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**Reproductive Health Commodity Security
Country Case study: Nigeria**

**Commissioned jointly by
The Department for International Development and the
Netherlands Ministry of Foreign Affairs**

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October 2005

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Acknowledgements

The team would like to express its thanks to all those who generously shared their time and insights to inform this report, and trust that it will be useful to national as well as international players. However, the authors take all responsibility for the content and any inaccuracies.

Abbreviations

AFRH	Association for Family and Reproductive Health
ARVs	Anti-Retroviral Drugs
CHAN	Christian Health Association of Nigeria
B/CEOC	Basic and Comprehensive Essential Obstetric Care
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisation
CIDA	Canadian International Development Agency
DCDPA	Department of Community Development and Population Activities
DFDS	Department of Food and Drugs Services
DFS	Department of Finance and Supplies
DHPR	Department of Health Planning and Research
DHS	Demographic and Health Survey
DPH	Department of Public Health
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
FP	Family Planning
HSDP	Health Sector Development Programme (World Bank)
HSR	Health Sector Reform
ICs	Injectable Contraceptives
IUD/IUCD	Intra-Uterine Contraceptive Device
LGA	Local Government Area
MCH	Maternal and Child Health
MICS	Multi Indicator Cluster Survey
MDG	Millennium Development Goals
MMR	Maternal Mortality Reduction
MVA	Manual Vacuum Aspiration
NACA	National Action Committee on AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NARHS	National AIDS and RH Survey
NASCP	National AIDS and STI Control Programme
NEEDS	National Economic Empowerment and Development Strategy
NGO	Non Government Organisation
NHMIS	National Health Management Information System
NPHCDA	National Primary health Care and Development Agency
NPI	National Programme on Immunization
OCs	Oral Contraceptives
PAC	Post Abortion Care

PATHS	Partnership for the Transformation of Health Services
PHC	Primary Health Care
PPPs	Public Private Partnerships
RH	Reproductive health
RHCS	RH Commodity Security
RTIs	Reproductive Tract Infections
SDP	Service Delivery Point
SEEDS	State Economic Empowerment and Development Strategy
SFH	Society for Family Health
SPARCHS	Strategic Pathway to RHCS
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate

1. Executive Summary

1.1 Introduction and background

DFID is supporting country studies in Cambodia, Nigeria, Uganda and Zambia, in order to contribute towards an improved understanding of RH commodity security (RHCS). The studies aim to provide evidence for specific proposals for action at country and/or international level, and for dialogue with bilateral and multilateral donors on the resolution of RH commodity supply crises, within the Reproductive Health Supplies Coalition. A further two country studies are taking place in 2005, financed by the European Commission.

A team of two consultants, Nel Druce (HLSP Institute) and Yomi Oduwole (Futures Group Europe) undertook the Nigerian case study in October 2005. The team used the standard methodology developed for the case studies, including interviews and document review. A marker group of commodities was tracked, linked to reproductive health services, including safe motherhood, STI prevention and treatment, and family planning.

1.2 Context

Reproductive health: Nigeria's CPR is among the lowest in the world, with only about 8% of currently married women using a modern method. There are significant regional disparities, in line with poor education and socio-economic indicators in the Northern states. Low use is linked to low demand, with continuing preferences for large families, as well as difficulties in accessing services.

The 2003 Nigeria DHS indicates that over half of users (58%) obtain their oral contraceptives from the private sector – whereas two-thirds of IUD clients use the public sector. Socially marketed brands account for over 80% of reported condom use, and nearly three-quarters of OCs sold or distributed.

Maternal morbidity and mortality are very high. Abortion is illegal unless it is to save the mother's life, but there are over 600,000 unsafe abortions a year, which account for over a third of maternal deaths in facilities. According to the DHS, the proportion of women giving birth at a facility ranges from only 10% in the poorer northwest to up to nearly 85% in the southeast.

Policy environment: Following decades of military rule, Nigeria's health system is viewed as weak, poorly co-ordinated and fragmented, with substantial devolution to state and local government levels where capacity is limited. The reform-minded minister is initiating far reaching health reforms. These are in line with Nigeria's national development and poverty reduction strategy, NEEDS, which also emphasises MDG achievement.

Reproductive health is highlighted in the national health reform strategy, with a focus on maternal health and access to essential obstetric care. Policy and strategy recognise the importance of RHCS as the need for strengthening equipment and commodities supply and logistics. The reproductive health policy includes a range of family planning methods, as well as access to emergency contraception and post-abortion care.

There is substantial dependence on external funding across all Federal departments, including for public sector RH activities. However, RH was allocated a budget at

Federal level for the first time in recent years (albeit nominal) in 2004, following strategic advocacy by the RH Unit for a newly named budget line for maternal mortality reduction.

Overall, donor co-ordination in the health sector is described as weak, both between partners and with government. Although there are several co-ordination fora for RH, they are regarded as consultative and informational rather than strategic in function.

Procurement and distribution: Most essential drugs and supplies (including for safe motherhood and STIs) are purchased at state and facility level. There is widely reported lack of transparency, and limited economies of scale or use of quality assured sources. Supplies are erratic and weak, dependent on out-of-pocket (patient) finance, and frequent emergency local procurement by facilities. Certain Federal vertical programmes, including TB, immunisation, and ARV treatment, store and distribute commodities centrally, although logistics are weak.

There are two main commodity procurement channels. All public sector contraceptives, and some condom procurement, are secured by UNFPA on behalf of government, drawing on country programme and CIDA funds, as well as global level UNFPA funds. The majority of condoms as well as significant proportions of contraceptives are provided by the social marketing programme run by Society for Family Health (SFH), funded by DFID and USAID. This is regarded as one of the most efficient social marketing programmes in the world, with commodities purchased from PSI. Condoms are also about to be supplied through the World Bank MAP via NACA to states.

National drug policy: All products provided by UNFPA and SFH, and the majority of safe motherhood supplies, are represented on the essential drugs list and registered with NAFDAC, the national food and drugs regulatory agency. (The concerning exception is magnesium sulphate, used to treat pre-eclampsia and eclampsia.) Commercial sales of contraceptives are low: limited presence in the market is attributed by suppliers to the negative impact of leakages of public sector commodities. Leaked products at low prices were verified during pharmacy visits carried out during the assessment.

1.3 Findings

In this context, recent efforts to strengthen Nigeria's FP commodity supply system are positive. Nigeria was the first country to adapt and use the international SPARHCS guidelines. The process resulted in three major outputs:

- a thorough assessment and understanding of the problems and challenges for the six components of RHCS (finance, policy, logistics, service delivery, demand and co-ordination)
- a consensus among the major government and development partners about short and medium term actions needed, with special focus on re-designing and re-introducing the Commodity Logistics Management System (CLMS).
- an RHCS strategy – the Strategic Plan for Reproductive Health Commodity Security 2003 – 2007, plus financial projections to 2015.

Its initial success was due to the combination of strong government leadership by the RH Unit, co-ordinated technical inputs provided by JSI DELIVER and UNFPA, and by the engagement and involvement of stakeholders across public and private sectors. The RHCS Stakeholder Group continues to be consulted on major issues.

In terms of results, there have been improvements in availability at service delivery points – availability of most commodities is above 75% at all levels. This is in contrast to an assessment in 2001/02, which revealed equally high levels of stockout of contraceptives.

However, there are also serious concerns. There is limited funding for training in some states, and the new pull system is demanding on facility staff. Reporting and stock management at all levels is weak, which severely limits accurate forecasting and appropriate stocking. Overall, government capacity to forecast and to budget and plan for commodity supply is growing, but still has limitations.

The initial SPARHCS process was restricted to contraceptives and condoms, although ministry staff were cognisant of the serious needs relating to maternal health. The RH Unit and development partners are finalising a proposal to develop a safe motherhood (delivery) kit. Questions of costing and pricing, and funding, procurement and distribution are to be clarified – however, it seems likely that the kit will be procured at central level and distributed through the CLMS.

Religious leaders and scholars are major players in the success or failure of policy advocacy efforts, and in shaping consumer demand. Advocacy among both opinion leaders and consumers must be tailored to the Nigerian context, which is affected by a complex mix of national and international influences. The US government's position on RH issues is felt indirectly, as well as directly expressed in financing restrictions. It is also the case that many Nigerians independently hold similar views to that of the US Congress, supporting the recent stress on abstinence, for example.

Recent efforts by NGOs and government, funded by USAID, have engaged Muslim leaders in developing a supportive position statement on RH policy, and included a study visit to Bangladesh, where a range of RH services are compatible with Islamic law.

Overall, about 40% of health services are provided by Christian organisations, but this varies greatly by state, from over 75% in some states to near zero in the predominantly Muslim north. Use of mission facilities is quite low across much of the south. Although CHAN has an HIV/AIDS policy, dialogue on, and promotion of family planning is limited. CHANPHARM became an independent not-for-profit procurement and distribution agent, and is perceived as increasingly effective and well-governed. However CHANPHARM neither stocks nor supplies contraceptives and condoms.

Other civil society players include IPPF's affiliate, PPFN, and several indigenous NGOs, such as ARFH, carry out advocacy, and provide commodities and services. IPAS Nigeria is promoting access to EOC in several states, including post abortion care plus wider service strengthening.

1.4 Conclusions and recommendations

Re-positioning reproductive health: Federal government and major donors stress the achievement of the child and maternal health MDG goals. However, the focus has been on access to essential obstetric care. This may represent a missed opportunity, given substantial evidence that child spacing improves both mother and children's health. This so-called repositioning of family planning is helping advocacy for prioritising and financing the RH package. Such a position also takes into account socio-cultural discomfort with family planning promotion as a separate activity, and preferences for the term 'child spacing'.

Innovative work for an enabling environment should be continued through strengthening informed demand among people as both consumers and citizens, and their leaders or representatives. Continued advocacy among opinion leaders, especially religious leaders, is critical.

