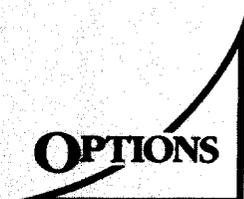


A series of black silhouettes depicting a family scene. From left to right: a woman pushing a stroller with a child inside, a woman holding a baby, a young child standing, a man lifting a child into the air, and a woman standing with two children.

# OPTIONS

The logo for 'OPTIONS' features the word in a bold, serif font, positioned above a thick, black, upward-curving line that forms a partial triangle on the right side.

**OPTIONS**

**for Population Policy  
The Futures Group  
Carolina Population Center  
Population Reference Bureau, Inc.  
The Development Group, Inc.  
The Urban Institute**

PN-ABY-128

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**Private and Public  
Service Systems for  
Family Planning:**

**Policy Assessment in Nigeria**

by

Linda Lacey  
Barbara Torrey

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**O**PTIONS for Population Policy II is a five-year project funded by the Office of Population of the U.S. Agency for International Development. The goal of the project is to help A.I.D.-assisted countries formulate and implement policies that address the need to mobilize and effectively allocate resources for expanding family planning services. The project provides technical assistance to:

- improve the analytic capacity of developing country institutions to design, manage, and monitor family planning programs;
- assess legal and regulatory policies affecting the delivery of family planning services;
- promote efficient use of public sector resources in family planning programs; and
- increase private sector participation in service delivery.

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**Private and Public Service Systems  
for Family Planning:**

**Policy Assessment in Nigeria**

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Linda Lacey

Carolina Population Center  
University of North Carolina

and

Barbara Torrey  
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OPTIONS II Project

Field Work Completed: March 9 - 27, 1993

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# LIST OF ACRONYMS

AAO	A.I.D. Affairs Office
DPA	Department of Population Activities
IEC	Information, Education & Communication
FDA	Federal Drug Administration
FHS	Family Health Services
FMOHSS	Federal Ministry of Health and Social Services
FOS	Federal Office of Statistics
FP	family planning
GNP	gross national product
HIS	health information system
LGA	Local Government Authorities
NACCIMA	Nigerian Association of Chambers of Commerce, Industry, Mines and Agriculture
NDHS	Nigerian Demographic and Health Survey
NGO	Non-governmental organization
PPFN	Planned Parenthood Federation of Nigeria
PHC	primary health care
RIS	Resource Intensification Strategy
SMOH	State Ministry of Health
USAID	United States Agency for International Development
UNFPA	United Nations Fund for Population Activities

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# EXECUTIVE SUMMARY

The OPTIONS II policy assessment trip to Nigeria by Linda Lacey and Barbara Torrey focused on analyzing current family planning policy issues, identifying and prioritizing key constraints and formulating an approach to family planning policy reform. The team examined legal, regulatory, and medical barriers, as well as Nigeria's new decentralized primary health care system.

Important economic and social factors, which were considered in the recommendations, included the economic recession, the decentralization of the primary health care and family planning bureaucracy, and the differences between de jure and de facto laws and regulations. Other important factors considered in the recommendation include: the apparent increasing demand for contraception, especially among unmarried women; the lack of involvement of the pharmaceutical industry in Nigeria in the production of family planning products; and the nature of the distribution system for family planning products.

## I. Short-Term Suggestions

A number of recommendations were suggested, given the objective of the trip and the current state of flux of the many economic, social and political factors. Two of the most important recommendations are short term and pertain to the federal level.

### a) identify the Market for Family Planning Services

- Consider conducting a market segmentation analysis to determine in more detail the potential market for family planning services and supplies among multiple segments of the Nigerian population. Currently, there are three national data sources available to conduct such a study. The analysis will be valuable to both the public and private sectors, and will enable projects to complement one another by providing a basis for understanding future demand for services as well as potential service providers. It can also serve as a model for future data analysis of the Federal Office of Statistics (FOS) Quarterly Contraceptive Prevalence Surveys.

### b) work with the Nigerian Federal Drug Administration (FDA)

- Work to develop a supportive approval process for contraceptive issues, for example approval of implants or classification of oral contraceptives as over-the-counter drugs. Since both Kenya and the U.S. have already approved Norplant, they may be able to help the Nigerian FDA speed up the approval process for Norplant and other contraceptives.

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## II. Long-Term Suggestions

The Family Health Services (FHS) Project has played a major role in strengthening the federal, state and local governments' capacity to expand family planning services in Nigeria. We recommend that the Mission build on the existing work of the FHS Project. Our long-term recommendations focus on providing support to federal and state government organizations that are responsible for guiding and supervising decentralized family planning services.

### a) Strategy to Support Decentralized Family Planning Services

- Continue to provide technical assistance to the following federal institutions: the Department of Population Activities (DPA) of the Federal Ministry of Health and Social Services (FMOHSS) to build their capacity to work with local government authorities (LGAs) in areas of advocacy and consensus building; FOS for the conduct of demographic and health surveys and the publication of results; and the Department of Primary Health Care (PHC) of FMOHSS for its role in national-level planning, monitoring and evaluation.
- Continue to support the PHC departments of the state ministries of health (SMOH). A key resource within the state PHC department is the family planning coordinator. These coordinators provide most of the commodities and training to the family planning managers within the LGAs. We suggest that FHS II continue to build the skills of the coordinators in areas of advocacy, management and supervision.

### b) Policy Analysis, Monitoring and Evaluation of the FHS Resource Intensive Strategy (RIS)

Policy analyses are needed to assess the priority assigned to family planning by the LGA health committees. Studies are also needed to examine funding priorities of elected councils that must select which development projects to support among a number of pressing community needs. LGAs will vary in priorities for family planning. It is also critical that the FHS Project designs a system of evaluation and monitoring that will allow FHS staff and the government to learn about the linkages among the tiers of government and capacity building within the LGAs.

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## III. Other Suggestions

### a) Assess Capability to Produce Local Commodities

- Consider developing coordination with the Nigerian Association of Chambers of Commerce, Industry, Mines and Agriculture (NACCIMA) to ensure that

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pharmaceutical raw materials needed for the domestic production of family planning supplies are taxed at a lower rate than the imported finished products. There are 47 Nigerian pharmaceutical firms and an increasing demand for family planning products. It will be important that the local industry help meet some of the increasing demand for family planning commodities.

