NIGERIA

SPARHCS FIELD TEST REPORT

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LIST OF ACRONYMS

BCC – Behavior Change Communication

CIDA – Canadian International Development Agency

CS – (RH) Commodity Security

DHS - Demographic Health Survey

DCDPA – Department of Community Development and Population Activities

DELIVER – DELIVER Project (John Snow, Inc.)

DFID – Department For International Development (U.K.)

DPH – Department of Public Health

FCT – Federal Capital Territory

FEFO – First Expired First Out

FMOF – Federal Ministry of Finance

FMOH – Federal Ministry of Health

FP – Family Planning

HC – Health Center

HMIS – Health Management Information Systems

IEC – Information Education Communication

LGA – Local Government Authority

LIAT - Logistics Indicator Assessment Tool

LMIS – Logistics Management Information Systems

LSAT - Logistics System Assessment Tool

MIS – Management Information Systems

NDHS - Nigeria Demographic and Health Surveys

POLICY – Policy Project (The Futures Group International)

PMS – Patent Medical Stores

PPFN – Planned Parenthood Federation of Nigeria

PRB - Population Reference Bureau

RH – Reproductive Health

RHCS – Reproductive Health Commodity Security

SDP – Service Delivery Points

SFH – Society for Family Health

SOP – Standards of Practice

SP – Service Provider

SPARHCS – Strategic Pathway to Reproductive Health Commodity Security

SWOT – Strengths, Weaknesses, Opportunities, Threats

TAC – Technical Advisory Committee

TAG – Technical Assistant Group

TQM – Total Quality Management

TOT – Training of Trainers

USAID – United States Agency for International Development

WB - World Bank

WG – Working Group

1.0 INTRODUCTION

By the year 2015, the global contraceptive shortage is projected to increase from between $140 to $210 million annually. Other Reproductive Health (RH) commodities will have additional serious shortfalls. This is happening in the face of uncertain donor support. Much debate has been devoted to strategies for closing the projected global gap in contraceptives and RH commodities, including condoms for STI/HIV prevention. While it is true that the problem is global, it must also be addressed on a country-by-country basis. It will take the efforts of governments and organizations in each country with the expertise and understanding of the circumstances to meet this huge challenge. No one organization can meet it. Everyone must work together as partners.

The Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) was designed with this objective in mind. The SPARHCS was developed by 40 organizations in the worldwide RH community to help developing countries ensure that all men and women have appropriate access to RH commodities and services, including condoms for the prevention of HIV/AIDS. The SPARHCS is a comprehensive, long-term approach to help countries through a technical and strategic process that leads to the efficient development of a contraceptive security strategy, which can be both implemented and monitored by countries and their donor partners.

2.0 NIGERIA RHCS PROFILE

A wealth of information needed even before beginning work in Nigeria for the SPARHCS Basic Diagnosis already existed in documents such as the Demographic Health Survey (DHS), World Bank (WB) Reports, Service Provider Assessments (SPA), UNFPA, USAID, Population Reference Bureau (PRB), World Population Data Sheet, Reproductive Health projects & reports from NGOs and other organizations working in reproductive health.

Gathering information on essential data needed before visiting Nigeria was a sensible way to facilitate the workload in-country and avoid duplication of effort during the Basic Diagnosis. The data presented on the following pages were collected before traveling to Nigeria for the field test in July 2002. Only the *Summary Demographic And Public Health Trends Relating To RHCS* table in the SPARHCS country RHCS profile template was included since the data for other tables in the template were not available. In addition to this table and the sources of data used to complete the table, a chart representing the potential gap in future funding for contraceptives and condoms is also included.

Table 1. Summary Demographic And Public Health Trends Relating To RHCS

Category	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
Year	**1992**	**1997**	**2002**	**2007**	**2012**
Contraceptive Prevalence Rate (CPR) Modern Methods	4.7%[4]	7.7%[4]	11.9%[4]	17.1%[4]	22.3%[4]
CPR All Methods	8.2%[4]	13.5%[4]	18.8%[4]	24.2%[4]	29.6%[4]
Total Population	95.3m[4]	112.9m[4]	130.5m[4]	149.5m[4]	169.7m[4]
Number of Women of Reproductive Age	21.3m[4]	25.6m[4]	29.9m[4]	34.5m[4]	39.6m[4]
Number of Females	47.2m[4]	55.8m[4]	64.4m[4]	73.6m[4]	82.2m[4]
Number of Males	47.9m[4]	57.0m[4]	66.1m[4]	76.0m[4]	86.2m[4]
Total Fertility Rate (TFR)	6.2[4]	6.0[4]	5.7[4]	5.3[4]	5.0[4]
Percent of Population Urban	35.0%[10] (1990)	39.6%[10] (1995)	44.0%[10] (2000)	48.3%[10] (2005)	52.1%[10] (2010)
Percent of Population Rural	65.0%[10] (1990)	60.4%[10] (1995)	56.0%[10] (2000)	51.7%[10] (2005)	47.9%[10] (2010)
HIV Prevalence	1.8%[5] (1990)	4.6%[5] (1996)	5.1%[5, 6] (1999)		
Infant Mortality Rate	81.7[5]	76.5[5]	72.5[5]	68.4[5]	63.4[5]
Maternal Mortality Ratio	1,000 (1990)		800		

