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Nigeria: Reproductive Health Commodity Security Situation Analysis

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Abstract
Reproductive health commodity security (RHCS) is the ability of every man, woman, and youth to be able to choose, obtain, and use quality contraceptives and other reproductive health commodities whenever he or she needs them. Therefore, the availability of commodities is essential in achieving demand and commodity security. Nigeria has been working toward achieving RHCS, starting with the development of an RHCS strategy in 2003. To further update and continue with the efforts, the authors conducted a reproductive health commodity security situation analysis to assess and understand the current situation.

This RHCS situational analysis provides information for strengthening the efforts to improve RHCS and for developing an updated national strategic plan.

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Abbreviations and Acronyms

ACPHCC	Assistant Coordinator Primary Health Care Centre
ACQUIRE	Access, Quality, and Use in Reproductive Health
AHIP	Adolescent Health Information Project
AKTH	Aminu Kano Teaching Hospital
ARFH	Association for Reproductive and Family Health
BCC	behavior change communication
CBD	community-based distributor
CBO	community-based organization
CCM	Country Commodity Manager
CCW	Central Contraceptive Warehouse
CHAN	Christian Health Association of Nigeria
CHEWs	community health extension workers
CHIME	Center for Health, Information, Monitoring and Evaluation
CIDA	Canadian International Development Agency
CLMS	contraceptive logistics management system
CMS	Central Medical Stores
CNO/HOD	chief nurse officer/head of division
COC	combined oral contraceptive
COCP	combined oral contraceptive pill
COMPASS	Community Participation for Action in the Social Sector Project
CPR	contraceptive prevalence rate
CS	contraceptive security
CSO	civil society organization
DCR	daily consumption record
DFID	(UK) Department for International Development
DHS	Demographic and Health Survey
DPH	Department of Public Health
ECP	emergency contraceptive pill
EDL	essential drug list
ENHANSE	Enabling HIV & AIDS, TB and Social Sector Environment Project

EOC	emergency obstetrical care
FBO	faith-based organization
FCT	Federal Capital Territory (Nigeria)
FCTA	Federal Capital Territory Administration
FEFO	first-to-expire, first-out
FHD	Federal Health Department
FHI	Family Health International
FMOH	Federal Ministry of Health
FOMWAN	Federation of Muslim Women's Associations in Nigeria
FP	family planning
GDP	gross domestic product
GHAIN	Global HIV/AIDS Initiative Nigeria
GNI	gross national income
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HMB	Health Management Board
IEC	information, education, and communication
IMR	infant mortality rate
IPPF	International Planned Parenthood Federation
IUCD	intrauterine contraceptive device
JCHEWs	Junior Community Health Extension Workers
JSI	John Snow, Inc.
LGA	local government area
LMIS	Logistics Management Information System
LSAT	Logistics Systems Assessment Tool
MCH	maternal and child health
MMR	maternal mortality ratio
MNPI	Maternal and Neonatal Program Effort Index
MOH	Ministry of Health
NACA	National Agency for the Control of HIV/AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NDHS	Nigeria Demographic and Health Survey
NEEDS	national economic empowerment and development strategy
NGO	nongovernmental organization
NHIS	National Health Insurance Scheme
NMA	Nigeria Medical Association

NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NPI	National Programme on Immunization
NYSC	National Youth Service Corps
OJT	on-the-job training
PHC	primary health care
PPFN	Planned Parenthood Federation of Nigeria
PSN	Pharmaceutical Society of Nigeria
RH	reproductive health
RHCS	reproductive health commodity security
RHCSAT	Reproductive Health Commodity Security Situation Analysis Tool
RIF	Requisition and Issue Form
RIRF	Requisition, Issue, and Report Form
SDP	service delivery point
SEEDS	State Economic Empowerment and Development Strategy
SFH	Society for Family Health
SMOH	State Ministry of Health
SN/M	serial number
SOGON	Society for Gynaecology and Obstetrics of Nigeria
SOPs	standard operating procedures
SP	service provider
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
STGs	standard treatment guidelines
STI	sexually transmitted infection
TFR	total fertility rate
TWG	technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization (Geneva, Switzerland)
YEDA	Youth & Environmental Development Association
YOSPIS	Youth Society for Prevention of Infectious Diseases and Social Vices
VCT	voluntary counseling and testing (HIV/AIDS)
VFT	vaginal foaming tablet

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Thanks also go to all of the stakeholders who shared the valuable information, opinions, and perspectives that went into informing the assessment.

We hope that this report will contribute to improving the reproductive health commodity security situation in Nigeria.

Executive Summary

This assessment is a continued effort by the Reproductive Health Branch and Contraceptive Logistics Management System section of the Department of Public Health of the Federal Ministry of Health (FMOH) to improve and strengthen reproductive health commodity security (RHCS) in Nigeria. This situation analysis attempts (a) to identify the strengths and weaknesses in seven key areas that affect the availability of reproductive health (RH) commodities in Nigeria and (b) to make recommendations to start the process of updating the RHCS strategy. The seven key areas include political and socio-economic context, coordination of (reproductive health commodity security (RHCS), commitment toward RHCS, financing for contraceptives and services, provision of family planning commodities, client utilization and demand, and the logistics system capacity.

