

# PROFIT

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- Private Health Care Providers
- Employer-Provided Services
- Innovative Investments and Transfers

Promoting Financial Investments and Transfers

PROJECT PERFORMED FOR  
**U.S. Agency for International  
Development** *(Office of Population)*

**Deloitte &  
Touche**



Deloitte Touche Tohmatsu International

In association with

Boston University Center for International Health

Multinational Strategies, Inc.

Development Associates, Inc.

Family Health International

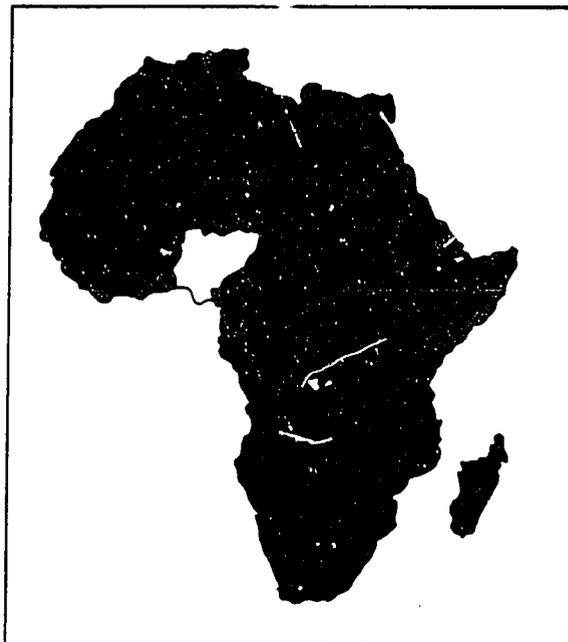
# PROFIT

Promoting Financial Investments and Transfers

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## COUNTRY ASSESSMENT: NIGERIA, 1992



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September 30, 1992

Dr. Jennifer Adams  
U.S. Agency for International Development  
Office of Population  
Family Planning Services Division  
Room 809, SA-18  
Washington, D.C. 20523

Dear Dr. Adams:

PROFIT is pleased to submit the Country Assessment document for Nigeria. The document details our analysis of the investment climate for PROFIT projects in Nigeria and defines PROFIT's strategy for involvement in areas relevant to the project.

The assessment document is the product of visits to Nigeria by PROFIT's core staff and extensive contacts with Nigerian private sector firms, cooperating agencies, and private voluntary organizations involved in family planning activities, as well as USAID/Nigeria. As such, it reflects PROFIT's current strategy for developing private sector family planning initiatives in Nigeria.

PROFIT looks forward to implementing this strategy with your support and guidance. If you have any questions, or wish to discuss the document, please feel free to contact me at (703) 276-0220.

Very truly yours,



Donald R. Nicholson II  
PROFIT Project Director

cc: Mr. Eugene Chiavaroli, USAID/Nigeria

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## PROFIT COUNTRY ASSESSMENT - NIGERIA, 1992

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## I. INTRODUCTION

The objective of the PROFIT project is to increase developing country resources -- funds, services and commodities -- for family planning by encouraging private sector involvement. PROFIT will achieve this by focusing on three routes of involvement:

- Innovative Investments
- Private Health Care Providers and
- Employer-provided Family Planning.

In its first year, PROFIT conducted initial visits to Bangladesh, Brazil, Colombia, Indonesia, Jamaica, Mexico and Nigeria. Potential project interventions were identified in each country and draft Country Assessments developed. During subsequent country visits, additional information was collected on the potential projects, addressing the concerns of PROFIT functional specialists in the areas of Family Planning, Finance, Investment, Marketing, and Evaluation.

The resulting Country Assessments are designed to provide a summary of relevant demographic data, to identify feasible private sector interventions through PROFIT, to assess potential impact of these projects in terms of PROFIT objectives and to guide the design of PROFIT services for that country. The Country Assessments examine the private sector environment at a high level and focus on the areas where PROFIT may best work in the country. These Assessments will be followed by detailed Project Papers on selected interventions.

PROFIT conducted two trips to Nigeria during FY 1992. During the first trip from January - February 1992, Albert Angulo of PROFIT worked with the USAID/Lagos in the development of a Project Identification Document for the Family Health Services Project. In addition, preliminary project concepts were identified. In June-July 1992 PROFIT undertook a second trip to follow up on potential interventions and to pursue contacts. PROFIT activities and progress on interventions were documented in the February 1992 and July 1992 trip reports by Albert Angulo and the Nigerian Merchant Bankers Association Hospital Study by James Janeski, Consultant to PROFIT. The identified interventions are outlined in Section IV of this report.

