



# Contraceptive Security in Nigeria

## Assessing Strengths and Weaknesses



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## **USAID | DELIVER PROJECT, Task Order 1**

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### **Abstract**

This report describes a contraceptive security assessment conducted in Nigeria in March 2008. The assessment identified strengths and weaknesses in seven key areas that affect the availability of reproductive health (RH) commodities in Nigeria. It also made recommendations for ways to start the process of updating the reproductive health commodity security (RHCS) strategy.

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# Abbreviations and Acronyms

ACQUIRE	Access, Quality, and Use in Reproductive Health
ARFH	Association for Reproductive and Family Health
BCC/IEC	behavior change communication/information, education, and communication
CBD	community-based distributor
CBOs	community-based organizations
CCM	Country Commodity Manager (software)
CCW	Central Contraceptive Warehouse
CHEWs	Community health extension workers
CHIME	Center for Health, Information, Monitoring and Evaluation
CIDA	Canadian International Development Agency
CLMS	contraceptive logistics management system
COMPASS	Community Participation for Action in the Social Sector Project
CPR	contraceptive prevalence rate
CSO	civil society organization
DFID	(UK) Department for International Development
DHS	Demographic and Health Survey
EDL	essential drug list
ENHANSE	Enabling HIV & AIDS, TB and Social Sector Environment Project
FBO	faith-based organizations
FHI	Family Health International
FMOH	Federal Ministry of Health
FP	family planning
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
IEC	information, education, and communication
IPs	international partners
IUCD	intra-uterine contraceptive device
JCHEWs	junior community health extension workers
LGA	local government area
LMIS	logistics management information system

NACA	National Agency for the Control of HIV/AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NDHS	Nigeria Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NGO	nongovernmental organization
NHIS	national health insurance scheme
NPHCDA	National Primary Health Care Development Agency
NPI	National Programme on Immunization
NYSC	National Youth Service Corps
OJT	on-the-job training
PPFN	Planned Parenthood Federation of Nigeria
RH	reproductive health
RH/FP	reproductive health/family planning
RHCS	reproductive health commodity security
RHCSAT	Reproductive Health Commodity Security Situation Analysis Tool
RIF	Requisition and Issue Form
RIRF	Requisition, Issue, and Report Form
SDP	service delivery point
SFH	Society for Family Health
SMOH	State Ministry of Health
SOGON	Society for Gynaecology and Obstetrics of Nigeria
SOP	Standard Operating Procedure
SPs	service providers
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
TFR	total fertility rate
TWG	Technical Working Group
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
YOSPIS	Youth Society for Prevention of Infectious Diseases

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This summary is taken from the report titled “Nigeria: Reproductive Health Commodity Security Situation Analysis,” March 2008, which was authored by Marie Tien, Sylvia Ness, Ugochukwu Amanyeiwe, Echendu Adinma, Uzo Ebenebe, and Azubike Nweje. (Awaiting publication)



# Executive Summary

The contraceptive security assessment conducted in Nigeria in March 2008 attempts to identify the strengths and weaknesses in seven key areas that affect the availability of reproductive health (RH) commodities in Nigeria. These seven areas include political and socio-economic context, coordination of (reproductive health commodity security (RHCS), commitment toward RHCS, financing for contraceptives and services, provision of family planning commodities, client utilization and demand, and the logistics system capacity. The assessment also attempts to make recommendations to start the process of updating the RHCS strategy.

The assessment revealed that a number of enabling policies provide a supportive framework for reproductive health for women, men, and young people. However, the National Reproductive Health Policy and Strategy and the RHCS strategy have not been adapted to the state level to fit the context of each state with accompanying indicators and targets. This lack of adaptation is partially the result of a lack of awareness on the part of state-level stakeholders about the need to develop state specific policies related to reproductive health. Additionally, although RH as a priority is commonly addressed, specific family planning (FP) activities are not always included in health reform initiatives. Where one finds a commitment for family planning, that commitment has not always been demonstrated with adequate financing for programming.

Many states do not have any funds dedicated to RH or FP. Therefore, those states lack funds to do any extensive FP programming, training, awareness creation, supervision, or provisions to purchase additional commodities outside the cost-recovery system. Setting a precedent at the central level in the creation of a budget line item for FP programs and using those funds to purchase commodities translates commitment into action that will provide an example for states to follow.

The contraceptive logistics management system (CLMS) manages, tracks, and distributes FP commodities. Forecasting is conducted twice a year with the forecasting and procurement committee that comprises government, nongovernmental organizations (NGOs), and development partners. All procurement of contraceptives is managed using procurement systems from the United Nations Population Fund (UNFPA). Issues data rather than consumption information are used to prepare forecasts affecting the ability to make more accurate forecasts. The lack of quality consumption data is partly attributed to low reporting rates and inaccurate completion of the Requisition and Issue Form (RIF) or the Requisition, Issue, and Report Form (RIRF) from the state, local government area (LGA), and service delivery point (SDP) levels.

A cost-recovery system was designed to ensure a continuous supply of contraceptives, but because of low demand for family planning, sales are often not enough to generate sufficient funds to purchase additional supplies and to support other logistics activities including incentives for the health worker.

Storage is fairly adequate, but several warehouses require some sort of renovations. State-level storage is adequate, but better practices are needed to ensure that the quality of the commodities is not compromised.

The transportation of commodities is currently a major issue that has caused distribution delays at the state level. Funding for transportation relies on cost-recovery funds rather than having a reliable, easily accessible source of dedicated funds.

Although all contraceptive methods (injectables, orals, male and female condoms, intra-uterine contraceptive devices [IUCDs], and implants) are available in the country, injectables, orals, and condoms are available mainly at the SDP level. Injectables are the most preferred method of choice mainly because of privacy reasons and easy accessibility at public sector facilities. Very little demand exists for long-term methods such as IUCDs, implants, and male and female sterilization (2 percent for these methods) partly because of a scarcity of trained health workers who can provide those methods. There was a nationwide stockout of Exluton/Microlut and Microgynon at the time of this assessment with several facilities stocked out of those brands. Also observed was a selective stockout for some commodities lasting between 74 and 130 days.

At all levels of health care delivery in Nigeria, the shortage of skilled workers is exacerbated by high attrition rates and frequent transfers, which, in turn, compromise the ability of the system to offer quality FP services. There are issues of the quality and frequency of CLMS supervision by state- and federal-level personnel to monitor health worker performance. Religious and cultural beliefs are also common barriers to accessing and promoting contraceptives. Those factors, among others, have contributed to low accessibility of FP services and a decreasing contraceptive prevalence rate from 8.6 percent (1999) to 8.2 percent (2003) among currently married Nigerian women who use modern methods.

