HP+ POLICY *Brief*
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Evidence and Advocacy

Unlocking Resources for Family Planning in Nigeria

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Overview

With a total population exceeding 175 million, Nigeria continues to grow by an estimated 3.2 percent per year (National Population Commission, 2009). If this growth persists, the country's population could double in just 22 years. Nigeria's high fertility rate drives this growth—a typical Nigerian woman gives birth to 5.5 children in her lifetime, on average (National Population Commission and ICF International, 2014). Contraceptive use remains low, with less than 10 percent of all married women using any modern method of family planning (National Population Commission and ICF International, 2014). These conditions contribute to high-risk pregnancies, increasing the probability of premature death for Nigeria's women and children.

While the policy environment for family planning in Nigeria has improved significantly in recent years, insufficient funding for family planning has impeded contraceptive uptake. Recognising the complexity of this challenge and the need for evidence-based project design, the Health Policy Plus (HP+) project in Nigeria, funded by the U.S. Agency for International Development, conducted a qualitative assessment of the family planning policy and funding landscape nationally and in Bauchi, Sokoto, and Ebonyi states in 2016. A total of 26 national and 50 subnational stakeholders were interviewed, including decision-makers, donors, implementers, and advocates. This brief highlights key assessment findings with a focus on family planning financing, as well as next steps for addressing barriers to family planning under HP+.

National Family Planning Funding Context

- The Reproductive Health Division of the Federal Ministry of Health's Family Health Department is responsible for securing funding for family planning commodities. The National Assembly and the Office of the Presidency serve as key decision-makers, approving any family planning allocation and funding release.
- As captured in the 2016 Appropriation Act, the national government refers to itself as a provider of "counterpart" funding for family planning, implying its status as secondary funder with donors serving as principal sources.
- Between 2012 and 2016, the national government met just 11 percent of its FP2020 pledge to provide US$3 million per year for the purchase of family planning commodities and an additional US$8.35 million for life-saving maternal, newborn, and child health commodities.

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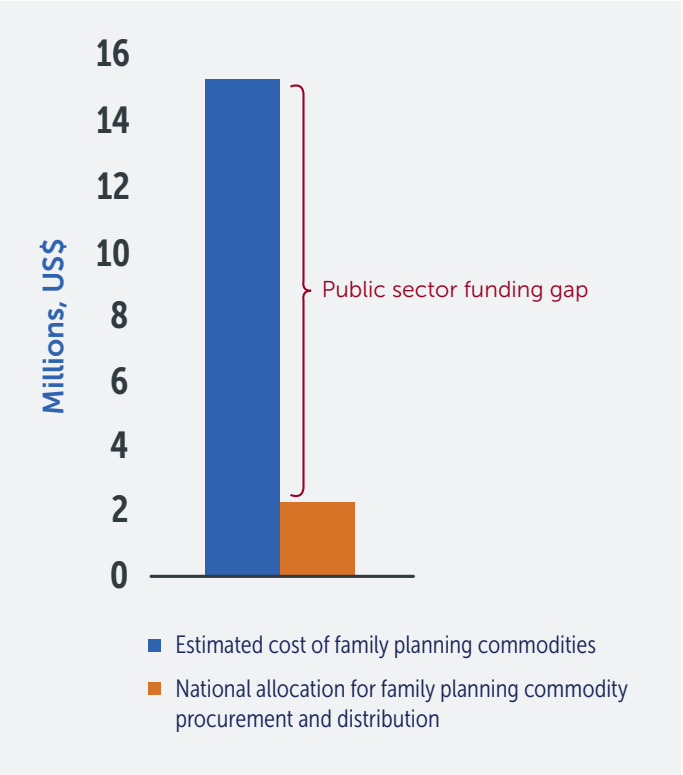
- Public sector family planning commodity funding is severely insufficient (see Figure 1). Family planning commodity procurement, distribution, demand creation, and data management are predominately donor-funded.
- The bulk of civil society family planning advocacy efforts are focused on the Federal Ministry of Health rather than the full range of national health financing decision-makers.
- A share of national actors self-identify as advocates when they actually work on demand creation, demonstrating a weak understanding of advocacy and limited capacity to carry it out.
- The private sector is not well-understood and is perceived to consist mostly of pharmaceutical companies, rather than the broader for-profit segment of Nigeria's economy. As a result, it remains untapped as a source of potential family planning financing.

Figure 1: 2016 Public Sector Family Planning Commodity Funding Gap



Source: Association for the Advancement of Family Planning, 2016; Federal Government of Nigeria, 2016.

Conversion rate of 1 NGN = .0030 US$.

