NIGERIA PRIVATE SECTOR HEALTH ASSESSMENT

July 2008

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PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

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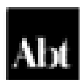

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CONTENTS

1. **Executive Summary** ... 1

2. **Objectives** ... 3

3. **Background** ... 5

4. **Assessment Methodology** ... 9

5. **Findings** ... 11

   5.1 Private-Sector Service Providers—Number and Distribution ... 11

   5.2 Constraints to Private-Sector Providers ... 12

   5.3 Service Regulation ... 14

   5.4 Service Quality Monitoring and Assurance ... 16

   5.5 Private-Sector Product Supply ... 18

   5.6 Product Quality ... 21

   5.7 Cross-Cutting Area: The National Health Insurance Scheme ... 22

6. **Recommendations** ... 25

Annex 1: Scope of Work ... 31

Annex 2: Documents/References Consulted ... 35

Annex 3: List of Contacts ... 39

ACRONYMS

ARV	Antiretroviral
CHAN	Christian Health Association of Nigeria
CHANPHARM	Christian Health Association of Nigeria- Pharmacy Procurement
CHEW	Community Health Extension Worker
COMPASS	Community Participation for Action in the Social Sector Project
CPR	Contraceptive prevalence rate
DCA	Development Credit Authority
DFID	UK Department for International Development
DHS	Demographic Health Survey
HAART	Highly active antiretroviral therapy
HMO	Health maintenance organization
IPPF	International Planned Parenthood Federation
IRHIN	Improved Reproductive Health in Nigeria
IUD	Intrauterine device
LGA	Local government area
MDS	Manufacturers Delivery Services
NACA	National Action Committee on AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NGO	Nongovernmental organization
NHIS	National Health Insurance Scheme
OC	Oral contraceptive
PCN	Pharmacy Council of Nigeria
PMV	Patent medicine vendor
PSP-*One*	Private Sector Partnerships-*One*
SFH	Society for Family Health
TBA	Traditional birth attendant
THT	Total Health Trust
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. EXECUTIVE SUMMARY

At the request of the United States Agency for International Development (USAID)/Nigeria, Private Sector Partnerships-*One* (PSP-*One*) conducted an assessment of the private sector in Nigeria for the provision of reproductive health and family planning products and services. Increasingly USAID and other donors are seeing the limits of focusing exclusively on the public sector to achieve reproductive health goals. This assessment's primary purpose was to identify ways for USAID and other stakeholders to engage the private sector to achieve Nigeria's reproductive health goals.

The assessment team met with product and service providers at all levels (hospitals, clinics, general practitioners, gynecologists, nurse and midwife clinics, traditional birth attendants, pharmacists, patent medicine vendors, and pharmaceutical wholesalers and sub-wholesalers). In addition the team met with the professional associations and regulatory bodies for different providers to understand the regulatory and enabling environment for providers. Given the importance and potential impact of the National Health Insurance Scheme (NHIS) that is being rolled out, the assessment team took a particularly close look at the possible consequences of the scheme and the opportunities and risks associated with it.

KEY FINDINGS:

Although a large portion of Nigeria's population uses the private sector and consumers pay a high out-of-pocket share for health expenditures, much of those funds go toward low-quality products and services. Too little regulation is being enforced to ensure that minimum quality standards are met.

Despite the large population, the demand for contraceptives and reproductive health services is in a market-building stage. Interventions that link supply to demand creation will produce the best results. The quality and quantity of private-sector providers can be increased, but it should be done in targeted areas and with targeted groups where demand is established and growing.

Although there is no shortage of well-trained providers (doctors, nurses, midwives, and pharmacists), they are not being encouraged to open their own private practices. The main barriers are poor infrastructure, no access to credit, and unfair competition with unregulated, less-skilled providers. Furthermore, nurse and midwife practices are constrained by the requirement for physician supervision.

The NHIS is a well-designed plan that could encourage higher quality practices among private providers, increase consumers' financial access to services, and pool risk across a wider share of the population. That being said, there are major challenges in getting providers and consumers to understand how the scheme works as well as training providers, health maintenance organizations (HMOs), insurance regulators, and enrollees.

NEXT STEPS:

In addition to PSP-*One*'s planned intervention to develop training materials to help doctors manage costs under the capitation scheme, USAID should explore how to expand its work with HMOs to promote reproductive health and family planning services to all of their providers and enrollees.

USAID and other donors should investigate the best alternatives for supporting the NHIS rollout. Based on this assessment, the top areas would be provider and enrollee communications and training for insurance regulators.

There is a strong need to support regulatory enforcement and advocacy work regarding provider quality in the private sector. In the pharmaceutical sector, brokering a better partnership between the Pharmacy Council of Nigeria and the National Agency for Food and Drug Administration and Control could have far-reaching consequences in increasing the access of to quality drugs, including contraceptives to Nigerians.

An assessment of the microfinance sector and a more in-depth look at the financial and training needs of health providers is necessary to design a program that can help establish service providers in underserved areas and help existing ones expand or improve their businesses. This assessment should identify mechanisms to extend the existing Development Credit Authority guarantee to these providers.

USAID should conduct a detailed feasibility study for establishing a pharmaceutical network that combines the benefits of access to credit, pooled procurement, training, and branded promotion in exchange for working in underserved areas and adhering to quality standards. Consideration of regulatory issues also will be important in determining such a network's feasibility. This undertaking could be done on a pilot basis; if positive results are demonstrated, these results could inform a larger effort that advocates changes to national laws.

2. OBJECTIVES

The objective of the Private Sector Partnerships *One*'s (PSP-*One*) assessment of the private health sector in Nigeria is to help the United States Agency for International Development (USAID) and other stakeholders develop a strategy for working in an increasingly complex private-sector environment to achieve reproductive health goals. This assessment focused on supply channels for products and services and the regulatory environment affecting the quantity and quality of product and service providers. Given its potential to influence the quality and provision of private-sector products and services, particular attention was given to the National Health Insurance Scheme (NHIS) and the issues related to its rollout. Specific tasks included assessing:

- the diversity and distribution of private providers of products and services
- the opportunities for and constraints to private-sector participation
- the capacity of providers participating in health maintenance organization (HMO) insurance schemes
- the NHIS benefit plan and operations for its potential to increase provision and support demand for health services, especially for contraceptives and reproductive health needs

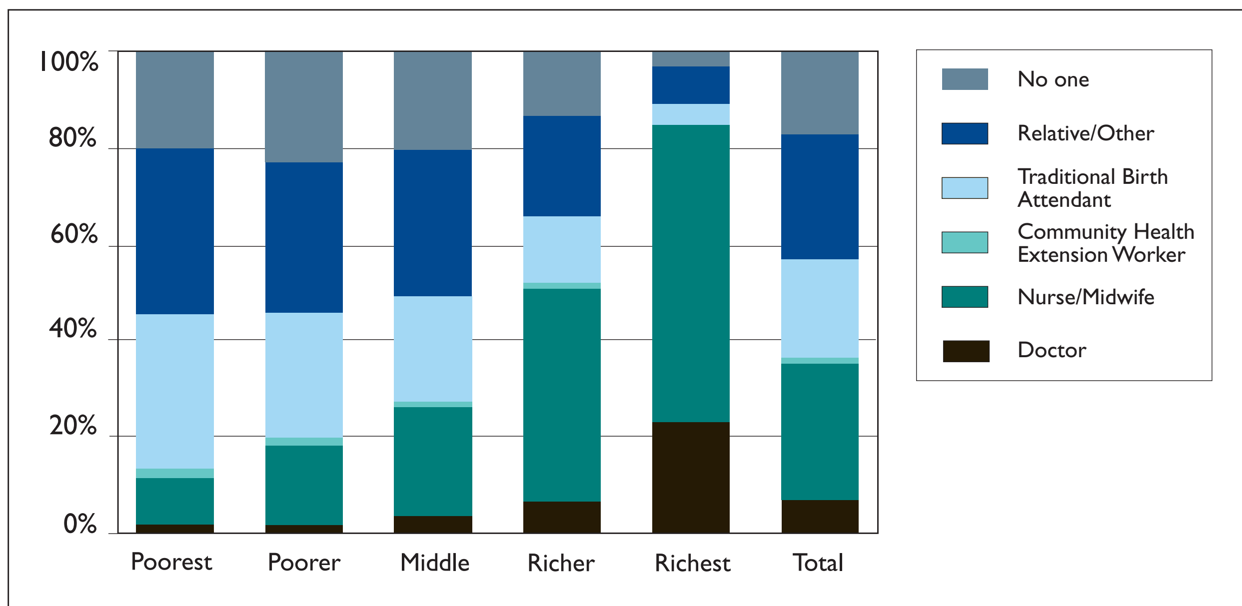
3. BACKGROUND

Economic Background: Nigeria's economy is still dependent on oil, which contributes about three-fourths of government revenues and about a third of gross domestic product. The oil sector, however, supplies little local employment, and the wealth earned by some people from this resource is in sharp contrast to the widespread poverty throughout the country. Gross national income per capita is still only around $400. During Sani Abacha's regime in the 1990s the economy stagnated, but in the past three years there has been significant progress reducing the level of official debt; liberalizing trade; attracting foreign investment; and stimulating the private, non-oil sector. In 2005 the non-oil sector grew by 8 percent. The government increased capital requirements for banks leading to rapid consolidation in the banking sector and increasing the banks' ability to lend to smaller enterprises. Corruption is still a major problem in the public and private sectors, but government efforts to increase transparency regarding its procurements and prosecute dishonest officials is helping to improve Nigeria's image. Many more years of consistent progress on these fronts coupled with policies to address the inequities of wealth, however, will be necessary for the benefits of progress to be felt across a wider segment of the population.