Financing mechanisms: National efforts to improve RHCS can be in part attributed to the legacy of the pre-1999 military government. The withdrawal of USAID in 1995, following the international de-certification of Nigeria, had a profound and devastating impact on RHCS, and brought questions of finance and sustainability to the fore. These concerns are linked to the introduction of the four level cost recovery system, as part of the CLMS, which enables the ring fencing of funds at each level to support purchase from the next level, transport and supervision.

At Federal level, a commodity fund is accumulating. This is building strong government ownership, and is a step towards reducing dependence on external finance (albeit mainly of symbolic value at present). It also could provide an opportunity for channelling matching finance (from development partners or Nigeria's new debt relief) to commodity purchase, for example to build a national revolving fund for maternal health commodity supply, managed by Federal government.

Health system development: In effect, a highly verticalised system has been re-introduced for contraceptive supply (operating in a similar way to that of the TB programme, for example). This is not surprising given the weaknesses in the health system at state level, poor access to other commodities such as essential drugs, concerns about the marginalisation of family planning in the face of public health emergencies, and the continued donor support to vertical programmes at Federal level, including new ARV programming.

However, such an approach must aim to dovetail with medium term health system development plans, especially for state and LGA levels. Building on their current state programmes, DFID and WB are planning to focus on 'lead states' from 2006. While Federal and international resources for RHCS will continue to be critical, it seems that additional resources could also be leveraged at state level.

Demand creation: There is wide awareness that, with supply side improvements, major efforts are needed to encourage more clients in both public and private sectors, which have to date been limited.

So far, national RHCS actions have focused mainly in the public sector. Reasonable collaboration takes place between the public sector and social marketing programmes, but there is also some territoriality. The government may consider reviewing its role as a 'dual champion': to take care of the public sector on the one hand, but also to take a strategic overview of the whole market – public, social marketing, NGO and commercial - in order to ensure that all citizens have access to the best possible products at a price they can afford.

It is recommended that the issue of demand creation is used as an entry point to a more strategic approach for overall market development and developing the role of PPPs. Consideration should be given to designing a facilitated process to support stakeholder dialogue and strategy formulation, through the RHCS Stakeholders Group. Condom policy and programming would benefit greatly from an independent rapid review of all players in the market, commissioned by NACA.

Role of UNFPA: UNFPA's technical contributions to the SPARHCS process and to the joint development of the CLMS are critically important and widely recognised.

However, the agency could enhance its support to facilitate overall government leadership in developing its broader strategic role, for example in stewarding the overall market, or in building planning capacity at state level.

The commodity financing procedures and arrangements of UNFPA appear rather opaque to stakeholders. It is important that the total value of commodities, including any in-kind supplies from UNFPA NY is known and included in the annual RHCS plan and budget, even if they are financed and procured through funds held by UNFPA in the medium term.

It is recommended that the DCDPA is further facilitated to play the lead role in forecasting, monitoring and budgeting for supplies (albeit through a virtual budget held by UNPFA). As part of building government ownership, strengthening communication and involvement are recommended – through for example, involving developing country government representatives in governance functions of any global level financing mechanism.

Access and equity: The cost recovery system involves charging a fee to all clients, irrespective of socio-economic status. Prices to consumers are set below those of private and NGO providers. However, there is no information on access by the poorest. This assessment supports the recommendation by the UNFPA Country Support Team for a study to assess access and willingness to pay by the poorest.

Quality assured suppliers: Pre-qualification by a recognised international process of both generic and branded suppliers could help fast track NAFDAC regulatory processes, especially for generic products, although the product must still be registered by NAFDAC.

Essential commodities - magnesium sulphate: This assessment noted that magnesium sulphate is not on the essential drug list, and nor is it widely available or used for treatment and prevention of pre-eclampsia or eclampsia. It is recommended that the RH Unit review WHO's guidance and evidence, with a view to considering and taking any necessary steps.

2. Introduction and methodology

DFID wishes to contribute towards an improved understanding of RH commodity security (RHCS) at country level within the wider policy environment and support for sexual and reproductive health and rights by:

- applying a 'drivers of change' lens to the agents, structures and institutions involved in selected countries and examining the impact of new aid mechanisms such as poverty reduction budget support and health SWAPs on commodity security;
- undertaking detailed country studies that lead to specific proposals for action at country and/or international level; and
- providing evidence for consensus building with bilateral and multilateral donors towards effective resolution of RH commodity supply crises and strengthening dialogue within the Reproductive Health Supplies Coalition.

Through the DFID Health Resource Centre, DFID is supporting country studies in Cambodia, Nigeria, Uganda and Zambia. A further two country studies taking place in 2005 are financed by the European Commission.

A team of two consultants, Nel Druce (HLSP Institute) and Yomi Oduwole (Futures Group Europe) undertook the Nigerian case study in October 2005. The team used the standard methodology developed for the case studies, including tracking a group of marker commodities to represent supplies required to deliver reproductive health services. A list of key informants is attached as at Annex 1, documentation consulted is at Annex 2, and TORs at Annex 3.

3. Country context

3.1 RHC demand and supply profile

3.1.1 Use of contraception and condoms

Nigeria's CPR is among the lowest in the world. According to the 2003 Nigeria DHS, only about 8% of currently married women use a modern method (total 13% traditional and modern). Preferred methods are injectables, the pill and male condoms. There is a slight upward trend from the 1999 survey (compared to the increase from about 3% in 1993 to over 7% in 1999). Married women in urban areas (20%) are twice as likely to use a modern method as their rural counterparts. Use of modern methods is much lower in the poorest quintile (7%) versus the richest (30%).

There are significant regional disparities, in line with education and socio-economic indicators. In the wealthier Southern states, where women tend to be better educated, the average family size is 4.1 children, and 10-20% of currently married women use contraception. The TFR is nearly seven in the poorer Northern regions, where the CPR is only 3%. Marriage and sexual debut tend to be earlier in the North. Cultural and religious factors are important – about one quarter of women are opposed to family planning or face opposition from a family member or someone else.

There is evidence to suggest that low use continues to be linked to low demand, as well as difficulties in accessing services. Knowledge is high - eight out of ten women and nine out of ten men know of at least one modern method. Nigerians continue to

express a desire for large families, which is the most common reason for not using contraception. Women have an average of 5.7 children (TFR), with no major difference between urban (4.9) and rural (6.1) women. Although educated women have fewer children, those in the richest quintile have an average of over four.

Overall about half of married women want to delay their next birth or to limit family size. Unmet need is only 17% – women who want to limit family size or space births, but are not using contraception. Two thirds of non-users among married women do not intend to use a method in the future. Ever-use of modern methods is much higher – about one third of married women, and over 60% of sexually active unmarried women.

Public sector facilities charge a fee for contraceptives, in common with other health services and commodities. The NDHS indicates that over half of users (58%) obtain their contraceptives from the private sector – with nearly three quarters of OC users buying from pharmacies, whereas 66% of IUD clients use the public sector.

While the socially marketed brand, 'Gold Circle' accounts for over 80% of reported condom use, it is more difficult to assess market share for OCs and ICs, as brand recognition by respondents is much lower. Commodity sales and distribution data show that 15% of OCs in the market were provided by the public sector, with three-quarters accounted for by the socially marketed brand. The share for ICs is roughly equal. See Table 1 for a summary of the market breakdown.

3.1.2 Other reproductive health issues

Maternal morbidity and mortality remain very high. The 1999 MICS found an MMR of 704, ranging from 166 in the South to over 1500 in the North. About 40% of women experience pregnancy related and other reproductive health problems, such as vaginal fistula. Abortion is illegal unless it is to save the mother's life, but there are over 600,000 unsafe abortions a year, which accounts for over a third of maternal deaths in facilities.

According to the DHS, the proportion of women giving birth at a facility ranges from only 10% in the poorer northwest to up to nearly 85% in the southeast. Overall, only one-third of deliveries are assisted in a facility by a trained attendant (doctor, nurse/midwife). Barriers to seeking care are mainly ones of direct and indirect costs, including fees, transport and time.

With regard to HIV and AIDS, the 2003 sentinel surveillance survey found a prevalence of 5% among pregnant women, with no significant urban/rural differences. However, studies have found prevalence in vulnerable groups such as sex workers to be as high as 75%.

3.1.3 Commodity supply

A JSI/Deliver rapid assessment in 2001/02 revealed high levels of stockout of contraceptives in the public sector – three quarters of facilities visited lacked OCs, 60% lacked condoms, and half lacked ICs.

Most states lack sufficient BEOC and CEOC sites per numbers of population served according to UN guidelines. With respect to the study's marker list of commodities, magnesium sulphate is neither available nor used widely for the treatment of (pre)eclampsia, except in tertiary facilities. However, it is mentioned in the recent FMOH/WHO emergency obstetric care manual.

In one survey by IPAS in three northern states, only three quarters of EOC facilities had basic drugs and equipment, and only half of those providing PAC had MVA equipment, with many providers especially nurse midwives lacking in training and experience.

A 2002 FMOH/WHO survey found that only one third of public health facilities provided STI treatment. Over 70% of survey respondents used the private sector, including traditional healers, pharmacies and patent medical stores (licensed drug retailers) (NARHS 2003). In another recent survey with WHO and HAI International in 2003, the FMOH also report that over half of all key essential medicines were unavailable at facility level.

Access to HIV testing, to PMTCT and to ARV treatment is mainly restricted to tertiary care settings, and subject to interrupted and fragmented commodity supplies (NHSSP for HIV/AIDS).

3.2 National and state policies and the policy environment

3.2.1 Poverty reduction and health policy

Nigeria is a highly federalised country, with its Federal Capital Territory and 36 states. The latter have substantial autonomy. The states are grouped into six geopolitical zones, to which some regional functions are also allocated. The definition and division of roles and responsibilities between federal government, the zonal authorities, the autonomous state governments and the 774 local government authorities remains a work in progress. Nigeria's President, the current PDP government, including the Federal health minister are highly committed to reform efforts. However, the government's second term ends in 2007, and the picture after that is less clear. At state level, there is wide variation in commitment and performance among governors and state health commissioners.

