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Nigeria: Reproductive Health Commodity Security assessment

Kano State

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Reproductive Health Commodity Security Situation Analysis

Kano state

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Abstract
Reproductive health commodity security is the ability for every male and female to be able to choose, obtain and use quality contraceptives and other reproductive health commodities whenever he or she needs them. Therefore, the availability of commodities is essential in achieving demand and commodity security of contraceptives.

Nigeria has been working towards obtaining RHCS with the development of a RHCS strategy in 2003. To further update and continue the efforts started, a reproductive health commodity security situation analysis was conducted in Kano to assess and understand the current situation in the State. The findings and recommendations from Kano State were used to inform the national RHCS report as well as future RHCS work in Kano.

This RHCS situational analysis provides information on the current situation to be used in future planning and advocacy. It provides information for improving the commitment, coordination, and resources for family planning commodity security specifically in Kano State.

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Acronyms

ARFH	Association for Reproductive and Family Health
BCC	Behaviour change communication
CCM	Country Commodity Manager
CCW	Central Contraceptive Warehouse
CBD	community-based distribution/distributor
CHAN	Christian Health Association of Nigeria
CHEWs	community health extension workers
CLMS	contraceptive logistics management system
CMS	central medical stores
CPR	contraceptive prevalence rate
CS	commodity security
CSO	civil society organization
DCDPA	Department of Community Development and Population Activities (former dept)
DCF	Donor Coordination Forum
DFDS	Department of Food and Drug Services
DFID	U.K. Department for International Development
DFS	Department of Finance and Supplies
DHPR	Department of Health Planning and Research
DHS	demographic and health survey
EDL	essential drug list
ECP	emergency contraceptive pill
ECWA	Evangelical Church of West Africa
FCT	Federal Capital Territory
FEFO	first-to-expire, first-out
FMOH	Federal Ministry of Health
FP	family planning
HC	health centre
HIV/AIDS	human immunodeficiency virus / acquired immune deficiency syndrome
IEC	information, education, and communication

IMR	infant mortality rate
IUCD	intrauterine contraceptive device
JCHEWs	junior community health extension workers
JSI	John Snow, Inc.
KANET	Kano Network of DPs
LAM	Lactational Amenorrhea Method
LGA	local government area
LMIS	logistics management information system
MCH	maternal and child health
MMR	maternal mortality reduction
MOH	Ministry of Health
M&E	monitoring and evaluation
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
PHC	primary health care
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
RHCS CC	reproductive health commodity security coordinating committee
RIF	requisition and issue form
RIRF	requisition, issue and report form
SDP	service delivery point
SEEDS	State Economic Empowerment and Development Strategy
SFH	Society for Family Health
SMOH	State Ministry of Health
SOP	standard operating procedure
SP	service provider
STI	sexually transmitted infection
TFR	total fertility rate

TWG	technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

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Executive Summary

This assessment is a continued effort by the Reproductive Health Unit and Contraceptive Logistics Management System Section (CLMS) of the Department of Public Health in the Federal Ministry of Health (FMOH) to improve and strengthen reproductive health commodity security (RHCS) in Nigeria. This situation analysis attempts to identify the strengths and weaknesses in seven key areas that affect the availability of family planning commodities in Nigeria, and particularly in Kano State, and to make recommendations which are meant to serve as a starting point to establish Reproductive Health Commodity Security in Kano State.

Methodology

A three-week situation analysis was conducted by a team from the USAID | DELIVER PROJECT and UNFPA consultants to assess the socio-economic context, policies, commitment, financing, commodities, client utilization and demand, and logistics system in the country. This team, working with the FMOH, conducted a number of workshops, reviewed key documents, and conducted site visits in six of the thirty-six States. To gain an in depth perspective of the RHCS situation in Kano State, a two-day stakeholder workshop was held at the state level and an assessment team visited key sites in the state, interviewing health staff at the State, Local Government Area (LGA), and Service Delivery Points (SDP) to gather information for the assessment. The assessment was based on the Reproductive Health Commodity Security Assessment Tool (RHCSAT), a tool developed by UNFPA and based on two pre-existing tools: the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS), a comprehensive methodology for RHCS; and the Logistics Systems Assessment Tool, for more detailed analysis of supply chains.

Summary of findings

There are a number of enabling policies that provide a supportive framework for reproductive health for men, women, and adolescents at the National level. However, the National Reproductive Health Policy and Strategy and the RHCS Strategy has not been adapted to fit the context of Kano State (or any state), nor are there stated indicators and targets for RH at that level. This is partially due to insufficient funding for reproductive health and more explicitly for family planning. Additionally, while maternal mortality reduction is an affirmed priority in Kano State, there is little commitment for family planning. This is demonstrated in that specific family planning activities are not included in health reform initiatives or given precedence in either the discussion surrounding reduction of maternal mortality, nor securing the funding necessary to carry out activities in this area. All public sector family planning commodities are donated to the FMOH by UNFPA. While short-term needs are being fulfilled by donors' financial commitments, the government (FMOH and SMOH) should begin planning to buy their own commodities, building long-term sustainability for RHCS.

As mentioned, Kano State has not had any funds dedicated to reproductive health or family planning in the past and therefore was unable to do any extensive family planning programming, training, awareness raising, supervision as well as purchase additional commodities outside of the

cost recovery system. Starting in 2008, a line item for RH has been included in the health budget (five million Naira), setting a precedent which should be followed through by accessing and using those funds to secure RHCS in the State. Future budget planning can now build on this timely precedent.

The Contraceptive Logistics Management System (CLMS) manages, tracks, and distributes family planning commodities at the central level. Forecasting is conducted twice a year with the forecasting and procurement technical working group in conjunction with UNFPA. All procurement of contraceptives is managed using UNFPA's procurement systems. Issues data rather than consumption information are used to prepare forecasts, impacting the ability to make more exact forecasts. The lack of quality consumption data is partly attributable to low reporting rates and inaccurate completion of the RIR/RIRF forms from the State, LGA and SDP levels, with Kano State being near the bottom ranking of the six states surveyed. Health worker shortages and turnover influences health worker capacity to follow CLMS guidelines. There are also issues of the quality and frequency of supervision both to monitor health worker performance in CLMS and health worker performance in general. A cost recovery system was designed to ensure a continuous supply of contraceptives. But because of low demand for family planning in Kano State, sales are not enough to generate sufficient margins to purchase additional supplies, to pay for transport, and provide incentives for the health worker. Storage is adequate at the State level but better storage practices are needed to ensure commodities are not compromised. Transport of commodities from the central level is currently a major issue which has caused distribution delays to the State level, at the same time Kano State has not ordered once since receiving seed stock in 2006. Funding for transport is reliant on cost recovery funds rather than through a reliable, easily accessible source of dedicated funds.

Although all contraceptive methods (injectables, oral contraceptives, male condoms, IUCDs, and implants) are available in the state, injectables, oral contraceptives, and male condoms are mainly available at the SDP level. The most popular methods are injectables and pills. Injectables are the most preferred method mainly due to privacy reasons and are commonly accessed at public sector facilities. There is a shortage and nationwide stock out of Exluton/Microlut and Microgynon. Several facilities during the field visit were out of stock of these brands. Long periods of stock outs (between 74-130 days) for all contraceptives have occurred in the last six months nationwide.

A shortage of qualified health workers exists at all levels in Kano State (as in Nigeria in general), and high attrition rates, low recruitment rates to training schools, and transfers exacerbate the ability for the system to offer quality family planning services. This has contributed to low demand and a decreasing contraceptive prevalence rate from 2.5 percent (1999) to 1.7 percent (2003) (currently married women using modern methods) in the North West region of which Kano State belongs. Religious and cultural beliefs are common barriers to accessing and promoting contraceptives. There is very little demand for long term methods such as implants and female sterilizations partly due to a scarcity of trained health workers to provide these methods.

Major recommendations

- Ensure family planning and RHCS is integrated and addressed in health policies, guidelines, strategies and health reform programs at the state level
- Demonstrate commitment towards RHCS by providing an annual budget line item for family planning to include funds for the procurement of commodities. The budget line item should have provisions for:

  - Adequate funding for transportation of commodities from the Central level
  - Refresher training on the CLMS for coordinators and service providers to improve accountability, accuracy, and reporting of logistics data
  - Training to increase health worker capacity on family planning skills
  - Updating and strengthening family planning coordinators' supervision skills

- Create State level RHCS committee to raise the profile of reproductive health and family planning, improve coordination among NGOs, development partners, and providers of reproductive health services and initiate steps to develop State specific strategies and targets
- Develop State specific RHCS strategic plan
- SMOH, along with partner, should hold joint bi-annual work planning and progress meetings
- Make forms, SOPs and STGs available at all SDPs with OJT follow-up to ensure adherence to guidelines
- Budget line earmarked to roll out "Free Ante Natal Care" beyond state level
- Through supervision efforts, enforce health worker adherence to ordering schedules in order to avoid low stock levels and buying from the open market
- State MOH and FP Coordinator should immediately submit RIRF form for re-supply of commodities to central level
- Kano State should develop a pro-active strategy to increase the enrolment and graduation of health workers from nursing and midwifery schools annually (especially female health workers). Advocacy should be done to support this change at the national level

Conclusions and next steps

As noted above, this assessment was undertaken to identify the strengths and weaknesses of the RHCS situation in Kano State. The preliminary findings and recommendations were presented to key stakeholders by the in-country team members after the departure of the consultants. This analysis will be used by stakeholders to decide how to move forward to include RHCS in Kano State health activities and agenda.

Introduction

The Federal Ministry of Health (FMOH) of Nigeria, in collaboration with UNFPA and the USAID | DELIVER PROJECT, 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 commodities for men and women. RHCS is seen to support the achievement of the Millennium Development Goals that have bearing on reproductive health and reproductive rights. The Strategic Plan for RHCS was developed as a five year strategic plan, lapsing at the end of 2007.

Before updating the Strategic Plan for RHCS, it was felt that there was a need to take a close look at the most recent RHCS situation in Nigeria, updating the original 2001 SPARHCS assessment and gathering data to see what progress has been made in the intervening period. In order to do this the FMOH partnered with UNFPA and the USAID | DELIVER PROJECT to do a National Reproductive Health Commodity Security Situational Analysis, using the RHCSAT tool. The 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. A national report provides the synthesized findings from the assessment. This report provides the findings specifically for Kano State. The findings from Kano State contribute to the overall objective to provide current information to feed into an updated national RHCS strategy within the context of Nigeria's reproductive health and family planning program.

Purpose

The purpose of this RHCS Situation Analysis Report is to identify and analyze the strengths and weakness in seven key areas that affect the availability of reproductive health commodities in Kano, specifically family planning commodities, and to make recommendations for strengthening RHCS. The recommendations are intended to assist in the planning and improvement of RHCS in Kano

Objectives

The objectives of this situation analysis were to:

- Identify the background situation of RH commodity security in Kano State;
- Introduce and increase awareness on the Reproductive Health Commodity Security concept and the framework components in Kano State;

- Start collecting information on the status of RHCS in Kano State on family planning commodities regarding the:
  - Political and socio-economic context
  - Coordination of RHCS
  - Commitment towards RHCS
  - Financing for contraceptives and services
  - Provision of family planning commodities
  - Client Utilization and demand
  - Logistics system capacity;
- Understand and identify strengths and weaknesses of Kano State's RHCS situation;
- Identify any information gaps on the RH components;
- Prioritize strengths and weaknesses of each of the RHCS components;
- Develop recommendations to address the strengths and weaknesses needed for improvement of RHCS in Kano.

Methodology

This RHCS Situation Analysis entailed a participatory, multi-stakeholder process for collecting and analyzing information about Kano State's RHCS situation including: document review, focus group discussions during a Kano State stakeholder workshop, site visits to the State and local government area (LGA) stores, and to service delivery points (SDP). After the interviews and visits were completed, preliminary findings and recommendations for Nigeria, where the Kano findings were incorporated as part of the national findings, were presented for feedback at a RHCS Stakeholder Debriefing.

The methodology for this assessment is based on the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) framework (see Figure 1) developed and adapted by UNFPA, USAID, and other partners.

