PD-ABM-503

DRAFT REPORT
May 24, 1991

Prepared for

USAID/Lagos and
Office of Population
Bureau for Science and Technology
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024

Management Review of the Nigerian Family Health Services Project

by

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Fieldwork
April 29 - May 17, 1991

Produced by

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Report No. 91-122

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ACKNOWLEDGMENTS

The team would like to thank the staff of the FHS Project, the USAID Mission staff, the Family Planning Coordinators in Kaduna and Jos, Federal MOH officials, and individuals in private sector organizations for their complete cooperation and generous help as we reviewed this complex project.

PROJECT IDENTIFICATION DATA

1. Scope — Nigeria

2. Project Title — Family Health Services Project

3. Project Number — 620-0001

4. Critical Project Dates

Authorization Date:	07/09/87
Initial Obligation Date:	07/30/87
Grant Agreement Amendment 1:	08/24/87
Grant Agreement Amendment 2:	09/21/87
Grant Agreement Amendment 3:	07/10/88
Grant Agreement Amendment 4:	06/01/89
Grant Agreement Amendment 5:	06/15/90
Project Ending Date:	12/31/92

5. Project Funding to Date

	USAID Proposed funding levels	Funds Obligated to date
o IEC Component	$15.0 million	11.4 million
o Private Component	$10.7 million	8.8 million
o Public Component	$11.0 million	9.5 million
o Policy Component	$ 2.5 million	2.2 million
o Administration/ logistics	$ 6.0 million	5.5 million
o Evaluation/Audit	$ 1.5 million	0.8 million
o Contraceptives	$16.3 million	7.6 million
o Project Support	$ 4.0 million	2.6 million
	$67.0 million	$48.4 million

6. Mode of Implementation
   Bilateral Agreement: collaborative assistance mode

7. Contractors/Subcontractors

   Administration: Prime - African American Institute
   Subs. - Sweethill Associates

   Public Component: Prime - Pathfinder
   Subs. - Africare, IHP, MSH

   Private Component: Prime - FPIA
   Subs. - JSI, Margaret Sanger Center

   IEC Component: Prime - JHU/PCS
   Subs. - AED, CEDPA, PATH

   Policy Component: Prime - JHU/IIP
   Subs. - Africare

8. A.I.D./Nigeria Project Monitors
   Field Project Officer: Eugene Chiavaroli
   A.I.D./W Backstop Officer:

9. Previous Evaluations/Reviews
   Regional Inspector General's Report, September 1989
   Evaluation of Nigeria FHS Project, December 1989

EXECUTIVE SUMMARY

A Management Review of the Nigerian Family Health Services Project took place April 29-May 17, 1991. The review team consisted of John McWilliam (POPTECH, Team Leader), Harriett Destler (A.I.D./W), Pamela Wolf (A.I.D./W), Wale Shobowale (Transcon), Douglas Wear (consultant), and Nancy Williamson (FHI).

The FHS Project is a five-year (1988-1992) family planning services delivery project ($67 million, USAID; $33 million, Government of Nigeria) being implemented in Africa's most populous country. As of mid-1991, Nigeria's population was estimated to be 120 million and was growing at an annual growth rate of 2.9%.

The FHS Project is part of Nigeria's primary health care program. FHS has five separate contractors who are responsible for: IEC (JHU/PCS), public sector (Pathfinder), private sector (FPIA), policy and evaluation (JHU/IIP), and logistics and administration (African America Institute). A Project Administrator is responsible for Project coordination. The Director of the Department of Population Activities of the Federal MOH serves as Project Director.

The Management Review Team concentrated on only three components (private sector, public sector, and policy and evaluation) since these were thought to need the most attention. Field trips were taken in the Lagos areas as well as to the north (Kaduna, Zaria, and Jos).

PROGRESS

The team noted significant progress in family planning in Nigeria.

- There is general agreement among policy makers and the general public that Nigeria's population is growing too fast
- There are approximately one million users of modern methods in Nigeria, more than in any other country in Africa
- The demand for FP is clearly increasing
- There is an unmet need for effective methods such as pills, injectables, female sterilization and NORPLANT®
- Very extensive FP training programs are taking place throughout the country

- o 374 clinical FP service sites have been equipped as well as 2,158 service sites for non-clinical FP services
- o 1,600 IUCD kits will be distributed to public sector facilities in the next several months; 1,388 IUCD kits have already been sold through the private sector
- o Standards of practice and training curricula have been adopted
- o The management information system is improving and is yielding data on new acceptors and return visits
- o National information is now available on contraceptive use and source of supply through the 1990 Nigerian Demographic Health Survey
- o Two condom brands, "Right Time" and "Gold Circle," have been launched by Sterling and PSI respectively
- o A family planning logo has been adopted and will be launched in the coming months

PROBLEMS

The challenges to delivering FP services to the large and diverse Nigerian population are equally dramatic.

- o Fertility remains high (TFR of 6.0 in 1990)
- o Contraceptive use is low: 7.6% of all women 15-49 report use of any method with only 3.8% reporting a modern method
- o There are serious commodity shortages especially of pills and injectables, the most popular methods
- o The contraceptive commodity logistics system is still not working as intended
- o The FHS Project is unlikely to meet its targets (12% prevalence, 2.5 million acceptors in the 5th year) by the end of Project period, December, 1992
- o IEC materials are often stored in offices and not sent out to clinics where they could be used
- o The private sector distributor, Sterling, does not plan to advertise and market branded pills or foaming tablets for the next two years

RECOMMENDATIONS

Management

1. The FHS Project should be extended a year beyond the current ending date of December 1992. This will allow the Project to come close to its targets and to consolidate FP service delivery. The next FHS Project can be planned during 1992 and 1993 with the federal MOH, state MOH, and LGAs being integrally involved.

2. The salaries of all FHS staff should be thoroughly reviewed and appropriate adjustments made.

3. During the remainder of FHS-I, the FHS Project should move toward a functional organization with its units performing functions such as training, commodities, IEC, MIS, policy and evaluation in an integrated fashion.

4. The Divisions of FHS should select states and LGAs where they can work together to attempt to get a synergistic effect by integrating their activities.

5. In order to strengthen coordination among the Divisions of FHS, a "prime among prime" could be engaged to serve as a coordinating unit responsible for strategic planning, coordinating workplans, working with government and donors, MIS, and commodities. Another option is to strengthen the authority of and support for the Project Administrator.

6. The FHS Project should consider engaging a Nigerian Project Manager who has extensive experience in management and family planning service delivery.

7. The Management Committee should be revitalized and include representatives from FHS, MOH, the private sector, Nigerian universities, donors, and A.I.D./Washington. One subset of the Committee could focus on the functioning of the current Project while another focuses on future steps to increase family planning access and use in Nigeria. A strategic planning emphasis 'should be given to the Management Committee.

8. Contractors need to simplify and speed up their contracting mechanisms, including giving more authority to the Divisions in Lagos.

Commodities

1. The FHS Project needs to devote more attention to commodity problems.

2. Given the current pill shortage, obtaining and distributing pills should be done on an emergency basis.

3. An urgent appeal should be made by A.I.D. to UNFPA to send injectables immediately. Another potential source of injectables is purchase by the Government of Nigeria.

4. A contraceptive commodity/logistics unit should be set up either in the Project Administrator's office or in the "prime of primes." It may initially require outside technical assistance.

Public Sector

1. There are several options for how to institutionalize the distribution of public sector FP commodities: paying Sterling for this service rather than relying solely on "corporate citizenship;" piggybacking onto another commodity distribution system (EPI or eventually, the essential drugs program), or setting up a new government distribution system which would require strengthening and upgrading zonal and state warehouses.

2. NORPLANT® and female sterilization should be made more available by expanding the current "centers of excellence" through add-ons to AVSC in surgical contraception and AVSC/FHI in NORPLANT®. These activities should be integrated into the FHS Project.

3. Now that a very large number of people have been trained, there should be more concern with retraining, follow up and supervision of trainees to make sure they are using their training.

Private Sector

1. Steps should be taken to spin off the retail/social marketing components of FHS into an autonomous project based in the private sector organization(s) doing the work.

2. An assessment should be done of the other private sector activities (with private hospitals, clinics, parastatals, nurses/midwives, market women, etc.) to see which ones are cost effective and sustainable. The cost effective programs should be supported and strengthened and placed within an organization such as PPFN.

3. If Sterling is unwilling to commercialize and market pills and other methods such as injectables, another organization should be engaged to market these products.

4. Support for PSI's social marketing activities should be increased, including possible additions to their product line.

5. The Project should eliminate foaming tablets from the private sector program.

6. The Project should add injectables to the package of commodities being promoted in the private sector if the supply problems can be solved.

7. The Project requires stronger technical assistance in marketing.

IEC

Greater effort should be made to get IEC materials out to the service sites.

Policy and Evaluation

1. If the Futures Group is asked to complete the RAPID work, they should build on past work with JHU and NISER, incorporate the most recent data available including NDHS, and respond to locally identified information needs.

2. The Policy and Evaluation Division should work with the Federal Office of Statistics to implement the Family Planning Questionnaire in one national survey in 1992 so that it will be possible to measure whether FHS met its targets and to help in planning a new project.

3. Efforts should be made that the many planned constituency building activities are practical and supportive of the FHS Project and FP service delivery.

4. The PE Division and JHU/IIP need to prioritize their many activities so that the most important ones are completed in the next 18 months and the information they produce is widely disseminated.

5. The Non-Project Assistance funding mechanism could be used to encourage policy changes supportive of family planning services (customs, advertising, essential drugs, responsibilities of nurses, etc.).

A.I.D./Washington and USAID/Lagos

1. Given the size and complexity of the FHS Project as well as other A.I.D. supported projected which will be working in Nigeria (CCCD, MotherCare, OR in Africa, AVSC, AIDSTECH, etc.), more staff are needed in USAID/Lagos.

2. A.I.D./Washington (S&T/POP) should assign a backstop to the FHS Project and serve on the Management Committee.

Chapter I. INTRODUCTION AND PROJECT STATUS

A. Background

This management review report examines the Family Health Services (FHS) Project, a joint project of the Federal Government of Nigeria and the U.S. Agency for International Development (USAID) "to assist Nigeria in the implementation of its national population program and the managerial process for primary health care through both the public and private sectors." The project began in 1988 and is scheduled to end in December 1992. The Project Identification Data on page iii provides the basic information on the project.

The purpose of the project is to make family planning information and services widely available. This will be reflected in a nationwide contraceptive prevalence rate of 12 percent or approximately 2.5 million users by the end of the five year project period. Seventy percent of the users will be served by the private sector, receiving information and contraceptives through more than 12,000 commercial, community level or private outlets. In the public sector, information and service will reach 30 percent of contraceptive users through 3,600 government hospitals, maternities, health centers, and dispensaries.

To reach these end-of-project goals, a four-pronged strategy was developed linking together four distinct but inter-related components: private sector service delivery, public sector service delivery, information, education and communication (IEC), and policy implementation. Four U.S.-based prime contractors were chosen to implement each of these components assisted by U.S.-based subcontractors. An administrative and logistics contractor was chosen to serve the project, and a Project Administrator was hired to coordinate component activities.

The Management Review

Two implementation evaluations were included in the FHS Project Agreement. The first evaluation took place in December 1989 and it reviewed the entire project. USAID decided that, since the first evaluation was so recent, a management review looking at specific issue for the remaining project period would be more appropriate at this time. A final evaluation of the project is included in the Project Agreement.

USAID/Lagos in consultation with the Federal Ministry of Health (FMOH) requested that the Population Technical Assistance Project (POPTECH) undertake the management review. The scope of work for the review, the composition of the review team and the methodology used to carry out the review is found in Appendix A. The management review took place from April 29, 1991 to May 17, 1991.

B. PROJECT STATUS

Objectives

The overall program goal of family health services in Nigeria is to improve the quality of life by strengthening integrated health care services available through private and public facilities. Overall objectives include reducing infant mortality, maternal mortality, high risk pregnancies, and total fertility.

The FHS Project's purpose is to increase the acceptability and availability of integrated family planning information and services throughout Nigeria in both the private and public sectors. Specific targets include a contraceptive prevalence rate of 12 percent (70 percent through the private sector; 30 percent through public) and numerical targets for private and public sector outlets.

Overall Accomplishments

The Nigerian Family Health Services Project is national in its orientation. Each division has worked in a number of states and local government authorities; some activities such as the music video IEC project span several health zones encompassing many states. To date there have been numerous accomplishments of the components, individually and as a whole. Highlights of these achievement follow.

. FHS has activities in all 21 states and the federal capital territory

. Family planning has been integrated into the primary health care program of the government

. Standards of practice have been developed for all service delivery levels

. FHS Management Information System (MIS) for family planning has become a nationwide system and is beginning to produce more reliable and complete results

. A network of training centers of excellence and a network of trainers have been established to provide clinical, non-clinical, management and supervisory training

. A contraceptive marketing campaign has been launched in the private sector

. Provision of family planning through private nurse/midwife associations in 8 states has been instituted

. Contraceptives provided through FHS are available in commercial outlets throughout the country

. Awareness activities for family planning have been vigorously pursued: music video promoting family planning and the launching of the family planning logo is scheduled for July

. Statewide IEC campaigns have been initiated

. Family life education has been integrated into the secondary school curricula

. Evaluative studies have been undertaken to better understand the characteristics of family planning acceptors

Project Outputs

Project status at the time of this management review can be most simply assessed by looking at the project status at the time of the evaluation of the Family Health Services (FHS) project in 1989, progress since that date and then considering both in the light of the output requirements set forth at the start of the project. Since the overall program goal is to "improve the quality of life in Nigeria by strengthening integrated health care services available through private and public facilities", this section will focus on the outputs of the public and private services delivery components. This permits a quick assessment of progress in the last 12-15 months and suggests whether the project targets can be realistically reached in the remaining eighteen months until the project completion date.

Table 1 shows the results for the FHS/Public Sector. As can be seen, there has been a substantial effort in this most recent time frame, with most tasks more than 75 percent complete. The exceptions are in the training of non-clinical personnel, and the management information system (MIS) development and implementation. Although the manual has been completed and there has been extensive training in the use of the MIS, this system has yet to be fully implemented by the Federal of Ministry of Health. This is critical to making this project a truly joint effort of USAID and the Federal Ministry of Health.

Table 1

Public Sector Activities Outputs

Requirement	Status 12/89	Status 3/91
1. Clinics		
1000 for IUD ins.	107	370 (37%)
2600 non-clin.FP	82	2158(83%)
2. Training		
5200 public health personnel	267 clinical 194 non-clin. 599 mgt.	560 (56%) 480 (24%) 61% ToT, refresher: initiated
3. Standardized curricula	midwifery-under testing Hlth Tech, MD: not started	90% complete 80% complete not started
4. Service delivery protocols	8 needs assess.	75% complete
5. Provision of equipment	150 surveys	?
6. MIS development and implementation	manual developed 214 trained	completed?

Note: 27 subcontracts awarded 1/90-1/91 ($1.2 M)

Sources:
Evaluation of the Nigeria Family Health Services Project, 1989.
Nigeria Family Health Services Project Performance Report, March, 1991.