Nigeria's national level National Economic Empowerment and Development Strategy, NEEDS (2004), is sometimes referred to as its 'home-grown PRSP'. NEEDS, and the complementary SEEDS documents at state level, draw on three overarching strategies: empowering people to obtain their basic rights (increasing accountability for through a 'social charter' approach); promoting private enterprise and PPPs; and improving government performance through public sector reform.

Nigeria's challenges to achieve the MDGs are emphasised, and explicit links are made between poverty and ill-health. Improved access to quality affordable health services is highlighted as a strategy for reducing poverty and increasing equality: 'The plan is to improve the system of health care delivery, with emphasis on HIV/AIDS and other preventable diseases, such as malaria, tuberculosis, and reproductive health-related illnesses.Antenatal, postnatal, and family planning services and outlets will receive targeted support in order to reduce maternal and infant mortality'. However, while NEEDS has defined objectives across most of its components, it states that 'work is still ongoing' on defining the national health MDG targets.

NEEDS prioritises increased capital budgetary allocations (while rationalising 'bloated' recurrent budgets at both federal and state levels) through its recent debt relief agreements to social, infrastructure and other key sectors. The plan also acknowledges that fully developed and costed sectoral strategies for agriculture, the environment, health, education, water, and infrastructure are still works in progress, as is the streamlining and rationalizing of implementation agencies and the

coordination framework. A recent 2004 report, 'Delivering service in Nigeria: a roadmap' commissioned by the President from the UK Office of Public Sector Reform, highlights the enormous challenges of reforming the public sector, including health care.

The new National Health Policy 2004 also frankly acknowledges the many failures of current provision by the health system in delivering services and programmes including RH. It provides a summary of the pre-existing RH policy and strategy (see below) along with other priority areas. It strongly emphasises the core role of PHC as the framework for all services. The contribution of the private sector is also highlighted, together with the need for PPPs with private and not for profits, including CSOs at all levels. A new PPP policy is being developed for approval by the National Health Council in 2005.

The Health Sector Reform Programme (2004) presents a series of seven strategic thrusts, including overall government stewardship; health system strengthening; reducing disease burden (including RH); improving resources and management; access to quality health services; consumer awareness and involvement; effective collaboration and national and international partnerships. Communication, advocacy and M&E are cross cutting themes.

MDG related services are stressed, including reduction of maternal mortality. It is notable that family planning and other RH services have been incorporated into maternal health under the objective for reduction of disease burden. The focus is on access to EOC in particular. This in part reflects the 're-positioning of FP' as a key strategy for improving both maternal and child health, and means that efforts to achieve (and fund) the MDG MMR target can include FP and other RH services. It also perhaps reflects the adverse socio-cultural environment – expressed in both religious and political opposition - in some parts of the country for FP promotion as a separate activity. It is also noted here that the term 'child spacing' is increasingly used in preference to family planning, in accordance with religious and cultural sensitivities.

FP indicators are listed as increased knowledge and awareness of services (% with knowledge about benefits of child spacing and % of pregnancies not in high risk groups), as opposed to service utilisation. RHCS is represented in terms of ensuring supplies and equipment. Activities also include defining relevant standards and protocols, including the definition and costing of a minimum RH package as part of a basic PHC package.

3.2.2 Population, AIDS and RH policy

The 2003 National Policy on Population for Sustainable Development is fully in line with the implications of ICPD commitments, such as achieving universal access to RH information and services by 2015, and specifies the strengthening of the contraceptive supply and logistics management system.

The National AIDS Policy and Strategic Framework include reference to condom provision as part of prevention, but as yet there is no condom policy or programming strategy.

The National RH Policy, and the Strategic Framework and Plan 2002-2006 recognise RH both as a right, and as key to improving health and development. The Plan sets out seven components, including safe motherhood; FP information and services; adolescent RH; prevention and management of RTIs especially STIs and HIV; elimination of harmful practices such as FGM, premature marriage and sexual

violence against women, reproductive rights and gender equality; prevention and management of complications of abortion, and provision of safe abortion where law permits.

Strategies include advocacy and social mobilisation, promotion of healthy reproductive behaviours, and capacity building and research. The strategy for equitable access to sustainable quality health services includes components for strengthening logistics and supplies through institutional arrangements and procedures, and processes for purchase and distribution of materials, and ensuring that RH services are captured in the NHMIS.

Goal, purpose and output targets for 'creating the enabling environment that will support the provision of quality RH services at all levels of care' include the allocation of at least 5% of the health budget to RH, reducing MMR by 50% of 1999 figure, increasing CPR to 20%, increased population access to services within 5km, and increase in facilities offering EOC (by 10%) and other RH services (by 20%). However, the source of baseline information is not always clear, and a target increase in the number of facility based births assisted by a skilled attendant is not included.

There is no agreed monitoring system and slow progress in defining and costing the RH component of minimum service package. The strategic framework lacks specific RHCS indicators at overall output level (eg stockouts of key products), although the plan's activities include providing equipment for EOC, and procurement and distribution of commodities to all SDPs, plus upgrading staff skills to include IUDs, PAC, emergency contraception and surgical techniques.

RHCS is highlighted as the need for strengthening equipment and commodities supply and logistics, and in expanding services to include for example, PAC, EC, implants and permanent contraception, as well as OCs, IUDs and injectables, and promoting syphilis and gonorrhoea testing for all antenatal clients. The strategy explicitly recommends the promotion of condom use for dual protection.

The Strategic Plan for Reproductive Health Commodity Security 2003 – 2007 was an output of the SPARHCS process. This was a multi-stakeholder needs assessment and strategic planning exercise initiated in 2002 by the FMOH with USAID, UNFPA, JSI and other partners, initiated in response to a request by Nigeria following the 2001 Istanbul conference on commodity security. Nigeria was the first country to adapt and use the international SPARHCS guidelines.

The package covered in the Plan is for contraceptives, including condoms, and includes six strategic objectives: finance; policy; logistics; service delivery; demand; and co-ordination. See Section 4 for further detail on strengths and limitations of the process.

3.3 Government and agency roles: policy making and co-ordination

3.3.1 Federal and state government

The FMOH has seven departments and four units plus oversight over seven parastatals and 52 Federal teaching/specialist tertiary hospitals. Several major vertical health programmes (AIDS, TB, malaria) are managed by the Department for Public Health, although immunisation is managed by the parastatal, National Programme for Immunisation. Other parastatals include NAFDAC (the food and

drugs regulatory agency) and the National Primary Health Care Development Agency.

The national RH policy and strategy is led by the Reproductive Health Unit in the Dept for Community Development and Population Activities. However, important responsibilities are also held by the NPHCDA (for example the definition and costing of the minimum RH package and support to PHC implementation), and overlaps are reported.

The overall HIV and AIDS response is led by the National Action Committee on AIDS, with a major stress on care and treatment programmes, spearheaded by the Presidential Council on AIDS. The multisectoral response is reported to be weak so far, and dominated by the health sector.

The federal government is in process of reviewing FMOH functions and structure, with the aim of repositioning the ministry for better performance in its stewardship roles of policy making, regulation, standard setting and monitoring and evaluation. The new National Health Bill envisages that planning and implementation for service delivery will be delegated to the second tier, at state level for secondary care, and to the 774 LGAs for primary care.

According to the 2004 FMOH Repositioning Committee's report (Crisp et al 2004), the mandates of the FMOH and other tiers of government are not currently captured in either the Constitution or in legislation. There is serious fragmentation and lack of coordination of services throughout the FMOH. The most significant disruption is said to be in the fragmentation of PHC services, including RH. Policy formulation, planning and monitoring of immunisation, reproductive health, environmental services and other functions are not well coordinated, and there is poor clarity of roles and functions. At state and LGA level, capacity is generally felt to be very weak, particularly in policy and strategic planning. Each state ministry of health has an RH and FP co-coordinator, responsible for working with LGAs and SDPs.

Recommendations included a new department of family and community health, for the development of policies and supervision of the implementation of integrated family and community health services that form the basis of the primary health care system including RH. Other DCDPA functions would be relocated. The NPHCDA would be strengthened but focused to develop the systems and to provide technical support to the states and LGAs for PHC implementation.

However, it is clear that agreeing roles and functions for FMOH and parastatal reform, and strengthening state and LGA capacity, are slow and extremely challenging processes. A plan for action on the recommendations has not yet been articulated.

Several reviews and consultation processes, including the 2002 SPARHCS assessment, highlight the numerous challenges facing RH policy development and implementation. The assessment process identified inadequate logistics systems, with deficiencies in availability of services and commodities, lack of domestic political and financial commitment, lack of management co-ordination among all stakeholders, inadequate standard operating procedures and low male involvement (Strategic Plan for RHCS 2003).

According to an FMOH 2003 report published with USAID's Policy Project, FP scored low on the Policy Environment Score (which measured the degree to which the policy environment support effective policies and programmes for FP, adolescent RH and

HIV). In addition to similar issues to the above, it found fragmentation and limited impact; inadequate resource allocation at federal, state and LG levels (and diversion of funds to HIV/AIDS), poor quality, limited coverage and access to services in rural areas, inadequate skilled HR, low demand and socio-cultural barriers to take-up. Inadequate equipment and supplies of commodities were referred to as hindrances to safe motherhood and FP services, and contributing to poor outcomes for RH.

3.3.2 Partners and co-ordination

External partners play a very significant role in Nigeria's RH policy and its implementation. Bilateral agencies include USAID, DFID, CIDA and JICA; and the multilaterals, UNFPA, WHO, UNICEF. Ford, Packard and MacArthur foundations are also present.