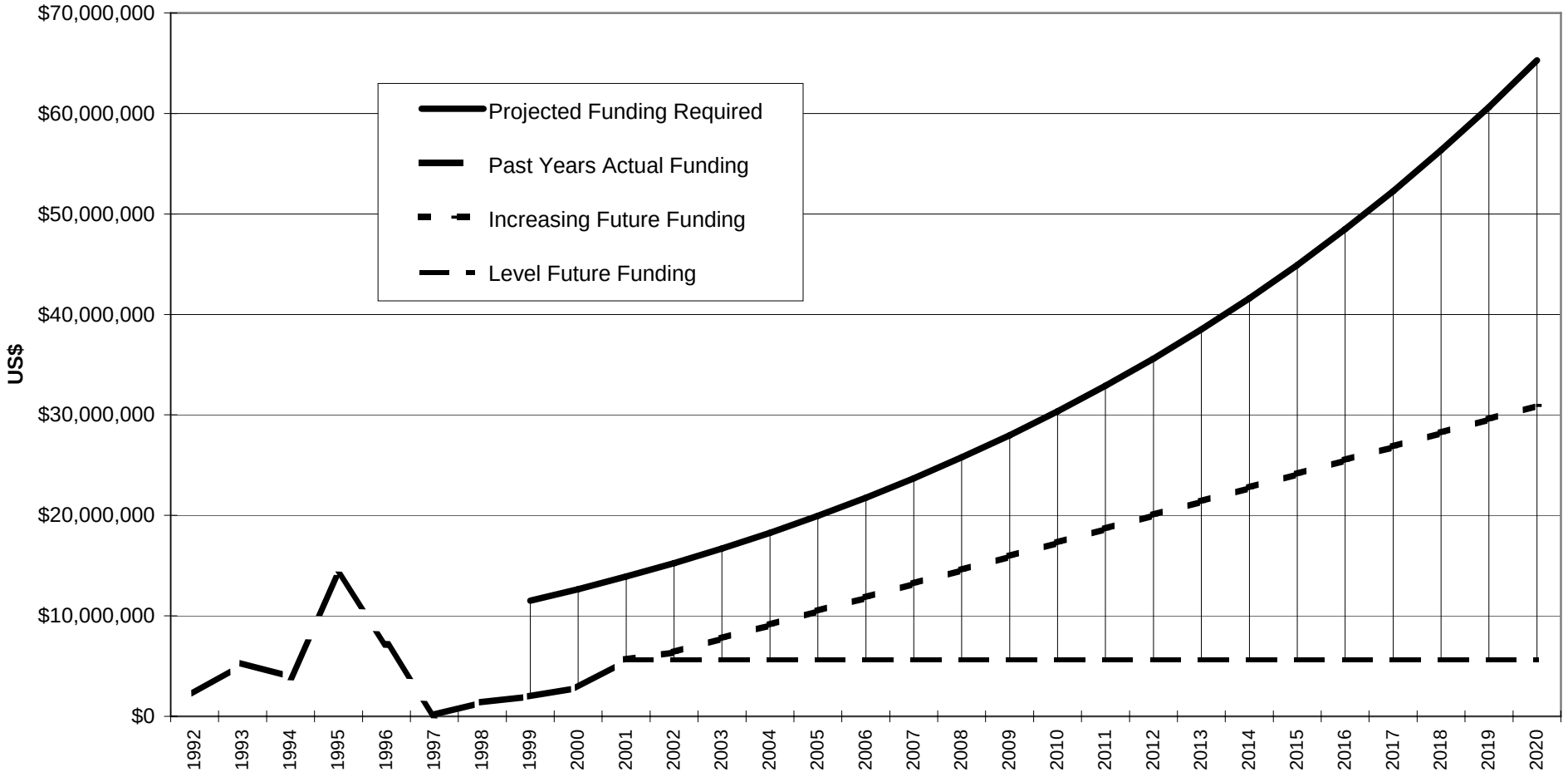
Table 2. Data Sources

Source No.	Source	Year	Web Site Address
1	Nigeria Demographic and Health Survey	1999	www.macroint.com www.measuredhs.com
2	Nigeria Demographic and Health Survey	1990	www.macroint.com www.measuredhs.com
3	The Nigeria Fertility Survey	1981/82	
4	Spectrum, DemProj & FamPlan, The Futures Group International [Projections based on data from sources 1, 2 & 3 above]	2002	www.tfgi.com
5	U.S. Census Bureau	2002	www.census.gov
6	Population Reference Bureau Briefing Packet	2001	www.prb.org
7	UNICEF Country Data Maternal Mortality	1995	www.unicef.org/statis/
8	Profiles for Family Planning and Reproductive Health Programs, 116 Countries (Ross, Stover & Willard), The Futures Group International	1999	www.tfgi.com
9	The Contraceptive Forecasting Handbook (DELIVER)	2000	www.deliver.jsi.com
10	World Population Prospects: Population Database, UN Population Division		www.esa.un.org/unpp/

Table 3. Census and NDHS Information

Year of last Census	1992
Year of next scheduled Census	2004
Year of next scheduled NDHS	2003

Graph 1: A Calculation of the Contraceptive and Condom Gap for Nigeria



3.0 METHODOLOGY

In February 2002, at a National RH stakeholders' meeting in Abuja, Nigeria, SPARHCS was introduced. The key Nigerian decision-makers and stakeholders present at the meeting, including representatives of the Federal Ministry of Health (FMOH) and the USAID Mission, agreed that the first SPARHCS field-test should be conducted in Nigeria. At this time, decision-makers in country chose to focus on contraceptives and condoms for the SPARHCS initiative.

The field-test was conducted from July 9-31, 2002. A team of six international consultants, representing four organizations (Policy Project/The Futures Group International, Commercial Market Strategies Project/Deloitte Touche Tohmatsu Emerging Markets Ltd., DELIVER/JSI, and USAID/W) participated in the field-test. The group worked with collaboratively with a national SPARHCS Committee and Team.

The Committee comprised 19 key stakeholders and decision makers working in reproductive health and included representatives of the FMOH, NGOs, donors, and other development partners. The SPARHCS Team consisted of 25 multi-disciplinary in-country experts (For list of Committee and Team members, see Attachment A).

The international consultants commenced the field-test exercise by orienting the Committee and Team on the SPARHCS process. They then introduced Team members to the SPARHCS Workbook and the course of action for conducting the Basic Diagnosis of the seven technical Components: Human and Organizational Capacity, Demand, Finance, Logistics, Policy, Private Sector, and Service Delivery.

The international consultants and Nigerian Team members collaborated on collecting information and data to complete the Basic Diagnosis of each of the seven SPARHCS Components. Team members collected information and data using several different methodologies including reviewing recent and relevant documents and studies, interviewing key informants in different sectors (including FMOH, NGOs, donors, commercial and other private providers, and international development organizations), and presenting preliminary findings and inferences to the wider SPARHCS team for verifying/vetting.

The group then analyzed these findings, identifying key issues to be addressed and knowledge gaps in specific commodity security-related areas. The methodology for analyzing and synthesizing the information varied among the different Component groups. Some listed the key issues and recommended remedial courses of action, while others conducted "SWOT" analyses on which they based their recommendations. These differences are reflected in the reports for the various Components that follow.

The Team compiled and prioritized a number of further assessments aimed at filling the knowledge gaps as well as a series of short-term actions that can be executed with little or no additional information. These actions and assessments were summarized in 46 "Task

Summary Sheets," that also detailed responsible parties, funding source, indicator, and due date.

At the end of the three-week period, the Team convened a Planning Day to present the Task Summary Sheets to the Committee for approval. In the coming months, the Team, led by a "Core Group" (ten Team members representing the FMOH, donors and NGOs who are responsible for coordination and communication), is expected to continue working on the SPARHCS process, ensuring the execution of the identified short-term actions and in-depth assessments towards a strategic planning workshop. At this workshop, which is planned for November, 2002, a few appropriate international consultants will return to Nigeria and, together with their Nigerian counterparts, analyze the assessment findings and develop a long-term commodity security strategy for Nigeria.

Together with a Process Facilitator, who was hired specifically for this purpose, the group of international consultants documented the field-test experience and made a series of practical recommendations for SPARHCS revision based on the field-test experience. These issues will be further discussed in a SPARHCS retreat slated for late September 2002.

4.0 COMPONENTS

4.1 ORGANIZATIONAL AND HUMAN RESOURCES CAPACITY

4.1a Introduction

Reproductive health commodity security (RHCS) can be achieved only when human and organizational capacity within a national health system is developed to an adequate degree. Team members assessed six aspects of human and organizational capacity that impact on RHCS. These are:

- Strategic Leadership and Management
- Human Resource Management and Development
- External Relations
- Other Core Resource Management (infrastructure, transparency, maintenance)
- Organizational Learning
- Sustainability

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Team members collected data using several methodologies in order to verify information. Relevant studies and documents were reviewed. This was followed by a survey of key informants with Ministry of Health officers from the Federal Capital Territory, the central Ministry, UNFPA, PPFN, and the POLICY Project Nigeria. Survey results are summarized below. Based on the literature review and the survey results, Capacity team members conducted a SWOT analysis, which was then presented to the SPARHCS Nigeria Team. After incorporating group feedback, the team identified key issues to be addressed through either short or long term tasks. This information is summarized at the end of the SWOT analysis.

Table 4. Capacity Survey Results

Question	Definitely Not	Probably not	Perhaps	Probably/Certainly
1. Do enough decision- makers in the MOH have an understanding of and commitment to RHCS?	Definitely not need awareness-raising across the board. Also, many understand but have inadequate commitment	At LGA there is some awareness but definitely need more awareness raising and IEC	It varies by state. The FCT is okay but not necessarily in other states. Need awareness raising.	Centrally PS, Minister, stakeholders involved but still need awareness raising
2. Do enough MOH staff have an understanding/commitment to RHCS?	Not at the LGA level. In Adeyemi's department but not rest of staff at all levels	Centrally there is more awareness than at the state or local level		
3. Does the MOH mission truly include RHCS?	Not at LGA and state level Included but not implemented		At federal level yes – there is a stakeholders committee	There is new Pop Policy but very new
4/5. Does the MOH have an effective RHCS strategy? Is it known?	No, waiting for SPARHCS	Problems with cultural/religious beliefs. Need grass roots info and town criers to spread info. Need lights/commodities in clinics. No one wants to work in HCs		Yes, the strategy has been developed but not implemented. Waiting for SPARHCS to add to RH strategy
6. Does the MOH have a policy in practice to collaborate with other organizations to strengthen RHCS?	The Minister never puts Pop and RH issues in top priorities and so funding			Yes the RH WG developed the RH Policy and Strategic Plan with Stakeholders. CLM TAC developed CLM working document.
7. Has the organization mobilized sufficient resources to meet the needs of RHCS?	WB loan for contraceptives and a budget line item for RH until. UNFPA working on revolving funds at LGA. Accounts in place at the state but not funded and were drawn down with non-FP expenditures.			
8. Are there resources mobilized or funds committed for the next five years?	No			
9. Does the MOH have a system for monitoring and evaluating progress toward RHCS?	Very little in place and what is in place needs strengthening. No performance indicators in place yet.		Federal monitoring built into a new strategic plan. Policy to monitor at state but no money/ transport so not done. Need training.	
10/11/13/14/15 /16/17/18/19. Are there enough skilled staff to: calculate current/future commodities? Unmet need? Order quantities? Operate LMIS? Interpret data/make decisions? Emergency orders? Months stock on hand? Medical stores? Policy skills? Interface w/ other sectors	No, Only people are at federal and a few at state level or FCT Issues with tariffs, imports, customs duties on many commodities.			President has waived tariffs for insecticide treated materials (bed nets) and HIV/AIDS