#### b) Legal and Regulatory Issues of FHS Resource Intensive Strategy

We have a number of suggestions that focus on legal and regulatory issues that could be addressed in RIS states of the FHS Project during the transition period. The USAID Mission should consider the following in order of priority:

- working with the state ministries to relax the restrictions on the duties and responsibilities of the nurses and midwives where there are not enough M.D.s to provide adequate services.
- working with the Nigerian Association of Nurses and Midwives to allow their members to change the laws for establishing maternity and family planning homes in areas where few doctors exist.
- restoring the FMOHSS model edicts on quality control of private health establishments and encouraging the states to adopt them to improve the quality of services provided in the health clinics.
- using the state pharmacy board relicensing authority to require private sector pharmacies to stock family planning supplies.
- encouraging the states to modify the standard practice of requiring many revisits of clients in areas where the distances to clinics are considerable.
- working with the state ministries of justice to increase the age of first marriage to ages appropriate in the states.

There is no formal regulation on the minimum age of family planning clients and on consent of spouse. But practices vary among states and need to be addressed at that level if there is a local problem. The restriction on abortions is also a major barrier, but is too sensitive for USAID to address.

Tables 1, 2, and 3 summarize some of these recommendations and the specific responsibilities of the tiers of the government and the Primary Health Care Development Agency. Nigeria is in the midst of considerable economic, social and political changes. These changes pose a challenge to policy reform. A fuller discussion of these issues is provided in the detailed trip report.

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# PRIVATE AND PUBLIC SERVICE SYSTEMS FOR FAMILY PLANNING: POLICY ASSESSMENT OF NIGERIA

## I. Scope of Work

The purpose of the March 9 - 27, 1993 OPTIONS II trip to Nigeria by Linda Lacey and Barbara Torrey was to develop a policy agenda for the new family health project, Family Health Services II (FHS II), June 1994 - 1999. The scope of work for the policy assessment presented in the November 1992 cable from the A.I.D. Affairs Office (AAO) in Lagos focused on child survival, population and AIDS. OPTIONS II was asked to focus on population issues and address the following tasks:

- a) analyze current family planning policy issues in Nigeria;
- b) identify key policy issues and constraints;
- c) prioritize key policy constraints and identify policy changes that are most feasible and important to change; and
- d) formulate a proposal for AAO's approach to policy reform.

## II. Introduction

The objective of policy work in Nigeria is to serve the expansion of the contraceptive market, defined as the sum of total use in the country. The market is an holistic system, comprised of public sector providers, nongovernmental organizations (NGOs), and private commercial service providers. The latter category includes pharmacies, medical stores, and private practitioners. The market and its potential for expansion are influenced both by macroeconomic and development forces, and by forces within the service system. At the sector level, the growth in use of any given service system (i.e., public, private commercial and NGO channels) will be affected by incentives and constraints in that system and the inter-relationships among the systems. Users will seek services according to a complex judgement of convenience, price, attractiveness of service, and opportunity costs in a system. The provision of services is shaped by factors such as legal and regulatory climate, financing and organizational structure.

To increase the market for family planning services, a number of key population policy issues need to be considered:

- an understanding of the market for family planning services;
- federal-level policy issues and constraints;
- federal decentralization of family planning services to state and local governments; and
- state and local government policy issues and constraints.

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These issues, which were highlighted by AAO, will be addressed following a review of relevant economic and development issues and an empirical overview of the present family planning market.

### **III. Market for Family Planning Services**

As stated above, there is one market for family planning services in which all current and potential providers and users participate. In most countries, including Nigeria, the service providers include those with public, private commercial and NGO affiliations. All users are and will be served by this set of providers. Given the enormity of the task of ultimately serving Nigerian families, it is imperative that each family planning service system participate to its fullest. Getting the most strategic participation out of each system is the challenge facing national programs as they plan for expansion and make decisions for use of limited resources.

The interaction among the systems in the market depends on the policy climate as well as sector-level policies. Actions in one part of the market are reflected in reactions elsewhere in the market. For instance, government and donor actions to expand subsidized services may have the unintentional effect of crowding out the private commercial channel, interfering with its ability to serve its target market. The interactive nature of these relationships can be beneficial to the market and spur service provision and use, or it can have a dampening effect. In either case, program managers must recognize the phenomenon of the market, if they expect to get the most from changes in the system. Recognition of the importance of the market entails recognition of other features as well—that the public sector has the responsibility to assure access to those who cannot afford private commercial services, that public sector funds be targeted to those users, and that there are families who can afford and prefer commercial services. Thus it is important to develop a climate where each service system actually serves its target market; and where policy support, legal and regulatory reform, and organizational structure all reinforce the concept of a family planning market founded on active participation of all service systems. Such a situation ensures the best use of scarce resources.

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#### **A. Economic and Development Factors**

Among the many economic and development factors affecting the family planning market, there are four timely and salient factors that affect present policy planning in Nigeria:

- the economic recession in general and the growth in the federal deficit as a percentage of the gross national product (GNP), in particular. The federal deficit as a percent of GNP was 4.4 percent in 1985; in 1992 it was 52 percent. This

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extreme increase suggests that the federal government will not be able to afford a public sector system serving everyone and that the private sector should be encouraged to expand.

- the decentralization of the primary health care and family planning bureaucracy. Such decentralization is taking place, resulting in a whole new agenda at local levels, including new priorities and direction for the evolution of publicly-funded primary health care and family planning. Other issues, such as constraints on clients, and quality control must also be considered.
- the existing pharmaceutical industry in Nigeria and their nonexistent role in family planning. There are 47 active pharmaceutical companies already in Nigeria producing about 20 percent of the total drugs consumed. Pharmaceutical shares are actively traded on the Nigerian stock market, but none of the local pharmaceutical companies manufactures family planning products.
- the probability that the current demand for family planning commodities exceeds the supply. The current recession and government deficits are likely to exacerbate the gap by increasing the demand and decreasing federal funding to services simultaneously (Preliminary National Logo Distribution Overview, October 1992).

## **B. Sector-Level Forces: Supply and Demand**

Overall demand for family planning in Nigeria is low. The 1990 Nigerian Demographic and Health Survey (NDHS) shows that the percent of all women in their reproductive ages using any method is 7.5 percent with 3.8 percent using modern methods. Of the modern methods, oral contraceptives are most popular (1.4 percent), followed by the IUD and injectables (both at 0.7 percent). There are marked differences between women currently in union and those who have never married. About 6 percent of currently married women use any method of contraception, with 3.5 percent using modern methods. Among women who have never married, 15 percent use any method and close to 5 percent use modern methods, mostly oral contraceptives and condoms. Regional differences also exist, with the Southeast and Southwest regions taking the lead in the use of modern contraceptives.