Overall, donor co-ordination in the health sector was described by informants as weak, both between partners and with government. This was also highlighted by the Re-positioning Committee, with many donor respondents dissatisfied with their present operational relationships with FMOH. Development partners complained that there is a lack of a coordinating mechanism between them and the FMOH. There is more extensive donor dialogue taking place on immunisation, given the challenges facing implementation.

No Federal programme was reported to have an annual or multi-year budgeted plan or planning process, setting out key areas and targets, which would enable donors to more systematically allocate finance or technical support. The malaria programme is in process of developing such a plan.

Major US implementing agencies and programmes in RH include JSI's Deliver (logistics strengthening), Compass (NGOs, communities and providers in USAID's five focal states), and Enhance (enabling policy environment).

World Bank/IDA credits are offered to nearly all states through the Bank's Health Sector Development Programme, with a focus on developing infrastructure and providing equipment. DFID's health policy and system strengthening programme, PATHS, works with four states, and includes EOC as a theme. From 2007, the Bank, DFID and USAID plan to collaborate more closely in a group of lead states (identified through the SEEDS (State Economic Empowerment and Development Strategies – i.e. state-level PRS) benchmarking process. This process, led by Federal government and supported by all donors, ranks states in terms of good governance, with particular emphasis on the quality of public expenditure management.

There are several co-ordination mechanisms for RH, led by the DCDPA. The RH Partners Forum for development partners and major implementers aims to meet every three months, and there is a National RH Working Group, meeting occasionally. While useful for information exchange, neither is regarded as highly strategic and meetings have become irregular. There is also the RHCS Technical Team (FMOH, Deliver and UNFPA) and Stakeholders Group (includes NASCP, CHANPHARM, and SFH - Society for Family Health), which dates from the SPARHCS process and continues to be consulted as required on relevant issues by the RH unit.

	Male condom	%	Female condom	%	OCs	%	ICs (2 products)	%	EC	%	IUCDs	%
Public sector	4.2 mill	2%	84,000 (but low consumption)	-	800,000	15%	850,000 (>940,000 dist)	44%	0	-	70,000 (>116,000 dist.)	62%
Socially marketed***	150 mill	81%	0 (started 2004/5)	-	3.87 mill	74%	900,000	46%	490,000	75%	41,000	36%
NGOs**	500,000	<1%	?	-	150,000	3%	85,000	4%	15,000	2%	1,000	1%
Commercial sector	30 mill	16%	?	-	400,000	8%	120,000	6%	150,000	23%	1,000	1%

Table 1: Contraceptives and condoms market (distribution/sales)

Source: SFH sales data 2004, FMOH/DCDPA distribution data 2004

*** Includes supplies to NGOs eg 2.5 million condoms

** NGO supplies by UNFPA/DCDPA and other sources (ie non-socially marketed brands)

3.4 Financing, procurement and distribution

The FMOH Re-Positioning Commission found that, in the context of overall budget constraints, donor-driven dependence and funding are an impediment to needs-based planning and implementation. Several key informants for this study referred to RH as one of the 'partner' or 'donor' driven programmes.

Overall, the FMOH budget is viewed as insufficient. The Commission heard that because of inadequate funding, 'many units/departments are unable to carry out planned activities in line with their mandates. They thus are dependent on development partners for even basic office support. This has resulted in implementation of donor-driven projects, with the result that only projects and programmes that enjoy donor support seem to be visible, such as AIDS and malaria.' A case was also made to the Commission that even though the management of sexually transmitted infections significantly reduces the risk of HIV infection, few partners are supporting STI programs and very little STI control activity takes place.

There is near 100% dependence on off-budget, external financing for public sector RH activities. RH was allocated a budget at Federal level for the first time in recent years (albeit nominal) in 2004, following strategic advocacy by the RH Unit for a newly named budget line for MMR. None was allocated for commodities, although a small amount was allocated to RHCS related activities. RH budget lines do not exist at state level.

There are two main commodity procurement channels. All public sector contraceptives, and some condom procurement, is managed by UNFPA on behalf of government, drawing mainly on a national CIDA grant (to 2008), together with UNFPA country programme and global funds. These commodities are provided to the DCDPA for distribution to both the public sector and selected NGOs.

Total public sector procurement in 2004 by UNFPA Nigeria (via UNFPA NY) amounted to about US\$2.5 million, not including commodities provided in kind procured centrally. No emergency (short term) orders or stockouts at national level were reported since 2002, except for condoms (ordered in response to NGO

requests). Estimated projections made during the SPARHCS for public sector condoms, ICs, IUDs and OCs made using FAMPLAN modelling indicate that the public sector budgetary needs for commodities alone will rise from just over US\$4million in 2004 to over US\$6million in 2010. CIDA funding is for about US\$9 million over five years. Should demand increase as projected, shortfalls are therefore likely.

USAID and DFID fund Society for Family Health to provide socially marketed contraceptives and condoms to private sector retailers (pharmacies and patent medical stores) and to many NGOs. PSI is subcontracted to procure all commodities, with Crown Agents managing importation and clearance. Smaller proportions are commercially supplied (see Table 1).

In theory, there is a strong separation between public and private supply channels – SDPs engaged with the CLMS systems are required not to buy commercial or socially marketed products. Before the rejuvenation of the supply system in 2003/4, this was a common practice, as state and LGA co-ordinators, and SDPs, sought to fill stock gaps by purchasing from SFH distributors or commercial outlets.

Leakage levels to the private sector are unquantified (and not addressed in the CLMS as it currently operates). UNFPA products are not branded and are also distributed through NGOs. However public sector products, including ICs, were found in several pharmacies visited during the assessment. Leakage (and cheap resale prices) was also given as the major reason for lack of market expansion by a representative of the commercial sector.

RH commodities for safe motherhood and STIs are purchased through Nigeria's highly decentralised procurement system along with other drugs and equipment. Federal disease control programmes manage drug distribution through the central medical stores and programme distribution channels. In the past, essential drugs were purchased by the Food and Drugs Department through a WB loan facility, using Crown Agents. However, the decentralisation of operational functions to the 52 federal health institutions, and delegation to state ministries and LG health departments means that little bulk or pooled procurement (and storage, distribution etc) takes place at national level.

The country assessment for the WAHO West Africa RHCS sub-regional strategy (Regional Informed Buying Initiative) found a mix of procurement practices at other levels, including shopping, open tendering and selective tendering. Emergency local procurement by facilities was frequent, based on very little knowledge and sharing of pricing information sources. Although federal and state institutions are meant to use 'due process certification', interviewees for both that assessment, and this one, were candid about lack of transparency in procurement, and limited economies of scale or use of quality assured sources.

Within the FMOH, there is some procurement capacity. ARV supplies funded through the federal NASCP budget line and GFATM are procured from the India generic company, Ranbaxy (which has local representation), following international competitive tendering by the Procurement Unit in the Dept. for Research and Planning. A 2004 assessment of ARV supply found a somewhat unwieldy but transparent mechanism (using the federal government's 'due process certification') involving several actors in government. However the small size of annual orders was reported to limit potential price reductions from Ranbaxy, the sole supplier. PEPFAR supplies are managed for government by Axios, procured by Crown Agents, and

distributed through a new contract with CHANPHARM to designated federal hospitals and some other state hospitals.

State capacity and financial resources to procure and manage distribution of drugs and equipment is reported to be very limited. Drug revolving funds (DRFs) have been the major mechanism to generate finance for drug purchase, at state and LGA level, as well as at facilities¹. However, the extent to which they are functional is questionable. PATHS and Crown Agents, through the DFID Health Commodities Project, are providing equipment and drugs in focal states, but there has been less input into strengthening procurement processes. PATHS also supports DRF strengthening, including guidelines for financial management, community accountability and exemption/deferrals for the poor. Technical assistance has included pharmacy advice on essential drug list development and promoting rational drug use.

There are several parallel systems for storage, supply and distribution of vertical programme commodities. All family planning commodities supplied by UNFPA are stored, managed and distributed by CLMS staff from the contraceptive warehouse in Lagos. The federal central medical stores in Lagos provides storage services only for commodities supplied through the federal health programmes (eg TB drugs, ITNs), plus narcotics and now ARVs. Distribution is managed by the federal health programmes, with mixed results in terms of stock movement (eg insecticide chemicals have expired). Vaccines are stored and distributed separately by the NPI, with warehouses at zonal level.

3.5 National drugs policy, legal and regulatory issues

All contraceptives and condoms imported by UNFPA and SFH are imported branded products. They are registered with NAFDAC, the national regulatory agency, and their generic equivalents are on the essential drugs list. This is similar for products required for safe motherhood, with the notable exception of magnesium sulphate (for the treatment of pre-eclampsia and eclampsia). However, it is noted that CHANPHARM has obtained a waiver for this product's importation, and some tertiary institutions make up the compound in their own pharmacies. Misoprostol (Cytotec) is registered, but only for ulcer treatment (and not pregnancy related complications).

All products should be registered before marketing in-country. For example, SFH and PSI are now registering their new mid-market condom brand. NAFDAC, is undertaking a major effort to stop marketing on non registered products, but this is a major issue given the extent of poor quality and counterfeits available. Many condom brands are available on the market but fewer than ten are registered. WHO or other international prequalification processes can speed up registration with NAFDAC but does not provide exemption from any of the registration steps

There is a possibility that generic ICs and ECs may be registered as the market develops, and local production of high quality products is a longer term possibility. However, at present no generics are registered, and no applications have been made.

¹ DRFs are a mechanism for ring-fencing funds to purchase essential commodities at primary and secondary facilities in Nigeria. A DRF is usually established by provision of a stock of medical supplies (capitalisation). User fees are generated through using the stock, which can be used to replenish as necessary. Standards and guidelines are being put in place, which include community based governance arrangements, and an exemptions and deferrals system.