# Introduction

The government of Nigeria, in collaboration with development partners, became one of the first countries to incorporate Reproductive Health Commodity Security (RHCS) into its programs in 2002, after completing a comprehensive Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) assessment. Soon thereafter, a National Strategic Plan for Reproductive Health Commodity Security (Contraceptives and Condoms for HIV/AIDS) was put in place in October 2003. The aim of RHCS is to ensure sustained universal access to and use of reproductive health (RH) commodities for men and women. RHCS contributes to the achievement of the Millennium Development Goals that have a bearing on reproductive health and reproductive rights. Developed for RHCS was a five-year strategic plan that would lapse at the end of 2007.

Before the strategic plan for RHCS could be updated, a need existed to take a close look at the most recent RHCS situation in Nigeria, to update the original 2001 SPARHCS assessment, and to gather data to see what progress has been made in the intervening period. To do this, the Federal Ministry of Health (FMOH) partnered with the United Nations Population Fund (UNFPA) and the USAID | DELIVER PROJECT to conduct an analysis using the Reproductive Health Commodity Security Situation Analysis Tool (RHCSAT). This assessment aimed to bring stakeholders together to review the prevailing situation with regard to RH commodity financing, supply chain management, and other aspects of the health logistics system.

The purpose of the RHCS Situation Analysis was to identify and analyze the strengths and weaknesses in seven key areas that affect the availability of RH commodities in Nigeria, specifically family planning (FP) commodities, and to make recommendations for strengthening RHCS.

The objectives of this situation analysis were to identify the background situation of RH commodity security in Nigeria, to introduce and increase awareness on the RHCS concept and the framework components, to understand and identify strengths and weaknesses of the country's RHCS situation, and to collect information on the status of RHCS in the country about FP commodities regarding the following:

- Political and socioeconomic context
- Coordination of RHCS
- Commitment toward RHCS
- Methods of financing for contraceptives and services
- Provision of FP commodities
- Client utilization and demand
- Logistics system capacity



# Background

The Federal Republic of Nigeria is located in West Africa and has a population of 140 million people (National Population Commission Census figures, 2006). It has the largest population in Africa and the tenth largest in the world.

The population of Nigeria is predominantly rural, with two-thirds of Nigerians living in rural areas. Among the population, 70.8 percent of the people live below the poverty line (UNDP Human Development Report, 2007/08). Nigeria's youth-dominated age structure, with approximately 44 percent of the population younger than 15 years old, will have a significant effect on the growth rate, particularly because almost half of the population will be at or reaching reproductive age within the next 15 years. The fertility rate in Nigeria is also high, at an average of 5.7 children per woman (Nigeria Demographic and Health Survey [NDHS], 2003). Though the total fertility rate (TFR) has declined slightly from 6.0 in 1990, the current rates—coupled with the desire for a large family—indicate that further immediate decreases will likely continue to be minimal.

Current use of family planning (FP) methods in Nigeria is low. Only 8 percent of currently married women use a modern method, and only about one in four women obtain modern methods from a public sector facility (NDHS, 2003). In addition, intention to use family planning among currently married women who are not currently using an FP method is also relatively low, at 27 percent (NDHS, 2003). About 74 percent of users get their oral contraceptives from the private sector, while two-thirds get intra-uterine contraceptive devices (IUCDs) from the public sector. Socially marketed brands account for 80 percent of condom sales and two-thirds of oral contraceptives (NDHS, 2003).

The health sector in general has very weak services, as acknowledged by a Nigerian government document: “The health system in Nigeria and health status of Nigerians are in a deplorable state” (Health Sector Reform Programme, 2004–2007; FMOH, 2004). Significant problems include low motivation of health workers, no budget line for many needed programs, and weak coordination between federal and state governments. According to the World Health Organization (WHO) health statistics for 2002, government per capita spending on health amounted to five U.S. dollars.



# Family Planning Services in Nigeria

The National Health Policy in Nigeria provided for a three-tier structured health system of primary, secondary, and tertiary care. In addition to the three levels, faith-based organizations (FBOs) also provide reproductive health/family planning (RH/FP) services, as well as community-based distributors (CBDs) who supply male and female condoms and combined oral contraceptives (COCs). CBDs obtain their supplies through the primary care facilities, although some are currently working with and supplied by local nongovernmental organizations (NGOs).

RH/FP are not priority areas and are, therefore, often understaffed and underfunded. A Maternal and Neonatal Program Effort Index (MNPI Futures Group) cites that only 33 percent of births are attended by skilled personnel. Moreover, health centers and district hospitals received average ratings in comparison to other countries in the sub-Saharan region. Their rating of FP services suggests limited current service provision.

About 40 percent of health services are provided by Christian organizations, although this percentage necessarily varies widely from state to state (DFID RHCS Report, 2005). In addition, Islamic organizations provide health services in a number of sites. Promotion of FP services is limited, and some commodities are currently provided through NGOs. Civil society and NGOs such as Planned Parenthood Federation of Nigeria (PPFN) and the local NGOs such as Association of Reproductive and Family Health (ARFH) are active on a national scale.

Also at the national level is the National Agency for the Control of HIV/AIDS (NACA), a government institution with the mandate to coordinate the AIDS response and to liaise with stakeholders to do so. NACA provides leadership; monitors the epidemic; and oversees policies, programs, and projects having to do with HIV/AIDS issues. It partners with a wide variety of international development agencies and NGOs.

The National Agency for Food and Drug Administration and Control (NAFDAC) is a parastatal of the Federal Ministry of Health (FMOH) with the mandate to regulate and control drugs, medical supplies, food, and so forth, which are locally manufactured or distributed in Nigeria. All such products have to be registered with or receive a waiver from NAFDAC to be supplied to clients in Nigeria.

National Health Insurance Scheme, Insurance Health Fund (funded by the Dutch), several health maintenance organizations (HMOs) that provide health insurance schemes, and many local and international NGOs are involved in supplying services or funding for services.

In the private sector, a number of private doctors and hospitals provide health care for those who can afford their services.



# International Donors

All public sector family planning commodities are donated to the Federal Ministry of Health (FMOH) by the United Nations Population Fund (UNFPA). Although the private sector is a source of contraceptives for nearly 60 percent of married women of reproductive age, the (UK) Department for International Development (DFID) and U.S. Agency for International Development (USAID) donate a majority of their commodities. And although short-term needs are being fulfilled by donors' financial commitments, the government should start contributing funds to ensure long-term sustainability for reproductive health commodity security (RHCS).