Figure 1: Strategic Pathway to Reproductive Health Commodity Security Framework

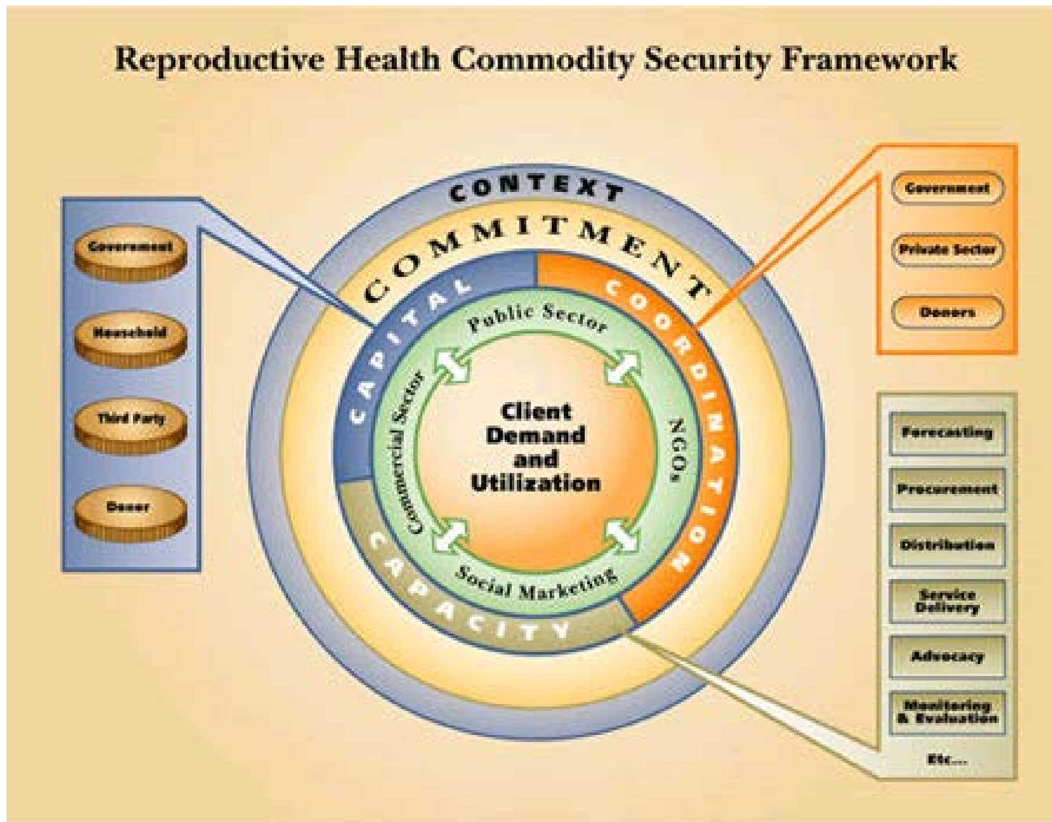


Figure 1 above depicts how six essential RHCS elements impact upon client demand and utilization of **commodities**. In every country, there is a **context** that affects the country's prospects for achieving RHCS, including national policies and regulations that bear on reproductive health and particularly on the availability of reproductive health supplies, and broader factors like social and economic conditions, political and religious concerns, and competing priorities. Within this context, **commitment**, evidenced in part by supportive policies, government leadership, and focused advocacy, is a fundamental underpinning for RHCS. It is the basis from which stakeholders invest the necessary **capital** (financing), coordinate for commodity security (CS), and develop necessary capacities to ensure CS. The boxes in the figure elaborate on each of these three components. **Coordination** involves government, the private sector, and donors to ensure more effective allocation of resources. Households, third parties (e.g., employers and insurers), governments, and donors are all sources of capital. Additionally, **capacities** must exist for a range of functions, including policy; forecasting, procurement, and distribution; demand generation; service delivery; supervision, monitoring and evaluation, to name a few. **Clients** (youth, women and men), at the center of the figure, are the ultimate beneficiaries of RHCS as product users, and as shown by the double headed arrows, the drivers of the system through their demand (SPARHCS).

The assessment tool used to conduct the situation analysis is based on two well-tested tools: SPARHCS and the Logistics System Assessment Tool (LSAT). The RHCS Situation Analysis Tool

(RHCSAT) contains questions relating to these seven core components of RHCS: context, coordination, commitment, capital, commodities, client demand and utilization, and capacity.

Assessment Team

The assessment team was composed of one USAID | DELIVER PROJECT consultant, one USAID | DELIVER PROJECT Nigeria office member, one USAID/Nigeria member, and one FMOH member who traveled to the State and visited LGA and SDP health facilities. All team members participated in interviewing and data collection. The Kano State stakeholders workshop team was composed of four USAID | DELIVER PROJECT Nigeria office staff, three project consultants and one USAID/Nigeria member.

Training on the Assessment Tool

A one-day training on the RHCSAT was conducted for all field team members prior to data collection.

Data Collection

The RHCSAT (and its interview guide) was the main data collection tool. A group of stakeholders adapted the tool to the National and State levels and field tested them prior to the assessment. Several quantitative indicators were also tracked by each team. Data collection took place through a variety of methods:

- The team held a focus group discussion in Kano during the State level workshop. RH stakeholders represented the public (SMOH) system, civil society, social marketing, local Non-governmental organizations (NGOs), and other key stakeholders.
- Data was collected during field visits to the State, LGA, and SDP storerooms and facilities.
- The USAID | DELIVER PROJECT consultants conducted a desk review of various policy documents, program publications, surveys, Nigeria Demographic and Health Survey (NDHS), and internet resources.

Study Limitations

Kano was one of six States selected to represent all of the six geopolitical areas in Nigeria. The team visited two urban and one rural LGA. The LGAs and facilities selected were chosen randomly attempting to sample tertiary, secondary and primary health care centers. In terms of type, sites were selected by State Family Planning (FP) Coordinators from State and LGA storage facilities, and service delivery points (health centers). The findings from the selected facilities offer anecdotal evidence of the particular facility and are not representative of the entire State. However, the sampled facilities taken together can provide generalized findings of the strengths and weaknesses of the contraceptive security situation in the State.

Site Visits

Within the State three LGAs were visited, with two SDPs per LGA. One rural LGA was selected out of the three. A few local NGO's and Community Based Distributors (CBDs) were also interviewed. For a more detailed list of facilities and contact persons please refer to Appendix C.

- State storeroom
- Kumbotso Comprehensive Health Center
- Shekar Primary Health Care Center
- Filimushe MCH Center
- Kabuga Health Clinic
- PPFN Kano State
- Fajewa PHC
- Takai NYSC Clinic (Cottage Hospital)
- Community Based Distributors
- COMPASS Project
- YOSPIS NGO

Commodities Assessed

The family planning commodities evaluated for this assessment included five methods of contraceptives:

1. Condoms (male and female)
2. Injectable contraceptives (Noristerat and Depo-Provera)
3. Oral Contraceptives (Exluton/Microlut, Microgynon and Lo-femenal)
4. Intrauterine contraceptive Devices (IUCDs)
5. Implants (Implanon and Jadelle)

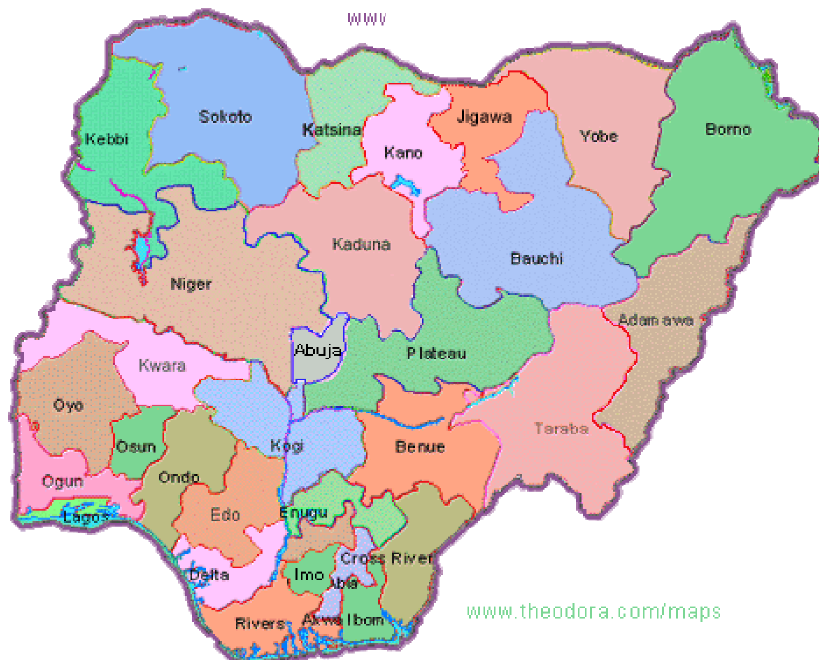
Assessment Findings

State context

In Kano State, just as in Nigeria, there is a context that affects the prospects for RHCS. State and National policies and regulations bear on family planning and reproductive health and on the availability of contraceptive supplies in particular. In addition, broader factors like social and economic conditions, political and religious concerns, and competing priorities affect the provision of reproductive health services and supplies.

Kano State is located in North-Western Nigeria and was created in May 1967. Kano has 44 LGAs and is home to 9.4 million people making it the most populous State in Nigeria. Hausa and English are the predominant languages. The majority of the population is of Hausa ethnicity. Islam is the principal religion. Kano's economy is based on oil revenues, distribution of finished goods, and agriculture (millet, sorghum, peanuts, and beans). Kano is one of Nigeria's leading manufacturing States with industries in tanning, oilseed processing, meatpacking, and furniture productions. It also has a vibrant textile industry. The state has more than 18,684 square kilometres of cultivable land and is the most extensively irrigated state in the country.

Figure 2: Map of Nigeria



The State Ministry of Health is responsible for the implementation of the National Health Policy and for oversight on all other health issues. It coordinates and supervises the institutions in the health sector owned by the State government. As an autonomous entity (from the national government), they can institute their own policies to supplement national ones and configure their own system for governance of the health sector at the State level.

The National Health Policy of 1988 was essentially designed to achieve health for all Nigerians, based on the philosophy of social justice and equity. The National Health Policy provided for a three tier structured health system of primary, secondary and tertiary care:

- Primary Health Care level — constitutes the entry point into the health system and is the responsibility primarily of the Local Government Areas. At this level general health services that are preventive, promotive, protective, curative, and rehabilitative in nature can be accessed. Private Medical Practitioners also provide care at this level.
- Secondary Health Care level — referrals from the Primary Health Care level are generally directed to this level. The level consists of General and Specialist Hospitals usually established by State Governments.
- Tertiary Health Care level — this level is the apex level of health care in Nigeria and includes Teaching Hospitals and other specialized hospitals such as Psychiatric, Orthopaedic, Ophthalmologic, as well as specialized care centres. The Federal Government takes responsibility of tertiary health care, and is expected to provide at least one tertiary facility in each State of the Federation.

In addition to the three levels, there are also Community-Based Distributors (CBDs) of contraceptives who supply male 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 NGO's.

There are two semi-autonomous parastatals in the MOH: The Hospitals Management Board (HMB) and the Drugs Management Agency (DMA).

Within the HMB is a public health department. The HMB is responsible for:

-
- Recruitment, training, remuneration, promotion and discipline of staff of all State government-owned hospitals and health centers
- Coordination and supervision of the activities of all zonal Hospitals Management committees in the State
- Purchase, renovation and rehabilitation of hospital equipment and structure

The Drugs Management Agency is responsible for procurement, storage, production and supply of high quality drugs to Government hospitals at affordable prices. Its mandate includes the continuous provision of all essential drugs through a revolving drug fund.

The desire for large families continues to be the norm for the majority of Nigerians, with more than two thirds of women considering 5 or more children to be ideal and men wanting 2 more on average than women (2003 NDHS). Kano State, located in the Northwest region, has its own story. Women and men in the Northwest want more children than anywhere else in the country, with the ideal amount of children for women being 8.6, and men 12.8. Predictably, desire to limit children is the lowest in the Northwest Region, at 7%. Unmet need for family planning in the Northwest is about 11%.

With population growth at 2.83 percent per year, this puts tremendous pressure on Kano State which has an average density of 281 persons per square kilometer, the most densely populated state in the North by far (DHS 2003), with almost 10 million inhabitants. High maternal and child mortality rates play a pivotal role in the provision of RH and FP services, with maternal mortality rates in the North as high as 1,500/100,000, highlighting the need for increasing visibility of RHCS to ensure the health of mothers and children. The Kano SMOH strongly supports efforts to reduce maternal mortality through its programming. In this context Family Planning, as a part of Reproductive Health services, focuses on provision of commodities for birth spacing and limiting family size (2003 DHS). It is important to note that for some in Kano, the only role for Family Planning is when the life of the mother in endangered.

One of the major threats to RHCS is the severe shortage in skilled health personnel from CHEWs, nurses, midwives, and doctors. There is difficulty in recruiting personnel from other States because of stated policies of hiring indigenes or the belief that outside personnel will not be accepted, do not have the needed language or cultural skills to work in the particular environment of Kano State. The state is unable to recruit and train enough health workers due to general low education rates in the 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. There are policies regarding enrollment into schools of midwifery limiting the number of graduates to only 50 a year, which is inadequate to meet the needs of the population.

