

PD-ABC-803

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NIGERIA

TRIP REPORT

Private Sector Assessment

Technical Assistance

June 23 - July 17, 1986

Contract No. AID/DPE-3034-C-00-5072-00

ASSESSMENT OF THE PRIVATE SECTOR
AND ITS RELEVANCE FOR FAMILY PLANNING PROGRAMMING
IN NIGERIA

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This report was written for USAID/Lagos under the Enterprise Program,
Contract Number DPE 3034-C-00-5072-00

July 1986

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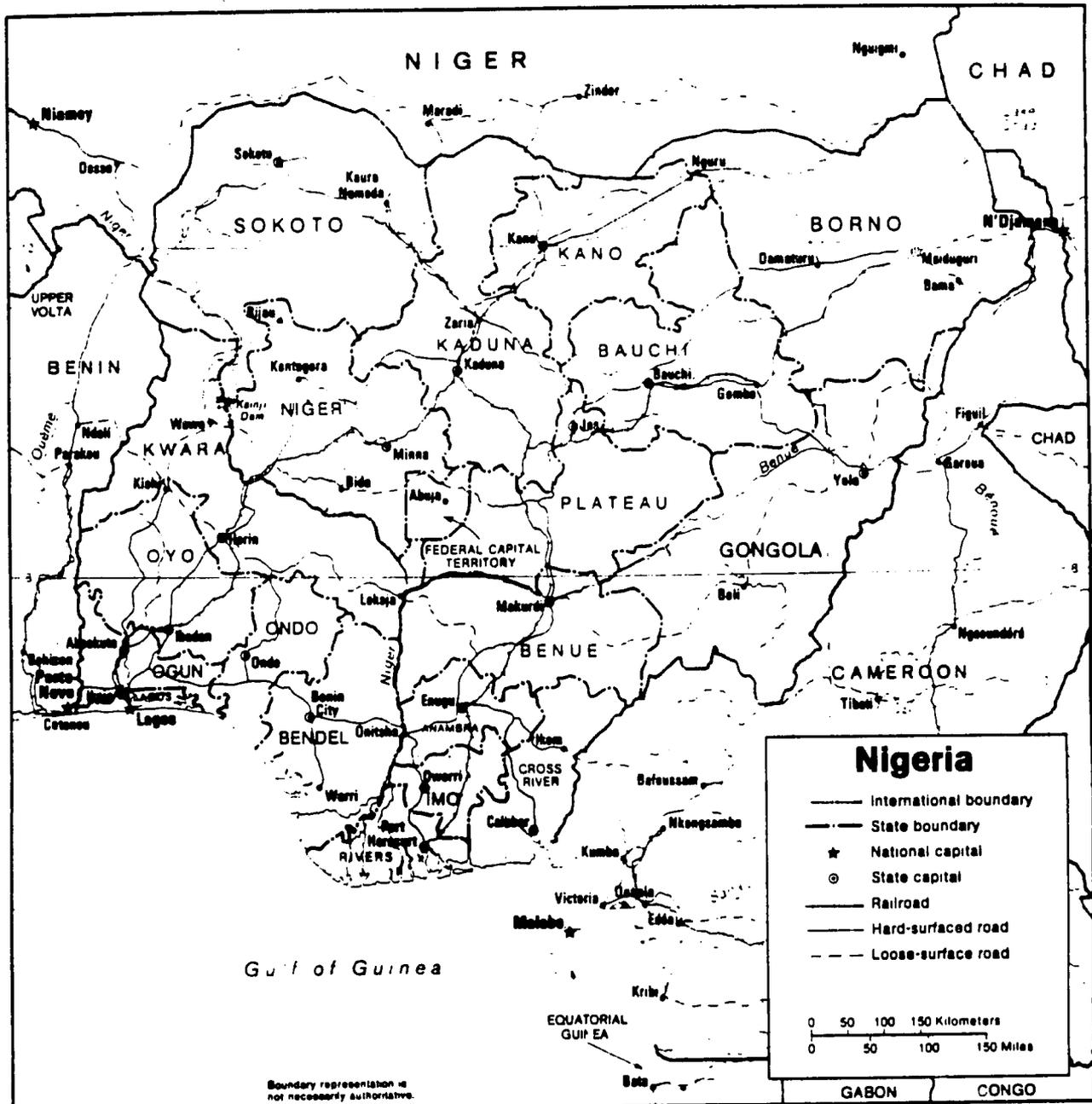
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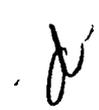


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GLOSSARY

ANC	Ante-natal care
CBD	community-based distribution
CHAN	Christian Health Assn. of Nigeria
FPFA	Family Planning International Assistance
GON	Government of Nigeria
IEC	Information, Education and Communications
ITF	Industrial Training Fund
MAN	Manufacturers Assn. of Nigeria
MCH	Maternal and Child Health
NECA	Nigerian Employers Consultative Assn.
NGO	Non-Governmental Organization
NLC	National Labor Congress
NMA	Nigerian Medical Assn.
PMS	Patent Medicine Stores
PPFN	Planned Parenthood Federation of Nigeria
TBA	Traditional Birth Attendant
TIPPS	Technical Information on Population for the Private Sector
USAID	United States Agency for International Development



EXECUTIVE SUMMARY:

In response to a request from USAID, two consultants conducted an assessment of the private sector in Nigeria on behalf of the Enterprise Program. Only the "for-profit" component of the private sector was studied; private voluntary and Christian mission-related activities were excluded. A broad range of private and public sector people were interviewed, facilities visited and documents reviewed. Based on the data collected and an analysis of the private sector, findings are presented on what the private sector is doing and what it might do to expand family planning efforts in Nigeria. This assessment enlarges upon the considerable private sector activity already underway under AID sponsorship by such groups as FPIA, TIPPS and Enterprise in Lagos, Ibadan and Kaduna and provides additional evidence that the private sector offers inviting programming possibilities throughout Nigeria for work in family planning.

The private sector in Nigeria is well developed and offers many opportunities for family planning programming. For purposes of this study, the private sector is divided into the market and service components, each with its formal (organized) and informal (unorganized) aspects. In the former, the distribution of pharmaceuticals and contraceptives from the manufacturer/importer to the consumer was investigated. With the objective of making contraceptives available, accessible and inexpensive, the major findings and recommendations were:

Findings

1. Lack of awareness about family planning and some cultural traditional resistance to the idea.
2. Contraceptives are in short supply and expensive.

Recommendations

- Demand generation in the form of an IEC campaign is required. Radio should be emphasized and the message should stress the health benefits of family planning (for mothers and children).
- a) The market must be "flooded" with contraceptives and different distribution systems tested - the top - down approach as currently being followed by Sterling Products and a closed system with identified outlets supplied by a limited number of distributors.
 - b) Contraceptive imports should be limited to the most popular brands, listed separated from drugs and exempted from duties and taxes.

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- c) The pilot project testing the effectiveness of the informal sector (market women) should be expanded.

3. Contraceptive users typically receive their contraceptives from inadequately informed sources (pharmasistis and even patent medicine stores).

Training courses should be developed to instruct those manning the contraceptive supply network (including pharmacists, PMS owners, market women, TBAs, clinics, maternity homes).

4. In general, the private sector is unaware of the roles they could play in promoting family planning.

Business associations (eg., Chambers of Commerce and Manufacturers Association) should be briefed and oriented on family planning and encouraged to participate actively in family planning program.

5. The public is concerned about adulterated drugs and have more confidence in products having proper packaging.

Any mass distributed oral contraceptives should be properly packaged; this could be done inexpressively by printing and providing envelopes to retailers with the bulk-packaged contraceptive supplies.

The service component of the private (for-profit) sector consists of a well-developed infrastructure of health practitioners, especially in the urban centers of Nigeria. Some efforts are already underway with FPIA and the Enterprise Program to initiate family planning activities in clinics attached to industrial facilities. The principal findings and recommendations include:

Findings

1. The health needs of employees in the organized sector are covered by onsite clinics or under retainership arrangements with private clinics. Family planning services are not provided under wither system.

Recommendations

- a) Efforts by Sterling Products and Enterprise to establish family planning capabilities industrial should be expanded.
- b) Efforts should be made to convince firms using retainerships that family planning services should be included, thus requiring upgrading of clinical and motivational skills at involved clinics.
- c) Orientation of business leaders should begin with the affinity groups but rely heavily on interaction with corporate directors at head-

quarters, to change company policy to include family planning services as part of the health package.

2. Maternity homes have contact with a sizable portion of mothers, especially in urban areas, but provide no family planning services.
 - a) Maternity homes should diversify services by adding family planning services.
 - b) At least one midwife in interested maternity homes should be trained in clinical family planning skills.
 - c) Midwives should pay a portion or all of the training, costs since they will increase their income as a result.

3. A significant portion (as high as two - thirds or even three - quarters) of all births in Nigeria are conducted by TBAs.
 - a) TBAs should be trained to motivate and support (ie, supply contraceptives) a CBD program. Their incentive would be a portion of the selling price of the oral contraceptives.
 - b) TBAs should pay for this training as they will earn income as a result.
 - c) TBAs should act as outreach workers receiving support (medical referral and supplies) and supervision from a local maternity home or, where not available, public clinic or facility.
 - d) Equipment required for maternity homes to provide family planning services should be made available at a reasonable price and with credit arrangements, so that private facilities can afford to purchase.

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4. A lack of knowledge exists regarding the private resources existing in each state (quantity and location).

An inventory must be conducted for each state which is being considered for private sector programming to identify number, type, and location of private health facilities and practitioners (e.g., TBAs) by LGA which can provide family planning services.

Our overall assessment of the private (for-profit) sector seems to indicate that it has considerable potential as an important, if not primary, means of providing family planning services in Nigeria. As data in the report will demonstrate, the private sector infrastructure, capacity and resources vary from region to region and state to state, requiring specific program features and implementation plans for each. With USAID support in the form of contraceptive supplies and capacity building in family planning skills in the existing structure, the private sector can be expected to respond effectively to the growing and soon-to-be-generated demand for contraceptive services.

I. INTRODUCTION

The Government of Nigeria (GON) and the United States Agency for International Development (USAID) have discussed the development of a large-scale family planning program. Preliminary discussions have focused considerable attention on the possibility of the private sector playing a more significant role in the delivery of family planning services in the country.

Before such a program can be conceptualized and designed, there is a need for a clearer understanding of what the private (for-profit) sector consists and how it functions in Nigeria. Consequently, an assessment of the private sector in the country was requested by USAID of the Enterprise Program so as to describe its operation and to consider what role it might play in a national family planning program (Attachment I). The scope of work for the study is included as Attachment II.