Health Background: Nowhere is the neglect during the Abacha regime more apparent than in the health sector. The mortality of children under 5 years old is estimated at 201 per 1,000 live births, maternal mortality is about 800 per 100,000 live births, total fertility is 5.7 children per woman, modern contraceptive methods have an 8 percent prevalence rate, adult HIV prevalence is estimated at 5 percent, and immunization rates are low with only 13 percent of 1 year olds receiving all of their recommended vaccinations (World Bank 2005).

These outcomes suggest that the health care system is struggling. When one looks at service and consumption indicators, it is clear that neither the public- nor private-sector health systems are functioning effectively. According to World Health Organization (WHO) National Health Account analysis from 2003, consumers pay a high share of health expenditures—67 percent of health expenditures come from out of their pockets versus 26 percent from the government and 7 percent from the private sector (that is, private insurance and employers). Too often consumers forego treatment or pay for medical care from unskilled providers. No treatment is sought for 31 percent of children with a fever or who have symptoms of an upper respiratory infection (Demographic Health Survey 2003). Twenty percent of children with diarrhea receive no treatment (Demographic Health Survey 2003), and 66 percent of deliveries occur in the home with a skilled provider only attending 35 percent of them. While this behavior is especially true for the poor, unassisted or using unskilled providers for deliveries occur in all income groups. As shown in Figure 1, even in the richer quintile of the population close to 50 percent of deliveries are occurring with unskilled providers.

FIGURE 1: ASSISTED DELIVERIES BY INCOME LEVEL (DEMOGRAPHIC HEALTH SURVEY 2003)



One of the key determinants of health—and reproductive health in particular—is educational status, particularly for females. Nigeria faces major challenges in this area as well; gross enrollment rates for males are about 25 percent higher than they are for females, and there are significant gender gaps in educational attainment and literacy. These findings suggest that USAID Nigeria's strategy for linking its educational program to its health program is well founded.

DEMAND FOR REPRODUCTIVE HEALTH PRODUCTS AND SERVICES

The contraceptive prevalence rate (CPR) is only 8.9 percent for modern methods (Demographic Health Survey 2003), despite years of USAID and others investing in family planning programs. Even at this low level, this rate masks large discrepancies in contraceptive use among different segments of the population. Among sexually active and unmarried women, for example, the use of modern methods is 38.6 percent. The CPR for modern methods in the Northeast is 4.2 percent, but it is 23.1 percent in the Southwest. The CPR for married women with no formal education is 2.3 percent compared to 21.7 percent for women who have received higher education.

Knowledge of family planning methods is low among women with low educational attainment and in certain parts of the country. Only 60 percent of women in the Northeast can cite even one modern method of contraception (Demographic Health Survey 2003). And 56.3 percent of women were not exposed to any family planning messages through any media for the year prior to the 2003 Demographic Health Survey (DHS). In the Northeast 76.6 percent of women did not hear any family planning messages.

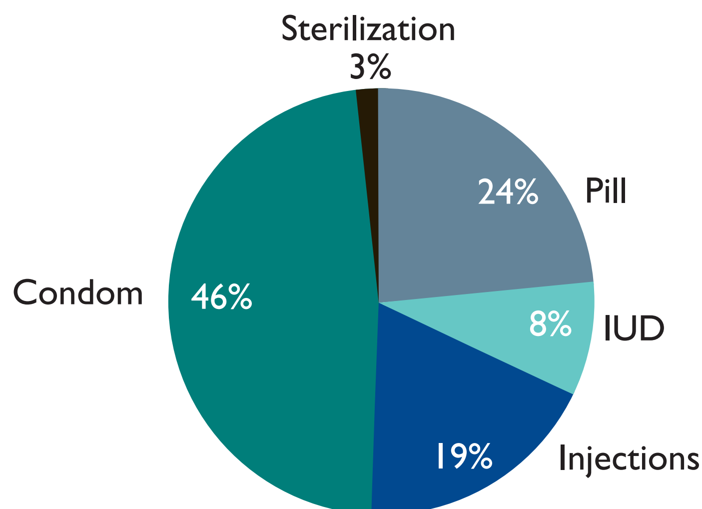
The lack of progress in improving national CPR can be attributed to a number of factors:

- traditional values that favor large families
- religious views against contraception or birth control, especially in the North
- low levels of education for women
- inconsistent training of providers in contraceptive technologies and counseling
- weaknesses in the public-sector system and complexity in the federal system that complicates contraceptive logistics and financing

Nevertheless there are encouraging messages from staff that have been working for many years in reproductive health in Nigeria (such as the International Planned Parenthood Federation (IPPF), the Society for Family Health (SFH), and Pathfinder). There seems to be broad consensus based on years of experience about the best ways to promote family planning and reproductive health. Past efforts to make the economic arguments for small families and birth control have failed and tended to create suspicions. Increasingly, practitioners agree that emphasizing the reduction of maternal morbidity and mortality makes the most compelling case for family planning to Nigerians. Taking this approach has quieted outright antagonism to birth-spacing messages and made it more acceptable for providers and couples to discuss contraception. Moreover SFH's research, which showed a high correlation between couples communicating and family planning, underpins a communications strategy that should be effective for large segments of the population.

The private sector has filled some of the gaps left by the public sector in supplying contraceptives to Nigerians, especially through the national social marketing program. The importance of social marketing and the private sector is reflected in the existing method mix which favors methods available in retail outlets such as condoms, and pills, which account for 70 percent of methods selected. The next most popular method, injectable contraceptives, is sold through the social marketing program.

FIGURE 2: NIGERIAN CONTRACEPTIVE METHOD MIX (DHS 2003)



Demand for products and services in the private, commercial sector is too low in the aggregate to speak of a national market for the private-sector provision of reproductive health products and services. As the aforementioned regional disparities show, however, in some states and among some population segments there are viable markets for commercial suppliers. In other states there is a nascent market being built via social marketing and other subsidized interventions. In other areas it is probably more accurate to describe a premarket phase in which acceptance of birth-spacing principles and knowledge of contraceptives has to be achieved before a market can exist.

4. ASSESSMENT METHODOLOGY

The assessment team consisted of Taara Chandani (health networks and health finance), Rich Feeley (health financing and policy and regulatory environment), and Jeff Barnes (social marketing and products). In addition the team relied on in-country expertise from the Community Participation for Action in the Social Sector Project (COMPASS) (Dr. Habib Sadauki) for provider services and quality issues. SFH (Jennifer Anyanti, Sadiq Abdulsamad, and Wale Adedji) provided information about the pharmaceutical sector. Particular attention was given to the NHIS given its planned expansion and potential to increase consumers' ability to access health services, ensure stable income for private providers, and ensure provider quality. PSP-*One* already had begun supporting one of the HMOs involved in expanding access to the scheme, Total Health Trust. The scope of work for the assessment is Annex 1 of this report.

Prior to the in-country assessment, team members conducted a literature review of the health situation in Nigeria, reviewed government and USAID country strategies, and studied many of the reports addressing the status of reproductive health (such as DHS 2003 and the National HIV/AIDS and Reproductive Health Survey) and related topics, including provider quality, contraceptive security, and sources of health financing. While this assessment focuses on family planning rather than HIV/AIDS, as many of the issues for the private sector in HIV/AIDS are the same (such as product supply, human resources, and quality assurance) a number of HIV/AIDS reports and organizations were consulted as well. A bibliography of reports and documents consulted is in Annex 2.

During the in-country assessment, the team interviewed informants from regulatory bodies and professional associations. Unlike the public sector, which has well-defined structures and entry points, the private health sector is often loosely organized. Therefore regulatory bodies and professional associations are usually the best places to start when assessing issues affecting a broad range of private providers. In Nigeria few private providers operate in group or corporate settings that allow for sharing resources and economies of scale. The exceptions to this generalization are the HMOs and the faith-based organizations that are a part of the Christian Health Association of Nigeria (CHAN). CHAN has more than 350 member institutions, many of which share the benefits of procuring drugs and supplies through Christian Health Association of Nigeria-Pharmacy Procurement (CHANPHARM). HMO networks do not pool procurement or share facilities, but they are beginning to share training resources. The providers interviewed were selected with a view to getting a wide range of scopes of practice and, therefore, included specialists, general practitioners, nurses, midwives, traditional birth attendants, pharmacists, and patent medicine vendors (PMVs). More attention was given to private commercial providers than private non-governmental or faith-based providers.

Because of time constraints, the assessment team could not visit all of the sites or meet with all of the people necessary to make a national assessment. Visits were limited to Abuja, Kano, and Lagos. In Kano and Lagos, however, the team did visit providers in their clinics, hospitals, pharmacies, and PMV stores to better understand the conditions in which providers work. To understand the pharmaceutical distribution system, site visits were made to the wholesale markets in Kano and Lagos where selected wholesalers were interviewed. The complete schedule of meetings is in Annex 3.

5. FINDINGS

5.1 PRIVATE-SECTOR SERVICE PROVIDERS—NUMBER AND DISTRIBUTION

Although the majority of the population uses the private sector for its reproductive health needs, most registered providers are in the public sector. This fact, however, should be qualified by noting that many of the providers who are registered as public-sector providers also practice in the private sector either formally or informally. This phenomenon makes it difficult to quantify precisely the number of service providers operating in the private sector as distinct from the public sector. Even knowing the numbers of providers practicing in either the public or private sector is problematic as registration lists are not updated systematically, and there is no mechanism or incentive for verifying that registered providers are actually practicing. In a country that is losing significant numbers of health providers to overseas employment, death, and attrition, registration statistics likely overestimate significantly the amount of providers in practice.