Drugs are a mix of locally produced or imported generics and branded products. There is no process for agreeing a recommended retail price, which limits efforts to maintain affordable prices. The FMOH Medicines Prices survey (with WHO and HAI) found that innovator brand medicines were on average 400% more expensive than their lowest price generic equivalent (with a range from around 200% to almost 700% in eight African countries)

Tariffs of 25% and taxes of 5% are applied to products imported for private sector sales. There are exemptions for not-for-profit use, obtained through presidential waiver but this can be a very slow and unwieldy annual process. Through high level lobbying, SFH has obtained an executive order from the President to allow donor funded contraceptives and condoms to enter duty-free, at least until 2007. However, PPFN has experienced delays in receiving duty exemption certificates. Its commodities ordered in 2004 are expected in November 2005, and 2005 commodities not before March 2006. This clearly results in gluts in stock in the short term, and risk of expiry in the medium term.

Quality assurance remains weak in the public sector. UNFPA imports are not batch tested. SFH houses a condom testing unit for NAFDAC and NASCP, staffed by government employees. Socially marketed imports are tested routinely.

3.6 Role of non-state providers, civil society and other actors

3.6.1 Social marketing and commercial suppliers

SFH is an indigenous Nigerian not for profit organisation, set up by, and maintaining strong links, with PSI. It distributes about 81% of total condoms used in Nigeria. There has been an increase in socially marketed sales in 2002 from 132 million (about 13% growth over 2 years), although growth rate declined to 2% in 2004. The DFID funded sexual and reproductive health programme targets high-risk communities and most-at-risk groups such as female sex workers, transport workers, uniformed services personnel and out-of-school youth, although recent reviews indicate that community based interventions could be further strengthened. Over 80% of the socially marketed Gold Circle condoms are likely to be used in high risk sexual encounters primarily in sex work, casual sex and other non-marital non-cohabiting relationships. Gold Circle costs less than a fifth of commercially available mid priced condoms.

SFH is regarded as one of the most efficient condom social marketing programmes in the world. It has over 40 registered private sector distributors, and 16 detailers (promoters and trainers), working out of nine depots. It uses a cash and carry system, with no credit provided to retailers.

PSI and SFH are registering a second subsidised product, branded by PSI as Lifestyle, with NAFDAC. PSI and its national partners have agreed with the generic US based company Ansell Ltd to socially market Lifestyle as a mid price brand in several African countries. However, priced at over five times that of Gold Circle, Lifestyle's ability to shift users into a so called second tier market is questionable. PSI is also planning a survey (through the USAID funded PSP1 programme) to analyse and the private sector market, as part of assessing demand for this product.

SFH branded products have about 74% of the OC market, and less than 50% of the IC market. However, contraceptives were not much promoted by SFH until a mass

media campaign on OCs, ICs and IUDs in 2004, and further promotion is planned. However, demand has increased, for ICs by 23%, and OCs for 26%, on 2002 sales. Demand for IUCDs has dropped by about half. SFH are now preparing a major new promotion for their branded products, called Q Quality campaign, which will include a provider brand and a training package for suppliers.

Overall little is known about the role and extent of the organised and informal for profit private sector in providing RH commodities, and there are conflicting views as to the importance of commercial products. The local representative of a major R&D company neither imports products nor promotes contraceptives, claiming negative impact from leakages of public sector commodities as the principal disincentive. Leaked public sector commodities are provided in commercial outlets at 10% of regular commercial prices, a finding verified during several pharmacy visits.

A very positive step has been for IPAS to register and make MVA equipment available through three national distributors.

3.6.2 Civil society and the faith based sector

Religious leaders and scholars are major players in policy advocacy efforts, and in shaping consumer demand. Christian and Islamic groups offer selected RH services as part of primary and secondary care. The Federation of Muslim Women's Associations of Nigeria (FOMWAN) is the major umbrella organisation for health services provided by Islamic providers. Although Muslim religious leaders are not generally supportive of family planning, most are willing to recommend condom use in the context of HIV/AIDS prevention. This is in contrast to the position taken by most Catholic providers.

Overall about 40% of health services are provided by Christian organisations, but this varies greatly by state, from over 75% in some states to near zero in the North. Use of faith based services is quite limited in the south. CHAN represents both Protestant and Catholic providers - 23 denominations in all, with over 400 institutions, managing 4000 SDPs. Although CHAN has an HIV/AIDS policy, there has been little open dialogue among members on RH more widely and no condom or FP promotion. It is also often stated that, at facility level, practice varies considerably, and both contraceptives and condoms may be available. Several years ago, a PAC project was introduced to five centres, but has been discontinued, due to lack of initial engagement and sufficient consensus among member institutions.

The final session of an RH summit supported by DFID with PPFN in 2004 was reportedly dominated by minority perspectives on post abortion care from a section of the Catholic Church, to the detriment of a wider consensus building process. CHAN staff perceive that dialogue with church leaders on RH as a whole has not yet been sufficient, but that CHAN is in no position to initiate such a dialogue, given its status simply as an umbrella group. This would need to take place at a much higher level. Following advocacy and dialogue in 2005, including a national FBO conference on maternal mortality reduction and repositioning reproductive health, a new national faith based advisory council has been set up, which is viewed positively.

CHANPHARM became an independent not-for-profit procurement and distribution agent for pharmaceuticals and other supplies in 2004, with DFID support through Options and Crown Agents. It is perceived as increasingly effective and well-governed. Its main customers are CHAN members, but it has an ambitious business plan, aiming to provide a quality assured source of essential drugs to public and private providers. At present, 90% of its procurement is international, from the IDA. Through its network of six depots, it is also managing the ARV supply chain for

Axios, although few CHAN members are providing services as yet. CHANPHARM is the private sector partner in the Benue Bulk Medical Stores, a new joint venture supported by DFID/HCP with Benue state ministry, to build capacity, and procure quality products. CHANPHARM neither stocks nor supplies contraceptives and condoms. It does procure magnesium sulphate, having obtained a special NAFDAC permit to import.

PPFN, IPPF's affiliate, has 18 clinics (down from 36 two years ago) and has outposts and CBD in all 36 states. Rationalisation of clinics resulted from budgetary constraints and indicates a strategic shift to increased HIV/AIDS prevention activities that do not require clinic settings. PPFN received seed stock of condoms from SFH. Despite delays in receiving 2004 and 2005 commodities ordered through IPPF, it has adequate commodities to meet requirements for one year. It is also procuring condoms through SFH, as well as some products through DCDPA/UNFPA.

Several indigenous NGOs, such as ARFH, carry out advocacy and provide commodities and services.

IPAS Nigeria is promoting access to EOC in several states, including PAC plus wider service strengthening. IPAS is working with the National Council for Women's Societies – which has influence at state and LG levels, to build demand for access to care as a right.

USAID's new Compass programme and INGOs also provide support to local (and to date) small scale efforts with NGOs, CSOs and private provider associations in their targeted states. These projects aim to increase provider knowledge and skills for RH, including quality assured products, and to advocate for increased demand in communities for quality services.

For example, Pathfinder International works with the private sector in Kano state – partners include the professional association of private medical practitioners, the medical women's association, and provide training and supplies at subsidised prices (from SFH), including MVA equipment obtained via IPAS. In some cases, they link with government providers to provide training and access to commodities, as well as supporting advocacy for improved health services and equipment and supplies.

4 Findings and key issues

4.1 Efforts to strengthen procurement, financing and supply systems

The SPARHCS process in 2002/03 resulted in three major outputs: a thorough assessment and understanding of the problems and challenges for the six components of RHCS; consensus among the major government and development partners about short and medium term actions needed; and an RHCS strategy. The process is financed through the CIDA grant to UNFPA and some country programme funds, USAID funding for technical assistance, as well as a small contribution from the new RH domestic budget line.

SPARHCS' initial success as a process was due to the combination of the strong leadership provided by the then RH co-ordinator (now DCDPA Director), co-ordinated technical inputs provided by JSI DELIVER and UNFPA, and by the engagement and involvement of stakeholders across public and private sectors. Two progress

assessment surveys have been carried out by DCDPA, with UNFPA CST in UNFPA supported states and by DELIVER in USAID focal states.

RHCS successes to date include:

- Strongly motivated leadership by the DCDPA CLMS team, together with partner buy-in, resulting in a joined-up approach to RHCS.
- Continuing consultation with the RHCS Stakeholders Group, that includes the private not for profit sector (CHANPHARM and SFH)
- Significant and co-ordinated technical support to most states, supported by UNFPA's country programme in its 15 focal states, by DELIVER in USAID's five focal states, and (to a more limited extent) by DCDPA in remaining states with DELIVER and other partner support
- Clear focus on short term priorities, particularly on strengthening the supply and logistics system, in order to improve the supply side function.
- Rationalisation and harmonisation of the system, through standardising management tools and reports for SDPs, LGAs and state RH departments, and by removing the zonal centres (managed by NPHCDA) from the supply chain.
- Joint re-design and introduction of the CLMS, agreed by the stakeholders at federal, state and LGA levels – 4,500 providers were trained by January 2005, and about three quarters of SDPs have one provider trained (Deliver survey).
- Introduction of a new cost recovery system and guidelines at SDP level, including seed stocking all SDPs in 2003 to kickstart the system
- Improved reporting and data management at all levels of the system – by end 2004, about a third of states were providing usable data returns.

In terms of results, there have been improvements in availability at SDPs – availability of most commodities is above 75% at all levels and there are reasonable levels of SDP and LGA participation. Co-ordination on the unified approach to the procurement and supply chain has been strong. At the central level, ability to enumerate and order supplies from UNFPA has also improved, using UNFPA software. Orders have been made well in advance for 2003/05 and 2006/07, and there have been no 'emergency' requests except for condoms since 2002.