Table 2 shows the progress and status of FHS/Private Sector. This component has shown progress, particularly in the establishment of a network of commercial vendors and service delivery sites and the training of private sector family planning providers and retailers. One fundamental requirement that has not been completed is the MIS system for the private sector. Whereas the public sector MIS system (with all the attendant problems always associated with large, new databases) has now been established with public sector service sites regularly reporting their activity, the private sector service delivery sites are not yet in the system. With the private sector component committed to delivering seventy percent of the services, this shortcoming makes it most difficult to assess the project's overall status viz. new acceptors, method mix, couple years of protection and contraceptive prevalence targets.

Table 2

Private Sector Activities Outputs

Requirement	**Status 12/89**	**Status 3/91**
Distribution network		
4375 commercial	3500 (80%)	3500(80%)
5650 private s.d. sites	627 (11%)	1525(27%)
2100 vendors	503 (24%)	1134(54%)
Training		
4000 pharmacists	939 (23%)	3540(91%)
1000 vendors	473 (47%)	1350(135%)
2100 IUD ins.	720 (35%)	1449(69%)
Family Planning Commodities		
$17 million	$ 2.5 million	$ 5+ million
MIS		
Private sector	sales info	s.d. sites not in system
Market Research		
comm. sales market research	early results	completed

Table 2 Private sector (continued)

TA to Subcontractors		
monitoring visits	underway	ongoing
IEC Activities		
market research		
f.p. promotion		
advertising	underway	ongoing

Note: 53 subcontracts (1/90-1/91)$ 2.3 million

Sources:
Evaluation of the Nigeria Family Health Services Project, 1989.
Nigeria Family Health Services Project Performance Report, March, 1991.

New Acceptors (Public Sector)

Tables 3 shows the new acceptors in the public sector 1988-1990 for Nigeria and for the primary health care zones. While there has been a considerable increase in Zone A (+42 percent), the results for the other zones have shown a decline in the number of new acceptors. In the face of the overall program objective of achieving 12 percent contraceptive prevalence, or in reaching 2.5 million users, these trends appear quite worrisome. There has been the suggestion that the service statistics prior to 1990 are artificially inflated, due to the misconception on the part of some providers that funding for each site was directly correlated with the number of new acceptors. This would lead to the conclusion that there has been a decline, when in fact, there may have been no change or a slight increase. However, in reviewing the sales data from the private sector, (not presented here), sales dropped for condoms, VFTs and pills between 1989 and 1990. Another possible explanation for this apparent decline could be the extreme shortage of commodities and the logistics situation reported throughout the project period. (This is discussed at length elsewhere in this report). We have been assured by project staff responsible for the MIS, that the data for 1990, at least, should be reliable and form the baseline for assessment of trends in the future.

Table 3

New Acceptors (Public Sector) by Zone and Year

	1988	1989	%	1990	%
Zone A	117541	68172	-42.0	97409	+42.9
Zone B	105715	99609	- 5.8	86593	-13.1
Zone C	89188	117753	+32.0	84639	-28.0
Zone D	64200	66341	+ 3.3	67525	+ 1.8
TOTAL	376644	351875	- 6.6	336166	- 4.5

Table 4

Method Mix of New Acceptors (1990)

	Nigeria	Zone A %	Zone B %	Zone C %	Zone D %
Orals	31.5	20.1	26.2	31.0	52.7
Injection	9.3	7.6	9.5	8.7	12.0
IUCD	24.1	43.8	28.5	7.6	9.8
Condoms	21.3	15.8	25.1	29.8	12.6
Foaming Tab	13.2	9.3	9.4	22.4	11.5
VSC	0.3	2.5	0.3	0.3	0.6
Other	1.0	0.9	0.9	0.1	0.9
	100	100	100	100	100

Source: FHS/Policy Information Note: Family Planning Growth in the Public Sector

Table 4 shows the method mix of new acceptors in the public sector for 1990. As can be seen, the method mix varies dramatically by zone, most likely a reflection of religious and cultural preferences. Zone D, for example, has nearly two-thirds of the new acceptors choosing oral contraceptives or injectables, while in Zone C we see a much greater preference for vaginal foaming tablets than anywhere else in Nigeria. To what extent this method mix has been influenced by supply problems is uncertain.

Voluntary surgical contraception still comprises a very small proportion of new acceptors, yet the team visit to Jos revealed acceptance of this method and demand which exceeded the clinical services available.

Target Setting Exercise

In 1990, the family planning coordinators (public sector) participated in a target setting exercise, whereby they were to review the number of new acceptors in 1989 and estimate the increase expected in 1990 and planned for 1991. Table 5 shows the targets set for 1990, the actual number of new acceptors (see Table 4), and the targets set for 1991. Although the targets were set for the individual states, they have been aggregated by zone for presentation here. It can be seen that the 1990 new acceptors fell short of the target set for that year. Whether these targets are realistic is difficult to assess, but it seems unlikely that the 1991 target, requiring a 33 percent increase will be reached.

Table 5

Results of Target Setting Exercise
New Acceptors
Public Sector

	1990 target	1990 actual	1991 target
Zone A	101,044	97,409	121,769
Zone B	121,983	86,593	138,505
Zone C	74,208	84,639	88,311
Zone D	85,016	67,525	112,714
NIGERIA	382,251	336,166	461,299

C. Demographic Health Survey (DHS) Results

The status of the FHS Project and the potential for achieving the proposed targets must be viewed in the context of the results of the Nigerian Demographic and Health Survey conducted in 1990. It included a household survey as well as a provider survey. At the time of the FHS management review, only the preliminary report on the household survey was available.

In the household survey, 8,781 eligible women (15-49) were interviewed. This sample size allows zonal but not state estimates of health and fertility. Between 1981/82 and 1990, the total fertility rate declined slightly (6.3 to 6.0). In 1990, fertility was considerably higher in the north (6.) than in the south (5.5). Half (48 percent) of married women either wanted no more births (15 percent) or wanted to wait two or more years for the next one (33 percent). These figures suggest a large potential demand for family planning. Nearly 50 percent of women knew of at least one method of family planning, while only a third knew of where they could obtain a method.

Current use remains low: 7.6 percent of all women and 6.0 percent of currently married women reported that they were using a method. The rates for modern methods were 3.8 percent for all women and 3.5 percent for married women. The most popular methods were periodic abstinence and pills. Contraceptive use was considerably greater in urban areas, in the south, and among the better educated. One half of users obtained their method from a hospital or health center (whether public or private) while 28 percent were supplied by a pharmacy or patent medicine shop.

It is likely that most child spacing in Nigeria is still due to traditional methods such as breastfeeding and postpartum abstinence. Data on breastfeeding trends (1981/82 to 1990) are not yet available. But as of 1990, most babies were still being breastfed and 92 percent were breastfed for more than 9 months. No national data are available on induced abortions although they are reported to be numerous. Women's age of marriage is still low.

The preliminary results of the NDHS indicate that despite the low contraceptive prevalence rate in Nigeria there has been

. a slight decline in fertility in the last ten years

. increased awareness about family planning methods

. a desire to limit family size or space their births

. great demand for family planning

Chapter II. PROGRAM APPROACH

A. Background

To reach the end-of-project goals as enumerated in the Chapter I, a four-pronged approach was developed linking together four distinct but inter-related components: public sector service delivery, private sector service delivery, information, education and communication (IEC), and policy and evaluation. The approach has the following characteristics:

1. It is national in scope with project activities taking place in all 21 states of the federation.

2. The public sector service delivery component (see Chapter V)

works with various levels of government (the Federal Ministry of Health,State Ministries of Health, selected Local Government Authorities [LGAs]);

strengthens the family planning component of the primary health care program of these various levels of government through staff training, equipping of selected service delivery points, improvements in management systems for family planning, and technical assistance.

3. The private sector service delivery component (see Chapter IV)

works with five types of groups: commercial firms in distributing and marketing contraceptives; for-profit health establishments, such as private physicians and nurse/midwives; not-for-profit health establishments, such as religious mission hospitals and clinics; not-for-profit organizations, such as the Planned Parenthood Federation of Nigeria (PPFN); and organized sector groups such as employer/employee-based programs in factories and vendor associations;

provides contraceptives to these five groups, as well as using the distribution network of Sterling Products Nigeria to provide contraceptives to State Ministries of Health to distribute to public sector service sites;

strengthens the family planning component of the various health groups with which it works through training programs, the supply of special equipment, such as IUD kits, and technical assistance.

4. The IEC component

works with the various levels of government in the health and education sectors, NGOs interested in health and family planning, and various media -- radio, TV, print, interpersonal -- to raise the level of knowledge about family planning to 80 percent of the population aged 15-49;

accomplishes this goal through activities aimed at the national level, such as music videos and family planning logo launchings, and at the state and LGA levels through IEC campaigns and working with NGOs that have local constituencies. The production and distribution/ dissemination of information on family planning, through pamphlets, posters and other print materials is an important activity of this component.

5. The policy and evaluation component (see Chapter VI)

works with the public and private sectors to develop policies, strategies, and action plans at the national, state and selected LGA levels to advance family planning;

accomplishes this by strengthening the indigenous planning process, developing positive support for family planning from influential and constituency groups and evaluating and documenting family planning policy and program acceptability and accomplishments.

6. Management of the components is the responsibility of the Division Heads and the prime contractors for each of the components. Overall coordination of the project is the responsibility of the Project Administrator. (see Chapter III)

C. Issues and Recommendations

1. Issue: Feasibility of the approach and meeting specific targets

The overall goals and objectives of the FHS project are noted above. The feasibility of reaching each of the specific FHS targets that are a part of the Project Agreement is discussed here.

Target # 1: "a national contraceptive prevalence rate of approximately 12 percent, with 70 percent of that amount served through the private sector, and 30 percent through the public sector."

The 12 percent target does not specify married women or all women. Nor does it distinguish between modern or traditional methods. As of mid-1990, the Nigerian Demographic Health Survey (NDHS) contraceptive prevalence rate (modern and traditional methods) was 7.6 percent for all women and 6.0 percent for currently married women.

Is the 12 percent prevalence a realistic target by the end of 1992? Given the possibility of a lower number of acceptors in 1990 than 1989 (see Chapter I), the commodity shortages (see Chapter VII), and the fact that only modern methods are being actively promoted, it is unlikely that the 12 percent target will be met in the next 18 months.

Will the FHS project be able to determine whether the 12 percent target is met by the end of 1992? It will not unless an agreement can be worked out between FHS/Policy and Evaluation (PE) Division and the Federal Office of Statistics (FOS) for including the family planning questionnaire (FPQ) in the periodic household survey.(see recommendation in Chapter VI)

Recommendation:

The FHI project's completion date should be extended. Not only is more time necessary for project activities to be intensified and redirected in order to meet the 12 percent target, the added time will provide a period in which further planning can take place for a possible follow on project.

Target # 1: "...with 70 percent of that [12 percent prevalence] served through the private sector, and 30 percent through the public sector."

The 1990 NDHS found that 37 percent of current users of modern methods of contraception reported getting their method from government providers (hospitals, health centers or doctors). The percentage varied considerably by method: 61 percent of IUDs, 29 percent of pills, 45 percent of injectables, but only 14 percent of condoms were obtained from government facilities. If the current shortage of pills and injectables persists (see Chapter VII) and the social marketing of condoms expands, the government's share may decline in 1991. In this case, one could expect that the 30/70 mix may be plausible but due in part to a shortage of popular commodities (pills and injectables) provided by government facilities.

Target # 1a: The private sector service delivery goal is to provide "family planning information, services and /or commodities through approximately 12,000 private sector outlets."

According to FHS records, as of March, 1991, there were approximately 7,304 private sector distribution outlets (3,875 commercial outlets, 2,568 private health providers, and 771 vendors/ workplaces/associations). This does not include additional outlets being served by Population Services International (PSI). By the end of the project, the number of commercial outlets is likely to exceed the target; the number of private health providers is likely to fall short of the target; and the number of vendors/workplaces/associations is likely to equal the target. Overall, it is quite possible that the overall target of 12,000 private distribution outlets will be met.

While the above service delivery outlet targets may be reached, the private sector may not achieve its goal of 1.2 million users in the fifth year of the project. (If the whole project seeks to achieve 2.5 million users in the fifth year and the private sector is responsible for 70 percent, then the number of users is 1.75 million. Yet FHS documents note the private sector service delivery goal is 1.2 million users.) As of the end of the third year (March, 1991), the average number of Couple Years of Protection (CYP) over the first year years per method were: condoms - 35,283 CYP; pills - 22,635 CYP; vaginal foaming tables(VFT) - 1,513 CYP; and IUDs - 18,564 CYP for a total of 77,995 CYP. (These data are from Sterling Products Nigeria wholesale sales and the taxi driver program, but exclude the other private sector programs such as hospitals, clinics, nurse/midwife programs and market women programs for which data are not easily available.)

The estimates of private sector CYP for the fifth year of the project are: condoms ("Right Time" - 208,500 CYP, PSI "Gold Circle" - 40,000 CYP; pills - 27,388 CYP; VFT - 1,831 CYP; IUDs - 22,462 CYP for a total of 300,181 CYP in year 5 of FHS for the private sector. (These data use Sterling's own projected sales of "Right Time" condoms, the elimination of the unpackaged "Blue Panther" condoms, the inclusion of PSI "Gold Circle" condoms, and assumes a 10 percent annual increase in pills, VFT, and IUDs. The reason that pills and VFT are projected for a 10 percent annual increase is that Sterling has no current plan to commercialize these products during the next two years and thus, it is assumed that sales increases will be modest. (see Chapter IV).

It is clear that even if the contributions of the private hospitals, nurse/midwives, clinics and market women are significant, the total private sector CYP will not approach either 1.2 or 1.75 million but will be closer to 300,000 - 400,000 CYP in Year 5.

Target # 1b: The public sector service delivery goal is to provide "family planning and health-related information and services through at least 3,600 public service delivery points."

As of 1990, there were approximately 1,450 service points in the public sector doing family planning. It will be a challenge to establish over 2,000 more clinics in the next 18 months.

Target # 2: The overall IEC goal is to have "80 percent of the population aged 15-49 have knowledge about family planning concepts."

According to the NDHS, nearly 50 percent of women knew of at least one method of family planning in mid-1990 -- the measure of family planning knowledge being used here. (The extent of knowledge among Nigerian men has not been assessed as far as we know.) With very vigorous IEC efforts during the next 18 months, directed toward telling people about the existence of specific methods of family planning, it might be possible to increase this percentage to 80 percent by the end of 1992, assuming that this is the emphasis of the IEC effort and assuming that the government allows this kind of advertising/IEC.

At this point, it is not known whether there will be an appropriate FOS survey to measure women's knowledge toward the end of FHS (see policy and evaluation recommendation requesting the Federal Office of Statistics to include a family planning module in its household survey in Chapter VI).

Target # 3: Another goal of the FHS is to bring about "attitudinal changes favoring smaller family norms."

According to the NDHS, almost half of women either want to finish childbearing or postpone the next pregnancy for at least two years. Only 31 percent are sure that they want a child right away. This indicates a large potential demand for family planning already. There is no information on Nigerian men's attitudes.

Target # 4: The last goal of the FHS project is to institute "a capability for policy implementation and strategic planning for the national family planning effort."