Question	Definitely Not	Probably not	Perhaps	Probably/Certainly
12. Are there enough members in the MOH with skills for demand creation?	Only people are at federal and a few at state/ FCT. Some in health ed branch DPH/ IEC but not active	Not enough posters and materials.		
20. Are there other human or organizational capacity issues that may keep the MOH from supporting RHCS?	Facilities inadequate, not enough prescribers, not trained. Strategy communicated but no funding. No commitment from responsible staff/top.	No LGA storerooms		
21. Do members of the organization have adequate service delivery skills?	Some do. Only MDs insert Norplant in general hospitals. FP 6 wk training course funded by UNFPA. SFH certified providers but many have left. Trying to change pre-service curriculum to add.	Not enough numbers either. Problems with payment, no accommodations, 5 nurses for 24 hour shift on wards resulting in low morale		
22. Do members receive in-service training in appropriate areas?		Some TQM and service provision in-service at FCT level	Until 94 some states did logistics training. Some service provider training in FP but not enough.	
23. If commodities for the prevention and control of HIV/AIDS are included in RHCS, are there sufficient skills to deal with HIV/AIDS prevention and control?	Some counseling skills at state and federal level but need more training across all levels. HIV/AIDS program coming up with counseling document to include counseling of affected and effected persons			
24. Do service delivery providers have the skills needed to help consumers choose, obtain, and use commodities of their choice?			There are limited skills across all levels but need more training in most places.	
25. Does the FMOH have the capacity and resources to train officials and staff in the skills covered above?	Trying to move training to pre-service rather than in-service. Faculty needs to be upgraded in new curricula after developed	Working to upgrade curricula of medical and nursing schools so in line with paradigm shift	56 nursing schools 40 health technology schools 25 tertiary institutions do training	
26/27. What are the organizational structures? Does the organization readily adapt to change?		Inadequately skilled staff. Job descriptions present. Performance reviews done annually for upper levels. Promotions based on performance/ written and verbal interview. Salary increase with promotion. Yr increase automatic	Half of MOH staff in Lagos. Monthly senior management meeting does not always happen and not well utilized (14 Lagos) Depends on who initiates change and at what level. If Minister asks respond quickly; if others, no.	Posted on wall at FCT. At FCT DPH has responsibility for nurse midwife providers after they receive their 6-week training and can move them to meet needs.
28. Is information available within the organization? Horizontal and vertical and one and two way?	No formal job descriptions at state level	The FCT structure is more flexible but this is the person not the organization	National Council of Health in place for one year. At state LGA heads meet. Can invite directors, commissioners or programmatic.	

4.1b SWOT Analysis

Internal Strengths	Internal Weaknesses	External Opportunities	External Threats
Logistics ▪ Officers at the federal level that can be trained ▪ Adequate storage facility at central level ▪ 2 Zonal warehouses adequate ▪ State warehouse facilities that can be repaired ▪ LSAT completed ▪ 2 small Toyota 4-wheel drive vehicles in good repair ▪ Functioning Contraceptive Logistics TAG committee ▪ Draft contraceptive logistics working document ▪ Training needs assessment in three states	**Logistics** ▪ Not enough staff especially at zonal, state, and LGA levels ▪ No incentives to work in rural areas ▪ SOP/policies/procedures/job descriptions not available ▪ Inadequate management capacity across levels ▪ Lack of coordination ▪ Inadequate supervision due to lack of knowledge/transport ▪ Inadequate storage facilities at SDPs, LGAs, state, zonal levels ▪ Lack of transport ▪ Lack of adequate cost recovery	**Logistics** ▪ CIDA Fund for Cost Recovery available for logistics software development and training ▪ Deliver just completed in-depth logistics assessment	**Logistics** ▪ Use of revolving funds for activities other than RHCS and contraceptives ▪ No funding from FMOF
Service Delivery ▪ Cost recovery funds available in some states ▪ Revised curricula for 6 week FP Training Course ▪ Large number of FP officers trained in course (more than 600) ▪ Available health facilities that can be upgraded ▪ Officers who can be trained ▪ Revised SOP (policies, guidelines, standards. Job descriptions) ▪ Service delivery needs assessment available for 3 states ▪ Limited national manpower assessment available ▪ Cost recovery funds available in some states ▪ Performance improvement initiated in some states ▪ Revised Population Policy approved ▪ Revised RH Five-Year Strategy (draft) ▪ National Health Council in place ▪ Semi-annual meeting with all Health Commissioners ▪ Similar meeting at state levels where LGA heads meet ▪ Performance appraisals conducted at central level ▪ 56 nursing schools, 40 health technology schools, 25 tertiary training institutions	**Service Delivery** ▪ Not enough staff with correct skill mix at zonal, state, LGA levels ▪ Existing staff does not have adequate training ▪ Staff not distributed correctly ▪ No incentives to work in rural areas and/or improve morale ▪ Poor communication skills ▪ SOP/policies/procedures/job descriptions not available ▪ Performance improvement activities not conducted in most states ▪ Facilities that ensure privacy for counseling not available in SDPs ▪ Inadequate contraceptives, supplies, and equipment in many SDPs ▪ Inadequate sterilization instruments due to equipment/knowledge ▪ Inadequate management capacity across levels ▪ Lack of coordination ▪ Inadequate supervision due to lack of knowledge and transport ▪ Lack of transport ▪ Lack of adequate cost recovery/targeting scheme ▪ Reporting requirements too complex ▪ Absence of MIS and HMIS ▪ Inadequate political commitment to and awareness of RHCS ▪ Inadequate # staff with HIV/AIDS with VCT skills all levels ▪ Salary paid late to some staff (approximately 25%) ▪ Performance appraisals not done at lower levels of system ▪ Need to upgrade curricula and faculty at training schools	**Service Delivery** ▪ UNFPA/USAID/CIDA/DFID continue to support population activities ▪ Private sector Donors provide contraceptives ▪ Visions project on population activities and performance improvement ▪ UNFPA supports FP training for staff ▪ Political commitment to AIDS prevention increases condom availability and promotion	**Service Delivery** ▪ Staff with inappropriate skill sets posted to choice jobs due to external political influence ▪ Unable to adequate leverage HIV/AIDS condom promotion activities due to centralized control of AIDS program ▪ No funding from MOF

4.1c Key Issues

- Inadequate dissemination of information/reports on surveys and reports conducted by various organizations for manpower planning and development and facility utilization.
- Curricula and faculty of training schools are not upgraded.
- Lack of management and coordination capacity.
- Inadequate supervision due to lack of skills and transportation
- Standards of practice, policies, procedures, job descriptions, and performance appraisal not available
- Inadequate political support and commitment to RHCS
- Inadequate staffing at zonal, state, and LGA levels.
- No training needs assessment or training plan.

4.1d Short Term Tasks

- Additional Data Collection for secondary data analysis
- Initiate Annual FP Coordinator's Meeting with Service Delivery
- Baseline Assessment in Public-Private Sector

4.1e Long Term Tasks

- Projection of Staffing Requirements
- Three-Week Training for SPARHCS Team Members

4.2 DEMAND

4.2a Introduction

Demand is the current consumption of any RH commodity based on recent history and trends in increase. Demand includes allowances for elimination of present shortages and stock-outs and for intended programmatic expansion, such as new clinics being built. Current demand is often opposed to unmet need. Unmet need represents the larger demand for an RH commodity if clients who were offered information about it would choose it if they had economic and geographic access.