Table 1: Demographic, Health, and Development Indicators

Indicator	1999	2003
Total Population	5.6 (1991)	9.4 million
Total fertility rate (TFR)	5.8	6.7
Contraceptive Prevalence Rate (modern methods)	8.6 (National) 2.5 (North West)	8.2 (National) 3.3 (North West)
Unmet need for spacing	10.1 (National) 21.9 (North West)	11.8 (National) 9.9 (North West)
Infant mortality (per 100,000 births) (national)	78	100
Maternal Mortality		1,690 per annum (2007)
Source of contraception – public sector (national)	42.9	22.8

Sources: 1999, 2003 NDHS; www.kanoonline; Wikipedia, http://allafrica.com/stories/200710230440.html

Policies and Regulations

There are a number of national strategies, policies, and frameworks that affect family planning and commodity security and are relevant to each State in the country including Kano. Most policies include language, guidelines and responsibilities to be carried out by each State. These include:

- **The National Policy on Population for Sustainable Development**, 2005- The policy looks at possible consequences of unmanaged population growth and puts forth goals and targets to "improve the quality of life and standard of living of the people of Nigeria", including improvement in the reproductive health of all Nigerians at every stage of their life cycle.
- **National Reproductive Health Policy and Strategy**, 2001- 2006 (Federal Ministry of Health) - The policy aims to create an enabling environment for reproductive health providing a broad outline on training, services, commodities, IEC, monitoring and evaluation, financing and research at the National, State and Local Government Areas. One of the areas the policy seeks to address is the low level of awareness and utilization of contraceptive and natural family planning services. Contraceptive prevalence rate targets are placed within the context of reducing unwanted pregnancies in all women of reproductive age from 8.6 percent to 20 percent. The provision of condoms is mentioned in the prevention of HIV/AIDS transmission. There is a target of a 50 percent increase in reproductive health information and services. Family planning is mentioned specifically as one of the components of reproductive health.
- **Nigeria National Youth Policy and Strategic Plan of Action**- The health component of this policy strives to "seek and offer solutions to youth problems such as drug abuse and addiction, teenage pregnancy, sexually transmitted diseases, HIV/AIDS, cultism, examination malpractices, etc". The policy recognizes certain rights of youth related to health, including the right to adequate health-care, the right to protection against the dangers of substance abuse, alcoholism, sexual harassment and exploitation, and HIV/AIDS, the right to be protected against harmful

traditional practices, and the right of the disabled to be provided with the special treatment which his/her condition requires.

- **National Guidelines for the Integration of Reproductive Health and HIV Programmes in Nigeria**- The guidelines provide a national strategy and framework for the integration of RH with HIV services and vice-versa following the belief that integration will maximise health outcome achievements and ensure a more efficient use of resources. The guidelines provide a broad framework for eventual integration of all RH and HIV services. It also provides a framework for commencement with minimal package of FP and VCT with eventual scaling up to include all possible services in RH and HIV at all levels of the health service system in Nigeria.
- **National RHCS Strategic Plan**, 2003-2007 - The Strategic Plan covers RHCS for contraceptives and condoms for STI and HIV/AIDS prevention. The Strategic Plan includes supplies for all modern methods of contraception, including condoms which are used in the prevention of HIV/AIDS and other sexually transmitted infections (STIs). The "dual role" of condoms in the provision of contraception is also recognized. The Strategic Plan covers six components: finance, policy, logistics, service delivery, demand, and coordination. It was develop in collaboration with the government, development partners, NGOs, civil society, the private sector, and individuals.
- **National Adolescent Health Policy –** 2007 – The policy provides a framework for adolescents and young people (10-24 years of age) with the aim to provide advocacy, resources, and interventions and to generate political will and creating safe environments to ensure their optimal health. The policy sets targets for reducing maternal mortality by 75 percent and unwanted pregnancies by 50 percent among young people; and to integrate family life and HIV/AIDS education into primary and secondary curriculum. Sexual and reproductive health rights are one of nine key interventions.
- **National Health Insurance Scheme** – the NHIS was developed to ensure that every Nigerian has access to quality healthcare services. The scheme covers the formal and informal sector, vulnerable groups, and other groups. The mission is to ensure fair financing of health costs through pooling and cost-sharing to protect against the high cost of health care through pre-payment programs.

In addition, Kano State has the following policy which includes RH and FP services:

- **Free Antenatal & Delivery Services Policy**

As indicated, there are a number of national policies, either adopted or in draft form, which specifically identify and support access to quality reproductive health services for women, men, and adolescents, as well as informed choice for each of these client groups. Existence of these policies is helpful for Kano State as they provide a supportive general environment. The lack of training on and dissemination of most of these policies in Kano State suggests that further efforts are needed to disseminate, educate on and promote national policies. The Free Antenatal & Delivery Services Policy is an important one that helps to address the high maternal mortality rates in the State. In actuality this policy is only implemented in urbanized areas, indicating that more emphasis on funding the program and hiring trained staff sufficient enough to roll it out in all areas is needed. Kano State has launched the National Population Policy at the State level.

Existence of a National RHCS Strategic Plan indicates a favorable policy environment for RHCS at the national level. However, the fact that the plan has been allowed to expire and is not in itself

financed indicates need for increased visibility and funding for RHCS. While a strategic plan exists at the national level and includes provisions for State level activities, *there is no counterpart plan existing in Kano State.*

Kano State, and in fact each State in the republic, has a varying context. A Kano State level plan should respond to the needs and context of the state. Kano State and LGA RH targets are nonexistent, resulting in lack of direction and accountability for State and LGA level coordinators. National policies are not widely available in Kano. A similar situation exists concerning availability of SOPs and STGs; although some Service Providers (SP's) were aware of their existence, none were available on site. Family Planning services and targets are not addressed in National or Kano State health reform documents such as NEEDS and SEEDS, another barometer of the lack of focus on these issues, at both levels.

Funding at the State level for dissemination and implementation of these policies is insufficient, as is funding support from the national level. A newly created line item for RH in the 2008 Kano State budget is a positive breakthrough, leaders in RH and FP will need to follow up with their requests to include funds for policy dissemination and implementation in the future.

Although UNFPA funded the production and printing of a user friendly version of the National Population Policy for Sustainable Development entitled, "What you need to know about The National Policy on Population For Sustainable Development", during the assessment key informants noted that none of the 20,000 copies produced had been heard of or seen in Kano State. The national Population Commission intends to translate the Policy into 3 Nigerian languages (Hausa, Igbo, and Yoruba), with funding assistance from the UNFPA. The National RH Policy and other related policies have not been translated into local languages. As Kano State is predominantly Hausa speaking, it will be important to consider funding Hausa translations of user friendly versions of important policy documents, SOPs, STGs, job aids and wall posters.

A cost recovery scheme has been implemented nationwide, including Kano State, for contraceptive commodities, while associated services are provided free of charge. The cost recovery scheme is intended to act as a revolving fund, some of the monies from client purchasing are set aside for re-purchase of commodities and the resulting margin from these purchases is anticipated to provide for needed supplies and transportation to pick up re-supply commodities. To date, no cost recovery funds have been accessed in Kano State, although a separate account has recently been allocated to keep cost recovery funds separate from other State funds.

In Kano State the margin generated from cost recovery is not enough to meet the needs of the program. It was observed that this is partly because of low client use of products, therefore there is not enough income to cover logistics costs. In States where the client uptake was higher, the margin was in most cases sufficient to cover transport and basic supplies such as disinfectant, cell phone minutes to contact supervisors, etc.

There is currently no RHCS or RH coordinating group in Kano State, although related issues are discussed in meetings held by the Donor Coordination Forum (DCF) and the Kano Network meeting. In order to elevate RH/RHCS issues, a committee should be formed with all of the relevant stakeholders invited and involved. In this way the committee can concentrate on issues specific to RHCS.

No contraceptives are currently purchased with State (or national) government funds. Kano State is dependant on Implementing Partners, who donate all commodities in the public system. Furthermore, Kano is reliant on the forecasts and the distribution system of the national level.

Currently, as there are some issues at the central level in regards to regulation of soon to expire products and a malfunctioning distribution system, Kano has not received product since the first seed stock was given in 2006. Kano State has also not followed the standardized system by requesting an order at any time during that period. Kano State should use some of its cost recovery funds to purchase commodities (placing an order with the central level). Since the State has not ordered in some time, many facilities are stocked out of certain commodities, driving clients to use commodities from better stocked (and more expensive) private and socially marketed sources. Some clients are even referred to provider owned facilities where it is alleged that the commodities have been diverted from the public sector for profit making.

The National Health Insurance Scheme (NHIS) can be accessed through the HMO *Premium Private* in Kano State. Although it is not currently covering a wide population in the State, it is envisioned to eventually expand to cover civil servants, formal and informal sectors, as well as vulnerable groups. At present the NHIS does not cover family planning commodities or services, although they do counsel on use of FP.

Kano State uses the National essential drugs list. The 2003 version included condoms (with or without spermicide), foaming tablets, diaphrams with spermicide (which are not currently being provided in the public system), IUCDs (Copper & Lippe's Loop), injectable contraceptives (levonorgestrel implant, medroxyprogesterone acetate injection & Norethisterone enanthate injection), oral contraceptives (ethinyloestridiol plus levonorgestrel, ethinyloestridiol plus norethisterone & norethisterone). Not all of these products are available in the public system, but some are in stock through private pharmacies or PPFN clinics.

The only age- or parity-related restriction that formally limits access to contraceptives is that the client must be of reproductive age. Informally, cultural practices still allow the husband to make the final decisions on the use of family planning. While 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 Kano State. In fact, we were told there are widespread radio campaigns raising awareness for RH and FP.

Reproductive health services are provided primarily through health facilities by doctors (where available), nurses/nurse midwives, Community Health Extension Workers (CHEWs) and Junior Community Health Extension Workers (JCHEWs), trained according to their respective pre-service curricula. There is also a standard training program in Kano State but the trainers and funding are often not available for them to participate. Community-based distributors (CBDs) provide condoms and re-supply oral contraceptives, they are required to obtain certification, undergoing training to counsel their clients on these commodities. This training is often undertaken by various NGOs (with varied training programs). Service Providers of all types are very thin on the ground. More female service providers are needed at all levels, as female clients will often not seek the services of male providers.

It is intended that Service Providers (SPs) undergo further in-service and step-down trainings in accordance with newly adopted commodities, protocols, guidelines or forms. Although there are training and certification requirements for providing family planning and other RH services including a mandatory 6-week training, funding to roll-out this training on a nation or statewide basis is currently not available and many SPs join the general population in their lack of knowledge regarding the benefits and side effects of FP.

Standard treatment guidelines exist at the National level, notably 1) Family planning service provision standard operating procedures, 2) Monitoring and Supervision of Dispensing practices and 3) Universal Safety Precaution Guidelines. Some service providers are aware of Standing Orders or Standard Operating Procedures but not all SP's in Kano State have been trained in their use. Many service providers that we encountered had undergone training in disposal of sharps and appeared to be using their disposal containers. A streamlined CLMS system with new forms is in place in Kano State. Although the Guidelines on the CLMS system were not viewed, almost every facility had the CLMS Job Aide and appeared to be using it.

Strengths

1. "Free Antenatal & Delivery Services" Policy adopted which is inclusive of RH and FP services
2. Focus on Reduction on Maternal Mortality Rate by SMOH
3. National policies emphasize informed choice on multiple (modern and traditional) methods
4. No formal restrictions on dispensing and accessing commodities
5. National Policies ensure access to family planning for all persons of reproductive age
6. Contraceptive Management Logistics System job aide present and in use
7. No restrictions on media adverts
8. Commodities available at pharmacies and NGOs
9. Some service providers are aware of Standing Orders or Standard Operating Procedures

Weaknesses

1. No RHCS/RH policy specific to Kano State;
2. FP services and targets not addressed in Kano State health reform documents;
3. Inadequate dissemination and implementation of polices at State and LGA level;
4. Shortage of trained service personnel (esp. female) providing services & commodities;
5. Lack of knowledge by the SP & general population about benefits and side effects of FP commodities;
6. Many SPs do not have formal or any recent FP training;
7. Lack of availability of commodities at government owned clinics;
8. Diversion of clients from the clinics by the service providers (referring them elsewhere to get commodities, sometimes to self-owned stores);
9. Lack of supervision & monitoring;
10. Focus of FP services is mainly towards adult population;
11. Inconsistent availability of SOPs, STGs at State level.

Recommendations

1. Adapt National RHCS strategy to Kano State context;
2. Create State and LGA level RH targets;
3. Revise existing RH Policies to fit state context and distribute among all RH/FP stakeholders;
4. Enroll service providers in 4-week FP course on theory and clinical skills;
5. Develop guidelines for standard service provision of FP (esp. on counseling);
6. Advocate for translation of national polices and ensure they are disseminated at the State Level with orientation;
7. Make SOPs and STGs available at all SDPs with OJT follow-up to ensure adherence to guidelines;
8. Include Family planning services and targets in State health reform documents such as SEEDS.

Coordination

Coordination among key stakeholders and markets facilitates commodity security by leveraging resources and avoiding duplication of efforts. These key stakeholders include not only development partners, the private sector, and civil society but should also include members from other line ministries such as the ministry of finance, programs in charge of communication campaigns, civil society, and supply chain experts.

As previously mentioned, there is no Kano State RHCS or RH committee. There is a Donor Coordination Forum (DCF) that meets to identify State health needs and areas for intervention. The SMOH then assigns local NGO's and IP's to a geographic area in the state to make sure there is not duplication of services. The DCF is chaired by the SMOH and consists of representatives from: SMOH, Ministry of Planning, Budgeting and Finance, Ministry of Local Government and different donors such as GHAIN, ACCESS, AQUIRE, PATHS, Pathfinder and others. They are supposed to meet every first Tuesday of the month but in reality, meet about four times per year. Another important coordinating body is Kanet, or the Kano Network, which is a forum of NGO's that meets twice per year to discuss any development related issue, including achievements, constraints and the way forward. The State ministries are always invited. While these forums do provide some place for RHCS/RH issues to be raised, Kano State needs a RHCS/RH forum of its own to focus specifically and strategically on these issues.