The remainder of this document is structured as follows:

- Section II - provides an overview of the country's demographics and a profile of the family planning environment. Elements of the macroeconomic, social and political environment which are relevant to PROFIT are identified for brief discussion.
- Section III - examines the areas of Innovative Investment, Private Health Care Providers and Employer-provided Family Planning, the mandated areas of PROFIT operation, within the context of the country.
- Section IV - describes the potential interventions identified in each country, outlines the relationship to PROFIT objectives, and examines the potential benefits of the activity.

/

## II. COUNTRY BACKGROUND

Nigeria is the fourteenth largest country in Africa, situated on the Gulf of Guinea in West Africa with a total area of about 356,700 square miles. The country was a British colony until it gained independence on October 1, 1960. The Nigerian Federation now consists of 30 states and the Federal Capital Territory of Abuja.

In November 1991, after many postponements, an official Nigerian census was taken. President Babangida announced in March 1992 that Nigeria's population was officially estimated at 88.5 million, with 50% of the population below 15 years of age. This figure was lower than the 122 million figure calculated by international agencies over the past decade. Nonetheless, Nigeria remains the most populous country in Africa and the Government of Nigeria (GON) perceives current fertility and population growth rates as being too high at 6% and 3% respectively. These high rates have strained the population's access to food, employment, health and education facilities. In particular, the urban areas have suffered from a combination of population growth and high rates of rural-urban migration, resulting in an urban population which grew from 4 million in 1950 to 17 million in 1980.

In an effort to stem high population growth rates, provisions for the delivery of health services have recently been amended with new emphasis on decentralization, increased NGO and commercial sector cooperation, and increased emphasis on quality and innovative health care financing. The GON is also decentralizing responsibility and authority for family planning service delivery to local government areas (LGAs) to increase community participation.

The 1990 Demographic and Health Survey (DHS) showed that among currently married women only 6.0% are using a contraceptive method and only 3.5% are using a modern method. Moreover, less than half (46%) of all Nigerian women age 15-49 know of at least one method of family planning. The problem of demand is compounded by lack of information on supply outlets. According to DHS, one quarter of the women who had heard of the two most frequently mentioned methods, the pill and injection, did not know where they could obtain the methods. This was also true for condoms.

While overall use of family planning is low, the DHS study shows that some women are more likely to use contraception than others. They include women from urban areas and the Southwest. Women who use contraceptives are also more likely to already have had five or more children. Nonetheless, total demand for family planning in Nigeria is relatively low at 27% of married women, and it is estimated that only 6% of that demand is being satisfied. In other words, the small demand that does exist is largely unmet. (See Appendix A)

The private sector plays a significant role in the provision of family planning services. According to the DHS, 47.2% of family planning services are delivered through the private sector. The remainder are provided through government facilities (36.7%), Planned Parenthood Federation of Nigeria (PPFN) (4.3%), and religious organizations, friends and relatives.

Of Nigeria's 7,700 hospitals and clinics providing GON-sponsored primary health care, approximately 1,500 facilities provide family planning services, with 900 offering full services including IUD insertion and voluntary sterilization. Private health care providers in Nigeria also include traditional practitioners and a growing number of trained professionals (physicians, nurses, midwives, pharmacists).

A.I.D. has made contraceptives available in some states through social marketing arrangements, such as "Gold Circle" through which condoms are available at subsidized prices to low-income consumers. In addition, Sterling Drug has introduced with A.I.D. assistance, the "Right Time" condom and targeted the upper echelon of the market ("A" and "B" groups). Sterling has also introduced unbranded subsidized pills, injectable and Vaginal Foaming Tablets with modest success. The private sector is the supply source for 62% of pill users, 20% of IUD users, 49% of injections users and 55% of condom users. A more detailed analysis of the source of supply for family planning services is presented in Appendix B.

In the area of health care service, private profit-making ventures are viewed with suspicion and some ministries attempt to control and limit their participation in public health programs. Traditionally cooperation between the public and private sectors has been limited. Nonetheless, the public sector is beginning to charge for some services as cost recovery becomes essential to sustainability.