Forecasts are conducted together twice a year by UNFPA and the FMOH by the Forecasting and Procurement Committee. The FMOH and UNFPA use the Country Commodity Manager (CCM) software, which is largely a forecasting tool, as they forecast and quantify public sector contraceptive requirements that use issues data. Once a forecast is completed, a request is made by the FMOH to UNFPA to procure the contraceptives. A comprehensive, national forecast is not conducted with USAID, DFID, and the Society for Family Health (SFH). SFH, a social marketing organization provides an estimated 74 percent of the condoms in Nigeria. Given that organization's large role in the supply of contraceptives, conducting a joint national level forecast with SFH and with all of the major suppliers of contraceptives would be a worthwhile exercise (a) to determine the extent to which the public sector is meeting demand for contraceptives and (b) to identify any gaps.



# Findings from the Contraceptive Security Assessment

## Context

In Nigeria, as in every country, there is a context that affects the prospects for reproductive health commodity security (RHCS). National policies and regulations bear on family planning (FP) and reproductive health (RH) and on the availability of contraceptive supplies in particular. In addition, broader factors such as social and economic conditions, political and religious concerns, and competition of priorities affect the provision of RH services and supplies.

The desire for large families continues to be the norm for most Nigerians, with more than two-thirds of women considering 5 or more children to be ideal and with men wanting 2 more children on average than women want (Demographic and Health Survey [DHS], 2003). Population growth is projected to be as high as 2.9 percent per year, according to the newly available draft 2006 census (Population Commission, 2007). The provision of quality services is pivotal to reducing the high maternal mortality rate, thus highlighting the need for increasing visibility of RHCS to ensure healthy mothers and children. In this context, FP—as a part of RH services—focuses on providing commodities for spacing births and limiting family size (NDHS, 2003).

One of the major threats to RHCS is the severe shortage of skilled health personnel from community health extension workers (CHEWs), nurses, midwives, and doctors. Some states are reluctant to bring personnel in from other states because of a preference for hiring indigenes or because of the belief that outside personnel will not be accepted as a result of sociocultural factors. Some states are unable to recruit and train enough health workers because of general low education rates in their state. The staffing shortage jeopardizes the ability of the health care system to offer quality services and should receive adequate human and financial attention in order to achieve RHCS. Table 1 summarizes the important indicators concerning reproductive health in Nigeria.

**Table 1. Demographic, Health, and Development Indicators**

Indicator	1999	2003
Total population (million)	115	140 (2006)
Total fertility rate (TFR)	6 (1990) 5.2 (1999)	5.7
Percentage of population that is urban	36	34
Percentage of population that is rural	64	66
Population growth rate	2.6 (2000)	2.9 (2.83)
Gross national income (GNI) per capita	\$790	\$900
Adult female literacy rate	56 (2000)	59 (2002*)
Adult male literacy rate	72 (2000)	74 (2002*)

<b>Indicator</b>	<b>1999</b>	<b>2003</b>
Number of women of reproductive age	28,234,000 (2000)	29,107,771
Infant mortality (per 1,000 live births)	78	100
Maternal mortality (per 100,000 births)	289**	800
Contraceptive prevalence rate (modern methods)	8.6	8.2
Unmet need	17.5	16.9
Source of contraception—public sector	42.9	22.8
HIV prevalence	4.5 (1996)	4.4 (2005)
Average age of marriage for men and women	26/18	>23/<19
Average age at delivery of first child	20	20.3

Source: Nigeria Demographic and Health Survey, 1999 & 2003; World Bank/WDI, 2007.

\*Earthtrends, 2003.

\*\*DHS acknowledges data issues and believes this number is a very low estimate (the State of Political Priority for Maternal Mortality Reduction in Nigeria and India cites a 1999 study that indicated this rate is more like 704).

## Policies and Regulations

A number of strategies, policies, and frameworks influence family planning and commodity security in Nigeria. A number of those policies, either adopted or in draft form, specifically identify and support access to quality RH services for women, men, and adolescents, as well as informed choice for each of those client groups. Existence of the National RHCS Strategic Plan indicates a favorable policy environment for RHCS. However, the fact that the plan has been allowed to expire and is not in itself financed indicates a need for increased visibility and funding for RHCS. Although a strategic plan exists at the national level and includes provisions for state-level activities, no counterpart plan exists at the state level, which is a necessity in Nigeria's decentralized system in which the states are basically autonomous.

Funding at the national and state levels for dissemination and implementation of such policies is insufficient. Although a budget line exists for maternal mortality reduction (2005–2007), which has been used to implement RH/FP trainings and general capacity building, no specific line item shows an allocation for RH. An allocation for FP commodities in 2007 was not accessed; commodity funding is completely donor dependent at this stage. Existing financing for supervision and training is positive, but it is acknowledged that this financing is currently inadequate to meet the supervision and program implementation needs from the national level to the state level and that financing is often nonexistent from the state level to lower levels of the system.

A National RHCS Stakeholders Committee exists to move forward the agenda of RHCS; however, the committee is not funded through government sources and has not met in the past year. The committee relies on donor funding for its activities and meetings. The committee is chaired by the Permanent Secretary of the Federal Ministry of Health (FMOH) (or by a representative) and has a broad group of stakeholders in its membership. If meetings can be revitalized and the wide variety of members engaged in such issues, this forum could be a driving force for RHCS in Nigeria.

Nigeria does have a national health insurance scheme (NHIS) that currently covers much of its urban civil servants and is envisioned to eventually expand to cover formal and informal sectors, as well as vulnerable groups. At present, the NHIS does not cover FP commodities or services, although it does counsel on use of FP. The NHIS is in the process of updating its guidelines, and

this change presents an opportunity for recommendations to be made by FMOH for inclusion of FP commodities and services.

The only age- or parity-related restriction that formally limits access to contraceptives is that the client must be of reproductive age. Informally, in some sections of Nigeria, cultural practices still allow the husband to make the final decision on the use of family planning. Although policies stipulate equal access for adolescents, in reality, cultural barriers exist in easily accessing contraceptives, which leaves the decision of whether to supply contraceptives to sexually active adolescents to the discretion of the provider.

Advertising and promotion of RH services and commodities, including contraceptives and condoms, is not formally restricted. In some states, this lack of restriction has led to widespread advocacy campaigns; in other states, local pressure from religious leaders has inhibited such promotion.