A team of two consultants visited Nigeria between 23 June and 17 July. The three main regions* in the country were visited: the North (Kaduna and Kano States), the Southeast (Rivers, Anambra, Imo), and the Southwest (Oyo and Lagos). A large number of representatives from both government and for-profit health-related organizations were interviewed (Attachment III) to learn about their current activities and discuss how a family planning effort involving private sector elements would be most efficient and effective.

The main body of this report to the Mission is divided into four parts. First is the background section which describes the population problem in the country and what is currently being done to address this issue. The rationale for involving the private sector in a family planning program is also articulated. The next section is an overview of the private (for-profit) sector, identifying the formal and informal aspects of both the market and service components. The next two sections focus on the market and service activities, respectively. Each component is described in some detail, outlining how it functions, particularly in relation to health and family planning, and what actions/issues might be considered in any future family planning exercises. The final section is the conclusion which summarizes the main findings of the report.

*Nigeria can be divided into three regions: the North consisting of 10 states (Bauchi, Benue, Borno, Gongola, Kaduna, Kano, Kwara, Niger, Plateau and Sokoto); Southeast with four (Anambra, Cross Rivers, Imo, Rivers); and Southwest with five (Bendel, Lagos, Ogun, Ondo, Oyo). Generally, the South is more densely populated, than the North.

II. BACKGROUND

1. The Problem

The last official Nigerian census was conducted in 1963. Since that time the population has been projected based upon an estimated 2.5% annual growth rate. However, the most detailed demographic study of Nigeria, the Fertility Survey of 1981/82 (World Fertility Survey, International Statistical Institute, 1984), estimates the annual growth rate at 3.3%. The population of Nigeria, therefore can range from a figure of 98.5 million in 1986 (based on the 2.5% growth rate) to 117.5 million (if the 3.3% growth rate is used). Concern is raised when one considers that at the high annual growth rate, the country's population will double in slightly less than 22 years. This means that if the growth rate is not reduced, Nigeria will reach the 300 million figure by the year 2025 and, in all likelihood, assume the dubious distinction of being the third most populous nation in the world.

Nigeria is a country of great ecological, ethnic, and cultural diversity. One cannot generalize; what might apply in one region or state may not necessarily apply in another (even in the case of adjacent states). To a large extent, however, the large family norm prevails. In the North, it is attributed to conservative Islam where each child is viewed as a gift from Allah. In the predominantly Christian South, the church as well as culture venerate fertility and have promoted high fertility. Polygyny is a common practice throughout Nigeria and leads to competition among the wives to produce children for the husband; more equals better.

The Fertility Survey of 1981/82 reveals some prevailing attitudes. Only 5% of the women interviewed did not want any more children. The number of offspring desired was over 8. Only 20% of the women had ever heard of an effective modern method of contraception. While only 2% had ever used a modern method, another 12% had tried ineffective (traditional) methods. Although all regions were low in terms of knowledge and practice, the South demonstrated slightly better results.

The need for family planning increases as traditions change. There is an increasing tendency to reduce the period of sexual abstinence after delivery. Moreover, the duration of breast feeding is decreasing. The result is a shorter period of natural infertility and, as a result, shorter intervals between births. The negative impact of this on the health of the mother as well as the infants is well documented. Infant mortality dramatically increases with birth intervals of less than two years, birth order over four and when born to women over 35. The impact of short birth intervals and high parity is also of concern in terms of the mother's health status.

Awareness of family planning and why it is important for the health of the mother and children is still very low in the country. Resistance to the idea of limiting the number of progeny continues to be strong. Nonetheless, a slight increase in contraceptive usage has been noted in the last year or so as the effect of the severe economic crisis in Nigeria is

being felt at the individual family level. The expense of supporting a family has made people (especially in the urban areas) consider means of reducing the number of children. With high inflation (estimated at 60% a year) and static wages, parents can no longer afford big families.

2. Existing Private Sector Family Planning Programs

During its first two decades of independence, Nigeria did not pursue family planning actively. However, even in the 1970's a Population commission was formed and individual institutions, such as the Lagos Island Maternity Hospital, carried on pioneer programs. Likewise, demonstrations, programs were carried out in the then Southeastern states in the Calabar area, as well as in Alameda Bello University. In fact, the country advocated a pro-natalist policy. It was not until the oil boom began to falter in the 1980s that decision-makers began to show concern that the burgeoning population was a deterrent to the economic and physical well-being of the country. Support for a family planning policy and an active program has however, grown significantly in recent time, with a national population policy being drafted and circulated in late 1985 and expected to be formally accepted within the next few months.

Much of the limited family planning work carried out in Nigeria until recently has been done by non-governmental organizations (NGO). The most active NGO has been the Planned Parenthood Federation of Nigeria (PPFN) dating from 1964. It has offices in 14 states where they have operated clinics, usually at government health facilities. A number of large hospitals (university teaching, government and private) have also provided family planning services, usually as part of Maternal and Child Health (MCH) programs. However, as the Fertility Survey data show, these efforts have reached only a small percentage of the eligible couples in the country.

Within the last few years, public and Government facilities have begun developing their family planning programs. Family Planning Coordinators have been appointed at the state level. Health staff have received training in the clinical aspects of family planning, giving all the states a core of trainers who can train other health workers. In addition, significant amounts of contraceptives and some equipment have been provided, usually by donor agencies, to a selected number of public health facilities.

As shall be described in detail in this report, the private health sector in Nigeria is extensive. The vast network of pharmacies, private practitioners, hospitals and clinics provides contraceptives to those women requesting them and often motivate those who should be utilizing them to limit or space births. These facilities offer the full range of methods: barrier methods, pills, IUDs, injectables. The network of private pharmacies and even patent medicine stores (PMS), is another source of contraceptives, especially the pill. However, to date, the private family planning efforts have been uncoordinated and remain at a low level of intensity.

USAID has supported a number of innovative activities in the private sector. Some of the most interesting include:

- Market Women (Oyo state, Ibadan - Columbia University; Ogun State - Population Services International). Early in 1986, 33 market women in Ibadan began selling illness treatments (malaria, ORS, first aid) and contraceptives (pills, condoms, and foam tablets). At least 8 of the 33 exhausted their supplies within the first five weeks of the project and requested resupply. Another 35 women have been trained. The market women benefit (increased income) as do the customers (lower prices).
- Traditional Birth Attendants (TBA) (Benue State - American College of Nurse-Midwives). This project trains TBAs as contraceptive distributors. The women earn modest amounts of money by retaining the mark-up of 25%. The price to the client is still cheaper than other retail sources. First results are encouraging.
- Contraceptive Distribution (Sterling Products - FPIA). The promotion and distribution of contraceptives (condom, pill, foam tablets) through over 7,000 registered pharmacists and 4,000 PMSs in all states. Moreover, approximately 70 companies' health staffs will be trained in family planning and their employees provided contraceptives.
- TIPPS (John Short and Associates) - carrying out cost-benefit analysis and research studies among employees of Lever Brothers and Gulf Oil to determine demand by method. Also plan to conduct workshops for consumers product manufacturers and oil industries in Nigeria.
- Enterprise (Lever Brothers Nigeria-JSI). The health facilities at Lever Brothers plants will be upgraded through the provision of staff training and equipment to provide family planning services to employees. Another project with Health Aids, Ltd. is being developed.

3. Rationale for Utilizing the Private Sector

When one considers how family planning services will be delivered to the public, several options present themselves. Basically, they fall into three categories, public, private voluntary and private for-profit facilities. Of course, any national program must utilize all resources and

cannot depend exclusively on any one. The strengths and weaknesses of each must be identified and a system developed that will be interactive and complementary rather than parallel and duplicative.

a. Public. State Ministries of Health have begun to develop a family planning capacity with the training of some key staff in each state and the provision of a limited amount of equipment and contraceptive supplies to selected centers. It has been observed that the public health services have been seriously affected by the recent economic crisis. Many states no longer have sufficient resources to train new health staff members, procure supplies, provide transportation or even retain staff. The states in the South have been particularly affected. Some states spend 90% or more of their annual budgets on salaries alone, leaving little for supplies, transport, training, supervision. Several states have had to retrench health workers - 350 in Imo, 800 in Bendel. Others, like Rivers, are not replacing workers who resign or retire. Most states in the South have called a halt to capital expenditures in health and introduced charges for health services. Whereas health workers used to be trained at the government's expense, individuals in many states must now pay their own way. Fees have also been introduced for some health services in a number of states. The northern states apparently have not been quite so seriously affected to date and still provide for staff training and free health services, but this may not be the case in the future. The financial constraints on the government system combined with the limitations placed on imports have led to what is referred to as the "Out of Stock" or "O/S" syndrome. With limited drug supplies at health facilities, patients are given prescriptions to purchase medicines at a local pharmacy.

The Government funding problem is not likely to be resolved in the near future; in fact, it is likely to get worse before it improves. Any attempt to rely heavily on the public sector for family planning service delivery must thus consider the capacity of the system to sustain such a program. For this reason, the potential of the existing private infrastructure as family planning service deliverers is being considered. In any program involving the private sector, there are several vitally important functions the government might carry out, including control (through the registration process) and referral (clinical backup in case of complications).

b. Private Voluntary Efforts. Although not included in the scope of this assessment, the important role played by private voluntary agencies in family planning in Nigeria to date must be recognized. Until recently the PPFN was the only multi-institutional agency to devote itself to the problem in the country. They developed a network of clinics to deliver family planning services. However, with the public sector now actively involved in family planning, the role of PPFN's clinical services may not be as important in the future. New strategies and activities for the organization must be identified and developed. One possibility is investigating ways of becoming more economically self-sufficient through cost-recovery schemes. There will be a growing need for quality family planning services at reasonable prices (between low-cost government and

costly private practitioners). It is appropriate that a non-profit organization test such an approach in the Nigerian context.

Another NGO that should be mentioned is the Christian Health Association of Nigeria (CHAN). This 10 year old organization has over 200 church-related health units spread around the country. One of its principal services to its members is coordinated, bulk purchasing of pharmaceuticals (between N1 and N1.5 million worth per year). This includes contraceptives*. With the Christian Churches being so influential, especially in the southern part of Nigeria, and the network of missions being so widespread, a possible role for this group will be discussed in the section describing the Service Component of the private sector.

c. Private (For-Profit) - Few developing countries have such a well developed private sector, especially in the health field. Nigeria has been described as a "nation of traders", and this is as true in the health field as in any other. Because the private sector has yet to develop a family planning program, it makes sense to consider what the private sector can contribute to the effort. It is important at this formative stage to consider how the existing pieces can fit together to provide the strongest program at the least cost.