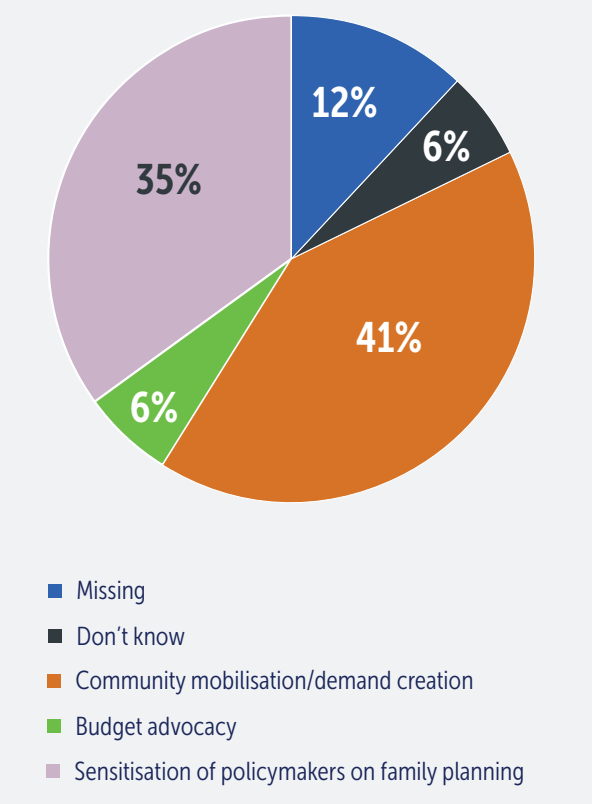
Subnational Family Planning Funding Context

- At subnational levels, responsibility for family planning has traditionally been shared by state and local governments, consisting of complex and duplicative health service management structures. To address this issue, the National Primary Healthcare Development Agency introduced the "Bringing Primary Health Care Under One Roof" (PHCUOR) initiative, which shifts primary healthcare functions—including family planning—from Ministries of Health to State Primary Healthcare Development Agencies or Boards.
- State compliance with the new, poorly understood governance structure is a necessary condition for implementation of the National Health Act, and for meeting eligibility requirements for accessing additional health funds from the Basic Health Care Provision Fund. However, at the state level the fund is not yet seen as a possible new source of family planning funding by decision-makers and advocates.
- With the exception of contraceptive commodities—largely procured by the federal government through the family planning basket mechanism—most components of family planning programming in Sokoto, Bauchi, and Ebonyi require funding (e.g., commodity transport, consumables procurement, and transport for supportive supervision). Development partners, healthcare facilities, and patients themselves are the primary sources of most family planning funding at subnational levels. For instance, women/couples bear the burden of consumables procurement for modern methods, and are often charged for commodities—which should be free—so that health facilities can recoup costs and cover

expenses unfunded by the public sector. Importantly, the public sector is perceived to play a small role in funding family planning in each state.

- No specific budget lines for family planning exist at the state level. Instead, family planning is integrated in the general reproductive health budget in all three states. Directing general reproductive health funds for contraceptive services is difficult in an environment of competing financial priorities and economic recession.
- In the absence of family planning budget lines in each state, there is no access to reliable and timely data on funding flows. As a result, the identification of funding gaps for advocacy purposes does not occur and such messages are rarely shared with decision-makers.
- Most civil society groups focus attention on generating community awareness and demand, with high-level advocacy around policy or funding serving as an infrequent, misunderstood add-on. As at the national level, advocacy is frequently conflated with demand creation (see Figure 2). Nearly two-thirds of decision-makers interviewed had never interacted with family planning advocates.

Figure 2: Perceived Role of Advocacy Groups



Summary of Key Financing Issues at National and Subnational Levels

- **Insufficient public sector funding** for relevant components of family planning at both national and subnational levels
- **Severe donor dependency** across components of family planning, including commodity and consumable funding, last mile distribution, demand creation, data management and use, and human resource development (i.e., training and retraining of family planning service providers)
- **Weak advocacy capacity** among local actors/civil society, characterized by self-described advocates conflating policy advocacy with behaviour change, incorrect identification of decision-makers, and poor data use/analysis and persuasive communication
- **Poor understanding of the health and family planning financing space** among public sector and civil society actors—including possible new sources of funding like those of the National Health Act—attributed to rapidly changing roles and responsibilities brought on by the roll-out of PHCUOR
- **Lack of transparency surrounding the spending of health funds** on family planning—characterised by limited access to reliable and timely data on funding flows—and a weak culture of accountability within the public sector
- **Inexperience with advocacy targeting new sources of family planning funding,** particularly the broader for-profit segment of Nigeria's economy

The Way Forward

To address the many challenges to sufficient and sustainable funding for family planning in Nigeria, local actors must be empowered with the evidence and skills needed to successfully make the case for increased investments. Areas of support should include: a) strengthening family planning civil society groups at subnational levels; b) building the capacity of advocates in the areas of health and family planning financing, advocacy, and decisionmaker mapping (for proper advocacy targeting and accountability); c) supporting local evidence creation and use, with a focus on accurate tracking of funding needs, flows, and gaps; humanizing demography; and storytelling around family planning; and d) ongoing technical assistance to support and empower local advocates.

Towards this end, HP+ is pursuing two key national and subnational programming components in Nigeria: 1) supporting evidence creation; and 2) building capacity of local stakeholders to successfully advocate for increased funding for family planning programmes. Under these components, HP+ will conduct numerous activities and support national and state-level initiatives to increase family planning resource mobilisation, including:

- Establish and/or strengthen national and state family planning advocacy groups and train them on advocacy, accountability, and financial analysis
- Support advocacy groups in developing and implementing costed workplans geared towards increasing funding for family planning
- Conduct financial analyses designed to identify and fill family planning resource gaps
- Develop, present, and disseminate national and state-level presentations (based on RAPID modelling data) to support advocacy for family planning resource mobilisation

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