Discussions with national NGOs to join the CLMS have already involved PPFN, and CHANPHARM has been invited to participate (should it decide to supply these commodities). Additionally, UNFPA and state co-ordinators are re-introducing CBD programmes in five states with LGAs, NGOs such as ARFH and village development committees, to increase take-up.

However, there are also serious concerns. CLMS involves the return of distribution data, rather than consumption data, and there is no means of redistributing unused stock. Reporting and stock management at all levels is also weak. These constraints severely limit accurate forecasting and appropriate stocking. Central warehouse and store stock control procedures are also poor. Information provided by UNFPA on costs and financing arrangements, and ordering and shipment progress could be strengthened.

Overall, therefore, government capacity to forecast and to budget and plan for programme commodity is strengthening, but still has limitations.

Other limitations include:

- Limited funding to provide on-the-job refresher training to providers in CLMS, especially in the orphan states – many SDPs are struggling to record and return data, and the move to a pull (as opposed to a push) system represents a very significant challenge at all levels.
- Weak capacity at LGA level. However, in one state, staff were able to access funding to attend training through the World Bank's Health Sector Development Programme.
- Poor and restricted storage facilities at the contraceptive warehouse in Lagos – some commodities are at risk of accelerated deterioration as well as expiry, and new condom orders are likely to overwhelm the space.
- Inadequate transport for national-state distribution

RHCS has focused on improving supply, and on updating providers at SDPs through the state trainers. In effect, a highly verticalised system has been re-introduced for contraceptive supply (operating in a similar way to that of the TB programme, for example). This is not surprising given the current and severe weaknesses in the health system at state level, poor and fragmented access to other commodities such as essential drugs, concerns about the marginalisation of family planning, and the continued importance of donor support to vertical programme approaches at Federal level.

There has been dialogue on harmonising logistics systems for drugs distributed by the vertical programmes – linked to the Department for Public Health's development of a GFATM round 5 proposals with DFID (which was unsuccessful). However, DELIVER is not recommending the integration of the logistics management of the various vertical programmes. Given the overall lack of co-ordination between the vertical programmes themselves, individual systems need to be strengthened before integration can be considered. DELIVER is providing assistance with improving ARV logistics and is therefore taking long term need for integration into account while developing shorter term solutions.

The initial SPARHCS process was restricted to contraceptives and condoms, although ministry staff were cognisant of needs relating to maternal health. The RH Unit and development partners, together with others such as PATHS, UNFPA, WHO and Crown Agents are finalising a proposal to develop a safe motherhood (delivery) kit. UNFPA will procure pilot kits for selected pilot LGAs in each zone. Types of kit, content and target audience are still being defined (e.g. community versus facility level), but the facility kit will include MVA equipment. Questions of costing and pricing, and funding, procurement and distribution are to be clarified – however, it seems likely that the kit will be procured at central level and distributed through the CLMS.

Some discussion has taken place with SFH concerning the use of social marketing techniques and channels for the kit. However, although a member of the RHCS Stakeholder Group, CHAN and CHANPHARM have not been involved with SM kit discussions. This is of concern, given their importance both as an umbrella for many PHC providers and as a distribution agent.

4.2 Impact of wider environment and international support

4.2.1 Sustainability and financing issues

Recent efforts to strengthen RHCS in Nigeria can be in part attributed to the legacy of the pre-1999 military government and the effect on donor involvement. The

withdrawal of USAID in 1995, following the international de-certification of Nigeria, had a profound and devastating impact on RHCS. Through its co-operating agencies, USAID had been providing substantial capacity building and supplies to both public and private sectors – contributing to the rise in CPR from 3% to over 7% in the 90s. While DFID continued to fund the private sector social marketing initiative, the public sector experienced a major loss of resources, to which the stagnant CPR in the 2000s can be in part ascribed. Cessation of funding by such a major donor caused a major shock to the system frequently referred to by government and donors alike, and brought questions of finance and sustainability very much to the fore.

These concerns provoked the introduction of a four level cost recovery system, as part of the CLMS, with similarities to the country's existing state, LGA and facility drug revolving fund models, and including the fourth national level. The charges to clients are about 40% of the product's global cost price. The cost recovery scheme does not allow for exemptions for the poorest, and there is no data on the impact of this on access. This issue is further discussed in the next section.

While a small percentage of the cost recovery funds at federal level are used for supervision and transport, most are accumulating in a designated UNFPA account, in order to ring fence the funds, albeit with DCDPA signatories. Discussions about use of the funds are in process – for example as a reserve in case of donor withdrawal, support for infrastructure development or the introduction of new commodities. At the same time advocacy continues with federal government to include an RH budget line.

At SDP level, a third is retained as an incentive for providers, and for facility use (e.g. for transport). Two-thirds is deposited with the LGA for re-supply, where a further percentage is retained for transport and supervision, and similarly at state level. Bank accounts with three government signatories should be established at LGA and state level. Indeed, where this has not happened, some state RH co-ordinators have had to purchase on credit from Federal level, because no funds were available. Although FP products are not regarded as 'community commodities' (unlike drugs), state RH co-ordinators are encouraging VDCs to monitor use and loans from the accounts. Facility staff are also encouraged to buy basic RH commodities with their third, such as soap and gloves to reduce costs of delivery for the women and their families.

4.2.2 Health system reform and donor support

Health reform and financing: Current actions to strengthen RHCS must be seen in the context of wider government efforts for health reform, which offer both threats and opportunities for RH. Donors are unlikely to provide on-budget support at federal level in the near future. Development partners, notably the Bank and DFID are exploring how to support public sector reform and PPPs through a range of aid modalities, including sector and budget support at state level. This is in the wider context of improving performance in public expenditure management, budgeting processes and basic service delivery in health, education and improved infrastructure.

Other positive developments include the strengthening of national procurement capacity, as part of ARV treatment access scale up. The planned national health insurance scheme for the formal sector will include antenatal care and delivery, but not necessarily FP commodities. Schemes for the informal sector are not envisaged in current proposals.

Donor dependence and lack of domestic budgetary commitments encourage a verticalised and ring fenced approach to RHCS. This is also a response to fears that family planning is seen as an 'appendage', which will not be prioritised if a choice

must be made between drugs and contraceptive purchase and supply (if included in an integrated RDF or logistics system for example).

On the other hand, the repositioning of FP within maternal mortality reduction, and the stress placed by federal government and major DPs on achieving the child and maternal health MDG goals as an aim of HSR, gives RH advocates a revitalised platform for prioritising and financing the RH package.

DFID, WB and USAID are currently reviewing priorities and how to best complement efforts with UN and other partners to support multi-sectoral efforts and capacity strengthening at state level. DFID and WB are planning to focus on 'lead states' from 2006, which have been identified through the SEEDS benchmarking process. The SEEDS strategic frameworks also provide new opportunities to build capacity at state and LGA level. The needs and processes for strengthening state capacity also have implications for the FMOH role – which also needs stronger capacity to support state planning functions and ability to drive service delivery.

Donor co-ordination: There is some lack of clarity among the lead UN agencies for RH in terms of responsibilities particularly for promoting safe motherhood and improving service delivery. The issue is included in the CPs of all three agencies. UNICEF is promoting women and child friendly health services, and has attempted to bring together major federal players in DCDPA, DPH and NPHCDA. WHO and UNFPA have an SSP for RH, focusing on control of RTIs. UNFPA has focused on RHCS and FP, and has just begun to develop its SM activities as per its CP. WHO is making technical contributions to national policy and guidelines, and developing EOC models of care, with six demonstration sites.

DFID's imminent health MDG project with the three agencies is reported to have stimulated better collaboration during its design phase, and aims to generate stronger cross agency synergies.

UNFPA's technical contributions to the SPARHCS process and to joint development of the CLMS are critically important and widely recognised. However, the agency is not offering significant support to facilitate overall government leadership in developing its broader strategic role in, for example stewarding the overall market, or in building planning capacity at state level. It is noted that links with the private sector nor social marketing are not mentioned in UNFPA's CP. Decisions to provide NGOs with increased condom supplies appear to have been taken in the absence of a wider approach to condom programming that takes social marketing into account.

Co-ordination between DCDPA, UNFPA and DELIVER on the CLMS has been good: resulting in a shared vision and workplan. However, the overlap of states receiving support from both UNFPA and USAID, coupled with the number of 'orphan states' which receive more limited TA for the CLMS, is unfortunate.

The various RH working groups and committees, including the RHCS stakeholders group are operating more at the level of information exchange rather than engaging in strategic planning and partnerships. UNICEF has also promoted safe motherhood committees at national and state levels but at national level it meets rarely, and they are functioning in only some states, such as Jigawa (see box 1). Given limited resources, it may make sense to have one overarching RH committee at state level, especially where child spacing services are linked to safe motherhood.

4.2.3 Impact of the wider policy environment and advocacy efforts

Socio-cultural and religious factors: Advocacy among both opinion leaders and consumers must be tailored to the Nigerian context, which is affected by a complex mix of national and international influences. The US government's position on RH issues is felt indirectly, as well as directly expressed in financing restrictions.

Similar views to that of the US Congress are held independently by many Nigerians. Several government and other informants felt that there had been too much stress on condoms in past, and that the A had been left out of ABC. The 2003 National HIV/AIDS Policy takes a balanced view, stating that 'the use of condoms as a method of preventing HIV/AIDS shall be promoted through appropriate education', and that 'all mass media marketing of condoms shall promote abstinence and mutual fidelity as the best protection'. For example, the new 'Zip-up' abstinence campaign introduced by SFH in consultation with others is in line with the National HIV/AIDS Policy. It also reflects most FBO views and, by taking these into account, is felt to be an important way to engage them. The role of condoms in disease prevention, rather than as a contraceptive, tends to be accepted among FBOs, especially Muslim organisations.

However, it is also the case that NACA is taking quite a robust and independent stance with regard to the US position, with the chair publishing a letter in the NYT recently, and taking part activities organised by the advocacy group Change.