The private (for-profit) sector approach makes sense for Nigeria from several different perspectives. First, the country has yet to develop fully a public sector program. Moreover, the constraints on the public sector, especially economic, make sustainable programming in the years to come a serious concern. On the other hand, the private sector in Nigeria has a well developed infrastructure that offers opportunities to provide a range of family planning supplies and services which are accessible and affordable. Moreover, the private sector has the capacity to absorb at least a portion of the start-up costs (training and equipment). It has an incentive both to promote family planning and do quality work. The more they do, the more money they earn. If they provide good services, their customers will return for other services and the word will spread; conversely, poor quality work or insensitivity will result in decreased business and income. Finally, assuming sufficient demand, once the system is set in motion, the private sector has the ability to sustain a family planning program without the need for any financial support, either foreign or indigenous.

4. Methodology

The Scope of Work (Attachment II) for the Assessment of the Private (for-profit) Sector in Nigeria is very broad. The methodology developed to complete the work consisted of four discrete steps:

*Even though the Catholic Church is a member and does not approve of the use of contraceptives, it does not prevent other CHAN members from procuring and utilizing and indeed some "Catholic" institutions such as the Zuma Memorial Hospital have a long history of supporting family planning.

- definition - the private sector was divided into the market and service components, each of which is further subdivided into formal and informal aspects.
- interview/observation - relevant actors representing various components that directly or indirectly affect the private sector were interviewed. These include:
 - national associations/organizations
 - government officials at national and state levels
 - private facilities
 - private practitioners
 - traditional practitioners
 - consumers
- regionality - the private sector in the three principal regions of the country (north, southeast, southwest) was studied to identify differences due to available resources as well as culture and tradition. Moreover, urban and rural market and service operations were studied to provide information about current capacities and future possibilities.
- operations - health and family planning-related activities were studied in some detail, focusing on logistics, management, financial, training aspects in order to identify possible approaches and required support for a private sector family planning effort.

Before the market and service aspects are described, it is useful to look at the private sector in more general terms. This is the focus of the next section.

III. OVERVIEW

1. Economic Climate

Nigeria is currently in the midst of a severe economic recession which has had and continues to have a significant impact on private sector activities. With its heavy dependence on oil exports for its revenue as well as foreign exchange, Nigeria has suffered as the price of crude oil has plummeted. Government spending has been curtailed, hurting business. Moreover, in an effort to conserve its scarce foreign exchange, the government has drastically reduced imports. The shortage of raw materials, parts, supplies, equipment has severely reduced the productivity of the economy and caused prices to increase rapidly. As the supply of goods shrinks, the prices rise. At the same time, as import licenses are restricted, the illegal importation of goods raises prices since they have been paid for in expensive black market procured foreign exchange.

The current economic crisis has forced the government and business community to consider new ways in which to cope and survive. One way has been to encourage the local production of goods which heretofore have been imported. This is particularly true in agriculture and for products for which raw materials are available or can be developed indigenously. In addition, the government has recently announced plans to deal with the greatly overvalued Naira by instituting a two-tier exchange system. Scheduled to be introduced in August, this policy will allow the Naira to float and find a truer value.

2. Definition

The private sector consists of the organized or formal and the unorganized or informal aspects. The former is guided by laws and regulations and often includes associations between concerns with similar interests concerns to promote common causes. The latter consists of smaller businesses owned by individuals as well as traders and laborers. They operate on their own. The term "unorganized," however, does not mean they are "disorganized"; on the contrary, they are often astute business men and women and they account for the majority of private sector activity in Nigeria. It is the informal sector which has the greatest contact with the consumer. It is more free-wheeling and operates to a greater or lesser extent outside official bureaucratic controls. While the formal and informal aspects differ dramatically from one another, they do not operate totally exclusively; as shall be described, the two are linked and often overlap and interact.

For the purposes of this private sector assessment, it is useful to further disaggregate the profit-making sector into market and service components. The market part includes the productions or importation of goods for sale to customers. It involves such activities as manufacturing, distribution, wholesaling, retailing. The second component consists of those who provide services to clients. It includes such professions as bankers, lawyers, doctors and health personnel. The next two sections will focus on some detail as what the formal and informal aspects of the market and service components of the private sector consists of and how they

function. The next section examines the market component; this is followed by the service component. As shall be illustrated, there is overlap and relationships between the market and service components as well as the formal and informal aspects.

IV. MARKET COMPONENT

1. Description

Figure I is a graphic presentation of the Market Component of the Private Sector in Nigeria. The component is divided into two parts. The formal and informal.

a) Formal - The organized aspect consists of companies registered with the government which are regulated by certain policies set by the government. These firms fall into three categories:

Schedule I - require little technical expertise and capital investment and are, therefore, wholly Nigerian owned.

Schedule II - require some technical expertise and capital investment, and Nigerians must hold majority interest (60% equity participation).

Schedule III - require considerable technical expertise and capital investment with Nigerians holding a minority interest (40% equity).

Many of the large companies belong to an umbrella organization the National Association of Chambers of Commerce Industry, Mines and Agriculture which has an autonomous chapter in each state with Lagos being the largest by far. Lagos publishes a directory of member companies; membership is voluntary, thus not all large companies are members. The Lagos Chamber of Commerce has 17 trade groups. The Chamber offers a variety of services to its members including advice on matters relating to the national economic and financial notices, trade regulation, and other business issues. It facilitates contacts between businesses and analyzes economic and business trends. The chamber also hold seminars, lectures, workshops at which members discuss common problems with a view to taking joint action.

Specialized groups also exist. For example, 25 years ago the Manufacturers' Association of Nigeria (MAN) was formed representing manufacturers from around the country. MAN has 13 branches. It's objective is to influence general policy (of government and members) in regard to industrial, labor, social, legal, training and technical matters. A list of MAN members is included as Attachment IV.

The Nigerian Employees Cumulative Association (NECA) represents the interests of the employers' and deals mainly with labor matters on behalf of the employers. Finally, there are the Labor Unions which have been combined by government mandate in the leftist leaning National Labor Congress (NLC). The union represent the workers and employees in negotiations and discussions with management. It was not possible to determine the number of workers in the organized sector.

The goods that are manufactured or assembled locally and imported go through a series of distributors and wholesalers until they reach retail outlets.

b) Informal - The unorganized sector constitutes the majority of private activities in Nigeria. It can be defined as all those enterprises and business men and women not within the mainstream of policy makers, trade union or employers association. It consists mostly of small concerns under individual ownership. They manufacture or import sometimes without license. The retail traders in small shops, in open markets, along the roadside, and hawkers all belong to the informal market component of the private sector.

2. Mechanics

During the course of the private sector assessment, we paid particular attention to pharmaceuticals and especially contraceptives, to determine how products move through the market component from the manufacturer/importer to the ultimate consumer.

At the national level there is a Pharmaceutical Trade Group with 34-member firms in the Lagos Chambers of Commerce and Industry (Attachment V). In the last several years as foreign exchange has become increasingly scarce, import licenses for pharmaceuticals have been reduced drastically. Only a fraction of the drugs required are imported officially. No separate line item is given for contraceptives; because there are other items which are in greater demand hence can command higher prices and better returns, importers rarely use their allotment of foreign exchange for the importation of contraceptives. If they do import some, it is in relatively small quantities.

Some contraceptives are handled by the large distributors- Hoechst handles 10 varieties of Schering contraceptives while Sterling Products, as mentioned, is responsible for distributing the USAID supplied Noriday. The mark-up between the wholesale and retail prices are high. Attachment VI provides an example for the Schering contraceptives. According to the Schering price list, there is a 10% to 11% increase between wholesale and chemist with an additional 50% tacked on for the retail price. The Noriday price is set at 67K per cycle wholesale and N1 retail. As can be seen from Attachment VII, the average prices at the chemist shops visited were higher than the suggested retail prices. For example, Noriday was seen as high as N5 (at both pharmacies and private clinic). Observations indicate that high prices result from a combination of forces emanating from both formal and informal aspects. One is insufficient stock. The importation restrictions have greatly reduced the quantities imported. As a result, a large percentage of the contraceptives are apparently entering the country

through the informal sector. Travelers bring back small lots from abroad. Chemists take frequent trips abroad. Huge amounts come in through licensed bulk import--agents in the huge markets at Onitsha as well as Aba (Ariaria and New Market) and Lagos (Church Street)** join forces and order large container loads of drugs.

Drugs are shipped throughout Nigeria from Onitsha, although some people are reluctant to patronize the market because of unscrupulous dealers who sell bogus medicines. A third reason for the high prices is the number of middlemen. Each person in the distribution chain has the incentive to sell the product rapidly to the next level so that he can realize his mark-up quickly. This results in wholesalers turning the commodity over to a few sub-wholesalers who sell it to small wholesalers who, in turn, sell it to retailers. With each party realizing his 15-20% profit, it does not take long for the product to reach a high price.

Demand for a particular product is also a factor in the determination of a products price. Some brands, such as Microgynon, are very popular. Women will pay high prices to procure it since they are reluctant to switch brands. Gynecologists' endorsement and word of mouth (from friends) seem to explain this brand's popularity. Retailers complain about new products, like Noriday, which have not yet been actively marketed*** and are not attractively packaged. The pills, on a card with plastic bubbles with no outer wrapper, do not appear "finished" to the consumer and may even give the impression that it has been tampered with; consumers in Nigeria are weary of being tricked.

Retail outlets include pharmacies, patent medicine stores (PMS), clinics and markets. Source of supplies to these outlets varies. In some cases, large wholesalers sell their products to large pharmacies. In others, large wholesalers sell stock to smaller wholesalers who in turn sell to pharmacies. Sometimes, pharmacists, especially smaller ones, go to smaller wholesalers (often large pharmacies) to procure stocks. Wholesalers can control prices to some extent by controlling the flow of drugs. Even if a wholesaler is reluctant to do this, employees sometimes buy and distribute stock. Officially, a distributor can control the price at which retailers sells his product and can withdraw it if it exceeds the

One chemist said he traveled weekly to London to procure drugs.

** The pharmaceutical market at Onitsha is reputed to be the largest in West West Africa with over 2000 stalls (many split into two or three separate shops). Aba has a total of approximately 500 stalls.

***The newspaper advertisement (Attachment VIII) was run in June. The Government has recently issued orders that contraceptive pills cannot be advertized in the mass media. The primary fear is that "school girls" (unmarried adolescents) will be swayed by the promotional material and begin using the pill and "be corrupted."

set price. In reality, however, this does not happen since this requires distribution directly to the retail outlet which rarely occurs. Moreover, the general mentality appears to be "what the market will bear" in terms of price. Pharmaceuticals and contraceptives in Nigeria are currently reacting as expected to basic forces of supply and demand. As the pipeline fills, particularly with AID-supplied commodities, the prices are gradually falling.