The accomplishment of this goal will be hard to evaluate. Certainly, efforts are being made to improve policy implementation and strategic planning. A Population Action Plan was prepared by the Department of Population Activities. Efforts are being made to improve health and family planning information systems. Planning officers have received training. However, in the effort to decentralize the primary care and family planning effort, it is somewhat unclear what the roles of the federal and state ministries of health will be in support of local government authorities (LGAs) which are now considered to be the crucial government level for service delivery.

Recommendations:

At the federal level, the Project Management Committee (refer to Chapter III), could serve as a forum for strategic planning for the next steps for advancing family planning in Nigeria.

Efforts should continue at the state level to improve the capacity in strategic planning and policy implementation through fact finding missions, Family Planning Coordinator meetings, target setting, etc.

2. **Issue: Functional organization of FHS**

The possibilities of organizing FHS along more functional lines have not been fully exploited. For example, there may be more efficient ways to combine some training activities for the private and the public sector. Having a stronger MIS/evaluation unit within the project could also be beneficial. The 1989 evaluation report recommended more functional division within the project.

Recommendation:

Over the remainder of the project, there should be a move toward more functional organization. This could be accomplished by closely coordinated work plans for the major components and by holding inter-divisional working groups (training, MIS, commodities) which discuss mutual problems, propose, monitor and document (through minutes of the working group meeting) solutions.

3. **Issue: National vs. geographic focus**

The decision by the Federal Government of Nigeria to have a national FHS project to serve the entire nation was the right decision. In the past, pilot or model family planning projects have been tried in one or two states and in selected LGAs only to be discontinued when external funding ceased. FHS, on the other hand, has worked closely with the FMOH in establishing nationwide systems, e.g. MIS, standards of practice, training standards that provide the basis for a permanent family planning program within the national health system. Also, by the project working in all states, the state ministries of health and other important government and non-governmental organizations in the states have family planning as one of their areas of intervention. While the level of FHS activity and the adoption of family planning may differ from state to state, each state has a program upon which it can build.

The recent devolution of responsibility for primary health care to LGAs offers a further opportunity for the project to develop family planning services. The importance of working at the LGA level was anticipated in the design of the FHS project, whereby model LGAs were to receive special attention. Over the past three years the public sector and IEC divisions have trained significant numbers of LGA service providers, supervisors and managers. Their experience in training LGA-level personnel will provide lessons on how the project can work more closely with this level of government.

Recommendations:

The public and IEC divisions should review their state workplans and choose a limited number of LGAs (possibly two per state around the state capital or major city) in which they can work together in the remaining project period to ensure that family planning service delivery systems and IEC efforts are fully functioning. A joint workplan should be developed and amended to the state workplans of the divisions.

Upgrading subnational (zonal) offices to provide more technical and logistic assistance to the states and LGAs in the C and D zones should be considered in a follow-on project.

4. **Issue: Delivery of services - method mix**

One way of improving fertility control is to promote the more effective methods. Fortunately, it appears that there is strong demand for pills and injectables in Nigeria and even implants and tubal ligation have been well received. Foaming tablets do not appear to be popular. IUDs fall in between hormonal methods and spermicides in popularity: IUD

supplies are good and an increasing number of people have been trained to insert them but they may not be most women's first choice.

FHS has provided a vast array of family planning training opportunities for health professionals. Through projects outside of FHS, voluntary surgical contraception and NORPLANT are available in some "centers of excellence" (university teaching hospitals).

Currently, there appears to be a mismatch between what methods many Nigerian women prefer and what is available. IUDs and foaming tablets are available but many women want injectables and pills (especially Noriday). A progestin-only pill, Ovrette, does not seem to have a well established place in the program and may not be understood as being primarily for breastfeeding women. The demand for tubal ligation and Norplant are increasing even though the supply is very limited.

Recommendations:

Improving supplies of pills (especially Noriday) and injectables will go a long way in eliminating this mismatch. (see Chapter VII) After consulting with the family planning coordinators in some states, foaming tablets might be scaled back where demand is limited.

The capability and supplies for providing tubal ligation and Norplant should also be expanded. This could be achieved in the next 30 months through a buy-in to AVSC/Family Health International and through incorporation of these contractors into FHS II. This will achieve an integrated program, whereby long-term reversible and permanent methods will be incorporated into training, counselling, service delivery, and follow-up of clients.

5. **Issue: Combined public/private endeavor**

The FHS project is a combined public/private endeavor under the aegis of the Federal Ministry of Health. It is a unique project in that a private sector firm, Sterling Products Nigeria, is distributing the contraceptives to state warehouses for the public sector service delivery program. The project is also unique in that the major emphasis of the project is the provision of family planning through the private sector; 70 percent of all family planning users are expected to get their contraceptives through the private sector. (The recent NDHS shows that about 63 percent are getting their contraceptive supplies through the private sector.)

In many countries, private sector family planning programs are separate from public sector programs. While the FMOH has not exerted undue control over the private sector component, there is concern that public sector storage and distribution of contraceptives should be controlled by the public sector. (This issue will be discussed further in Chapter V)

There is also concern that the contraceptive marketing program of the private sector division does not receive the attention it deserves when it is combined in a public sector program. In a country as large as Nigeria with as vibrant a private sector, and with a large public sector delivery system with its own challenges, it would seem logical that there would be a separation between public sector services and commercial contraceptive marketing.

Recommendation:

In developing a possible new project, contraceptive social marketing should constitute its own project. Government oversight would be incorporated in the project, but the project would be established in the private sector.

6. **Issue: Marshalling resources for family planning**

Even though the FHS project is the largest population assistance project supported by USAID in Africa, with USAID providing up to a total amount of $ 67 million and the Government of Nigeria up to a total amount of $33.5 million, there are resource gaps that need to be examined. At the present time, contraceptives are not in adequate supply in the country (see Chapter VII), clinical equipment for the upgrading of clinics is limited, and vehicles for family planning staff to provide services, transport commodities and supervise outlying clinics is grossly inadequate. A system for the distribution of contraceptives in the public sector has not been instituted. Information on family planning is just beginning to be disseminated to the population and much more needs to be done. If new methods of family planning, such as NORPLANT® are to be introduced in Nigeria in a major way (see Issue: Delivery of services- method mix, above), the present resource level for contraceptives is inadequate. The resources needed to develop an effective family planning program that would achieve the goals stated in the Nigerian Population Policy is well beyond the scope of the present project, though the ground work laid by the project shows where resources can be more effectively used.

A joint effort should be mounted by the Government of Nigeria and international donors to access more resources both from the various levels of government in Nigeria and from external funds. UNFPA's proposed new country program and the World Bank's proposed IDA loan for population activities will provide some of the needed international

resources. Other bilateral resources will be required and USAID should be prepared to provide assistance and to access other sources of funds for family planning. For example, a new A.I.D. project, PROFIT, has as its goal to access funds for family planning in countries where there may be international debt that can be swapped or where there are blocked funds that can be bought. Once these resources are freed, they can be programmed into the family planning effort.

Recommendation:

In the design of a new family planning project, the resources of the government and the international donors should be closely coordinated to avoid overlap and maximize impact. Closer coordination among the population donors and with the government should be pursued.

Chapter III. PROGRAM MANAGEMENT

A. Background

The FHS project is currently structured with five prime contractors fulfilling the following functions: IEC, private sector service delivery, public sector service delivery, policy and evaluation, and administration/logistics. This design was an outgrowth of the difficulties in the coordination and management of numerous centrally funded projects operating during the period 1983 through 1987. This strategy was essentially a consolidation of activities which were ongoing in an independent fashion, yet all striving to reach the common goal of increasing awareness of and use of contraceptive methods in order to assist Nigeria in implementing its national population policy. The project is executed through five separate contracts, each with its own output targets and contractual obligations, and each reporting to a home office in the United States.

A Project Administrator, through a personal services agreement with USAID, coordinates FHS activities.

B. Accomplishments

* FHS management has assisted in the coordination of the critical inputs that are necessary for the development of a family planning program both within the primary health care program of the government and through the private sector.

* FHS management has assumed the role of senior family planning adviser to USAID/Lagos and to the federal government, through management's indepth knowledge of family planning and demographic issues and the overall understanding of the activities of each of the divisions of the FHS Project.

C. Issues and Recommendations

1. Issue: Component management vs central management

Component management

The management function for undertaking FHS project activities is component-centered; that is, each division of the project has its own management structure. This is necessary due to the contractual setup of the project and the different administrative rules and management systems of each of the prime contractors and subcontractors.

Considerable time and energy is therefore consumed in dealing with management issues within each component. In other possible configurations, management could have a central function. The advantage of central management is the standardization of administrative rules and management systems across projects, e.g. subcontracting, subproject approvals, fiscal control and, moreover, it allows substantive units to concentrate their resources more on technical matters.

The management function of the FHS project is further complicated by the fact that similar project activities are carried out by different divisions, without being fully coordinated. When these activities are systemic in nature, such as commodity management and MIS, the lack of coordination may adversely affect the project's overall effectiveness. When these activities are functional in nature, such as training, the lack of coordination may affect the project's overall efficiency.

Two of project divisions, IEC and Policy and Evaluation, are not involved directly with service delivery. They have their own annual workplans, striving toward their individual contractual output requirements. In many family planning projects, IEC is more integrally connected with service delivery than in the FHS project. Likewise, Policy and Evaluation units are service components that help family planning service providers in overcoming policy and administrative obstacles to the provision of contraception and help to provide the "big picture view" of where the family program is and where it is going. While, both the IEC and policy and evaluation divisions may wish to become closer to the two other family planning services divisions, the independent status of each of the divisions does not facilitate closer cooperation.

The above situation leads to the conundrum that while there may be good will among divisions to collaborate more, meaningful and systematic collaboration is difficult.

Central management

Two factors have affected the central management of the FHS Project. USAID project direction in Lagos has not been consistent. Five different USAID officials have had authority over the Project in its three years. Secondly, the role of the Project Administrator and his authority over the project components has been hampered by the contractual status by which he was hired. A personal services contract with USAID disallows him from signing authority. Contractually, he has no authority over the Project components. The 1989 evaluation recommended that the post of Project Administrator be strengthened giving him "greater latitude to act on the behalf of USAID in agreed upon areas." This is only recently being considered with the new USAID/Lagos administration. In addition, the Project Administrator's office is limited in the functions it can carry out due to lack of mandate and personnel. A personal services contract does not have the backstopping capacity of institutional contracts.

Lastly, the departure of the Project Administrator offers an opportunity to rethink how central management of the Project could be amended taking into account the component management structure described above.

Recommendations:

Two options should be considered in the replacement of the Project Administrator:

(a). The Project Administrator's position could be an A.I.D. direct hire who would have signatory authority. In this case, while the divisions of the Project would still be responsible to their respective firm contractors, the Project Administrator would be responsible for review and approval of subcontracts, thus controlling to a large extend how the Project functions as a whole. He or she would be able to represent A.I.D. and the Project, and thereby assure that USAID guidelines, administrative procedures, etc. are adhered to.

(b). The Project Administrator's position could be filled through a buy-in to an S&T/POP centrally funded project. There are several projects whose mandates include the management of family planning programs and whose resources include broad technical and managerial skills.

Besides the strengthening envisaged in the adoption of one of the above options, the office of the project administrator should be given a broader mandate and the financial and human resources to carry it out. The mandate would include:

- the responsibility for commodity logistics coordination through the provision of a full time logistics manager.

- the responsibility for MIS coordination of the public and private sector family planning divisions.

- spearheading the strategic planning aspects of the FHS program through

  * the development of a team approach to set directions for future activities.

  * the identification of present program constraints and development of strategies to overcome them.

  * the setting of realistic targets directly related to family planning delivery results.

  * the orchestration of multi-year strategies in the form of joint annual workplans of the FHS divisions which would assist in the development of resource allocation plans.

- the responsibility to increase the linkages between the FHS project and key Nigerian public and private sector individuals and institutions.

In the longer term, project administration and leadership should be shared with a Nigerian co-director. Different ways to implement this recommendation could be considered. Possibly the Nigerian director could administer the project with a U.S. contractor serving as chief project adviser or vice versa. In either case, both individuals should have strong technical and managerial skills with experience in and a commitment to family planning programming.

2. Issue: Approval of Nigerian subproject contracts

Currently all contractors require approval from the U.S. based office for all subprojects. One contractor has permitted the Lagos Division Director authority of up to $ 10,000. To date, over 175 subcontracts have been signed -- an enormous achievement knowing the difficulty in getting headquarters' approval for subprojects and then USAID approval. However, if FHS is to accomplish all its tasks within the present project period, quicker approval and implementation of activities is needed.

Although the present system, in theory, provides more fiscal control over funds, serious delays have resulted from both the time needed to negotiate back and forth between the Lagos FHS division office and the recipient, between the contractor headquarters and FHS division office in Lagos, and between REDSO/WCA and USAID/Lagos.

The 1989 evaluation report recommended that "USAID, REDSO and the contractors should establish guidelines on the approval of subcontracts that would facilitate their expeditious processing." Although the parties were sympathetic with the need for speeding up the contracting process, they could not figure out how to act upon this recommendation with the result that subcontracted activities remain slow.

Recommendation:

The recommendation dealing with the approval of subcontracts from the 1989 evaluation should be implemented. Guidelines may set limits on how long an authorizing body can take in the review and approval of any subproject; a system for facilitating the approval process may be instituted, such as, periodic visits by headquarters technical staff where all subprojects would be reviewed and finalized and carried back to the authorizing body for official approval, not further technical review; official sanction letters from USAID/Lagos when subprojects are not approved by contractors within a certain time frame may be considered; establishing a relationship with the Office of Population Cognizant Technical Officers for the contractors working in Nigeria and asking them to facilitate the approval process may be considered; and, more delegation of authority for subproject approval (including

signing authority up to a certain financial limit) to Lagos-based Directors should be instituted, as recommended in the 1989 evaluation.

3. **Issue: Personnel management**

Because of the design of the Project, FHS staff are subject to the salary schedule and benefits of the individual prime contractors and the restrictions placed on the contractors by USAID. Since the start of the Project, the economic situation in Nigeria has deteriorated and the salary of staff and benefits have not been adjusted. This has caused discontent among staff, particularly when adjustment in salary and benefits have been made in similar foreign assistance projects. There is a danger that some of the key staff may leave due to financial reasons. USAID/FHS has indicated that it would review the salary schedule and employment rules and regulation.

Recommendation:

The review of salary and benefits should be conducted as soon as possible and adjustments made to bring all FHS staff (from directors to drivers) on par with parallel positions in the private sector.

4. **Issue: Project Management Committee**

The FHS project has a standing Project Management Committee. It is a high level policy making body that has not been fully exploited to deal with strategic issues of how family planning in Nigeria can be advanced more effectively and quickly and how the FHS project might contribute. The newness of family planning and the FHS project may have diverted this committee's attention on strategic issues to try to solve some of the more mundane but important project management issues.

Recommendations:

The mandate of this committee and its membership should be reviewed by the government and USAID. It may be necessary to constitute two types of committees for overall management and strategic planning. One committee would deal with important management issues; the other would look to the future and begin to plan on how the family planning effort in Nigeria could be strengthened. The composition on the first committee may include Nigerian government, Nigerian universities, the private sector, FHS, USAID and A.I.D./Washington members who are very familiar with the FHS Project and the management issues that it faces.

