serves approximately 30 - 40 percent of Nigeria's population. A substantial number of health personnel have been already trained as providers, trainers, and managers of IEC and service delivery functions, but many of these require updating of their knowledge and technical skills. Many more need to be trained to accommodate the rapid expansion of services. The private sector component will identify, train and certify potential service providers according to the level of expected service provision. The project will provide training as follows:

- management training and supervision involving largely public sector administrative and supervisory personnel at federal, state and LGA levels;

- clinical service delivery involving both public and private sector physicians, midwives, nurses; and,

- IEC and outreach skills as well as non-clinical method service delivery, involving community health workers, dispensary and outreach workers, and a variety of private sector services providers such as pharmacists, market women, taxi drivers.

The project will insure that all service providers are trained and certified to achieve technical excellence in the services to be offered. Training subjects will include: counseling and client motivation techniques; health benefits and medical risks of each method; client screening for contraindications and provision for appropriate alternatives; and, identification and management of complications. Proper maintenance of clinic service records and of clinical equipment will also be taught where appropriate. Supervisors will be trained to oversee and give on-the-job training to service providers, to identify technical problems in service delivery and enhance staff proficiency.

The private sector has the potential to provide a major proportion of contraceptives over the life of the project. However, it is recognized that commercial marketing and community based distribution projects invariably raise issues of safety and quality assurance. Accordingly, these initiatives will be approached with appropriate caution and carefully monitored in the early implementation phase of the project. Indeed, training for private sector providers will be more rigorous than for public sector and certification through the public sector will be required.

b. Availability of Sufficient and Constant Supply of Contraceptives and Materials

Supplies for family planning projects, even more than most other health care supplies, need to be available on a regular basis in sufficient quantity. The requires thorough planning and development of a reliable commodity supply system.

Contraceptive requirements for this project are included in Appendix 1 of this Annex. The distribution of contraceptives between the public and private sector, and among methods, are detailed in Table 1-A and 1-B. Table 2 gives the estimated method-specific contraceptive use by year. Table 3 summarizes commodity requirements by year in which supplies are to be ordered, so an adequate reserve stock of commodities is maintained at all times. Table 4 summarizes total estimated costs of project commodities in the year in which shipments are to be made.

For the entire project period, contraceptives are expected to cost $17.0 million, of which $2.5 million (15 per cent) will be for the public sector and $14.5 million (85 percent) for the private sector component. Not factored into this budget amount is a possible increase in condom and spermicide use due to the impact of the FMG Anti-AIDS educational program. It is estimated that possibly 500,000 condoms will be required in the first project year, increasing at a minimum rate of 5 percent annually. It is expected that by 1992 approximately $1.0 million will be required for condoms for AIDS prevention.

While sufficient funding to cover all project contraceptive requirements for the first three years is anticipated, the funding for AIDS related condoms and spermicides as well as the post-project period remains uncertain. During the first three years, potential donor sources and mechanisms for funding will be aggressively explored. The process has begun, and encouraging indications of interest have been indicated from two potential sources, UNFPA and the World Bank. Donors will be kept informed and involved as the program evolves and exact needs are determined. Formal mechanism for donor/lender involvement will be built into the evaluation process.

The project will arrange for large amounts of contraceptives to be made available through the public and private components to service providers, and ultimately to users. This process will involve ordering and shipping commodities from the U.S. through the S&T/POP central procurement system,, clearing goods at port of entry, initial warehousing at a central location in Lagos, and timely transportation to state stores or private distributors. The S&T/POP central procurement system is ordinarily utilized. To avoid wastage, annual contraceptive projections

will be calculated and contraceptives will be ordered on a periodic basis. Technical assistance in commodity projections will be provided by CDC and other S&T/POP resources as required.

In this project, based on past experience with the FPIA-funded commercial marketing project, Sterling Products (Nigeria) Ltd. will centrally manage the contraceptive import, warehousing, and in-country distribution for both private and public sector activities. Project staff will periodically assess the functioning of this system and work with the SMOH and private sector service delivery personnel to overcome any deficiencies in storage, recordkeeping, and requisitioning.

c. Availability of Information for Clients to Make Informed Decisions

The availability of consistent and appropriate information on family planning concepts and the use of contraceptives is key in facilitating a potential client's ability to make an informed decision. To be most effective, information should be presented through a variety of familiar and culturally appropriate channels. These channels include:

Print materials: pictorial booklets for low-literates on health and economic benefits of childspacing; posters depicting motivational themes and available methods; reference guides for heatlh workers when counseling potential clients; materials to promote commodities and inform buyers;

Mass media: radio/television and traditional drama and variety programs with family planning concepts integrated into the scripts; advertisement indicating availability and location of services; testimonials by traditional and religious leaders to mobilize their constituencies.

Three factors must be considered in planning the project's IEC activities:

- whether the materials can be developed and produced;
- whether the produced materials can be distributed; and
- when once distributed, whether materials can be effectively used.

Production capabilities. Nigeria has a long-standing tradition of a free press resulting in a sophisticated network of 35 radio and 22 television stations and 19 daily and 16 weekly newspapers and magazines covering all of Nigeria. The ability to produce high quality programs and print materials varies from state to state. However, equipment and materials are in evidence and the creative and technical skills needed for design and production are available to create entertaining yet educational materials and programs.

Dissemination capabilities. Besides the network of broadcasting and circulation mentioned above, the Ministry of Information has a network of centers in every state with a mobile capacity to bring information to the community level. Film projectors, mobile vans, public address systems all lend support to disseminating information to

potential clients who may not visit clinics. Materials for clinic use produced at the national and state level have been distributed to clinics through the MOH network and through the Planned Parenthood Federation of Nigeria's state branches. Sterling has been instrumental in transporting tons of print materials to state ministries of health as well. All these channels are available to this project.

Interpersonal communication capabilities. Once materials are available at the clinic level, service providers need to be adept in using them during counseling and outreach to help clarify concepts of family planning and to assist in the use of modern methods. Health workers are receiving in-service training from the Ogun MOH School of Family Planning and the University College Hospital in Ibadan on family planning methods, motivation, and IEC materials development. This project will capitalize on the great potential for integrating a material development/counseling/motivation session into the family planning clinical curricula. An important element in future IEC training programs will be classroom discussions aimed at reducing provider biases for or against specific methods to insure a truly informed choice by all clients.