Private clinics usually receive their stocks in a similar manner, either from drug wholesale suppliers or by going to the supplier/sub-wholesaler themselves. Both pharmacies and clinics are part of the formal sector since they must register with the Ministry of Health and meet certain specifications. Pharmacies register with the Chief Pharmacist and clinics usually with the Chief Medical Officer. While it is possible that some pharmacies and clinics may not be registered, this is apparently rather uncommon.

The informal sector can serve as retail outlets for contraceptives. First there are PMSs. PMSs can be part of the formal sector since they are supposed to be registered with the government. However, many, possibly half, of the existing PMSs are not registered. Moreover, most of them (registered and unregistered) sell prescription drugs which they are not permitted to stock. They usually get their supplies from chemist shops in urban areas at slightly less than retail cost. A PMS is usually the only source of medicine in the rural areas.

Market sellers are another potential retail outlet. The initial success of the previously mentioned Ibadan market women (Section II.2) effort has been encouraging. With markets being such an important part of Nigerian life, market women could serve as retailers to a not insignificant portion of women.

Many consumers appear to prefer going to a pharmacy to get their first cycle of pills. Cost and convenience are the reason. If they go to a clinic they must wait, register (costing from N8 to N20), undergo a full medical examination, and pay another N5 to N10 for the contraceptives. Thus, the least cost for which a new client can obtain one cycle of pills is approximately N25. Pharmacists are obviously cheaper.

As in most developing countries pharmacies in Nigeria usually do not demand prescriptions for drugs including contraceptives. Pharmacists' knowledge and advice to women on how to use the pill is often rudimentary.

3. Recommendations

Indicators of a successful provision of contraceptives for a national family planning program are availability, accessibility, and low cost. Discussion with actors in the market component of the private (for-profit) sector indicate that important factors required to achieve such a goal include IEC (information, education, communications), briefings and communications, briefings, advisory groups, supplies, distribution through a network of retail outlets, training, packaging, and expansion of the informal sector.

a) IEC - A persuasive and pervasive awareness-building campaign for demand generation is an essential first step if contraceptive usage is to grow. IEC effort must be sensitive to cultural traditions and should stress the health aspect of family planning. Many of the people interviewed emphasized the need to promote "rest" between births as important for the health of both the baby and the mother. At the same time informants said pointing out the economic disadvantage of large families would have little impact*. Special marketing techniques (such as focus groups to identify perceptions and resistances points) would be useful in developing regional or even state level IEC campaigns. Radio has been found to be the most effective means of mass communications. When the efforts of FPIA and Population Communications Service (Johns Hopkins) are systematically available, they will provide useful information on how to proceed with the IEC activities. In addition, posters should be designed for display outside pharmacies informing the public what contraceptives are available and the price.

b) Briefings - Top policy makers interviewed in both the public and private sectors stressed the need to be fully briefed on family planning efforts. Misconceptions abound, especially when a foreign agency is involved. Some see population "control" being thrust upon them by an outside force. Business leaders also wanted to know what is going on and the Chambers of Commerce and MAN can be helpful for much publicity, especially as it affects them. Seminars and workshops for business leaders for informational and exchange of ideas purposes were thought to be a good way to promote and legitimize private sector family planning activities. The same is true at the state level where officials should be sensitized to the potential role of the private sector and the importance of including the private sector in state family planning programs. Because health and family planning have traditionally been viewed as a public sector responsibility, some initial resistance to private sector involvement might be expected.

* This is particularly true in the North where the Muslim population is taught that Allah will provide for all offspring.

c) Advisory Groups - As the project planning process advances the need for local advisory groups will grow. As mentioned and demonstrated, the private sector in Nigeria is complex and full of potential difficulties and obstacles. To avoid these, having local leaders who are experienced in all aspects of the private sector and are committed to family planning will permit a much more realistic and potentially successful program to be developed. State planning efforts should be a combination of representatives from both the public and private sectors.

d) Supplies - If USAID is to provide contraceptives, it will have to consider doing so in huge quantities - enough to "flood" the market to assure availability and low cost. It is extremely difficult to estimate demand at this time since IEC efforts are only beginning and supply pipelines are only beginning to be filled. There is an obvious need to make more precise estimates by looking at different models so that a supply strategy can be developed. Currently the supply of and demand for contraceptives can be described as highly volatile and is likely to remain so for the next four or five years. Steps must be taken to guard against overstocking or shortages, and the private sector must play a role in determining the appropriate level of supplies. The need was raised to consider other possibilities such as indigenous production, initially of condoms but eventually pills in the longer term future.

Several pharmacists and leaders in the pharmaceutical field pointed out that there were strong advantages to limiting the number of contraceptive brands allowed to be imported in addition to the USAID variety. While they identified the programmatic advantages of having only three or four kinds imported, the operational difficulties of controlling this are obviously great. It would help if contraceptives were made a separate line item in import licenses rather than being lumped together with "drugs" in general. All import duties and taxes on contraceptives should be removed to reduce prices. A number of medical directors of clinics mentioned their concern over the difficulty of procuring IUD supplies. As a growing number of women apparently are adopting this method of contraception, the production problems in the U.S. and supplies from USAID are a mounting concern. Alternative sources of Cu7s and CuTs will have to be located.

e) Distribution and Retail Outlet Network - Interviews with wholesalers and retailers identified two potential strategies for contraceptive distribution, the top-down approach and the closed system. The former depends solely on the market mechanism. In it the product flows through the distributors and wholesalers to the retailers. As suggested above, this can function effectively if the supply of the commodity in question is available in sufficient quantity to prevent scarcities and the resulting high prices.

The second approach establishes a distribution system which begins with identified outlets (network of markets, PMSs, clinics, maternity homes, pharmacies, public facilities). A group regularly services this

network with contraceptive supplies. Control is maintained by the distributor. With commodities available at no cost, funds are available to cover recurrent costs*. To determine the efficacy of such a system, it should be tested on a pilot basis.

f) Training - A considerable amount of work has been done to train family planning clinicians in Nigeria. Private sector participants (e.g., industrial health clinic staffs) are beginning to be included. More must be done to expand these efforts to include a greater number of private sector people. For effective retailing of contraceptives, it is important that the pharmacists and those operating PMSs, where a significant portion of women will procure their supplies, receive additional training. All those who handle oral contraceptives must be aware of the importance of the clinical aspects, the need for a medical examination, and must be familiar with counterindications, as well as know how to take a medical history.

g) Packaging - Based on interviews with pharmacists and clients, there is a community held view that the pill imported by USAID should be in individually wrapped packages. This adds to the cost but the possibility of doing it locally should be investigated. Envelope wrappers could be printed and supplied to the retailers. The cycles could still be distributed in 100-cycle packages and individual packets inserted into the envelopes by the retailer. This could be done for a minimum cost and should be covered within the "wholesale cost" of the commodity.

h) Informal Sector Expansion - The market women pilot exercise in Ibadan may warrant expansion. The administrative support for such efforts could come from the Private Practicing Midwives Associations with the nearest maternity homes being responsible for the supply, supervision and support for individual agents. The integrated health-family planning package of goods should be maintained.

* An outline of such a system has been suggested for Imo State as part of a family planning service delivery program (Pyle, March 1986).

V. SERVICE COMPONENT

1. Description/Mechanics

A representation of the Service Component of the Private Sector in Nigeria is presented in Figure II. This assessment involves private practitioners (doctors, nurses, midwives) who do or could provide family planning and midwifery services to clients. As in the case of the Market Component, we can identify a formal and informal aspect.

a) Formal - There are national groups or associations of professional health practitioners. In the case of physicians, there is the Nigerian Medical Council in Lagos where every doctor practicing in Nigeria is supposed to be registered. Nevertheless, trying to determine the number of physicians currently practicing in Nigeria is difficult. The Council says approximately 12,000 are registered, but this includes every "ever registered" doctor; those who have emigrated, retired or died have not been deducted. There is also a Nigerian Medical Association (NMA), a professional organization to which physicians can belong. The NMA was disbanded several years ago by the government after it was accused of being involved in the organization of a nationwide doctors' strike. Recently, however, it is being reorganized and is once again becoming active.

There is a similar set-up for nurses and midwives. First, there is the Nursing and Midwifery Council of Nigeria in Lagos which registers all nurses and midwives, totally over 40,000. As in the case of the Medical Council, the register is not updated, thus making it difficult to ascertain the current number of active nurses and midwives. There is also the National Association of Nigerian Nurses and Midwives which serves as a trade union and is a member of the National Labor Congress (NLC). Nurses and midwives in both the public and private sectors are invited to join.

There are branches of the national organizations at the state level. For doctors, there are National Medical Council offices as well as recently renewed NMA branches. There are often Private Practicing Physicians Associations, but most are not active (or "rather defunct," as we were told) and often unable to function because of the intense rivalry between private health facilities in most of the state capitals where the majority are located. Nurses and midwives have state-level branches of their association (Attachment IX) enroll a good percentage of the nurses and midwives practicing in the state. Within the last several years, Private Practicing Midwives Associations have been established in an undetermined number of states but no national organization has yet been organized. Offices of the branches Imo and Rivers States described their activities and monthly meetings.

The formal sector of private health services facilities includes registered hospitals, clinics and maternity homes. They must register with the state Ministry of Health. The registrar usually comes under the Chief Medical Officer. The criteria for registration include staffing (requisite number for services provided and for size of the facility plus their

qualifications) and physical specifications (proper facilities available for intended services and general standard of environmental sanitation). The schedule and cost of registration differs by state. Some states only require initial registration while others require annual renewals. Some examples are:

<u>State</u>	<u>Initial Registration Fee</u>	<u>Annual Renewal Fee</u>
Imo	N 50	N 25
Kano	N 500	N300
Rivers	N1000	None

The registration cost usually depends on the use of the facility as determined by the number of beds. The annual renewal is important in that it enables the MOH to update its list and maintain/control standards in the private sector. Annual renewal offers an important linkage mechanism between private and public sectors.

The number of registered health facilities varies greatly from state to state. In most cases, private facilities are heavily concentrated in large urban areas, especially capital cities. Rarely are clinics and maternities found in rural areas. There are some exceptions, however, such as Imo State which has an extensive and widely distributed network of over 300 maternity homes. A similar pattern reportedly is found in Anambra and Ogun States.

i) Retainership Agreements: A large portion of the workers in the organized sector receive health care benefits through their employers. Some businesses, especially the larger industrial or production units, have their own clinics and health staffs to attend to their workers' health needs. Many businesses, especially those with a large number of office workers, such as banks, trading houses and insurance companies have developed retainer relationships with private clinics in the city where they operate. The nature of these retainerships differ markedly in several respects:

- Employees Covered - There are a number of different groups of workers which might be covered. The distinction is made in many cases between senior staff (top-level management workers) and junior staff (lower level workers which constitute the vast majority of workers). The most common types of coverage found under retainership arrangements are: senior staff only; senior and junior staff members only; senior

staff and dependents and junior staff; senior and junior staff and dependents*.