Methodology

A team from the FMOH and consultants from the USAID | DELIVER PROJECT and the United Nations Population Fund (UNFPA) conducted a three-week situation analysis to assess socioeconomic context, coordination, commitment, financing, commodities, client use, and demand, as well as the capacity of the system in Nigeria. This team conducted two workshops, reviewed key documents, and visited 6 of the 36 states to interview health staff members at the state level, local government area (LGA), and service delivery points (SDP) to gather information for the assessment. The assessment was based on the Reproductive Health Commodity Security Assessment Tool (RHCSAT), a tool that was developed by UNFPA and is based on two preexisting tools: (a) the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS), which is a comprehensive methodology for RHCS, and (b) the Logistics Systems Assessment Tool (LSAT), which provides more detailed analysis of supply chains.

Summary of Findings

A number of enabling policies provide a supportive framework for RH for women, men, and young people. However, the national RH policy and strategy and the RHCS strategy have not been adapted to the state level to fit the context of each state with accompanying indicators and targets. This failure is partially to the result of a lack of awareness on the part of state-level stakeholders about the need to develop state-specific policies on reproductive health. Additionally, although RH as a priority is commonly addressed, specific family-planning (FP) activities are not always included in health reform initiatives. Commitment for FP exists, but that commitment has not always been demonstrated with adequate financing for programming. All public-sector FP commodities are donated to the FMOH by UNFPA. Although the private sector is a source of contraceptives for nearly 60 percent of married women of reproductive age, most of their commodities are donated by UK Department for International Development (DFID) and U.S. Agency for International Development (USAID). Short-term needs are being fulfilled by donors' financial commitments; however, the government should also start contributing funds to ensure long-term sustainability for RHCS.

Many states do not have any funds dedicated to RH or FP and, therefore, lack funds to do any extensive FP programming, training, awareness creation, or supervision, nor do they have provisions to purchase additional commodities outside the cost-recovery system. Setting a precedent at the central level in the creation of a budget line item for FP programs and using those funds to purchase commodities translates commitment to action that will provide an example for states to follow.

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

Health worker shortages and turnover influence the capacity to follow CLMS guidelines. Other issues are the quality and frequency of supervision that will monitor health worker performance on the CLMS. A cost-recovery system was designed to ensure a continuous supply of contraceptives, but because of low demand for family planning, sales are often not enough to generate sufficient funds to purchase additional supplies and to support other logistics activities, including incentives for the health worker.

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

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

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

The shortage of skilled workers at all levels of health care delivery in Nigeria, which was exacerbated by high attrition rates and frequent transfers, compromises the ability of the system to offer quality FP services. Religious and cultural beliefs are also common barriers to accessing and promoting contraceptives. Those factors, among others, have contributed to low accessibility of FP services and a decreasing contraceptive prevalence rate from 8.6 percent (1999) to 8.2 percent (2003) among married women using modern methods.

Key Recommendations

- Ensure that family planning and RHCS are integrated and addressed in health policies, guidelines, strategies, and health reform programs.

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

Conclusions and Next Steps

This assessment identified the strengths and weaknesses of the RHCS situation in Nigeria and will be part of a larger process that will be used to inform the revision of the strategic plan to improve RHCS in the country.

Introduction

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

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

Purpose

The purpose of this RHCS analysis is (a) to identify and analyze the strengths and weaknesses in seven key areas that affect the availability of RH commodities in Nigeria, specifically family-planning commodities and (b) to make recommendations for strengthening RHCS. The recommendations are intended to be used as part of a strategic-planning process that begins with this analysis and continues with country stakeholders to update the National Strategic Plan for Reproductive Health Commodity Security.

Objectives

The objectives of this situation analysis were to accomplish the following:

- Identify the background situation of RH commodity security in the country.
- Introduce and increase awareness of the RHCS concept and the framework components.
- Collect information on the status of RHCS in the country on family-planning commodities in seven key areas:

  Political and socioeconomic context

  Coordination of RHCS

  Commitment toward RHCS

  Finances for contraceptives and services

  Provision of family-planning commodities

Client use and demand

Logistics system capacity

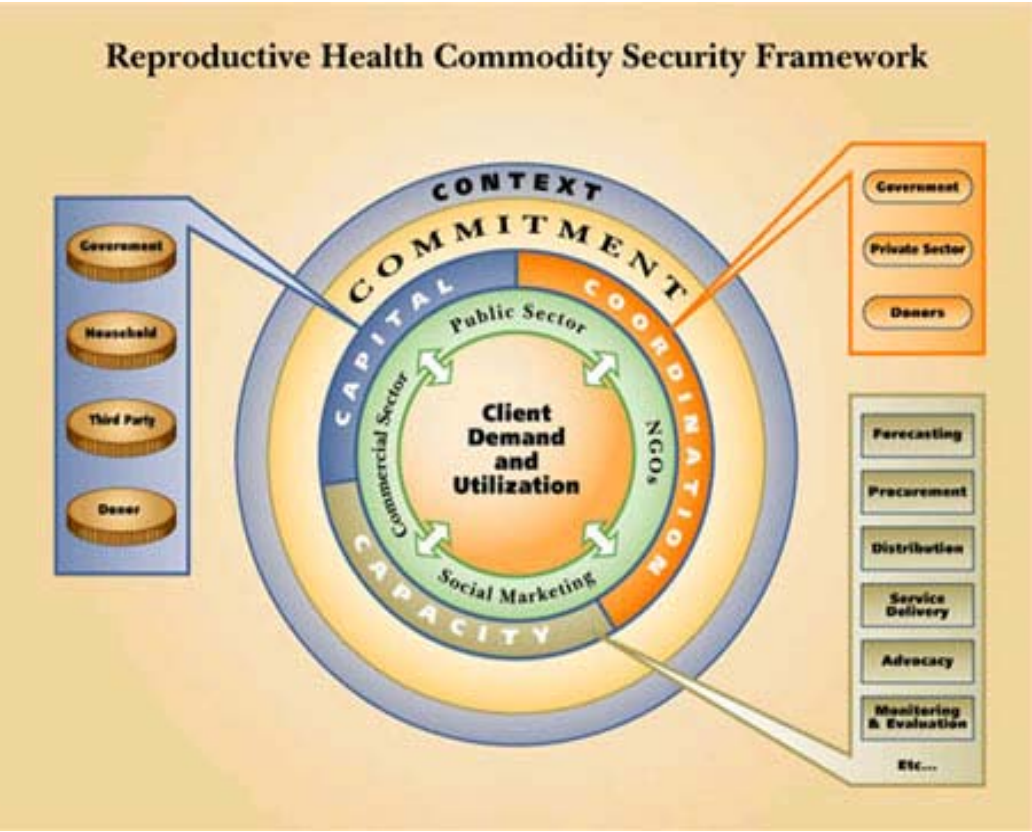
- Understand and identify strengths and weaknesses of the country's RHCS situation.
- Identify any information gaps on the RHCS components.
- Set priorities for strengths and weaknesses of each of the RHCS components.
- Develop recommendations for the improvement of RHCS in Nigeria and feed them into the development of the updated strategic plan.

Methodology

The situation analysis of RHCS entailed a participatory, multistakeholder process for collecting and analyzing information about Nigeria's RHCS situation including (a) document review: (b) focus-group discussions during a national stakeholder workshop: and (c) site visits to states, local government area (LGA) stores, and service delivery points (SDPs). After the interviews and visits were completed, preliminary findings and recommendations were presented for feedback at a RHCS stakeholder debriefing.

The methodology for this assessment is based on the RHCSAT framework (see figure 1) developed and adapted by FMOH, UNFPA, USAID, and other partners.

Figure 1. Reproductive Health Commodity Security Framework



Source: SPARHCS.

Figure 1 depicts how seven essential RHCS elements (context, commitment, coordination, capacity, capital, and client use and demand) influence client RHCS. In every country, there is a **context** that affects the country's prospects for achieving RHCS, including national policies and regulations that bear on reproductive health (particularly on the availability of RH supplies) and on broader factors such as socioeconomic conditions, political and religious concerns, and competing priorities.

Within this context, **commitment**—evidenced in part by supportive policies, government leadership, and focused advocacy—is a fundamental underpinning for RHCS. Commitment is the basis from which stakeholders invest the necessary **capital** (financing), coordinate for commodity security (CS), and develop necessary capacities to ensure CS. The boxes in the figure elaborate on each of those three components. **Coordination** involves government, the private sector, and donors to ensure more effective allocation of resources. Households, third parties (e.g., employers and insurers), governments, and donors are all sources of capital. Additionally, **capacities** must exist for a range of functions, including policy; forecasting, procurement, and distribution; demand creation; service delivery; and supervision, monitoring and evaluation. At the center of the figure, **clients** (youth, women, and men) are the ultimate beneficiaries of RHCS as product users and, as shown by the double-headed arrows, are the drivers of the system through their demand.

The assessment tool (RHCSAT) used to conduct the situation analysis is based on two well-tested tools: SPARHCS and the Logistics System Assessment Tool (LSAT). The RHCSAT contains questions relating to the seven core components of RHCS: context, coordination, commitment, capital, commodities, client demand and use, and capacity.

Assessment Team

The six assessment teams, were supported by UNFPA and the USAID | DELIVER PROJECT. Each team was made up of representatives from the FMOH and the State Ministry of Health (SMOH), a consultant, and a representative of UNFPA and the USAID | DELIVER PROJECT.

Training on the Assessment Tool

The RHCS Technical Working Group reviewed and adapted the tool and field tested it prior to the assessment. Subsequently, a one-day training on the tool was conducted for data collectors from the FMOH, SMOH, UNFPA, and USAID | DELIVER PROJECT.

Data Collection

The RHCSAT (and its interview guide) was the main data collection tool. Each team also tracked several quantitative indicators. Data collection took place through a variety of methods:

- The team held two focus group discussions, one at the national level in Abuja and one at the state level in Kano. RH stakeholders represented the public (Ministry of Health) system at the national, state and LGA levels. Civil society, social marketing, local nongovernmental organizations (NGOs), the National Health Insurance program, and other key stakeholders also had representatives at both workshops.
- Data were collected during field visits to state, LGA, and SDP.
- Key informant interviews were used to collect information from development partners.
- The consultants conducted a desk review of various policy documents; program publications; surveys, including the Nigeria Demographic and Health Survey (NDHS); and Internet resources.
- Preliminary findings were presented to stakeholders at the end of the exercise; feedback was used to finalize the report.