Family planning services and commodities are provided by a variety of sources. The 1990 NDHS shows that government hospitals and health centers provide about 37 percent of family planning services. The Planned Parenthood Federation of Nigeria (PPFN) provides about 4 percent and the private commercial sector (including pharmacies, medical stores and private hospitals and health centers) provides close to 50 percent of services. The source of services and supplies varies by method. Of those women using oral contraceptives, 62 percent obtain them from the private commercial sector, primarily from pharmacies and

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medical stores. The majority of IUDs are inserted in government facilities (about 61 percent). Injectable users receive their injections from both public facilities (45 percent) and private doctors or clinics (48.5 percent).

The 1992 FOS Quarterly Contraceptive Prevalence Survey suggests that the demand for family planning is increasing in Nigeria. While the FOS data are still in preliminary stages of analysis, they suggest that the percent of women using any method and modern methods has increased during the past two years. Analysis of the December 1992 Quarterly Contraceptive Prevalence Survey suggests that the percent of currently married women using any method has almost doubled<sup>1</sup>. About 12.6 percent of currently married women use any method and 6 percent use modern methods, primarily oral contraceptives followed by injectables. About 19 percent of women never in union use any method, with close to 13 percent using a modern method. Among all current users, 46 percent receive services from government sources (28 percent hospitals and 18 percent health centers), 7 percent from PPFN, and 43 percent from the private commercial sector, mostly medical stores followed by pharmacies, hospitals and clinics.

The findings from the 1990 NDHS and the FOS surveys provide some insight into the demand and supply of services in the coming years. The data suggest that:

- women in all reproductive ages are using contraceptives.
  - Young unmarried women use family planning because they are postponing marriage until careers are established.
  - Married women use birth control in place of postpartum abstinence.
  - Older women use methods to avoid being pregnant grandmothers.
- unmarried women are almost twice as likely to use family planning as married women.
- the private commercial sector meets most of the demand for temporary methods such as pills and condoms.
- the public sector meets most of the demand for long-term methods such as the IUD, Norplant and sterilizations.
- the Southwest and Southeast regions report the highest prevalence figures in Nigeria.

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<sup>1</sup> Rural and urban weights that were used in the 1990 NDHS were applied to the 1992 Quarterly Contraceptive Prevalence Survey.

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## C. Recommendations with Discussion

### Conduct a market segmentation analysis

**Possible USAID Activities:** We strongly recommend that the USAID Mission conduct a market segmentation analysis to study in more detail the potential market for family planning services and supplies among different segments of the Nigerian population. We advocate analyzing currently existing data, from a market-oriented perspective.

**Discussion:** In the interest of achieving the greatest impact from such a study, the following issues need to be addressed: identifying consumer needs and preferences; defining the target market for each method and source of services; and identifying the comparative advantage of the service delivery channels.

Consideration of these issues forms part of a strategic planning process. Strategic planning can begin with analysis of demographic and service data to identify the demand for family planning services and effective approaches for delivering services. This knowledge brings the consumer into the picture: relating services to fertility needs, risks and preferences, as well as to other characteristics such as previous use of commercial health services, use of traditional methods, etc. From this vantage point, it is possible to initiate planning processes that weigh alternatives, select courses of action, specify actors, objectives, timeframes, and resource requirements.

There is an increasing recognition that each service delivery sector needs to understand and cater to its target market. This exercise identifies which providers will furnish users with various methods under different service systems and timeframes. In addition, the principles of mobilizing data and targeting services to consumers, with each provider playing its strategic role, facilitate the likelihood of programs attaining sustainability in the long-term. Lastly, such an analysis will be valuable as the information will facilitate the coordination of programs (i.e., less program overlap).

Three national data sources are available to conduct the market segmentation analysis. These include the Nigerian Fertility Study of 1981/82, the 1990 Nigerian Demographic and Health Survey, and the FOS Quarterly Contraceptive Prevalence Surveys of 1992. The surveys were conducted over a ten-year period and there are differences in the questionnaires used. Although these factors pose a slight constraint, the data shed light on present and future demand for services as well as indicate the market share of different types of providers.

### Dissemination of market segmentation analysis

**Possible USAID Activities:** Provide technical assistance to FOS to disseminate the findings of the family planning surveys to the private sector in particular, but also to the public sector. This effort could be coordinated with the broad dissemination of the market segmentation report.

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**Discussion:** In order to encourage the private sector to enter the family planning market, it will need up-to-date information from the market segmentation analysis about the increasing demand for family planning and changing consumer characteristics. The dissemination of the information can take the form of brief consumer demand reports authored by the FOS, or wall charts summarizing the data for public display. The FOS realizes that in order to get the full value from the surveys it is conducting, it needs to make the findings much more accessible than the usual statistical reports. The Director of FOS, Mr. Ajayi, explicitly requested IMPACT-style publications to communicate the policy issues in Nigeria.

#### **IV. Federal Policy Constraints Facing both the Public and Private Sectors**

Nigeria's national family planning policies were outlined in the National Policy on Population for Development, Unity Progress and Self-Reliance of 1988. Many of the laws and regulations affecting family planning, however, were largely in place before the policy was adopted and few have been changed since. Moreover, while many of the laws and regulations are de jure, they are implemented at the discretion of the state and local level. Therefore, any policy initiatives must consider the costs of changing de jure laws that are not enforced against changing de facto practices that are barriers to the broader distribution of family planning services.

The challenges are to:

- distinguish between the de jure policies at the federal level and their de facto implementation at the state and local levels;
- focus on those federal policies that will remain federal functions despite decentralization, and that are constraining both supply and demand;
- select the de facto policies that are implemented at the state and local levels that can improve the accessibility of family planning and propose modifications of them in the resource intensive states; and
- list those policies that are barriers, but should not be part of a USAID policy strategy.

Because of the difficulty in working with legal and regulatory barriers at the federal level, we suggest that only two areas be addressed and that the remaining challenges be dealt with at the state and LGA level. The two activities addressed are unlikely to ever be decentralized and therefore can only be addressed at the federal level:

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- ❑ collaboration with the Nigerian Federal Drug Administration (FDA) to facilitate their work of approving family planning products; and
  - ❑ expansion of the private sector Nigerian pharmaceutical industry by reducing the import taxes on pharmaceutical raw materials, especially those that are essential to the manufacture of family planning products.