In the North, junior staff dependents were often not included. In the South (e.g., Ibadan), one clinic having among the highest number of retainerships in the city reports that two-thirds include all dependents. At a Lagos clinic having agreements with nearly 100 firms, almost all retainership covered dependents. The number of women employees covered by these retainership programs varies depending on the part of the country -- in the North the workforce is almost entirely male, while in the South, such as Port Harcourt, office staffs are said to be almost half female.

- Services Rendered - The services included in typical retainership agreements tend to be restricted to curative health care. Specialized services such as surgery or obstetric services are usually not covered. As mentioned, family planning and preventive services are sometimes covered under the guise of other services.
- Costs - Charges incurred by a retainership company are maintained over a month and charged at months' end. In some of the larger retainership agreements consultation fees are dropped and a discount of 5% to 10% is given. Sometimes a minimum charge is levied each month regardless of whether the clinic's services are used.
- Selection - Companies request a number of clinics to respond to their search for retainer clinics. They specify what services they want and whom they want to cover and the clinic responds with their costs. Negotiation on terms and an inspection of the facility are completed before the retainership is finalized. A number of clinics are usually chosen by a company according to instructions and criteria laid down by the personnel section of the company headquarters, in most cases, Lagos. Multi clinics give the employees a choice in terms of quality as well as location.

As a general rule, the larger the private health facility, the more dependent it is on businesses generated by retainers. Some clinics visited derived 70-80% of their income from these arrangements. It was repeated more than once that the "public could not afford the high rates." This dependency on the retainership business is currently causing economic hardship in many of the clinics. Some companies have ceased operations altogether while others have cut their workforces dramatically, thereby reducing clinic incomes. Other companies have reduced the amount set aside

* Sometimes there are restrictions or "limited dependents" which means one wife and three or four children. Companies often require clinics to put the patient's pictures on their record for identification. Still employees try to circumvent the rules and put pressure on clinics to go beyond the scope of the retainership agreement. The highly competitive situation encourages clinics to accede to client requests.

for health care, either in total or per employee. Once the limit is reached, health services are either discontinued or are charged to the individual. Unfortunately, the tendency in hard times the cutbacks often start with the most vulnerable employees at the bottom, the junior staff and dependents.

The competition among the clinics for the retainership business is fierce. Many of the medical directors complain that there are too many clinics for the amount of business available. There are laws which restrict the doctors or clinics from advertising; this makes them reluctant to attempt any outreach or motivational efforts. Thus they are relatively passive actors, who have yet to develop marketing strategies which might increase their business.

Family planning is not a service paid for by most companies with the exception of the very wealthy firms. A number of clinics visited, however, do motivate and provide women contraceptives when she requests or is determined to need for health reasons. The services are charged as a regular "medical visit" and the contraceptives as "drugs."

There are accusations that some of the charges to the companies under retainerships are inflated and that the retainers are unethically negotiated. These charges are impossible to verify but with the current unfavorable economic climate and companies being severely constrained, high prices only result in more rapid depletion and exhaustion of the limited health care funds. A few clinics have taken measures like lowering their rates to encourage greater utilization by the public, thereby decreasing their dependence on retainership business.

b) Informal Sector - The informal or unorganized sector consists of unregistered clinics and maternity homes as well as traditional healers and TBAs. The existence of unregistered clinics and maternity homes is known, but it is difficult to estimate the extent. Several state governments are currently in the process of tightening their registration procedure to ensure universal registration.

TBAs are responsible for the majority of deliveries in most parts of the country; they account for as high as 75% of all births in Nigeria. The dependence on TBAs varies by region and even state. In the North, for instance, an estimated 90% of the deliveries are done at home by TBAs.* Even in some of the southern states such as Rivers and Lagos, the percentage of TBA deliveries is said to be in the neighborhood of 70%. Lagos is interesting because an estimated 60% of the over 1000 TBAs identified are male; male TBAs are most common in Lagos city itself.

* In conservative Islamic areas women are encouraged to remain at home. This largely explains the reliance upon TBAs and has prompted the Kano MOH to develop an extensive domiciliary care program for women.

According to informants where a woman delivers her baby is partially a function of economics. The higher income groups or elite stratum (possibly top 5%) utilize the clinics where a delivery can cost N500 to N1000. The maternity home clientele comes from the relatively small middle class. Typically, maternity costs at these facilities are N10-15 for registration, N3-10 per ANC visits (which include tetanus toxoid immunization), and N50-60 for delivery in the smaller cities up to N200 or more in the metropolitan cities. On the other hand, a TBA may ask only N15-25 per delivery or accept in-kind payments. For this reason, an increasing number of women seem to be opting for the latter. Maternity homes report a 50% drop in business in the last year. Up to half of the women who attend the ANC sessions at maternity homes deliver at home.

The traditional healers include several specialists such as herbalists and bone-setters. There is an attempt being made to organize the traditional sector in the form of the Nigeria Association of Medical Herbalists. The head of this organization believes the traditional healers could play a motivational role in a family planning program, particularly among traditional leaders and male population. The Association has branches in each of the states which consists of a number of societies of traditional practitioners. Three states have formed TBA associations -- Cross Rivers, Lagos, and Sokoto. The national association's office in Lagos can provide the addresses and names of the chairmen of the state branches.

Many of the states have made efforts to identify and train active TBAs. The training focuses on hygienic delivery practices but also give some attention to family planning. The courses vary greatly in duration -- from three months in Kaduna, to two weeks in Rivers, to one week in Kano. Over 1,600 TBAs were trained in Kano State between 1978 and 1982. In Rivers State last year approximately 200 were trained by the government. The government in Port Harcourt is now contemplating a trial with a selected few of the trained TBAs to see if they can successfully carry out family planning work in their respective areas, much like the USAID-funded project in Benue.

The midwives in charge of maternity homes are generally not trained or current on family planning techniques; but do motivate women during their ANC and post-natal sessions for family planning. They refer interested patients to nearby private clinics or public facilities for the services. Even TBAs recommend to some women that they should space or limit the number of children they have. All they can do is to prescribe some herbs which, as one TBA admitted, "are not very effective."

2. Recommendations

The service component of the for-profit private sector has tremendous potential for the delivery of family planning services to a large portion of the Nigerian population. The infrastructure is in place but to date has not been activated for family planning purposes. Most of the programming possibilities, therefore, involve reorienting the private practitioners and developing their capacities to deliver contraceptive services. Among the activities required to do this are: background studies, inventory taking, advising group formation, commercial enterprise orientation, maternity homes support, CBD and TBA development, training and equipment provision.

a) Background - Program design must pay particular attention to cultural settings, especially the beliefs and practices associated with women and childbirth. Currently only anecdotal and imprecise estimates exist on the percentages of infants delivered in public, private institutions (hospitals, clinics, maternities), prayer houses and at home. Who attends these births (doctor, midwife, trained TBA, untrained TBA, relation) is also largely unknown. A country-wide sample survey of birth practices would be useful to provide program planners with state-specific information on who could carry out interpersonal contraceptive motivation as well as refer clientele to clinical services or provide services themselves. This would supplement information in the contraceptive prevalence survey.

b) Inventory - The private sector assessment underscored the great variations existing among the states. This is particularly true when referring to resources which can be applied to family planning programs. Several states visited had mapped (Kaduna) or were in the process of mapping (Rivers) the public health facilities (health centers, clinics, dispensaries). It would be helpful if private clinics and maternity homes were included on such maps to indicate the distribution of potential sites for contraceptive depots for community-based retailers. Gathering and presenting this information in conjunction with state officials provides the opportunity to identify strengths and weaknesses in the respective infrastructures and consider how the two might complement each other.

c) Advisory Groups - As in the case of the market component, it is essential that advisory groups be established to work with the state planning committees to help design a viable and feasible private sector service component for a family planning program. Committed individuals consisting of a few respected private practitioners (doctors, midwives), representatives from the TBA and private business associations (personnel or service specialists) would be helpful in identifying ways in which the various parts of the private sector would function together and with the public sector to benefit the population with available, accessible, inexpensive family planning services. At the national level, the more recently formed National Council for Population Activities should be supported so that it could serve as an advocate of strong private sector involvement in population programming.

d) Commercial Enterprises - FPIA and the Enterprise Program have initiated efforts to introduce family planning into industrial clinics. Considerable potential can also be envisaged in convincing commercial firms utilizing retainership arrangements that family planning services should be included and be provided to their staffs. TIPPS, which has conducted studies to determine the savings to be realized by companies when a worker accepts family planning, could apply this methodology to companies having retainership agreements. Presentations would be made to Boards of Directors at the headquarters of firms (often large banks and insurance companies) in Lagos. The second aspect of this approach would be to upgrade private clinic staffs, where required, by providing clinical training in family planning and special equipment. Because most of larger clinics having the bulk of the retainerships already have a fairly high level of gynecological expertise and family planning experience on their staffs, only a limited amount of additional clinical training (mostly in the form of contraceptive update) may be required.

Interviewers in Lagos pointed out the benefits of presenting such information and of including family planning services to groups such as MHN and NECA. Gaining the support of influential business leaders is important in establishing trends and for the idea to gain momentum. Companies would be asked to rethink what is in their interest, not only in family planning but in the whole industrial health care financing issue as well. Ultimately a private sector program would strive to have companies invest in family planning using their own resources, relieving the need for any donor assistance. For this to happen, firms must not only be convinced that providing family planning services is in their economic interest, but importantly, that the expertise required to implement such efforts must be locally available. Consequently, it is important to develop a local capability to promote and service family planning activities in the commercial sector.

e) Maternity Homes - Without exception, interviewed midwives who operate maternity homes were interested in expanding their services to include family planning. This would enable them to provide clinical family planning services and only refer clients with complications. Matrons of these facilities will require clinical training(4 to 6 weeks) and some equipment. Maternity homes would serve primarily urban centers, although in a few states (e.g., Anambra, Imo, Ogun) they are found in rural areas as well. As more midwives are being trained at their own expense and government can no longer afford to absorb them all (some are even being retrenched), a program extending credit to begin a self-sustaining maternity-MCH-family planning facility in rural areas could be tested.

f) Community-Based Distribution (CBD) - TBAs are a potentially valuable resource at the community level. TBAs interviewed expressed an interest in learning about family planning and serving as local motivators, referral agents and contraceptive suppliers. In order to ensure proper clinical supervision and support, TBAs would work in conjunction with a nearby health/family planning facility. Such centers would conduct medical exams to ensure that women could safely take the oral contraceptive. It would also be available if complications arose. Type of facility, whether public or private, would depend on what was available . In urban areas, TBAs

could work with the closest maternity home. They would refer clients to these homes, which would be good for their business, and in turn, would make a small amount of money from the regular sale of pills to the women. In rural areas, private facilities are typically not available, which would mean utilizing public facilities within easy reach of TBAs. The contraceptive supply distributions system described in the last section would be responsible for supplying the urban and rural supply points.