Study Limitations

A state was selected from each of the six geopolitical areas, and each state team visited two urban and one rural LGA. The LGAs and facilities were selected randomly in an attempt to sample tertiary, secondary, and primary health care centers. In terms of type, sites were selected by state family-planning (FP) coordinators from state, LGA, and service delivery points. The findings from the selected facilities offer anecdotal evidence of the particular facility and are not representative of the entire state or country. However, the sampled facilities taken together can provide generalized findings of the strengths and weaknesses of the contraceptive security situation in the country.

Site Visits

The six states visited were selected from the six different geopolitical areas and were as shown in table 1. In each state, teams visited at least three LGAs, with two SDPs per LGA. One rural LGA was selected out of the three. A total of 18 LGAs and at least 36 SDPs were assessed. In addition, some private hospitals, local NGOs, community-based distributors (CBDs), and local pharmacies were also visited. For a more detailed list of facilities and contact persons, please refer to Appendix C.

Table 1. Field Sites Visited

Zone	State	Local Government Area
South-East	ABIA State Family-Planning Store	**Umuahia North LGA** Federal Medical Centre Umuahia North Urban Clinic
		Ohafia LGA Abiriba General Hospital Isiama-Elu Health Centre
		Aba South LGA Family-Planning Clinic, Health Office Family-Planning Clinic, Abia State University Teaching Hospital
South-South	Akwa-Ibom	**Offot Edina LGA** University of Uyo Teaching Hospital
		Nsit Ibom LGA Nsit Ibom Model Primary Health Care (PHC)
		Oron LGA Operational Base Warehouse PHC Oron General Hospital Oron
		Ikono LGA PHC Operational Base Ikono General Hospital Ikono
North-East	Bauchi Bauchi State Storeroom	**Dass LGA** Dass Town Maternity Wandi Health Clinic

		Ganjuwa LGA Kafi Madaki Town Maternity Sabon Kariya PHC Soro PHC 10 Soro CBDs
		Bauchi LGA Bauchi Specialist Hospital Urban Maternity Fahimta (local NGO)
		Katagun LGA Urban Maternity Town Maternity
North-West	Kano	**Kumbotso LGA** Comprehensive Health Center Shekar Primary Health Care Center
		Gwale LGA Filimushe Maternal and Child Health (MCH) Center Kabuga Health Clinic Planned Parenthood Federation of Nigeria (PPFN)
		Takai LGA Fajewa PHC Takai NYSC Clinic (Cottage Hospital) YOSPIS (Local NGO) Community-Based Distributors
North-Central	Nasarawa State Family-Planning Store	**Obi LGA** General Hospital PHC Obi town
		Toto LGA National Model PHC Gadabuke Basic Health Centre
		Nasarawa Eggon LGA Wowyen PHC Nasarawa/Eggon Town PHC
South-West	Ogun State Family-Planning Store	**Ijebu Ode LGA** State Hospital Family Health Clinic, Oke Oyinbo
		Imeko-Afon LGA Primary Health Care Complex Imeko General Hospital Ilara Health Clinic
		Abeokuta South LGA State Hospital, Ijaiye Oke-Ilewo Family Health Center

Commodities Assessed

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

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

Country Context

The Federal Republic of Nigeria is located in West Africa and has a population of 148 million people.[1] The fourth largest country in Africa, Nigeria has diverse topography, climate, and cultures. It has the largest population in Africa and the 10th largest in the world. Bordered by the Atlantic Ocean in the west, Nigeria has mangrove swamps in the Niger Delta and grasslands in the Sahelian northern part of the country. (See figure 2.)

Figure 2. Map of Nigeria

Nigeria is a federal republic that comprises 36 states and a Federal Capital Territory (FCT), which are grouped into six geopolitical zones: North-Central, North-East, North-West, South-East, South-South, and South-West. There are also 774 local government areas (LGAs) and six area councils in the FCT.

[1] http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/NIGERIAEXTN/0,,menuPK:368906~pagePK:141132~piPK:141107~theSitePK:368896,00.html

Nigeria has a tropical climate with rainy and dry seasons. The rainy season is generally from April through September, and the dry season is from October through March. Because of the size of the country and the varying climate zones, soil conditions, and vegetation, Nigeria has a wide range of agricultural products, and it was upon those facts that the economy was based until recently.

Since 1980, two-thirds of the country's gross domestic product (GDP) has come from oil. Until recently, the government controlled most industrial and commercial enterprises, but that situation is now giving way to privatization. With the move to democratic rule in 1999, economic policies have been more favorable to investment. Since then, the performance of the domestic economy has improved (NDHS, 2003).

Nigeria became a republic on October 1, 1963. It is culturally and linguistically diverse, with more than 374 identifiable ethnic groups. The three major groups are the Igbo, Hausa, and Yoruba. Before coming into existence as a nation state in 1914, groups such as the Benin, Hausa-Fulani, Jukun, Kanem-Bornu, Nupe, and Oyo lived in kingdoms and emirates with sophisticated government structures. The nation-state was governed as a crown-colony type of government by the British until the early 1950s, when Nigeria moved toward partial self-government.

Population and Family Planning

The population of Nigeria is predominantly rural, with two-thirds of Nigerians living in rural areas. According to the UNDP Human Development Report (2007/2008), 70.8 percent of the population lives below the poverty line. Nigeria's youth-dominated age structure, with approximately 44 percent younger than 15, will have a significant effect on the growth rate, particularly as almost half the population will be at or reaching reproductive age within the next 15 years. The fertility rate in Nigeria is also high, at an average of 5.7 children per woman (NDHS, 2003). Although the total fertility rate (TFR) has declined slightly from 6.0 in 1990, current rates—coupled with a desired large family size—indicate that further immediate decreases will likely continue to be minimal.