RH services are provided primarily through health facilities by doctors (where available), nurses or nurse midwives, CHEWs, and junior community health extension workers (JCHEWs) who are trained according to their respective preservice curricula. In the states in which they are active, community-based distributors (CBDs) provide condoms, resupply oral contraceptives, and counsel their clients about such commodities.

## **Coordination**

Coordination among key stakeholders and markets facilitates the commodity security by leveraging resources and avoiding duplication of efforts. The key stakeholders include the private sector, the state ministry of health (SMOH), development partners, programs in charge of communication campaigns, supply chain experts, and civil society, as well as members from other line ministries such as the ministry of finance.

The National RHCS Stakeholders Committee consists of representatives from the following:

- The ministries of Health, Planning, Women’s Affairs, Education, Youth, and Finance
- The Armed Forces Health Services and the police
- The National Primary Health Care Development Agency (NPHCDA)
- The National Agency for Food and Drug Administration and Control (NAFDAC)
- The Department of Food and Drugs
- Hospital Services
- International groups such as the Canadian International Development Agency (CIDA), (UK) Department for International Development (DFID), Family Health International (FHI), United Nations Population Fund (UNFPA), U.S. Agency for International Development (USAID), and World Health Organization (WHO)
- Community Participation for Action in the Social Sector Project (COMPASS)
- Organizations such as Ford Foundation, Packard, Engender Health, Access, Quality, and Use in Reproductive Health (AQUIRE), Center for Health, Information, Monitoring and Evaluation (CHIME), and Federation of Muslim Women

- Health groups such as Association for Reproductive and Family Health (ARFH), Adolescent Health and Education Project, Pharmaceutical Agency of Nigeria, Society for Family Health, Planned Parenthood Federation of Nigeria (PPFN), Christian Health Association of Nigeria, and Society of Gynaecology and Obstetrics of Nigeria (SOGON)
- And other stakeholders

The committee was created in 2002 and is chaired by the permanent secretary of the FMOH. The FMOH has taken the lead in this coordination effort but is hampered by inadequate funding. The committee is supposed to meet twice a year but has not met since 2006. When the committee was active, the meeting attendance was reportedly more than 75 percent. In addition to the issue of funding, which mostly pertains to financing attendance for civil society partners, a series of changes and the reorganization within the government itself have made meeting difficult.

The National RHCS Stakeholders Committee was created to function as the decision-making body, and its meetings need to be attended by officials at the policy-making and decision-making levels. Of course, the committee needs to meet regularly and to receive ongoing funding in the FMOH budget. As a decision-making body, the committee should release an annual report on RHCS that can be shared with all stakeholders. That report should detail progress made and upcoming activities. In addition to the larger committee, subcommittees or technical working groups (TWGs) should be in place to address and coordinate specific functions, such as forecasting; procurement; distribution; and behavior change communication/information, education and communication (BCC/IEC).

The National RHCS Stakeholders Committee has no counterpart committee at the state level. Some states are presently coordinating between the SMOH, NGOs, and international partners (IPs), but no formal RH or RHCS committee exists. As each state designs its own work plans and works autonomously from the FMOH, it would be judicious for each state to invite the stakeholders working with RHCS in that state to form a committee that will coordinate their activities.

In some states, NGOs and IPs have taken on an important role in training and follow-up supervision of CBDs and service providers (SPs), as well as promotional activities. It was observed that although this role took place with public sector employees, the coordination between the agencies was poor or nonexistent. Coordination at the level of the SMOH would enhance contributions by local NGOs and IPs and would help strengthen the program generally by ensuring proper use of resources. SMOH and its partners should hold joint biannual work planning and progress meetings.

Under the guidance of dedicated, motivated state and local government area (LGA) coordinators, some states and LGAs are working closely with their public sector, NGO, and IP colleagues. This coordination is not, however, institutionalized because it stems from the motivation and dedication of specific personnel. Creating an RH or RHCS coordinating committee with a strategic plan and with state-level targets and indicators is one way to institutionalize coordinating mechanisms. Because some committed personnel are already leading those efforts, one FP coordinators' meeting could be dedicated to laying the groundwork for such a mechanism, and those already involved (at state and LGA level) could be invited to share their lessons learned. Such a meeting would be dedicated to practical strategies such as (a) how to formalize the coordination mechanism, including strategies to form and keep committees invigorated; (b) joint work planning and budgeting; (c) development of targets and indicators; and (d) reports of results to key state-level decision makers.

Although a reporting system is in place and personnel receive feedback during supervisory visits, the reports and feedback are currently inadequate to inform decision making. Because supervisors have

insufficient funds earmarked for supervisory visits at all levels, those visits are not regular enough to give feedback to SPs. In turn, SPs are less likely to fill out their reports or to fill them out correctly when they receive such inadequate training and supervision. At facilities where supervision was taking place regularly, it was noted that both reporting rates and accuracy of reporting were greatly increased. Service providers need feedback on their reporting: (a) whether they are filling out the forms correctly, (b) how to do it if they are not, (c) what specific feedback they made about any comments, (d) what the follow-up was on requests for products that are stocked out, or (e) what to do with expired products.

The FMOH Contraceptive Logistics Management System (CLMS) Section manages the supply chain for contraceptives. It collaborates with UNFPA to do a biannual contraceptive forecast using Country Commodity Manager (CCM), a software tool that uses issues data from the public sector. Further coordination in those areas by the TWG of the National RHCS Stakeholders Committee could bring more comprehensive information to the table for decision makers.

Although the private sector is serving 58 percent of the population's contraceptive commodity needs, there is modest coordination between the public and the private sector (NDHS, 2003). At the national level, some momentum exists toward public–private partnership. The coordination between the public sector and the Society for Family Health (SFH) (for social marketing) is viewed as a move in this direction. In terms of the commercial sector, however, the dialogue is nascent, with a newly formed Public Private Sector Forum. A forum of this sort should be addressing demand creation, training, and raising awareness in FP, thereby using the existing expertise in both sectors. This assessment did not witness any dialogue between public and private sector at the lower levels, although some SPs do refer their clients to the private sector when they are stocked out of a product.

## **Commitment**

Existence of supportive policies and dedicated budget line for RH in general with an emphasis on contraceptive commodities security specifically is the surest sign of commitment that a government can show for RHCS. This approach also provides an enabling environment for all stakeholders, including donors, development partners, NGOs, and relevant civil society organizations (CSOs) that are working in the area of RH within a country. Continuous, focused advocacy for RH and FP is the vehicle that ensures that the subject remains on the forefront of a country's critical issues; it also allows for sensitization of both national policy makers and the community in general.