Several small-scale CBD experiments utilizing TBAs are currently operating in Nigeria. Serious questions are raised about long-term viability, control, supervision and referral. While theoretically the idea of income-earning community distributors (i.e., TBAs) is appealing, financial concerns involving supply and support for such a system must be addressed. To help answer these questions more experience in large-scale programs is required to identify what works best and develop a formula that can serve a significant population.

g) Training - Significantly, efforts have been made in Nigeria in the last several years to strengthen family planning training among the public sector health staff. The work of INTRAH, Johns Hopkins and the University of Ibadan has been commendable. This training has begun to affect the private sector, but more will have to be done if the potential of the private sector is to be realized. For one, staffs of private clinics servicing companies through retainerships will require training if family planning is added to the services provided. Since most of the larger clinics have a fairly high standard of gynecological expertise and family planning experience, the training they require is mostly contraceptive update. What is missing and required is IEC and motivational/counseling skills. The possibility of clinics training or hiring one or even two motivators to meet with company employees to explain the benefits and mechanics of family planning was not met with much enthusiasm. The medical directors could not conceive of such a person covering their salary through increased business. Cost and feasibility studies on the profitability of using staff to do motivational work would be helpful. They would demonstrate the economic rationale as well as provide the support that clinics could utilize to apply for bank loans to add IEC personnel to their staff.

For the upgrading of industrial clinic personnel the possibility of utilizing Industrial Training Funds (ITF)^{*} was raised. If universities and private organizations (like PPFN) could qualify as training institutions funded by ITF, family planning training among the industrial sector could be supported without exogenous funding.

*Ten percent of salaries are contributed to the ITF and companies are reimbursed 60% of training costs for employees.

Clinical training of midwives running maternity homes will also be required. The midwives interviewed said they would be willing to pay for a significant portion, possibly all, of the training course since they expect to increase their income as a result of acquiring a new skill. Costs would depend on length and location but could be kept to a minimum by having the public health staff trained in family planning serve as trainers and having the course conducted at LGA levels. Efforts should be made to keep courses as short as possible to reduce opportunity costs for the midwives.

Finally, if a CBD program relying on TBAs is included in a family planning program, a large number of TBAs will require training in clinical aspects and how to market contraceptives. As in the case of the midwives, TBAs expressed a willingness to absorb the cost of training in view of potential earnings. Selected maternity homes could be developed as training sites for TBAs, giving them an additional source of income. Several maternity homes visited were training auxiliary nurses at their facilities.

h) Equipment - The private clinics and maternity homes mentioned the need for a limited amount of family planning equipment. Currently they are experiencing difficulties procuring quality equipment at a reasonable price. Arrangements should be made to provide inexpensive, quality good equipment (e.g., gynecological examination tables and lamps), the facilities in many cases would be willing and able to purchase them. Some private practitioners mentioned that if the payments could be spread out over time, they could more easily pay for the equipment. Thus mechanisms such as revolving funds or bank credit must be tested as possible approaches.

VI. CONCLUSION

This assessment of the private (for-profit) sector in Nigeria is a beginning. Our consultancy represented the first effort to look broadly at what the private sector consists of in this large and diverse country, and how the infrastructure and resources (human and physical) might be applied to the provision of family planning services. The interviews confirm that great potential exists in the private sector, both in the market and service components. Some of the possible programming approaches mentioned in the sections on the market and service components are already being tested; others must be developed in greater detail and tried on trial bases in several locations. While pilot exercises are usually fought with problems when expanded or replicated in the public sector, the difficulties in the private sector may be expected to be reduced since the profit motive prevails and less organizational and political constraints are introduced. There will continue to be a need for information gathering and sharing about what works and how.

The private sector offers not only a great opportunity to carry out innovative family planning programming but also represents one of the few options that can be identified to address effectively and efficiently the already large and increasingly more serious population problem in Nigeria. With almost 25% of Africa's population and heading toward becoming the third most populous country in the world, the need for family planning increases. The capacity of the public sector to assume this responsibility is not feasible--their resources, both financial and human, are limited and shrinking. On the other hand, the private sector is vital and can be activated with a minimal input. By supplying contraceptives and some capacity/institution building, USAID could assist the private sector in becoming an effective family planning force within the reasonably short time of five to six years. Not only will this help Nigeria reduce its population growth rate, but it will also provide an opportunity to demonstrate the capacity of the private sector to assume a major role in the provision of family planning services.

ATTACHMENT I

USAID REQUEST FOR PRIVATE SECTOR REVIEW IN NIGERIA

TELEGRAM

PAGE 01
ACTION AID-011

1046Z

3734 030042 AID

INPUT AND INITIAL TRAINING.

ACTION OFFICE POP-04
INFO AFCD-01 AFCV-03 AFPU-04 AFTR-05 AMAD-01 PDPR-01 PPF8-02
C-02 CALI-02 CPP-01 CMC-02 CT-01 STHF-01 LACT-01 11-06
MHS-09 AFDA-02 OHB-07 RELO-01 TELE-01 AFNG-03
/056 AU

6. PLEASE ADVISE IF ENTERPRISE WILL BE ABLE TO PROVIDE EXPERTS TO UNDERTAKE THIS PRIVATE SECTOR SURVEY. WE ESTIMATE THIS TASK COULD BE COMPLETED IN FOUR TO SIX WEEKS.

INFO LOG-00 PASS-00 /000 V
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KEYS MACHANUS
AMERICAN EMBASSY
LAGOS

P 311043Z MAR 86
FM AMEMBASSY LAGOS
TO SECSTATE WASHDC PRIORITY 0339
INFO AMEMBASSY ABIDJAN

CLARK

NOTE: PASSED ABOVE ADDRESSEE BY OC/1

UNCLAS LAGOS 03816

ADM AID DIRECT RELAY

E.O. 12356: N/A
SUBJECT: POPULATION - ENTERPRISE PROJECT

TO: NANCY HARRIS
-- DEPUTY DIRECTOR
-- ENTERPRISE PROGRAM
-- JOHN SHOW, INC.
-- 1100 WILCOX BLVD.
-- 9TH FLOOR
-- ARLINGTON, VA 22209
-- TEL: 703-528-7474

APR 1 1986

1. A FEW BASIC FIGURES FROM A RECENT THREE PAGE REVIEW OF THE PRIVATE SECTOR'S POTENTIAL ROLE IN DELIVERING OFT IN NIGERIA INDICATES A GREATER NUMBER OF POTENTIAL SERVICE POINTS THAN HERETOFORE THOUGHT:

FOR EXAMPLE:

- (1) THERE ARE 40 PHARMACEUTICAL MANUFACTURERS IN NIGERIA.
- (2) OF THE 12,000 PHYSICIANS, 9,000 ARE IN PRIVATE PRACTICE.
- (3) THERE ARE 3,600 PHARMACISTS WHO OPERATE 5,200 DRUG STORES.
- (4) THERE ARE 20,000 REGISTERED PATENT MEDICINE SHOPS AND AT LEAST AS MANY UNREGISTERED ONES.
- (5) THERE ARE AT LEAST 4,000 REGISTERED MATERNITIES.
- (6) THERE ARE TENS OF THOUSANDS OF HAWKERS, MARKET WOMEN AND TBAS.

2. IT IS HOPED THAT THE PRIVATE SECTOR WILL BE DELIVERING 80 PERCENT OF THE CONTRACEPTIVES IN NIGERIA IN THE NEXT FEW YEARS.

3. IN ORDER TO TAKE ADVANTAGE OF THIS POTENTIAL AND TO MAXIMIZE ITS EFFECTIVENESS AND SAFETY, WE NEED TO KNOW A GREAT DEAL MORE ABOUT HOW THE PRIVATE SECTOR FUNCTIONS, E.G., HOW ONE GAINS ACCESS, TRAINING, SUPPLIES, NEW PRODUCT INFORMATION, ETC.

4. THEREFORE REQUEST TWO PERSON TEAM MAKE STUDY OF THE FOLLOING PRIVATE SECTOR ELEMENTS IN THE THREE MAJORITY MARKET ZONES (THE EAST, THE NORTH AND THE WEST). URBAN AND RURAL SECTIONS SHOULD BE DESCRIBED AND QUANTIFIED. A DETAILED STUDY IS NOT NEEDED, BUT A DESCRIPTION OF HOW THE SYSTEM(S) WORK, INCLUDING THE BASIC ECONOMICS OF IT, WOULD BE OF IMMENSE VALUE.

5. IF PROPERLY DESIGNED, WE BELIEVE THE PRIVATE SECTOR WILL BECOME SELF-SUPPORTING EXCEPT FOR CONTRACEPTIVE

UNCLASSIFIED

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ATTACHMENT II

Scope of Work

A two-person team will work in Nigeria on consultancy basis for approximately one month. During that period, they will study and describe how the private sector functions in order to identify and design effective/appropriate strategies for initiating/strengthening family planning activities and programs in the private sector.

The study will include a review and description of the formal and informal components of the private sector. For each component, the industry and the practitioners will be covered. In the case of Industry, the primary focus will be on manufacturers and distributors. Under the latter, wholesalers, retailers and hawkers are included. Regarding the Practitioners, doctors, midwives and traditional practitioners (such as birth attendants, healers, herbalists and religious healers) will be covered.

In order to complete the study:

- Existing private sector family planning programmes supported by donor agencies, including USAID Cooperative Agreements will be reviewed and briefly described, as they illustrate lessons of how various components of the private sector

functions;

- Four regions will be covered during the study to ensure geographical, cultural and ethnic representation. The four regions selected are also the areas where private sector activities are concentrated. The four areas are Kaduna/Kano in the North; Port Harcourt in the East; Ibadan in the West; and Lagos, the Federal capital;
- Each component will be studied to determine how it operates in the urban as well as rural settings and what significant differences exist; 50 - 100 miles around the three regional cities will be visited;
- For each component, relevant respondents/actors will be interviewed and observed;
- Specific possible private sector family planning program activities will be developed for at least two components for illustrative purposes and will include elements such as cost, training, price control, quality control, incentives.
- Knowledge gaps and required future studies to provide a basis for sound family planning

programming in the private sector of Nigeria will
be identified.

A report will be prepared presenting an overview of the private
(for-profit) sector and how it does and can relate to family planning in
Nigeria.