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

The health sector in general has very weak services, as acknowledged by a Nigerian government document quoted as saying, "The health system in Nigeria and health status of Nigerians are in a deplorable state" (Health Sector Reform Programme, 2004–2007; FMOH, 2004). Significant problems include low motivation of health workers, no budget line for many needed programs, and weak coordination between federal and state governments. According to the World Health Organization (WHO) health statistics for 2002, government per capita spending on health amounted to US$5.

Nigeria Health System

Nigeria's first national health policy (1988) was essentially designed to achieve health for all Nigerians and was based on the philosophy of social justice and equity. The national health policy provided for a three-tier structured health system of primary, secondary, and tertiary care:

- Primary health care level—This level constitutes the entry point into the health system and is primarily the responsibility of the LGAs. At this level, general health services that are preventive, promotive, protective, curative, and rehabilitative in nature can be accessed. Private medical practitioners also provide care at this level.
- Secondary health care level—Referrals from the primary health care level are generally directed to this level. The level consists of general and specialist hospitals usually established by state governments.
- Tertiary health care level—This level is the apex level of health care in Nigeria and includes teaching hospitals, federal medical centers, and other specialized hospitals such as psychiatric, orthopedic, ophthalmologic, and specialized care centers. The federal government takes responsibility for tertiary health care and is expected to provide at least one tertiary facility in each state of the federation.

In addition to the three levels, there are also faith-based organizations (FBOs) that provide reproductive health (RH) and FP services, as well as community-based distributors (CBDs) that supply male and female condoms and combined oral contraceptives pills (COCPs). CBDs obtain their supplies through the primary care facilities, although some are currently working with and supplied by local nongovernmental organizations (NGOs).

Devolution of health care to the state and local government levels has been challenging, in part because of a lack of capacity in both human resources and financing at these levels. States and LGAs do not have a sufficient number of skilled personnel or the funds to train and hire skilled personnel for many types of health services. Access for the people in rural areas is difficult because not enough facilities exist to serve the population. The access problem is especially disturbing because two-thirds of the country's population lives in rural areas.

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

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

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

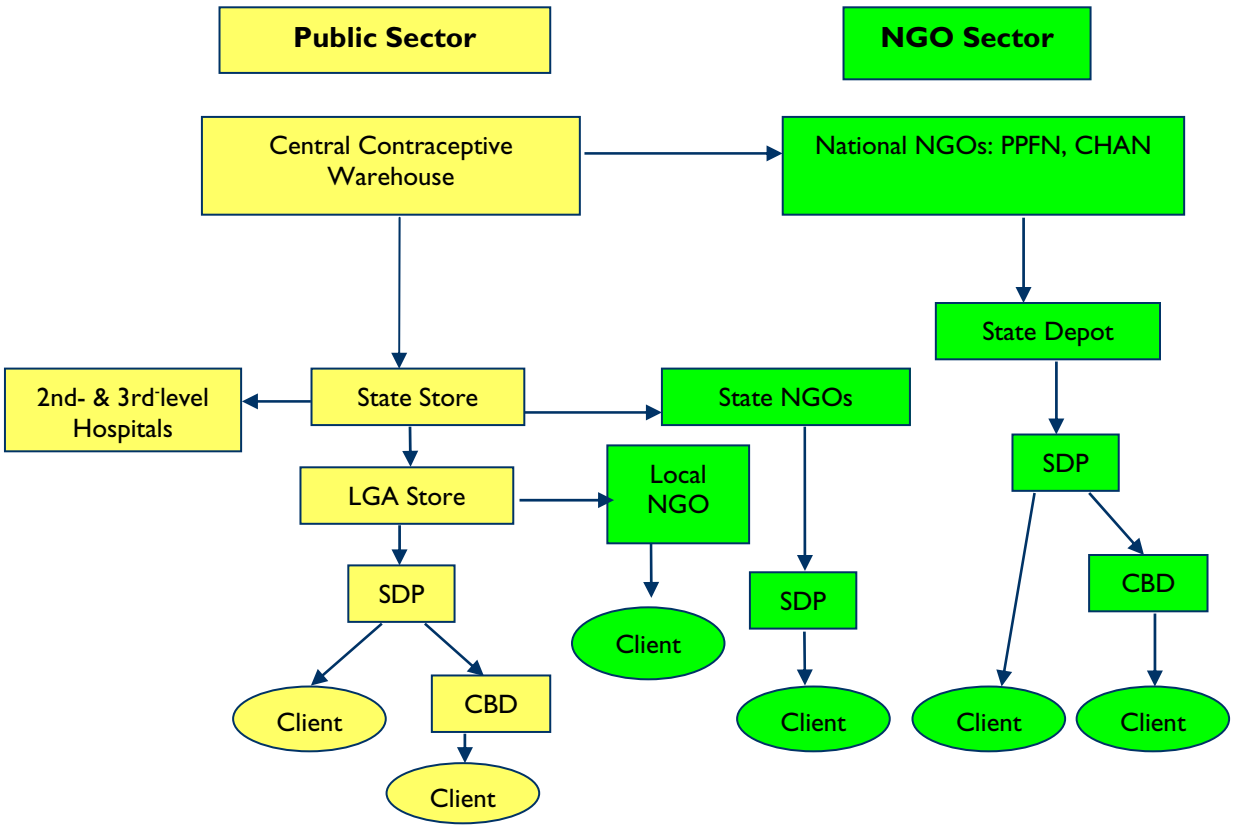
The National Agency for Food and Drug Administration and Control (NAFDAC) is a parastatal of the Federal Ministry of Health with the mandate to regulate and control drugs, medical supplies, food, and other products that are locally manufactured or distributed in Nigeria. All such products

have to be registered with, or receive a waiver from, NAFDAC to be supplied to clients in the country.