USAID is not working directly with government, but through its CAs. While US government policy restricts direct investment in condom procurement for general population use and abortion services (defined to include emergency contraception), it can be used for PAC. CAs such as SFH are working legitimately and innovatively with USAID and other financiers such as DFID to provide the full range of products.

However, SFH also report limited funds to promote condoms to the general population, and it is noted that the recent campaign (financed by USAID) to promote child spacing excluded condoms, despite FMOH policy on dual protection.

CHANPHARM currently keeps no stock of contraceptives and condoms, due to apprehension about member institution reactions, despite the fact that many of their denominations provide products and services. This represents a missed opportunity – it is not a policy decision, but rather appears as a reluctance to incur controversy in the absence of a clear position. There are reports of members with public sector or SFH products in stock. It is also the case that these types of products have lower margins and are therefore less attractive for CHANPHARM to purchase, given its restricted financing and cash flow.

The FMOH has withdrawn the emergency contraceptive pill from its supply chain, reportedly due to low demand and anxieties about abuse. There are concerns about the rationale for this, given that the method is prescribed and provided by trained staff, and is part of the national RH policy. There is also demand - states and LGAs are requesting from PATHS or buying from SFH.

On the positive side, both the FMOH, with UNFPA, and SFH have recently stepped up supply and promotion of the female condom, although take up is slow.

There is also evidence that willingness to provide PAC services is increasing among both government and FBOs. PAC and equipment supply is included in EOC strengthening activities at state level, and benefits from WHO advocacy. As far as the important faith based sector is concerned, IPAS Nigeria subcontracts to providers in

three major denominations (ECWA, NKSD, and COCIN), and a few Catholic missions are starting to provide care.

Building an enabling policy environment: The RH Unit is finalising a national advocacy package for working with policy makers, legislators, religious leaders and BCC (with PATHS support) on adolescent health, safe motherhood and family planning. A government-NGO subgroup of the National RH Working Group is developing an advocacy proposal for influencing both consumers and funding agencies, for submission to the international RH programme of the Gates Institute at JHU (Gates and Packard funding).

ENHANSE, the successor to USAID's POLICY project, is providing support to the DCDPA for creating an enabling policy environment. Senior advisers and officials in the Nigerian government had a significant presence in the West Africa Reproductive Health Network's regional conference on the repositioning of FP, and follow-up advocacy activities are taking place. Actions to 're-position FP' include a formal memo to the chief economic adviser to make the case for increased government budgeting, and advocacy with senators involved in women's affairs. Some advocacy is taking place with state health commissioners but there is no direct leverage.

Significant dialogue is taking place with religious leaders and organisations, and an FBO conference for MMR was held earlier in 2005.

Pathfinder and POLICY Project (USAID/Packard funded) initiated a process to facilitate Muslim leadership in developing and publicising a position on the national RH policy that is in line with Islamic principles. This included a study visit to Bangladesh, where most RH services are viewed as compatible with Islamic law.

Among Muslim leaders, there remain some concerns about Western influence. Several published statements comment on the tensions of working in an environment where partner motives are perceived to include political objectives, naming the USA, 'American Agendas', and Europe. Important links have been made with FOMWAN in some states to increase demand for FP, and to assess and strengthen services provided in clinics.

Dialogue is also developing with the Catholic church, but 'natural family planning' is still the main method promoted. It is acceptable with some players to discuss and facilitate access to condoms for disease prevention.

As mentioned in the previous section, serious efforts are being made to increase accountability and demand side pressure, through work with both civil society and through state support programmes such as PATHS (see Box 1). RH state staff also reported awareness raising with village development committees, about the need to involve community representatives in monitoring and preventing illegal use by officials of money in drug revolving funds.

Box 1 Improving accountability: addressing the three delays in Jigawa State

The DFID funded PATHS programme is working with stakeholders in government, civil society and the private sector to mobilise a multi-sectoral response for improved access to maternal health care, in line with the national RH strategy. A state level safer motherhood committee has been set up, involving the ministries for women's affairs and health, civil society and other players. Women's affairs are taking forward actions on delays 1 and 2, and health is leading on delay 3².

Public sector clinics make up most of Jigawa's health system. Activities started in two out of the state's five emirates to strengthen two CEOCs and four BEOCs per emirate. Inputs included skills upgrading and new equipment, including for PAC (MVA techniques). At state level, PATHS is strengthening the state CMS and distribution system with Crown Agents support, through the Health Commodities Project. If there are local stockouts, drugs are purchased using facility DRF funds from designated local pharmacists and stores. Although contraception is not publicly promoted, one-to-one advice on child spacing is given 'by the back door' to women. There is a strong preference for injectables in Northern states, given that their use can be kept confidential by the woman. FP supplies are distributed through state and LGA channels, where state staff have been trained in TOT by the DCDPA.

On the demand side, and to address the first and second delays, political and religious leaders have recognised the need, and are advocating for the use of improved services in their communities and demanding scale up to other emirates. Some communities have set up emergency loan schemes to meet transport and other costs, and families are developing delivery plans (including obtaining the husband's signature in advance for permission to travel). Rural transport union members have been mobilised to help with referral transport where needed, and trained in life saving skills.

4.2.4 Public-private sector engagement

So far, national RHCS actions have focused mainly in the public sector, led by DCDPA and UNFPA. There is evidence of some territoriality and competitiveness with the social marketing sector, for example concerning the decision of DCDPA to supply generic UNFPA condoms to NGOs (which may already receive branded ones from SFH). For example, the recent plateau in the growth rate in socially marketed condom sales is perceived as a success by the public sector in increasing the demand for its products, rather than a possibly concerning an overall market trend.

As summarised in Box 2, there is an increasingly complex male condom market, in both public and private sectors.

Needs are therefore emerging for stronger dialogue and partnership not just with SFH but with the commercial sector as well on RHCS more widely. Issues include:

- Contracting for distribution and storage – especially given challenges facing CLMS current capacities
- Using marketing techniques in the publicly funded sector for demand creation

² Pregnancy-related mortality is mainly due to three delays in accessing care: (1) deciding to seek appropriate medical help for an obstetric emergency; (2) reaching an appropriate obstetric facility; and (3) receiving adequate care when a facility is reached.

- Safe motherhood delivery kit branding, pricing and distributing
- Understanding the impact of SFH's new Q Quality campaign and logo on the public sector
- Overcoming the barriers to introducing new products and quality affordable commercial brands as the market grows
- Support for NAFDAC's role in registering, regulating and quality assuring products, and for advocacy with advertising regulators
- Tackling the tariff and tax bottleneck
- Reviewing regulation and roles of pharmacies and patent medical stores – and considering accreditation and franchising schemes

Box 2: Increasing complexity in the male condom market

The number of commercial brands has grown from six to 60 since the late 90s, but only a few brands are registered and there is no routine quality testing. The market is also becoming more segmented. The socially marketed brand, Gold Circle, is gaining a reputation as the 'poor man's condom', with high use by sex workers. NACA has requested SFH to provide support to developing a new brand called Options, to be purchased by SFH and piloted in hotels by NACA. However there is no strategy for brand servicing, and Options' future is unclear, with some hopes that a commercial operator may take it on.

At the same time, SFH and PSI are also planning to introduce a new mid-price Lifestyle condom. The rationale for introducing new socially-marketed brands, as opposed to supporting a quality assured local commercial distributor to scale up supply of an existing brand (to support longer term sustainability) is not clear to all stakeholders. In longer term, NACA is also keen to stimulate local manufacturing.

UNFPA/DCDPA has supplied to NASCP, but report a lack of strategic linkages with state HIV AIDS coordinators – stocks could be provided if costs could be recovered. Additional stocks of UNFPA non-branded/generic condoms have been ordered and are being supplied to NGOs, such as STOPAIDS, although there is no targeted distribution or cost recovery strategy. These NGOs already source commodities from SFH. The World Bank MAP programme is supporting NACA, which is planning to use credits to procure further condoms on behalf of states. The procurement strategy is not yet clear but NACA must use ICT in line with WB procedures. A distribution strategy has not been developed.

Given that most informants accept that condoms are best provided and promoted by the private sector, there is concern about oversupplying the public sector and risk of expiration, in the absence of valuable warehouse space and evidence that that condoms are overstocked elsewhere in the system. There is also a risk of waning retailer interest in the face of increased access to free condoms, and lack of clarity about brand positioning with respect to 'Options'.

5 Conclusions and recommendations: Opportunities and entry points

5.1 Repositioning reproductive health

Reducing maternal and child mortality, two of the health MDGs, are strongly emphasised by both the Federal government, and by major donors such as DFID, the World Bank and USAID. There is substantial evidence that child spacing improves both mother and children's health³. However, so far senior Federal and state government officials, and donor partners, have responded to these MDG targets with a focus on increasing access to EOC and immunisation.

This stress may represent a missed opportunity for addressing wider RH issues, given Nigeria's very low CPR. There is growing support among government, FBOs and other major stakeholders to 'reposition family planning' as a key but neglected driver for reduction of child and maternal mortality.

Enhanced support to states provides opportunities for including other policy objectives for RH as well as EOC, which would be in line with the broader objective in the FMOH's health sector reform strategy. While increasing domestic and international resources for RHCS is critical, it seems that additional resources to complement those of CIDA, UNFPA and USAID (technical assistance) may be better leveraged at state level, as well as Federal level. For example, it may be possible to build on the success of RH co-ordinators in a few states to access WB/IDA credits for CLMS training. However, this will also require significant advocacy and lobbying with state officials and PHC Directors (as set out in the DCDPA's Repositioning action plan).

Innovative work should also be continued on improving access through addressing the long and short routes of accountability – making policy makers and providers more accountable to people, by strengthening informed demand among people as both consumers and citizens, and their leaders or representatives. Continued advocacy among opinion leaders, especially religious leaders, is critical. In particular, time may be right for a more focused dialogue with leaders of the Catholic Church, perhaps through identifying change agents within the church itself.