These two suggestions are presented in Table 1 and discussed below in more detail. Suggestions for dealing with state-level legal and regulatory barriers are discussed later in this report.

## **Recommendations with Discussion**

### Collaboration with the Nigerian FDA

**Possible USAID Activities:** USAID, in coordination with UNFPA and the World Bank, should consider funding a consultation in Nigeria with representatives from the U.S. and Kenyan FDA who have been responsible for contraceptive approvals. These representatives could advise the staff of USAID, UNFPA, the World Bank, and the Nigerian FDA about the approval of Norplant in the U.S. and Kenya. If the Nigerian meeting were productive, a second meeting held in the U.S. might be considered to reinforce the outcomes of the first meeting.

**Discussion:** The Nigerian FDA is as frustrating to Nigerians as the U.S. FDA was to many Americans for years. Its treatment of the Norplant application is symptomatic of an agency that is overworked, understaffed and does not set its own agenda. Norplant has the first of two necessary approvals to be included on the Nigerian Essential Drugs List. This approval has taken five years and the second and final approval has yet to be granted. Since other West African countries are waiting for Nigeria to approve Norplant, it is worth assisting the Nigerian FDA in their approval process.

Kenya, Burkina Faso, and the U.S. all have approved Norplant. Therefore, it might be helpful for FMOHSS to hold a seminar (with FHS support) that includes representatives from each of the four FDAs to discuss their professional concerns. The more general issue is how to encourage decision makers within the Nigerian FDA to be more efficient and responsive to the needs of the family planning community. These improvements may best be accomplished by providing technical assistance to the Nigerian FDA from the U.S. FDA, perhaps in cooperation with UNFPA or the World Bank. The U.S. FDA has been plagued for years with inefficiencies and inadequacies. However, the recent commissioner has performed such an extraordinary management job that he was asked to stay on by the Clinton Administration. Therefore, the U.S. FDA could share some of the strategies it used to streamline and improve its own operation.

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Successful collaboration on Norplant would also provide an opportunity to improve the approval and registration process for other family planning commodities. For example, Population Services International (PSI), charged with social marketing of contraceptives in Nigeria, has had to register pills and condoms with the Nigerian FDA. They would welcome coordinated assistance provided to the Nigerian FDA to improve the regulatory process.

The U.S. FDA, in fact, had a formal agreement with the Nigerian FDA from 1981-86. During that time, a resident advisor helped the Nigerians set up a research lab, assisted in inspections and import operations, and established a consumer education program. The head of the Nigerian FDA recently visited the U.S. FDA and requested further assistance. Unfortunately, lack of funding precluded the U.S. FDA from responding. The U.S. FDA would be interested in providing technical assistance if USAID were interested in funding the effort.

### The Expansion of the Private Nigerian Pharmaceutical Industry

**Possible USAID Activities:** The Nigerian Association of Chambers of Commerce, Industry, Mines and Agriculture (NACCIMA) has already identified the constraints on the expansion of a Nigerian pharmaceutical industry. USAID should consider coordinating with them to ensure that raw materials needed for the production of contraceptives are taxed at a lower rate than finished contraceptive products. Prince Juli, of the Juli Pharmaceutical Corporation, will likely have much influence in building an alliance to encourage the pharmaceutical industry in general and the production of family planning products in particular.

**Discussion:** The Nigerian pharmaceutical industry is thriving with 47 active firms. Twenty-seven have foreign collaboration; they are trading on the Nigerian stock exchange, and have recently been selling well. Nigeria's market for drugs is about US \$700-800 million a year (Staff Appraisal Report, Federal Republic of Nigeria Essential Drugs Project, December 1988). This amount is large enough to support a local raw materials manufacturing industry. Yet the Nigerian pharmaceutical companies are only producing 20 percent of the drugs consumed in Nigeria today, none of which are contraceptive products.

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The report of the Committee on National Drug Policy for Nigeria (October 1988) stated that "every effort should be made to encourage the development of the local pharmaceutical industry." This committee visited India and Bangladesh to study the pharmaceutical industries of those countries. Committee members were surprised to learn that the industry in Bangladesh was more sophisticated than Nigeria's. Bangladesh has a larger potential market but is poorer than Nigeria.

One of the reasons that the Nigerian pharmaceutical industry is not as developed as it might be stems from the considerable import taxes (25-35 percent) on finished products, which are sometimes even higher on raw materials. NACCIMA recently asked publicly for a reduction on the duties, especially on pharmaceutical raw materials, to 5 percent. This

**Table 1:**  
**Summary of Legal, Regulatory and Medical Policy Issues to be  
 Addressed at the Federal Level in Nigeria**

Policy Issue	Authority	Problem	Recommendation
<p><b>Public Sector:</b> Drug approval process</p>	<p>FDA</p>	<p>New drugs must go through a two-stage approval process. Norplant has taken 5 years and does not yet have final approval.</p> <p>Prescription vs. over-the-counter designation determines how drugs can be advertised.</p>	<p>Consider working with FDA using their colleagues in the U.S. and Kenya to encourage the final approval.</p> <p>Explicitly court the FDA the same way commercial firms do.</p>
<p><b>Private Sector:</b> Nigerian pharmaceutical industry</p>	<p>Ministry of Trade</p>	<p>Import duties on drugs are now 25 - 35 percent. Duties on raw materials are often higher than on final products.</p>	<p>Work with NACCIMA and the Ministry of Trade to reduce tax on pharmaceutical raw materials.</p> <p>Work with FOS to conduct a market segmentation analysis of the family planning market and disseminate results to the pharmaceutical industry and other relevant private and public sector providers.</p>

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reduction would allow the industry to expand to meet the general health needs of the Nigerian people and their more specific family planning needs.

Any efforts to increase local manufacture would have to be considered in light of the availability and pricing of contraceptives available from other sources. As described above, there is one contraceptive market in which different service systems take part, and actions on the part of one provoke reactions in other parts of the system. The overall attractiveness of local manufacture to private entrepreneurs will be affected by the availability of subsidized commodities unintentionally competing for the same target market. Analysis of the contraceptive market would form the basis for decisions to push forward with support for the development of local manufacture.