Specific factors which have an overall effect on family planning prospects, and PROFIT's role, in Nigeria are:

- Government Commitment to Family Planning. The Government of Nigeria has an ambitious population policy specifically focused on increasing family planning use and reducing population growth. In June 1988, the GON enacted the National Policy on Population for Development, Family Progress and Self-Reliance (NNP). The NNP promises Nigerians the right to decide the number and spacing of their children and the right of access to family planning information. The NNP fertility targets for 1995-2000 include:
  - Reduction of the total fertility rate from 6 to 4 children.
  - Reduction of the number of women bearing more than four children by 50% by 1995 and 80% by 2000.
  - Reduction of the present growth rate of 3.3% to 2.5% by 1995 and 2.0% by 2000.
  - Reduction of pregnancies for women under 18 and over 35 by 50% by 1995 and 80% by 2000.
  - Reduction of the number of women who marry before age 18 by 50% by 1995 and 80% by 2000.
  - Extension of available family planning services for voluntary users to 50% by 1995 and to 80% by 2000.
  - Increase contraceptive education and services available to adult males by 2000.
  - Increase in family planning information available to all adolescents by 2000.
  - Reduction of infant mortality to 30 per 1000 live births by 2000.

While most authorities consider these targets to be overly optimistic, increasing willingness on the part of the government to work with international organizations is

expected to help the government to reach the set targets. For example, recent increases in contraceptive prevalence rates have been attributed in part to the five year (1988-1992) \$100 million Family Health Services Project (FHS) funded jointly by A.I.D. and the Federal Ministry of Health (FMOH). The program assisted in the improvement of the population policy, development of a national Information, Education and Communication (IEC) program and the training of public and private sector providers. A.I.D. is in the process of designing a new seven-year bilateral project (FHS-II). The project will focus on increasing family planning information and services throughout the country, focusing on activities with a high potential for increasing contraceptive usage.

The highly decentralized political structure of Nigeria, which is composed of a Federal Capital Territory, 30 states and 589 local governments, adds to the difficulties of implementing a national family planning program. Moreover, approximately 40% of the Federation funds have been allocated to state governments on the basis of population size, creating a disincentive for state-level family planning programs.

- Family Planning Knowledge/Attitudes. There is a great deal of work to be completed before attitudes toward family planning change in Nigeria. The social status of Nigerian women and men is linked with demonstrated fertility and many couples plan "insurance" births in order to attain a desired family size of five or more children. Marriage in Nigeria is nearly universal and often occurs at a young age, and often in a polygamous setting. According to the DHS study, among currently married non-users of contraception, 68% said they do not intend to use family planning in the future. Those who did intend to use family planning typically already have four to five children.
- Religious and Ethnic Diversity. Nigeria has over 400 different ethnic groups and a variety of official languages. The three predominant ethnic groups are the Hausa-Fulani (representing the northern Muslim majority), the Yoruba (southwest), and the Igbo (east). Approximately half of Nigeria's population is Muslim, one-third Christian, and the remaining minority is animist. Longstanding religious feuds, ethnic rivalries, and extreme poverty make the Nigerian environment a volatile one. On May 19, 1992, President Babangida banned all political, religious and ethnic associations other than the two government-approved political parties. These two parties, the Social Democratic Party and the National Republican Convention, were formed in 1990 as part of a carefully phased transition program to a US-style presidential system by January 1993 (elections are scheduled for December 5, 1992).

Family planning services must recognize and accommodate these separate cultures and needs; the efforts to involve the private sector must acknowledge the obstacle presented by uncertain political scenarios. While the GON has expressed support for family planning policy, endorsement from religious and traditional leaders has been less apparent. Moreover, it is unclear what approach the newly elected government will take to population policy.

- Economic Climate. The economic growth of the 1970's, fueled by increasing oil reserves and exports, created expectations for prosperity and triggered a shift from an agricultural economy to one that relied on oil for more than 95% of its export earnings. Since then, a declining worldwide economy and drop in oil prices has left Nigeria with a recession, high unemployment, declining government resources and inflation rates above 30%. In the 1970s, government subsidies provided approximately 90% of public health institutions' revenue, a level that became unsustainable in the leaner 1980s. Nigerian economic growth is weakened by insufficient political commitment, increased social demands, corruption, and a shortage of external resources.
- Investment Environment. Private investors are attracted to Nigeria on the basis of its market size, its dominant position in West Africa, and the emergence of a more investor-friendly environment. In 1989, the GON tried to encourage foreign investment through amendment of the 1977 Nigerian Enterprises Promotion Act (NEPA). These reforms allowed higher levels of foreign ownership, up to 100% in certain industries. Foreign direct investment has been steady for the past three years, primarily directed to the energy sector, infrastructural expansion, commercial real estate, locally-sourced manufacturers, and health care.

Nigeria's has a high external debt, currently about US\$30 billion. Despite 1991 debt rescheduling agreements with both the London and Paris Clubs, GON debt service obligations for 1992 are \$5.8 billion. These debt levels constrict the amount of credit available domestically for investment, but may provide a vehicle for creative leveraging.