The second committee might include representatives from the same groups and persons representing the international donor community and experts in family planning development. By having two committees, both important aspects of planning could be addressed: how the project can achieve the goals it has already set for itself, and what should be the next steps in advancing family planning in Nigeria, including the next phase of the FHS Project.

5. **Issue: More USAID and Office of Population Backstopping**

The FHS project is the largest family planning project that A.I.D. supports in Africa and there is no full time population officer backstopping it. Moreover, there are many other population and family planning related activities supported by A.I.D. that could be accessed by the Nigerian government, if there was more support by the USAID/Lagos. For example, operations research, voluntary surgical contraception activities, Norplant trials, DHS follow up are all population activities that are available and, in some cases, have been accessed that require USAID backstopping. In addition, AIDS initiatives and MotherCare are other important projects that require USAID backstopping.

In addition, the Office of Population has identified Nigeria as one of its priority countries for the provision of family planning assistance. As new opportunities for funding projects in the Africa region are identified, it will be important to have a S&T/POP staff member be knowledgeable about the Nigeria program. This person would become completely familiar with the FHS project and other population initiatives in Nigeria and be called upon to facilitate actions at A.I.D. and with contractors and donors to further population assistance to Nigeria.

Recommendation:

USAID should appoint a full time population officer in Lagos. In addition, it should request the Office of Population to designate an officer in the Office to backstop USAID's Nigeria population assistance program.

IV. PRIVATE SECTOR SERVICE DELIVERY

A. Background

In the design of the FHS project, exploiting the vibrant private sector in Nigeria for the provision of family planning services and commodities was seen as the critical intervention to raise prevalence quickly. No other country in sub-Sahara Africa has the private sector potential as Nigeria does, and therefore USAID and the Government of Nigeria took the bold step to develop a project that assigned major responsibility for family planning service delivery to that sector.

The prime contract to implement the private sector service delivery component was given to Family Planning International Assistance. Major subcontracts were developed with John Snow, Inc. and the Margaret Sanger Center.

To reach 70 percent of the 2.5 million family planning users targeted in the FHS Project Agreement, the FHS/Private sector service delivery component is charged with:

* providing $17 million of family planning commodities

* distributing contraceptives to 4,375 commercial outlets, 5,650 private health providers and service delivery sites, and 2,100 vendors, workplaces and associations

* conducting training of 4,000 pharmaceutical personnel, 1,000 vendors, and 2,100 nurses and doctors

* establishing a MIS for the private sector

* conducting technical assistance to Nigerian subcontractors

* working closely with the IEC contractor in areas of market research, family planning promotion and advertising.

B. Accomplishments

* At the third year mark, the number of commercial outlets served is above target, medical and other service delivery sites is on target, and the number of vendors, workplaces and associations served is below target.

* At the third year mark, the number of persons trained has exceeded the target.

* Market research has been undertaken and the "Right Time" commercial condom has been launched as a product of Sterling Products Nigeria.

The FHS private sector component must be credited for implementing a large quantity of highly diversified programs on a national basis within a three year period. There is no question that they have been able to achieve substantial accomplishments under very difficult circumstances.

Due to the length of time allotted, the **main** emphasis of the Private Sector Management Review was placed on the various retail sales programs: Sterling Products, the "Right Time" condom, and the PSI "Gold Circle" condom. Overall marketing and management issues were reviewed and analyzed. The major issues that were noted, and recommendations follow.

C. Issues and Recommendations (See Appendix B for a more detailed discussion of these issues as well as other Private Sector issues)

1. Issue: Sterling's commitment and interest in marketing and distributing a commercial line of family planning products

Sterling Products Nigeria is one of the leading manufacturers and distributors of over-the-counter pharmaceuticals in Nigeria. Assisted by FHS, it has recently launched a mass media advertising campaign for packaged "Right Time" condoms and has distributed the product through its system nationwide. This has been a major achievement of the FHS/Private Division working with Sterling.

Sterling does not plan to immediately continue with commercializing pills and VFTs as originally planned by FHS. Their reasons are the following: (1) Sterling does not want to proceed with a new marketing campaign for a contraceptive commodity until it can evaluate the success of "Right Time" condoms after a full year of sales. (2) Sterling is worried about possible law suits arising from the use of products such as the oral contraceptive; (3) Sterling does not manufacture or market any contraceptive products anywhere in its worldwide system : these products are not within its usual product line or "corporate mandate".

Sterling may be willing to proceed with commercial marketing of other contraceptive products if the product indemnification issue can be cleared up to its satisfaction and if "Right Time" is commercially successful. However, the earliest it would make a decision on commercially launching any other product would be in one year, and it would then take 8 months to a year to develop packaging, advertising, etc., making the launch of the pill occur approximately May, 1993.

The relationship with Sterling is an extremely important cornerstone of the Private Sector efforts of FHS. FHS/Private Sector is to be commended for establishing and nurturing this relationship over a number of years. Beyond the significance of the commercial sales in this program, the Sterling relationship is vitally important for the nationwide distribution of the public sector commodities (see Chapter VII). There is little question that Sterling, as one of the two largest pharmaceutical manufacturers/ distributors in Nigeria, with 12 regional warehouses, is certainly one of the most able firms in the country to provide this service.

Recommendation:

USAID and FHS should take the initiative to fully discuss the above situation with Sterling and decide whether Sterling should be used at this time for commercial marketing of pills.

2. **Issue: Social marketing vs. commercial marketing**

There is also concern that Sterling's approach to market other contraceptive products would follow the same commercial strategy as the "Right Time" condom -- focussing on A and B consumers (those who can pay higher prices for commodities) rather than consumers at the lower end of the economic scale.

Recommendation:

Due a shortage in existing commercial contraceptive products, there is room for both commercial level products as well as subsidized social marketing products.

In addition to Sterling's activities, USAID should expand the availability of social marketing products.

3. **Issue: Alternative means to commercially market and distribute contraceptive products.**

As stated above, the willingness of Sterling to take on other contraceptive products is still in question. In terms of expediting the commercial marketing of the oral contraceptive, and VFT, if desired, Sterling's Managing Director did not express any objections to another firm or firms marketing these products.

FHS/Private is already working with another organization and distributor in marketing condoms, Population Services International (PSI) and PHARCO, a Nigerian pharmaceutical distributor. PSI/PHARCO operate a contraceptive social marketing project in five states in Zone B, through the Society for Family Health. In 1990, this project sold 1.133 million "Gold Circle" condoms to CDEF consumers. PSI would like to expand its marketing program to include oral rehydration solution and oral contraceptives. Besides, PSI/ PHARCO there may be other firms that could be considered for social marketing of contraceptives in Nigeria; however, the management review team did not have to identify other leads during the length of its stay.

Recommendations:

USAID should consider additional support to PSI beyond the provision of free condoms (presently through 1991 only). PSI appears committed to the principles of social marketing and could provide an additional means of distribution for a packaged pill, as well as other products. With some subsidies, the marketing staff and breadth of the program could be increased. This warrants further discussions between USAID, FHS and PSI.

A review of other pharmaceutical manufacturers/ distributors to ascertain their ability and willingness to market contraceptives would be beneficial.

4. **Issue: Administrative, technical and managerial deficiencies**

Examples of problems in administrative and technical backstopping include: (1) memorandum of understanding between Sterling and FPIA has not been signed by FPIA, even though Sterling has already committed itself by signing it October 1990. (2) Failure to respond in a timely manner to Sterling's request for clarification on product indemnification. (3) The Sterling "Right Time" advertising campaign, paid for by FPIA, was not pre-tested, while pretesting was in the original workplan. (4) Failure to respond in a timely manner to PSI's request for information from Ansell, so that PSI could receive approval from the Nigerian FDA in order to begin their advertising campaign for the "Gold Circle" condom. (5) Providing CPTs six months late.

The low results in terms of CYP through the private sector initiatives to date have been documented in Chapter II. The prospects that great strides can be made in increasing CYP in the private sector in the remaining project period are not bright. This is due in some degree to the lack of strategic planning by FHS/private sector in a number of areas.

For example, FHS/Private Sector's 4th year work plan states that for 1 million cycles of pills and 1 million vaginal foaming tablets would be sold, based on the assumption that both would be commercially launched in the same manner as the "Right Time" condom. Without a major marketing campaign for both, it would not be reasonably expected that sales in the 4th year for pills could reach this goal taking into account that in the 2nd and 3rd years, 225,000 and 580,000 pills were sold by Sterling. For VFTs, it is unrealistic taking into account that only 454,000 have been sold over the period April 1988 through March 1991. Another example of lack of strategic planning is FHS/Private Sector's plan to end the advertising subsidy for "Right Time" condom at the end of two years, which corresponds to when the FHS program ends at the end of 1992. Sterling's 4 year plan calling for the advertising and product purchase subsidy to end at the end of year 3, in 1994, when the FHI/Private Sector program ends at the end of 1992. Sterling's pricing and profit projections are based upon a 3 year amortization of costs. If subsidies were to end in the second year, it would cause Sterling to increase the wholesale price of "Right Time" by an even greater yearly amount.

Recommendations:

USAID should take immediate steps to bolster the technical backstopping and the technical assistance provided in marketing to FHS/Private Sector Division.

Streamlining of administrative, managerial, and financial procedures between FPIA headquarters and the FHS/Private Sector Division should be initiated as soon as possible.

4. **Issue: Method mix**

Besides the issue raised previously concerning the commercial marketing of pills, other changes in method mix for commercial products must be considered. By all accounts, injectables are in high demand in both the public and private sector; however, there is a lack of supply. As discussed in Chapter VII, UNFPA, the major supplier of injectables is in the process of ordering one million units. Private sector distributors working with FHS could buy injectables from UNFPA at a reduced cost (in dollars, landed duty free) for commercial distribution. This might be one option for getting this popular commodity into the Nigerian marketplace.

While USAID cannot directly purchase injectables, an A.I.D. program can support the promotion and sales of injectables through advertising, production of IEC materials, etc.

The vaginal foaming tablet is the opposite case. It is not a popular method; it is expensive ($10.40 per CYP), and sales have been very low, an average of 151,000 units per year over 3 years.

Recommendation:

The VFT should be dropped from the FHS/Private Sector program and FHS should make every effort possible to add an injectable to the private sector program.

V. PUBLIC SECTOR SERVICE DELIVERY

A. BACKGROUND

The Public Sector family planning component of the FHS project was contracted to the Pathfinder Fund as the major contractor. Medical Sciences for Health (MSH) Africare, and International Health Programs (IHP) were contacted by Pathfinder to assist in carrying out project activities. The main objectives of this component are to:

* expand and improve the public sector family planning services throughout Nigeria;

* strengthen the capacity of Nigerian institutions and personnel; and,

* put management systems in place to conduct the public sector family planning program.

Specifically, the component is responsible for

. equipping a total of 1,000 clinics for clinical FP and another 2600 for non-clinical FP services.

. supporting the training of over 5000 persons that include village health workers, nurses, midwives and doctors; and in addition to the training related to health delivery,

. supporting the training of over 800 LGA, State and Federal planners and managers in planning and supervision.

. providing necessary support to the FMOH in developing standard curricula and standard orders for delivery of services throughout Nigeria. These are developed for all levels of health practitioners and for all levels of training from VHWs to medical students and doctors.

. Moreover the component is also responsible for assisting the FMOH in developing a management information system that permits it to monitor the family planning program.

B. Accomplishments

Establishment of FP Clinics

By the end of 1990, the component has established a total of 374 FP clinics through its subcontract with Africare who was contracted to deliver 500 sets of FP equipment to appropriate clinic sites. Africare is now about to commence the phase four of its contract which will enable it to distribute the remaining sets of equipment before the end of 1991.

It is worthy to note that Africare sources about 60 percent of its equipment locally and it also provides, where necessary technical assistance to these local manufactures in the areas of design, finishing details and packaging. Secondly, Africare involves the Federal Ministry of Health and state ministries of health officials in the clinic survey exercises thus providing the states with relevant skills in clinic assessment.

Training

One area where the effort of the FHS project is readily acknowledged by both Federal and State officials is the area of training. The public sector planning family component had, by the end of 1990, provided the following types of training:

- Training of tutors and trainers: 271 out of a target of 350.
- Clinical and non-clinical training: 2440 out of target of 3500.
- Refresher courses for physicians,
  CHEW and VHW: Yet to start.
- Management Training: 1262 out of 2094
- Specialized US-based training: 9 out of 24

The provision of 271 tutors and trainers and 58 network trainers in FP management has put into place a pool of trainers which the states now utilize to provide their own training often without further reference to he project. The multiplier effect of this training input is thus just beginning to be seen.

Development and standardization of curricula

Through the support provided by the public sector family planning component, FP has now been incorporated into the curriculum for the schools of midwifery nationwide while the same exercise is in progress for the schools of health technology. Similar exercises for nursing and medical schools have been initiated. The significance of these exercises is that by the time the processes are completed, all the trainees coming out of all the health institutions in Nigeria - doctors, nurses, midwives, and CHEWs would have had training in FP thus reducing the future needs for extensive in-service training in clinical and non clinical skills. Moreover, considering the reluctance and resistance often met with when training curricula of established institutions are being amended, these "breakthroughs" are no mean achievements.

In addition to these, in-service training curricula for clinic service providers, CHEWs and VHW's are virtually completed. Service protocol and standing orders which will serve as reference materials for CSPs are also almost completed.

Management information system

This component has completed the development of the MIS forms, the MIS training manual and has also supported the printing of an agreed quantity of the various forms for the FMOH. Areas of disagreement on the utilization of the forms are being resolved.

C. Issues and Recommendations

1. Issue: Establishment of FP clinic

The FHS/Public is for to establish 1000 clinics equipped for comprehensive FP information and clinical services and another 2600 developed for non-clinical services. However, the Public Sector's contract with Africare is for only 500 sets of equipment for clinical FP services. The FHS/Public Sector workplan for year 4 indicates that 750 sets of equipment will be supplied while Africare only intends to supply the outstanding 125 sets, or so, during its phase IV activities. There is thus an outstanding 500 sets of equipment to be provided by FHS/Public Sector.

Meanwhile, PPFN has received requests formally to set up family planning clinics in their areas. The LGAs would provide the needed space while PPFN was to provide the basic equipment for clinical and non-clinical family planning. PPFN has in turn passed this request to the FHS project.,

Recommendation:

FHS/Public Sector should take immediate steps to extend its contract with Africare for the supply of the other 500 sets of equipments. These should then be supplied during the remaining part of the project's life-span to those parts of the country that have been shown by the DHS survey and the surveys undertaken by Africare to be ready for more service delivery points. The LGA clinics mentioned above should get priority in such equipment placement as long as they meet the set criteria.

The present lead time of 10 to 14 months between clinic assessment and actual placement of equipment should be reduced to about 3 - 4 months. This can be achieved by providing the states with criteria for placement based on the experienced obtained from previous surveys.