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4.2b Situation Analysis

The Demand Component group took into account the information in the Country RHCS Profile, with specific reference to method mix, as well as the Nigeria Demographic and Health Surveys (NDHS) of 1999 and 1991. Of special interest to the group were the data from the recently conducted LSAT and LIAT (see Logistics Component report), which showed considerable evidence of stock-outs of contraceptives at service delivery points throughout the country. This was of great concern since a crucial point taken into consideration was that since current demand was not being met, it would be unwise to use scarce resources to create additional demand. Assuring sufficient supply for current demand

was seen as cautionary in determining whether demand creation activities should be engaged in to address attempts to fulfill unmet need. The group further fully recognized the interrelationship of the Demand Component with other Components, especially those dealing with supply-side issues, most notably the Logistics Component, as well as the Policy, Finance and Service Delivery Components. Taking all of this into account, the group was nevertheless of the opinion that although demand creation activities should not be emphasized until supply-side problems were corrected, especially the avoidance of stock-outs, certain activities related to demand creation should go forward in anticipation of improvements in contraceptive supply. Such activities include preparation for refresher training of health workers in demand creation and ensuring the availability of IEC materials and job aids. Once supply problems are corrected, demand creation could be increased to begin taking care of unmet need. Another crucial issue addressed was the need to continue and intensify demand creation for condoms for HIV/STI prevention. Given the overriding public health concern of HIV/AIDS, coupled with the multiplicity of outlets for condoms, it is believed that there should be no de-emphasis of demand creation for such products. There was further recognition of the fact that demand creation methods for HIV/STI condoms are different from methods traditionally used to generate demand for contraceptives.

Using information from a variety of sources, such as the NDHS mentioned above, as well as interviews with knowledgeable resource persons, the Demand Component group compiled the data tables as presented in the Nigeria Field Test Edition of the SPARHCS Workbook. Tables 1 and 2 on the following page summarize these data. Please note that in the Tables commercial sector and social marketing have been combined since the main social marketing organization in Nigeria, Society for Family Health, is the major provider of contraceptives and condoms to the commercial sector, NGOs and others. As mentioned above, the tables show that considerable stock-outs exist, especially in the public sector (FMOH).

4.2c Key Issues

Based on the information collected and analyzed, the Demand Component group identified the following issues:

- Inadequate availability of IEC materials;
- Inadequate client and community education and outreach resulting in a low level of awareness and utilization of RH/FP services and commodities;
- Deficiencies in interpersonal communication and counseling skills of providers (partly responsible for poor quality of service);
- Limited accessibility to RH/FP facilities, particularly in the rural areas due to scarcity of clinics and limited means of transportation;
- Cultural and religious beliefs which act as barriers to RH/FP utilization (myths and rumors about some FP methods);
- Low level of male involvement in RH/FP (the increasing high risk behavior of adolescents and youths is cause for concern given the fact that the most vulnerable to HIV/AIDS is the 15-24 year age group);
- Inadequately functioning logistics system -- deficiencies in availability and utilization of RH/FP services and commodities.

To identify actions which could impact on these issues, the Demand Component group developed the short term tasks listed on the following page. Additionally, several other tasks, notably the request for a market segmentation study, were coordinated with other Components which will actually perform the required tasks.

Table 5. Supply Sufficiency for Current Demand

Estimated percentages of how well current demand is being satisfied by organization and method.										
Organization/Sector	Combined Oral Contraceptives	Progesterone Only Pills	Injectable		Condom	Implant	IUD	VFT	Postinor	Diaphragm
			Noristerat	Depo-Provera						
FMOH (LSAT/LIAT data, 2002)	38%	6%	28%	53%	58%	NA	62%	10%	68%	NA
Commercial Sector/Social Marketing (SFH data, 2002)	100%	NA	0%	100%	100%	NA	100%	50%	NA	NA
Commercial Sector/Social Marketing (LSAT/LIAT data, 2002)	74%	4%	73%	69%	94%	NA	62%	26%	77%	NA
NGO: PPFN (PPFN data, 2002)	90%	30%	70%		Female: 100% Male:50%	40%	90%	30%	NA	10%

Table 6. Projected Unmet Need

Estimated percentages of Unmet Need as a percentage beyond Current Demand (see Table I). (Note: The figures represent the additional percentage of Contraceptive Prevalence beyond Current Need that could potentially be realized if the Unmet Need were fulfilled. Totals do not add precisely due to rounding errors.)									
Organization/Sector	COC	POP	Injectable	Condom	Implant	IUD	VFT	Other (non-commodity methods)	Total
FMOH	1.1%		1.9%	0.4%	NA	1.9%	NA	0.2%	5.5%
Commercial Sector/ Social Marketing/ NGO	2.5%		0.8%	2.7%	NA	0.5%	NA	0.2%	6.7%
Other	0.4%		0.1%	0.4%	NA	0.1%	NA	0.3%	1.3%
Total (all sectors)	3.9%		2.8%	3.4%	0.1%	2.5%	0.1%	0.3%	13.3%

4.2d Short Term Tasks

- Inventory of IEC Materials and Activities
- Assessment of Existing IEC Structures at the State and Local Government Authority Levels
- Male Involvement in RH/FP Activities

4.3 FINANCE

4.3a Introduction

The Finance Component examines the adequacy of funding to make contraceptives available to all those who need and want them. It determines the major sources and uses of funds for

RH commodities, identifies resource gaps, develops future scenarios for financing, and develops actions to ensure financial security. Basic diagnosis of finance Component involves the following:

- Current sources and uses of funds for contraceptive commodities
  - Federal and state governments
  - Donors
  - Out-of-pocket
  - Private sector/NGOs
  - Health Insurance
- Adequacy of current level of financing
- Future scenarios

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Table 1, 2 and 3 summarize the information collected through key informant interviews and review of reports and records.

Table 7. Cost Recovery Policies and Practices

	Current practices
Government order or guidelines	The cost recovery system is decentralized. No government order or guidelines are in existence to guide the collection, retention and use of revenue generated.
Exemption	Fees are charged from everyone. Poor are not exempt from paying for contraceptives.
Charges	Registration fee (one time) Nominal charges for contraceptives
Pricing	Prices vary greatly across rural/urban areas, different regions and different facilities. Prices are fixed based on market rates – lower than the NGO, social marketing and the private commercial sector.
Retention of revenue	There are different practices: ▪ Some facilities keep only 15% of the money collected and deposit the rest (85%) in the FP account at the state level. ▪ Some facilities deposit all the money collected in the FP account at the state level. ▪ In some states, facilities keep 10% of the revenue, LGAs keep 20% of the revenue and states keep 20% of the revenue. About 50% of the collected revenue gets deposited in the FP account.

	Current practices
Use of revenue	The collected revenue is used for: ▪ Emergency procurement of contraceptives ▪ Purchase of consumables ▪ Monitoring and supervision
Distribution of contraceptives	The contraceptives are allocated free of charge from the federal to state level. Prices are fixed at the facility level.

Table 8. Contraceptive Pricing Chart

Contraceptive Type	Commercial (for profit sector) (Non SM)	Patent Medical stores and Pharmacies	Social Marketing	NGOs[1]	Public
Gold circle (condom)		10-20	<10-20		2-10
Cool (condom)			5 -10		
Duofem		15-20	10-20		10-17
Lofemenal		20-30	15-20		5-20
Confidence			15-20		
Postinor 2 (pill)			50-100		
Noristerat (injectable)	30-100	25-150	30-100		10-70
Depo Provera (injectable)	30-100	40-100	30-100		15-70
Copper T (IUD)	50-100	50-150	50-500		20-150
Rough Rider (condom)	150-200				
Twin Lotrus (condom)	50-150				
Durex (condom)	100-200				
Romance (condom)	50-100				
Exotica (condom)	50-200				
Postinor (pill)	15-20	10-50			10-50
Mestrogen (pill)	10-20				
Microgynon (pill)	20-100	20-80			10-15
Gynocosid (pill)	50-100				
Neogynon (pill)	20-100				
Lofemenal (pill)	10-20				
Lippes Loop (IUD)	100 & more				
Excluton					5-10
Nologo		3-10			1-10
Foam tablets		5-120			20-80
Combined Orals				15	
Progestin				15	
Condom				1.5	

[1] PPFN contraceptive prices (average)

Contraceptive Type	Commercial (for profit sector) (Non SM)	Patent Medical stores and Pharmacies	Social Marketing	NGOs[1]	Public
Injectable				70	
Implant				3500	
Spermicide				150	
IUD				150	
Diaphragm				100	
VFTs				150	

* Prices in Naira

Sources: Distribution survey 2002; Logistics Management Survey 2002; and PPFN.