## **V. The Decentralization of Federal Sector Family Planning Services to State and Local Governments**

In this section we review and provide recommendations to USAID on ways to support the newly decentralized family planning program within the primary health care system in Nigeria. First, a brief overview of government decentralization of family planning services is provided. The overview is followed by FHS strategies employed, a list of constraints, and recommendations for possible USAID activities.

### **A. Decentralized Family Planning as part of Primary Health Care**

The LGAs have mandatory responsibilities for primary health care. The Constitution of the Federal Republic of Nigeria, Decree 1989 states that the functions of the LGAs include: a) the provision and maintenance of primary, adult and vocational education; b) the development of agriculture and natural resources; and c) the provision and maintenance of health services (Federal Republic of Nigeria, 1989).

Local governments, with assistance from the FMOHSS and the SMOH are slowly developing capacities to provide primary health care services. FMOHSS provides policy guidance and strategic support to the states and the Federal Capital Territory. Supervision of primary health care for states and LGAs is the responsibility of four regional primary health care zonal offices. In the past, the zonal offices were the responsibility of the FMOHSS. At present, the zonal offices are the responsibility of the Primary Health Care Development Agency, a new parastatal organization that consists of former FMOHSS staff. SMOH plans and coordinates the state health care system and provides training and other support to LGAs.

The LGAs are responsible for providing primary health care services, mobilizing community support and maintaining health infrastructure. The LGA primary health system includes village health posts, dispensaries, health clinics, and primary health care

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centers. There are a total of 7,725 public service delivery points, 19 percent of which provide family planning services (Nigeria Country Program Strategic Plan, 1993-2000, August 1992). A detailed overview of responsibilities among the tiers of government and the Primary Health Care Development Agency is provided in Table 2.

Primary health care consists of 10 components including maternal and child health. Family planning is part of maternal and child health. Family planning services are offered to prevent unwanted pregnancies, secure the desired number of pregnancies, space pregnancies, and assist couples in limiting the size of their family (National Health Policy, 1992).

#### Local Leadership:

Within the public sector, local leadership in family planning service delivery is vested in the LGA health committees. Local government-elected councils, in consultation with the SMOH, are responsible for establishing the health committee. The committee includes representatives of the council, the State Hospital Management Board, NGOs, professional health staff, and leaders of the local community. The functions of the health committee include: a) formulating project proposals; b) delivery of services; c) intersectoral coordination; d) collection of basic data; and e) mobilization of resources (National Health Policy, 1992). State ministries are slowly transferring responsibilities to the committee. Health staff in LGA clinics report to the health committee chairperson rather than to the SMOH, as done previously.

Within the LGA, the elected council makes all financial decisions regarding the allocation of federal resources. The health committee and primary health care (PHC) staff of the LGA present their budget to the council for approval. The council, though, collects and reviews all development budgets. In an urban LGA such as Mainland Lagos, the council reviews five major budgets: works and housing; education; agriculture and rural development; community development and welfare; and health. Most of the budget for health is for staff salaries. There is little money budgeted for drugs and medicine. In the Lagos Mainland LGA budget, family planning commodities were not even included since contraceptives are received from the state family planning coordinator.

The Chief Medical Officer and the health committee must lobby the elected council to approve the health budget. Like most politicians, elected councilmembers support those budgets that generate the most political support. Because the health budget must compete with other development programs, the health budget can vary from year-to-year. Policy analyses are needed to assess funding priorities of LGA elected councils.

The LGA family planning manager within LGA clinics plays a key leadership role in ensuring that family planning issues are included in the primary health care annual plan and budget. The LGA family planning managers receive most of their technical support, training and commodities from the state family planning coordinator.

**Table 2:  
Responsibilities of Tiers of Government and Primary Health Care Development Agency:  
Nigeria 1993**

TASKS	FEDERAL MOHSS	STATE MOH	LGA	PHC DEV.AGENCY
Advocacy	Gain support of other federal ministries, and the private sector	Gain support and involvement of other state ministries and private sector	Elicit support among formal and informal leaders in the community	
Legislation	Formulate legislation and regulations as needed	Advise on legislation and inform the general population		
Planning	Develop national plan Provide technical support to the states and LGAs in developing plans	Develop family planning state plan and assist LGA with FP program plans	Develop annual plans that prioritize needs of the community	Offices in Lagos and the four zones. No state offices. Will assist LGAs in developing plans and budgets
Coordination	Coordinate all health and family planning activities	Coordinate family planning efforts at the state level, and among LGA FP managers within PHC	Coordinate efforts among groups within the community. Mobilize community support	Coordinates its effort with FMOHSS, SMOH, and the donor community
Monitoring and Evaluation	Develop impact evaluation strategy Develop HIS, collect and analyze data from the state and LGA facilities Monitor change and report findings	Collect additional FP data from LGAs and state health facilities, send to federal government and donors Analyze data for planning purposes	Collect facility data on service delivery and submit it to the state and federal MOHSS	Monitor PHC and FP. Focus on the quality of the HIS service statistics Assist states in collecting HIS data Disseminate findings
Training	Support teaching hospitals and university programs	Provide training in FP for LGA staff		Through coordination with SMOH, will identify gaps in training in LGAs and provide training when necessary
IEC	Develop national IEC strategy to be adopted by the state MOH	Develop mass media materials for LGAs		
Logistics		Provide FP commodities to LGA FP manager	Maintain facilities for service delivery	
Supervision		Supervise efforts at LGA level Hold quarterly FP manager meetings		

Sources: Federal Ministry of Health, National Health Policy Strategy, Lagos: Federal Ministry of Health, 1988; Discussions with key government officials, PHC Development Agency and FHS staff

## Financial Support:

The LGAs can receive financial support for primary health care from five sources: local taxes, the Federation Account, the FMOHSS (through the model LGA special grant program), the state budget, and in some cases, external donor organizations. However, the majority of funding received by LGAs comes from federal transfer payments, that is, the Federation Account. The more money LGAs generate locally, the less they receive from transfer payments. This system provides little incentive for the LGAs to generate revenues locally.

It is unclear how the state ministries provide funding to the LGAs. At present, the states provide financial support for state health personnel who have been transferred to LGA health facilities.