2. **Issue: Training**

While it is true that the training support provided by the public sector is readily appreciated by the states and also constitutes an essential part of most of the ongoing state projects, the emphasis on the type of training should now reflect specific needs for each part of the country. The NDHS report, the MIS returns have all shown that while the A and B zones already have a receptive audience among the women of reproductive age, the C and D zones would still require more awareness efforts to make them sufficiently receptive.

Recommendations:

Using the geographic focus approach discussed earlier, the training in a state in C or D zone could focus more on IEC and outreach activities for example while A and B zones focus on refresher courses for their earlier generations of trained FP providers. This should be without prejudice to other ongoing training programs nationwide.

3. **Issue: Management information system**

As the FHS project continues to assert itself as "the source" of FP information in Nigeria, the MIS developed by the public sector component has become the only tool available for obtaining the total picture of the FP situation in the country in the public sector. It therefore becomes necessary that the system be continuously supported and fine-tuned.

Recommendations:

Any area of disagreement between the MIS forms and the PHC forms should be quickly resolved as both systems complement each other.

The "Trouble Shooting Team" approach should continue to be supported by project funds and while efforts to transfer these skills to the federal technical facilitators continue, the Trouble Shooting Teams should be retained at least till the end of this project.

The state fact finding exercise being carried out by the policy component with MIS returns from the public sector should continue but with those states likely to be selected for geographic focus being given the priority. The findings should then form the principal tool for the states strategic planning and are more likely to improve not only the prevalence of contraceptive users but also the quality of the services being provided.

4. **Issue: Commodities**

The general shortage of commodities being experienced in the public sector facilities have earlier been mentioned. These shortages affect mainly the pills, and injectables - Depo provera and Noristerat (supplied by the UNFPA). The usual method of replenishing stock by any clinic with shortages is as follows:

STATE CLINIC

(Request)

STATE FP COORD

SPNL ZONAL PATHFINDER LAGOS

STORE

(Re-supply)

SPNL LAGOS FPIA - LAGOS

The long chain allows for many potential areas of bottlenecks and delays.

Recommendation:

While still retaining the SPNL distribution network, the proposed renovation of the Zonal and State stores should be commenced without further delay. This could be started for example with zone A that is said to be ready for this intervention. Commodities from SPNL central warehouse in Lagos can then go directly to these zonal warehouses from where they can be distributed by zonal officers or Federal Zonal Officer as the case may be to the state stores. The re-ordering pattern under such a system would then be as follows.

STATE/LGA CLINIC

STATE FP COORD

PHC ZONAL OFFICE SPNL LAGOS

Operations research on how the public sector distribution of contraceptive works in Zone A should be a priority. The finding will help to determine the feasibility of separating completely public/private distribution of contraceptives in the long term.

5. Issue: Future Trends

The public sector is, and will continue to be important provider of family health services in Nigeria especially in the rural parts of the country where the majority of the population still live and which understandably do not hold much attraction for the private sector. For this reason, the GON will continue to seek support for this sector of the health system.

The entire $70m loan being negotiated by the Federal Government from the World Bank will be to support the public sector, the $30m country program being proposed by the UNFPA for Nigeria will have a substantial part of it going into the public rural health services and the European Development Fund being provided for Nigeria under the Lome IV convention have all been converted to grants. This is yet another potential source of resources for the public sector health and family planning programmes. (see Chapter II on marshalling resource for family planning).

Chapter VI. POLICY AND EVALUATION

A. Background

The objectives of the Policy and Evaluation Division (PE) as well as the name of the Division have changed over time. According to recent Project documents, the objectives are to strengthen the capacity of the public sector and encourage the private sector to develop policies, strategies, and action plans at the national, state and selected LGA levels; to strengthen the indigenous planning process; to develop positive support from influential and constituency groups; and to support innovative short-term, inexpensive evaluative strategies from documenting policy and program acceptability.

The PE Division began work in early 1989 and has a four year contract. Johns Hopkins University/IIP is the major contractor of this component. It is more difficult to assess the contribution of the PE Division than the other components of FHS. The Management Review Team did not receive documentation of accomplishments and impact from JHU/IIP. Thus it is especially difficult to evaluate the effectiveness of JHU/IIP's contribution to policy change in Nigeria. The team did receive a list of outputs from FHS staff in Lagos and a memo on the prospects for achieving the original targets established for Policy.

B. Accomplishments

Over the first two and a half years, the FHS Policy and Evaluation (PE) Division and JHU/IIP'have:

. Provided equipment, training and technical assistance to the Department of Planning, Research, and Statistics and the Department of Population Activities

. Worked with the FPCs and state policy makers to plan future strategies for expanding family planning

.Supported a financial diagnostic study in four states

.Supported a survey of the budgetary process in six states

.Provided institutional support to the National Council for Population Activities

.Developed and pretested a family planning questionnaire to be included in a periodic national household survey

. Supported fact-finding missions in six states. Reports are under preparation

. Completed a Client Record Survey in Oyo State. Preliminary report available May 1991. This survey can serve as a model for other states

. As part of constituency building, conducted workshops for policymakers and other influential individuals, public lectures, and a newsletter

. Organized a Further Analysis Group of Nigerian Researchers who are qualified and available to do secondary analyses

It was not possible to determine whether the work of the Division has changed either the Nigerian population/family planning policy environment or policy implementation. It appears that the focus of Policy has been more on population policy than on practical issues of implementation of family planning services.

C. Issues and Recommendations

1. Issue: Quantity and quality of work

The Division has a very small staff at FHS but a very large number of activities. There is a danger that these activities may be too scattered and with insufficient follow through. For example, six Fact Finding Mission Reports are being completed, but will the findings be widely disseminated in each of the key states and to other interested parties? Will the client record survey done in Oyo State be replicated elsewhere?

The quality of some of the products could be improved. Figures did not add up in the state target document and the first client record survey report was muddled.

Recommendation:

The Division Director, JHU/IIP and the Project Administrator should prioritize current activities for the next eighteen months and not take on new tasks.

2. **Issue: RAPID presentations**

The PE/JHU/IIP contract is supposed to complete RAPID-type cost-benefit models of FP in Nigeria, adapted for critical audiences. Some initial work has been done by staff of JHU. The local institution identified to do the adaptation was NISER. A proposal to complete the work by NISER to JHU is prohibitively expensive. At this point, the work has bogged down.

Recommendation:

The Futures Group has been asked by USAID to visit Nigeria and adapt the RAPID model to include newly available Nigerian data such as the NDHS. If this approach is taken rather than having JHU finish the job, there should be some attempt to build upon the previous work of JHU (Siralgedin and Zhao) and the collaboration with NISER, incorporate the recent Nigerian data, and make the presentations appropriate for the different audiences in Nigeria.

3. **Issue: Family Planning Questionnaire**

The original plan was to have the FOS administer, as part of the government's periodic household survey, a family planning module every six months. This may not be feasible since FOS is asking for a large sum of money to collect these data in only a single survey.

Recommendations:

PE should arrange with FOS to have one survey contain the current FPQ during the current FHS Project, preferably in mid to late 1992 so that data can be analyzed and presented by mid-1993. The government could be asked to cost share this activity as part of its contribution to FHS.

In order to get routine information on family planning, a shorter version of the FPQ could be designed which would obtain the bare minimum of information to evaluate the progress of FHS in meeting its targets (knowledge of FP method, plus the information on the FP Client Record form plus source of supply). FOS could be asked to include this in future surveys.

4. **Issues: Constituency-building activities**

In the coming 18 months, many constituency building activities will take place: 82 seminars/community level meetings mostly in the Northern states (PPFN), regional 2-5 day workshops for 240 women leaders (Nigerian Association of University Women); national 3-5 day workshops for 420 leaders of the uniformed forces and the Nigerian Medical Association; workshops for 300 federal, state and LGA planners; two annual strategic planning meetings with the FPCs; and state level cost benefit seminars for 200 key financial leaders.

Given the very limited staff of the Policy Division, one wonders how it will be possible to do all these constituency building activities during the next eighteen months. It may prove to be difficult to convey appropriate, accurate and practical information to so many groups.

Recommendation:

Every effort should be made to develop practical goals, supportive of FHS and the expansion of family planning services, for these constituency building activities. For example, meetings of the Nigerian Medical Association would provide a good opportunity for contraceptive updates, presentations of NDHS data, updates on sterilization services' and Norplant in Nigeria, and results from Fact Finding Missions, and the FP Client survey.

5. **Issue: Making use of the Nigerian Demographic and Health Survey**

The Further Analysis Group (FAG) is available to prepare policy relevant analyses from NDHS if they have the opportunity and receive some technical assistance, and in some cases, equipment.

Recommendation:

Selected FAG members should be commissioned to do policy relevant analysis of NDHS. JHU/IIP, NDHS, and FOS could all be involved in this activity with FHS/Policy doing the coordinating. The end product would be papers and slide presentations to be given at a national seminar (with possibly regional activities to follow) in late 1991.

6. **Issue: Dissemination of information**

As PE produces more finished products (i.e. Fact Finding Missions, Client Record Survey Report, secondary analyses of NDHS), the issue of dissemination becomes more important. There will also be a need to disseminate information on FHS as a whole which JHU/IIP might help with.

Recommendation:

A PE staff member or consultant be asked to prepare appropriate mailing lists and oversee the distribution of PE papers to the relevant audiences.

7. **Issue: Policy impediments to family planning service delivery**

There are many unresolved practical policy issues including customs, FP advertising, essential drugs, and responsibilities of nurses. The Policy and Evaluation Division has not focussed on these important practical issues. One mechanism for resolving these and related issues would be to use a Non-Project Assistance mechanism rather than including this in the mandate of a policy component in a future project.

Recommendation:

Non-Project Assistance should be applied to solving practical policy issues which are impeding family planning service delivery in Nigeria.

Chapter VII. COMMODITY LOGISTICS AND SUPPLY

A. Background

Currently, FHS/Private (FPIA) has the primary responsibility for commodity logistics. This responsibility includes forecasting of commodity needs, procurement, shipping, distribution, monitoring of storage facilities (condition and supply),and responsiveness to requests for resupply. These requests originate from all components of FHS/Public and FHS/Private sector projects including Sterling Products and PSI Gold Circle CSM Program. FHS/Private must ensure that all products arrive in a timely manner in Nigeria.

Actual product distribution to both the public and private sector program's outlets is provided by Sterling Products Nigeria, a U.S. owned subsidiary, and one of Nigeria's largest and most successful pharmaceutical manufacturers and distributors. Under the present memorandum of understanding (effective 11/1/90-12/31/91), Sterling will distribute public sector contraceptives at no cost to the project, for the Government of Nigeria as a "corporate citizenship activity". This is provided through the Sterling central warehouse in Lagos and twelve regional warehouses.

The total FHS budget allows for $ 16 million dollars for the purchase and shipment of family planning commodities. This figure excludes personnel, overhead, monitoring and expenses associated with the Management Information System (MIS). From March 1988 to date $ 5.2 million dollars worth of commodities have been procured for the FHS project. This amount comprises the following units shipped to Nigeria to date:

- 42.3 million condoms
- 396,000 IUCDs
- 5.9 million oral contraceptive cycles
- 5.4 million vaginal foaming tablets

Additionally, this $5.2 million expenditure includes the following inventory present in the FPIA warehouse New Windsor, Maryland:

- 24.9 million condoms
- 223,000 IUCDs
- 1.2 million orals
- 1.7 million foaming tablets

Commodity Chain

The following list gives the flow of commodities:

1. **FORECASTING:** Forecasting is done by FHS/Private and FHS/Public based on requests made and past usage

2. **FPIA --- ST/POP/COMMODITIES (PROCUREMENT)**
Contraceptive procurement tables (CPTs) prepared by FPIA

3. **SHIPPING TO FPIA** (New Windsor)

4. **SHIPPING TO LAGOS:** Requires 6-8 weeks

5. **STERLING CLEARS GOODS ---- TO CENTRAL WAREHOUSE LAGOS**

6. **STERLING ZONAL WAREHOUSES**

7. PUBLIC

STATE WAREHOUSE

Shipments based on monthly sector (Commodities request form) which are submitted by FHS/Public to FHS/Private

PICK-UP BY F.P. COORD.

DELIVERY TO SERVICE DELIVERY POINTS

PRIVATE

DELIVERY TO SALES POINTS

Sterling generates requests summaries and public or NGO's, hospitals, etc. will make request directly to Sterling
OR

PROJECT PICK-UP

B. Accomplishments

. Sterling has provided an excellent network of warehouses, distributors and commercial outlets for family planning commodities

. As part of their "corporate responsibility" program, Sterling operates the public sector commodities distribution system at no cost to the Project

C. Issues and Recommendations

It is quite clear that the FHS program's varied efforts have successfully stimulated interest in and use of family planning, that demand is on the rise, and that clients are willing to pay for these services (even in the public sector).Now that demand is growing, there could be serious consequences to weaknesses in the supply chain. The management review team found a serious shortage of some commodities which was evidenced both in Lagos and on the field trip to Kaduna and Plateau States. This commodity problem could have the following consequences:

. As has occurred in Zimbabwe, the prevalence could rise without the concomitant reduction in fertility due in part to use that is not continuous

. Unwanted pregnancies leading to abortion

. Women being compelled through necessity to use methods of contraception which are not their first choice

. general discrediting of the family planning program

A significant number of problems have existed, and continue to exist in the procurement and distribution system within the FHS project. In order for FHS to achieve its objectives and goals, these problems must be rectified. A discussion of possible sources of the supply problem with appropriate recommendations follows.

1. **Issue: Forecasting**

As one of its activities, FHS/Private is responsible for "continuous determination of the quantities of contraceptives and other family planning equipment required for project implementation in both the private and public sectors on the basis of review and analysis of the private sector MIS, and preparation of contraceptive procurement tables and documentation for contraceptive procurement." Contraceptive procurement tables (CPTs) for 1991-2 were submitted six months late despite repeated requests from the AID/W division responsible for contraceptive procurement. The widespread shortages of the Lo-Femenal oral contraceptives indicates a serious problem in the timing and accuracy of these projections.

2. **Issue: Monitoring and tracking**

It is also FHS/Private's responsibility to undertake "improvement of contraceptive and family planning equipment storage, inventory control and monitoring systems....so that orders can be tracked continuously and shipments can be traced quickly." There were critical supply problems noted in a February 1990 report "USAID/Nigeria Family Planning Commodity Inventory and Distribution Analysis" which presents the results of visits to all 21 states plus Abuja. The absence of oral contraceptives (LoFemenal) was reported in nine states.

The management review team's visit to Kaduna, Zaria and Jos found a severe shortage of public sector pills (Lo-Femenal) to the extent that there was no stock in any warehouse visited and almost no supplies in the clinics. There are presently only 44 cartons of Lo-Femenal in the Sterling/Lagos central warehouse. This specific pill shortage has existed for some time. A continuous and regularly scheduled review of stocks in hand, with appropriate reporting and timely resupply requests would alleviate this problem.

Recommendations:

Emergency arrangements should be made to replenish the supplies of oral contraceptives. USAID/Lagos should inform the ST/POP Commodities division of the situation and the need for an immediate shipment of LoFemenal

USAID (Director, Office of Population) should inform UNFPA/NY of the absence of injectables in the public sector clinics and request its urgent assistance in supplying injectables. Another potential source of injectables is the Government of Nigeria.