Nigerian taxes include corporate and personal income tax, capital gains and capital transfer taxes. Foreign investors benefit from certain tax benefits including the exclusion of corporate dividends from taxation for an initial three years and tax exemptions for other forms of income earned by foreign companies. In 1990 the Nigerian government removed restrictions on the amount of investment capital allowances claimable by companies engaged in the manufacturing business.

Informal barriers to investment are still prevalent. Policies lack bureaucratic and legal consistency and in some cases small gifts or facilitative payments are expected. Nigeria's political and economic instability continues to make both domestic and foreign businesses cautious of the country's investment environment.

### III. SCENARIO FOR PROFIT INVOLVEMENT

The PROFIT Project's mandate is to operate in the areas of Innovative Investment, Private Health Care Providers and Employer-provided Family Planning. Accordingly, these areas are analyzed below in the Nigerian context.

#### A. INNOVATIVE INVESTMENTS

##### Local Production of Contraceptives

In 1990 there were 102 licensed pharmaceutical manufacturers in Nigeria, 14 of which were associated with multinational companies. The majority of their production is in over the counter (OTC) preparations. At this time, there are no contraceptive products being manufactured in Nigeria. Instead, there is a contraceptive supply shortage and a perceived need for local manufacturing which would help reduce reliance on donated or heavily taxed imported commodities.

Efforts to stimulate local production of contraceptives have been hindered by the need to import many raw materials, high tariffs and poor pharmaceutical manufacturing facilities. In addition, the private sector is less likely to enter the market as long as it must compete with programs that offer free or subsidized products.

The environment is complicated by Nigeria's fragmented distribution system for contraceptives which includes registered pharmacies, registered patent medicine stalls, retail outlets, marketplace traders, dispensing doctors, institutional outlets, and black market providers. Retailers are hampered by stock-outs in public sector warehouses and at service delivery points. Continuous brand name supplies cannot always be assured and prices vary widely. In addition there is an increasing number of untested counterfeit products entering the marketplace.

While there are major obstacles to overcome in establishing any manufacturing, marketing, or distribution venture on a commercial basis in Nigeria, the need for a reliable supply of affordable, quality contraceptives seems to exist. Therefore PROFIT will consider such an investment.

##### Trade Barriers and Regulatory Reform

Barriers to private provision of family planning services and commodities include restrictions on permitted suppliers and the variances in regulations in different states. For instance, market tradeswomen are no longer allowed to provide oral contraceptives; village health care workers are allowed to provide pills in some states and not in others; and pharmacists are not allowed to dispense injectable contraceptives although they are allowed to give other forms of injections.

Import licensing was abolished in September 1986 and goods not specifically prohibited are now freely imported into the country, subject only to the availability of foreign exchange by the importer. An import duty of 25% is levied on most pharmaceutical products with the exception of medications containing vitamins, which have a 30% duty. The import duty on raw materials for pharmaceuticals is 20% and is expected to increase to 25% in 1994. Imports by private companies, on behalf of government agencies, are subject to import duties. whereas finished pharmaceutical products imported directly by the state governments are exempt. High duties have resulted in a significant amount of smuggling of pharmaceutical products into Nigeria.

#### Financial Transfer Mechanisms

PROFIT projects may leverage A.I.D. funds by including other participants such as third party investors. Opportunities in project financing and debt swaps are also available at this time in Nigeria. Debt swaps involve the purchase of Nigerian dollar debt at a discount and converting it into Naira through a monthly foreign exchange auction held at the Central Bank (the last Friday of each month). Currently, the minimum amount for debt swap transactions is \$250,000, and premiums of up to fifty percent can be achieved over the official exchange rate (about 10 Nairas per dollar). Approximately 22 Nairas per dollar can be obtained through foreign exchange auctions swaps, compared with 19 Nairas in the free market (parallel rate). It is possible to utilize debt swaps to leverage dollars coming into Nigeria in benefit of A.I.D. programs, other CAs, and PROFIT itself.

## **B. PRIVATE HEALTH CARE PROVIDERS**

According to a recently submitted report to UNFPA, in 1989 there were 17,954 medical practitioners, 64,303 nurses, 52,378 midwives and 5,318 pharmacists registered in Nigeria. The FHS project has been effective in tapping this large pool of health care providers. Over 6,000 of these providers now provide family planning services and commodities.