A recent study, sponsored by the National AIDS Committee, based on a survey of 290 public-sector facilities, estimated the number of providers in the public sector in 2006 as shown in this table.

TABLE 1: PUBLIC SECTOR HUMAN RESOURCES

Category	Estimate
Doctors	18,277
Medical interns (house officers)	2,991
Nurses and public health nurses	38,625
Midwives	7,850
Nurse midwives	75,597
Laboratory scientists	5,620
Laboratory technicians and technologists	10,330
Radiographers	2,883
Pharmacists	3,929
Pharmacy technicians and assistants	8,757
Administrators	6,932
Medical record officers (data managers)	12,682
Public health (nursing) officers	6,994
Environmental health officers	7,768
Community health officers	12,169

NACA unpublished report on Human Resources 2006

The sample for this study was low so the confidence interval is high. At the 95 percent confidence interval, the estimate in the table is plus or minus 2,384. WHO has estimated that approximately 35,000 doctors and 210,000 nurses and midwives in the public and private sectors are registered in Nigeria.

After subtracting the number of public-sector providers from the previous table and discounting by 15 percent to correct for the private providers who are licensed but not practicing, then a rough estimate for the private sector would be 11,473 doctors and 56,400 nurse and midwives. These estimates should be used with caution; they do not account for market conditions that might encourage providers to work in the public sector rather than the private one or encourage more doctors than nurses to practice. Nevertheless even rough estimates show that the human resources in the private sector are comparable with the public sector.

For products and services, there is a shortage of delivery points relative to the population size—especially outside major cities where the disease burden is greatest. This shortage is not due to a lack of qualified graduates from medical schools. The Association of Community Pharmacists estimates that the nine different pharmacy schools are graduating nearly 1,000 pharmacists per year. The recent study commissioned by the National Action Committee on AIDS (NACA) estimated between 400 and 900 graduates per year. Still, the number of pharmacists practicing as retail community pharmacists is barely increasing. The Association of Community Pharmacists says it has only 1,000 active practicing members. (Approximately 6,300 pharmacists work in the public sector.) WHO estimates on the density of providers (public and private) per 100,000 people in Nigeria in 2003 are:

- physicians: 28
- nurses: 170
- pharmacists: 5
- community health workers: 91

As with all statistics in Nigeria, these national averages mask large regional variances. Using the records of registered nurses and midwives, PSP-*One* estimated the density in the state of Jigawa to be 6.75 nurses and midwives per 100,000, far less than the national average of 170.

5.2 CONSTRAINTS TO PRIVATE-SECTOR PROVIDERS

The factors that constrain the provision of private-sector reproductive health services in Nigeria are the same for most small- and medium-sized businesses: a lack of access to credit, poor infrastructure, and unregulated competition. There is little consolidation of private-sector providers into group practices that would allow the sharing of equipment and infrastructure. In some states, faith-based health clinics that employ significant numbers of providers may share resources to keep costs down. Individual practices suffer from diseconomies of scale because they must each pay for their own offices, medical equipment, security, generators, and other supplies. Some investment in medical equipment is considered necessary to attract clients. A number of practitioners said consumers are reluctant to pay for a consultation unless some service is rendered or some equipment is used. This attitude encourages inappropriate use of equipment and overinvestment in instruments that could be shared between providers in a group practice.

Until recently average salaries for skilled providers were higher in the private sector than the public one; an expected trend given the greater insecurity of employment in the private sector. In the last couple of years, however, the government increased provider salaries so that public-sector salaries are usually higher. Nurses and midwives entering practice can expect to earn between 20,000N and 25,000N per month (between $160 and $200) in the public sector versus 7,000N to 18,000N (between $56 and

$144) in the private sector. These public-sector salary increases are likely to increase pressure on private clinic operators to raise their salaries for nurses and doctors, which will hurt their profitability and discourage further investment.

While this assessment did not evaluate opportunities in the banking sector, most of the providers in private practice indicated that formal access to credit is almost unheard of in the health sector. The conditions of lending virtually exclude assisting young doctors who do not have established clientele and require three to five years to build a practice. Most of the providers who have established their own businesses have done so through personal and family savings. The only provider contacted who had obtained a bank loan was a pharmaceutical wholesaler in Kano who said the loan was to purchase stock and that he had to offer other stock as collateral for the loan.

Until recently the banking sector was overextended and banks were only able to lend to the most profitable businesses. Recent efforts by the Ministry of Finance to improve stability and performance in the banking sector by increasing capital requirements have led to significant consolidation. Some of the new, stronger banks now are expanding their lending portfolios. USAID Nigeria recently concluded a Development Credit Authority (DCA) deal with two of the larger banks: Zenith Bank, working in credit access to medium and small enterprises, and Fidelity Bank, working in housing mortgages. The program for medium and small enterprises is not sector-specific, and health providers could be eligible to participate in it. This program provides for loans up to 5 million naira at competitive interest rates.

Although new lines of credit may offer opportunities for health providers, they also create new risks, especially for providers who are unaccustomed to, or even resistant to, managing their practices as businesses. Some of the initial work with Total Health Trust providers and comments informants made during the assessment suggest that cost-management or tracking systems are rare for private practices. Even doctors who have spent most of their careers in private clinics tend to see themselves as public servants. During a meeting of the Pharmaceutical Council, an official in its national body proudly asserted that community pharmacies are not businesses but are services. That statement may be an admirable expression of spirit, but the reality is that community pharmacists require profits to work in a community and improved business management would extend the reach of their services.

Most providers are members in their professional associations, but those organizations vary from one chapter to another in their effectiveness. Typically each state has a different chapter in addition to the national body. In theory all associations offer continuing medical education, conduct advocacy work on issues of significance to their members, and encourage adherence to quality standards. The majority of professional associations' members work in the public sector and have their membership fees deducted directly from their salary. Private-sector providers contribute a much smaller share to the revenues of professional associations. As a result issues of interest to private-sector providers receive lower priority. Because of difficulties collecting dues from private-sector providers and because private practices are less profitable, the Kano chapter of the nurse and midwife association does not expect contributions from its private-sector members.

While there are private-sector associations for each professional group (nurses and midwives, pharmacists, and medical doctors) most are not active and do not have chapters in every state. The associations with which the assessment team met were probably among the more active. Even with the national associations' chapters, it was clear that association leaders struggled to meet the needs of their members. In general the professional associations are caught between having to provide significant levels of service while relying on the inadequate resources of their members. This problem was true

for associations of small-scale providers, such as the community pharmacists, as well as for the Guild of Medical Directors, which is the association of clinic and secondary facility managers.

5.3 SERVICE REGULATION

In general the scopes of practice for service providers are well thought out and do not constitute a constraint to private-sector development. The Ministry of Health has a thorough designation of reproductive health responsibilities printed in the booklet *National Family Planning Reproductive Health; Guidelines and Standards of Practice*. For family planning, the guidelines specify the following scope of practice.

- Patent medicine vendors (PMVs) and traditional birth attendants (TBAs) can sell condoms and oral contraceptives (OCs) for refills (they must refer first-time OC users to qualified providers for consultation).
- Licensed pharmacies can sell emergency contraception and OCs without prescription.
- Nurses can counsel patients about family planning, initiate and resupply oral contraceptives, and administer injectables.
- Midwives can perform all of the aforementioned functions plus insert intrauterine devices (IUDs) and implants (if they have been trained how to perform this procedure).
- Physicians can perform all of these functions.

The Pharmacy Council of Nigeria (PCN) regulates pharmacies and PMVs. The impetus for creating the PMV practice was to expand access to basic medicines in rural and underserved areas. The Ministry of Health drove this undertaking, and initially it was responsible for issuing PMV licenses. But this function proved controversial, especially as PMVs in urban areas proliferated because of ineffective enforcement of licensing guidelines. The PCN is making a more concerted effort to ensure adherence to the laws defining PMVs' scope of practice. PMVs have no minimum training requirement, although several of the ones the assessment team interviewed have Community Health Extension Worker (CHEW) qualifications or nurse or midwife training. Responsibility for licensing PMVs was transferred back to the PCN in 2003, which has slowed down issuing of licenses in an effort to exercise more control over the localization of PMVs. A number of PMVs have not had their licenses issued despite having submitted their fees and applications more than a year ago.

Pharmacy Council published a list of drugs that PMVs can dispense. It includes basic painkillers, antimalarials, antihelmitics and over-the-counter antiseptics, cold and cough remedies, and vitamins. It does not include antibiotics or drugs requiring prescriptions. The approved PMV drug list shows only condoms and foams as allowed family planning supplies. All parties understand that OC resupply is permitted for PMVs under Ministry of Health policy, but the absence of OCs on the published list could be abused by inspectors, as they are authorized to seize any drugs in a drug shop that are not on the list. Most of the PMVs the assessment team visited sold antibiotics and other drugs not on the list of approved medicines.