### **Commitment in the Public and Private Sectors**

Currently, Nigeria has a National Policy on Population for Sustainable Development, a National Reproductive Health Policy and Strategy, a National RHCS Strategic Plan and Guidelines for Integration of HIV/AIDS and RH. The support by the FMOH for a second commodity security assessment, which would make Nigeria the first among many countries to do two assessments, demonstrates the continuing commitment and attention toward RHCS. All of those moves are evidence of significant commitment that has empowered the public sector—the FMOH and the development partners—to take leadership in improving reproductive health service delivery in general, as well as striving to ensure commodity security. The existence of those policies serves as a means and a platform for highly visible private sector involvement.

The private pharmacies all carry FP commodities; even though the commodities are at a cost higher than the subsidized price at public sector health facilities, they are readily accessed by the clients with

confidence in sustained supply and confidentiality. The NGO, the CSO, and the private sector with their parallel logistics systems ensure availability of a wide range of commodities in the private sector. They also provide services in a socioculturally appropriate context, which is significant in Nigeria where religious concerns make family planning a touchy subject.

To date, funding for reproductive health is channeled through maternal and child health programs; although a national RH budget line that has been created, it has yet to become operational. RH programming in Nigeria is mainly donor driven because the commodities are donated to the FMOH. The government of Nigeria has yet to translate existing policy into action such as using the government budget for procuring contraceptive commodities.

The private sector in Nigeria with regards to RH is made up mainly of NGOs such as PPFN, SFH, indigenous community-based organizations (CBOs), and for-profit pharmacies and clinics that provide RH/FP services. Through the support of donors and development partners, PPFN and SFH provide the most significant evidence of private sector participation in RHCS, and they run a parallel logistic system different from that used by the FMOH. SFH uses social marketing strategies to ensure that commodities are available to providers nationwide while PPFN provides commodities at their clinics and to the CBOs they support.

## **Advocacy**

Advocates for RHCS abound in the FMOH, but until recently, there seemed to be a lack of strategic means of ensuring positive and focused RH advocacy from the FMOH Reproductive Health Branch. The Reproductive Health Bill submitted to the National Assembly was not passed, which led to an invitation of the FMOH by the House to make a presentation on the importance of RH to the nation's highest decision-making body. At the time of the assessment, the FMOH RH team had yet to make this presentation. This timing presents a good opportunity to advocate and demonstrate the importance of supporting family planning and the potential effect when RH programs are not fully funded.

Advocacy through the media is typically sponsored by the NGOs and development partners at prohibitive costs through the radio and television. The jingles, skits, and sitcoms usually come under the guise of HIV prevention communications, and sometimes they advocate for birth spacing to improve the quality of life for women. Only in a few tolerant states do such communications address and inform the needs of adolescents and unmarried youths. Recently, donor funding has supported the training of a media staff in the basics of family planning, maternal mortality reduction, and birth spacing.

## **Health Sector Reform and Development Assistance**

The current National Economic Empowerment and Development Strategy (NEEDS) does not address family planning and reproductive health; however, the next version will include a more encompassing chapter on health care in general and will address FP and RH issues. The FMOH presently depends on donor support for RHCS. UNFPA provides the commodities, and the USAID | DELIVER PROJECT provides technical assistance for the administration and improvement of the CLMS. Evidence of evolving public-private partnerships for RHCS was found at both national and state levels.

## Financing

Adequate funding to support RHCS is the cornerstone of any national RH funding. To date, Nigeria has not released any funds to procure contraceptive commodities. All funding for RH activities is through allocations for maternal and child health programs. The fledgling national health insurance scheme does not cover FP commodities, and households provide the source of funding for those commodities.

### Government and Donor Funding

Specific government funding for FP and RHCS is currently nonexistent. However, between 2005 and 2007, 20 million naira (US\$173,913) from the maternal mortality reduction program's budget has been used for RHCS capacity building, supervision, and meetings. Donors are solely responsible for all commodity procurement for the public sector to date. The main donors are the following:

- UNFPA donates through the global thematic Trust Fund and CIDA Trust Fund for contraceptives procurement.
- DFID purchases condoms and injectables for social marketing and provides them to SFH.
- USAID procures Depo-Provera, Duofem, and IUCDs for SFH.

Even private sector organizations such as SFH procure commodities through USAID and DFID, while PPFN is supported by IPPF. The 50 million naira (about US\$434,782.50) allocated by the government of Nigeria in 2007 for the procurement of contraceptives was not released. Kano State just adopted a program line system of budgeting and created a budget line for RH starting with 5 million naira (about US\$43,478.26) for 2008. Although the funds were yet to be released at the time of writing this report and how the monies will be used is yet to be determined, the Kano example serves as a best practice that can be emulated by other states.

A cost-recovery scheme has been implemented nationwide for contraceptive commodities in the public sector. The system was established in 2003 to generate funds for resupply at the state, LGA, and service delivery point (SDP) levels to ensure the sustainability of contraceptives. The cost-recovery scheme is intended to act as a revolving fund where monies from contraceptive sales generate margins. Although commodities are sold to the client at heavily subsidized prices, all other services are free of charge. Margin amounts are pre-established at each level and are used to support administrative and logistics functions while commodities are procured from the next higher level using the resupply funds.

At the federal level, about 20 percent of the funds is recovered to support commodity procurement and logistics. To date, however, Nigeria has never released or used those funds for contraceptive procurement as was originally intended. At the state level, 88 percent of stores and 92 percent of health facilities have been able to use funds for CLMS (LIAT, 2007). At the LGA level, 30 percent of the income generated is used for transportation, monitoring, and incentives. The field visits revealed that, overall, the margins were not enough to meet the needs of the program. It was observed that this low margin is due in most part to low client use of products. Where the client uptake was higher, the margin was, in most cases, sufficient to cover transport and basic supplies such as disinfectant, cell phone airtime to the contact supervisor, and other related activities. At the state level and at some facilities, accessing the margin to use for logistics activities is often challenging, because the funds are part of the general health fund rather than in a separate cost-recovery account. Only 22 percent of stores had a separate contraceptive account (LIAT, 2007).

No waiver system exists for the poor client; though at no level of service delivery did the subsidized user fee present a barrier to access.