Table 9. Expenditure on Contraceptives

Classification	**1999**	**2001-2002**	
	FMOH	**FMOH**	**Global fund**
Postinor 2	2.6		
Triregol	4.0		
Copper T	2.5	11.2	10.4
Depo Provera	2.6	22.2	746.6
Condoms	8.1		19.8
Lofemenal and Duofem		11.2	
Microgynon			18.5
Female condom			2.3
Foam tablets			39.4
Insertion and removal kits		7.7	
Sphygnmanometer		3.6	
Stethescope		3.6	
Vehicles and screen		10.8	
TOTAL	**19.8**	**70.3**	**837**

In Millions of Naira

4.3b SWOT Analysis

STRENGTHS	**WEAKNESSES**
▪ Existence of a budget line item for RH ▪ Alternative financing mechanisms are in place ▪ Financial autonomy at the hospital level	▪ Inadequate financial commitment at the FMOH level; and lack of commitment at the state levels in the form of allocation of finances. ▪ Low priority for financing population activities ▪ Government RH commodities and services are not targeted ▪ No reliable information on the current and projected financial requirements for the procurement and distribution of RH commodities ▪ Underdeveloped cost sharing and risk sharing schemes ▪ Lack of financial planning for meeting contraceptive requirements ▪ No provision of free contraceptives for the poor ▪ Cumbersome procedures for releasing funds
OPPORTUNITIES	**THREATS**
▪ Increasing attention of international agencies and researchers to contraceptive security ▪ FMOH's concern regarding resource scarcity for population activities ▪ Large and growing private sector market ▪ Well established social marketing mechanisms ▪ High out-of-pocket expenditure ▪ Possibility of getting low price contraceptives in bulk from international agencies ▪ Strong presence of various donor agencies and CAs (USAID, DFID, CIDA, VISION, POLICY, etc)	▪ Uncertain and declining donor support ▪ Increasing resource gap o High population growth rate o Increasing demand for family planning as a result of increasing awareness and education levels o HIV/AIDS pandemic ▪ About 66% of the population is below poverty line

4.3c Gaps Identified

- Inadequate financial commitment at the FMOH level; and lack of commitment at the state levels in the form of allocation of finances.
- Low priority for financing population activities

- No reliable information on the current and projected financial requirements for the procurement and distribution of RH commodities
- Underdeveloped cost sharing and risk sharing schemes
- Lack of financial planning for meeting contraceptive requirements
- No provision of free contraceptives for the indigent
- Cumbersome procedures for releasing funds
- Uncertain and declining donor support
- Increasing resource gap
    - High population growth rate
    - Increasing demand for family planning as a result of increasing awareness and education levels
    - HIV/AIDS pandemic

4.3d Short Term Tasks

- Assessment of financial resource requirements for RH
- Develop a Strategy to Ensure Sustained Flow of Financial Resources
- Collaboration with international agencies and commercial (for profit) sector
- Household FP expenditure

4.3e In-depth Analysis

- Developing Operational Guidelines for cost sharing/recovery
- Market Segmentation Analysis
- State Reproductive Health Accounts

4.4 LOGISTICS

4.4a Introduction

The Logistics Component of the SPARHCS covers supply chain management to help ensure RHCS for the commodities chosen by the decision makers in country. In the case of Nigeria, those commodities were "contraceptives and condoms."

LOGISTICS COMPONENT TEAM MEMBERS

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Mr. Bartholomew Ukenye – Admin/Logistics Officer; NPHCDA Edo

As with all seven SPARHCS Components, the members of the Logistics Component group of the Nigeria SPARHCS Team examined the Nigeria RHCS Country Profile started by the consultants before coming to Nigeria. They also used the SPARHCS Workbook (Nigeria field-test edition) as part of their Basic Diagnosis. The forms in the Logistics Component of the Workbook helped them review the existing supply chains comprehensively to see how contraceptives and condoms were managed and to identify strengths, weaknesses, and gaps. In addition to the instruments in the SPARHCS Workbook, the members of the Logistics Component group profited from the recently completed Logistics System Assessment Tool (LSAT) and the Logistics Indicator Assessment Tool (LIAT) done by the DELIVER Project. The Logistics Component group members and the other SPARHCS Team Members received a debriefing on the two studies and a preliminary report. Some of the group had served on the team doing the studies in the previous weeks. (Results of the LSAT and LIAT in Nigeria are available through the DELIVER Project.)

The Logistics Component group identified ten "Short Term" Tasks and two "Long Term" Tasks for the Logistics Component to contribute to the Contraceptive and Condom Security in Nigeria. (These tasks are listed below, with the complete Task Summary Sheets annexed to this document.) As with the other Components, this group peer reviewed their proposed tasks with other members of the Nigeria SPARHCS Team and received feedback prior to proposing the tasks to the Nigeria SPARHCS Committee.

The members of the Logistics Component group were generally knowledgeable about and experienced in RH logistics in Nigeria, and this background was essential in identifying logistics tasks to support CS. It should be noted that the FMOH was well represented in the group, and that the knowledge of the FMOH supply chain was understandably stronger than the supply chain for social marketing and for the commercial sector. Information on the commercial (for profit) sector supply chain will always be more difficult to obtain because the commercial sector involves so many different actors who operate differently and do not collect information as other sectors do. Also, for a variety of reasons they may be reluctant to share their information.

It was quite clear that logistics for social marketing and some NGOs is effective, with the social marketing program generating a major part of the CYPs in the country. A decade ago, the FMOH also had a functioning logistics system, but the current system is very problematic. There is virtually no logistics management information system (LMIS), a fact that makes demographic-based forecasting a necessity. Since contraceptives are in insufficient supply, stock outs are inevitable. (See LSAT and LIAT reports.) Providers at SDPs do not routinely monitor stock levels or order regularly, because supplies are not routinely provided and because of staff turnover over the years, many of the providers have not been trained.

There is a scarcity of information on how many FMOH health facilities provide FP, how many staff have been trained, and how many clients they have. NGO SDPs, depending on where they obtain their supplies and how they are supported, may function better. Both FMOH and NGO SDPs are reported referring clients to private sector patent medical stores

to obtain contraceptives. This practice needs further review but is not to be discouraged as such. It seems indicative of the ability of the commercial sector to provide contraceptives when the logistics for other sectors is not successful.

4.4b Key Issues

Contraceptive security is a complex, and many key issues cannot be identified as specific to any one SPARHCS Component. The issues should be looked at in conjunction with the key issues of the other Components.

- Follow up on some of the identified tasks will be essential at the Logistics Workshop being presented with DELIVER in October.

- Task # 2 below, "Distribution of Contraceptives and Condoms to the Zones and States," is logical and essential, and UNFPA has funding. In some cases key SDPs will easily receive commodities because of their proximity to zonal and state warehouses. In many instances, however, there is no assured transport beyond the state level.

- The forthcoming market segmentation analysis, a "long term" task under the Finance Component, should be key in determining pricing structures and even which sectors (public, private, social marketing, commercial, etc.) have the highest growth potential. More attention in logistics should be given to the sectors with high growth and efficiency potential.

- Condoms for the prevention of STI/HIV are implicit in several of the tasks. Condom supply should be treated in detail at the Strategic Planning Workshop.

- Some of the tasks identified may be less realistic or less immediately related to CS than other tasks are, but it is clearly within the purview of the Nigerian Committee and Team to propose such tasks and attempt to mobilize resources for them.

4.4c Short Term Tasks

- Harmonizing and Strengthening of Contraceptives Logistics Management System (CLMS) Mechanisms/Functionality in DCDPA/FMOH
- Distribution of Contraceptives and Condoms to the Zones and States
- Preparation for Logistics Redesign Workshop
- Improving Forecasting Capabilities for Contraceptives and Condoms
- Placing Orders for Contraceptives and Condoms
- Establish Sub-Committee of Stakeholders Group for Procurement of Contraceptives/Condoms
- Advocacy for Adequate Allocation and Prompt Release of Funds for Contraceptives/Logistics
- Improving Storage Conditions of Contraceptive Commodities and Condoms
- Provision of Adequate Security to Warehouses
- Emergency Distribution of Contraceptives and Condoms to Address Imminent Stock-outs

4.4d Long Term Tasks

- Carry Out Logistics Redesign Workshop
- Conduct TOT on Redesigned LMIS Forms and Family Planning Logistics (FPLM) Guidelines

4.5 POLICY

4.5a Introduction

Reproductive health commodity security is unlikely to be achieved without appropriate policies in place. There are two fundamental issues, both which must be addressed to ensure a favorable policy environment. First, favorable policies must be formulated where they do not exist. And second, existing policies that act as barriers to contraceptive security, either deliberately or through unintended consequences, must be removed or reformed so that all actors in the public, NGO and commercial sectors do not face unnecessary constraints in meeting the reproductive health needs of their respective clients. This Component assesses what policies are currently in place, whether they have positive or negative impacts on contraceptive security, what these existing gaps are, and how feasible it would be to address them. The Policy Component involves the assessment of the following:

- Policy or legal framework for access, availability and affordability
  - National policy and political environment
  - Regulations
  - Policies that affect the private sector and the following Components
    - Finance
    - Demand creation
    - Logistics
    - Service delivery
    - Human and organizational capacity

Analysis of the Policy Development Process was conducted on the following potential stakeholder organizations:

- National Agency for Food and Drugs Administration (NAFDAC)
- National Population Commission
- National Civil Service Commission
- Ministry of the Federal Capital Territory (FCT)
- Federal Ministry of Industries
- Federal Ministry of Finance
- Christian Council of Nigeria (CHAN)
- Nigerian Union of Journalists
- Nurses and Midwifery Council of Nigeria
- Pharmaceutical Society of Nigeria
- Nigeria Medical and Dental Council
- Guild of Medical Director

POLICY COMPONENT TEAM LEADERS

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Table 10. Policy Inventory Summary

Question	Answers with respect to Contraceptives and Condoms
1. Are there customs duties (import taxes) on these products? If yes, state the amount.	No duty/tax for public sector imports/donations. Private (commercial) sector pays 25% duty plus 5% VAT
2. If there are customs duties (import taxes), are there any exemptions from the duties? If yes, tell which products or which importers are exempted.	There are exemptions for Public sector contraceptives and Donations
3. Are there sales taxes? If yes, tell how much the taxes are, and tell if there are any exemptions.	5% sales taxes (VAT) are paid by private (commercial) sector
4. Are there price controls?	None
5. Are there restrictions on product importation or distribution? If yes, explain.	None (except for products not approved by the National Agency for Food and Drugs Administration NAFDAC). No newspaper advertisement of contraceptives except in medical journals
6. Is there a clear and timely product registration procedure? Explain as appropriate.	Yes. All importers and products must be registered and approved by NAFDAC.
7. Are these products included on the national essential drug list? If yes, specify products as needed.	Contraceptive products are registered in the essential drugs list
8. Is there a separate and dedicated line item in the national budget for contraceptives and for any other RH commodities selected for the SPARHCS?	There is no dedicated budget line for contraceptives. To date commodities are purchased by adhoc arrangements.
9. Are there regulations that limit client access or choice? Examples include a minimum age requirement, marital status requirement, spousal permission requirement, and parity (minimum number of living children requirement). If there are regulations, list them.	None. However, service provider attitudes and practices hinder adolescents and unmarried young persons at Service Delivery Points.
10. Is there policy or regulation prohibiting advertising of products? If, yes, list the policy.	Yes. There are restrictions on airing time for radio and television advertisements for condoms
11. Is there a policy requiring employers to pay for RH products and services for employees?	None

Question	Answers with respect to Contraceptives and Condoms
12. Are RH products and services covered under a national insurance or national health system?	Yes; under the national health insurance scheme which presently covers only the public sector and selected organized private sector
13. Are these products manufactured in the country? If so, list the name of the manufacturer(s) and any data on quantities of these products manufactured in a recent year.	None

Table 11. Policy Rating Result

Response = Much less than effective; less than effective; effective; more than effective; very effective; don't know; not applicable

1. How effective is the national population/RH policy?	Less than effective
The 1988 National Population Policy (NPP) had problems with implementation. The revised NPP (ratified in November 2001) is yet to be approved. The RH Policy 2001 is yet to be implemented. A strategic framework and plan for the RH policy has just been developed and adopted.	
2. Is there high-level government support for RH policies/programs (funding, supportive statements, etc.)?	Less than effective
There is evidence of good political support based on statements by leaders at all levels. However, support from government has not been matched with funding.	
3. Is there effective coordination among/between national governments, NGOs, private sector, and international donors and funders?	Less than effective
Coordination is improving but still weak. A national guideline for coordination, monitoring and evaluation of the national population program has just been developed.	
4. If there are policies in the area of health sector reform (decentralization, integration, financing), do they support RHCS effectively?	Less than effective
The Federal Ministry of Health's Health Sector Reform Process is still on going under the World bank supported Health System Funds Development Project. The project intends supporting the Reproductive Health Contraceptives Security (commodity purchase).	

5. Is government action to provide services effective?	Less than effective
Reproductive Health interventions have been mostly uncoordinated and marked by vertical initiatives and projects. However, the development of the RH Policy and Strategic Framework and Plan is an evidence of governments resolve to provide more effective and efficient RH services.	
6. Does the MOH support logistics for commodities, such as communication with staff, in-service training, and budget support for logistics services?	Effective
Federal Ministry of Health has no budget line for RHCS. However, there is a Commodities Management and Logistics system in place. Staffs are trained but there is still a great need to further strengthen staff skills, and improve the communication and logistics systems.	
7. If there is a stated policy on HIV prevention, is it being effectively implemented? (Programs, funding, supportive statements, etc.)	Effective
There is a multisectoral national response and plan of action (HIV/AIDS National Emergency Plan). There is also a high level political commitment and popular support. The National Agency for AIDS Control has just been established (July 2002). The National HIV/AIDS Policy is under review.	
8. Does government effectively support the role of the NGOs?	Less than effective
Government seems to appreciate the role of NGOs in Reproductive Health. However, there is no concrete and sustained support to NGOs. Token involvement of a few groups, for example, the planned Parenthood of Nigeria (an major NGO in FP/RH), in workshops and decision-making events. No national NGO/Civil Society networks exist to support RHCS efforts.	
9. Does government effectively support the role of the Commercial (for profit) Sector?	Much less than effective
Government has not been able to create and maintain the right environment to support the commercial (for profit) sector despite the significant role they play in RH service delivery in Nigeria. For example, there is 25% tariff on RH commodity imports plus 5% tax. Delays at the Nigerian ports create a huge cost in demurrages that are consequently borne by the RH clients. The Commercial sector representatives are often ignored by key policy decision-making bodies.	

10. Is there effective communication between RH stakeholders and the mass media journalists in support of RH causes?	Less than effective
Isolated and adhoc contacts exist between RH stakeholders and media jounalists.	
11. Do civil societies receive effective support or training from the RH stakeholders so that they can advocate for RH causes?	Less than effective
The civil societies often benefit from capacity building schemes, which are mostly driven by donors/partner agencies. These opportunities are most often uncoordinated. As a result, only the few well-known groups keep getting the supports.	

Table 12. Analysis Sheet on Stakeholder Policy Process

Question on Stakeholder Policy Process	Yes	No	Comment/Specification
1. Is policy usually made within the organization (as opposed to collaboratively with other organizations?	7	5	Depends on how it affects the organization; During emergency situations; Sometimes a combination of both to ensure completeness; Cannot be internal affair if it affects people's lives.
2. Are information/data sought in policy development (data-based decision making?)	11	1	When enough time exists.
3. Is there need to help stakeholders have a common view and understanding?	11	1	To achieve a common good; It is necessary sometimes and if it not detrimental to the state.
4. Is policy change in the organization impacted by advocacy groups?	9	3	It depends on situation; When national interest is primary; Advocacy groups have an input to make; Not always; Yes, advocacy groups of the profession.
5. Is policy change in the organization impacted by the media?	8	4	Sometimes if it is for public good; At times as long as objectivity is maintained; Dissemination is very basic; To some extent.
6. Is policy change decentralized?	7	5	So as to maintain consistency and eliminate bias; Helps the monitoring units to function;

Question on Stakeholder Policy Process	Yes	No	Comment/Specification
7. Would it be feasible to influence this policy change in the organization?	11	1	If it is to the overall advantage to the nation
8. Would this change in the organization really impact RHCS?	10	2	Since government policy is binding on citizens and other stakeholders; If the organization is part of the health sector;