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

In the private sector, a number of private doctors and hospitals provide health care for those who can afford their services. (See figure 3 for the supply chain.

Figure 3. Health Commodities Supply Chain



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

Assessment Findings

Context

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

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

One of the major threats to RHCS is the severe shortage of skilled health personnel—community health extension workers (CHEWs), nurses, midwives, and doctors. Some states are reluctant to bring personnel in from other states because of a preference for hiring indigenes or because of the belief that outside personnel will not be accepted as a result of sociocultural factors. Some states are unable to recruit and train enough health workers because of general low education rates in their state. The staffing shortage jeopardizes the ability of the health care system to offer quality services and should receive adequate human and financial attention in order to achieve RHCS. (See the indicators in table 2.)

Table 2. Demographic, Health, and Development Indicators

Indicator	1999	2003
Total population (million)	115	140 (2006)
Total fertility rate (TFR)	6 (1990) 5.2 (1999)	5.7
Percentage of population that is urban	36	34
Percentage of population that is rural	64	66
Population growth rate	2.6 (2000)	2.9 (2.83)
GNI per capita	$790	$900
Adult female literacy rate	56 (2000)	59 (2002*)
Adult male literacy rate	72 (2000)	74 (2002*)
Number of women of reproductive age	28,234,000 (2000)	29,107,771
Infant mortality (per 1,000 live births)	78	100
Maternal mortality (per 100,000 births)	289**	800

Contraceptive prevalence rate (modern methods)	8.6	8.2
Unmet need	17.5	16.9
Source of contraception— public sector	42.9	22.8
HIV prevalence	4.5 (1996)	4.4 (2005)
Average age of marriage for men and women	26/18	>23/<19
Average age at delivery of first child	20	20.3

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

*Earthtrends, 2003.

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

Policies and Regulations

A number of strategies, policies, and frameworks influence FP and commodity security in Nigeria, including the following:

- **The National Policy on Population for Sustainable Development**, 2005–present. The policy looks at possible consequences of unmanaged population growth and puts forth goals and targets to "improve the quality of life and standard of living of the people of Nigeria," including improvement in the reproductive health of all Nigerians at every stage of their life cycle.
- **National Reproductive Health Policy and Strategy**, 2001–2006 (Federal Ministry of Health). The policy aims to create an enabling environment for reproductive health providing a broad outline on training; services; commodities; information, education, and communication (IEC); monitoring and evaluation; financing; and research at the national, state, and local government area (LGA) levels. One of the areas that the policy seeks to address is the low level of awareness and use of contraceptive and natural FP services. The policy aims to increase the contraceptive prevalence rate from the present 8.6 percent to 20 percent.
- **Nigeria National Youth Policy and Strategic Plan of Action**. The health component of this policy strives to "seek and offer solutions to youth problems such as drug abuse and addiction, teenage pregnancy, sexually transmitted diseases, HIV/AIDS, cultism, and examination malpractices." The policy recognizes certain rights of youth related to health, including the right to adequate health care; the right to protection against the dangers of substance abuse, alcoholism, sexual harassment and exploitation, and HIV/AIDS; the right to be protected against harmful traditional practices; and the right of the disabled to be provided with the special services that they require.
- **National Guidelines for the Integration of Reproductive Health and HIV Programs in Nigeria**. The guidelines provide a national strategy and framework for the integration of RH with HIV services and vice versa, following the belief that integration will maximize health outcome achievements and will ensure a more efficient use of resources. The guidelines provide a broad framework for eventual integration of all RH and HIV services. They also provide a framework for commencement with minimal package of FP and voluntary counseling and testing (HIV/AIDS), or VCT, with eventual scaling up to include all possible services in RH and HIV at all levels of the health service system in Nigeria.

- **National RHCS Strategic Plan**, 2003–2007. The plan covers RHCS for contraceptives and condoms for prevention of sexually transmitted infections (STI) and HIV/AIDS. The strategic plan includes supply of all modern methods of contraception, including condoms that are used in the prevention of HIV/AIDS and other STIs. The plan covers six components: coordination, demand, finance, logistics, policy, and service delivery. It was developed in collaboration with civil society, the government, individuals, nongovernmental organizations (NGOs), and the private sector.
- **National Adolescent Health Policy,** 2007. The policy provides a framework for adolescents and young people (10–24 years of age) with the aim to provide resources and interventions that will ensure their optimal health. Through advocacy, the policy also seeks to generate the political will for, plus create a safe environment for, its implementation. The policy sets target for (a) reducing maternal mortality by 75 percent and unwanted pregnancies by 50 percent among young people and (b) integrating family life and HIV/AIDS education into primary and secondary curricula. The topic of sexual and RH rights is one of nine key interventions.
- **National Health Insurance Scheme (NHIS)**. The NHIS was developed to ensure that every Nigerian has access to quality health care services. The scheme covers the formal and informal sectors, particularly vulnerable groups. The mission is to ensure fair financing of health costs through pooling and cost-sharing to protect against the high cost of health care through prepayment programs.