2. Bio-Medical Issues Specific to Technical Feasibility

a. Traditional Methods

Nigerians have a long-standing tradition of birth spacing achieved by the combination of post-partum abstinence and prolonged breastfeeding. It is currently estimated that some 30 to 40 percent of families are relying on these measures at any given time. The project does not propose to encourage substituting modern for traditional birth spacing wherever the latter continues to be fully observed. However, available evidence indicates that periods of abstinence and breastfeeding, particularly in the urban areas, are decreasing to the detriment of both maternal and child health as well as desired spacing. Wherever counseling determines that this occurs, health education and modern methods will be offered as an alternative.

b. Oral Contraceptives

Serious complications attributed to the use of oral contraceptives are statistically rare. Indeed, when potential risks attributed to utilizing contraception are weighed against benefits, oral contraception proves far safer then uncontrolled fertility, especially where rates of infant and maternal mortality remain high and morbidity associated with illegal abortion is endemic as in Nigeria. While this rationale justifies non-clinical distribution of pills, it is still incumbent upon providers to supply simple screening techniques to minimize risks for oral contraceptive users. Pilot projects in Nigeria have demonstrated the feasibility of this approach.

In Nigeria, a variety of formula of oral contraceptives is available in the private sector. Thus, the possibility of confusion and side effects exists when users switch from one brand or supply source to another. However, this should be minimized by the following new AID policy regarding pill formulations. On the basis of new scientific evidence regarding the relationship between the estrogen and progestogen content of oral contraceptive pills and the risk of circulatory problems,

USAID is adjusting the formulations of pills to be provided in AID-funded projects. One low-dose formulation of combined estrogen/progestogen pill and one low-dose progestin-only formulation (for lactating mothers) will be provided to reduce risks and minimizing confusion and side effects resulting from method switching. Furthermore, the new project will encourage, through training and informational materials, the provision of more than one cycle of pills per visit, a practice which already prevails now in many clinics. This change should enhance client satisfaction and decrease the incidence of pill formulation switching.

Under current arrangements, AID-assisted public sector projects in Nigeria are phasing in products in conformity with these principles. However existing stocks are expected to last through 1988. Moreover, under current agreements, different brands of oral contraceptives are provided to private sector distributors than those available in the public sector. Thus, users who change from public to private sources (and vice versa) for re-supply are still subject to confusion and possible side effects. Insofar as this is medically undesirable, USAID will investigate the possibility of providing the same formula of pills for both public and private sector distribution, even if practical considerations require different packaging. Over time it will be necessary to give attention to changes in oral contraceptive theory and practice in the training of health personnel as new scientific knowledge emerges and new formulas are introduced.

c. Intrauterine Contraceptive Devices (IUD)

In this project, the IUD promises to play a dominant role as the numbers of trained providers and fully equipped clinics grow. Since few women in Nigeria are likely to delay their first pregnancy and similarly very few are likely to elect sterilization, the IUD is particularly suited to multiparous women who want long term reversible protection.

While IUDs involve comparatively high initial costs since their insertion requires a fully equipped clinic and clinically trained health professionals, they generally are associated with higher continuation rates than pills or barriers methods. This is particularly true of the newer and longer-acting copper IUD's which are now replacing the discontinued Lippes Loop. Current training is addressing this change to the copper IUDs because of differences in IUD characteristics and insertion techniques.

The association of IUD use and increase risk of pelvic inflammatory disease (PID) has not been reported specifically in Nigeria. However, studies throughout the world have confirmed such as association. In recent years the extent of this problem has been attributed more to user behavior than to the device itself. As a result, careful screening of clients and limitation of IUD use to women at low risk of PID is known to reduce this risk. Since PID is known to be prevalent in Nigeria, screening careful selection and counselling of acceptors, proper insertion techniques and periodic followup of IUD users will be an important feature of the training and IUD service delivery components of public and private sectors

At present few institutions in Nigeria have the laboratory facilities for specific diagnosis of sexually transmitted diseases (STD). However, as less elaborate and less costly new technologies for diagnosis emerge, it may be possible for this project to address the contribution that

laboratory screening can make to add to the safety of IUD use and to the prevention of infertility. Until such time as better technology is available, careful STD screening through pelvic examinations and medical histories will be essential. These practices will be stressed during training and in-service protocols.

d. Condoms

Marketing statistics show that sales of condoms are increasing in Nigeria as elsewhere. The inclusion of condoms among family planning alternatives in both clinic and commercial based services is intended both as contraception and as prophylaxis against STDs. Even though AIDS is not yet prevalent in Nigeria, recent publicity given to the finding of two AIDs positive prostitutes among the first few thousand women tested in the country, and the recommendation by health officials that condoms be used to prevent the spread of this disease is certain to contribute to wider condom use. This phenomena should be monitored closely. Additional funds for condoms and spermicides may be required if there is a significant increase in their use due to AIDS prevention.

e. Newly Emerging Technologies

The possibility that the contraceptive implant (NORPLANT) may be approved by the US Food and Drug Administration (FDA) and accordingly incorporated into USAID's program of family planning assistance during the life of this project must be considered. Field trials of NORPLANT have been completed in Nigeria as part of worldwide collaborative studies. The results are not yet published but are described as favorable, both with respect to effectiveness and acceptability. To the extent that voluntary sterilization is not yet well established, long term reversible contraception, especially for women at high risk because of multiparity, will figure heavily in the diffusion of family planning in Nigeria. Accordingly, information about methods such as NORPLANT will be incorporated into the clinical training curricula, and special training for insertion and removal of sub-dermal implants is envisioned as a responsibility of the teaching hospitals should this or other new methods be introduced during the life of the project.

f. Effectiveness and Safety of Contraceptive Methods

The effectiveness and safety of modern contraceptives has been proved throughout the world. While actual use-effectiveness rates vary for many reasons, Table 1 indicating first year failure rates of "typical users" is a reasonable indicator of relative use-effectiveness by method.