Health care providers are often members of a professional organization making them relatively easy to reach. According to an A.I.D. report by John Tomaro (1992), all private profit-making providers are members of the Nigeria Medical Association (NMA) an umbrella group of licensed physicians. Under the NMA, the Guild of Medical Directors (GMD) was established in 1990 by a group of physicians who own and manage some of the larger private hospitals and clinics. The Guild was established to address the needs of private medical practitioners.

The National Association of Nigeria Nurses and Midwives is estimated to have a membership of about 10,000. In addition nurses and midwives can join the Private Nurses and Midwives Association of Nigeria (PNMAN). According to Tomaro, Nurses and Midwives are more likely to reach the rural areas. As the economic conditions

worsen, nurses and midwives become key providers of health care services since their fees are generally significantly lower than those of physicians.

According to the report, the high cost of health care to the consumer has resulted in a decline in utilization rates in both the public and private facilities. It is reported that the cost of attending a public facility is sometimes more expensive than the private facility because of time, transportation and the increasing requirement that the patient provide their own materials.

Nonetheless, the private sector remains an important outlet for the provision of family planning services. PROFIT will therefore assess whether opportunities exist to improve already existing family planning services or to add fee-for-service family planning to private facilities that do not currently offer such services.

### **C. EMPLOYER-PROVIDED SERVICES**

Approximately two-thirds of the Nigerian population works in agriculture, mainly on small farms producing cash crops and in fishing. There are also thousands of informal small businesses engaged in handicrafts and street merchandising. Less than 10% of the workforce is represented in "structured" employer entities. The few large employers are primarily engaged in manufacturing, brewing and bottling, automotive assembly, the pharmaceutical industry, mining, food processing, and retailing. There are several hundred independent banking, insurance, accounting and legal entities, as well as corresponding professional organizations.

The GON is a major employer, both through its agencies and GON-owned and controlled utility and manufacturing companies. The private sector is primarily involved in manufacturing, banking and finance, trade and other service industries.

Other than the very largest employers, Nigerian employers are not generally active in providing health or family planning services to their employees. Medical benefits are generally provided on a cost incurred/reimbursement basis, and usually include one wife and a maximum of four children. The care is often provided through fee-for-service agreements with private hospitals and clinics and the quality of care varies widely. Charges are generally not agreed upon prior to service. Employed women usually have maternity benefits limited to three months pay with no provision for medical cost recovery.

Employers are reportedly feeling increased social pressure to improve medical benefits and have become more aware of the benefits of family planning services. An example for the role of employers in the provision of family planning services are three oil companies - National, Total and Mobil all of which train staff to become family planning providers. The companies receive their commodities through either Sterling Pharmaceutical or the Transport Workers Association Chapters. Other employers, such

as A.G. Leventis & Co., have been active in disseminating family planning information among their staff. Nonetheless, the Enterprise project, which was active in developing Nigeria's employee based programs, concluded that they are not the most efficient mechanisms for promoting family planning in Nigeria. This conclusion was based on employee reluctance to use such service because of concerns over privacy. While it seems that employer based programs will not be a priority for PROFIT investment, if possible PROFIT should meet with some of the large employers to re-assess the situation first hand.

#### **IV. POTENTIAL PRIVATE SECTOR INTERVENTIONS**

Through assessment of the Nigerian environment, as outlined in Sections II and III, PROFIT determined the following:

- Due to the low contraceptive prevalence rate it will be difficult for PROFIT to operate in the Nigerian context.
- The private sector is a key player in the family planning arena, particularly in the area of service delivery.
- While it may be difficult for a commercial venture to compete in the area of manufacturing/marketing/distribution, the need does exist for a reliable source of affordable quality contraceptives.

PROFIT concluded that it would be appropriate to investigate opportunities in both manufacturing/distribution and service delivery in more detail.

Outlined below are two projects that were identified in the earlier visits to Nigeria. One project is in the area of manufacturing/distribution, the other in service delivery. Both projects are being considered for implementation. However, PROFIT will continue to assess additional opportunities in both areas prior to final investment.

##### **A. JULI PHARMACEUTICALS**

###### **Description**

Juli Pharmaceutical and Stores Nigeria, Ltd. (Juli) is a local pharmaceutical wholesaler and retailer. The company operates twelve outlets marketing various pharmaceutical products, medical equipment and general goods as well as standard medical laboratory and diagnostic units. Other services include supply to the Federal and State government, United Nations

agencies, hospitals, and pharmacies. Juli also provides pharmacy information centers and personnel training programs for pharmaceutical staff. Juli is planning to move into manufacturing in 1994 beginning with fast moving products such as antimalarial and antibiotics.