The Kano RHCS Stakeholders Committee should be seen as the decision-making body, and its meetings need to be attended by officials at the policymaking and decision-making levels, and of course they need to meet regularly and receive ongoing funding in the SMOH budget. After its inception, an early activity for the committee would be to draft a strategic plan, including State level targets and indicators. Other areas to address are coordination of behavior change communication, marketing, and promotional activities, supervision and training between the public and the social marketing sectors. As a decision making body, the Committee should release an annual report on RHCS, detailing progress made and upcoming activities, to share with stakeholders. In addition to the larger committee, sub-committee's or Technical Working Groups (TWGs) should be in place to address and coordinate specific functions, such as reporting, supervision, distribution, cost recovery scheme, BCC/IEC, etc. For example, a TWG could be formed to look at the non-availability of

contraceptive commodities in many public sector facilities and make their recommendation to the committee for how to alleviate this problem.

Creating a RH or RHCS coordinating committee with a strategic plan and State level targets and indicators is one way to institutionalize coordinating mechanisms. As there are some very strong personnel already leading efforts in other States (and impetus to start one by the Kano State Coordinator), one FP coordinator meeting could be dedicated to laying the groundwork for such a mechanism and those already involved (at State and LGA level) invited to share their lessons learned. Such a meeting would be dedicated to practical strategies like: 1) how to formalize the coordination mechanism, including strategies to form and keep committees invigorated 2) joint work planning & budgeting, 3) developing targets and indicators and 4) reporting results to key State level decision makers.

NGOs and Implementing Partners have taken on an important role in training and follow-up supervision of CBDs and SPs as well as promotional activities. It was observed that although this took place with public sector employees, the coordination between the agencies is poor. Coordination at the level of the SMOH would enhance contributions by local NGOs and DPs and help strengthen the program overall by ensuring the best utilization of resources. The SMOH along with partners should hold joint bi-annual work planning and progress meetings. Currently there are no formal existing coordination mechanism among SMOH and IPs to determine areas of coverage and gaps and to leverage resources.

Although there is a reporting system in place and personnel receive feedback during supervision visits, these reports and feedback are currently inadequate to inform decision making. Because supervisors have no or few funds earmarked for supervision visits at all levels, these 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 inadequate training and supervision. At facilities where supervision was taking place regularly, it was noted that reporting rates and accuracy of reporting was greatly increased. Service providers need feedback on their reporting: if they are filling out the forms correctly, how to do it if they are not, specific feedback on any comments they made, follow-up on requests for product that are stocked out or what to do with expired product. In addition, providers with clear problems need help. For example, Gwale LGA secretariat burnt down 4 months ago but they have not received new CLMS forms. In an environment with good coordination, provision of new forms and supportive supervision and assistance to get them up and running would have occurred.

Funds must be set aside for the purpose of supervision. Without coordination between the levels of the supply chain, each level operates in a void, as if not connected to the others. One solution mentioned, in lieu of earmarked funds for supervision, is regularizing phone calls or emails for feedback from each supervisor. The SMOH should also work with partners to map out coverage of FP facilities and identify facilities with difficulties in following CLMS guidelines and increase supervision to these facilities.

State Family Planning Coordinators and LGA Coordinators are supposed to meet regularly, although in reality these meetings are infrequent due to the previously mentioned difficulties of funding and also to the shortage of personnel. Some coordinators are filling multiple roles and are unable to travel for meetings or supervision for this reason.

Although the private sector is serving 58% of the populations contraceptive commodity needs, there is modest coordination between public and private sector (DHS 2003). There is a need at the State level to form a forum to address training and awareness raising in FP, utilizing the existing expertise in both sectors. This assessment did not witness any formal dialogue between the public and private sector in Kano State, although some SP's do refer their clients to the private sector when they are stocked out of a product. This forum could be part of the larger RHCS coordinating body.

Section 1.01

Strengths

1. Existence of Donor Coordination Forum (DCF);
2. Existence of Kano Network (Kanet), donor coordinating body;
3. Quarterly NGO networking meetings to coordinate activities, joint advocacy and IEC campaigns;
4. State FP Coordinators hold meetings to share what's going well and challenges they are facing.

Weaknesses

1. Not all stakeholders are invited to existing coordinating fora (e.g. National Population Committee, USAID| DELIVER PROJECT);
2. No existing RH/FP coordinating mechanisms between State and NGO providers of FP/RH to discuss programs, issues, and challenges;
3. Poor feedback mechanisms in both directions (State, LGA and SDP level). Reporting rates are low; feedback on the reports that are received is not regularized or designed to occur in the absence of face-to-face supervision;
4. Weak monitoring and supervision between LGA and SDP levels;
5. Non-existent public-private partnership for RH/FP activities at both state and LGA levels
6. Inadequate staff and funding for supervision at all levels.

Section 1.02

Recommendations

1. Create State level RHCS coordinating committee, or RH committee with a RHCS sub-committee;
2. Draft a strategic plan for RHCS in Kano State, including State level targets and indicators;
3. Update stakeholders list and invite *all* stakeholders to coordination meetings. SMOH should take the lead in coordinating activities among NGO and DPs (partners);
4. SMOH should attend NGO Networking meetings & report back to Ministry & RH committee;
5. SMOH should take the lead in coordinating activities among NGO and DPs (partners);
6. SMOH, along with partners, should hold joint bi-annual work planning and progress meetings;
7. SMOH and partners should map out coverage of FP facilities and identify facilities with difficulties in following CLMS or other guidelines and increase supervision to these facilities;
8. Budget line earmarked to roll out "Free Ante Natal Care" beyond state level;
9. Re-initiate & regularize FP Coordinator meetings to share challenges, troubleshoot, maintain and improve supervision skills. Earmark funds in State budget to support travel to these meetings;

10. Disseminate annual Kano State report on RHCS (situation, progress, coming months activities);
11. Increase coordination with private sector to leverage resources and expertise in demand creation, training, and awareness raising in FP;
12. Dedicate one FP Coordinator meeting to discussing how to formalize the coordination mechanism, including strategies to form and keep committees invigorated, joint work planning & budgeting, developing targets and indicators and reporting results to key State level decision makers.

Commitment

Commitment to RHCS in Kano State is almost non-existent. Religious and political factors play a role in dictating whether there is an enabling environment for RHCS. Key informants widely believed that reproductive health is viewed to be synonymous with family planning which is not acceptable by the religious tenets of Kano thus illustrating the need for targeted advocacy to ensure ongoing education and sensitization on how RHCS is one of the vital components to reproductive health and the general health of the population. Though reproductive health activities are championed under the realm of maternal health care, explicit commitment to procurement of contraceptives and ensuring commodity security remains absent.

Commitment in the Public and Private Sectors

Though the public sector (Kano state government) has no explicit commitment to RHCS, the for-profit private sector and the NGO/Civil society organizations are involved in family planning activities. Commodities are readily available in private pharmacy shops and NGOs supported by donors to provide services for all who want to access these services. The SMOH does not provide any funds towards the purchase of contraceptives.

Advocacy

Advocacy at all levels on RH/FP issues is not a priority in Kano and this is a reflection of the perception of family planning in the community. Community awareness is mainly via radio programs under the themes of birth spacing and maternal health and these are usually sponsored by donor organizations at high costs. Many of these are focused in the urban area. No government funded jingles or programs for FP currently exist. Advocacy to decision/policy makers and religious leaders is almost non existent as only a few NGOs such as Adolescent Health and Information Projects (AHIP), with donor support, have undertaken sporadic advocacy activities to the higher levels.

Health Sector Reform and Development Assistance

RH/FP activities or RHCS itself are not specifically addressed in any of the Kano State health sector reforms or development assistance programs that are currently ongoing.

Strengths

1. Civil Societies such as AHIP, FOMWAN are engaged in advocacy for RH/FP activities and collaborate with other stakeholders to advocate RHCS, they also help generate awareness in the community and provide relevant information to decision makers;
2. NGOs such as IRHIN, SFH, PPFN sponsor jingles and programs on radio during which sites with availability of contraceptives are mentioned to empower individuals who seek the services. Such organizations can be said to champion RHCS within the Kano state private sector;
3. PPFN and SFH champion RHCS within the private sector;
4. Private pharmacies provide a ready source for RH commodities at a higher cost.

Weaknesses

1. RH/FP commodities are categorically "orphaned" from the state health sector reforms;
2. Advocacy in the form of community sensitization is non existent for hard-to-reach LGAs, as even the civil society groups that carry out such activities tend to operate within the urban city limits;
3. Decentralizing of decision making from state to LGA levels led to a deterioration in primary health care services and this further adversely affects RHCS;
4. RH/FP activities including RHCS is totally donor driven with the public sector.

Recommendations

1. Kano state MOH should endeavor to make RHCS a priority issue by creating a specific line item budget for RH activities that goes beyond capacity building (as the proposed 2008 RH budget indicates) to include funds for RHCS specific activities;
2. Develop a Kano state-specific strategic advocacy plan that is culturally appropriate in addressing RH issues including FP/birth spacing;
3. Government-owned media should also initiate and sponsor jingles and programmes particularly on RH/FP;
4. Find creative ways of breaking barriers to discuss RH and RHCS in the electronic media;
5. Incorporate RH/FP specific information in the SEEDS.

Financing

The Kano State government has not invested any funding for RH or for RHCS. In 2008 a line budget of $5 million naira was created for reproductive health. It was not possible to determine if the proposed budget details would include any funding to support training of staff in family planning, contraceptives, transport for supervision, or any other logistics related activities.

Government, Donor Funding

Funding for RHCS and RH/FP in general, is purely supported and driven by implementing partners. The private sector and civil society organizations receive resources from private, outside sources to run their programs to provide RH services and commodities to the public.

Kano State follows the national cost recovery scheme for contraceptive commodities. The system was established in 2003 to generate funds for re-supply at the State, LGA, and 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. While 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. At the State level it is used for supervision and transportation while the rest of the money is remitted to the FMOH (approximately 20 percent) who reportedly has set aside these monies since the inception of the streamlined CLMS program.

The low demand for contraceptives in Kano State has had repercussions on the cost recovery system. The level of margins has been inadequate to fulfill the intentions of cost recovery to ensure funds for transportation and purchase of additional commodities.

An exemption system for contraceptives is not available to the indigent client; though at no level of service delivery did the subsidized user fee appear to present a barrier to access.

Current and Future Funding

Although the allocation for RH activities in 2008 is a promising achievement to demonstrate government commitment, there is no concrete evidence for any potential future funding for contraceptives. To continue this positive trend the State should consider allocating funds from the RH budget to supplement cost recovery resources as one step to create additional commitment for RH.

Strengths

1. Newly created budget line item for RH programming in 2008 (5 million naira) financed by State government though yet to be released;
2. Priority given to MCH provides funding indirectly for RH/FP for birth–spacing.

Weaknesses

1. No budget line item for RH contraceptives commodities;
2. No financial support from State level for purchase of contraceptives, supervision, or transportation;
3. No waiver system for the poor (only MCH services have a waiver system in place). Clients are charged for FP commodities.

Recommendations

1. State MOH and LGAs should create a FP line item budget or allocate funds for FP to include funds for supervision, transport, and commodities, and other logistics activities;
2. The LGA PHC budget should come directly to the PHC unit from the state ministry to the local government to allow easier access to funds & implementation of activities including FP/RH interventions;
3. Regular financial reports to be provided to policy makers to enable them to appreciate the need for RH/FP activities funding.

Commodities

The same contraceptive products provided nationally are also offered in Kano with the exception of Jadelle implants. The SMOH carries nine types of contraceptives. Short-term methods include the male and female condom, combination and progestin only oral contraceptives, and injectables. Long term methods include IUCDs and implants (see table below). Jadelle implants were introduced into the country last year and because the State has not ordered any products since 2006 Jadelle is not available in Kano.

Table 2: Contraceptives Offered by the SMOH Program

Condoms	Injectables	Pills (combined & progestin	IUCD	Implants
Male Female	Depo- Provera Noristerat	Lo-Femenal Microgynon Exluton/Microlut	Copper T	Implanon[1]

Although all of the facilities visited had Noristerat, orals, and some male condoms available, these are all below minimum levels. With the popularity of Noristerat and an unspecified arrival date of

[1] Implanon is being phased out and being replaced with Jadelle which was introduced in the last quarter of 2007

the next distribution of commodities, the continuous availability of contraception cannot be guaranteed for family planning clients in Kano.

A breakdown by region for the North West for source of contraceptives is not available, but the national results most likely reflect to a certain degree the situation in Kano State. The primary source for contraceptives is the private sector providing 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).

Table 3: Source of contraception

Source	Pill	IUD	Injectables	Male Condoms	Total
Public Sector	**18.6**	**65.5**	**48.4**	**4.1**	**22.8**
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
Private Sector	**74.0**	**32.5**	**48.0**	**59.2**	**57.7**
Hospital or clinic	2.3	30.3	17.9	0.6	7.5
Pharmacy	71.6	0	25.1	58.3	48.8
Private doctor	0	0	4.3	0.3	1.0
Other	**5.5**	**0**	**1.0**	**29.1**	**14.3**

Source: 2003 NDHS

The field assessment revealed there are a wide variety of prices in the sale of contraceptives. When commodities run low health workers purchase commodities in the open market and sell them at higher prices to the client. Even when products are purchased within the CLMS distribution system, different prices are being used. The table below provides a sample of varying prices health workers have charged clients at the SDP level.