Serious complications attributed to modern contraceptive use are statistically rare, and to a great extent can be prevented by proper method selection, appropriate screening of acceptors, counseling and early identification of symptoms.

Progressive changes in the technology of family planning have in themselves contributed to the effectiveness and safety of modern contraceptive use. The development of new, longer acting copper IUDs and lower dose oral contraceptives, along with refinements in counselling and selection of methods according to user characteristics have greatly

reduced the already rare occurrences of serious sequelae of use of these methods and are incorporated into the procurement and clinical training components of this project.

The maternal mortality rate among Nigeria women is extremely high. An estimated 800 mothers die in connection with each 100,000 live births; for women over the age of 35 this rate doubles to approximately 1,600 maternal deaths per 100,000 live births. On the other hand, Nigerian women under 35 years of age who use contraception would be expected to experience much lower mortality rates resulting directly from contraceptive complications. These rates would be approximately one per 100,000 women using pills and two per 100,000 using IUDs. For women over 35, these rates would increase slightly to 23 and 4 for pills and IUDs, respectively. Consequently, the use of contraception, when compared with the risks of child bearing in Nigeria, can be considered much safer and conducive of enhanced maternal and child health.

TABLE

1

First Year Failure Rate In Typical Users, by Method*

Method	Pregnancies in 1st Year Per 100 Users
Chance (no method)	70.00
Voluntary Surgical Contraception (tubal ligation)	0.45
Voluntary Surgical Contraception (vasectomy)	0.15
Injectable Progestin	0.25
Combined Birth Control Pills	2.0
Progestin only Pill	2.5
IUD	4.0
Condom	10.0
Diaphragm with spermicide	13.0
Foams, jellies, suppositories	15.0
Coitus interruptus	23.0
Fertility awareness techniques	20.23

Source: Family Planning Methods and Practice: Africa, Centers for Disease Control, Atlanta, USA 1983

*N.B. Use-effectiveness varies greatly according to the education and motivation of the client. Thus these rates cannot be assumed to be applicable throughout Nigeria.

CONTRACEPTIVE COMMODITIES PROJECTIONS

A. Background

It is estimated that 20 percent of the Nigerian population consists of women of reproductive age, and that roughly 75 percent of these are in marital unions. Of the remainder, an unknown proportion is sexually active. As a reasonable order of magnitude, we may consider 17 percent of the total population to be in the pool of women/couples eligible for family planning services.

The problem of forecasting contraceptive commodity requirements is essentially one of estimating, on the basis of whatever relevant information is available, how many of these women will be "protected" by each contraceptive method in each year through program-provided services and then translating this protection into required commodities.

Both environmental "non-program" and more program-responsive factors influence patterns and levels of contraceptive use. Among non-program factors to consider in estimating future coverage are the level of socio-economic development and cultural acceptability of family planning and of specific methods. In the Nigerian context, strongly pronatal cultural values, along with male dominance and general social conservatism, particularly in rural areas and especially in the predominantly Muslim north, must be recognized. As has already been observed in Nigeria, these impediments are by no means immutable barriers, yet will require that proposed strategies be culturally sensitive, and recognition that different subpopulations will progress at different rates, and with varying patterns of method mix.

Information on the social and administrative milieu within which the program must operate has been used in conjunction with more direct program-related information on past program performance, non-program contraceptive practice, and intended future intensity of program expansion efforts. In addition, the experience of other countries at similar developmental levels has provided useful insights into prospects and strategies for expansion.

Among program factors which particularly influence likely rates of growth are the expansion of planned program activities designed to create demand for family planning, particularly through IEC activities, and activities to increase supply, through increased inputs of trained personnel, and numbers of clinic and non-clinic based service providers. In addition to increasing physical access of services to potential clients, increased availability of a range of modern contraceptives is critical to unimpeded program growth.

Taking the above considerations into account, the following estimates the level of contraceptives that will required throughout the life of the project.

B. Contraceptive Use Estimates

The estimates provided in Tables 1-A and 1-B represent the design team's best collective judgment of what is attainable under the project through both private and public sector initiatives. It is recognized that there is a considerable degree of uncertainty involved in such estimates, yet it is the considered opinion of the team that if the various project components are implemented as planned, and if the political climate continues to be increasingly favorable to family planning/birth spacing efforts, it is not unreasonable to expect 2.1 million women to be current users of modern, project-provided contraceptives by the end of 1992. This would represent a little over 10 percent current prevalence at that point. In addition, it is considered reasonable to expect that between 0.4 and 0.5 million women would be protected by non-project modern contraceptives, provided through such channels as the UNFPA's provision of injectables, and non-project commercial activity, as well as through hospital and private clinic based contraceptive sterilization. This would provide for a total prevalence of about 12 percent of the eligible population.

The mix of methods estimate is based on past experience, plus the training, IEC, and service delivery expansion strategies of the project. The target is ambitious, but not beyond the horizon of reasonable expectations.

The derivation of specific method targets proceeded roughly as follows. First, an overall end-of-project prevalence target was established during group consultations. Next, this target was subdivided among the public sector, private sector, and non-project providers. Within each of the two project sectors, estimates were made in group discussions of what might be accomplished with each method, given the planned strategies and resources targeted to these methods. This process involved a series of modifications of an original projection which involved the following:

a) For the public sector, which experienced more than a doubling of the 1986 coverage by each method, compared with 1985, and given the continuing rapid expansion of the program, it was felt that a further doubling in 1987 was feasible. A further 50 percent increase in 1988, and again in 1989, was followed by a 33 percent 1990 increase. This in turn was followed by a 25 percent increase in 1991, and again in 1992. Subsequent modifications, while not involving large percentage changes of these figures, resulted in a decision to allow for somewhat slower IUD expansion from 1990, and somewhat more ambitious growth in condom use, reflecting a planned strong male motivation thrust. It was initially judged that this sector should be able to account for roughly 800,000 current users in 1992, or about 40 percent of the project total. The actual program target was subsequently set at 881,000, based on aggregation of specific method component projections.

b) For the private sector initiative, alternate initial projections were discussed. The basic expansion model involved an exponential 50 percent annual increase in each method, through the life of the project. However, re-examination of these figures in the light of planned method mix, and planned expansion strategies, resulted in an increase in the IUD target, and some modifications of projections for the other three methods. The private sector project component was estimated to be able to provide about 1.2 million users in the final project year.