## Current and Future Funding

Currently, obtaining future commitments from the government for contraceptive spending is not yet a reality, although a budget line for maternal mortality reduction has been created. Continued donor funding alone will not be adequate to support all contraceptive procurement and to fund CLMS or ensure RHCS on a long-term basis. A funding gap for contraceptive commodities exists; even social marketing and NGOs depend on the donors for commodity procurement. Accurate consumption data are not available, and this lack adversely affects forecasting capacity and thus affects the ability to determine future financing needs. Future funding also depends heavily on the commitment of the government because current total dependency on donors is not sustainable. In the short term, funding from CIDA, DFID, UNFPA, and USAID seems to be stable for at least one to two years. However, to increase leadership, to demonstrate true commitment, and to generate financial sustainability of contraceptive security, the government of Nigeria should start contributing its own funds to the purchase of contraceptives and other RHCS initiatives.

## Commodities

The public sector offers 10 types of contraceptive commodities. Short-term methods include the male and female condom, combined and progestin-only oral contraceptives, and injectables. Long-term methods include IUCDs and implants (see table 2). All of the methods are donated to the FMOH by UNFPA. DFID is also a major contributor procuring Gold Circle condoms and Noristerat for SFH. USAID currently procures Depo-Provera, Duofem, and Copper T 380 IUCDs for SFH and may begin procuring Jadelle.

**Table 2. Contraceptives Offered by the FMOH Program**

<b>Condoms</b>	<b>Injectables</b>	<b>Pills (combined and progestin)</b>	<b>IUCD</b>	<b>Implants</b>
Male	Depo-Provera	Lo-Femenal	Copper T	Implanon
Female	Noristerat	Microgynon Exluton/Microlut		Jadelle

The primary source for contraceptives is the private sector, which provides 58 percent of modern methods among current users. The private sector is the most common source for oral contraceptives (71 percent), with private pharmacies as the most frequent supplier among private sector facilities. The public and private sector are equal choices for clients to obtain injectables (48 percent for both). Condoms are not frequently accessed through the public sector. They can be widely found in the private sector through shops or other private sources, but the majority of the condom market is found in private pharmacies (58 percent).

SFH distributes the largest amount of contraceptives in Nigeria through social marketing programs. Those programs provide all short- and long-term methods except female condoms. PPFN also provides family planning services and commodities and provides the same contraceptives as the public sector, plus emergency oral contraceptives and vaginal foaming tablets (VFTs).

**Table 3. Source of Contraception**

Source	Pill	IUD	Injectables	Male Condoms	Total
<b>Public Sector</b>	<b>18.6</b>	<b>65.5</b>	<b>48.4</b>	<b>4.1</b>	<b>22.8</b>
Hospital	10.9	47.0	22.9	3.1	13.1
Health center	4.9	12.9	19.0	0.4	6.5
FP clinic	1.3	5.6	6.0	0.5	2.4
<b>Private Sector</b>	<b>74.0</b>	<b>32.5</b>	<b>48.0</b>	<b>59.2</b>	<b>57.7</b>
Hospital or clinic	2.3	30.3	17.9	0.6	7.5
Pharmacy	71.6	0.0	25.1	58.3	48.8
Private doctor	0.0	0.0	4.3	0.3	1.0
<b>Other</b>	<b>5.5</b>	<b>0.0</b>	<b>1.0</b>	<b>29.1</b>	<b>14.3</b>

Source: NDHS 2003.

Products must meet the national standard before they can be registered in the country. Product registration is required of all methods and brands including generic products. Additionally, only the manufacturer is allowed to register all products. Most contraceptive commodities are on the essential drug list (EDL), require registration, and are subject to duties. Donor-supplied products are exempted from duties. Products that are not on the EDL require justification for need before they can be processed for registration. The registration requirement has sometimes caused delays.

No local manufacturing of contraceptives takes place in Nigeria.

## Client Utilization and Demand

Between 1999 and 2003, the contraceptive prevalence rate (CPR) stagnated at 8.9 percent among all women who were currently using contraceptives. The results from the 2003 DHS showed that male condoms were the most commonly used method (38 percent), followed by pills (22 percent) and injectables (18 percent). Additionally, when a comparison is made between 1999 and 2003, decreases in CPR occurred in all methods except for male condoms, which had an increase from 26 percent to 38 percent.

The decreases follow the same trend among currently married women and will be the focus of discussion because they are the group most at risk of pregnancy. CPR declined from 8.6 percent to 8.2 percent from 1999 to 2003. Injectables (2.0 percent) are the most popular modern method. However, there was a decline in injectable use from 2.4 to 2.0 percent. One of the reasons this method is popular is the discretion it provides among married women. The reasons behind the decline should be addressed because it could be an indicator that a woman's ability to protect herself from pregnancy is decreasing. Oral contraceptives also became less popular with a decline in CPR from 2.6 percent to 2.0 percent. Both injectables and orals were available at health facilities during the field visits. The only increase in CPR was the use of male condoms (1.2 to 1.9 percent).

Although the short-term methods have declined, a corresponding increase should occur in long-term methods such as implants and female sterilizations. However, the data show virtually no additional uptake among those two methods. Even sharper decreases occurred in IUCD use between 1999 and 2003, with CPR currently at less than 1.0 percent. And virtually no use of implants exists. The very little demand for implants can be partly attributed to the low number of

skilled, qualified service providers, coupled with the high cost of receiving such methods. Low demand for implants may continue as a result of the recent introduction of Jadelle and the transition time needed to train service providers to offer and counsel on this brand.

Pills, injectables, and condoms have almost equal popularity in terms of method mix (22 percent, 24 percent, and 23 percent, respectively). Future use of contraception among those not currently using also shows a similar trend in preference for injectables (27.7 percent) and pills (22.6 percent). Increasing the use of methods that require less resupply—such as IUCDs and implants—can help alleviate the need for women to make revisits that incur transport costs and time, as well as time required by the service provider to assist the client.

Women who have higher education, who live in urban areas, and who are between the ages of 20 and 39 are more likely to use contraceptives. Those living in urban areas are more than twice as likely to use contraceptives as women in the rural area (13.9 percent versus 5.7 percent, respectively). Although the prevalence rate is higher in the urban area, CPR declined between 1999 and 2003 from 15.7 to 13.9; in the rural area, CPR stagnated at 5.7 percent. The South-West region has the highest CPR of 23.1 percent, followed by the South-South (13.8 percent) and the South-East (13.0 percent). Education is also a factor in use of modern methods; its effect shows contraceptive use of 2.3 percent for women with no education to 21.7 percent for those with higher education. As the number of living children increases, use of contraception also increases from 1.4 percent with no children to 11.0 percent with 5 or more children.