Table 4: Sample of contraceptive unit prices at public sector facilities and NGO's (Naira)

Method	Public Sector Facility Prices	Select NGO Prices	CLMS unit cost
Injectables	60, 100	80, 100	60
Orals	15, 20, 50	30	15

condoms	2 for 1, 30	1.5	1
IUCD	250	--	100
Implants	--	3000	1550

Outside of the public sector several NGO's provide contraceptives. Some receive them through their own sources, through donations from international organizations as well as purchased from SFH. Their prices are slightly higher than the public sector (see table 4 above).

Strengths

1. Most facilities have between 2-3 methods – injectables, orals and condoms – no facility is completely stocked out of all contraceptives.

Weaknesses

1. Wide discrepancy in contraceptive prices because of purchases taking place outside the approved distribution system.

Recommendations

1. Display national price list for contraceptives at public health facilities;
2. Through supervision efforts, enforce health worker adherence to ordering schedules to avoid low stock levels and buying from the open market;
3. Ensure Noristerat will be available until additional injectables are re-supplied.

Client utilization and demand

Between 1999 and 2003 the national contraceptive prevalence rate (CPR) for modern methods fell from 8.6 percent to 8.2 percent among currently married women using contraceptives. In the Northwest region, where Kano State is captured, although there was an increase in CPR from 2.5 percent to 3.3 percent in modern methods, this is can be mostly attributed to the Lactational Amenorrhea Method (LAM) (1.7 percent) which was not included in the 1999 DHS (see table 5). When LAM is taken out CPR decreased from 1999 (2.5 percent) to 2003 (1.7 percent) (see Table 5). Looking at individual methods there were slight decreases in the use of pills (1.1 percent to 0.6 percent), and injectables (0.9 percent to 0.8 percent), although they remain to be the most popular methods (Injectables-0.8 percent; pills-0.6).

Table 5: Use of Contraception

Family Planning Methods	National % current use (1999)	Northwest % current use (1999)	National % current use (2003)	Northwest % current use (2003)
Any method	15.3	3.2	12.6	4.9
Traditional Method	5.8	0.2	4.3	1.6
Modern Method	8.6	2.5	8.2	3.3
Pills	2.4	1.1	1.8	0.6
IUCD	2.0	0.2	0.7	0.1
Injectables	2.4	0.9	2.0	0.8
Condom (male)	1.2	0.1	1.9	0.1
Sterilization (female)	0.3	0.1	0.2	0.1
Implants[2]	0.1	-	0	-
Vaginal method (1999) LAM, emergency contraception (2003)	0.2	0.0	1.4 (LAM); 0.1 (EC)	1.7 (LAM); 0 (EC)
Total use of modern methods	8.6	2.5	8.2	3.3

Source: 1999, 2003 NDHS

Many health workers noted that injectables are popular because of the privacy and convenience they offer. Noristerat is the most popular brand with fewer side effects than Depo-provera, which seems to have higher discontinuation rates.

Table 6: CPR for Northwest (without LAM)

Family Planning Methods	Northwest % current use (1999)	Northwest % current use (2003)
Pills	1.1	0.6
IUCD	0.2	0.1
Injectables	0.9	0.8
Condom (male)	0.1	0.1
Sterilization (female)	0.1	0.1
Implants[3]	-	-
Total use of modern methods	2.4	1.7

Source: 1999, 2003 NDHS

[2] Sample size not large enough to calculate CPR for implants

[3] Sample size not large enough to calculate CPR for implants

A regional comparison shows the North West having the second lowest CPR rate (3.3 percent) after the North East region (3.0 percent).

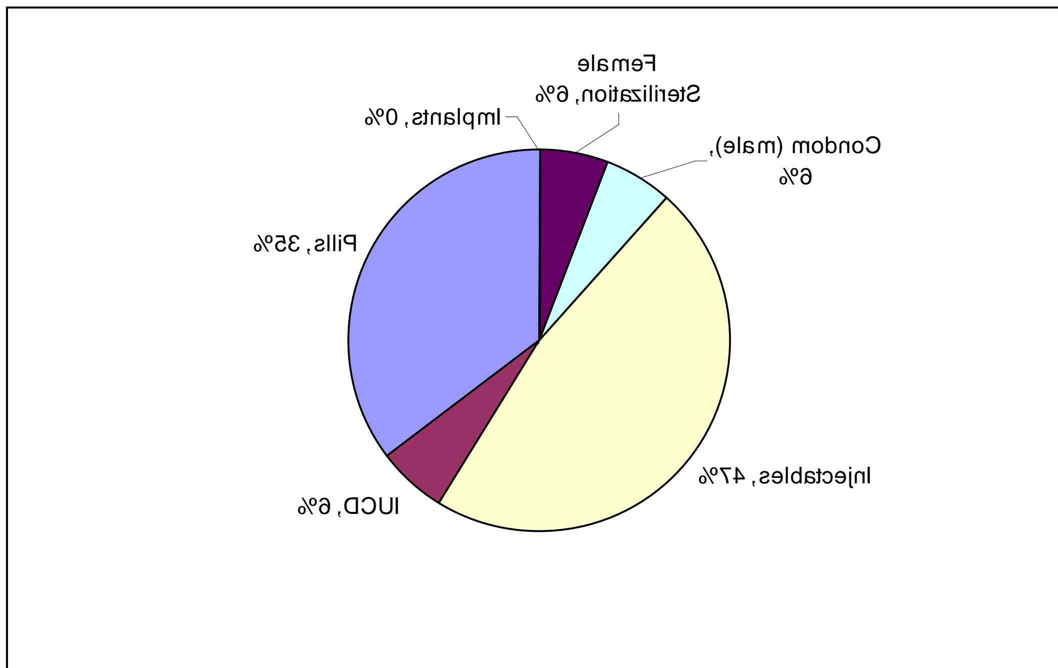
Table 7: CPR by Region

BY REGION	1999	2003
North Central	n/a	10.3
North East	2.2	3.0
North West	**2.5**	**3.3**
South East	9.1	13.0
South West	15.5	23.1
South South	n/a	13.8
Central	10.9	n/a

Source: 1999, 2003 NDHS

Figure three below provides an additional depiction of method mix without LAM and shows injectables making up 47 percent of the method mix and pills with 35 percent. Male condoms, IUCDs, and female sterilization have equal method mix of 6 percent each. There are very few qualified health providers who can insert implants and a limited number of facilities who can offer female sterilization which support the low to non-existent CPR for these two long-term and permanent methods. To reduce the frequency of health facility re-visits on women and for health workers, as well as ensuring availability of a well balanced method mix; investments should be made to increase the uptake of these methods.

Figure 3: Contraceptive method mix - North West region (2003)



UNMET NEED

Nationally, total unmet need decreased slightly from 17.5 to 16.9 percent. There was a slight increase 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. Unmet need is very similar for urban and rural women (17.3 and 16.7 percent respectively). Unmet need is highest for women between the ages of 20-44 which is the same age group with the highest use of contraception indicating there is a great need for contraceptives that it not being met.

Regionally, the Northwest has the lowest unmet need (11.1) and also the lowest CPR (3.3) among all six geopolitical regions. Determining why unmet need fell between 1999 and 2003 should be further investigated to understand why demand has fallen for modern contraceptives.

Table 8: Unmet Need for Contraception

UNMET NEED	1999	2003
For Spacing Births	12.9	11.8
For Limiting Births	4.6	5.1
TOTAL UNMET NEED	**17.5**	**16.9**
BY AGE		
15 – 19	14.8	14.6
20 – 24	22.7	16.4
25 – 29	17.0	17.1
30 – 34	17.9	19.1
35 – 39	18.1	18.1
40 – 44	15.4	19.3
45 – 49	11.9	11.4
BY RESIDENCE		
Urban	16.6	17.3
Rural	17.9	16.7
BY REGION		
North Central	n/a	21.8
North East	12.2	18.1
North West	**24.4**	**11.1**
South East	20.9	18.9
South West	15.7	17.2
South South	n/a	24.5
Central	16.3	n/a
BY EDUCATION		
No Education	15.6	14.1
Primary	21.7	21.0
Secondary	19.5	20.7

Higher	10.7	14.7
BY WEALTH QUINTILE		
Lowest	n/a	14.9
Second	n/a	15.6
Middle	n/a	16.7
Fourth	n/a	19.9
Highest	n/a	18.0

Source: 1999, 2003 Nigeria Demographic and Health Survey

The reason for low demand may also be attributed to limited exposure to family planning messages and the North West is more conservative than many of the other regions where religious and cultural factors heavily influence the ability to practice family planning.

The North West had the third highest percentage of women who had not been exposed to any family planning messages for any source. In general, women in the north had less exposure than women in the south.

Table 9: Exposure to family planning messages (women)

BY REGION	Radio	TV	Newspaper/ Magazine	Poster/leaflets /brochures	Town crier/public announcements	None of the specified media sources
North Central	26.3	14.4	9.7	14.4	7.7	69.7
North East	20.8	7.6	5.7	9.7	3.9	76.6
North West	**39.3**	**10.8**	**4.6**	**5.4**	**2.7**	**60.4**
South East	53.6	27.5	18.4	14.9	10.2	41.1
South South	49.1	36.2	23.1	28.1	20.9	44.7
South West	63.8	47.1	20.9	23.8	8.0	30.1

Source: 2003 Nigeria Demographic and Health Survey

Furthermore, family planning was discussed by only 1.5 percent of health workers when they made home visits in the North West. This region also has the highest probability of not discussing family planning at the health facility (96.9 percent).

Table 10: Contact of non-users with family planning providers

BY REGION	Women who were visited by a CHEW who discussed family planning	Women who visited a health facility and discussed family planning	Women who visited health facility didn't discuss family planning	Did not discuss family planning with CHEW or at a health facility
North Central	2.9	5.9	24.2	92.4
North East	3.0	4.5	22.9	94.4
North West	**1.5**	**2.3**	**28.0**	**96.9**
South East	4.4	2.4	30.0	94.3
South South	7.1	10.8	17.0	85.4
South West	5.0	15.4	23.0	82.2

Source: 2003 Nigeria Demographic and Health Survey

In the North West more than half (51.6 percent) of all couples disapprove of family planning. Only 17.4 percent both approve which is the lowest acceptance rate among all of the regions. The attitude of couples towards family planning is a helpful indicator to determine if additional education and awareness raising is needed to increase acceptance of family planning. The North West shows that it has the highest resistance or barrier to adopting family planning. During the field visits one of the most common reasons given by a health worker for a client to discontinue family planning was spousal objection. Other reasons for discontinuation were side effects and wanting to become pregnant.

Table 11: Attitudes of couples toward family planning

	Woman approves of family planning			Woman disapproves of family planning		
	Husband approves	Husband disapproves	Husband's attitude unknown	Husband approves	Husband disapproves	Husband's attitude unknown
BY REGION						
North Central	40.6	11.0	15.8	1.8	16.6	6.3
North East	18.0	11.4	11.9	2.8	38.7	9.3
North West	**17.4**	**7.5**	**8.1**	**1.8**	**51.6**	**6.6**
South East	50.7	9.1	6.2	2.9	22.4	3.5
South South	47.4	17.8	9.5	2.1	13.8	38
South West	60.6	11.5	12.8	0.7	8.2	1.8

Source: 2003 Nigeria Demographic and Health Survey

Access and utilization to family planning services are limited for a number of reasons. Nationally, health worker shortages exacerbate the ability to provide quality health care. In Kano this problem is particularly prevalent. There are shortages of qualified health workers and particularly female health

workers, limiting access to family planning services. Many programs are centered in urban areas and health workers are unwilling to work in rural areas. Kano is also challenged with issues of high attrition and transfer rates.

Many of the health workers interviewed during the field assessment had not received any formal training on family planning or had not received any recent refresher training. Only one had attended the 6-week family planning course. It is intended that service providers undergo further in-service and step-down trainings in accordance with newly adopted commodities, protocols, guidelines or forms to meet training and certification requirements for providing family planning and other RH services, however, development partners have limited funding to offer the family planning course on a wide scale basis. Additionally, only nurses and midwives were allowed to attend this training. There is an urgent need to train and hire additional health workers to increase the number of health workers who can provide FP services.

Other difficulties in accessing contraceptives include cultural and religious barriers. Men cannot serve women in some areas and the opposite sexes are uncomfortable purchasing condoms from each other. Other reasons given by the health workers include: low involvement by men in family planning issues, women cannot visit health facilities unless accompanied by their husbands, and men have a strong influence on the women's ability to use contraceptives.

The National Adolescent Health Policy Nigeria and National Youth Policy and Strategic Plan of Action mentioned earlier offers guidance in providing family planning services specifically to adolescents. These policies contain objectives and responsibilities to be undertaken by each State to ensure services are targeted to adolescents. However, there are very limited family planning services in the public sector available to adolescents in Kano.

NGO's function as an alternative source for family planning services for both adolescents as well as the general public. They provide youth friendly services and are closely involved in the community. Their activities extend into schools to raise awareness, to counsel and to provide referral services. Volunteers working with NGO's access the community through peer educators and community based distributors to increase male involvement and distribute contraceptives in the markets. NGOs employ the media to increase awareness and provide sensitization for FP.

A State level information education and communication and behavior change campaign does not exist, however, several NGO's and development partners produce radio jingles and dramas on family planning. Decentralization of decision making from the State to the LGA level has affected the ability to ensure adequate attention to family planning.