For both the public and private sector, further projections involving continued program growth of between ten and twenty percent annually, were made for the two post-program years of 1993 and 1994, so that planning for an orderly phase-over to other commodity providers would be facilitated in later program years. All these estimates of annual use, by project component and method, are found in Table 2.

C. Cost of Commodities and Timing of Shipments

Once the estimates of commodities required by the project within a specific year had been determined, the next task was to estimate the quantities to be shipped at specified time periods, in order to meet current needs, and maintain sufficient reserve stocks to avoid risk of shortages at any level of the program. It was decided that the amount to be shipped in any calendar year should always be sufficient to provide an "end of year" reserve stock, or "buffer", equal to 125 percent of the estimated use of that commodity in the following year. To determine the required stocks, AID/ST/POP central contraceptive procurement tables were prepared.

Since the project will run through 1992, the final shipments of project-procured commodities required to carry the project through 1992, and into the start of 1993, would be provided in 1991, and would be budgeted accordingly. These quantities, and their estimated cost, are shown in Tables 3 & 4. In addition, it was recognized that to plan an orderly transition to whatever structures and donors follow this project, it would be advisable at this time to make some very preliminary estimates of the first two post-project year requirements, and also to make some estimates of likely contraceptive costs for 1992 and 1993, which must be met through non-project sources if the commodity pipeline is to remain filled. These figures are also contained in these tables.

For estimation of program year costs, the gross requirements were adjusted to account for commodities already in stock or already on order for shipment later in 1987. The resulting net requirements were multiplied by the appropriate cost of the commodity, plus shipping to and within Nigeria.

While these estimates of contraceptive requirements and costs represent the best estimate of what will be needed, it is recognized that programs never precisely conform to projections, and that the longer the projection period is, the less accurate the projections are likely to be. The project calls for two mid-project reviews, which will allow for mid-project modification of targets and strategies, in the light of project experience. In accordance with standard AID practice, there will be an annual review of prior years' actual commodity use. This information will be used annually to update the procurement tables for the subsequent shipping period for each specific method. At the time that these annual national contraceptive procurement tables are prepared, state-specific estimates will also be made for the public sector, based on the previous year's actual commodity usage, as shown by current management information form, "Summary of Family Planning Users and Contraceptives Issued/Dispensed."

Table 4 shows the funds that will be required to assure an adequate supply of contraceptives throughout the life of the project.

Annex Q
Appendix 1
Table 1A

ESTIMATES OF 1992 COVERAGE BY AID SUPPLIED CONTRACEPTIVES
(User and Commodity numbers in 1000s)

	Public		Private		Total			
	Commodity amount	Users	Commodity amount	Users	Commodity amount	Users	% of total Users	% coverage of eligible Women (1)
IUCD	250	625	140	350	390	975	46.7	4.87
Orals	1875	144	4550	350	6425	494	23.7	2.47
Condoms	10000	100	45500	455	55500	555	26.6	2.78
FTs	1200	12	5000	50	6200	62	3.0	0.31
Subtotals	x x x	881	x x x	2005	x x x	2086	100.0	10.43 (2)

Table 1 B

USERS, BY PROJECT COMPONENT, IN FINAL PROJECT YEAR, 1992

	Public		Private		Project Total		% Public vs. Private		
	Users	%	Users	%	Users	%	Public	Private	Total
IUCD	625	70.9	350	29.0	975	46.7	64.1	35.9	100.0
Orals	144	16.3	350	29.0	494	23.7	29.1	70.9	100.0
Condoms	100	11.4	455	37.8	555	26.6	18.0	82.0	100.0
FTs	12	1.4	50	4.1	62	3.0	19.4	80.6	100.0
Subtotal	881	100.0	1205	100.0	2086	100.0	42.2	57.8	100.0

* (1) based on an estimated 20 million eligible women in 1992;

(2) non-project contraceptive practice is expected to add about 2 per cent to this project total, bringing total coverage through modern methods up to about 12 per cent.

Annex Q
Appendix 1
Table 2

SUMMARY OF EXPECTED CONTRACEPTIVE USAGE, BY YEAR AND PROJECT COMPONENT (1000's)

		Pre-project 1987	Project Period 1988	1989	1990	1991	1992	Post - Project 1993	1994
ItCD (units)	Public	80	120	180	210	230	250	275	300
	Private	10	20	30	50	85	140	150	160
	Sub-total	90	140	210	260	315	390	425	460
Orals (cycles)	Public	400	600	900	1200	1500	1875	2250	2700
	Private	600	1000	1600	2400	3500	4550	5300	6200
	Sub-total	1000	1600	2500	3600	3800	6425	7550	8900
Condoms (pieces)	Public	1200	1800	2400	4500	7500	10000	12000	14000
	Private	7500	11250	16875	25000	37500	45500	54600	65000
	Sub-total	8700	13050	19275	29500	45000	55500	66600	79000
VFTs (tablets)	Public	240	360	540	720	900	1200	1350	1620
	Private	2000	2500	3000	3500	4200	5000	5800	6600
	Sub-total	2240	2360	3540	4220	5100	6200	7150	8220

Annex Q
Appendix 1

Table 3: Summary of Required Commodities, by Year of Ordering, to Maintain Adequate Supplies

(In thousands of units)

		1987	1988	1989	1990	1991	1992	1993	Project Total 1987-1991
IUCD	Public	-	15	218	235	255	281	306	723
	Private	5	33	55	93	154	153	162	340
	Total	5	48	273	328	409	434	468	1,063
Orals	Public	-	-	300	1,575	1,969	2,344	2,812	3,844
	Private	650	1,750	2,600	3,775	4,813	5,487	6,425	13,588
	Total	650	1,750	2,900	5,350	6,782	3,196	9,237	17,432
Condoms	Public	-	-	-	4,875	10,625	12,500	14,500	15,500
	Private	9,563	18,281	27,031	40,625	47,500	56,875	67,600	143,000
	Total	9,563	18,281	27,031	45,500	58,125	69,375	82,100	158,500
Foaming Tablets	Public	-	-	-	585	1,275	1,388	1,687	1,860
	Private	3,125	3,125	3,625	4,375	5,200	6,000	6,800	19,450
	Total	3,125	3,125	3,625	4,960	6,475	7,388	8,487	21,310

NOTE: In each year, sufficient quantities will be ordered to bring the end of year commodity levels up to 125 percent of the estimated following year requirement. This will allow for adequate reserve stock at all times at all program levels, including central and state warehouses, and zonal and LGA intermediate stores, and individual clinics.