The National Nurse and Midwife Council licenses both groups. Midwifery has been a higher qualification for nurses who already had been registered. In a change of policy, the government is just beginning to train some combined nurse midwives at first degree with the expectation they will serve in the

community. There are still large rural areas where the highest level of reproductive health professional available is a CHEW or TBA. This detail partially explains why such a large percentage of deliveries are assisted by TBAs. Government policy is to tolerate TBAs but emphasize referrals and training so they recognize high-risk pregnancies that are beyond their competency. A nurse midwife can undertake the full scope of practice permitted by the council in his or her own private facility. This support includes well-child and reproductive health care and treatment of "minor illness," but it also extends to malaria and common infectious diseases. There is a list of primary care drugs that the registered midwives may prescribe, stock, and dispense. This list includes all family planning products described previously, except implants (which are too new to be on the list).

Nurse and midwives must have and renew a practicing certificate every three years, and they must attend one approved workshop in each three-year period to qualify. There is no computerized list of registered nurses or midwives with practicing certificates, so any conclusions about distribution depends on information from public-sector postings and data on licensed private practices from the states. The nurse and midwife council approves training programs.

A nurse may open a private nursing home and a midwife may open a private maternity home after five years of being registered and serving in the public or private sector. Each state health department issues the license for the private facility, not the nurse or midwife council. The home may be an outpatient-only practice, but it can have beds and a maternity home performs deliveries. States can enforce standards in excess of those established by the National Nurse Midwife Council, so there are discrepancies between the states. In Lagos state, for example, a maternity home must be supervised by a physician, although the national law (1992) says only that the licensee must "demonstrate unequivocally that there is prompt access to a practicing obstetrician and gynecologist or an experienced medical practitioner …who has legal responsibility for attending in emergencies." It seems possible to comply with this law through a referral agreement and on-call or transfer arrangements, but Lagos state requires on-site supervision by a doctor. The law appears to preclude a government-employed practitioner from obtaining a private practice facility but not from working in one. The nurse associations seem to accept this interpretation, but the Nigerian Medical Association says that many private facilities are owned and operated by doctors with government positions, and that when he was minister of health, Dr. Ransom-Kuti permitted this arrangement.

Virtually all states have a supervisory requirement involving physicians, which in practice means that nurse midwives must pay physicians a consulting or supervision fee. Unfortunately the lack of clarity about how much supervision is required constitutes a constraint for some nurse midwives wishing to establish their own practices. At the Zakaria Nursing and Midwife Clinic in Kano, for example, a physician earns a flat salary of 45,000N per month for being at the clinic seven hours a day, five days a week, and he earns 50 percent of all fees charged. Such costs can significantly hinder a clinic's profitability. These arrangements appear open to negotiation between the proprietor of the nursing clinic and the physician, with the physician having an advantage as the clinic must have some arrangement with a doctor to satisfy the supervision requirement.

The Nigerian Medical and Dental Council registers physicians. Renewal of registration (a practicing certificate) is required every two years, according to the acting registrar, with 24 hours of continuing medical education required in each renewal period. The council also approves the institutions that are qualified to conduct continuing medical education. Especially in the case of family planning, the Ministry of Health (often with donor funds) and nongovernmental organizations (NGOs) perform most

clinical update training. Ministry of Health training programs are nominally open to the private sector, but there are no mechanisms for identifying and recruiting private providers to attend government- or donor-supported training. Typically invites to private-sector providers are ad hoc and depend on personal connections. Of course, given the fluidity between the public and private sectors, public-sector investments in training often reach private-sector facilities. It is unclear what the criteria are for courses that qualify as continuing medical education, although the standards seem to be flexible. All councils think that training about management within the NHIS (such as capitation, covered benefits, and preventive skills) would be appropriate for continuing education credits.

Under its own rules and procedures, each state health department licenses facilities. Before providers can establish a practice, the state must license their facility—even if it is licensed and registered at the national level. The licensing requirements vary from one state to another, as does the monitoring and enforcement of licenses.

5.4 SERVICE QUALITY MONITORING AND ASSURANCE

The assessment team was not able to identify any significant assessments of the quality of care in the private sector, even with a limited focus on reproductive health. Government and donor resources have been focused on the public sector, and the main strategies addressing quality have involved increasing and strengthening supervision and training. Thus most of the evidence about quality in the private sector is partial and anecdotal. Paradoxically the private sector in Nigeria seems to provide both the best and worst quality of health care. In Lagos and other major cities, some of the private hospitals and clinics serving the upper-income groups offer the best care in the best facilities with the most well-trained staff in the country. The vast majority of private-sector care (and the vast majority of the out-of-pocket expenditures), however, are spent on providers at the other end of the spectrum—TBAs, community health workers, PMVs, traditional healers, and quack doctors.

Given the high share of deliveries attended by TBAs (20.4 percent according to the 2003 DHS), government and policy makers cannot ignore these providers. Still there are concerns about the quality of TBAs' services. According to COMPASS staff that works with some TBAs in Lagos, the focus of collaboration with TBAs is to improve their links to clinics, train them to recognize complications, and emphasize the need for referrals. A small study of TBAs in Atakumosa, Nigeria, identified a number of common concerns of TBAs: lack of a facility for deliveries, no recognition of at-risk pregnancies or complications, and lack of referrals. The TBAs the assessment team interviewed who had benefited from COMPASS training were able to cite the signs of at-risk pregnancies that should be the basis for referrals. During the discussions, however, they also said that in traditional practice, complications call for incantations or other more occult solutions. For traditional providers it is not customary to refer patients to more qualified providers. This information points to another factor in the use of unskilled providers in the private sector: an apparently large number of Nigerians do not perceive quack doctors or traditional healers as low-quality practitioners of Western medicine, but instead view them as quality providers of African medicine. This belief raises a broader issue about western "modern" medicine vs. African traditional medicine that would require more research to design effective demand-creation strategies.

Data is available in the DHS on one indicator of quality: informed choice for contraception. On this basis private-sector providers seem to be offering lower quality services than the public sector.

TABLE 2: INFORMED CHOICE IN PUBLIC AND PRIVATE SECTORS

	Informed about side effects of method used	Informed what to do if side effects are experienced	Informed of other methods that could be used
Public sector	64.5%	60.3%	69.5%
Private medical sector	36.1%	34.8%	46.6%

Source: Demographic Health Survey 2003

To be fair the DHS classified pharmacies as a private source; as many women obtain OCs from pharmacies, in the aggregate this table is comparing public-sector providers that have higher scopes of practice with private ones. Nevertheless it does underscore the need to improve quality in the private sector. This finding is one of the reasons SFH has emphasized training pharmacists and PMVs as one of its quality-improvement strategies in the Improved Reproductive Health in Nigeria (IRHIN) project. Even if equivalent scopes of practice were considered, it would not be surprising if public-sector providers were better informed as they have had greater access to donor-supported training.

Quality monitoring and assurance among private service providers is mostly theoretical. State ministries of health, which issue licenses, are responsible for ensuring that facilities comply with licensing regulations. But in reality these ministries have few resources to conduct any quality-control or monitoring activities. (The fees received for licensing are supposed to fund continuing education, advocacy, and monitoring.) The professional associations also are expected to have a role in assuring quality. Large chapters of the National Medical Association have committees on ethics and discipline that investigate complaints against licensed providers. Complaints are rare, however, and investigations and sanctions still rarer. Identifying poor-quality providers is dependent on patients having the courage to make a formal complaint.

Continuing medical education conducted by professional associations also contributes to quality, but these sessions are offered on an opportunistic basis and not in response to any training-needs assessments. The exception would be continuing medical education sponsored by NGOs, such as Pathfinder and SFH, which have designed training strategies around documented provider needs. Pharmaceutical companies also sponsor continuing medical education, and some contraceptive manufacturers have supported continuing medical education in reproductive health.

The only mechanisms for quality assurance in the private sector are through the routine renewal of licenses and verification that educational requirements have been met. The NHIS manages an accreditation system, although the standards for selecting providers are not high (it focuses on facility infrastructure without any assessment of provider knowledge or service quality). NHIS has prioritized rolling out the scheme and extending coverage to as many providers as possible, as long as they demonstrate a valid facility license and professional (medical council) registrations. The HMOs feel these standards are basic and would prefer to raise the bar and have a more central role in accreditation themselves. Discussions are underway between the NHIS and HMOs to find cost-effective mechanisms to institute quality assurance and monitoring, or to involve an independent body that can assume these functions.

5.5 PRIVATE-SECTOR PRODUCT SUPPLY

One simple measure of the security of contraceptive supplies is the number and diversity of entities manufacturing them in or importing them into a country. By this measure Nigeria is doing well with a variety of governmental (national), donor (USAID, the United Nations Population Fund (UNFPA), and the U.K. Department for International Development (DFID)), NGOs (SFH, IPPF, and CHANPHARM), and commercial entities bringing contraceptives into the country. On other measures, however, Nigeria is not doing as well. DELIVER's contraceptive-security index considers distribution systems, information systems, forecasting, policy, gross national product per capita, poverty level, and other demand and use criteria. On this aggregate score, Nigeria is the 9th worst country of the 57 that were assessed. While this index has a bias toward public-sector systems, the policy and demand criteria are relevant for the private sector and Nigeria scores poorly in those areas as well.

Most donor investments to increase and improve reproductive health supplies have focused on the public sector. Besides product procurement and donations (especially from USAID, UNFPA, and DFID), effort and investment has gone into strengthening the logistics and management systems of governments at all levels. In this respect the decentralization of the federal system has complicated efforts to make products available on a sustainable basis in the private sector. Simple logistics systems tend to be the most sustainable, but the federal system in Nigeria necessitates working through the national, state, and local government area (LGA) governments, even when it would be more efficient not to. After the fall of the Abacha regime, USAID funded the DELIVER project to support the government's contraceptive logistics system, which had suffered from neglect since the departure of USAID from Nigeria in the early 1990s. A midterm evaluation of the DELIVER project showed significant progress from 2002 baseline in systems and overall availability, but many problems remain in terms of stockouts. During the six months prior to the survey, 14 to 33 percent of service-delivery points experienced prolonged stockouts of injectables or pills (DELIVER Midterm evaluation).