Nationally 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 of injectables (27.7 percent) and pills (22.6). Increasing the use of methods that require less re-supply such as IUCDs and implants can help alleviate the need for women to make re-visits which incur transport costs and time as well as time required by the service provider to serve the client.

Women with higher education who live in urban areas and are between the ages of 20-39 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 while in the rural area CPR has stagnated at 5.7 percent. The South West region has the highest CPR of 23.1 percent with higher rates in the South South (13.8) and Southeast (13.0 percent). Education is also a factor in use of modern methods showing increases from 2.3 percent for women with no education to 21.7 percent for those with higher education. This trend is also true 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 in these policies. For example, in the National Reproductive Health Strategic Framework and Plan there are strategies 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 service providers. This would be an ideal place to insert specific language to increase service for the poor and placement of service providers in rural settings to increase access.

Table 12: Contraceptive Prevalence by Background Characteristics (currently married women)

Contraceptive Prevalence	1999	2003
BY AGE		
15 – 19	1.2	3.8
20 – 24	2.6	6.6
25 – 29	6.7	10.0
30 – 34	12.7	9.5
35 – 39	13.3	10.9
40 – 44	12.1	8.8
45 – 49	9.4	5.4
BY RESIDENCE		
Urban	15.7	13.9
Rural	5.6	5.7
BY REGION		
North Central	n/a	10.3
North East	2.2	3.0
North West	2.5	3.3
South East	9.1	13.0
South West	15.5	23.1
South South	n/a	13.8
Central	10.9	n/a
BY EDUCATION		
No Education	3.1	2.3

Primary	10.1	11.2
Secondary	16.2	18.3
Higher	28.0	21.7
BY WEALTH QUINTILE		
Lowest	n/a	3.6
Second	n/a	2.9
Middle	n/a	6.7
Fourth	n/a	9.2
Highest	n/a	20.5
BY NUMBER OF LIVING CHILDREN		
0	1.3	1.4
1-2	3.5 (1), 7.8 (2)	7.4
3-4	8.7 (3)	9.6
5+	12.5 (4+)	11.0

Source: 1999, 2003 Nigeria Demographic and Health Survey

Strengths

1. Noristerat widely known;
2. Price does not appear to be a factor in access;
3. Private sector a viable alternative to providing commodities and increase FP awareness;
4. Radio Jingles and drama by the State, SFH, CEDPA, Pathfinder on FP;
5. Sensitization seminars for community leaders by Pathfinder and CEDPA on FP;
6. NGOs using peer educators as well as CBDs to increase use of family planning and awareness of HIV/AIDS, and STIs;
7. NGOs targeting youth;
8. NGOs have good referral system for services;
9. NGOs provide training on FP counseling.

Weaknesses

1. Cultural and religious barriers limit access and acceptance of family planning
    a. Skilled male providers are prohibited from serving female clients within the city
    b. Low number of qualified female staff limit clients ability to access services
    c. Men feel uncomfortable buying condoms from females SPs (and vice versa);

2. Many SPs do not have formal or current training on FP counseling;
3. Public sector services for adolescents are not widely available;
4. FP demand creation poor at LGA level.

Recommendations

1. Ongoing advocacy to the commissioner of LGA Affairs, LGA directors of personnel and LGA persons in a bid to reduce staff transfers and increase recruitment of appropriate skilled personnel;
2. Kano State should develop a pro-active strategy to increase the enrolment and graduation of health workers from nursing and midwifery schools annually. Advocacy should be done to support this change at the national level;
3. State level should take the lead to coordinate activities among all RH providers, NGOs and IPs to better leverage expertise in demand creation, FP training, service provision, better CLMS management;
4. Hire additional skilled female health workers and male services providers as well as additional CBDs to do outreach in rural areas;
5. Advocate to religious and community leaders on FP, sensitizing the community through health talks and outreach activities;
6. Integrate the FP Unit with other health units or programs at the SDP level to increase client confidentiality and uptake of FP.

Capacity

Product Use

National standard operating procedures (SOPs) and guidelines have been developed for FP/RH management which applies to the State level. These include: the FP/RH service protocols, FP/RH Policy and Guidelines, monitoring and supervision of dispensing practices, universal safety precaution guidelines, and the CLMS guidelines and job aid. Many of the facilities did not have copies of these SOPs or guidelines. The CLMS job aid was sited in at least three of the facilities. Some facilities displayed wall posters on birth spacing and choices of contraceptives. Because of a combination of skilled health worker capacity and inconsistent supervision practices, the monitoring of treatment and adhering to protocols is not closely monitored. The use of supervision checklists was not always in evidence.

The lack of supervision by the SMOH has led to varying practices to secure commodities. Because commodities are not ordered following the established CLMS schedule some health workers purchase on their own when there is low supply of contraceptives. This has led to health workers having to go outside of the logistics system to purchase contraceptives on the open market or from other health facilities.

It was observed in a few of the facilities that they follow proper disposal procedures for syringes by disposing into safety boxes.

A majority of the behavior change communication work is done through NGOs and implementing partners such as AHIP, PPFN, COMPASS, YOSPIS and others. In different capacities they conduct awareness raising campaigns to encourage and increase the use of family planning methods. These organizations work with communities, adolescents and religious leaders to sensitize these groups towards FP, provide referral services, counsel and educate on different FP methods.

A market segmentation exercise has not been conducted for an individual State in Nigeria but it would be a useful exercise to do given the specific market, demographics, and demands within each State and would help determine how markets can be better segmented so that public resources can be better targeted to those most in need.

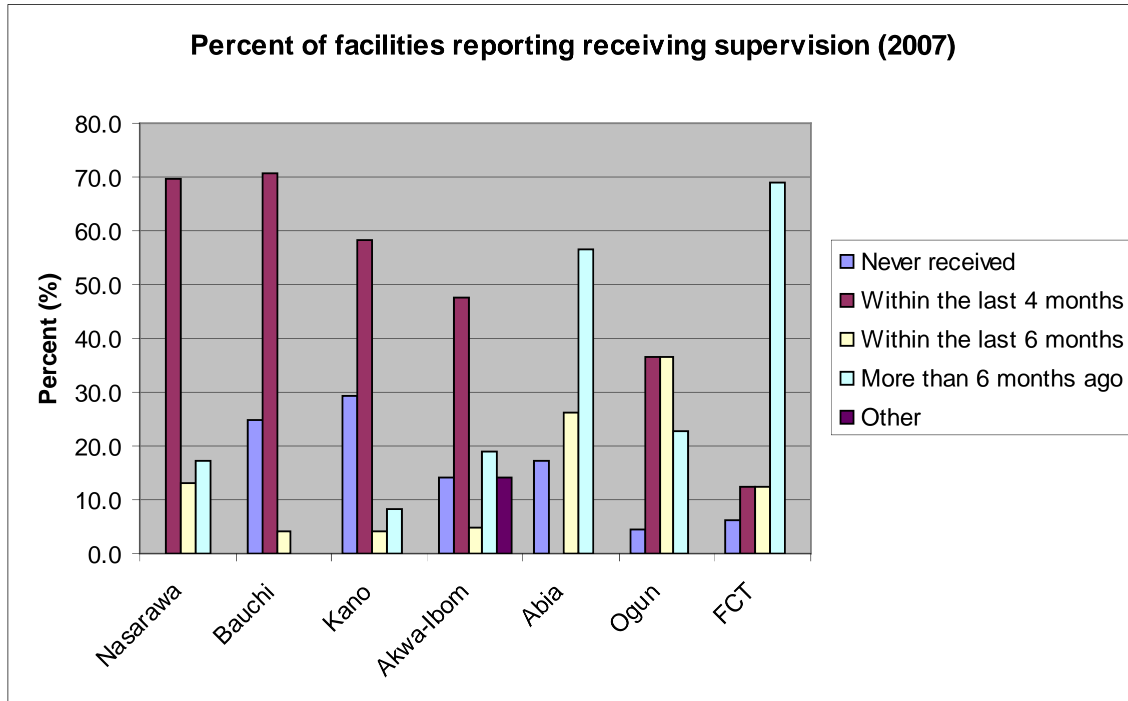
LMIS

Kano State is one of three streamlined CLMS States. CLMS forms should be used to maintain logistics information through the use of tally cards, requisition issue and report forms (RIRF), daily consumption records (DCR), and cost recovery record forms.

The FP Coordinator, a MCH Coordinator from each LGA and a service provider from each SDP were trained in the streamlined CLMS in 2006. However, since then there has been staff turnover it is common for there to be current service providers who have never received CLMS training other than through on-the-job training. Service providers at the SDP level have difficulty completing the RIRF forms although they generally have a better understanding of filling out the DCR. There are several reasons for this. Some of the SP's do not understand the principles behind the calculations on the RIRF form. Many of the service providers do not follow the reporting and ordering schedule and as a result fall out of practice and forget how to complete the RIRF. It was also found that health staff would fill out the forms only when supervision visits were coming up. The MCH coordinators are able to fill out the forms and do so whether they order supplies or not. The quality and consistency of supervision appears to be a strong factor in the ability of the service provider to accurately follow the CLMS forms and procedures.

It was also noted that with more recent frequent supervision the completion of the CLMS forms improved greatly when some of the forms were reviewed during the field visit. One of the common barriers mentioned to supervision was the lack of funds from cost recovery for transportation. In addition, the multiplicity of forms required by other programs and agencies puts an additional burden on health workers. The figure below shows that over half of the facilities surveyed in the 2007 LIAT in Kano received supervision within the four months prior to the survey and 30 percent had not received any supervision.

Figure 4: Percent of facilities reporting receiving supervision



Note: Figures are not representative of each State due to small sample sizes

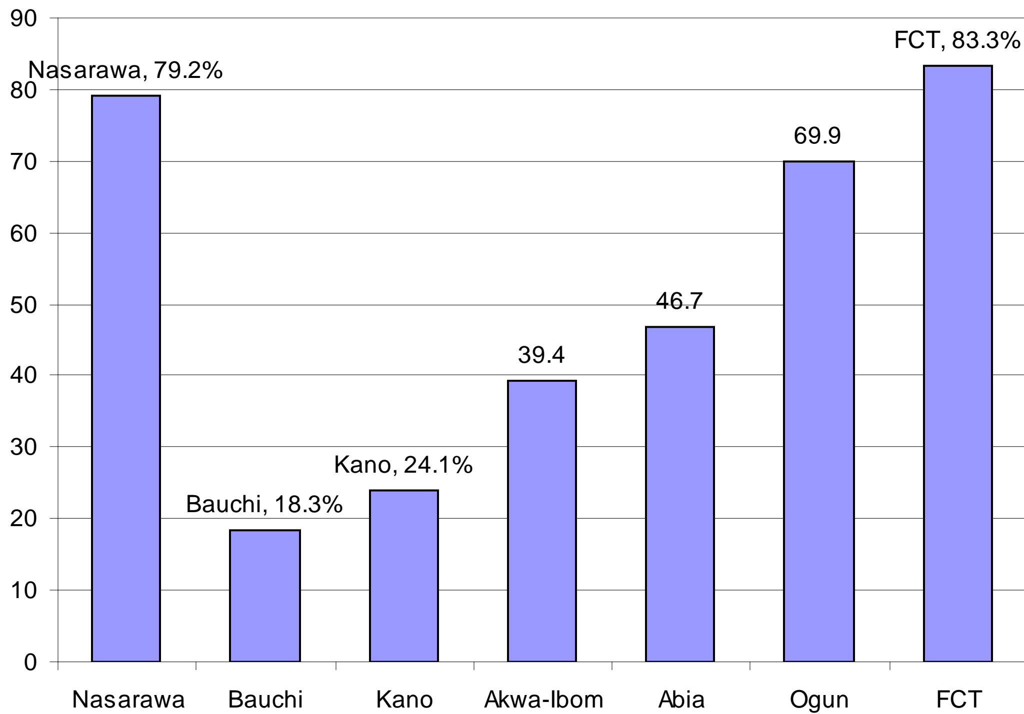
Source: 2007 LIAT

In the USAID | DELIVER PROJECT supported LGAs there are two-three month routine monitoring and supportive supervision meetings with the MCH Coordinators to provide OJT, feedback and monitoring of the CLMS forms to check for accuracy and completeness, and to reinforce proper record keeping and inventory practices. These are supposed to be done together with the SMOH and FP coordinator. However, there have been issues with staff and supervisors not attending these meetings.

Although only 3 LGA's were visited in Kano, one SDP (non-DELIVER supported) was not using the current CLMS forms nor did they have anyone trained in the CLMS, possibly indicating that the use of the forms and availability of forms may not be uniform across the State and an indication that during supervision visits monitoring the use of the CLMS may not be uniform by all MCH coordinators.

Accurate and consistent reporting is weak in Kano State. The data that is sent in from the SDP and LGA levels are not utilized to monitor performance nor are they used to determine consumption, trends or monitor stock status. This is an important indicator of weak accountability and LMIS practices at both the SMOH and FMOH levels. Reporting should occur every two months from the SDP to the LGA and every quarter by the LGA to the State level. The figure below shows only 24 percent of facilities sending in their RIRFs to the appropriate level during the six months period preceding the 2007 LIAT.