FHS is considerably underspent on the commodities allocation (which is approximately 25% of the AID contribution) and should start programming its contraceptive requirements as planned so that there will be a three month supply of contraceptive supplies in the clinics and a six month supply in all storage (warehouse) facilities)

3. **Issue: Leakage of public sector goods into private sector**

A possible contributing factor to the public sector supply shortages is the leakage of commodities into the private sector. During visits to retail outlets it was noted that public sector pills were available for sale. While efforts have been made to reduce this problem, present realities may make it difficult to totally eliminate this problem.

Recommendation:

FHS should systematize its monitoring of pharmacies and other retail outlets to ascertain the degree of leakage and establish trends. The results of this monitoring may provide the basis for changes in commodity accountability.

4. **Issue: Public sector distribution arrangement**

During a meeting with top management of SPN, they noted that incoming commodity shipments have been erratic over the length of the program. They further noted that at various times they are out of stock on certain items for as long as three months, and regularly reported this to FHS/FPIA New York. They stated that (a) since they did not have the authority to order contraceptives directly and (b) their first concern was with their own distribution of commodities, that the public sector commodity products were on shorter supply than the private sector products.

Logistics problems extend to the zones. The zonal coordinators for the public sector do not have vehicles; this clearly hinders their ability to effectively monitor, track and deliver supplies to the public sector service delivery points.

Recommendations:

Various options should be considered to facilitate public sector distribution of commodities:

. More oversight is needed by FHS administrator of public sector commodities in the Sterling warehouses

. With FHS funds, Sterling could employ a public sector storekeeper

. FHS should consider an arrangement in which SPN is paid for the distribution of the public sector commodities. This would provide the needed incentive for more oversight of and responsiveness to commodities logistics and the concomitant needs of the project.

Vehicles should be purchased for zonal coordinators as soon as possible

5. **Issue: Overall responsibility for commodity logistics**

In view of the importance of a good commodities logistics program, the fact that there are problems with the Nigeria program is of gravest concern to the management review team. There have been persistent and considerable difficulties in logistics management over the length of this program. There are lessons to be learned from the excellent technical assistance that USAID has provided in commodity logistics in various programs around the world.

Recommendations:

A new commodities logistic contractor should be chosen by AID who has a proven track record in logistics management.

Additionally, a full-time logistics manager should be appointed and should report to the Project Administrator or appropriate AID mission personnel

AID should consider whether a short- or medium-term mission by a logistics management expert could serve in the interim while the two recommendations above are being arranged.

CHAPTER VIII. STRATEGIC PLAN FOR FAMILY HEALTH SERVICES PROJECT

The attached, pull-out table summarizes the main recommendations of this management review. The table is divided into three phases: until the end of 1991; from January 1992 to December 1993; and, a new project starting in 1994. The main recommendations are listed by management, service delivery, policy and other.
Some recommendations in the next six months have been starred to point out the urgency of initiating these particular items.

STRATEGIC PLAN FOR FAMILY HEALTH SERVICES PROJECT

	PHASE I (5/91 thru 12/91)	PHASE II (1/92 thru 12/93)	PHASE III NEW PROJECT - 5 YEARS
MANAGEMENT	.extension of project completion date	.establishment of strategic planning/management unit	.Planning/coordination
	.reconstitute project management committee	.broader mandate for new project administrator	.Nigerian co-director
	.review salary/benefits for all FHS staff	.move toward functional roles	.Donor coordination
	.appoint pop officer for AID/Lagos	.upgrade zonal offices to assist states and LGAs	.Non-Project Assistance
	.appoint ST/POP backstop	.geographical focus	
SERVICE DELIVERY	."emergency" commodity relief	.focus on service delivery targets (CYPs; users)	
	.renovation of zonal and state stores	.support to AVSC/FHI for long-term and permanent methods	.AVSC/FHI part of FHS .separate CSM Project
	.vehicle purchase for zonal coordinators	.marketing TA to FHS/Private	
	.monitoring of retail outlets for leakage	.support to PPFN and PSI	
	.extension of contract w/Africare	.continuation of trouble-shooting team	
	.removal of VFT from private sector .resolution of MIS forms	.improve reporting system in public and private	
	.oversight of public sector commodities distribution	.reprogramming of commodity requirements and $	
POLICY	.TARGET and RAPID analysis	.prioritize current activities .secondary DHS analysis . survey containing FPQ	.Non-Project Assistance to encourage policy changes
OTHER	.short TDY by commodities logistic team	.full-time commodity logistics manager .new commodities contract	

Appendix A

Scope of Work

Appendix A

Scope of Work

Scope of Work for Management Review of the Nigeria Family Health Services Project

The objectives of the management review are to: 1) determine the degree to which the project has or will achieve its purpose, 2) assist the FMOH and USAID to determine if the project should be modified in way at this mid-point in order to meet the project's purpose, and 3) provide guidance to the FMOH and USAID on future directions for A.I.D. - funded family planning assistance of Nigeria. The 1989 evaluation will serve as the baseline document for the management review. Since so little time has elapsed since that evaluation, another evaluation of the project was not considered necessary at this time.

To fulfill these objectives, the management review will

a) assess the present project status, in terms of CYP, numbers of new acceptors, sales figures from CSM, and commodity logistics records. The recent DHS survey results will also be used in this assessment.

b) assess the progress made in the implementation of the recommendations from the December 1989 evaluation. In cases where the recommendations may not have been implemented or where implementation has not proceeded as quickly as anticipated, the management review will ascertained why, if the situation still warrants action, and what actions should be taken.

c) assess particular project subcomponents and strategic issues that were highlighted in the 1989 evaluation. These project subcomponents and strategic issues are:

d) - Program approach: the adequacy of the overall program approach and its implementation in marshalling project resources and those from other USAID projects and donors and the Nigerian government to carry out activities required to raise contraceptive prevalence. Issues to be examine include expansion of coverage, method mix, sustainability.

e) - Program management: the planning, administration, monitoring and evaluation of the program and the coordination of the program's component parts and the contractors carrying them out. Issues to be examined also include USAID/FHS/Government relations.

f) - Private sector service delivery: the prospect that currency efforts in the social marketing of contraceptive will meet FHS goals and will lay the foundation for a sustaining commercial contraceptive program.

g) - Public sector service delivery: the prospect that current efforts working with PHC Department of the FMOH, state ministries of health, and LGAs will meet FHS goals and will lay the foundation for a sustaining family planning focus in the programs of those authorities.

h) - Policy Implementation: the progress made in strategic planning, fiscal support, institutional support and program evaluation and feedback. Issues to be examined include the linkages between the public and private sector project components and the policy implementation component in regard to policy initiatives undertaken by the project. (The 1989 evaluation could not document progress made in these areas since the policy component had only begun activities a few month prior to the evaluation).

i) identify the critical issues that need to be addressed by the Government of Nigeria and USAID during the remaining project period in order to accomplish the goals of the FHS project. Guidance to USAID and the Government of Nigeria on whether, and if so under what conditions and how, further USAID assistance to family planning should be provided.

Composition of Mangement Review Team:

John McWilliam, Technical Director, Population Technical Assistance Project (team leader).

Harriett Destler of the Family Planning Services Division of the Office of Population, Bureau for Science and Technology of A.I.D.

Wale Shobowale, Executive Director, Transcon Associate.

Douglas Wear, an independent consultant.

Nancy Williamson, Director of Program Evaluation Division, Family Health International.

Pamela Wolf of the Research Division of the Office of Population, Bureau of Science and Technology of A.I.D.

Methodology of the Management Review:

The team met for two days in Washington, D.C. to be briefed by A.I.D., the major contractors of the FHS project, and the DHS staff responsible for the Nigerian Demographic Health Survey.

Upon arrival in Lagos, the team met with USAID, the FHS Project Administrator and senior staff of the Project. Interviews were held with FHS Project staff, Nigerian government officials at the federal level (Federal Ministry of Health), at the state level (Ministries of Health in Plateau and Kaduna), and at Local Government Authority level (Kaduna and Zaria LGAs), persons involved in family planning and primary health care at university teaching hospitals (ABU and Jos), representatives of major family planning/ health NGOs (PPFN, AVSC, NCPA), and persons in the private sector who are cooperating with the project (Sterling Products Nigeria, PSI/PHARCO,Associated Markets). The list of individuals contacted is attached.

The FHS Project provided the team with many of the materials it has produced and summaries of its achievements.

USAID and FHS staff facilitated the team's visit, providing the team with logistics support and secretarial help. The team is grateful to USAID and FHS for their assistance and is appreciative to the time and hospitality given to the team by Nigerian officials and persons interested in family planning in Nigeria.

List of Persons Contacted

AID/Washington

Mr. Henry Merrill, Former AAO AID/Lagos
Ms. Betsy Brown, ST/POP/FPSD

Washington/Others
Mr. James Cotter, Facilitator

USAID/Lagos

Mr. Eugene Chiavaroli, AAO
Mrs. H.O.Shitta-Bey, Program Officer
Mrs. Sandy Ojikut

US-Based Contractors

Mr. James Crawford, The Pathfinder Fund
Ms. Connie O'Connor, Family Planning International Assistance
Dr. Stella Goings, Institute for International Programs, JHU
Dr. Phyllis Piotrow, Center for Population Communications, JHU
Mr. Jose Ramon, Population Communications Services, JHU
Ms. Susan Krenn, Population Communication Services, JHU
Dr. Henry Mosley, JHU/IIP

Family Health Services Project Staff

Dr. Richard Sturgis, Project Administrator
Ms. Elizabeth Lule, Data Coordinator

IEC:
Mr. Kim Winnard, Country Representative, PCS/JHU

Policy and Evaluation:
Mr. Akin Akinyemi, Country Representative, IIP/JHU

Public Sector:
Dr. Victor Oluyemi, Country Representative, The Pathfinder Fund
Mr. Mike Egboh, Program Officer, The Pathfinder Fund
Ms. Bola Lana, Training Officer, The Pathfinder Fund

Private Sector:
Dr. Uche Azie, Associate Regional Director, FPIA

Federal Ministry of Health

Prof. Olikoye Ransome-Kuti, Honorable Minister of Health
Dr. S.K. Gyoh, Director General
Dr. O.E.K. Kuteyi, Director, Department of Population Activities
Dr. P. Otti, Deputy Director, Department of Population Activities

Dr. A.A.O. Sorungbe, Director, Department of Primary Health Care
Dr. Patrick Okungbowa, Deputy Director for Operations, PHC
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Dr. Kayode Oyegbite, Special Assistant to the Minister

Non-Governmental Organizations, Lagos

Dr. B. Sulaiman, Director, Planned Parenthood Federation of Nigeria
Dr. Adetunji, AVSC
Mr. Layi Jokotoye, Chairman, NANNM
Dr. U.U. Esiet, Project Director, Excel Clinics
Ms. Tina Brown, Project Coordinator, EKO Hospital

United Nations Population Fund
Dr. Alphonse McDonald, Country Representative
Dr. Babs Sagoe, Senior Programs Officer

The World Bank
Dr. Esther Boohene, Sr. Population Specialist
Dr. David Radel, Sr. Population and Health Specialist

Commercial Organizations

Sterling Products (Nigeria) Ltd.:

Mr. Govind Agrawal	Managing Director
Mr. George Thorpe	Marketing Manager
Mr. O. J. Udofa	Group Contraceptives Manager
Mr. V. F. Bonin	National Sales Coordinator
Mrs. O. A. Marsha	Director Training
Mr. Akpabio	Accountant

PSI:
Mr. Michael Quist, Resident Advisor

Pharco Nigeria:
Mr.E.A. Owoade, National Sales Manager

Upjohn (Togapharm):
Mr. Yomi Uduwole, Marketing Manager

Concept Unit (Advertising Agency):
Mr. Lere Awokoya, Managing Director

Associate Markets Nigeria Limited (National Oil Mini Mart Program):

Mr. Ayo Ogunriola Managing Director

National Oil Company:

Mrs. Sheri Balogun Merchandising and Sales Promotions

NITEL (Nigerian Telecommunication):

Ms. Esther O. Daodu — Project Manager
Dr. R. A. S. Balogun — Medical Director FP Program

NEPA (National Electric Power Authority):

Mrs. Lawanson Project Manager FP Program

Kaduna State
Mrs. Rhoda La'ah, FP Coordinator, Kaduna State
Dr. Y. Madaki, Director, PHC, Kaduna State
Mr. A.Y.M. Anka, PHC Liaison Officer, Ministry of Health
Mr. Mohammed Balarabe, State Manager, PPFN, Kaduna
Mr. Benjamin Ayeni, State Finance Officer, PPFN, Kaduna
Mrs. Dije Gimba, IEC Programme Officer, PPFN, Kaduna
Mrs. Aisha S. Abubaker, Zonal Program Officer, The Pathfinder Fund
Mr. Ibrahim A. Bebeji, Programme Officer, UNFPA, Kaduna
Mr. Alhaji I. Uthman, Territorial Manager, Sterling, Kaduna
Dr. J. Akuse, Director, SEFA Hospital, Kaduna

Ahmadu Bello University:
Prof. A.B. Bendipo, Director of Institute of Health
Prof. C. Ekwempu, Department of Obstetrics and Gynecology

Plateau State

Jos University Teaching Hospital:
Dr. O.A. Tomobola
Mrs.. J. Falum

Dr. I.O. Ujah, Deputy Director ASC Project
Mr. Samaila I. Usaini, Manager, PPFN, Jos

Plateau State Ministry of Health:
Deputy Family Planning Coordinator
Director of Family Health Services

Mr. S.A. Bulayos, Technical Manager, Sterling Warehouse, Jos
Mrs. Jael A. Kwakfut, Project Manager, Market Women Project, Jos
Mrs. Zipporah G. Mafayai, Zonal Program Officer, Pathfinder Fund

Appendix B

Private Sector Discussion

Appendix B

Private Sector Discussion

A. Background

In the design of the FHS project, exploiting the vibrant private sector in Nigeria for the provision of family planning services and commodities was seen as the critical intervention to raise prevalence quickly. No other country in Sub-Sahara Africa has the private sector potential as Nigeria does, and therefore USAID and the Government of Nigeria took the bold step to develop a project that assigned major responsibility for family planning service delivery to that sector.

The prime contract to implement the private sector service delivery component was given to Family Planning International Assistance. Major subcontracts were developed with John Snow, Inc. and the Margaret Sanger Center.

To reach 70 percent of the 2.5 million family planning users targeted in the FHS Project Agreement, the FHS/Private sector service delivery component is charged with:

* providing $17 million of family planning commodities
* distributing contraceptives to 4,375 commercial outlets, 5,650 private health providers and service delivery sites, and 2,100 vendors, workplaces and associations
* conducting training of 4,000 pharmaceutical personnel, 1,000 vendors, and 2,100 nurses and doctors
* establishing a MIS for the private sector
* conducting technical assistance to Nigerian subcontractors
* working closely with the IEC contractor in areas of market research, family planning promotion and advertising.

B. Accomplishments

* At the third year mark, the number of commercial outlets served is above target, medical and other service delivery sites is on target, and the number of vendors, workplaces and associations served is below target.
* At the third year mark, the number of persons trained has exceeded the target.
* Market research has been undertaken and the "Right Time" commercial condom has been launched as a product of Sterling Products Nigeria.