In some markets gaps in the public-sector supply system create opportunities for the private sector to provide contraceptives. With the exception of the social-marketing program, however, commercial supply sources have not achieved significant market shares. The largest player in the commercial market is Schering, which sells *Microgynon* through commercial channels and supplies *Noristerat* through SFH. The social-marketing products dominate their respective markets. According to SFH its condoms have a 73.8 percent share of the total market, its oral contraceptive have a 79.5 percent share of the total market, and the SFH injectable has a 61.3 percent share of the total market (the total market means all commercial and public sales and distribution) (Population Services International 2005 Annual Sales Report 2005). These statistics beg the question: With a population of more than 130 million people and a growing economy, why haven't more commercial manufacturers invested in increasing the Nigerian contraceptive market?

The current government's reforms are making Nigeria more business friendly, but change takes time to be felt, and for the moment Nigeria remains a risky place to conduct business. Unless companies feel their prospects are good for generating a higher-than-average return in a shorter-than-average payoff period, they will not invest. The contraceptive market in Nigeria has not reached a maturity that satisfies those criteria. As noted previously demand is low and distribution costs are high. Although supplies in the public sector are generally inadequate for meeting demand, they are unpredictable and there is frequent leakage from the public sector to the commercial one. Fear of competing with a dominant

player like SFH, which has non-profit status, and donor support also may be a factor. Finally there have been serious problems with drug counterfeiting and quality control in the past. The National Agency for Food and Drug Administration and Control (NAFDAC) has made a substantial effort to address these problems, but they persist and companies are reluctant to risk their brand equity where the possibility of knockoffs is high.

If reforms persist and the business climate continues to improve, opportunities for private commercial marketing of contraceptives may get better, especially for generic southern hemisphere-based manufacturers that offer quality contraceptives at lower prices than the research and development multinational companies. For this reason PSP-*One*'s initiative to launch a mid-priced OC should be instructive about the viability of commercial investment.

Another problem that constrains sustainable contraceptive supply is the insufficiency of product-delivery points. The number and coverage of pharmacies and product-delivery points is too low to reach potential users. SFH estimates that its products are sold in 300,000 outlets nationwide (2005 SFH Marketing plan 2005). The bulk of these outlets, however, are PMVs and non-traditional outlets selling condoms. The PCN reports 2,639 registered pharmacies as of the end of 2005. The number of pharmacies operating effectively is likely to be fewer than this number, as registration lists rarely are corrected to accommodate pharmacies that have closed. Not only is the number of pharmacies small, but their distribution is inequitable as well. According to the PCN, there are only three registered retail pharmacies for all of Jigawa state and its 4 million people. This figure is in sharp contrast to parts of Lagos where pharmacists complain about an excess of competition in certain residential areas. Even with demand at low levels, if providing OCs (for first-time users) and injectables is restricted to pharmacies, the number of outlets is inefficient to maintain access to contraceptives. No amount of investment by contraceptive manufacturers will address this issue. One must look at the factors that are discouraging the creation of more retail pharmacies.

As noted for services, many of the constraints to opening small businesses apply to pharmacies. Lack of access to credit, poor infrastructure, high transportation costs, and low consumer willingness to pay are all important factors that discourage trained pharmacists from opening retail outlets, especially in more rural areas. All of the pharmacists and PMVs the assessment team interviewed said they were obliged to start their businesses with savings and family support, and that the lack of access to credit for working capital is an ongoing constraint to maintaining sufficient stocks, meeting demand, and staying profitable.

Unlike the public-sector logistics systems, private-sector channels for product delivery are rational and efficient in urban areas. SFH uses commercial channels available to all commercial providers, so their system reflects the private sector. SFH delivers its products to a number of depots managed by Manufacturers Delivery Services (MDS). Then a network of 50 approved wholesalers procure SFH products from MDS depots on a cash-and-carry basis. These wholesalers then serve retail outlets. All of SFH's wholesalers are licensed pharmaceutical wholesalers, but there are many operating in Nigeria that are not licensed, especially in the three large unregulated drug markets of Lagos, Onitsha, and Kano. Even some licensed wholesalers that operate facilities that conform to the laws sell in the unregulated drug markets because of client demand. The following data from SFH's 2004 Distribution survey shows the efficiency of this system.

TABLE 3: PERCENTAGE OF RETAIL OUTLETS THAT PERCEIVED DIFFICULTIES STOCKING SFH PRODUCTS, BY PRODUCT

Condom	Oral contraceptive	Emergency contraception	*Noristerat*	*Depo Provera*	IUD
6.9%	7.1%	8.9%	10.8%	7.3%	8.2%

TABLE 4: PERCENTAGE OF OUTLETS ABLE TO REFILL ORDERS FROM WHOLESALER IN LESS THAN A MONTH, BY PRODUCT

Condom	Oral contraceptive	Emergency contraception	*Noristerat*	*Depo Provera*	IUD
80.2%	66.5%	73.1%	55.1%	59.1%	51.3%

Although far from perfect, these indicators contrast favorably with the public sector's system. While efficient, the private sector's distribution channels are difficult to regulate for quality (see section 5.6). Unlike most sub-Saharan countries where pharmaceutical products are distributed in channels distinct from fast-moving consumer goods, in Nigeria these products are distributed in the same channels and are handled and stored by traders in conditions inappropriate for pharmaceutical products.

Like pharmacists, PMVs resupply from pharmaceutical wholesalers and are subject to the same transportation and restocking costs, although the range and quantity of their products is generally a small fraction of a pharmacy's. SFH estimates that 200,000 PMVs operate in Nigeria, although it is hard to identify a reliable source of data for this figure. As with other facilities, licenses are issued at the state level and there is no authority aggregating data at the national level. Moreover data at the state level is likely to be unreliable. Issuing of PMV licenses has passed from the Ministry of Health to the PCN, which has been reluctant to issue licenses. According to the PMV association, a large number of PMVs operate with their license applications pending for longer than a year. This delay has lead to a number of PMVs operating without licenses.

According to the regulations, PMV proprietors only need to read, write, and pass an interview. In fact a significant number of PMV proprietors have medical training well beyond what it required—community health agents, midwives, and nurses all operate PMVs. The assessment team met a retired nurse and a midwife who operate PMVs. Both of them said that they opened a PMV facility because it was the easiest facility to obtain a license for and establish in terms of the regulatory requirements and the required capital. It is hard to know how prevalent this situation is, but it points to one reason so many PMVs exceed the scope of practice for their facility and to the difficulties of small health entrepreneurs. Both the nurse and the midwife admitted to selling antibiotics, giving injections, and providing other drugs not on the approved list of medicines for PMVs. When asked about it, they maintained that the scope of practice for their profession allowed them to supply these products and services, even though they were operating in a facility that is not legally able to do so.

According to many informants, the intent of creating the PMV facility was to increase access to basic palliative care in rural areas. A large number of PMVs, however, are established and operating in urban and peri-urban areas, some in close proximity to pharmacies. The location of PMVs in urban areas is the

biggest source of tension between pharmacies and PMVs because PMVs can compete against pharmacies with lower operating costs. In theory such competition should be limited and managed by issuing PMV licenses for sites that are far away from pharmacies. According to the Pharmacists Council of Nigeria Act of 1992 (Ogunbona 2005), there is no restriction of PMVs to rural areas. The law only states that there should be no more than three pharmaceutical premises in a shopping area and that they should be "well spaced out." Elsewhere it states that no two premises should be within 200 meters of each other. Even with such flexibility, there are some urban areas where even these limitations are not respected. It is unclear to what degree the problem is with licenses being issued improperly or whether PMVs are not respecting the zoning restrictions on their licenses. The assessment team heard reports of both occurring.

In recent months the PCN has been engaging in a public campaign to restrict PMV licenses and sanitize the pharmaceutical market. It is organizing regional meetings with pharmacists and members of the licensing committees in a number of states. While the PCN is addressing serious issues concerning the quality of drug handling, storage, and dispensing, it is unlikely that reducing the number of PMVs in urban areas will provide a lasting solution. Keeping PMVs out of urban areas will not make it any more viable for them to establish and maintain their businesses in rural areas. Moreover it is unclear that the existing pharmacies can meet the demand or that many new pharmacies would open in urban areas if PMVs were kept out and unskilled pharmaceutical wholesalers were put out of business. The existing pharmacists lack the capital and business training to move the quantities the market demands. It is instructive that after NAFDAC shut down the Kano informal wholesale drug market, the market reestablished itself within a few months and now appears larger than ever. Formal trained pharmacists could not take advantage of the closure and mobilize a viable alternative to meeting the demand, even while offering better quality.

5.6 PRODUCT QUALITY

Assuring product quality is done through two main functions: the first is ensuring drug purity, which NAFDAC regulates, and the second is ensuring that pharmaceutical products are stored, handled, shipped, and sold in conditions that protect the efficacy of the products. This latter function is the domain of the PCN. NAFDAC is a national government agency with staff and budget supported by the government. While the PCN is mandated by the government to issue licenses and monitor licensed facilities, it is not a government agency and receives little or no government financial support. It is expected to perform its job with the proceeds of licensing fees. In the past few years, NAFDAC has become a high-profile government agency, due largely to the charisma of its director, Dr. Dora Akunyili, and her crusade against illicit drug manufacturers and distributors. The progress NAFDAC has made is impressive. All of the wholesalers the assessment team contacted said that NAFDAC inspectors frequently monitored the markets and that no one would risk buying and selling drugs that did not carry the NAFDAC registration. Some wholesalers said that if they were approached with drugs that had an NAFDAC number from a dubious source, they would call NAFDAC to make sure the registration was legitimate.