Annex Q
Appendix
Table 4

TOTAL $ REQUIREMENTS ($1000's), FOR CONTRACEPTIVES, AND FREIGHT (1) BASED ON 125% END OF YEAR RESERVE, FOR BOTH PUBLIC AND PRIVATE SECTORS, 1987-1993, AND PROJECT LIFE TOTAL FOR 1987-1991 (2)

Method	Sub-project	1987	1.38	1989	1990	1991	1992	1993	Project Life* 1987 - 1991
IUCD	Public	-	15	231	259	293	334	382	798
	Private	5	34	58	102	177	182	203	377
	Sub-total	5	49	289	361	470	516	585	1175
Orals	Public	-	-	46	252	335	420	534	633
	Private	193	537	824	1234	1598	1849	2217	4387
	Sub-total	193	537	870	1486	1933	2269	2751	5020
Condoms	Public	-	-	-	263	584	750	943	847
	Private	447	932	1433	2194	2613	3413	4394	7618
	Sub-total	447	932	1433	2457	3197	4163	5337	8465
Foaming Tablets	Public	-	-	-	62	136	153	194	199
	Private	328	330	384	566	556	660	782	2064.
	Sub-total	328	330	384	628	692	813	976	2263
All project Contracep-tives	Public	-	15	278	836	1349	1657	2053	2478
	Private	973	1833	2699	3996	4944	6104	7594	14446
G.T.	Grand total	973	1849	2977	4832	6293	7760	9648	16923

(1) Of the total of $16,923, $15,385 is the actual commodity cost, and $1,538 is the estimated direct freight cost. In addition, another 462 thousand dollars should be budgeted for warehousing, handling, insurance and documentation.

(2) All supplies to be used during 1992 and into start of 1993 will have been procured by the end of CY 1991.

ANNEX R

ADMINISTRATIVE ANALYSIS

The Administrative Analysis presents a descriptive narrative of the organizations participating in the FHI-II project. USAID/Lagos and the FMG will implement the project through the collaborative assistance mode with four carefully selected US-based organizations with extensive experience in managing population activities in Africa. The FMG will provide counterparts at the national, state and LGA levels integrating activities between several ministries and encompassing both the private and public sectors.

A. Primary Implementing Organizations

The range of the analysis covers the primary implementation organization, the expected AID participation, probable FMG ministries and private agencies.

Under the collaborative assistance mode, the accountability for delivery of FHI-II project outputs will be undertaken by organizations with demonstrated competence in implementation of population programs: Family Planning International Assistance (FPIA) for the private sector; The Pathfinder Fund for the public sector; Johns Hopkins University/Population Communication Services (JHU/PCS) for the IEC component; and, University of North Carolina (UNC) Population Center for policy.

As stated in the PID, the use of the collaborative assistance mode makes possible the following improvements:

1. Ensures greater continuity in programming;
2. Simplifies and consolidates programmatic and administrative responsibilities; and,
3. Focuses programmatic direction more clearly

The four initially selected organizations are all well-established and experienced in developing and implementing population/family planning programs in Africa in general, and Nigeria in particular. All have demonstrated sound and practical administrative and financial systems which have proven in the past to be responsive to management constraints in Nigeria.

1. The Pathfinder Fund

Pathfinder is a public non-profit foundation established in 1957 which promotes and supports population and Family Planning activities in developing countries. The organization has a track record of taking risks, when required, and exploring creative ideas with organizations and individuals in the promotion and provision of family planning services.

Pathfinder has a long history of involvement in Nigeria. It has worked with six university teaching hospitals in providing clinical training; assisted in a number of public sector planning workshops;

initiated the first community-based contraceptive distribution inNigeria; provided IEC assistance in the reprinting of family planning method booklets developed by The Planned Parenthood Federation of Nigeria (PPFN) and JHU/PCS; and provided commodities worth over $90,000. Pathfinder currently has a country office headed by a Nigeria country representative.

2. Family Planning International Assistance (FPIA):

FPIA is the International Division of the Planned Parenthood Federation of America, Inc. Over the past 15 years, 500 projects have been developed in 55 countries and commodities valued at $80 million have been shipped to over 100 countries. FPIA projects currently serve about 1.4 million users annually.

FPIA has a wealth of experience, especially in managing private sector projects in Nigeria. It is operating eight projects with a broad range of grantees. FPIA's most innovative project taps into the Sterling Products (Nigeria) Ltd. marketing and distribution network. With an outlay of only $47,000, plus commodities, contraceptive sales earned about 1.2 million ($800,000) naira in the first year of the project.

The seven other FPIA projects are with religious groups, hospitals and a university. Each has its own individual approach.

3. Johns Hopkins University/Population Communication Services (JHU/PCS)

Population Communication Services (PCS) was established at the Johns Hopkins University (JHU) in 1982 to provide a broad technical base for transferring knowledge, skills and funding world-wide to developing countries.

JHU/PCS has broad experience in developing and implementing IEC projects in Nigeria. It has visited 15 of the 19 states, implemented nine projects with positive results, and has negotiated nine more projects currently in various stages of development. JHU/PCS was closely involved in the first two official state FP launchings (Kwara and Ogun) and, through PPFN, has developed and produced more than 300,000 copies of method-specific pictorial booklets in Yoruba, Hausa, Ibo and Pidgin English. Various radio, TV and print materials have also been developed through projects with state ministries of health.

4. University of North Carolina Population Center

Established in 1966, the Carolina Population Center (CPC) has provided technical assistance and institutional development in 30 developing countries, for policy development, demographic data collection and analysis, and research programs in population and family planning. CPC and its community of scholars represents one of the largest groups of university population specialists in the U.S.