Figure 5: Percent of facilities sending in RIR / RIRFs

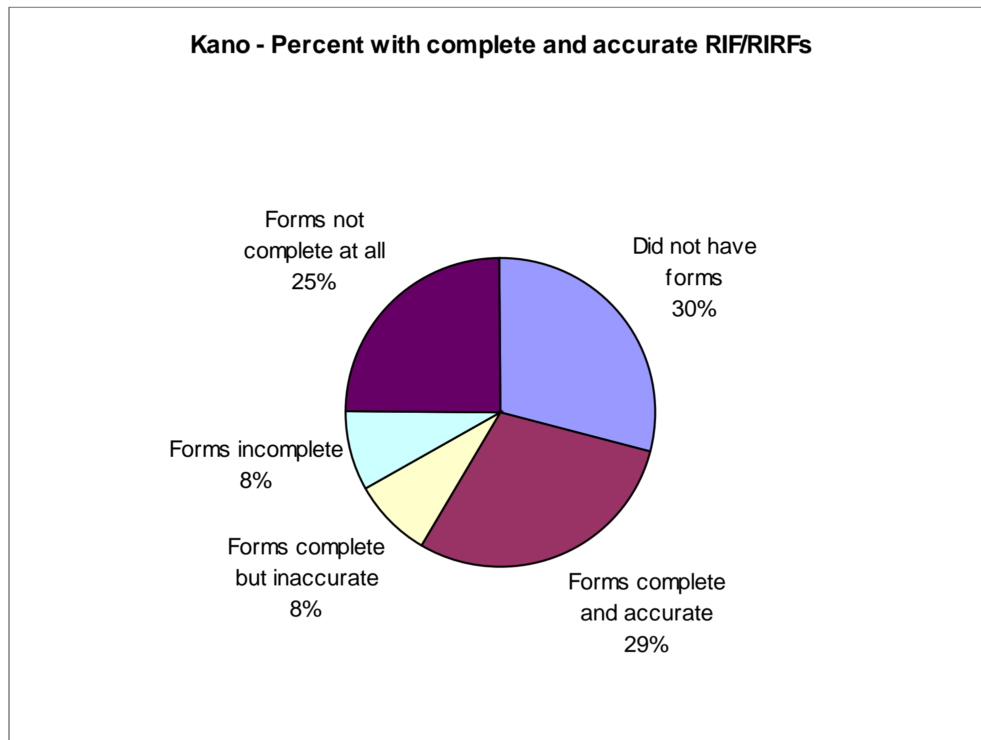


Note: Figures are not representative of each State due to small sample sizes

Source: 2007 LIAT

In figure 6 a little less than 30 percent of the forms sent in were complete and accurate. It also shows that almost 30 percent of facilities did not have the CLMS forms at all. Although these figures are not representative of the entire State it does provide a snapshot into performance of some facilities in Kano and is reflective of the situation found during both the LIAT and this assessment.

Figure 6: Percent with complete RIRFs



Note: Figures are not representative of the State due to small sample sizes

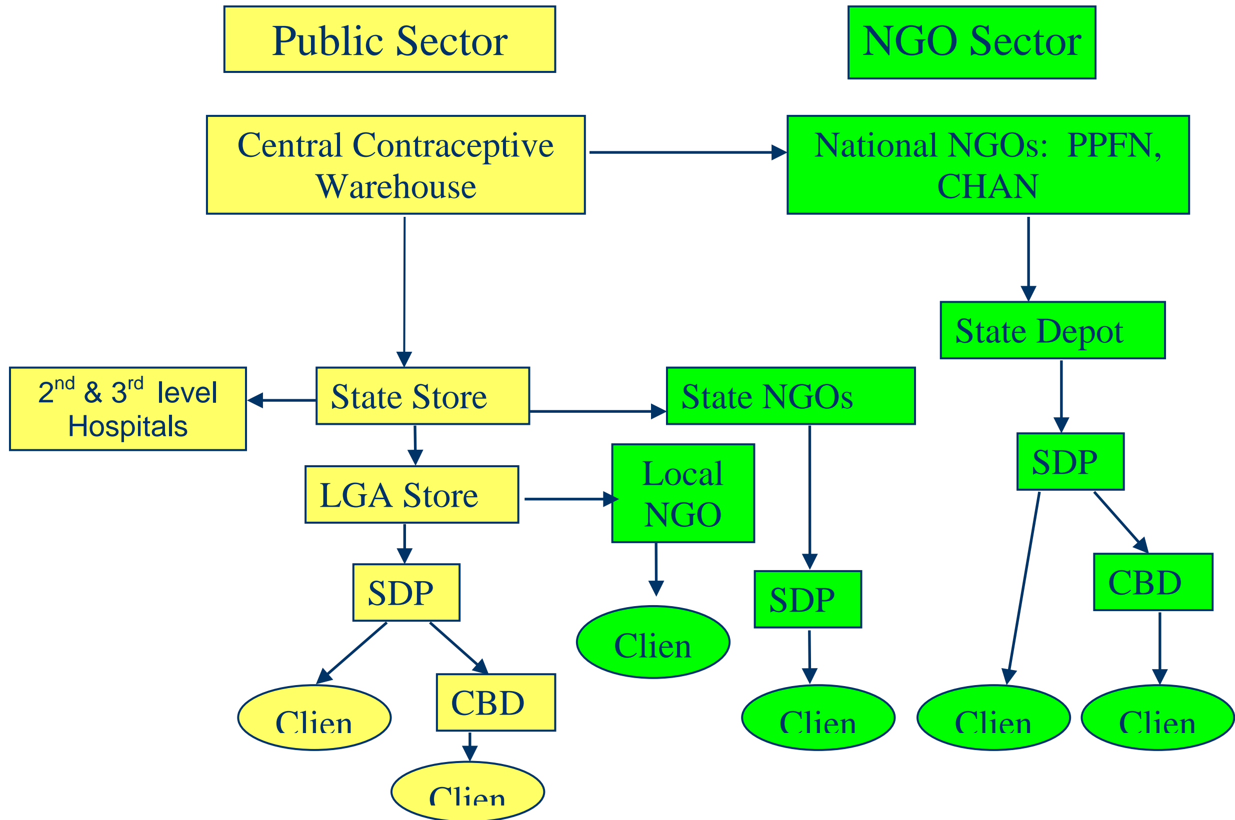
Source: 2007 LIAT

Obtaining Supplies/Procurement

There are varying procurement and ordering practices taking place among the facilities that were visited. The SDP should order and report every two months, the LGA submits forms on a quarterly basis and the State level every four months. In practice, the LGA and SDP levels order infrequently. One LGA only ordered twice within the last year. The SDP level facilities who have ordered contraceptives generally receive their supplies from their MCH Coordinators within one-two days. Some MCH Coordinators reported not receiving the amount of quantities ordered. Table 13 below shows the reporting and ordering schedule that should be followed by the SDP, LGA, and State level.

The State level store is currently out of stock of all injectables, Microgynon, Exluton/Microlut, implants, and female condoms because the State has not ordered any contraceptives since they received seed stock after the CLMS training in 2006. Supplies of male condoms and IUCDs are available at the store. The injectable Noristerat is a very popular method and brand and all of the facilities where stock could be verified had it in stock. However, because of the stock out of injectables at the State store level, the breakdown of the State to re-order supplies, and difficulties with transport at the central level, there is potential for disruption of this commodity in the near future.

Figure 7: Health Commodities Supply Chain



Source: Reproductive Health Commodity Security Nig RH.2008.ppnt

Inventory Control

Kano is one of three States following the streamlined CLMS system (Bauchi and Nasarawa are the other two streamlined States). Each level orders from the next level up using a pull system and should be adhering to established CLMS maximum and minimum (min/max) stock levels for each facility level (see table13 below). Stores should maintain a three month minimum stock level. At the field visit facilities min/max stock levels are not consistently followed. There is a different RIRF for each level that calculates re-supply using the stock level set up for each level. Out of the six facilities where stock could be verified four were not following min/max guidelines. This is most likely attributed to a number of reasons stated earlier. There is inconsistent supervision and many of the interviewed staff had not been trained in CLMS. Some staff are not aware of the min/max rule or they only order when supplies are low. One MCH Coordinator had not ordered any supplies within the last year because demand is low and she did not want to risk expiration of the commodities.

Table 13: Maximum and minimum stock levels for contraceptives for streamlines States

	Reporting and Ordering Cycle	Minimum	Maximum
State	4 months	4 months	8 months
LGA	3 months	3 months	6 months
SDP	2 months	2 months	4 months
CBD	1 month		

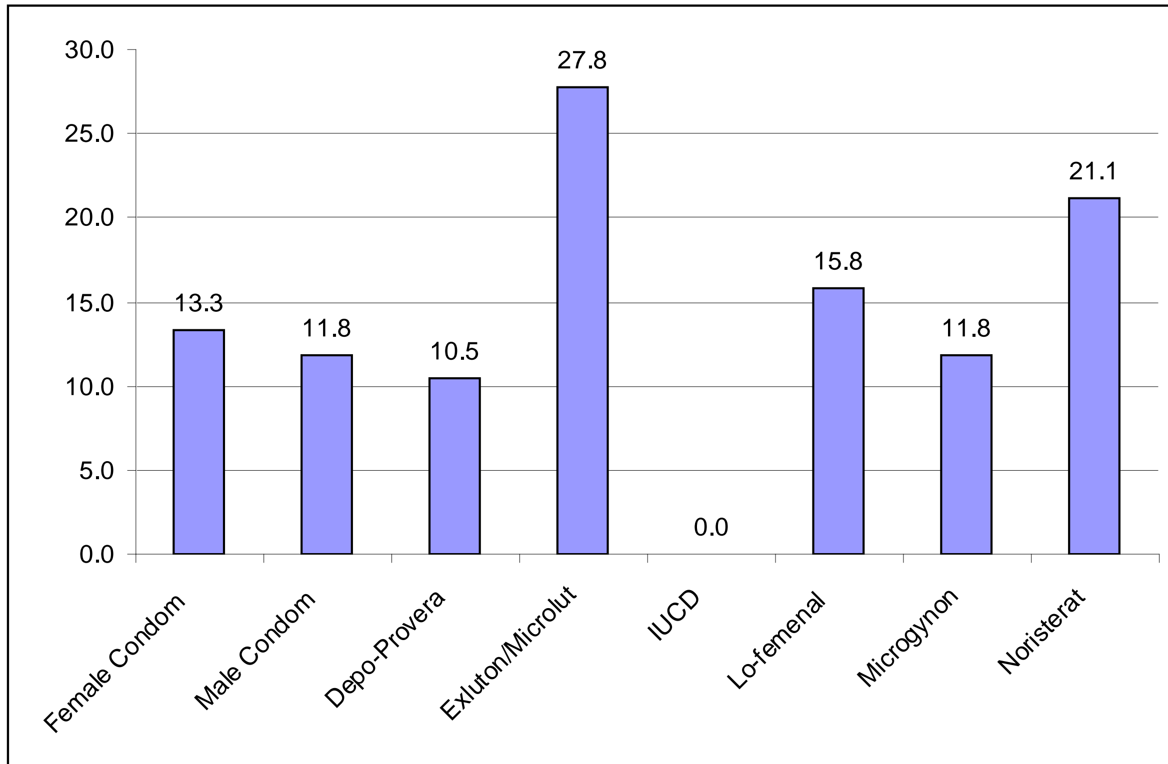
There are formal and informal re-distribution practices occurring within the LGAs during the USAID | DELIVER PROJECT led supervisory meetings. Among the project supported LGAs, the MCH Coordinators have the opportunity to sell and purchase commodities when they are brought together during the supervision meetings. The MCH Coordinators are asked to bring in their supplies as well as their forms to check their accuracy and completeness. This also allows the coordinators to re-distribute amongst each other any stock they may need or have excess amounts of. To some degree this most likely helps MCH coordinators and subsequently health facilities maintain minimum levels of stock.

Most of the health workers understood and were practicing First Expiry First Out (FEFO). Expired stock are removed from inventory but a check of some tally cards showed they were not correctly accounted for on the card.

Both the RIRF and the tally card can be used to account for losses and adjustment. The tally cards are being utilized by the stores and at the LGA level although in a few facilities expired products and losses were not being properly recorded on the card. Tally cards are kept in close proximity with the supplies. When calculating re-supply the RIRF takes into account, any losses that occurred in the previous months.

The figure below provides a snapshot of the contraceptives which have experienced stock outs in the previous six months. Exluton/Microlut (27.8 percent) and Noristerat (21.1 percent) had the highest stockout levels. All of the contraceptives had stocked out at some point in the last 12 months among the sampled facilities. Each facility had at least two products stock out in the last 12 months. Additionally, health staff noted that male condoms, Depo-Provera, Lo-Femenal, and Noristerat stocked out most frequently. None of the sites had all methods available on the day of the visit.

Figure 8: Percent of facilities stocked out of contraceptives in the previous six months (2007)



Note: Figures are not representative of the State due to small sample sizes

Source: 2007 LIAT

Warehousing and Storage

National warehousing and storage guidelines exist which apply to the State level. In Kano storage of commodities varied from facility to facility. Although the State Central Warehouse has adequate space the area is very dusty and poorly organized. There are only a few boxes of male condoms and IUCDs which take up two shelves so there is more than enough space for expansion and additional supplies when they come in. However, cleaning of the warehouse is needed as the boxes which store the contraceptives are covered in dust. The boxes could be better organized and labeled correctly. There was not any fire preventative equipment and the building was moderately ventilated with ceiling fans. The State storekeeper has not been trained in CLMS but has received some OJT from his immediate supervisor.