PROFIT is considering the establishment of a joint venture to manufacture, market and distribute (on a wholesale basis) a broad line of Nigerian brand name contraceptives. Juli was chosen because of its experience in pharmaceutical distribution and its desire to move into manufacturing. Moreover, as a fellow and past president of the Pharmaceutical Society of Nigerian and as the current president of the African-American chamber of Commerce, the company director, Prince Julius Adelus-Adeluyi brings a range of key contacts to the project.

The venture would most likely commence with contraceptive distribution services for the public, non-profit, and commercial sectors. The business may participate in other medical products if such participation is an asset to the promotion and distribution of contraceptives.

There are approximately 19 million Panther condoms (ordered by FPIA for marketing in Right Time packaging) currently available without a clear distribution channel due to Sterling Drug's withdrawal. A.I.D. has proposed that Sterling's Right Time be given to Population Services International (PSI), an international non-profit, to maintain the brand name (familiar to Nigerians as a quality product) but become a socially marketed product. PSI, through its pharmaceutical outlets (Togapharma and Pharco) is one of the few organizations in Nigeria with marketing capability and social marketing know-how.

PROFIT is investigating the possibility of a joint venture composed of PSI, Juli and PROFIT assuming the role of marketer and distributor for A.I.D.-donated contraceptive products (currently marketed under the "Right Time" logo) when Sterling Drug's contract ends in December 1992. This would allow both PROFIT and Juli to gain experience in marketing of distribution of contraceptives and to test the market before undertaking a larger commercial venture.

The PROFIT team is currently assessing with USAID/Lagos, PSI, and Juli the feasibility of a three partner team to market and distribute contraceptives, including Right Time condoms.

#### **Relationship to PROFIT Objectives**

The PROFIT/Juli, Plc. project would meet PROFIT's mandate of marketing, manufacturing, and distribution of contraceptives. The project will focus on increasing the readily available supply of affordable quality products available in Nigeria.

#### **Expected Impact**

Establishing the first Nigerian brand of contraceptives would be beneficial in terms of providing a reliable and convenient source of products. The venture would bring private sector standards to the areas of efficiency, pricing and quality. The environment seems right for this intervention, aided by actions taken by the GON to reduce cultural barriers to modern usage.

### Aspects to Examine/Next Steps

- Investigate the possibility of a joint venture with PSI
- Alternatively, investigate opportunities to distribute and market other contraceptives including pills, injectable and IUDs. Ideally this would be accomplished by using a donated product, however, this would not necessarily be a prerequisite to implementation.
- Investigate other potential joint venture partners among the pharmaceutical companies already doing business in Nigeria.

## **B. HMO SERVICE DELIVERY**

### Description

In January 1992, an opportunity was identified to provide health services, including family planning, to the employees of the Nigerian Merchant Bank, Ltd., and other members of the Nigerian Merchant Bankers Association. Initially, the development of a "captive hospital" was considered, but the concept was rejected as not meeting the needs of the banks, primarily due to the low and uneven quality of care available through the representative hospitals examined.

Instead, the idea of a Health Maintenance Organization (HMO) was developed which would provide a standardized health care program for 8,000 employees of the forty-five merchant banks, as well as dependents. Family planning services, including maternity (not commonly covered in Nigeria) would be featured by the HMO. Managed health care is a new concept in Nigeria, but the bank representatives welcomed the opportunity to exercise control over medical expenditures and to include family planning services as an element of preventive care and cost reduction.

### Relationship to PROFIT Objectives

The HMO project would sustain PROFIT's objective of supporting employer-provided family planning services.

### Expected Impact

In addition to the Nigerian Merchant Banker's Association, the HMO would be marketed to other industries. Strong government support is expected based on conversations with government officials, including officials of the Lagos University Teaching Hospital. Employers (notably service industries) are beginning to recognize the potential for cost savings in their employee health care packages through the inclusion of family planning services as part of the package.

### Aspects to Examine/Next Steps

- A survey is currently being conducted to determine the size and potential population to be served by the HMO. Results of that survey need to be examined and further financial analysis performed on the project.
- Mechanism implemented by other large employers to contain health care cost and provide family planning services should be examined before embarking on the establishment of an HMO.