4.5b SWOT Analysis

Internal Strengths	Internal Weaknesses	External Opportunities	External Threats
▪ The National Reproductive Health Policy and the 2001Revised National Population Policy support RHCS issues ▪ Relevant national policies are available indicating commitment of government to support RHCS agenda. ▪ Skilled and committed personnel are available and willing to move strategies forward. ▪ Vibrant Private commercial sector. ▪ Successful Social Marketing Program with nationwide coverage. ▪ High-level political support to HIV/AIDS at the national presidential level. ▪ Improved political environment that could support strategies for RHCS strategies. ▪ Universal Basic Education Program will improve literacy level. ▪ Growing NGO/Civil Society activities in support of population and RH issues.	▪ Weak political support and commitment at national and none at state and local government levels. ▪ Poor funding and zero budget line for RHCS (mainly ad hoc) ▪ High customs tariffs and taxes on RH Commodities and condoms ▪ No specific policy on RHCS ▪ Weak coordination for RHCS at all levels ▪ Weak monitoring and evaluation system. ▪ Weak advocacy efforts ▪ No private sector involvement in policy decision making ▪ Active private commercial sector but not involved in government policy decisions ▪ Restrictions on media advertisement of RH commodities and condoms ▪ Media coverage of FP/RH issues is weak ▪ Poor decentralization of RH/HIV/AIDS issues ▪ High level of misinformation on FP issues.	▪ Donor funding and technical assistance available for development of RHCS strategic plan ▪ USAID/POLICY and UNFPA funds available for advocacy ▪ RAPID Model for Nigeria launched ▪ POLICY to support use of RAPID for advocacy by FMOH and NGO/Civil Society Networks ▪ POLICY to strengthen NGO/Civil Society Networks at Zonal and state levels for RHCS ▪ RH development partners coordination meeting is being revived.	▪ Weak commitment from FMOH staff ▪ No budget-line and no funding from MOH for RHCS at all levels ▪ No political support to population and reproductive health issues ▪ Continued resistance, misinformation and barriers to FP and use of condom

4.5c Gaps Identified

Through a careful process of analysis of the prevailing policy environment, the following problems were identified:

- Weak political support and commitment on RHCS.
- Poor budgetary allocation on RH commodities and condom.
- High tariff and tax on RH commodities and condoms.
- Weak advocacy for population and RH issues.
- Restrictions on advertisement of RH commodities and condoms.
- Poor mechanism for effective private sector involvement.
- Poor mechanism for NGO and Civil Society involvement.
- Poor media involvement in support of RH issues.

4.5d Priority Areas for Action

- Advocacy for political support and creation of functional budget line and improved services.
- Strengthening of program coordination, monitoring and evaluation.
- Establishment of functional mechanisms for private sector/civil society/media involvement.
- Developing functional mechanisms for cost recovery schemes.

4.5e Short-term Tasks

- Dissemination of RAPID and REDUCE models to create a supportive environment for Population and Reproductive Health policies/program and SPARHCS.
- Policy Environment Score (PES) to determine the baseline environment for RHCS
- Confirm Customs Tariffs and Taxes – whether generalized or specified by commodity types.
- Find out details of the Advertising Practitioners Council of Nigeria's (APCON) regulations on RH commodities.
- Find out whether RH and FP services are covered in the provisions for the rural and informal sector under the National Health Insurance Scheme (NHIS).

4.5f Long-Term Tasks

- Review of Operational policies, guidelines and procedures at the clinic level
- Organize and Coordinate RHCS Stakeholders Forum
- Inaugural meeting
- Quarterly meetings
- Organize and coordinate Public Private sector Forum
- Bi-annual meetings
- Advocacy Skills Building /Training
- Advocacy meeting for political support and resources (including waivers) for RHCS.
- Monitoring and Evaluation of RHCS and SPARHCS

4.6 PRIVATE SECTOR

4.6a Introduction

Assessing the share of the private sector in overall reproductive health product supply and predicting the likely evolution of this sector can contribute to the design of a sound national contraceptive security strategy. Any "gap" between donor funding for commodities and the expected need for reproductive health products can be met in part by commercial brands sold through the private sector.

Based on a review of relevant documentation and reports, as well as interviews conducted with key stakeholders[2], the team was able to develop an overview of the private sector in Nigeria that included:

1. Market size and key players
2. Policy environment
3. Commercial Infrastructure
4. Donor funding

The Team identified key issues to be addressed (summarized in the following SWOT analysis), and came up with series of recommendations, some of which were prioritized for inclusion as Task Summary Sheets.

The NGO sector was well represented on the team, and their perspective therefore was well considered and documented. However, other key private sector players who could potentially have provided valuable insight to the process, were not present. This was particularly true of the private commercial sector. Input from some of these players was received *via* interviews, but more depth would have been useful, and not all players could be contacted.

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[2] Interviews were conducted with National Association of Community Pharmacists, Patent Medicine Dealers Association, Guild of Medical Directors, Association of General and Private Medical Practitioners, National Association of Private Nurses and Midwives, Nigerian Medical and Dental Council, Nursing and Midwifery Council of Nigeria, Pharmaceutical Society of Nigeria, Society of Gynecologists and Obstetricians of Nigeria, Planned Parenthood Federation of Nigeria, Society for Family Health, Association of Reproductive and Family Health, Chi Pharmaceuticals (representing Schering and Organon), Pharmacia, Wyeth, Pharmacies (3), Patent Medicine Stores (2), a Private Clinic (1), and a Private Hospital (1)

4.6b SWOT Analysis

STRENGTHS	WEAKNESSES
• Widespread coverage (re: PMS) • Serve a large number of people (51.3% of the population, NDHS, 1999) • More accessible (location and opening hours) • Less bureaucratic • Diversity of options for people to choose from (pharmacies, PMS, clinics)	• High cost of many products (commercial sector) • Poor regulation and control (particularly PMS) • Utilization of unskilled and untrained personnel • Practices such as the deliberate sale of expired products • Poor commodity management (e.g. poor storage conditions, not utilizing FEFO) • Wide (too wide) range of products on the market competing with commercial sector commodities • Subsidized social marketing products untargeted, raising the possibility that a substantial share leaks to people who would otherwise have purchased the product at the full price. • With the exception of PMS, they do not effectively reach poor/rural communities • Provide small proportion of long term methods (injectables and IUDs)
OPPORTUNITIES	**THREATS**
• Growing urban population (easy access for commercial sector) • Effective distribution network already in place • Demand creation activities taking place (but focused on condoms) • High out-of-pocket expenditure. Every member of the population pays for contraceptives – no exemptions, even in public sector. • No price controls for contraceptives • Well established social marketing mechanisms that may strengthen the private sector (and also the public sector) by creating new demand that spills over into demand for full-priced commodities (expands the market) • Tax exemption for donated commodities • Increasing attention of international agencies and researchers to contraceptive security • Possibility of purchasing low price contraceptives in bulk from international agencies	• Subsidized products in public and social marketing sectors (threat to commercial sector in short term) • Cultural and religious barriers, particularly in certain regions. • Restrictions on advertising (both health facilities and products/brands) • Tax exemption policies for donated products cumbersome and long • Tariffs on importation and taxes levied on commercial sector commodities. • Restrictions on remittance of funds (e.g. by pharmaceutical manufacturers) • No credit facilities available • Majority of population poor (66% below poverty line)

4.6c Priority Areas for Action

1. The Northern and rural areas of Nigeria represent not only the highest area of need in Nigeria, but also the greatest untapped potential for provision of family planning and reproductive health services. While for humanitarian reasons, these are obvious focus areas for provision of services, the social benefits of working in these locations would have to be weighed against the inherent risks these areas pose for the development of the private sector. For instance, the Northern and rural populations tend to be poorer and thus less likely to afford commercial sector prices. In addition, infrastructure such as roads and communication channels are likely weaker and thus less conducive to profitability of the private/commercial sectors.

2. A major constraint in defining both the current private sector market size as well as its future role is the dearth of detailed, country-specific information on its magnitude and configuration and the constraints to its development. Further research in this area needs to be conducted. A fundamental piece of research for defining the private sector market share and potential is a market segmentation study including the willingness and ability to pay of consumers. Information from this could be used to develop a market segmentation strategy that defines and promotes complementary roles for the public and private sectors (including social marketing, the commercial sector, and NGOs), specifically, which segments of the population each sector should cater to. This would be based on client need and ability to pay. This methodology should result in the most cost effective use of funds; the public sector could focus its resources on those most in need while promotion of the commercial sector would be aimed at those who are able to pay. In turn, the strategy would inform the development of targeting strategies and policies to ensure that publicly subsidized services and contraceptives are delivered to those groups who have the greatest need. Market segmentation questions could be included in the Household Survey to be conducted in 2003 by the Federal Office of Statistics. In addition, some relevant questions could be included in the Demographic and Health Survey, also to be conducted in 2003.