This change in attitude has been brought about through vigorous enforcement, including well-publicized product seizures, prosecutions, and inspections. NAFDAC's mandate includes not only drugs, but also food and other consumables. Thus far NAFDAC has not built sufficient capacity to test more than a small number of lots of drugs imported or manufactured. Its principle approach has been to lot test a

manufacturer to qualify it for an NAFDAC registration. Once registered, if a manufacturer produces a substandard lot, it is not likely that NAFDAC would be able to stop its distribution. WHO and DFID have helped NAFDAC build up this capacity, but there is still a way to go. DFID reports that a recent sampling showed that up to 40 percent of drugs were substandard, including drugs from NAFDAC-approved manufacturers. Contraceptives have not tested badly, but distribution of contraceptives along with other prescribed drugs is likely to be affected if NAFDAC institutes new procedures around batch testing prior to distribution.

Ensuring proper handling and storage of drugs is an easier problem than guaranteeing drug purity, but it is still one that requires significant resources. As currently funded PCN does not have such resources. Inspection of PMVs is funded only by the 1000n licensing fee, which is not enough to support staff and logistics capacity. Besides the zoning problem of PMVs, many sell drugs that are not on the approved list, and many store and repackage drugs in a manner inconsistent with policy. The assessment team observed a few PMV proprietors repacking products into smaller quantities to make them more affordable to consumers. This practice may seem harmless, but sometimes such actions can have serious consequences. To monitor PMVs closely enough to reduce or eliminate such practices would require far more resources than the PCN and its PMV committees are likely to be able to mobilize.

The two quality functions, or course, are not completely separate. It can be argued that the more untrained commercial traders are involved in selling drugs through unregulated premises, the more likely that low-quality drugs will find their way into the distribution channels. When qualified pharmaceutical staff in accordance with the law perform procurement, handling, and shipment, it is less likely that low-quality products will get into the system. According to the DFID representative, the lowest incident of substandard drugs was found in the city of Jos, due to the high proportion of drugs in that area that were procured through CHANPHARM's procurement agency, which procures mostly generic European drugs and manages drug importation and storage down to the retail level. The Partnership for Transforming Health Systems project has developed an interesting model in Benue state for a pharmacy depot that works on a revolving fund basis and resupplies both public- and private-sector providers. This model might be a way to ensure that low-quality products stay out of the commercial retail market.

Enforcement of quality-assurance laws has to be done with balance. Strict enforcement of all of the rules without any compensatory measures to increase access could put more drug sellers out of business and further reduce access to care. Moreover some of the regulations appear to add little value to drug quality; for example, according to the laws, pharmacy premises have to be owned and cannot be rented. Currently there is too little regulatory enforcement, however, which is compromising drug quality without increasing access where it is most needed.

5.7 CROSS-CUTTING AREA: THE NATIONAL HEALTH INSURANCE SCHEME

Several years in the making, the National Health Insurance Scheme (NHIS) is in the process of a national rollout. While it is still early in the operational phase, prospects are encouraging and the potential is significant, especially for developing the private sector for health. Most providers the NHIS contracted (80 percent) are private. A national health insurance scheme could increase financial access to health services for a large segment of the population, provide leverage for ensuring quality through provider accreditation, and encourage the creation of new health practices by ensuring providers have regular income streams. For these reasons the NHIS deserves special attention in any private health sector initiatives.

In the current phase of its rollout, the NHIS is limited to federal employees, their spouses, and up to four dependent children. As of June 2006, 700,000 people are enrolled, and the NHIS predicts enrollees will expand to 3 or 3.5 million by the end of July 2007 when all federal employees should be enrolled. The law provides for separate categories of the NHIS for government, the private formal sector, informal-sector groups, and vulnerable populations (such as children and people with disabilities). The strategy is to phase in each group as funds permit. The law calls for employer contributions to be 10 percent of an employee's salary and an employee deduction of 5 percent. To get started funds are not being deducted from federal employee's salaries for a two-year experimental period. Negotiations are underway with the states to expand NHIS to their employees, but there probably will be issues about the states' ability to fund 10 percent of their employees' salaries.

The NHIS is planning to operate through 24 HMOs. Eight HMOs were already in the commercial market and have active contracts with the NHIS. Recently the NHIS accredited an additional 16 HMOs. Even for pre-existing commercial HMOs, the number of NHIS enrollees is several times the commercial enrollment.

The NHIS system is based on a capitation payment (fixed sum per person regardless of services) to accredited primary care providers for most of the basic benefit package. The current primary care capitation fee is 550N per enrollee per month with no variation for location or enrollee demographics. There is no stop-loss limiting the risk the primary care provider assumes for the covered benefit package. From this capitation the primary care provider is expected to pay for his or her primary care services, antenatal and postnatal childcare, all required drugs from the essential drug list, and the first 15 days of required hospitalization. The NHIS reimburses the provider for up to four routine deliveries.

The selected primary care provider acts as a gatekeeper for referral services (to consultant specialists), which the HMO pays a fee for out of a portion of the full premium set aside to cover these costs. A woman's first pregnancy is to be referred to a specialist for delivery, although the primary care physician is to perform antenatal care until week 37 unless a complication develops. This first delivery and any C-sections are referred to a specialist, which the HMO pays. The HMO also pays fees for service for an additional 14 days of hospitalization (days 15 to 29), up to an annual cap of 29 days of inpatient care.

Family planning consultation is included in the primary care capitation. While family planning supplies are not an NHIS benefit, the provider can charge fees for services including IUD insertions and sterilization. NHIS has no policy against family planning, but it appeared that all services that could be left out of the reimbursement package (to keep premiums low and the system sustainable) were omitted. As with highly active antiretroviral therapy (HAART), which also is not included, it was reasonably expected that other, donor-supported efforts would make those services affordable and available.

All well-child care and routine childhood illness care is included in the primary care capitation. The primary care provider is to give all required immunizations at no cost to the patient, obtaining the vaccine from government stocks at no charge.

The NHIS covers essential drugs, with the patient to make a 10 percent copayment and the provider to pay the remaining 90 percent out of the capitation. The NHIS rules require the separation of prescribing and dispensing; the NHIS primary care provider is supposed to refer patients to a pharmacist unless his or her facility has a licensed pharmacy. The primary care provider arranges to pay the pharmacist (less

the 10 percent copayment) out of his or her capitation for essential drugs. The NHIS does not cover prescription drugs not on the essential drugs list. This scheme for drug reimbursement is not feasible in many areas of Nigeria because of the shortage of licensed pharmacies. Essential drugs obtained through PMVs are not reimbursable in the NHIS. Some doctors also worry that patients will not or cannot afford to travel to a pharmacy and they may not fill their prescription. Pharmacists are unhappy about being dependent on primary physicians for their payments. Now they will have to market themselves to physicians to be eligible for NHIS reimbursements. Consumers are not able to fill their prescriptions where they like, but instead will be limited to using pharmacists with whom their physician has a business relationship for reimbursement.

Enrollees are assigned to an HMO according to their place of work. HMOs provide a list of primary care providers and enrollees pick available providers from this list. Enrollees receive photo ID cards (for a fee). Frequent switching of primary care providers is permitted.

Most HMOs see a major skills deficit in primary care providers in terms of prevention, counseling, and patient management. Previously most of their practice was episodic clinical care. Incentives were to maximize prescriptions and tests (which the clinician often provided). Clinicians did not provide much in the way of prevention or patient education. Some doctors do not even know the immunization schedule. Enrolling providers into the scheme has been led by HMOs who have struggled with how to accredit providers without investing in expensive quality assessments.

State-level branches of the NHIS are responsible for accrediting providers. Nursing homes and maternity homes can become accredited NHIS primary care providers. State facility licensure is a prerequisite for accreditation, but established HMOs feel that some facilities are being accredited that should not be (and that would not be accredited in private plans).

The NHIS also accredits HMOs for both public (NHIS) and private plans, as well as banks and insurance brokers that participate in the plan. HMOs see this function as a problem and think that the NHIS blurs the boundaries between its operational and regulatory responsibilities.

The NHIS establishes the capitation and fee schedules for drugs, tests, and referrals. HMOs process and pay capitation and fee-for-service claims. They receive 15 percent of the total premium as an administrative fee, with 1.5 percent returned to the NHIS for regulation and reserves. Current primary care capitation is 550 naira per enrollee (no differentiation and no risk cap) per month, paid in advance. The Nigerian Medical Association and some providers complain that this amount is not enough, but it seems they have done little analysis of actual costs. One of the components of the management training PSP-*One* is developing in partnership with Total Health Trust (THT) will be the introduction of practical cost-tracking systems that allow providers to assess how they are doing under capitation and what the costs and benefits are for providing reproductive health services.

6. RECOMMENDATIONS

This section contains a short list of interventions that USAID and other donors might consider. The brevity of the assessment did not permit exploring detailed design issues, so most of these recommendations will require more detailed feasibility assessments or project design work. These interventions, or variants thereof, could be combined in different ways.