## Appendix A

| <u>Need for family planning services</u>   |   |              |             |   |              |            |                                  |              |             |                                |
|--|---|--------------|-------------|---|--------------|------------|----------------------------------|--------------|-------------|--------------------------------|
| Percentage of currently married women with unmet need for family planning, met need for family planning, and the total demand for family planning services, by selected background characteristics, Nigeria 1990 |   |              |             |   |              |            |                                  |              |             |                                |
| Background characteristic  | Unmet need for family planning <sup>1</sup> |              |             | Met need for family planning (currently using) <sup>2</sup> |              |            | Total demand for family planning |              |             | Percentage of demand satisfied |
|  | For spacing                                 | For limiting | Total       | For spacing   | For limiting | Total      | For spacing                      | For limiting | Total       |                                |
| <b>Age</b>   |   |              |             |   |              |            |                                  |              |             |                                |
| 15-19  | 15.7  | 0.3          | 16.0        | 1.3   | 0.0          | 1.3        | 17.0                             | 0.3          | 17.3        | 7.7                            |
| 20-24  | 13.6  | 1.0          | 14.6        | 4.7   | 0.4          | 5.1        | 18.3                             | 1.4          | 19.7        | 26.0                           |
| 25-29  | 13.2  | 2.9          | 16.1        | 5.3   | 0.7          | 6.0        | 18.5                             | 3.6          | 22.1        | 27.3                           |
| 30-34  | 12.1  | 6.0          | 18.1        | 3.7   | 2.8          | 6.5        | 15.8                             | 8.8          | 24.6        | 26.5                           |
| 35-39  | 11.2  | 12.7         | 23.9        | 2.9   | 5.8          | 8.7        | 14.1                             | 18.4         | 32.6        | 26.8                           |
| 40-44  | 6.1   | 23.7         | 29.7        | 0.8   | 7.6          | 8.4        | 6.9                              | 31.2         | 38.1        | 22.0                           |
| 45-49  | 4.1   | 39.3         | 43.4        | 0.4   | 4.2          | 4.6        | 4.5                              | 43.4         | 47.9        | 9.6                            |
| <b>Residence</b>   |   |              |             |   |              |            |                                  |              |             |                                |
| Urban  | 12.3  | 9.7          | 22.0        | 8.5   | 6.4          | 14.9       | 20.8                             | 16.1         | 36.9        | 40.4                           |
| Rural  | 11.3  | 9.2          | 20.5        | 2.0   | 1.6          | 3.6        | 13.3                             | 10.8         | 24.1        | 15.0                           |
| <b>Region</b>  |   |              |             |   |              |            |                                  |              |             |                                |
| Northeast  | 14.4  | 6.5          | 20.9        | 1.0   | 1.0          | 2.0        | 15.4                             | 7.5          | 22.9        | 8.8                            |
| Northwest  | 8.0   | 6.2          | 14.2        | 0.7   | 0.6          | 1.2        | 8.6                              | 6.8          | 15.4        | 7.9                            |
| Southeast  | 13.1  | 13.2         | 26.3        | 5.1   | 3.8          | 9.0        | 18.2                             | 17.0         | 35.3        | 25.4                           |
| Southwest  | 10.6  | 12.4         | 23.0        | 8.4   | 6.6          | 15.0       | 19.0                             | 19.0         | 38.0        | 39.5                           |
| <b>Education</b>   |   |              |             |   |              |            |                                  |              |             |                                |
| No education   | 10.0  | 9.8          | 19.8        | 1.0   | 1.0          | 2.0        | 11.0                             | 10.7         | 21.8        | 9.1                            |
| Some primary   | 15.4  | 10.4         | 25.7        | 3.2   | 4.6          | 7.8        | 18.6                             | 14.9         | 33.5        | 23.3                           |
| Completed primary  | 12.8  | 9.7          | 22.5        | 4.1   | 6.5          | 10.6       | 17.0                             | 16.2         | 33.1        | 32.1                           |
| Some secondary   | 21.0  | 4.4          | 25.4        | 12.6  | 4.4          | 17.0       | 33.6                             | 8.8          | 42.4        | 40.2                           |
| Completed secondary/higher   | 13.0  | 4.9          | 18.0        | 19.7  | 9.0          | 28.7       | 32.7                             | 13.9         | 46.7        | 61.5                           |
| <b>Total</b>   | <b>11.5</b>                                 | <b>9.3</b>   | <b>20.8</b> | <b>3.4</b>  | <b>2.7</b>   | <b>6.0</b> | <b>14.9</b>                      | <b>11.9</b>  | <b>26.8</b> | <b>22.5</b>                    |

<sup>1</sup>*Unmet need for spacing* refers to pregnant women whose pregnancy was mistimed, amenorrhoeic women whose last birth was mistimed, and women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and who say they want to wait two or more years for their next birth. *Unmet need for limiting* refers to pregnant women whose pregnancy was unwanted, amenorrhoeic women whose last child was unwanted, and to women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and who want no more children. Also excluded are menopausal and infecund women, defined in Footnotes 1 and 2 in Table 5.11.