## Observed Problems:

Primary health care is a fairly new responsibility for the LGAs. As expected, numerous problems have emerged as LGAs adopt this new community-based approach to service delivery. Olowu and Wunsch, a consultant team contracted by USAID/Lagos to assess decentralized primary health care issues in Nigeria, observed that LGAs lack adequate personnel and health committees that can solve problems, develop priorities, collect and use data for strategic planning, and develop realistic budgets (Local Governance and USAID Health Projects in Nigeria, November 1992). They also observed that mechanisms were not in place to supervise staff and monitor the use of resources. It will take several years to build up the capabilities of LGAs to effectively operate, coordinate, maintain and expand primary health care services, including family planning.

## **B. Strategies Used by the FHS Project to Respond to Decentralization**

The FHS Project (1988 - 1994) of the USAID Mission in Nigeria, has played a major role in strengthening the FMOHSS and the SMOH capacity to expand family planning services in Nigeria. Resources and technical assistance have been used to develop the capacity of state family planning coordinators to expand services within the state. As mentioned above, the coordinators are playing a critical role in providing technical assistance and commodities to LGA family planning managers. FHS has also devoted considerable resources to training staff within the public and private sector. In addition, IEC strategies have been implemented at the federal, state and local community level to raise awareness and use of family planning.

The project has also played a major role in designing the health information system (HIS) that is currently being used to monitor primary health care and family planning activities in the LGAs. The FHS Project has greatly contributed to improving the quality of family planning services, especially for long-term methods. These activities have assisted the Nigerian government's efforts to decentralize family planning services.

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During the remaining 18 months of FHS, the transition period, staff have redirected project resources to respond to the new responsibilities of LGAs. The new approach is called the Resource Intensification Strategy (RIS). FHS is coordinating its efforts with the Primary Health Care Development Agency, FMOHSS, SMOH and NGOs such as the Planned Parenthood Federation of Nigeria.

The RIS has targeted 10 states and select LGAs within the states (at least four per state). It focuses on building management, planning, coordination and supervision capabilities within SMOH through training workshops and one-on-one collaborations. Skill development areas include strategic planning; quality of care measures; data collection and analysis; monitoring and evaluation; IEC activities; and advocacy and constituency building. The zonal offices of FHS will play a major role in providing technical support to the states. The FHS zonal plans will be coordinated with those of the PHC Development Agency. FHS state-level plans will be jointly developed in strategic planning meetings with the 10 state ministries.

The FHS Project is working in LGAs that have private sector family planning efforts; offer or have the potential to offer broad-based services; serve a large population; show a demand for family planning services; and have local leadership that is willing to support family planning activities. The selection of the target LGAs is determined jointly by the SMOH and FHS.

RIS efforts are underway in five states and select LGAs: Abia (8 LGAs), Anambra (6), Plateau (15), Niger (7) and Osun (7). Additional states will include Oyo, Enugu, Bauchi, Kaduna, and another state yet to be identified. It is too early to evaluate these efforts. It does represent a strategy to use scarce resources to support both state and LGAs in family planning service delivery while collaborating with different divisions of the FMOHSS and the Primary Health Care Development Agency. FHS is designing an evaluation strategy so that the Mission can learn from this approach.

### C. Key Family Planning Policy Constraints Resulting from the Decentralization Process

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**Achieving national targets:** Nigeria's population policy has set a number of targets concerning IEC, contraceptive use and fertility reduction. A major problem that most countries face with decentralized services is that it is difficult to achieve national targets when local governments can pursue local priorities and interests. In the northern regions of Nigeria, in particular where contraceptive use is fairly low, family planning may be pushed aside for other primary health care interests and/or development programs.

**Promoting the method mix:** Oral contraceptives are the most popular method of modern contraception. While pills are an effective method of birth control, long-term family

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planning methods such as the IUD, injectables, implants and sterilizations are needed to reduce Nigeria's total fertility rate to four children per women. The SMOH and LGA family planning managers should be encouraged to implement activities that will assist the country in achieving the objectives and targets stated in the population policy. The state coordinator and LGA family planning manager will need training and technical assistance in selecting an appropriate method mix, generating demand for different methods through IEC activities and providing select long-term methods that meet the needs of individuals and couples in the community.

**Obtaining special budgets for family planning:** As mentioned, family planning is part of maternal and child health, which is one of ten areas of primary health care. Like other development programs, the budget for primary health care is decided by the elected council which means that the budget can vary from year to year. To ensure that the objectives and targets of the national population policy are met, family planning services may require a special budget or funding either from the federal, state and/or LGA levels.

While the Mission cannot provide special budgets for family planning, FHS II can focus on equipping health and family planning staff at all levels of government with advocacy skills so that they can work with interest groups and effectively lobby for program budgets, at all tiers of government. Interest groups can include women's groups (such as the Nigerian Council of Women's Society, different market women's associations, the Muslim women's association, etc.), medical leaders, or farming cooperatives. In Lagos state, the family planning coordinator advocates for family planning and is able to obtain a special budget for family planning from the governor's office.

#### D. Recommendations with Discussion

##### **Possible USAID Activities:**

**FHS Project Activities:** We recommend that the Mission continue using the current RIS approach of placing most of its resources in FHS zonal offices. Offices close to the RIS states allow FHS staff to tailor resources and technical assistance to select state ministries and LGAs. Given the diversity of Nigeria's population, flexibility is needed in designing programs to meet the needs of the states and LGAs, in particular the northern states which lag behind the country in use of modern contraceptives.

**Federal Level Activities: Training.** We recommend that the Mission continue to support training of FMOHSS and FOS personnel. At the federal level, FHS provides training and technical assistance in management, supervision, IEC, and monitoring and evaluation. Monitoring activities include technical assistance to the PHC Department of FMOHSS in designing the HIS, which also contains information on family planning services. Technical assistance will continue to be needed by FOS to increase its capacity to conduct the Quarterly Contraceptive Prevalence Surveys.

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**Federal Level Activities: Commodity Logistics.** We recommend that the Mission investigates alternate strategies for distributing family planning commodities. Sterling Nigeria Ltd. was responsible for distributing contraceptives. However, in July 1992, Sterling decided to discontinue its involvement in family planning commodities. The government wants to take over storage and distribution of commodities and has begun a number of activities to improve commodities logistics. Efforts include building warehouses near the federal and zonal offices, and training staff in commodities logistics. We recognize the need for more active government involvement in distributing commodities. However, we also encourage continued private sector involvement in distributing commodities to private sector outlets. FHS II will need to provide technical assistance and training in forecasting and inventory control to both the public and private sector organizations.