The FHS private sector component must be credited for implementing a large quantity of highly diversified programs on a national basis within a three year period. There is no question that they have been able to achieve substantial accomplishments under very difficult circumstances.

Due to the length of time allotted, the main emphasis of the Private Sector Management Review was placed on the various retail sales programs: Sterling Products, the Right Time condom, and the PSI Gold Circle condom. Overall marketing and management issues were reviewed and analyzed. The major issues that were noted, and recommendations follow.

C. **Issues and Recommendations**

1. Sterling and PSI Retail Programs - Product Roll-out and product mix.

A) Packaged Product Roll-out.

Plans for the Sterling Products retail sales program call for a sequential packaged product roll-out following the May 1991 launching of the Right Time Condom. FPIA's Year 4 Work Plan dated December 12, 1990 calls for launching of the Pill in the first quarter of Year "4" (Year 4 begins April 1991) and advertising for the vaginal foaming tablets following approximately four months later.

In meeting with the Managing Director and Director of Marketing of Sterling Products Nigeria (SPN), it was learned that Sterling has no immediate intention of continuing with the packaged sequential roll-out of the other two products. Furthermore, the Managing Director expressed great reservations in commercializing the other products due to potential corporate liability. Having just spent four years in Sterling's corporate headquarters in New York City, this new Managing Director is extremely worried about law suits arising from the use of the products such as oral contraceptives.

He stated that he had requested FPIA New York and Lagos for an amendment to his memorandum of understanding with FPIA covering the period November 1, 1990 to December 31, 1991. He is requesting an amendment that would indemnify Sterling Products Nigeria against any law suits arising out of the use of the oral contraceptive and foaming vaginal tablets. He requested this amendment three months ago and has not yet received a response.

Additionally, he pointed out that while the memorandum had been signed by Sterling on October 17, 1990, and USAID on January 8, 1991, it had never been signed by FPIA. While he is operating in good faith under the conditions of the memorandum, he does not technically consider the memorandum legally binding until he receives assurances of product indemnification and FPIA'S signature on the memorandum.

He further explained that Sterling worldwide neither produces nor carries contraceptive products and that the product line is not in the company's corporate charter and therefore he has to continually justify to corporate headquarters the marketing of these products in Nigeria.

It was learned that even if the product indemnification issue can be effectively resolved (or if he drops his concern on this issue), their plans are to wait a full year from the "Right Time" Condom Launch before making a decision as to whether to package and market the pill. That decision would therefore take place in May 1992 and given that it takes approximately one year to develop packaging, advertising, conduct research, package the product, etc., the actual launch of the packaged pill would therefore take place in approximately May 1993.

If one also refers to Sterling's Right Time 1991 Marketing Plan, it states on page 1 that: "oral pills appear to fit into a smaller, upper market segment. Its potential will be explored fully in due course and exploited if deemed to be worth investing in." Sterling further stated that they intend to follow the same pattern and time frame for packaged roll-out of the VFT, thus making that product introduction take place sometime in 1995. Sterling stated that they had discussed these considerations and plans with FPIA New York and Lagos management, although this had not been conveyed to FHS or Mission management.

This has significant marketing ramifications including the project's ability to reach its stated target of 1.2 million exceptors. For example, Sterling's sales of pills was 225,000 cycles in year 2 of the program (April 1989 through March 1990), and 580,000 cycles of pills in year 3 of the program (April 1990 through March

1991). FPIA's year 4 work plan calls for 1 million cycles of pills to be sold based upon the pill being commercially launched in the same manner as the "Right Time" condom.

The other significant item called into question is Sterling's commitment to contraceptives as a product line, and to the objective of social marketing, i.e. low priced subsidized product being marketed to the lower socio-economic groups. The commitment to social marketing objectives is further brought into question by comments from Sterling management that they have never been very concerned when they were out of stock of contraceptives for considerable periods of time, because these supplies were not part of any "commercial drive". This is further discussed in the commodity section of this report along with appropriate recommendations.

In terms of expediting the commercial marketing of the oral contraceptive, Sterling's Managing Director was asked by the Review Team whether he would have any objections if another firm were willing to begin marketing the orals immediately. His response was that this would be fine with him.

DISCUSSION

The relationship with Sterling is an extremely important cornerstone of the Private Sector efforts of FHS. FPIA is to be commended for establishing and nurturing this relationship over a number of years. Beyond the significance of the commercial sales in this program, the Sterling relationship is vitally important for the nation-wide distribution of the public sector commodities. There is little question that Sterling, as one of the two largest pharmaceutical manufacturers/distributors in Nigeria, with twelve regional warehouses, is certainly one of the most able firms in the country to provide this service.

RECOMMENDATIONS

It is recommended that the AID Mission AAO and Project Administrator meet with the Sterling Managing Director and Marketing Director as soon as possible in order to discuss these issues, as well as commodity logistics. It appears to be the appropriate time to clarify the relationship with Sterling, build upon it, as well as determine if additional alternative distribution sources may be needed.

Should it be determined to begin developing additional marketing/distributional relationships, the services of a marketing consultant to help evaluate and design these relationships is recommended.

B) RIGHT TIME CONDOM

The packaged "Right Time" Condom supported by the mass media advertising campaign, and point-of purchase materials was launched in May 1991. The Management Review Team was fortunate to attend the Lagos trade launching. This was attended by an extremely enthusiastic audience of some 150 wholesalers and retailers. At the close of the launch, Sterling received a substantial amount of orders from the dealers in the room.

A number of items concerning product positioning, pricing, the advertising campaign, and FPIA's subsidy to the "Right Time" condom should be noted.

The original plan called for the "Right Time" Condom to be targeted to CD socio-economic groups. Sterling's marketing department changed the target market to AB socio economic groups for two reasons, pricing and the positioning of the advertising campaign. In working through a 4-year financial analysis for the products (shared with the Management Review team) Sterling determined that the product would have to initially retail for N4.50 for a packet of 3 (38 cents).

There appears to be a shortage of other commercial brand condoms in the market, as no one is importing them on a regular basis due to the low profit margin, necessity of hard currency, and 35% duty on the product. However, when in stock, competing brands such as Prime, Durex, and Lifestyles, retail for N5.00 and up for a package of three. The PSI Gold Circle Condom is priced at N1.50 for three, although it is seen in retail outlets selling for N2.00 or N2.50.

Sterling management were quite clear in stating that they are handling the "Right Time" Condom as a normal commercial product in the same manner as they would handle all of their other commercial brands.

The advertising campaign positions the product for spacing children within marriage, as a "reliable means of child spacing for good health and well-being". The campaign shows a husband in a very upscale family saying he has "chosen to be a responsible father". Sterling and the advertising agency, Concept Unit, chose this very conservative approach so that the campaign would be approved by the Nigerian FPA. The campaign has high production values, however, one might question its very conservative approach without any use of humor or affection between the husband and wife in the commercial.

For a variety of reasons, including the advertising production (done in London), and the actual manual assembly of the "Right Time" packages, the launch was six months late, having been originally scheduled for November 1990. Therefore, the advertising campaign was not pretested, even though Sterling's original plan called for pre-testing and the production of the campaign cost N980,000 ($100,000) and has first year media expenditures of N2.6 million ($260,000). FPIA is paying for this advertising, however, we were informed by the agency and Sterling, that they never suggested pre-testing the campaign.

Sterling's 4-year plan calls for first years' sales of 5.56 million packs of three, or 16.68 million condoms increasing to 8.41 million packs of three or 25.3 million condoms in year 4. The present memorandum of understanding calls for Sterling to purchase the condoms at N.12 per condom (approximately one and a half cents) within the first year of the agreement (through 12/31/91). Additionally Sterling would contribute N.10 per condom sold toward the cost of advertising, which is to be paid upfront by FPIA. These amounts are to be negotiated in September 1990 for year 2. Sterling's 4-year plan calls for the advertising and product purchase subsidy to end at the end of year 3, in 1994. The present FHS program ends at the end of 1992, and Sterling's pricing and profit projections are based upon a 3-year amortization of costs.

DISCUSSION

Two things are of particular note. First, Sterling pointed out the importance they attach to the present financial projections and stated that if they have to end the subsidies in the second year, it could cause them to increase the wholesale price of "Right Time" by an even greater margin in year 2. Since FHS ends in 1992, this needs to be discussed with them.

Secondly, there should be no misconception that Right Time is a normal commercial product, not a social marketing product.

Particularly in light of a lack of consistent imports of commercial condoms, there should be a market for "Right Time". However, in light of the product positioning and pricing, FHS may want to provide stronger support to the PSI Gold Circle condom.

C) Product mix

Injectables

It would appear that consideration of a change in product mix is desirable. First, by all accounts, injectables are in very high demand in Nigeria. The final report of the KAP pretest of a Family Planning

Questionnaire, found injections to be method of choice (closely followed by pills). In a NITEL Clinic Program (Nigerian Telephone) injectables were the method of choice. Dr. U. U. Essiet, founder of the Eko Clinics confirmed the high demand for injectables.

While USAID cannot directly purchase injectables, an AID program can support the promotion and sales of injectables through advertising, production of IEC materials, etc. This is presently done in a number of CSM programs, most notably the Blue Circle project in Indonesia.

The management review team met with the UNFPA Country Director for the purpose of determining if UNFPA could donate injectables to the FHS project. UNFPA reported that it presently has no stock in country, however, they are in the process of ordering a combination of one million units of DepoProvera from Upjohn and Noristerat from Schering and 1.5 million units for 1992. They reported that it may take as long as one year to receive the commodities and that they cannot give any to FHS for the private sector program. However, the program can purchase these injectables from UNFPA at cost, in dollars, landed duty free.

The team also met with Upjohn's Lagos representative. Upjohn is represented by Togapharma Nigeria Limited. They are importing a line of Upjohn's products, including a very limited amount of DepoProvera, some 3 - 4 thousand units per year which are being sold at a wholesale price of N53 per piece. The limited importation is due to the import of DevoProvara by PPFN and UNFPA, which buy in bulk directly from Belgium, and pay approximately 10% of Togapharma's import price. The present import of 3-4 thousand units are being bought by workplace clinics and hospitals.

The Togapharma Marketing Manager offered to present a written proposal from FHS to Upjohn's Belgium headquarters for consideration.

RECOMMENDATIONS

FHS should meet with the local Schering office or representative and discuss the same concept vis-a-vis Noristerat. It would also be worth meeting with PPFN to determine if they would be willing to provide product to FHS. Various alternatives, including UNFPA's offer of purchasing products at cost, should then be discussed with potential distributors; Sterling, Pharco or whomever.

VAGINAL FOAMING TABLETS

In analyzing a number of factors concerning vaginal foaming tablets in the private sector program, the advisability of continuing with this method is brought into serious question.

* Over three year program period from April 1988 through March 1991, a total of 454,000 VFTs were sold in the private sector program for an average of 151,000 per year, or 1,513 CYPs per year.

* During the same period, a total of 1,248,000 units were shipped to Nigeria costing $120,000 excluding shipping, related salaries, overhead rates, etc.

* The cost per unit of the VFT is 10.4 cents, giving a CYP cost of $10.40, compared to $3.32 per CYP for _____ and Nominest and $4.51 per CYP for Noriday, Norquest and Norminest condoms.

* The effectiveness of the method itself is brought into question when there is a ten minute waiting period required and no instructions are distributed with the retail product which is currently being sold unpackaged.

* Sterling has no present plans to package or commercialize this product.

* PSI conducted a 9-month test market of a packaged VFT, named "Confident". They discontinued the product, as consumers reportedly did not like them and claimed that they gave a burning sensation.

* By all reports, this is an unpopular, undesired product in Nigeria, and the Final Report of the KAP Pretest of a Family Planning Questionnaire finds it the least desirable method.

DISCUSSION

There is reportedly some market for this product particularly among teenagers and young unmarried women. From the standpoint of offering the "supermarket" approach to contraceptives and for those acceptors who would not avail themselves of public sector services, AID may feel that it wishes to continue this product in the private sector program.

However, strictly from a marketing and cost standpoint it would not be advisable to continue this product in the private sector.

D. COMMODITY LOGISTICS

The subject of commodities is discussed at some length within the Commodities section of this report. The difficulty in commodities logistics is certainly a major constraint to the private sector portion of FHS, which is to contribute 70% of acceptors in the program. Sterling's "Right Time" 1991 marketing plan repeatedly points out that condom sales have been poor in certain times due to the lack of adequate stocks. The commodities logistics situation must be rectified in order for this program to be successful.

E. PSI/PHARCO GOLD CIRCLE PROGRAM

Population Services International (PSI) operates a CSM condom program in five states in zone B, through the Society for Family Health, a charitable organization they incorporated in Nigeria in 1985. 1.133 million Gold Circle packaged condoms were sold in 1990.

The present project operates under a memorandum of understanding signed with FPIA in April 1991. Under the terms of this memorandum, PSI will be provided at no charge, with 3 million non-colored, no-logo condoms in 1991. They are limited to selling the condoms in zone B, and restricted to a saled price of between 25 and 50 kobo per piece, thus the present package of three condoms is intended to retail for N1.50. (Blue Circle has been seen in retails outlets at N2.00 and N2.50 per package). The memorandum further calls for selling PSI 4 million condoms in 1992, at a price to be negotiated in November 1991.

PSI is marketing this condom to CDEF consumers, and is considering placing four condoms rather than three in a package, to retail at the same price of N1.50. In the future, PSI would like to market oral rehydration solution and oral contraceptives. PSI is using Pharco Limited, a Nigerian-owned pharmaceutical distributor, having warehouses in six regions. The team met with Pharco's Marketing Director and visited their Lagos warehouse.

DISCUSSION

Given the target audience and pricing for the Gold Circle Program, it falls within the definition of a social marketing program, whereas the "Right Time" condom is a commercialized product. Other than the provision of free condoms through 1991, PSI is funding all other activities in the program. PSI has one

employee in Lagos operating the program, Michael Quist, a Ghanaian who worked 22 years with Union Carbide in marketing positions in the U.S. and abroad. In addition to the services of Pharco, Mr. Quist has employed two nursing midwife detailers.

Mr. Quist has been with PSI in Lagos since November 1989 and his present contract expires in October 1991. He is clearly the driving force behind the PSI Nigerian program. The program's viability would be called into question should he choose not to renew his contract, and if he were not replaced with an individual of equal marketing strength.

There are two particular issues that need to be addressed. PSI asked FPIA in October 1990, for the Ansell product registration documentation, so they can register the condoms with the Nigerian FDA and thus start advertising. To this date, they have received no response, and thus have been unable to begin mass media advertising. They are presently using point-of-purchase materials and gold coin stickers are placed on the back of a number of buses.

The second issue is that PSI is presently being provided with the non-colored, no-logo condoms, which are the same condoms as in the public sector program. PSI is considering placing a self-adhesive Gold sticker on each individual condom in order to establish product differentiation; a costly and time consuming process.

RECOMMENDATIONS

1) PSI should be given the Ansell registration materials as quickly as possible so that advertising for this program may begin.