<sup>2</sup>*Using for spacing* refers to women who are using some method of family planning and who say they want to wait two or more years for their next child. *Using for limiting* refers to women who are using and who want no more children.

Source: Nigeria Demographic and Health Survey, 1990, p. 72.

## Appendix B

| <u>Source of supply for modern contraceptive methods</u>   |       |       |           |                  |                    |
|--|-------|-------|-----------|------------------|--------------------|
| Percent distribution of current users of modern contraceptive methods by most recent source of supply or information, according to specific method, Nigeria 1990 |       |       |           |                  |                    |
| Source   | Pill  | IUD   | Injection | Durex/<br>Condom | Total <sup>1</sup> |
| <b>Total government</b>  | 29.0  | 61.0  | 44.9      | (13.4)           | 36.7               |
| Government hospital  | 19.5  | 41.2  | 31.9      | (7.2)            | 25.9               |
| Government health centre   | 8.2   | 19.8  | 10.9      | (6.2)            | 10.0               |
| Government doctor  | 1.5   | 0.0   | 2.1       | (0.0)            | 0.9                |
| PPFM   | 2.3   | 7.8   | 3.6       | (3.6)            | 4.3                |
| <b>Total private</b>   | 62.1  | 20.0  | 48.5      | (54.9)           | 47.2               |
| Private doctor   | 1.5   | 0.7   | 8.3       | (0.2)            | 2.2                |
| Private hospital/health centre   | 4.1   | 18.6  | 35.6      | (4.0)            | 13.2               |
| Private pharmacy   | 23.9  | 0.0   | 0.0       | (14.2)           | 11.7               |
| Private patient medical office   | 28.8  | 0.0   | 3.0       | (30.7)           | 17.3               |
| Private market   | 2.0   | 0.0   | 0.0       | (4.1)            | 1.3                |
| Private place of work  | 1.8   | 0.8   | 1.6       | (1.7)            | 1.3                |
| <b>Total other sources</b>   | 5.9   | 11.1  | 3.0       | (11.7)           | 8.8                |
| Mission  | 1.5   | 10.1  | 1.6       | (0.0)            | 5.0                |
| Friends/relatives  | 4.4   | 1.0   | 1.3       | (11.3)           | 3.7                |
| Don't know/Missing   | 0.7   | 0.0   | 0.0       | (16.4)           | 2.9                |
| <b>Total</b>   | 100.0 | 100.0 | 100.0     | 100.0            | 100.0              |
| <b>Number of users</b>   | 121   | 65    | 61        | 46               | 329                |

<sup>1</sup>Users of foaming tablets (0.2 percent) and female sterilisation (0.2 percent) are excluded because there are fewer than 25 cases for each category.

Source: Nigeria Demographic and Health Survey, 1990, p. 47.

## **NIGERIA ASSESSMENT ACRONYMS**

|               |   |
|---------------|---|
| <b>CPR</b>    | <b>Contraceptive Prevalence Rate</b>  |
| <b>DHS</b>    | <b>Demographic Health Survey</b>  |
| <b>DPA</b>    | <b>Department of Population Activities of Nigeria</b>                                       |
| <b>FHS</b>    | <b>Family Health Services Project</b>   |
| <b>FMOH</b>   | <b>Federal Ministry of Health of Nigeria</b>  |
| <b>FP</b>     | <b>Family Planning</b>  |
| <b>GON</b>    | <b>Government of Nigeria</b>  |
| <b>IUD</b>    | <b>Intrauterine Device</b>  |
| <b>LGA</b>    | <b>Nigerian Local Government Area</b>   |
| <b>LUTH</b>   | <b>Lagos University Teaching Hospital</b>   |
| <b>NCGPD</b>  | <b>National Consultative Group on Population for Development</b>                            |
| <b>NEPA</b>   | <b>Nigerian Enterprises Promotion Act</b>   |
| <b>NGO</b>    | <b>Non-Governmental Organization</b>  |
| <b>NNP</b>    | <b>National Policy on Population for Development, Family<br/>Progress and Self-Reliance</b> |
| <b>NPC</b>    | <b>Nigerian Population Commission</b>   |
| <b>PPFN</b>   | <b>Planned Parenthood Federation of Nigeria</b>   |
| <b>PROFIT</b> | <b>USAID-funded Promoting Financial Investments and Transfers Project</b>                   |
| <b>PSI</b>    | <b>Population Services International</b>  |
| <b>USAID</b>  | <b>U.S. Agency for International Development</b>  |