**Federal Level Activities: Advocacy.** It is difficult for FHS II to directly promote advocacy skills among state and LGA health staff. The Mission needs to work through a federal or state office. While the Department of Population Activities (DPA) of the FMOHSS has been slow getting started, the situation is beginning to change as a result of new staff.

We recommend that FHS II provide technical assistance in advocacy activities to the DPA. It is beginning to work with pilot LGAs, experimenting with ways it can provide technical assistance in political advocacy. In the past, the DPA has had limited staff, which has made it a fairly weak organization. However, it has recruited several new staff members that have field experience at the LGA level.

**State Level Activities: Training.** We recommend that the RIS strategy to build the SMOHs' capacity to support the LGAs be continued. Training will continue to be a critical area of need. Skill development areas for training include service delivery (especially long-term family planning methods); strategic planning; quality of care measures; data collection and analysis; monitoring and evaluation; IEC activities; and advocacy and constituency building.

We suggest that FHS II continue to use sample surveys and operations research to assess the impact of training on quality of services and the expansion of family planning services. The training management information system that has been established by FHS can be used and expanded to monitor training activities.

**State Level Activities: Family Planning Coordinators.** As mentioned above, the state family planning coordinators can play a major role in meeting the needs of the LGA family planning manager. FHS has strengthened the capabilities of the coordinators. We recommend that FHS II continue to build their skill level and continue to provide commodities and a mechanism to get supplies to the LGAs.

**LGA Activities: Policy Analyses.** We recommend that the Mission continue with FHS efforts to determine appropriate strategies to work directly with highly populated LGAs that have the most potential for success. The RIS is experimenting with ways to

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provide a package of resources to select highly populated LGAs. While FHS has designed an evaluation strategy to monitor and evaluate its efforts, it is too early to determine the benefits and/or problems of working directly with LGAs in family planning service delivery. It may take several years to see results in terms of fertility decline. Efforts should be monitored annually to learn and share experiences among the LGAs.

The FHS Project is designing a system of monitoring and evaluation that will allow the Mission to assess the RIS. A number of small policy analyses could also be implemented in RIS LGAs to assess internal and external factors that can affect the provision of family planning services. Policy questions are presented below.

- What are the characteristics of LGAs that have the greatest potential to expand family planning services?
- What are the most appropriate strategies for expanding family planning services within LGAs?
- What are the best ways to supply public sector commodities to rural and urban LGAs? Should LGAs be given budgets to purchase commodities or be provided with commodities?
- What are the most effective lobbying strategies to increase funding for family planning at the LGA and state level?
- What are the best strategies to mobilize private sector resources in rural and urban LGAs?

## VI. Policy Issues at State and Local Levels

Although decentralization is primarily affecting the public service sector, decisions by LGAs will directly influence how the other service systems, including the private sector, operate. This influence is the result of the phenomenon of the market. Following are several recommendations that arise as a result of the decentralization process, but are not restricted to public services. The recommendations address the best ways to protect and mobilize resources at the local level to expand family planning services. Table 3 illustrates the recommendations.

### Recommendations with Discussion

#### Restrictions on the Establishment of Maternity Homes

**Possible USAID Activities:** The Nigerian Association of Nurses and Midwives has

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organizations in every state. They also have a strong interest in getting the laws changed to allow their members to set up maternity homes. The maternity homes would be ideal places to also help distribute family planning services to women who have just had a child. USAID should consider working with these associations to get the laws changed in states so that nurses and midwives can establish maternity and family planning homes without direct physician supervision in locations where there are not doctors.

**Discussion:** In 1988, nurses and midwives were given federal permission to open "maternity homes" on their own. The permission was almost immediately revoked because the medical association said that the homes required the supervision of an Ob-Gyn physician. In effect, the current law means that there can be no maternity homes where there is no Ob-Gyn physician. The states should consider modifying the current law to allow the regulation to be waived where there is no Ob-Gyn within a reasonable distance. Surely maternity homes run by nurses and midwives are better than no maternity homes at all. The need for waivers would vary by state and therefore is best dealt with at that level. Moreover, the medical associations are likely to be less influential and adverse to the policy at the state level than at the federal level, enhancing the possibility of such a waiver.

#### Quality Control of Private Health Establishments

**Possible USAID Activities:** It would be useful to resuscitate the model edicts on quality control that the FMOHSS developed several years ago. USAID might suggest that states use them as part of their licensing and relicensing procedure to ensure higher quality family planning services.

**Discussion:** The state governments license the private hospitals. But most states have weak quality controls on the hospitals they do license. Since good quality is one of the important factors in creating the demand for family planning, quality control should be strengthened. The FMOHSS gave the state ministries draft edicts as models for improving quality control several years ago. However, few states adopted these edicts. Reintroducing these edicts at the state level in conjunction with their licensing function, may increase the attention to quality of care issues.

#### Private Pharmacy Distribution of Family Planning Services

**Possible USAID Activities:** In order to broaden the distribution of family planning services, the state pharmacy boards should make as a condition of private sector pharmacy licensure, the requirement to stock family planning supplies and display the family planning logo. The head of the state pharmacy boards would be the key person for implementation of this recommendation.

**Discussion:** Nigeria has a national pharmacy board. But each of the thousands of pharmacies throughout Nigeria must be registered with its state pharmacy board. Neither the state pharmacy boards nor the Pharmacists Association are very strong, but both

Table 3:

**Summary of Legal, Regulatory and Medical Policy Issues to be Addressed at the State Level in Nigeria**

Policy Issue	Authority	Problem	Recommendation
Private Sector: Restrictions on establishment of maternity homes	FMOHSS	In 1988 nurses and midwives were given permission to open maternity homes, but it was retracted if there was no Ob-Gyn supervision.	Could modify the law at state level, depending on the availability of Ob-Gyns.
Quality control of private health establishments	State Hospital Licensing Commission	State permits to private hospitals provide little quality control. FMOHSS draft edicts have not been adopted.	Could work with the state licensing commissions to improve quality control in their licensing process.
Distribution of family planning products by private pharmacies	State Pharmacy Boards	Each pharmacy needs a permit from a state pharmacy board.	Could work with pharmacy boards in RIS states to require pharmacies to carry family planning products in order to get their licenses.
Private and Public Sector: Certification of health personnel and restriction of authority	FMOHSS	Nurses, midwives and pharmacists are prohibited from prescribing drugs, but most dispense pills and injectables.	Could consider working with RIS states to ensure adequate permission when doctors are unavailable.
Dispersement of medications and schedule of follow-up visits		Both are more stringent than in the U.S. because of a lack of supplies and concern for clients.	Adapt procedures to the circumstances of each state and the cost of transportation.
Marriage laws	DPA and Ministry of Justice	Current minimum age for marriage is 9. Despite two recent reform attempts, Ministry of Justice has taken no action.	Could consider working with the states rather than continue to struggle with the Ministry of Justice.
Age of client		There is no regulation on client's age, although women under 18 may be discouraged.	Ensure that local practices do not discriminate against young women.
Consent from spouse		Consent was once a standard but is no longer required.	Ensure that local practices do not require spousal consent.