Additional activities are needed to increase awareness, but increased resources are especially needed to better target the rural and disadvantaged population. Although many national policies include strategies to improve reproductive health, specific language targeting the poor still needs to be made more explicit about such policies. For example, in the National Reproductive Health Strategic Framework and Plan, strategies are addressing equitable access to quality health services and capacity building with specific activities to create and support family planning from SDPs to the community level and to train additional SPs. This plan would be an ideal place to insert specific language that will increase service for the poor and will place SPs in rural settings to increase access.

Total unmet need has decreased slightly from 17.5 to 16.9 percent. A slight increase occurred in unmet need for limiting births from 4.6 to 5.1 percent. However, total demand satisfied (unmet need plus current users) has decreased from 46.7 to 42.7 percent among currently married women. The unmet need is very similar for urban and rural women (17.3 percent and 16.7 percent, respectively). The unmet need is highest for women between the ages of 20 and 44, which is the same age group with the highest use of contraception, thus indicating a high need for contraceptives that is not being met. Geographically, wide differences in unmet need exist between the North-West region (11.1 percent), North-East (18.1 percent), and the South-South (24.5 percent). The North-East and North-West also have the two lowest CPR rates (3.0 percent and 3.3 percent, respectively) in the country.

This set of results can be attributed to a number of reasons that influence service access and use of contraceptives. The North-East and North-West are more religiously conservative, and knowledge of family planning is the lowest in those two regions among the six geopolitical areas—the implication being that less awareness for family planning generates low demand. Religious groups, both Catholic and Islamic, have strong influences on contraception practices and on the type of family planning media messages disseminated to the public. On occasion, the church had stopped broadcasting family planning messages. The North-East and North-West have restrictions against male providers serving female clients.

The field visits also found that many health workers have not received any recent training on FP skills and counseling. The ability of the health worker to educate women on the full choice of contraceptives influences a woman's ability to choose the method that is most appropriate and desired. If health staff members do not have a full understanding of each method, then they may counsel only toward specific methods or not counsel about side effects leading to discontinuation of use.

As mentioned earlier, an inadequate number of trained personnel exist at all levels including doctors, nurses and midwives, and CHEWs. Coupled with this inadequacy is a high attrition and transfer rate, as well as an inadequate number of female workers. Furthermore, the shortage in skilled health workers is also playing a role in access to specific methods such as long-term and permanent methods where both training and services for implants take place only at secondary and tertiary health facilities.

Adolescents, as a specific population, are addressed through strategies, frameworks, and policies. However, in practice, adolescents in some regions do not have the same access to public sector facilities because of cultural and religious biases and misconceptions, and health workers can refuse to provide services to them. This inadequacy could also be due to infrequent supervision at the LGA and SDP level, poor supervision practices, lack of monitoring, weak accountability, and lack of transportation to the more rural SDPs.

Several NGOs provide an alternative choice in accessing FP services and commodities. NGOs are conducting community-based outreach activities on a variety of RH issues including family planning. They are also raising awareness through radio jingles, community-based distributors, male motivators, and peer educators at the LGA and community level. Some NGOs are tasked with raising and tracking CPR in their focus facilities. NGOs and development partners are also (a) providing support and training on counseling, on improvement in quality of services, and on sensitization and advocacy campaigns; (b) drafting national FP guidelines and standard operating procedures (SOPs); and (c) working with the media. NGOs offer youth-friendly services and facilities.

The number of students who may graduate each year from a particular school is regulated by the Nursing Council. For example, in one state only 50 midwives graduate each year in a population of 10 million people. UNFPA will support contraceptive technology and counseling in its 15 supported states in 2008 while using the approved national curriculum. However, additional funds are needed to conduct the training nationwide.

During the field visits, a spouse's objection to using contraception was commonly mentioned as a reason for discontinuation. Some facilities require a letter from the husband providing consent to purchase contraceptives. The desire to become pregnant and the contraceptive's side effects were also common reasons for discontinuing use. Price was never mentioned as a factor. The consistent availability of stock was also a factor in the clients' ability to choose and use their method of preference.

## **Capacity**

### **Product Use**

SOPs, or standing orders, exist for RH/FP and logistics management. Those orders include the FP service provision SOPs, the monitoring and supervision of dispensing practices, the universal safety precaution guidelines, and the CLMS guidelines and job aids. Some health facility workers are aware of such SOPs, but they were not sighted or available in many of the health facilities. Some facilities had outdated SOPs from 1992. All service providers encountered had undergone training in disposal of sharp objects. Universal safety precautions were generally observed, such as the disposal of

syringes, through the provision of immunizations and the immunization campaigns that take place at health facilities during the National Program on Immunization (NPI). Printed copies of safety precautions were not always at the facilities. Some of the SDPs had posters displaying the full range of family planning or birth-spacing methods, but none had any type of standard treatment guidelines.

In general, health workers at the SDP level did not have current training on FP. The health workers may have had training during their education, but many had not received any recent training. Only a few said they had attended the 6-week FP course.

No unified national communication campaign strategy exists to encourage the use of modern contraceptives. Several development partners and NGOs, however, conduct behavior change communication/information, education, and communication (BCC/IEC) activities to increase awareness among the adolescent and adult population. Their activities include outreach campaigns to the community level, secondary schools, local markets, and male population.

Aside from stockouts and limited availability of all contraceptives, other reasons for the low demand for contraceptives are due to cultural, social, and religious factors. The low number of trained doctors and nurse midwives in implant insertion is another barrier to women using a long-term method of contraception.

The latest market segmentation study completed in 2003 showed that the poorest 40 percent of women of reproductive age are using only one-quarter of the public sector contraceptives. It would be a worthwhile effort to update the analysis and to use the results to design strategies around those who cannot afford or who have the most difficulty accessing public sector FP programs and contraceptives so that public sector resources can be better used for this population.

## **Logistics Management Information System (LMIS)**

Information on daily consumption, stock on hand, quantities, and cost of contraceptives are managed through the contraceptive logistics management system (CLMS), which is a paper-based system. The Requisition Issue and Report Form (RIRF), Requisition and Issue Form (RIF—used in the redesigned CLMS states), Daily Consumption Record (DCR), tally cards, and Cost Recovery Record are used to record and manage logistics information. In 2003, CLMS was redesigned to improve the efficiency and effectiveness of the system. Also in 2003, the cost-recovery system was introduced as part of the redesign, and it acts as a revolving drug fund to provide moneys for resupply and to oversee margins used to cover the costs of transportation and supervision, as well as incentives to health workers. In 2006, the CLMS was streamlined to simplify the inventory control system and to reduce the number of forms. It was piloted in three states.