ATTACHMENT III

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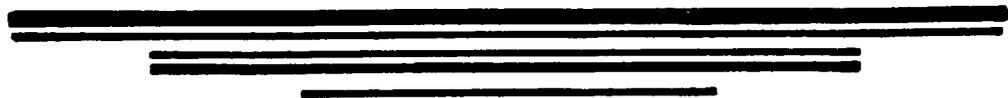
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ATTACHMENT V

PHARMACEUTICAL TRADE GROUP MEMBERS



**NIGERIA BUSINESS
DIRECTORY
1985/86**

**A PUBLICATION OF
THE LAGOS CHAMBER OF COMMERCE & INDUSTRY**

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**(088) PHARMACEUTICALS AND
TOILETRIES**

Alban Pharmacy Limited
128 Broad Street
P. O. Box 461
Lagos.
Tel: 661171

Chief Executive/Managing Director:
Chief A. Adekeye
Pharmaceutical and Optical Goods

**Associated Pharmaceutical
Products Limited**
Plot 3, Block A, Amuwo Odofin
Industrial Estate
P. O. Box 5571
Lagos.
Tel: 836192

Chief Executive/Managing Director:
Mr. K. M. Smith
Pharmaceutical Products Distribution

Bayer Pharmaceuticals Nig. Ltd.
Plot 13, Block A
Industrial Estate, Amuwo Odofin,
P. O. Box 250
Apapa
Tel: 801580—4

Chief Executive/Managing Director
Mr. P. Crosspietsch
Manufacturers of Pharmaceuticals

Commercial Medicine Stores Ltd.
23, Nnamdi Azikiwe Street
P. O. Box 89
Lagos.
Tel: 662682

Chief Executive/Managing Director:
Dr. R. O. Adebowale
Pharmaceutical

Continental Pharmaceuticals Ltd.
283, Agege Motor Road
Mushin,
P. O. Box 5080,
Lagos.

Tel: 960809, 961042, 961003
Chief Executive/Managing Director:
Prince A. A. Awofisayo
Pharmaceuticals

Dumex Pharmaceuticals Ltd.
Plot 4, Block F
Isolo Scheme
Oshodi
Tel: 836647, 837158, Home: 963749
Chief Executive/Managing Director:
Mr. J. C. Michell
Distributors of Pharmaceutical Products

Embechem Nigeria Ltd.
(May & Baker)
3/5, Separa Street
Ikeja Industrial Estate
P. M. B. 21049, Ikeja.
Tel: Office — 962332
Chief Executive/Managing Director:
Mr. K. F. Allen

*Pharmaceuticals, Chemicals, Agro Chemicals,
Industrial Chemicals & Plastic Manufacturers
and Distributors*

Executive Pharmaceutical Chemists
1, Toyan Street, Obalende
P. O. Box 53793,
Falomo.
Tel: 680722

Chief Executive/Managing Director:
Mr. Ayo Arole
*Pharmaceutical Retailing Wholesale and
Importation*

Farmex Limited
Km 38, Lagos-Abeokuta Road
Sango Otta, Ogun State
P. O. Box 4038, Ikeja.

or
c/o Mr. E. A. Hentschel
54, Oladipo Bateye Street
G. R. A., Ikeja.
Tel: 960396, 931575
Chief Executive/Managing Director:
Mr. E. A. Hentschel
Manufacture of Pharmaceuticals

Glaxo Nigeria Limited
41, Creek Road
P. M. B. 1120,
Apapa.
Tel: 803050, 803051—2
Chief Executive/Managing Director:
Mr. R. F. G. Trewick
*Pharmaceutical Manufacturers and
Distributors*

Healthcare Products Limited
25, Industrial Avenue,
P. O. Box 3136
Ilupeju.
Tel: 963206, 963210
Chief Executive/Managing Director:
Dr. A. Bennet
*Manufacturers and Distributors of Toiletries,
Cosmetics and Hospital Pharmaceuticals
products*

65

Jolliters Chemist Limited
172, Agege Motor Road
P. O. Box 8
Mushin.
Tel: 962300, 834390
Chief Executive/Managing Director:
Chief A. Makinde
Pharmaceutical Company

Juli Pharmacy
16 Kodesoh Street
P. M. B. 21222
Ikeja.
Tel: 964736
Chief Executive/Managing Director:
Mr. Julius Adeluyi
Pharmaceutical Trade and Super Markets

Kingsway Chemists (A Division of UAC)
Billingsway
Oregon Industrial Estate
P. O. Box 1063
Ikeja.
Tel: 901030/9, 964519, 682235
Chief Executive/Managing Director:
Chief E. A. O. Shonkan (Chairman)
Mr. P. R. Batchelor (General Manager)
*Importation and Distribution of Ethical
Pharmaceuticals, Photographic and Surgical
Equipment*

Major and Company Nigeria Limited
44, Burma Road
P. O. Box 351
Apapa.
Tel: 847130, 847137
Chief Executive/Managing Director:
Mr. D. B. Hoernecks
*Importers and Wholesalers of
Pharmaceuticals, Chemicals and Allied Trade*

M. D. S. (Nigeria) Limited
(A Division of UAC of Nigeria Ltd.)
Kofo Abayomi Avenue, Apapa
P. O. Box 1082
Lagos.
Tel: 877015
Chief Executive/Managing Director:
Chief E. A. O. Shonkan
*Warehousing, Pharmaceutical Products and
Distributors*

Merck Sharp and Hohme (Nig.) Ltd.
23, Warehouse Road
P. O. Box 5571
Apapa.
Pharmaceutical Products Distributors

Nicholas Laboratories Nig. Ltd.
6, Industrial Avenue
Ilupeju Industrial Estate
P. M. B. 21118
Ikeja.
Tel: 963358, 962001/2, 962725
Chief Executive/Managing Director:
Mr. J. B. Cowell
*Manufacture and Marketing of
Pharmaceuticals Household Toiletries
Products*

Nigerian Hoechst Limited
Oba Akran Avenue
Ikeja.
Tel: 961184
Chief Executive/Managing Director:
Mr. C. Onyemenam
Pharmaceutical

Pharco Nigeria Limited
290, Herbert Macaulay Street
P. O. Box 493
Yaba.
Tel: 800580-4
Chief Executive/Managing Director:
Mr. P. H. Manlik
*Importers and Wholesale Distributors of
Pharmaceutical Products*

Pfizer Products Limited
1, Henry Carr Street
P. M. B. 21111
Ikeja.
Tel: 961908, 900378, 900376
Chief Executive/Managing Director:
Mr. B. Bumpstead
Pharmaceuticals, Drugs for Human, Animals

Pharma-Deko Limited
Plot C, 15/3 Agbara Estate
P. O. Box 2784
Lagos.
Tel: 830686, 832305
Chief Executive/Managing Director:
Mr. T. J. Murphy
Pharmaceutical Co.

Roussel Nigeria Limited
5, Oba Adetona Street, Ilupeju
P. M. B. 1021
Mushin.
Chief Executive/Managing Director:
Mr. A. J. Mulrooney
Pharmaceuticals

Roche Nigeria Limited
Dopemu Road (Off 1st Flyover)
New Abeokuta Expressway
P. O. Box 463, Agege.
Tel: 960111
Chief Executive/Managing Director:
Mr. J. M. Westerhoff
Pharmaceutical, Marketing and Distribution

Rajrab Limited
21, Oduyemi Street, Anifowose
P. O. Box 1898
Ikeja.
Tel: 961606
Chief Executive/Managing Director:
Alhaji A. Faworaja
*Distribution of Pharmaceuticals, Chemicals
and Surgical Disposables*

Sandoz Nigeria Limited
Plot 9, Block A. Gbagada Estate
P. O. Box 3873
Ikeja.
Tel: 961769, 844140
Chief Executive/Managing Director:
Mr. W. S. Zerr
Pharmaceuticals

A. J. Seward (Division of UAC)
Billingsway, Oregon Industrial Estate
P. O. Box 1060
Ikeja.
Tel: 901030/9
Chief Executive/Managing Director:
Chief E. A. Shonekan
Mr. P. R. Batchelor
*Manufacturers of Medicines and Toiletries,
Importer and Wholesaler of Pharmaceutical
products*

Smith Kilme and French Nig. Limited
Plot 23, Block 'A' Ogba Road
Industrial Estate
P. O. Box 599
Ikeja.
Tel: 961563
Chief Executive/Managing Director:
Mr. E. F. Mechem
Pharmaceutical Sales and Manufacturing

Sterling Products Nigeria Limited
Ilupeju Industrial Estate
P. O. Box 3199
Lagos.
Tel: 900740—6, 964300
Chief Executive/Managing Director:
Mr. W. S. Price
Mr. N. E. Spiff
Manufacturers of Pharmaceuticals

Squibb Nigeria Limited
1, Kolawole Shonibare Street, Ilupeju
P. M. B. 12732
Lagos.
Tel: 931204, 931266
Chief Executive/Managing Director:
Mr. C. O. Aniyi
*Pharmaceutical and veterinary products im-
portation*

Up-John Nigeria Limited
Plot 1, Block F,
Oshodi Industrial Estate
P. M. B. 1182
Oshodi.
Tel: 962806
Chief Executive/Managing Director:
Mr. K. L. Neumueller
Importation and Supply of Pharmaceuticals

Universal Standard Drugs Limited
131, Isolo Road
P. O. Box 1617
Mushin.
Chief Executive/Managing Director
Mr. C. C. Umeike
Pharmaceutical Company

Wolox Chemical Ind. Ltd.
Kim. 15, Abeokuta Express Road, Onipetesi,
Agege
P. O. Box 3962
Lagos.
Tel: 846884
Chief Executive/Managing Director:
Mr. Wole Foresythe
*Manufacturers of chemical, Pharmaceuticals,
Cosmetics and household products*

West African Drug Company
Plot 3/4, Adewunmi Estate, Oregon
P. O. Box 434
Apapa.
Tel: 931901, 870432 (Home)
Chief Executive/Managing Director:
Chief M. N. Ugochukwu
Mr. L. O. Ayanfalu (GM)
Pharmaceutical importation and distribution

ATTACHMENT VI

PRICE LIST OF SCHERING CONTRACEPTIVES

<u>Product</u>	Wholesale Price	Chemist Price	Retail Price
Anovular	4.25	4.70	7.10
Diane	6.48	7.20	10.80
Eugynon	3.89	4.30	6.48
Eugynon ED	3.89	4.30	6.48
Logynon	2.77	3.10	4.62
Logynon ED	2.77	3.10	4.62
Micorgynon 30	3.89	4.30	6.48
Microgynon 30 ED	3.89	4.30	6.48
Neogynon	3.89	4.30	6.48
Neogynon ED	3.89	4.30	6.48

ATTACHMENT VII

RETAIL PRICES OF CONTRACEPTIVES

	<u>Ibadan</u>	<u>Port Harcourt</u>	<u>Kano</u>	<u>Kaduna</u>
Noriday	1.10	1.40	1.25	2.00
Ovulen 50	6.40	6.50	4.40	5.25
Nordette	7.20	8.50	8.60	--
Logynon	5.50	7.00	5.16	6.00
Eugynon 30	11.30	7.50	10.00	--
Ovral	7.40	8.50	8.00	--
Nordial 21	6.00	7.00	8.10	7.00
Microgynon 30	8.30	7.50	9.25	10.00
Gynovlar 21	7.50	8.50	12.00	--
Noracylin 22	5.25	--	--	--
Econ 30	--	--	4.60	4.40
Conova 30	--	1.95	5.00	4.00
Eugynon ED	--	--	14.00	--
Logynon ED	--	8.50	9.50	10.50
Lyndiol	--	--	8.00	9.50
Anovlar	--	9.50	12.50	--
Diane	--	11.60	9.00	9.00
Eugynon 21	--	--	10.00	--
Neogynon 10	--	8.50	10.00	9.90
Neogynon ED	--	8.50	--	4.50
Microgynon ED	--	10.50	--	8.50
Minovlar	--	8.50	--	--
Feninal	--	--	--	1.50

RETAIL PRICES OF CONTRACEPTIVES (Continued)

Ovidion	--	--	--	3.10
Riguin	--	--	--	2.50
Mordial ED	--	--	--	3.50
Trinordiol	--	6.50	--	--
Femulen	--	7.00	--	--
Breninor	--	9.10	--	--
Lestrin	--	15.00	--	--

Be a Proud Parent...