1a. Expand THT pilot training program to other HMO providers

As noted previously there is a significant need to train private providers enrolled with HMOs about managing costs and services in the NHIS capitation scheme. They will have a strong economic incentive to adopt improved management systems and, if further incentive is needed, such a training program could be part of the continuing medical education requirement for license renewal. Additional related topic areas include:

- patient counseling on disease prevention
- reducing the number of unneeded drugs and tests
- improved differential diagnosis skills
- family planning and reproductive health updates
- data tracking and control systems for effective capitation management
- accessing credit and planning for growth
- immunization schedules

Donor support could include curriculum development for the initial training sessions, literature and documentation, initial faculty support, and funding the steps to accredit and enroll the programs. This work could be performed in association with HMOs and provider associations, and it should be conducted with the blessing of the regulatory councils. External technical assistance can be used for curriculum development and design, but training resources can be mobilized from Nigerian management-training companies. A primary expected result from such a program would be new emphasis on preventive care, including family planning, as providers see its importance in keeping down costs and staying profitable under capitation. SFH or other local organizations familiar with national reproductive health strategies could be contracted to develop training modules and materials.

1b. Provider training to CHAN members

A different version of this curriculum could be adapted for CHAN and its member providers. As NHIS rolls out to providers in rural and underserved areas, PSP-*One* could help establish an NHIS technical-assistance unit at CHAN. This component might have a single office or be dispersed to each of CHAN's five zones. The HMOs and NHIS would train the technical assistance team, with the assistance of PSP-*One*. The technical assistance team then would be assigned for a two-year minimum to help CHAN members in the following areas:

- understanding the NHIS system and benefits package
- comprehending the NHIS accreditation requirements and the operational and facility changes needed to meet them
- learning about NHIS reporting requirements and the systems necessary to meet them
- understanding the principles of capitation and determining its impact on facility finances
- attracting NHIS enrollees, including communicating with NHIS beneficiaries about their benefits packages
- changing clinical practices in a managed-care environment
- managing the NHIS drug benefit

This work would be accomplished by formal training sessions and facility-specific consulting, and it probably would include a hotline for facilities to inquire about NHIS problems.

The success of this intervention could be measured by looking at the increase in the number of CHAN facilities that are accredited in the NHIS and the number of NHIS beneficiaries enrolled with these facilities.

2a. Conduct advocacy for greater coverage of family planning services within NHIS

Some of the work involved in creating cost-tracking systems in recommendation 1 could inform this advocacy work, as it would permit more accurate actuarial estimates in determining family planning benefits and impact on premiums and the capitation payment.

From a policy point of view, increased coverage might be easiest to achieve by passing through government family planning commodities at the current user fee and having the provider give to the patient at this fee. The government's supply may be unreliable, however, which would tend to undercut the private and social market for family planning. An alternative option would be to add the products (except perhaps condoms) to the primary care drug list, set a price at the wholesale generic level, and then require the primary care provider to offer all methods, but permit him or her to charge the 10 percent copayment.

From a primary care provider's point of view, a better alternative might be for SFH to provide family planning supplies and then set authorized copayments to be equal to the SFH wholesale charge. That way the provider would not be out any cash when supplying the method. This approach likely would require donor assistance in modeling the cost impact in the typical practice (particularly that of a midwife) serving a large number of women of reproductive age.

2b. Conduct advocacy for coverage of HIV services within NHIS

The number of centers that are trained and qualified to provide highly active antiretroviral therapy (HAART) is increasing. Currently 60,000 Nigerians receive antiretroviral drugs (ARVs) in government-supported programs.[1] Given HIV-infection levels, the Ministry of Health projects the need to have 1.2 million Nigerians on ARVs by 2009. Thus ARV management must be pushed outward and downward to additional providers. With effective treatment AIDS will become a common chronic disease in the NHIS

[1] In the early stages of the government program, an additional 10,000 Nigerians were thought to be receiving ARVs in the private sector.

population. Integration of AIDS treatment with other primary care probably is desirable if the provider has been trained and drug supplies are available. At least initially, however, many primary care providers will not be trained in managing HAART, so AIDS treatment likely will have to be handled as a referral service and paid on a fee-for-service basis.[2] If the NHIS policy is to be changed to include HAART and AIDS treatments, analytic work must be performed before a decision can be reached. It may be a few years before there are sufficient quality treatment sites to make HAART a nationwide NHIS benefit. But the analytic work must begin now if the policy is to change before the numbers of patients overwhelm the current government-funded system. This work would include:

- updating the study on the cost of AIDS treatment to reflect prices of services in the private sector and segregating drug and testing costs
- projecting treatment costs in segments of the enrolled population, with and without test costs, and comparing them to current capitation and levels of fee-for-service costs paid by the HMOs
- designing and testing alternative risk equalization mechanisms (Assuming that AIDS treatment is paid fee-for-service, an HMO will have different costs depending on the seroprevalence and uptake in the covered population. For example, an HMO covering the police in a high-HIV-prevalence state will have greater HAART costs than an HMO covering a lower-risk profession in a low-prevalence state.)
- reviewing the experience of integrating AIDS care into private HMO plans in Nigeria and in the Dutch-supported experiment with Hygeia in a lower-income population (this analysis may provide empirical evidence on uptake and cost)
- convening stakeholder groups to review the possibility of full AIDS coverage and mechanisms for accomplishing it
- assisting NHIS in evaluating the level of risk (uncertainty) in total costs associated with preferred methods of covering treatment for AIDS
- helping NHIS develop policies, procedures, and rates for implementing this benefit enhancement, if the decision is made to include AIDS treatment in the benefit package (this work perforce will include a method to pass donor-funded ARV drugs through to NHIS enrollees)

3a. Extend family planning promotion efforts to HMO members and enrollees

In keeping with the principle of not missing any opportunities, the work with HMOs for management training could open the doors to other interventions promoting family planning and reproductive health. SFH has begun working with HMOs to support their detailing activities in the IRHIN project. PSP-*One* could work with SFH and other in-country partners to develop, print, and distribute to NHIS providers a basic patient education brochure for family planning counseling (showing each method and its benefits, disadvantages, and contraindications). These materials would be adapted from information that has been used successfully in Nigeria and is consistent with current communications strategies and national policies. The materials would be targeted to both providers and consumers. HMO providers may have increased motivation to promote family planning if they see it as a means to staying profitable under the NHIS capitation scheme.

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[2] A primary care provider that is qualified to provide HAART could do so (thus integrating care) and be paid a fee-for-service for this treatment. This approach is consistent with existing NHIS policy that permits fee-for-service payment to qualified primary care providers after receiving HMO approval.

3b. Support existing demand-creation strategies and coordinate demand creation with public- and private-sector supply-side interventions

Whenever possible investments in demand creation should be bundled with investments in increasing the quality and quantity of contraceptive supplies. According to Mike Egboh, the Pathfinder representative, there continue to be cases where demand-creation initiatives have lead to frustrated consumers who cannot obtain contraceptives from either public- or private-sector sources. To prevent consumer frustrations and to build viable markets for reproductive health providers, increases in supply must be done in lockstep with demand creation. Therefore any interventions likely to increase the private sector's supply of products and services should be done in states where USAID and other donors are investing in increased knowledge and utilization of reproductive health products and services.

The team recommends continued support and investment in the existing communications strategies emphasizing maternal morbidity and mortality and birth spacing as a means to address these problems. Such communications create demand for both public- and private-sector products and services; in the current market the private sector is unlikely to make such investments. Moreover it is critical to the development of private-sector markets in reproductive health products and services that these promising demand-creation strategies be pursued and supported.

There is also the need to avoid missing opportunities to extend existing public-sector programs to the private sector. Private-sector providers need to be systematically brought into provider training activities that support quality and help build demand. The assessment team found no formal study assessing the quality of reproductive health services in the private sector, but anecdotal evidence suggests that many providers (and their clients) could benefit from additional training. The team found, for example, that at least two private-sector providers shared common myths about IUDs, including one who said she had been a "victim" of the IUD. Private-sector interventions should take advantage of networks like professional associations and the HMOs accredited under NHIS to expose private-sector providers to the same levels of training as public sector providers.

Communications also need to create demand among consumers for improved quality in their health products and services. Low-quality products and services are undercutting quality-assured products and services, as consumers seem satisfied with lower quality or are unwilling to pay a little more to be assured of good quality. The public campaign NAFDAC waged is a good first step to encourage demand for quality goods and services, but more needs to be done. And the message that quality is worth paying for needs to be extended to the services area as well.

4. Combine increased access to credit with management training for private providers

To address the needs nearly all private providers cited, PSP-*One* or its partner project, Banking on Health, could develop a program that trains providers (such as pharmacists, nurses and midwives, and physicians) to manage their practices more effectively and help them access credit for establishing or expanding their businesses. One strategy would be to partner with professional associations in priority areas for improving reproductive health where lack of access is an issue. This intervention would give priority to providers working in reproductive health in underserved areas. Alternatively this credit and management training could become a follow-on to activities 1a and 1b by working through the HMOs and building on work already begun. In either case this intervention would build on the work done with the DCA to establish a line of credit with Zenith Bank for small and medium enterprises.