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

Such a plan should respond to the needs and context of each state. State and LGA RH targets are nonexistent, resulting in lack of direction and accountability for state- and LGA-level coordinators. National policies are not widely available beyond the central level, because only a few are cited at the state level. A similar situation exists concerning availability of standard operating procedures (SOPs) and standard treatment guidelines (STGs) at the state level; these guides were inconsistently available from state to state. FP services and targets are not addressed in health reform documents such as the National Economic Empowerment Development Strategy (NEEDS) and the State Economic Empowerment Development Strategy (SEEDS)—another barometer of the lack of focus on these issues.

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

The United Nations Population Fund (UNFPA) funded the production and printing of a user-friendly version of the National Population Policy for Sustainable Development titled "What You Need to Know about the National Policy on Population for Sustainable Development." About 20, 000 copies were produced and disseminated (in a country of 140 million). The National Population Commission also intends to translate the policy into three Nigerian languages (Hausa, Igbo, and Yoruba), with funding assistance from the UNFPA. The national RH policy and other related policies have not been translated into local languages. Some advocacy kits and IEC materials have been developed, such as RH advocacy kits (for Safe Motherhood, adolescent reproductive health (ARH), and family planning, funded by ENHANSE).

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

The Reproductive Health Branch is involved in making decisions related to FP and RH commodities, including a joint biannual forecast exercise with UNFPA. The international development partners, especially UNFPA, U.S. Agency for International Development (USAID), and (UK) Department for International Development (DFID) are, however, funding the procurement of contraceptive commodities brought into the country, as they donate all contraceptives in the public system and all of the commodities for social marketing through the Society for Family Health (SFH). No contraceptives are currently purchased with government funds.

Nigeria does have an NHIS that currently covers much of its urban civil servants and that is envisioned to expand, eventually, to cover formal and informal sectors, as well as vulnerable groups. At present, the NHIS does not cover FP commodities or services, although it does counsel on the use of FP. The NHIS is in the process of updating its guidelines, which will present an opportunity for recommendations to be made by the FMOH for inclusion of FP commodities and services.

The FMOH is currently updating its essential drugs list (EDL), to which all contraceptives including implants will be added. The 2003 version of the list includes condoms (with or without spermicide); foaming tablets; diaphragms with spermicide (not currently available in the public system); intrauterine contraceptive device (IUCDs) (Copper and Lippe's Loop); injectable contraceptives (levonorgestrel implant, medroxyprogesterone acetate injection, and norethisterone enanthate injection); and oral contraceptives (ethinyloestridiol plus levonorgestrel, ethinyloestridiol plus norethisterone, and norethisterone). It is easier to bring drugs into the country if they are included in the EDL; however, they must still be registered with the National Agency for Food and Drug Administration and Control (NAFDAC) by the manufacturer, which is a stringent process. The importer cannot register on the manufacturer's behalf. Exemption from duties on contraceptives is available for contraceptives procured for the public sector, as well as for SFH socially marketed commodities, but the waiver process is a prolonged one. Exemption is an issue because of reportedly frequent changes in product brand. Private sector importers are subject to all duties.

For injectables, implants, and IUCDs, clients must either have a prescription or receive supplies directly from a trained provider. However, it appears that, in practice, clients are able to purchase many medicines from private pharmacies without a prescription.

The only age- or parity-related restriction formally limiting access to contraceptives is that the client must be of reproductive age. Informally, in some sections of the country, cultural practices still allow the husband

to make the final decision on the use of family planning. Although policies stipulate equal access for adolescents, in reality, cultural barriers exist in easily procuring contraceptives, thus leaving the decision of whether to supply contraceptives to sexually active adolescents to the discretion of the provider.

The advertising and the promotion of RH services and commodities, including contraceptives and condoms, are not formally restricted. In some states, this fact has led to widespread advocacy campaigns, but in others, local pressure from religious leaders has inhibited such promotion.

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

The intent is that service providers (SPs) undergo further in-service and step-down trainings in accordance with newly adopted commodities, protocols, guidelines, or forms. Although training and certification requirements exist for providing FP and other RH services, including a mandatory, four-week FP training, the funding to roll out this training on a national or statewide basis is currently not available. UNFPA planned to fund this training in all of its 15 supported states by the end of 2008.

Standard treatment guidelines exist, notably (a) FP service provision SOPs, (b) monitoring and supervision of dispensing practices, and (c) Universal Safety Precaution Guidelines, but they were seldom found below the state level.

Strengths

- National policies emphasize informed choice on multiple (modern and natural) methods.
- National policies ensure access to FP for all persons of reproductive age on a voluntary basis.
- A National Strategic Plan for Reproductive Health Commodity Security was developed in 2003.
- Contraceptive management logistics system job aids are present and in use at facilities.
- Most contraceptives are included on the EDL.
- In-country capacity exists to manage the national RHCS program.

Weaknesses

- Inadequate dissemination and implementation of polices exist at state and LGA levels.
- RHCS strategy has lapsed and was not adequately financed.
- Inconsistent availability of SOPs and STGs at state, LGA, and service delivery point (SDP) levels.
- States do not have RH policies specific to them.
- EDL products are still subject to duties (application of waiver required for exemption).
- FP services and targets are not addressed in health reform documents.
- Many service providers do not have formal or recent FP training.
- FP commodities are not covered by the NHIS.