Have children only because you care!



If you plan your family, you can have fewer children and care for them better.

Give your children the best in life: good food, proper medical care and a comfortable home. Give them a sound education — see to it that they become university graduates.

With Family Planning you will be in a better position to realise all these and your children will do you proud in future.

*Buy family Planning Aids
from your nearest Chemist
and Clinic today*



New Nigerian 2 June 1986

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Attachment IX

National Association of Nigeria
Nurses & Midwives State Officers and Offices

Hadji O. T. Muna
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
28 Agege Motor Road
IdiORO - Lagos

Ms. C. U. Nwugo
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
55, Zik Avenue
Uwani - Enugu

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Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
55 Oturkpo Road
Makurdi

Mr. O. Gordon
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
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Benin City

Ms. E. J. Lalle
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
1 Yandoka Street
P.O. Box 1101
Baudi

Ms. U. B. Ikpe
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
23 Ballantyne Street
Calabar

Mr. Eli Gamaniel
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
185 Airport Road
P.O. Box 121
Yola

Mallam Y. M. Ladan
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
STW 253 Daiko Road, Tundyn Wah
Box 412
Minna

Mr. I. Kaffoi
Senior Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
L8 Ahmadu Bello Way
Kaduna

Ms. S. O. Bolawole
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
NW5/81 Salvation Army Road
Ibadan

Ms. Olusola Somade
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
14 Kuto Road
Abeokuta

Mr. M. A. Tunwase
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
5 Oluwatuyi Quarters Road
Akure
Port Harcourt

Mr. T. H. Gofwan
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
4 Zaria Terrace
Jos

Mr. Alloysius Eke
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
c/o Mrs. J. P. Warmate, (JP)
UNIPORT Teaching Hospital
Port Harcourt

Mr. C. O. Njoku
Senior Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
5 Rotibi Street
Owerri

Mr. E. O. Ajoge
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
c/o General Hospital, UIH Wing
Ilorin

Alhaji M. A. Bilbis
Assistant General Secretary
National Association of Nigeria
Nurses & Midwives
256 Sultan Abubakar Road
Sokoto

Mr. E. Balami, A.G.S. Nannm
c/o Ishaku Dikko Amshi
Ministry of Health, Borno State
Maiduguri

Attachment X

Inventory of Health Facilities - River State

	Health Centers	Health Clinics	Dispensary	Maternity (Separate)	Hospitals	Clinics	Maternity Homes	Pharmacies	Patent Medicine
Ahoada (Alga)	5	13	7	1	---	10	4	---	113
Brass (Balga)	3	1	5	---	---	1	---	---	22
Bori (Bolga)	3	1	5	---	---	4	2	---	79
Degema (Delga)	6	6	1	---	---	---	2	---	27
Ikwere Etche (Kelga)	4	12	11	4	2	10	15	---	63
Bonny (Olga)	3	21	4	---	1	1	1	---	19
Okrika Tai Eleme (Otelga)	3	7	5	---	2	11	12	---	102
Port Harcourt (Phalga)	3	5	---	1	15	106	41	49	10
Sagbama (Salga)	---	1	10	---	---	---	---	---	26
Yenagoa (Yelga)	1	14	20	---	---	1	---	---	<u>29</u>
TOTAL	31	81	68	6	20	144	77	49	520

17.

rw-r--r--161/7	3167	Jul	24	17:59	1986	att.II	✓
rw-r--r--161/7	16396	Jul	24	18:30	1986	att.III	✓
rw-r--r--126/7	5613	Jul	24	13:48	1986	att.IX	✓
rw-r--r--194/7	990	Jul	24	18:16	1986	att.VI	✓
rw-r--r--161/7	2749	Jul	24	18:39	1986	att.VII	✓
rw-r--r--126/7	2703	Jul	24	13:49	1986	att.X	✓
rw-r--r--194/7	14212	Aug	1	18:45	1986	even.more.sht	X
rw-r--r--161/7	5070	Aug	1	16:39	1986	exec	✓ X
rw-r--r--161/7	6021	Jul	23	16:28	1986	fig.2	✓ X
rw-r--r--161/7	5556	Jul	24	15:24	1986	fig.1	✓
rw-r--r--161/7	1766	Jul	31	14:14	1986	gloss	✓
rw-r--r--161/7	20414	Aug	1	16:57	1986	intro	✓ X
rw-r--r--126/7	2555	Jul	22	15:16	1986	mm	X
rw-r--r--161/7	15579	Aug	1	18:09	1986	more.sht	X
r--r--r-- 072	8515	Apr	25	14:35	1986	pf	✓
rw-r--r--161/7	24354	Aug	1	17:35	1986	sht.	X
rw-r--r--161/7	907	Aug	1	16:40	1986	title	✓
rw-r--r--161/6	1162	Jul	31	14:15	1986	toc	✓

RECOMMENDATIONS ON MARKET COMPONENTS - (DAVID PYLE)

1. Consolidating and Expanding Social Marketing

Visits to the North, South East, South West and Lagos showed that most Chemists and some Patent Medical Stores are selling contraceptives to the Nigerian population. However, these contraceptives were found to be very expensive, some times available in very small quantities. only and were often handled by general shopkeepers who have not received training in handling contraceptives and disseminating family planning information. It is therefore recommended that:

- a) Sale of contraceptives by Chemists and Patent Medicine Stores (PMS) be formerly recognized as an important approach for providing family planning services in Nigeria.
- b) This approach should be consolidated and expanded. In order to consolidate as many Chemists as possible to have direct access to all contraceptive methods (i.e. Pills, IUCDs, Depo-provera, Condoms, Foam Tablets, etc.) PMS should also have direct access to pills, condoms, foaming tablets etc.
- c) The government of Nigeria and/or USAID to introduce and facilitate the implementation of measures which would enable the Chemists/PMS to acquire contraceptives cheaper than they are currently buying them (i.e. subsidizing the cost of pills or exempting importers from paying Sales Tax, Duty, etc.).
- d) Training to be provided to all the Pharmacists employed in Chemists selling contraceptives. The pharmacists trained should in turn train personnel employed by their Chemists not only to sell drugs but also to sell contraceptives. The training is to prepare them to disseminate family planning information to clients and sufficient and effectively provide guidance to clients of method use and where necessary provide counselling.
- e) Training to be provided to men and women selling drugs in PMS to be able to disseminate family planning information to clients, guide on method use and where necessary provide counselling to clients.
- f) Social Marketing approach using Chemists as outlets of contraceptives should be expanded by encouraging the pharmacists and Chemists who are not currently selling contraceptives to do so.
- g) Adequate and regular supply of all contraceptive methods to be made available to the Chemists at a reasonable price.

2. Availability And Cost Of Contraceptives

It was observed that contraceptives being sold by Chemists were extremely expensive especially the pills. It was also found that high pricing of Contraceptives was due to the general scarcity of supplies in the market and therefore the importers and or wholesalers who managed to bring some in sold them at a price of their choice. On the basis of this finding it is recommended that:

- a) Arrangements should be made to avail large quantities (large enough to flood the market). The assumption made here is that if contraceptives are available at reasonable prices in all distribution points and wholesale stores, the wholesale and retail prices will come down, thus making it possible for more people to come forward and buy contraceptives.
- b) In line with recommendation (a) above USAID should consider expanding contraceptive supply project (Sterling Project is a case in point).
- c) Nigerian government should consider amending regulations regarding importation of drugs such that contraceptives were made a separate line item on the license and allocate specific foreign exchange to ensure that those who obtain licenses to import drugs also include contraceptives in the stocks they bring in. This recommendation is particularly important for those contraceptives (e.g. pills which are popular and are moving fast from the shelves but are not provided by USAID. Examples of such contraceptives include Mycrogynon, Eugynon, Ovula, etc.

3. Supply and Distribution of Contraceptives

It was observed that currently contraceptives are obtained from various sources by distributors, wholesalers and retailers. Pills for example are mostly obtained from a Nigerian Hoescht, Nordey and condoms are obtained from USAID sources mainly Sterling Company. However, large quantities of contraceptives are being supplied by individual entrepreneurs who import or buy from other sources. It is recommended that:

- a) The source of contraceptives be reviewed with a view to streamlining standardising and making contraceptives directly available to Chemists, Patent Medicine Stores, through identifying distributors.
- b) One or two major distributors be identified, i.e. selling and or health aids. The appointed distributors to be charged with the responsibility of directly supplying contraceptives to retail points thus, limiting the number of middle-men handling contraceptives on commission basis before clients get access to them. By limiting the number of middlemen, the cost of contraceptives to clients will be tremendously reduced.
- c) Only those distributors having regional office with networks and transportation in major regions of Nigeria should be considered for appointment. The staff from the appointed distributors who will be involved in supplying, monitoring and accounting for the contraceptives should be provided with skills through training to enable them to perform such tasks.

4. It was reported/Observed that although contraceptives are available in some Chemists and PMS little effort has been made to inform the potential clientele about availability to such methods in the Chemists and PMS and even the few who are aware that the methods are available often are not aware of the prices. It is therefore recommended that.

- a) Information and Education/Awareness should be a component of social marketing of contraceptives. Use of radio should be maximised in this regard.

- b) Posters showing types of contraceptives available in Chemists by prices of contraceptives should be displayed outside each Pharmacy.