3. PMS and pharmacies are the most accessible sources of contraceptives for Nigeria's population, and already are the major source of pills and condoms. To address the serious issues of quality among PMS, there is a need to recognize their contribution, to license them to provide a wider range of contraceptives, to train them, and to set up regulatory and control mechanisms.

   Advocacy first should be conducted to change policies, laws and regulations restricting the range of products PMS and pharmacies can administer/provide. With adequate training and supervision, PMS could add pills, including emergency contraception, to the over-the-counter products they are legally permitted to supply. Pharmacists could be trained to administer injectables. The National Council of Women already has initiated some steps towards lobbying for such change.

Areas for training should be identified via a training needs assessment, but would likely include commodity logistics and management, and interpersonal communication and counseling, two areas identified as deficient among pharmacies. SFH already has experience in training pharmacists in injectable provision (when this product first was launched).

Towards ensuring quality, there is a need to institute regulation and/or supervision strategies for monitoring private sector providers. This could be performed through the umbrella and regulatory bodies/associations such as Patent Medicine Dealers Association or the Pharmaceutical Society of Nigeria/National Association of Community Pharmacists.

Non-traditional outlets (including kiosks, table shops, super markets, grocery stores, petrol filling stations, and hawkers), which are playing an increasingly important role in the provision of contraceptive services in Nigeria, could also be identified and trained. In addition, the role of community health workers could potentially be strengthened.

4. There is a need not only to strengthen the existing distribution network in the private sector but also to develop/strengthen private sector collaboration and partnership (already existing with SFH and PPFN) with the public sector in commodity logistics and distribution in order to address the serious deficiencies in the public sector's own logistics system. This may include joint sourcing of contraceptives to achieve lower costs through the economies of scale or contracting out to the private sector contraceptive procurement, management and distribution.

5. In interviews with a variety of providers (PMS, pharmacies, clinics), each stated that the two most important factors hindering the population's use of contraception are 1) lack of awareness and information, and 2) religious or cultural issues.

   There is thus a need to develop demand creation programs – e.g. generic campaigns for family planning. Another important area that needs to be addressed is behavior change communication and advocacy among traditional rulers and religious leaders to overcome cultural and traditional barriers to contraceptive use, particularly in the North.

6. Increase public/private sector partnership and collaboration through increased dialogue between the two and bring key private sector players into the commodity security dialogue. Ensuring private sector participation in relevant workshops and meetings also is crucial. This can take place through existing fora such as the State Design Team for the Vision Project and the National Working Group on Reproductive Health. Also replicating successful state-level models for dialogue in other states could be a successful strategy.

7. Commence dialogue to reform policies on advertising restrictions for reproductive health commodities, including allowing the promotion of specific brands.

8. Advocate for policy reform in the process for applying for tariff exemptions for donated commodities and/or exempt all import tariffs and VAT on reproductive health commodities including contraception.

9. Explore the proposed content of a National Health Insurance Scheme particularly with regard to family planning coverage. If necessary, advocate for the inclusion of family planning coverage in the national health insurance scheme. Develop and implement an advocacy program for expansion of the national health insurance scheme to include family planning services and commodities for the people in the informal sector including the poor. Conduct an in-depth analysis to assess the feasibility of establishing a community based insurance or revolving fund scheme and involving community based social/women groups and structures. In addition, private entrepreneurs should be encouraged to establish health insurance schemes.

4.6c Short-term Tasks

- Training of different categories of NGOs/private sector service providers including operators of non-traditional outlets

4.6d In-depth Analysis

- Assessing feasibility for local production of contraceptives

4.7 SERVICE DELIVERY

4.7a Introduction

The Service Delivery Component of SPARHCS is intended to examine the overall access, availability, affordability and quality of services for the target population for FP/RH commodities. During the basic diagnosis, the national service delivery team assessed the following:

Survey I (Product Availability) - the number of service delivery sites and other facilities involved in the managing and storing of commodities in the pipeline to the SDPs, average duration of stock-outs at the SDP level, number of stock-outs at other levels (central, regional and district) and average duration of stock-outs at other levels;

Survey II - norms and standards for available services and commodities, informed choice, client satisfaction, product availability, provider satisfaction and client accessibility to the SDPs;

Survey III – support of traditional practitioners by the SDP, effective practice to operate the SDP during a time which best serves the population, and norms and standards for:

1) documentation system (guidelines, protocols, job aids),
2) training of service providers,
3) provider performance,
4) addressing stock-outs,
5) management support provided to the providers.

SERVICE DELIVERY COMPONENT TEAM MEMBERS

Dr. O.A. Smith – Asst. Director/PMO II; RH Focal Person; FMOH/Dept. of Hospital Services
Mrs. E.O. Ladipo – Principal Community Health Sister; RHFP/DCDPA/FMOH
Mrs. U.I. Acha – Principal Nursing Officer; RHFP/DCDPA/FMOH
Mrs. Foyin Oyebola – USAID Nigeria

The team was generally knowledgeable about RH/FP service delivery issues, however, recent studies or literature were not readily available. Furthermore, because many NGOs involved in RH service delivery activities were not present, they could not be interviewed. However, the service delivery team was able to carry out structured and semi-structured interviews with other key stakeholders, which included public clinics, a public hospital, SFH, PPFN and the FMOH. The service delivery team was able to utilize preliminary data from the LSAT and LIAT, carried out by JSI/DELIVER. The information provided by JSI/DELIVER was particularly useful to the service delivery team because it showed evidence of contraceptive stock-outs at SDPs throughout the country. The team also reviewed the available literature and studies relevant to service delivery. Based on these interviews and the literature review, the team identified gaps in service delivery and came up with several short-term tasks to address the weaknesses in RH/FP service delivery.

4.6b Key Issues

Norms and Standards

- Outdated FP/RH service policies, standards, protocols, norms and guidelines
    - SOPs have not been updated and revised but new SOPs are in the process of being reviewed
- Lack of basic amenities: Unhygienic conditions, poor status, weak infrastructure, lack of water, lack of light and inadequate material support (e.g., equipment, IEC/BCC materials and drugs)
    - Lack of financial resources
    - Lack of maintenance of equipment
- Lack of management process (job descriptions, performance expectations, systems for feedback and self-evaluation and supervision/monitoring)
    - Lack of resources, planning and training
- Lack of integration b/w FP and RH (i.e., HIV/AIDS/STIs) services

Client Satisfaction

- Lack of client satisfaction
    - Poor interpersonal relationships and client provider interactions in the FP clinics
    - Long-waiting times
    - Short-duration of contact with the provider
    - Clients treated inappropriately by the SPs (e.g., discrimination of poor clients)
    - Lack of privacy and confidentiality

Provider Satisfaction

- Inadequate FP/RH knowledge and skills of SPs
- Insufficient number of trained SPs
    - Frequent transfer of providers
    - Absence of training and continuing education
    - Lack of financial resources
- Non-committed providers at FP clinics
    - Not clear about job expectations
    - No organizational structure, culture or support
    - Absent supervision

Access

- Poor service availability
        - Clinic hours do not always best serve the population
        - Lack of transport
- Inadequate number of sites for FP service delivery does not meet the needs of clients
- Absent outreach activities and inadequate public awareness and client information on FP methods
- Inadequate adolescent RH services
    - Limited youth-friendly SDPs
    - Unfriendly, judgmental, lack of gender sensitivity

Product Availability

- Inadequate provision of family planning services
    - Lack equipment and commodities (e.g., Norplant)
- Irregular supplies of commodities and the non-availability of contraceptive methods at primary service delivery sites
    - Inadequate system to place emergency orders or get additional stock
    - Inadequate supply of LMIS forms
    - Staff lack training in how to fill out LMIS forms
- Inadequate method-mix in clinics and insufficient number of sites offering FP methods in rural areas
    - Lack of motivation of providers
    - Lack of financial resources and materials
    - Lack of long-term planning

- No system in place to provide temporary/back-up contraceptive methods when stock-out exists

4.7c Short-Term Tasks

- Information-Sharing Meeting (For Organizations Involved in RH/FP Service Delivery)
- Review and Update Existing FP Protocols/Guidelines/Policy and Develop Job Aids and SOP
- RH/FP State Coordinators Meeting
- Advocacy Meeting for State Policy Makers
- Implementation of COPE

4.7d In-depth analysis

In-depth analysis activities are being carried out in cooperation with other Component groups.