5. Work with NHIS and HMOs to improve quality assessments for NHIS accreditation

As noted in the report, the weakness in quality assurance for NHIS is an ongoing issue. Given the quality-monitoring issues for health services, it would be a missed opportunity not to use the leverage NHIS accreditation offers to improve quality standards in the private sector. Moreover the NHIS scheme offers a funding source to support the time and effort that must be spent instituting quality-improvement measures. What is not clear at this stage is whether this function should be kept in-house at NHIS or whether NHIS should contract it out to HMOs or an alternate body. On one hand, HMOs have a stake in preserving their brand equity by ensuring that all member providers meet quality standards. On the other hand, there is need for standardization in the approach to quality monitoring, and doing so might be more difficult by having to work through multiple HMOs. Economies of scale might be lost as well. Also some work would be needed to develop cost-effective tools for assessing quality in the private sector. Some of the work PSP-*One* has done in developing a quality-improvement tool for a midwife network in Uganda could be adapted for the NHIS's needs. It is likely that professional associations would have to be brought into this intervention at the design and operational phases.

NHIS also made a request to the assessment team for technical assistance training insurance regulators who are needed to monitor the HMOs and providers. This need is a legitimate one to ensure good governance and public confidence in the NHIS. The team urges USAID and other donors to consider this request, even though it may be remotely linked to improving reproductive health in Nigeria.

6. Design and implement a pharmacy network pilot to test and evaluate new strategies for increasing quality and access to pharmaceutical products and contraceptives

The status quo in pharmaceutical supply is low quality and low access. Quality control measures on PMVs alone may further restrict consumer access to essential medicines. Support to PMVs without quality control could increase the race to the bottom and further undermine viable pharmaceutical provision. New approaches need to be designed, implemented, and evaluated to solve these difficult problems. PSP-*One* proposes designing a pilot pharmaceutical network with the following characteristics.

- Create a new PMV scope of practice with higher training levels required, but a larger range of products and services authorized with supervision by pharmacists.
- Conduct pooled procurement and distribution for network members building off of the CHANPHARM depot model developed in Benue state. Network members would be assured of selling quality products and competitive or cheaper prices, and they would be able to obtain them more conveniently than buying from unlicensed pharmaceutical wholesalers.
- Increase access to credit to establish and expand businesses.
- Strengthen supervision and quality monitoring of retail outlets by a network franchisor to be staffed by representatives of the PCN, the PMV association, and the Association of Community Pharmacists. One possibility would be to have pharmacists create rural satellite PMVs, which they would be responsible for supervising and resupplying.
- Conduct joint branding of all pharmacies and PMVs in the network to promote quality and increase clientele.

There are obvious links with recommendations 1 and 4 for training and access-to-credit for pharmacists. Such an undertaking also would require an in-depth feasibility study to:

- identify an area with significant needs but that also offers sufficient opportunities to create and maintain viable pharmacy businesses
- negotiate a design acceptable to the PCN, NAFDAC, and state ministries of health
- provide costs on the provision of services by the network franchisor and establish a fee structure for membership in the network
- design monitoring and evaluation strategies

Ideally representatives from the PCN, PMV association, and NAFDAC could be part of the design team for a pilot and would be involved in management and monitoring. The monitoring and evaluation design would have to permit evaluation of pilot subcomponents as well as the overall effect on increasing access to essential drugs and contraceptives. The pilot may prove to be a success in one area (such as increasing access to credit to support business expansion) while failing in another one. To best inform the advocacy efforts, which would follow the evaluation of the pilot, it is important that each subcomponent be considered in the evaluation design.

Depending on mission priorities and interest, PSP-*One* can develop these recommendations more fully, including cost estimates and illustrative timelines for implementation.

ANNEX 1: SCOPE OF WORK

SCOPE OF WORK: NIGERIA PRIVATE SECTOR HEALTH ASSESSMENT

BACKGROUND

- Health conditions: growing population of over 130 million, CPR at 8%, high maternal and childhood mortality rates. There is significant disparity in urban and rural CPR.
- Donor investment in reproductive health has primarily focused on the public sector with limited success.
- Highly developed, diversified private sector for products and services, accounting for 74% of total health expenditure (WHO). According to the 2003 DHS, 48% of current FP users obtained their method from a private-sector source.
- Contraceptive products in Nigeria are primarily supplied through social marketing channels. The Society for Family Health, a PSI affiliate founded in 1985, distributes 80% of contraceptives in Nigeria, serving both public and private sectors.
- Private insurance market growing since the mid 90's through managed care organizations that have primarily served corporate client groups.
- National Health insurance launched in 2005 to reach formal sector public employees, and eventually the informal sector. The schemes are managed through contracts with 8 HMOs that network with private providers. Eighty percent of NHIS providers are private.
- Potential impact of the insurance market on strengthening private sector delivery is enormous. It is expected that the NHIS/HMOs together will reach over 2 million people in the formal sector alone.

OBJECTIVES

PSP-*One* will conduct an assessment of the private health sector in Nigeria to assist USAID and other stakeholders develop a strategy for working in an increasingly complex private sector environment in order to achieve reproductive health goals. The assessment will focus on supply channels for products and services and the regulatory environment affecting supply. Given the role of NHIS in growing the private sector, PSP-*One* will place an emphasis on their ability to streamline private sector growth.

PSP-*One* will focus the assessment in 2-3 of the following states where USAID/Nigeria is implementing SO 13 programs: Lagos, Kano, Bauchi, Kaduna, Abia, Cross River, FCT and Nasarawa.

PRIORITY ISSUES IN THE PRIVATE SECTOR

Product Supply

- Contraceptive supply channels are largely in the hands of the private sector (including commercial manufactures, distributors and SFH as the primary social marketing firm).
- Public sector distribution is inefficient and experiences stock-outs.

- Licensed pharmacists are limited in number and inaccessible to rural communities.
- Proprietary patent medicine vendors comprise a major source of contraceptive products--OCs and condoms—with over 200,000 in country.
- There is lack of adequate regulations and/or enforcement of quality standards around manufacturing and retails of products (especially generics).

Service Delivery

- Diversified market of providers in the private sector, including full service clinics/hospitals, pharmacy shops, PMVs, midwife clinics, traditional rural providers, and significant disparity in urban vs. rural distribution.
- The clinical capacity and range of FP services and methods offered by private providers is varied, with limited access to training and membership in professional affiliations.
- Lack of streamlined licensing / accreditation of all private sector providers, especially those functioning within NHIS.

SCOPE OF THE NIGERIA PRIVATE SECTOR HEALTH ASSESSMENT

1. Assess the diversity and distribution of private providers:

- Providers who participate in NHIS/private HMO's (hospitals, clinics)
- Licensed pharmacists
- Private patent medicine vendors (PMV's)
- Midwife/nurse clinics
- Community based providers (quasi public?)
- Other?

PSP-*One* approach:

Conduct preliminary fact-finding meetings with:

- USAID CAs including SFH, COMPASS, and the ENHASE project
- Ministry of Health and NHIS
- Professional associations such as the Nursing and Midwife Council of Nigeria, Pharmaceutical Society of Nigeria, Association of General and Private Medical Practitioners of Nigeria (AGPMPN)

2. Identify regulated providers who participate or have the potential to participate in NHIS, and assess their capacity:

- Business and management skills
- Ability to promote a range of RH/FP and other health services
- Accreditation/monitoring systems for identifying providers for recruitment into HMO networks

- Quality systems for ensuring delivery of quality services and products

PSP-*One* approach:

- Meet with a cross-section of providers (GPs, pharmacists, PMVs, midwives) in rural and urban areas.
- Work through Total Health Trust to reach providers under managed care.
- Meet providers who are accredited to NHIS but not in the HMO network.
- Work with COMPASS to identify community based providers outside the insurance market (midwife clinics, etc).
- Work with SFH to identify main issues facing PMVs and select a sample group.

3. Assess policy-level opportunities and constraints to private sector participation

- Licensing requirements for different cadres of private providers
- Access to financial, clinical and other support services
- Ability to participate in NHIS
- Incentives and disincentives presented by NHIS
- Opportunities to facilitate growth of private sector to underserved rural areas, and in the context of NHIS, to informal segments of the population

PSP-*One* approach:

Meet with Ministry of Health, NHIS, HMCAN, professional associations and other regulatory agencies.

KEY ASSESSMENT QUESTIONS:

1) Can provision of products and services through PMVs be expanded while maintaining appropriate quality safeguards?

2) In the medium to long term, what policy or regulatory changes might be implemented to increase the number of pharmacists, especially in lower income, rural areas?

3) Can an effective accreditation/quality assurance system be established to facilitate expansion of HMO networks? What entity is best placed to play the role of arbiter of provider quality?

4) How can the reach of NHIS be expanded to increase informal sector consumers' purchasing power of privately provided health (especially reproductive health) products and services?

5) Does the structure of the NHIS capitation scheme adequately motivate private providers to offer contraceptive and reproductive health products and services? If not, what changes might be made to increase incentives?

6) Is there knowledge or attitudinal barriers to increasing demand for privately provided RH products and services? How might such issues be addressed through communications campaigns or HMO network promotion?

Composition of Team
Team Leader, Jeff Barnes
Networks, Health Financing Specialist, Taara Chandani
Policy/Regulatory & Insurance Expert, Rich Feeley
Clinical Services Quality Expert, COMPASS Nigeria

LOE and Timeframe:
10-12 days for each team member, over June 11-July 3, 2006

Deliverables
Debriefing to USAID/Nigeria, trip report, including recommendations and next steps around priority issues and interventions for USAID mission, CAs and PSP-*One*.

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ANNEX 3: LIST OF CONTACTS

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Leonard Ugwu- **Nigerian Patent Medical Vendors Association (NAPMED)**

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Dr. Abdulmumin- **Nigerian Medical and Dental Council**

Ms. Bissitugbobo- **COMPASS**

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