5.2 Financing, ownership and capacity building

Financing and procurement mechanisms at national level: The ring fenced fund arising from the national cost recovery scheme represents a significant step towards reducing government dependence on external finance (albeit mainly of symbolic value at present). It also could provide an opportunity for channelling matching finance (from development partners or debt relief sources) to commodity purchase in the medium term, for example to build a national revolving fund that is managed by Federal government for RH commodity supply.

Part of Nigeria's debt relief will be assigned to the health sector (about US\$150 million in the first instance). Donors and the FMOH are keen that additional funds be

³ The evidence indicates that 3 to 5 year intervals are associated with the lowest risk of death among children and better nutritional status. Birth intervals of less than 14 months are associated with a 250% increased risk of maternal death, compared to 27 to 32 month birth intervals. A birth interval of about 36 months is linked with best outcomes for both mother and child. USAID Bureau for Global Health 2002.

linked to making progress on the MDGs. Current proposals include adding it to FMOH budgets, including RH. Proposals have been discussed for conditional or matching (MDG linked) grants to states, through so-called virtual poverty funds. The political feasibility of this is questionable, given that state governors are accustomed to receiving shares of oil revenues with no strings attached. Absorptive capacity is also likely to be low for additional direct funding to state and LGA services. One possible alternative strategy would be to allocate debt relief to the cost recovery fund, perhaps renaming it the Maternal Mortality Reduction fund, and including the financing of safe motherhood kits as well as FP commodities.

In the longer term, national procurement by government (or by UNFPA on its behalf) using local funds may take place (as happened in Bangladesh). Recent improvements in the federal ministry's procurement procedures should ensure a transparent process giving value for money. UNFPA have already obtained a waiver to permit expenditure in this way. However, while demand and therefore volumes needed are low, coupled with little interest among quality assured international manufacturers and lack of local production, it makes sense for UNFPA to procure internationally on behalf of government, in terms of ensuring quality and economies of scale.

Forecasting and planning capacity: Accountability and local ownership is ensured by the CLMS, which should enable government-led forecasting, and by the growing reserve fund generated by the cost recovery scheme. Detailed projections for contraceptive and condom needs in public and private sectors were made for the SPARHCS assessment; but the combined actual cost of commodities is not readily available. It is important that the total value of commodities, including any in-kind supplies from UNFPA NY is known and included in the annual plan and budget, to be financed and procured through funds held by UNFPA in the medium term. Although internationally this is typical of many commodity donation arrangements in other programmes such as for some ARVs, it also represents a critical gap in financial planning⁴.

It is recommended that the DCDPA is further facilitated to play the lead role in forecasting, monitoring and budgeting for supplies (albeit through a virtual budget held by UNPFA). Finalising the RHCS indicator set, proposed by UNFPA is important. Investigating leakage issues is a further action needed, and could be addressed in due course through proposed amendments to the CLMS.

Addressing access by the poorest: The cost recovery system involves charging a fee to all clients, irrespective of socio-economic status. Prices to consumers are set below those of private and NGO providers. Informants were confident that the prices are low enough not to deter clients who visit an SDP. However, information on how the poorest may be deterred by indirect cost barriers, such as time and transport costs, is not available.

The DCDPA and UNFPA are planning a study to assess access and willingness to pay by the poorest, as recommended by the UNFPA CST team. This is highly recommended; given the inequity in use shown in the NDHS, and the fact that over 70% of the population live in poverty.

⁴ In the state visited by the team, it is noted that the FP co-ordinator knew the total cost at FMOH prices of the state's annual requests, knowledge that is linked to her role in purchasing commodities from the central level using the cost recovery fund.

5.3 Developing a budgeted programme plan

The RH and RHCS strategic framework provides solid overall direction, and the RU Unit has developed an RHCS operational plan for 2005/06. The RH unit is aware of partner activities, and synergies between for example UNFPA, USAID and PATHS but there is no overall picture or map to guide and maximise effort. Some links with other federal programmes exist, but it was mentioned for example that formal dialogue with NASCP and NACA was needed on condom programming. There is also limited strategic dialogue among partners, although it must be noted that this is true too of other programmes.

A multi-year budgeted plan, and a participatory planning process, would facilitate government and donor dialogue and the allocation of earmarked donor contributions and domestic funds. It should be developed with input from state officials and be informed by their needs, which would contribute to longer term capacity building. Ideally, state health ministries would develop sector priorities and plans in line with Federal policy, in order to feed into federal plans in a bottom up process.

5.4 Co-ordination for demand creation

The RHCS focus has been on technical inputs to strengthen the supply side. There have been fewer resources invested on influencing the overall policy and financing environment. As one informant said: 'We have the wheel, but the ground is rough, so progress is slow'. Efforts to advocate for a higher reproductive health profile with the federal ministry planners and with faith based organisations have ramped up in 2005. With respect to influence within government, the DCDPA's prominence is rising, given the importance of the MDG for MMR, and the respected leadership and vision of its new director.

The major challenge is demand creation – there is wide awareness that, with supply side improvements, major efforts are needed to encourage more clients in both public and private sectors, which have to date been limited.

There is acknowledgement of the importance of social marketing and the private sector, with the general view that the public sector's comparative advantage is in providing IUDs and ICs, with the private sector's strength in OCs and condoms. DCDPA, other government programmes and NACA work with SFH – who have provided assistance for example with the annual National AIDS and RH Survey, NACA's BCC strategy, and with NACA condom supply.

There is also the longer term question of the sustainability of socially marketed products – it must be noted that the future of their availability as subsidised commodities is equally dependent on external donors. Long term strategies for a sustainable overall (or total) market need to be considered by government, in its stewardship role. SFH/PSI approaches may not be the best for overall market development, given vested interests. Ultimately, public sector partnership with the commercial sector may also provide a sustainable option.

Informants indicated that they are open to partnerships, especially in the context of the national health reform policy thrust for PPPs. As one ministry official said: 'Consumers don't mind where they get a product from, public or private, so long as it's of good quality and affordable.' Both the SPARHCS strategic plan, and the more recent re-positioning action plan include PPP development, including a PPP forum.

But, so far, there is limited articulation of what such a strategic approach with private sector players might look like.

The role of the government in this situation can be seen as a dual champion: to take care of the public sector on the one hand, but also to take a strategic overview of the whole market – public, social marketing, NGO and commercial - in order to ensure that all citizens have access to the best possible products at a price they can afford.

It is recommended that the issue of demand creation is used as an entry point to a more strategic approach for overall market development and developing the role of PPPs. The RHCS Stakeholders Group would provide the forum for such an approach. It will be important to involve CHANPHARM as well as SFH, given its potential role in RHC supply. Consideration should be given to designing a facilitated process to support stakeholder dialogue and strategy formulation.

5.5 Condom policy and programming

The male condom market is becoming more complex, as demand has risen. Developing a condom policy and programming framework is included in NACA's strategic plan, and many would like to see a greater focus on prevention by NACA as part of its support to the multisectoral response.

Given this overall picture, there is an urgent need for an assessment of the total market, led by NACA, but involving DCDPA, NASCP and other SPARHCS stakeholders. The policy process would benefit greatly from an independent rapid review of all players in the market, and mapping of current issues, plans and linkages. This would support an approach to the total market, where government would lead a process to assess the current market, and the comparative advantages of the various providers and products for reaching different consumer segments. It would also provide a forum for discussing how HIV/STI prevention, including dual protection, can be better integrated within RH service delivery, and vice versa.

5.6 National-international interface and linkages

The commodity financing procedures and arrangements of UNFPA appear rather opaque to stakeholders – there is limited knowledge of how the global funding and procurement function works (or indeed could work better), and some confusion about the sources of finance available at global level. This can be disempowering and is in contrast to how other global mechanisms work, such as the Global Drug Fund for TB drugs, where country programmes are encouraged to develop a brief costed proposal for either a grant or drugs in kind.

As part of building government ownership, strengthening communication and involvement are recommended – through for example, involving developing country government representatives in governance functions of any global level financing mechanism. Experience with TB and malaria partnerships indicate that greater involvement may help in profile raising and resource mobilisation for RHCS.

As part of the WAHO Co-ordinated Informed Buying initiative for RHCS, an assessment was carried out in Nigeria⁵. It focuses almost exclusively on ARVs, and explicitly excludes FP commodities from its analysis, finding that there are no intentions for government to fund or procure locally. It states that contraceptives have typically been donated and procured externally, so 'no savings could be made through informed buying'. However, it also notes that informed buying could support VFM procurement in the future, should current practices change.

Pre-qualification by a recognised international process of both generic and branded suppliers could be useful to Nigeria agencies and to its pharmaceutical industry. For example, a local firm is getting pre-qualified for ACT production, which will enable its products to be eligible for purchase with GFATM funds both in Nigeria and more widely. The scheme could help fast track NAFDAC regulatory processes, although the product must still be registered by NAFDAC.

5.7 Essential commodities: magnesium sulphate

This assessment has noted that magnesium sulphate is not on the EDL, and nor is it widely available or used for treatment and prevention of pre-eclampsia or eclampsia. However its use is recommended in the FMOH emergency obstetric care manual for doctors and CHANPHARM has obtained a waiver from NAFDAC for importation. It is recommended that the RH Unit review WHO's guidance and evidence, with a view to taking the necessary steps, such as discussion with technical experts and existing users in Nigeria, inclusion in the EDL, dialogue with distributors, including CHANPHARM, and formal communication with state health commissioners etc.

⁵ Informed buying means benchmarking against pricing information obtained from suppliers and purchasers, nationally, regionally or internationally. There are several international sources and pricing guides on the internet for essential drugs, but less information is available for contraceptives.

Annex 1 - Persons met

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Mr Biodun Ogungbemi, Supplies and Logistics Officer, PPFN

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