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represent considerable potential in broadening the distribution of family planning products. Again, the licensing function of the states provides an opportunity to increase requirements on the local pharmacies to provide family planning supplies.

### Certification of Health Personnel and Definition of their Duties

**Possible USAID Activities:** In areas where there is a shortage of doctors, specific relaxation of the restrictions on the duties and responsibilities of the nurses and midwives should be advocated to the states ministries. Shortages could be identified in a census of doctors, nurses and midwives, and their geographic distribution should be obtained and updated at the state level.

**Discussion:** Both the certification of health personnel and the regulation of which services they are allowed to provide are determined at the federal level. For example, nurses, midwives, and pharmacists are prohibited from prescribing drugs. Only doctors can write prescriptions. And when doctors are available, the nurses, midwives, and pharmacists defer to their judgment and prescriptions. But a number of people said that the nurses, midwives, and pharmacists, in fact, dispense drugs and give injections when no doctor is available. The question is whether the de facto situation inhibits the distribution of family planning services. Where it does, then consideration should be given to developing modified regulations that would take into account that practices need to vary depending upon the availability of doctors.

### Dispersement of Medication and the Schedule of Follow-ups

**Possible USAID Activities:** Where the family planning distribution site is not easily accessible by its clients, the SMOHs should be encouraged to modify standard practices and provide clients with more cycles of pills, with fewer mandatory revisits. This modification would remove discrimination against rural dwellers.

**Discussion:** The standard practice of dispersement of medication and the schedule of follow-up visits in Nigeria is, in many cases, more conservative than in the U.S. In the U.S. women are often given oral contraceptive prescriptions for up to a year, on the condition that they return if there are any side effects. In Nigeria, generally, women are given a one-month supply of the pill, then upon a return visit are given three-months, and thereafter, are given six-month supplies. The standard practice in Nigeria is, in part, a function of the lack of supply; it is also a function of some clients not being able to afford a large supply at one time. But it is also because of the concern that women may misuse the pill, or not recognize the side effects. What the standard practice does not take into account is the cost in time and money for transportation to and from the family planning distribution site. Standard practice should take into account these costs to the client.

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## Marriage Laws

**Possible USAID Activities:** Facilitate the passage of a law allowing the Ministry of Justice in each state to be responsible for limiting the age of first marriage. In receptive states, the issue of an increase in the age should be explored with the Ministry of Justice in each state.

**Discussion:** The federal Nigerian law today prohibits marriage of girls before the age of nine years. In fact the average age of marriage varies from 15.2 in the Northeast to 19.7 years old in the Southwest (NDHS, 1990). There have been at least two attempts in recent years to change the federal legal age of marriage to 18 years. In October 1980, the Nigerian Law Reform Commission submitted proposals on a new marriage age to the Ministry of Justice, but no action was taken. More recently, DPA (with an intersectoral working group that included the Ministry of Justice staff) submitted a draft law to the Ministry of Justice that requested an increase in the age of marriage to 18 years. But again there has been no action. Given the lack of interest or demand at the federal level, this is an example of a law that might be better modified at the state level where social customs can be taken into account.

## Age of Family Planning Client and Consent from Spouse

**Possible USAID Activities:** None, unless either issue poses specific problems in a state.

**Discussion:** In fact there is no formal regulation on the minimum age of family planning clients, although some people said that women under the age of 18 may be discouraged in some places. Although there once was a requirement for the consent of the spouse in order to receive services, that law is also no longer in effect. Nevertheless, both of these practices are likely to vary considerably around the country. Again, it might be useful to ensure that these practices do not inhibit the use of contraception in RIS states.

The seven examples above of laws, regulations and practices that can inhibit the distribution of family planning are those that are better addressed at the state level than at the federal level of government. Relaxing these laws and regulations would promote access to and distribution of family planning services in the states by both public and private sectors. An issue that clearly affects both maternal mortality and fertility is the restriction on abortion except when the mother's life is in danger. This, in fact, is a law that is held over from the colonial days, yet it is so sensitive that there is no role that USAID can usefully play in reducing this barrier to safer family planning.

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## VII. Concluding Comments

The recommendations in this report are intended to support the considerable efforts of the current Nigerian USAID staff and program. The existent economic deterioration and political decentralization in Nigeria pose considerable challenges to the USAID program. In the midst of the economic and political changes, demand for family planning services is increasing. The challenge will be to concurrently increase the supply of family planning services. This feat will require using the comparative advantages of the public, private commercial and NGO sectors to provide adequate services. We hope that our recommendations provide some insight into how policy changes can take advantage of the different family planning sectors at the federal, state and local levels of government.

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# REFERENCES

Family Health Service Project, October 1992, *Preliminary National Logo Distribution Overview*

Federal Office of Statistics, December 1992, *National Integrated Survey of Households: Preliminary Report of Family Planning Survey of June and September 1992*

A.I.D. Affairs Office, Lagos, Nigeria, August 1992, *Nigeria Country Program Strategic Plan, 1993 -2000*

Federal Ministry of Health, 1992, *National Health Policy*

Olowu, Dele, and James Wunsch, November 1992, *Local Governance and USAID Health Projects in Nigeria*, A.I.D. Affairs Office, Lagos, Nigeria

Federal Republic of Nigeria, 1989, *The Constitution of the Federal Republic of Nigeria*

Federal Office of Statistics, 1990, *Nigeria Demographic and Health Survey*

Committee on National Drug Policy, October 1988, *Report of the Committee on National Drug Policy for Nigeria*

World Bank, December 1988, *Staff Appraisal Report, Federal Republic of Nigeria Essential Drugs Project*