The Contraceptive Logistics Management System was found to some degree in all the sites visited in which staff members had difficulty understanding and completing the RIF or RIRF and the cost-recovery forms on their own. This difficulty may be caused by several reasons such as nonadherence to reporting and request schedules so that the staff's use of such forms is infrequent. Since the inception of the program, there has been a high turnover of staff, and some of the existing staff members have had no training in CLMS or they gained their knowledge through on-the-job training (OJT). The supervision of CLMS has been inadequate because of a lack of commitment by coordinators. Where quality supervision was done, there was an accuracy and understanding of filling out the RIRFs. In some states, supervision is being carried out and led by development partners.

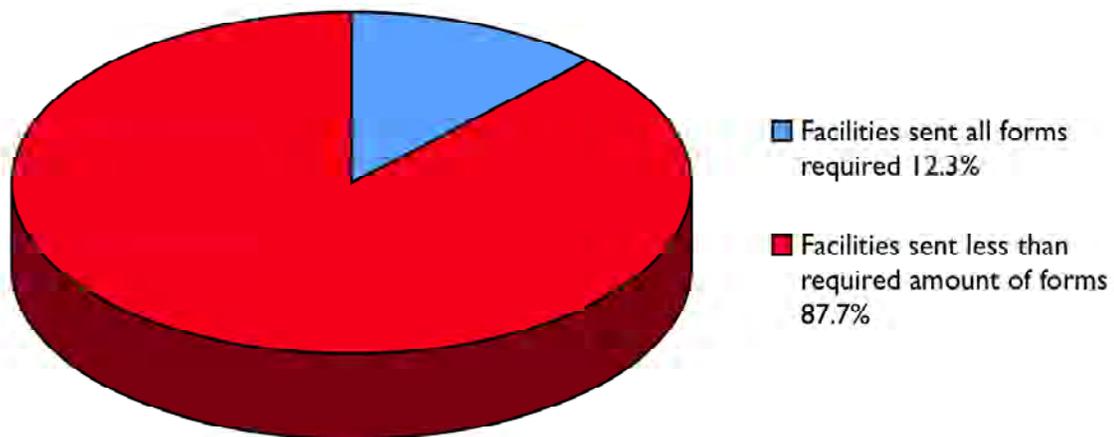
The CLMS operates as a pull system where each level orders from the next higher level. The RIF or RIRF is used for that purpose. The findings from the 2007 LIAT revealed that fewer than half of

the stores and SDPs had complete and accurate RIFs or RIRFs (see figure 1). The RIF or RIRF is completed at the state, LGA, and SDP levels and captures stock status, as well as average monthly consumption, losses, and quantity ordered for each level. Consumption data are available from the data collected from the SDP RIF or RIRF; however, these data are not used to forecast and procure at the central level because of inaccurate and weak reporting. Within each state were facilities that either were not using the CLMS forms or lacked some forms. An improvement in logistics data would allow the central level to start using consumption data to forecast and procure commodities.

The DCR tracks client consumption by method for each day and is tallied at the end of each month. It also tracks the amount dispensed to CBDs, as well as losses in inventory. Most of the facilities had this booklet, and the health staff did not report having difficulty completing the form. Tally cards are used at the stores for inventory of contraceptives.

The quality and frequency of feedback and reporting of the CLMS forms varied among the states visited. Only 12.3 percent of facilities sent in all required forms. A lack of feedback also exists from the upper level to the lower levels, which may contribute to the low reporting levels (see figure 1), especially if lower levels are not being held accountable for late or incomplete reports by the central level. In most states, supervision and monitoring occur in conjunction with development partners through a supervision schedule. In addition, regular review meetings of the LGA and state coordinators do take place to review the CLMS forms. A general finding among the field visits was that supervision is needed, especially at the lower levels.

**Figure 1. Percentage of Facilities that Send RIFs or RIRFs**



Source: LIAT, 2007

## Procurement and Obtaining of Supplies

The FMOH does not procure any FP commodities for the public sector on its own but uses UNFPA procurement facilities. The CLMS Section works closely with UNPFA to forecast and order commodities. The CCM is used to monitor the pipeline and to track current stock on hand, incoming stock, and issues trends annually. These data are tracked at the central level.

The LGA level orders on a quarterly basis from the state while the SDP level orders every two months. An ordering and distribution plan exists, but is not being followed because a formal transport system does not exist. There have been delays in distributing contraceptives down to the state level despite stock at the Central Contraceptive Warehouse (CCW). Previously, private transporters were hired to send contraceptives out to the states, but this system was modified in 2006 to use UNFPA/CIDA trucks to transport commodities to the states. In the meantime, when UNFPA/CIDA trucks are not available or when emergency orders are made, there is a formal or defined means of delivery using funds set up by the public sector for transportation. However, this system is often delayed by bottlenecks.

- Contraceptives were scheduled to be distributed to the states in February 2008, but this delivery did not occur because of the reasons stated earlier.
- At the LGA level, service providers that enjoy proximity to the LGA headquarters receive their products quickly.
- Rationing also occurred in the past because some states had not been regularly receiving supplies from the central level.
- NGOs such as PPFN, ARFH, and StopAID access and purchase public sector contraceptives through direct request to the central level.
- Standard operating procedures exists to ensure that contraceptives meet quality standards. NAFDAC is the body responsible for monitoring the quality of contraceptives, as well as all other health commodities imported into Nigeria.

# Recommended Strategies and Next Steps

This assessment identified the strengths and weaknesses of the reproductive health commodity security (RHCS) situation in the country and will be part of a larger process that will be used to inform the revision of the strategic plan to improve RHCS in Nigeria. The recommended strategies include the following:

- Ensure that family planning and RHCS are integrated and addressed in health policies, guidelines, strategies, and health reform programs.
- Demonstrate commitment toward RHCS by creating a budget line for RHCS that includes funds for the procurement of commodities, capacity building, supportive supervision, and demand creation.
- Strengthen coordination mechanism at all levels (resource mobilization, demand creation, and national forecast).
- Establish funding for reproductive health and family planning at the state and the local government area level.
- Create state-level RHCS committees to raise the profile of family planning; to improve coordination among NGOs, the private sector, development partners, and providers of reproductive health services; and to initiate steps that will develop state-specific strategies and targets.
- Update the national family planning strategy concerning behavior change communication and information, education, and communication with key development partners that will include messages targeted toward line ministries, rural areas, communities, and religious leaders to raise awareness for family planning.



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