CPC's experience in Nigeria relates to its participation as a subcontractor in the RAPID II program. CPC has also assisted the FMG in establishing goals, targets, program alternatives and evaluation criteria for the forthcoming population policy.

B. USAID and Primary Contractors

The successful implementation of this project depends on close collaboration between:

1. USAID/Lagos and REDSO/WCA;
2. USAID and the implementing organizations; and,:
3. The implementing organizations, themselves.

1. USAID/Lagos and REDSO/WCA

USAID/Lagos will be responsible for overall management of the project. To assist USAID, a full-time Project Coordinator will be hired to direct the various components of the project. The Project Coordinator will work closely with and report to the Health/Population Officer in Lagos. Annex L contains a detailed description and budget for this position.

USAID/Lagos is classified by AID as a "Schedule B" post, and, as such, receives priority support from REDSO/WCA in Abidjan for its program implementation. This support figures heavily in the administration and management of this project. Indeed, REDSO has been deeply involved in the development of the project, from the drafting of the program strategy through the PID to the Project Paper: A total of approximately 24 person months of effort have been devoted to project development.

A full complement of Mission services are available through REDSO/WCA on a periodic basis in all areas of program implementation, including project development, evaluation, contract management, commodity procurement, technical program areas (population, health, agriculture, economics, engineering) and legal guidance. These services are scheduled on an annual basis.

2. Project Committee

Although each major component has its own management plan, an overall project committee will be established which comprises representatives of each implementing organization, FMG counterparts and the Project Coordinator. Under the direction of the Project Coordinator, the Committee ensures coordination on issues between and among the collaborating agencies. This is especially true during the annual review and approval of workplans.

Since most of the programmatic and administrative requirements of the team will be provided through their own institutions (on-site and off-site) and substantial support will continue to be provided by REDSO/WCA, USAID/Lagos will not need additional staff, other than the hiring of the Project Coordinator to oversee the project.

3. Enhancing Collaboration

The ability of the implementing organizations to perform under the collaborative mode has already been tested in the design phase of this project. Consequently, this design is the result of a wide range of technical skills and expertise of different personalities and

organizations. One practical step, however, to ensure and enhance the interlinking of component activities is to physically house the projectstaff of the collaborating agencies in one office, thus allowing easier access, constant communication and feedback, regular meetings and the planning of joint monitoring and field visits. This arrangement will also achieve significant economies of scale in the provision of office space and support services.

C. USAID and the FMG

A strong linkage and collaboration with appropriate host country government and private sector counterparts is also needed to successfully implement this project.

USAID/Lagos and FMOH, representing the FMG, will identify key persons who will be responsible for this project in their respective organizations. Hence, FMOH will identify and assign counterparts to the Project Coordinator, Private Sector Component, Public Sector Component, IEC Component, and the Policy Component.

This combination of USAID collaborating agencies and their Nigerian counterparts comprises the joint USAID/FMG FHI-II Project Committee. This group will be the forum to discuss and resolve major coordination and implementation issues. The Committee will meet regularly at agreed intervals.

At the same time, each component will be encouraged to develop expanded coordinating/planning mechanisms to include representatives from its key participating agencies, especially for annual action planning or assessment.

D. Key Government and Private Agencies Involved in the Project

A wide range of government and private sector agencies will be involved in the overall implementation of this project. Each has a unique role to play and will have varying degrees of involvement. A brief description follows of the key agencies envisioned as participants in the implementation of this project. Table 1 of this Annex shows the primary relationship between each organization and the project.

1. Government Agencies

a. Federal Ministry of Health (FMOH)

FMOH, representing the FMG, will be the primary counterpart of USAID in this project. FMOH is responsible for the ultimate implementation of a population policy in Nigeria by the highest levels of government. FMOH has already drafted an Action Plan for the Family Planning Program for Nigeria (1986-1990) which has been used by all states as the basis for drafting their own state action programs. At the Federal level, FMOH will be the primary agency to coordinate family planning activities nationwide and will continue to play a leading role in orchestrating international, national and state inputs in support of population and family planning activities.

Under this project, activities have been identified to strengthen the key offices within the Ministry which will play strategic roles in the successful implementation of the project.

The World Bank and UNFPA have had extensive discussions with FMOH officials and identified several areas of possible collaboration. These include: 1) strengthening the public sector institutions providing family planning and maternal and child health services; 2) establishing reproductive health centers; and 3) strengthening the institutional capacity of the FMOH Health Education Division.

b. State Ministries of Health

Under the federal system in Nigeria, State ministries of health enjoy a large degree of autonomy from the Federal Government. However, the draft population program plans prepared by state ministry officials during the JHPIEGO workshop in 1986 reflect uniformity and consistency in supporting national program goals, as they were drafted using the framework of the FMOH action plan for a national family planning program.

The states have proven to be resourceful in initiating and expanding FP programs despite sporadic and limited resources. The presence of FP coordinators and deputies in all states has greatly facilitated the management and growth of the program in the past two years.

The state health ministries will play a key role in providing services through their network of hospitals and clinics, including those administered through the local governments. They are also expected to provide leadership in initiating and coordinating mobilization campaigns. Adequate resources will be made available by the project to develop a cadre of state and LGA-level FP managers, service providers and motivators to implement, coordinate and monitor more vigorous family planning programs.

c. Federal Ministry of Information (FMOI)

The Federal Ministry of Information (FMOI) which also has responsibility for Culture, oversees the public affairs, information and enlightenment policies and activities of the Federal Government. It is organized around a number of directorates and parastatals.

Within the Ministry, the Directorates of Domestic Publicity and Public Enlightenment execute publicity and social mobilization campaigns of the government through issuing posters, pamphlets, magazines and films, as well as through the radio, television and news agency organizations. The Ministry also operates Federal Information Centers and sub-centers with mobile vans with public address and film projecting equipment in all states of the federation, and in Abuja. Plans are underway for offices at the LGA level. This network is designed to make "the Federal presence" felt throughout the country.