2) Blue/Gold condoms are presently being used in the Nigerian private sector program in hospitals and clinics. It would be advisable to give the Blue Gold condoms to PSI rather than the plain condoms. This would eliminate any switching from possibly expired public sector stock, brand identification problems, or confusion in the consumers' mind.

3) AID should consider additional support to PSI beyond the provision of free condoms (presently through 1991 only). PSI appears committed to the principles of social marketing and could provide an additional means of distribution for a packaged pill, as well as other products. With some subsidies, the marketing staff and breadth of the program could be increased. This warrants further discussions between FHS/AID and PSI.

2. PROGRAM MANAGEMENT AND DESIGN ALTERNATIVES

A. Administrative, Technical and Managerial issues.

A considerable number of administrative, technical and managerial concerns became evident during the course of this management review. A number of them have been mentioned in Section 1 above. These include:

* Failure to sign the Sterling Memorandum of Understanding or respond in a timely manner to Sterling's request for product indemnification.

* Failure to respond in a timely manner to PSI's request for product registration documentation from Ansell.

* Providing CPTs six months late, inspite of repeated request from AID Washington's Commodities office. This is discussed in greater length in the Commodity Section of this report.

* Failure to insist on, or even suggest pre-testing the Right Time advertising campaign, despite considerable expenditure paid for by FPIA.

* Failure to properly monitor commodities logistics. As stated above, Sterling has complained of frequent shortages of product supply.

In November 1990, the advertising agency Managing Director and Sterling's Contraceptive Product Manager spent 17 days in London for the purposes of filming the television spot. The studio and actors for the production had been chosen and reserved. Due to a mix-up in the name of the account in the wire transfer to London, the funds were never released to the ad agency Managing Director, and both individuals returned to Lagos 17 days later without filming the spot. They incurred expenses including studio cancellation charges reportedly of more than $13,000.

The ad agency Managing Director reported that he telephoned New York and Lagos daily to attempt to get the problem rectified. Upon his return to Lagos he complained in writing to FPIA Lagos regarding the entire matter. They returned to London in January to film the spot. The failure to produce the television spot on the November trip was one of the reasons for the six-month delay in the "Right Time" launch.

DISCUSSION

The private sector has done an admirable job under very difficult circumstances in the program's first three years of extended the program's breadth and national reach to include training, nurses/midwives program, market women, taxi drivers, hospitals and clinics.

There is, nonetheless, a very apparent lack of marketing expertise and technical assistance provided by the New York office.

A CYP analysis explained in detail in the Project Status section of this report demonstrates that private sector CYP delivered in program year 5 is not likely to exceed 300,000 CYP, far short of the 1.2 million acceptors required in the program design. This figure does not include the non-retail programs of the private sector and in fairness, as is also noted in another section of this report, the 1.2 million acceptors was never probably never realistic from the program's inception.

What is of most concern, however, is that FPIA seems to believe and repeatedly states that they would meet or even surpass this objective. An analysis of FPIA's Year 4 work plan written in December 1990, reveals the same types of concerns regarding a lack of marketing perspective.

For example, they promise to sell 1 million VFTs in year 4 when average sales of this product over the three years of the program have been 151,000 units per year (203,000 in Year 3). Additionally, this is an unpopular product and Sterling has no plans to commercialize the product. Nor could they have, even if they had so desired, in time for year 4 sales. The exact same situation applies to their promise to sell 1 million pills in Year 4.

The promise of "launch of the pill is scheduled for the first quarter of the Year 4 - and vaginal foaming tablets advertising would follow approximately four months later" could have also never been achieved. Disregarding the fact that Sterling had no intention to commercialize this product immediately, the first quarter of Year 4 begins in April 1991, four months after the writing of their Work Plan. Since the

development of packaging and advertising takes eight to twelve months on average, and in December when the work plan was written the Right Time television spot had not even been filmed, this particular promise was quite an impossibility.

As for FPIA Lagos, the distinct impression one receives, which is collaborated by discussions with a considerable number of people, is that their hands are tied nearly totally by the New York Offices' policies and procedures. They appear caught up in a never ending flow of paper work, as well as a constant pressure from New York to achieve the numbers required to meet the program's contractual outputs. This does not allow little time for designing conceptualizing, or making mid-course changes in the program. In short there seems to be little time remaining for creative marketing.

RECOMMENDATIONS

Immediate steps are necessary to bolster the technical back-stopping and the technical assistance provided in marketing to the Lagos office.

Streamlining FPIAs administrative and financial requirements would be of considerable help to the project; for example, multi-year rather than single year contracts could be issued. Travel vouchers should not need to go back to New York for approval.

The private sector group should work more closely with the other units. For example, with the Policy unit - to help remove constraints, with the Public Sector unit - regarding commodities distribution, and with the IEC unit regarding the development of materials.

B. Other private sector programs

In addition to private sector programs serving retail outlets, the following other private sector programs were visited:

Eko Hospital Lagos

Excel Clinics/Otu Market (Dr. U.U. Essiet)

NANM (Association of Nurses and Midwives)

PPFN in Kaduna and Jos

SEFA Private Hospital

NITEL (Telephone company)

NEPA (Power authority)

Unfortunately, given time constraints, most of the emphasis of this review was placed on the retail programs; Sterling, Right Time, PSI Gold Circle/Pharco, and the National Oil Company mini-mart program. However, the following observations can be made and figures concerning meeting the objectives of these programs are provided in the Project Status section of this report.

The Excel Clinic Program was extremely impressive. The team met with Dr. U.U. Essiet, who founded the clinics and visited the Otu Market in Lagos. There are two free standing Excel clinics and efforts in three

markets in the Lagos area. This program has served some 16,000 clients over the last fifteen months, with a continuing client ratio of over 55%. Dr. Essiet's motivation and dedication is very impressive. He was quite pleased with the support he has been receiving from FHS, however, he does have a shortage of IEC materials, and requested that this be addressed.

The Eko Hospital, purportedly the best private hospital in Lagos, was visited. While appearing well designed and supported by FHS, what was particularly striking about this project was the small number of acceptors and continuing clients. In the course of the last twelve months, there were just over 300 acceptors with a rate of approximately 45% continuing. In looking through the daily register, there were a number of days without any clients and numerous days with one, two or three clients. There were no signs either inside or outside of the hospital indicating that there was a family planning clinic available.

FHS has provided training, supplies free contraceptives to the hospital, and paying the salaries of three full-time nurses in this program. With such a small number of clients, one might question the return on investment.

RECOMMENDATIONS

The mission should consider a team to give a more thorough look at these programs vis-a-vis their cost, in terms of number of clients served, and likelihood of sustainability over time.

Those that appear sustainable and serve substantial numbers of clients as in the Excel Clinic program, are certainly extremely valuable to the overall goals of FHS, and should be enthusiastically supported.

C. Private Sector Management/Design Alternatives

In the long-term, there is an overall question of the advisability of having the private sector program housed within the overall FHS program, and therefore being tied to government. By its very nature, it is not advisable to have government controlling or placing unnecessary restrictions on the private sector, or its activities.

While it is not feasible within the remaining one and half years of this project, a possible design alternative for a future FHS project would be to spin off the non-retail components of the private sector program to an organization such as PPFN.

The retail program could then be housed within the principal distributor, such as Sterling, with a Marketing Manager overseeing the program. Should this not be acceptable to the distributor, a separate program office could be established with a smaller staff to oversee the project.

RECOMMENDATIONS

The mission should conduct an analysis of PPFN's long-term viability, interest, and ability to manage the non-retail components of this program.

In a future program design, serious consideration should be given to housing the program management outside of FHS, and within a distributor, in its own office, or perhaps in an organization such as PSI's Lagos office.

ANNEX B

NIGERIA FAMILY HEALTH INITIATIVES II PROJECT

LOGICAL FRAMEWORK
(698-0462.20)

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

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

LOGICAL FRAMEWORK

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

LOGICAL FRAMEWORK

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

LOGICAL FRAMEWORK

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

NIGERIA FAMILY HEALTH SERVICES PROJECT EVALUATION (620-0001)

TERMS OF REFERENCE

I. BACKGROUND

USAID/Nigeria manages a $100 million development assistance program intended to help the people and government of Nigeria improve their social and economic well-being by reducing population growth rates and improving mother and child health status.

The portfolio of A.I.D.-financed activities includes three major activities.

1. The Family Health Services project was authorized in 1987 and funded in the amount of $67 million for a period of five years. The project assists Nigerian health personnel to provide better health care services in both the public and private sectors. Project activities got under way in April, 1988.

2. The Combatting Communicable Childhood Diseases Project is an AFR centrally funded project, the Nigerian segment of which has received both central and bilateral funds. The project's objective is to strengthen the ability of Nigeria to administer immunization, oral rehydration therapy and malaria treatment and prevention programs.

3. The Nigeria Primary Health Care Support Program, authorized in FY 1989 for $36 million, has as it's objective of which is to achieve policy reform in the health sector.

In addition to these major activities, AID has provided grants to PVO's to conduct programs in child survival and family planning, and is considering grants in river blindness prevention and AIDS prevention.

While the present evaluation will be of the Family Health Services Project, the evaluation team must have reference to both the CCCD and the Health Sector programs. The CCCD program, along with FHS, is one element in the governments approach to primary health care, and the evaluation team will be asked to look at linkages between the two projects, and coordination efforts undertaken and those which should be undertaken. The Primary Health Sector Program is fostering policy changes which are important to the achievement of FHS objectives and, again, the linkages are important.

II. DESCRIPTION OF THE FAMILY HEALTH SERVICES PROJECT

The overall objective of this project is to increase the knowledge and availability of family planning services and see that these services are fully integrated into the primary health care system. Specific objectives to be achieved include:

- a broad political and social constituency supportive of family planning policies and programs;
- wide availability of family planning information and services at reasonable cost in both private and public health facilities;
- a nationwide contraceptive prevalence rate of 12 percent or approximately 2.5 million users;
- 70% of users served by private practitioners through more than 12,000 commercial or private outlets;
- 30% of the contraceptive users served through 3,600 public sector health facilities such as government hospitals, maternities, health centers, and dispensaries.

The project focus is on four key areas:

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

2. public sector services to strengthen management systems and delivery capacities to introduce or expand clinic-based services in all levels of government facilities, from large teaching hospitals to village dispensaries, with initial efforts targeted at capital cities and model primary health care local government areas (LGAs);

3. information, education and communication to make people aware of the value of family planning, enhance the acceptability of smaller family norms and family planning, and to provide information on available options and services;

4. support for policy implementation and strategic planning for efficient mobilization of an effective and self-sustaining national family planning program.

Complementary and mutually-reinforcing activities under these four focus areas are being carefully coordinated to comprise an integrated project aimed at family health.

The project works with the federal and state ministries of health, local government authorities, and the National Population Commission. In the private sector, the project works with the Planned Parenthood Federation of Nigeria and other NGO's, and companies and clinicians who offer information, services, and contraceptives, including those provided for a fee.

Under contracts executed subsequent to the project authorization, technical and administrative services are provided by five prime contractors and several sub-contractors. The prime contractors are the Pathfinder Fund, Family Planning Assistance International, Johns Hopkins University Population Communication Services, the Johns Hopkins University Institute for International Programs, and the African American Institute. Sub-contractors are the Academy for Educational Development (AED), Program for Appropriate Technology in Health (PATH), the Center for Education, Development, and Population Activities (CEDPA); Sweethill Associates; John Snow, Inc.; the Margaret Sanger Center; International Health Programs of the University of California at Santa Cruz; Management Sciences for Health; and AFRICARE.

In addition, a personal services contract has been executed with an American professional who serves as project administrator.

III. PURPOSE OF THE EVALUATION

Via the acquisition and utilization of outside technical expertise, the Federal Ministry of Health and USAID/Lagos desires to conduct an interim evaluation of the project. The Project Assistance Completion Date of the FHS project is December 31, 1992.

III. OBJECTIVE OF THE EVALUATION

The evaluation is intended to provide the FMOH and AID with an independent assessment of the degree to which the project has or will achieve its purpose and the initial impact of the project. The evaluation will also assist the FMOH and USAID to determine if the project should be extended and or modified, suggesting modifications that might be made in mid-project, or if a second phase project should be contemplated.

IV. Scope of Work

The contractor is asked to field a team of experts to conduct an external mid-project evaluation of the Family Health Services (FHS) Project in Nigeria. The evaluation team will look at the planning and monitory components of the project, as well as implementation aspects.

Planning and monitoring. In reviewing project planning and monitoring, the team will assess whether overall project planning, as well as planning of each component, has been realistic and has taken into account the role that the project plays in the overall Primary Health Care focus of the FMOH, the role of other donors, and the interaction of the several components of the project itself. The team will assess the measures which the project, and its separate components, have taken to collect baseline data, and achievement data. Can the project determine the impact that it is having in meeting project objectives? In this regard, the team will review the information systems being put into place by the project to determine if they are integrated into the information systems being established by federal, state and local government authorities, and if they are compatible with with those being financed in other projects and by other donors. The team will also assess the administrative and logistics operations put into place to support other project elements.

The evaluation team should determine if the flexible implementation mechanisms which were put into place, both under the DFA and by the project, have resulted in an agresive and integrated family planning program. The 1989 FHS evaluation identified functional overlap as an issue and made recommendations for better utilization of the comparative advantage of each component. Have the measures taken to date strengthened internal integration and coordination? How can it be further strengthened. Are the relationship between FHS and the FMOH, States and LGA's productive. The FHS works with a number of partners in both the public and private sector. Are these linkages adequate and is capacity being built to the degree which will assure that progress to date is sustainable at the end of the project?

Implementation. In evaluating the implementation aspects of the project, the team will review training; information, education and communication; service delivery; policy and operational research; institution building (public and private sector, including NGO's); etc. This review will address questions of impact (present and potential) and sustainability. The team should review the FHS Project Evaluation of 1989 to determine if the project addressed the recommendations of the FHS Project Evaluation of 1989. Further, the evaluation will identify weak links in the implementation chain and provide recommendations to the mission on how to address them

The evaluation will look at project achievements to date. Is the project meeting with success such that project objectives can reasonably be expected to be achieved? In arriving at this assessment, the team should make use of the full range of documentation available, including analyses which were part of project design, Scopes of Work of the projects prime and sub-contractors, information and data collected by the Project, contractor reports, studies and research reports, government and other donors reports, etc.

In assessing sustainability, it should be noted that the FHS project is one component of the Government's Primary Health Care program. The administrative and financial locus of the PHC program is the Local Government Authority (LGA). The viability and sustainability of the family planning program will depend in large measure on the degree to which LGA's own and support the program and are able to implement it. Support to the LGA's from the federal and state levels are equally important. The evaluation team should have access to a financial analysis of the State Health ministries, as well as as several studies of how authorities and responsibility have been transferred to the LGA's.

Building Nigerian capacity in both the public and private sectors is an important element of the program. All components of the project have drawn extensively on the private sector (private individuals, firms, NGO's, universities, etc.). The evaluation team is asked to assess the success of this effort not only in delivering the product contracted for, but in capacity building.

Within FHS, the team should examine the flow of contraceptive commodities to private and public sectors. Where are the strengths and where does the system need modification and/or reinforcement? In the private sector, are finances adequately monitored? How can we begin the transfer of public sector commodity activities to the FMOH/States/LGA's?