Some of the SDP facilities visited need cupboards to store their commodities and the FP coordinator is making arrangements for this. Currently, several of the SDP facilities keep their commodities in unlocked cabinets inside paper bags and one was found to take the commodities home with them to prevent pest infestation and theft. Of the two LGA stores where storage conditions could be verified, the commodities were kept in locked cabinets.

The State store removes expired products from other stock and gives it to the Director of Pharmaceuticals for NAFDAC to collect and burn in the presence of a witness. He also noted that only NAFDAC has the authority to remove expired stock. Expired products at the lower levels are

given to the MCH coordinators. The Store conducts a physical inventory every three months. Some MCH coordinators conduct physical inventories although this was not always noted on the tally card.

Transport and distribution

At the State level funds generated from cost recovery are to be used for transportation to distribute commodities. There is not a separate program budget from the SMOH for transportation. Many noted they have used margins for transport although they observed that it is not always sufficient. Some MCH coordinators are situated close enough to the health facilities they are responsible for where transportation was not a major barrier to distributing commodities. Only the MCH coordinator overseeing the rural LGA has to travel at least one hour from her place of residence on a daily basis. The supervision meetings conducted by the USAID | DELIVER PROJECT serve as a proxy for distribution of commodities for the LGA level since coordinators bring their commodities for re-distribution amongst each other.

Strengths

1. Most MCH Coordinators understand how to complete CLMS forms;
2. State level has supervision checklist;
3. The MCH Coordinator is a factor in the SP's ability to understand and complete the CLMS forms;
4. RIRF forms can provide logistics data when filled out properly and forwarded upwards;
5. In general good record keeping of the DCR booklet;
6. Products at the SDP level have short lead times (re-supply within one day);
7. During review meetings SDPs order and get re-supply from their MCH Coordinators;
8. Most facilities conduct physical inventories at LGA level;
9. Large storage space at State level;
10. Some LGA commodities are kept in locked cabinets;
11. Service providers follow disposal procedures for syringes.

Weaknesses

1. State Central Store has not placed any orders since the inception of the streamlined CLMS;
2. At SDP level health workers do not have formal FP training in counseling or dispensing (mostly OJT);
3. Weak supervision by SMOH in providing guidance and feedback on completion of CLMS forms and following CLMS procedures. No evidence of supervision in some LGAs;
4. Service providers going to the open market to purchase contraceptives – not following CLMS guidelines for commodity purchase from public sector sources;

5. Service providers having difficulty accurately completing RIRF;
6. Commodities purchased on the open market by some SDPs are not recorded in the DCR;
7. Multiplicity of forms from other agencies is a burden on the SDP. Low awareness and availability of SOPs and STGs at the facility level;
8. Not all LGAs are using the CLMS system and tools;
9. No supplemental provision for transportation for supervision visits;
10. SDPs do not follow ordering schedule (reluctant to spend monies or do not have money);
11. Stock out at all levels of some commodities;
12. At State level injectables are stocked out;
13. Male condoms available in most facilities because of low uptake (except where there are male providers);
14. FEFO is not being consistently practiced partly because low levels, stock are used and do not stay on the shelf (except condoms);
15. State store is very dusty and unorganized;
16. At the SDP level contraceptives not always kept in locked cabinet;
17. Margins from cost recovery not sufficient to cover transportation and distribution of commodities.

Recommendations

1. State MOH should create a formal supervision structure that includes 1) a schedule to guarantee all facilities are visited on an established periodic basis, 2) tasks to be carried out, and 3) a supervision checklist for each level;
2. State MOH should improve supervision activities (MCH Coordinators and FP Coordinators) to improve regular supervision at all levels to ensure commodities are ordered according to CLMS guidelines and provide OJT on family planning skills;
3. State MOH and partners should provide training for supervisors to improve supervision skills;
4. Conduct market segmentation exercise to help determine how markets can be better segmented so that public resources can be better targeted to those most in need;
5. Make SOPs and STGs available at all SDPs;
6. State MOH and FP Coordinator should immediately submit RIRF form for re-supply of commodities
7. Verify stock levels of contraceptives, especially Noristerat, to forecast need prior to re-ordering from FMOH;
8. Create State level targets to increase the percentage of RIRF forms submitted to improve the availability of consumption data;
9. Conduct additional training and refresher training on CLMS at all SDP and LGA levels;
10. State MOH and partners should work together to integrate and minimize forms and create a standard HMIS form to collect required data;

11. Re-initiate FP Coordinator meetings to share challenges, issues, troubleshoot, and review supervision responsibilities;
12. Refurbish State store;
13. Supply SDPs with cabinets for commodity storage;
14. Emphasize proper storage practices during supervision visits;
15. Create line item budget for FP commodity with provision for transportation;
16. Coordinate with other DP supervision schedules to leverage transportation for FP and MCH coordinators.

Conclusions

This assessment is part of a larger effort to generate support and commitment toward improving not only commodity security in Kano State but simultaneously to improve the environment for reproductive health so that every person can choose, obtain, and use quality contraceptives whenever they need them. The findings and recommendations from this assessment will contribute towards the next Nigeria RHCS national strategy.

Kano State is in a position where great improvements can be made in RHCS if the will is there to move forward. Securing a budget line for RH in 2008 and high attendance at the stakeholders workshop demonstrate commitment by stakeholders to move forward with an RHCS agenda. Stakeholders took a big step during the RHCS stakeholders workshop by coming together at the end to discuss forming a committee to continue the momentum generated from the workshop and to be an advocacy body for RHCS. This committee can help Kano State create the financial resources and collaboration needed to demonstrate commitment for long-term RHCS. Next steps include finalizing the RHCS committee and developing a strategic plan, indicators and targets, specific to the context in Kano.

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Appendix A

Reproductive Health Commodity Security Stakeholders Workshop Agenda

Tuesday, March 18 – Wednesday, March 19, 2008

Kano State, Nigeria

Dates and times	**Activities**	**Responsible agents/Remarks**
Day 1: Tuesday, March 18		
9:00 - 10:00am	Opening prayer Welcome remarks Welcome Address Participant Introductions Review purpose, objectives and output of the workshop/Adoption of the agenda	Dr Daiyabu Mohammed, Director PHC/DC Hajiya Aishatu Isyaku Kiru, Hon. Commissioner of Health, SMOH Dr Ashiru Rajab, Deputy Director PHC
10:00 - 10:30am	Commodity Insecurity Game and discussion	Consultants
10:30 - 11:15am	Introduction to Reproductive health Commodity Security Methodology & Objectives	Consultants
11:15 - 11:30am	*Break*	
11:30 - 12:00pm	Reproductive Health Situation Update in Kano State – The Story So far	Hajiya Aishatu Lawan, FP Coordinator Dr Ashiru Rajab, Deputy Director, PHC/DC
12:00 - 1:30pm	*Lunch/Afternoon prayers*	
1:30 – 3:00	Introduce tool and review of Context & Coordination in Plenary	Consultants
3:00 - 4:45	Small group instructions Groups organized by components Break out into focus groups Assign notetaker/s and group presenters Identify strengths and weaknesses Identify information gaps	Participants & Consultants
4:45 - 5:00	Wrap-up and briefing on Day 2	Consultants

Dates and times	Activities	Responsible agents/Remarks
Day 2: Wednesday, March 19		
9:00 - 9:15	Opening Prayers Opening and introduction to Day 2	Dr Daiyabu Mohammed, Director PHC/DC
9:15 - 11:00	Continue focus group work Identify strengths and weaknesses Identify information gaps	Participants
11:00 - 11:15	*Break*	
11:15 - 12:30	Finish focus group work Prioritize strengths and weaknesses Identify information gaps / suggestions to modify tool for assessment Develop recommendations Prepare summary on findings and prepare presentation for large group	Participants Use Laptops
12:30 – 1:30	*Lunch*	
1:30 – 2:30	Finish Presentations	Participants
2:30 – 3:30	Plenary: Group Presentations	Designated Group Presenters
3:30 – 3:45	*Break*	
3:45 – 5:00	Plenary: Group Presentations	Designated Group Presenters
5:00 - 5:15	Wrap-up, Next Steps & Closing remarks	SMOH

KANO STATE RHCS STAKEHOLDERS WORKSHOP PARTICIPANT LIST

S/NO	NAME	ORGANIZATION
1	Auwalu Ibrahim	SMOH
2	Kayode Morenikeji	USAID
3	Aishatu Lawan	SMOH
4	Ahmad Garba Zango	SMOH
5	Nura Ibrahim	SFH
6	Fatima Abdu	FOMWAN
7	Abdulrazaq Alkali	YOSPIS- Kano
8	District Head	Tarauni Local Govt
9	Baba Isa Mohammed	Nat. population Commission
10	Mairo Bello	AHIP
11	Rep.Nasarawa District Head	Kano Emirate
12	Maryam Musa	PPFN Kano
13	Dr. Aminu Magashi Garba	Community Health & Research Initiative
14	Abdullahi Y Sule	YEDA
15	Inuwa Idris Yakassai	Min. of Information Kano
16	Dr. Ashiru Rajab	SMOH
17	Ummi Wada Waziri	ACCESS/JHPEGO Kano
18	Dr. F Hassan-Hunga	AKTH
19	Dr. Amir Imam Yola	SMOH Kano
20	Pharm. Gali Sule	SMOH Kano
21	Asmau Mohammed	SMOH
22	Dr. Ibrahim Ibn Muhammad	NMA Kano branch
23	Hon. Commisioner A.I Kiru	SMOH
24	A.S.Daurawa	SMOH
25	Dr. B A Umar	Kano State Shariah commission
26	Salamatu Ibrahim	Muslim sisters organization
27	Alh. Kabiru Garba	Rep. Nasarawa District headquarters
28	Dr. Bashir A Umar	Shariah Commission Kano
29	Bashirat L Giwa	USAID | DELIVER
30	Elizabeth Ogbaje	JSI
31	Sylvia Ness	USAID | DELIVER
32	Ugo Amanyeiwe	ABT Associates Inc.
33	Marie Tien	USAID | DELIVER
34	Elizabeth Igharo	USAID |DELIVER
35	Sharon Simpa	JSI

Appendix B

Reproductive Health Commodity Security Situation Analysis Stakeholders workshop

Kano State
March 18-19, 2008

Next Steps

- Formation of Kano State Reproductive Health Commodity Security Committee involving relevant stakeholders:
  - Commissioner of Health
  - Director of Public Health
  - Family Planning Coordinator
  - Ministry of Finance
  - Ministry of Planning
  - Ministry of Education
  - Implementing Partners
  - NGO's providing FP/RH services
  - Private sector providers
  - Community leaders
    - Establish terms of reference (tasks, identify chairman, meeting schedule, immediate next steps)
- Dissemination of workshop findings to RH/FP Stakeholders
- Fora for dialogue with religious leaders, male opinion leaders, and community leaders should be promoted as a means of sensitization & increasing male involvement
- Review membership of State Donor Coordination Forum to ensure all stakeholders are represented
- State MOH/FP unit should collaborate with Partners working on Safe Motherhood and other RH Services and HIV/AIDS to conduct Community Mobilisation and Sensitization on FP
- Training of relevant service providers in the clinics on effective communication and counseling in addition to FP training.

Appendix C

Field Visit

Kano State

Team Members

Elizabeth Igharo, USAID | DELIVER PROJECT

Greg Izuwa, FMOH

Aishatu Lawan, Kano State Family Planning Coordinator

Kayode Morenikeji, USAID

Marie Tien, USAID | DELIVER PROJECT

SMOH

Contact	Position
Hajia Aisha Isiyaku Kiru	Honorable Commissioner of Health
Dr. Ashiru Rajab	Deputy Director, PHC/DC

Kumbotso LGA

Contact	Position
Kumbotso Comprehensive Health Center	
Bahija Omar	MCH Coordinator
Rakiya	CHEW
Halima	Assistant Chief Nursing Officer
Mohammed Maiyali	AAPHCC, Essential Drugs
Shekar Primary Health Care Center	
Hawa Sanni Auta	CHEW

Gwale LGA

Contact	Position
Zainab Hussein	MCH Coordinator
Kabuga Health Clinic	
Yahuze Tshohu	Deputy PHC
Halima Muazu	Staff Midwife
Filimushe MCH Center	
Hadiza Garba	SCHEW
Planned Parenthood Federation of Nigeria	

Mariam Musa	State Project Coordinator, Clinic Officer
Community Based Distributor Community Based Distributor Community Based Distributor	Male motivator Market Based Distributor Peer Educator

Takai LGA

Contact	Position
Fatima Mohammed	MCH Coordinator
Fajewa PHC	
Binta Sana	CHEW
Abdulai Barba	Head-in-charge, CHEW
Takai NYSC Clinic (Cottage Hospital)	
Ladi Adamu	Chief Nursing Officer

YOSPIS (Youth Society for the Prevention of Infectious Diseases and Social Vices)

Contact	Position
Abdulrazak S. Alkali	Executive Director

COMPASS Project

Contact	Position
Fatima M. Bunza	State Team Leader F.C.T.
Habib M. Sadauki	Senior Advisor Reproductive Health

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