It should be noted that FMOI does not own any media outlets directly. However, it is the oversight ministry for a number of government parastatals, whose annual budgetary subventions are appropriated through FMOI. These include the Nigerian Television

Authority (NTA), the Federal Radio Corporation of Nigeria (FRCN) and the News Agency of Nigeria (NAN).

The FMOI also trains its middle and junior professional staff at the National Institute for Public Information (NIPI) in Kaduna. NIPI trains technical staff to operate public address equipment and cinema vans, as well as journalists for headquarters and state level editorial assignments.

1) Nigerian Television Authority (NTA). NTA is a Federal parastatal established by decree. It has a national network, with television stations located in each state, as well as a National Production Center based in Lagos and the NTA Television College at Jos. Among its major operational directorates are those for programs and news.

NTA broadcasts a high percentage of locally produced entertainment and educational programs in both English and the major Nigerian languages. While each state affiliate station is free to determine much of its schedule, there are mandatory slots for "network programs" every day. Regular planning and review sessions guarantee coordination among NTA stations, so that while a local and regional flavor is maintained by affiliate stations, a national character can also be projected. However, technical problems, especially related to transmission via the domestic satellite, often inhibit networking; so that it is sometimes necessary to send duplicates of taped materials for local airing. NTA's strengths include a number of popular national and regional drama serials and soap operas such as "Village Headmaster," "New Masquerade," "Alawada," etc. In addition, there are regular weekly education and public service programs for special-interest audiences, e.g., women and youth. Many NTA programs are sponsored by private sector organizations. Advertising during these programs is a major source of income. NTA also promotes national projects and campaigns, e.g., the War Against Indiscipline (WAI).

2) Federal Radio Corporation of Nigeria (FRCN). Through FM, medium wave and shortwave transmitters of varying capacities, FRCN engages in radio broadcasting at local, state and national levels in pursuit of Federal Government interests. It has a virtual monopoly on broadcasting to schools through its Schools' Broadcasting Unit, whose programs complement and supplement curricula in several primary and secondary school subjects. FRCN also produces, for nationwide transmission, programs of talks, sports, dramas, discussions, features, and traditional and popular music in English and major indigenous languages. Jingles in these languages are broadcast repeatedly during the day, making FRCN perhaps the most widespread channel of nationwide communication. FRCN also has substantial regional listenership through coverage from its transmitters located in Ibadan, Enugu and Kaduna. FRCN-2, an FM station, is urban and youth oriented, servicing Lagos and its immediate environs. In a bid to increase revenues, FRCN has been permitted to accept commercial advertising, a practice proscribed several years ago. This may include product sponsorship of programs as well as commercial jingles and paid spot announcements.

3) News Agency of Nigeria (NAN). Established in 1978, NAN has become the core of domestic news and features supply. With coverage of

all states, NAN produces a daily bulletin of general news, as well as an economic news service. NAN is also the official source for foreign news, so that material from Reuters, AFP, AP, TASS and PANA reach Nigerian media - newspapers, radio and television - through NAN to which most of them subscribe on an annual basis. NAN generates a large number of features on various political, socio-economic, health and development subjects, which are regularly carried in the Nigerian press. NAN also operates a news photo service. FRCN has a training school for news and program staff.

NTA, FRCN and NAN constitute a national multi-media network through which family planning information can be channelled. Selective inputs to strengthen various aspects of their operations, facilities and training activities are envisaged during the life of the project.

d. State Ministries of Information

Each state has a Ministry of Information: In most states, this ministry also has other functions such as responsibility for culture, social development, youth and sports.

Information activities include printing, production and news dissemination, either directly or through supervision of specialized parastatals (TV, radio, state-owned newspapers). Public information at the local government level is largely a responsibility of state ministries which engage in public mobilization through mobile vans with public address equipment, especially in rural areas.

e. Federal Ministry of Education (FMOEd)

The Federal Government has constitutional responsibility for secondary and tertiary level education. Therefore, it has established secondary schools, colleges of education, polytechnics and universities. However, through the National Policy on Education, the Federal Government also determines and coordinates curricula at the primary level.

FMOEd conceptualizes and implements the National Policy on Education. It is organized around several professional directorates, a number of which have specialized agencies of a parastatal nature attached to them. Among these are NERC and NETC.

1) National Educational Research Center (NERC). Soon to be upgraded to a parastatal, NERC has major responsibility for coordinating education inputs into the curricula of primary and secondary education. It organizes workshops for researchers, subject-matter specialists, school administrators and classroom teachers to prepare curriculum guidelines and teaching materials.

One of its current projects is the formulation of a Population Education Curriculum. With funding assistance from UNFPA, information on family life, family health and population is being included in the curriculum of eight subjects (including mathematics and English) at the secondary level. Teacher education, classroom handbooks and student manuals are envisaged. IEC activities through the mass media, e.g., national population quiz show, are planned by the IEC component of FHI-II.

2) National Educational Technology Center (NETC). Based in Kaduna, NETC is a federal resource for the production of audio-visual instructional materials. Its objectives include the training of teachers, student teachers and support staff in the application of educational technology, which includes educational television and radio broadcasting, audio-visual aids, photographic and cinemagraphic services, educational graphics and educational materials. NETC also produces and transmits educational programs on radio and television for primary, secondary and teacher training colleges. It also provides consultancy and maintenance service for Federal and state government institutions.

NETC is probably the best managed and endowed educational multi-media facility in the country. With well-equipped radio and television studios, photographic laboratories and graphics facilities, NETC can make video tapes, transfer 16 mm film to video tapes and vice versa, process and print color photographs and produce color slides. It is in the process of being converted into a profit-oriented parastatal.

f. National Population Bureau (NPB)

This is the technical support base for generating information about Nigeria's population and demographic situation. With a staff of over 120, it has offices in all the states. It has conducted surveys, including the National Fertility Survey, using trained field interviewers and demographic analysts. It has computer facilities, and can be relied upon to carry out specialized studies and surveys on behalf of the project.

g. The Federal Office of Statistics (FOS)

Among other tasks, FOS conducts a continuing national household survey. Each month, its staff and field workers interview 60 households per state, or a total of 720 households per state per year. Offices are located in each state with a complement of field supervisors and interviewers. FOS can provide general or specific statistical information as may be required, and will conduct special surveys or add a few population/family planning related questions to their regular survey instruments for the purposes of this project. Some technical support from the Policy Component would be necessary to upgrade the analyses of a population add-on.

h. University College Hospital (UCH)/Ibadan

UCH/Ibadan is the oldest and most respected teaching hospitals in Africa. It was the pioneer institution in the country to conduct clinical training in FP. With support from Pathfinder Fund and JHPIEGO, thousands of clinicians have been trained to provide FP clinical services. UCH is currently producing voluntary surgical contraception motivational booklets, the first in the country, in collaboration with JHU/PCS. UCH/Ibadan's managerial and technical capability will be augmented in this project to enable them to expand their in-service training programs, including speciality training for physicians.

i. Nigerian Nursing Council (NNC) and Nigerian Medical Council (NMC)

Both these institutions are Federal bodies which supervise exams and issue licenses to nurses and physicians, respectively. They will play a role in this project by building up FP pre-service training programs in medical and nursing schools. Since they also have oversight in nursing and medical curricula their participation in the project will have long-term impact on the development of a nationwide cadre of health professionals trained in providing FP services.

2. Private Agencies

a. Sterling Products (Nigeria), Ltd.

Under an FPIA grant, Sterling Products, a manufacturer and distributor of "over-the-counter" drugs, currently distributes condoms, pills and foaming tablets to over 2,000 pharmaceutical outlets nationwide. During the first year of operations, 1.2 million naira worth of contraceptives were sold.

This project will build on Sterling's past achievements and double the number of outlets and contraceptives distributed. Supplementary resources will also be provided for market research and advertising, the latter in close collaboration with the IEC component. For a more comprehensive description of Sterling Products, please refer to the private sector workplan.

b. Trading Companies

To reach a wider market beyond the Sterling pharmaceutical outlets, trading companies like Clark, Holt and United Africa Company (UAC) will be investigated for the willingness and ability to distribute contraceptives. Each of these firms has well-established networks throughout Nigeria. They reach supermarkets, department stores, market stalls and have depots in some of the major cities. The company that will be chosen will be provided with appropriate technical support in order to galvanize its participation in the project.

c. Planned Parenthood Federation of Nigeria (PPFN)

An affiliate of the International Planned Parenthood Federation (IPPF), PPFN is the pioneer organization in the promotion and provision of FP services in Nigeria. It has branches in 18 of the 19 states and is the leading organization in IEC. It has developed and produced method-specific booklets in four major languages for nationwide distribution and mounted a multi-media campaign in Plateau State.

PPFN spends a substantial amount of its resources on field motivation (home visits, group meetings, clinic-based counseling). A nationwide male motivation program in selected factories is also being conducted. On a fee basis, PPFN provides clinical training for nurses and doctors who work in the factory programs managed by Sterling Products. This project will help strengthen PPFN's capacity to expand its IEC, training and service providers network.

d. National Council on Population Activities (NCPA)

NCPA was formally inaugurated in December 1985 by the current Federal Minister of Health as a voluntary, non-profit, non-religious, non-political and non-governmental organization. NCPA's board is composed of eminent professionals coming from a multi-disciplinary background. A young organization, it has an executive director and maintains an office at the premises of PPPN.

NCPA's objectives include:

1) providing a forum for various private sector and voluntary organizations to coordinate their activities in ensuring that the need to plan population remains of central interest to the people and government of Nigeria;
2) undertaking programs of public enlightenment and education throughout Nigeria concerning problems of population growth, distribution and movement;
3) encouraging improvement in the quality of life of the Nigerian population through programs designed to foster better understanding of the importance of proper spacing of children among families and the value of having only those children for whom they can provide adequate care, nutrition, housing, clothing and education;
4) supporting and encouraging programs directed at improving the role and status of women in society, particularly with respect to their special significance in determining the quality and size of the family;
5) encouraging and supporting population education programs directed at youth and aimed at improving their awareness of population issues;
6) undertaking the publication and provision of information necessary for carrying out the various objectives of the Council; and
7) encouraging and actively supporting research into population dynamics concerned with fertility, mortality, distribution and movement as well as other population-related issues and to make the results of such research widely disseminated.

Although relatively new, the organization has already conducted a workshop for the National Union of Journalists, and organized market visits. Because its board is composed of eminent Nigerians, the organization has great potential for playing a pivotal role in population advocacy, IEC, training, and service provision. This project will help build NCPA into a strong full-service organization in population and family planning.

e. Other Private Sector Outlets

The strong private sector thrust of this project demands that a host of other service outlets be explored and tested. Hence, several networks of outlets will be developed. These networks include:

1) Association of Nurses and Midwives;
2) Association of Private Maternity Clinics and Hospitals;

3) Association of Factories and/or Employers with a Large Work force; and
4) Association of Public Transport and Taxi Drivers.

Where pilots efforts with any of these major groupings become promising, the project will provide appropriate resources for consolidation and expansion.

NIGERIAN ORGANIZATIONS AND THEIR EXPECTED COLLABORATION

	Private Sector	Public Sector	IEC	Policy Implementation
Federal Ministry of Health (FMOH)	XX	XX	XX	XX
State Ministries of Health (SMOH)	XX	XX	XX	XX
Federal Ministry of Information (FMOI)		XX	XX	XX
State Ministry of Information (SMOI)		XX	XX	
Nigerian Television Authority (NTA)			XX	
Federal Radio Corporation of Nigeria (FRCN)			XX	
News Agency of Nigeria (NAN)			XX	
Federal Ministry of Education (FMOE)		XX	XX	
National Educational Research Council (NERC)		XX	XX	
National Educational Technology Center (NETC)			XX	
National Population Bureau (NPB)		XX		XX
Federal Office of Statistics (FOS)		XX		XX
University College Hospital	XX	XX		
Nigerian Nursing Council (NNC)	XX	XX		
Nigerian Medical Council (NMC)		XX		
Sterling Pharmaceuticals (Nigeria) Ltd.	XX	XX		
Planned Parenthood	XX	XX	XX	XX
National Council on Population Activities (NCPA)			XX	XX