Key Recommendations

- Update the RHCS strategy by the end of 2008.
- Adapt national RHCS strategy to each state.
- Create national-, state- and LGA-level RH targets.
- Disseminate and translate national polices to state level.
- Facilitate the development of state RH policies to fit state context and to distribute them among all RH and FP stakeholders.
- Implement the RH policy with needs-driven components, particularly at the state level.
- For NHIS guidelines, write a letter from the FMOH to recommend inclusion of FP.
- Make SOPs and STGs available at all SDPs with on-the-job training (OJT) and with follow-up supervision to ensure adherence.
- Earmark funds to reinstitute FP course on theory and clinical skills outside of UNFPA-supported FP services and targets in health reform documents such as NEEDS and SEEDS.

Coordination

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

The National RHCS Stakeholders Committee consists of representatives from Ministries of Health, Planning, Women's Affairs, Education, Youth, and Finance; the Armed Forces Health Services; the police; National Primary Health Care Development Agency (NPHCDA); NAFDAC; the Department of Food and Drugs; hospital services; USAID; World Health Organization (WHO); UNFPA; Canadian International Development Agency (CIDA); DFID; Community Participation for Action in the Social Sector Project (COMPASS); Family Health International (FHI); Ford Foundation; Packard; Engender Health; Access, Quality, and Use in Reproductive Health (ACQUIRE); Center for Health, Information, Monitoring and Evaluation (CHIME); Federation of Muslim Women; Association for Reproductive and Family Health (ARFH); Adolescent Health and Education Project; Pharmaceutical Agency of Nigeria; Society for Family Health; Planned Parenthood Federation of Nigeria (PPFN); Christian Health Association of Nigeria; Society for Gynaecology and Obstetrics of Nigeria (SOGON); and other stakeholders. This committee was created in 2002 and is chaired by the permanent secretary of the FMOH. The FMOH has taken the lead in this coordination effort but is hampered by inadequate funding. The committee is supposed to meet twice a year but has not met since 2006. When the committee was active, the meeting attendance was reportedly more than 75 percent. In addition to the issue of funding, which mostly pertains to financing attendance for civil society partners, a series of changes and reorganizations within the government itself have made meeting difficult.

The National RHCS Stakeholders Committee was created to function as the decision-making body, and its meetings need to be attended by officials at the policymaking and decision-making levels. Of course, the committee needs to meet regularly and to receive ongoing funding in the FMOH budget.

As a decision-making body, the committee should release an annual report on RHCS, which details progress made and upcoming activities, to share with stakeholders. In addition to the larger committee, subcommittees or technical working groups (TWGs) should be in place to address and coordinate specific functions, such as forecasting, procurement, distribution, and behavior change communication (BCC) or IEC.

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

The FP coordinators' meeting is a good forum for states that are already coordinating to share best practices with states that have not yet begun this initiative. As states are at different stages concerning coordination, an early activity for each state committee would be to draft a strategic plan, including state-level targets and indicators. Another area to address—for those states that have not yet done so—is coordination between the public and the social marketing sectors regarding behavior change communication, marketing, promotional activities, supervision, and training.

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

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

Although a reporting system is in place and personnel receive feedback during supervisory visits, the reports and feedback are currently inadequate to inform decision making. Because supervisors have insufficient funds earmarked for supervisory visits at all levels, those visits are not regular enough to give feedback to SPs. In turn, SPs are less likely to fill out their reports—or to fill them out correctly—when they receive inadequate training and supervision. At facilities where supervision was taking place regularly, reporting rates and accuracy of reporting was greatly increased. Service providers need feedback on their reporting: (a) advice on how to fill out the forms correctly (if the reports are not correctly done), (b) specific replies to any comments, (c) follow-up on requests for product that are stocked out, and (d) advice on what to do with expired products.

At the central and state levels, funds must be set aside for supervision. Without coordination among the levels of the supply chain, each level operates in a void, as if not connected to the others. One solution mentioned, in the absence of funding for supervision, is regularizing phone calls or emails

for feedback from each supervisor. SMOH should also work with partners to map out coverage of FP facilities, to identify facilities that have difficulties in following contraceptive logistics management system (CLMS) guidelines, and to increase supervision to those facilities.

State FP coordinators and LGA coordinators are supposed to meet regularly, although in reality the meetings are infrequent because of the previously mentioned difficulties of funding and the shortage of personnel. Some coordinators are filling multiple roles and are unable to travel for meetings or supervision for that reason.

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

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

Strengths

- Existence of National RHCS Stakeholders forum with extensive membership.
- Active CLMS section or RH branch that exists in the FMOH, with personnel who understand the system.
- Existence of forecasting and procurement TWG to work specifically on those issues.
- Varying degrees of RH and FP coordination within states, with some very dedicated and motivated coordinators.
- State FP coordinator meetings to share best practices and challenges they are facing.

Weaknesses

- Lack of national- and state-level coordinating meetings on a regular basis, thereby creating a sense of inertia. Furthermore, when the meetings occur, top-level policy and decision-making executives of the various agencies are absent. That fact negatively affects planning for work, budgeting, supervising, setting targets and achieving goals, reporting and getting feedback, and understanding the proper functioning of the CLMS itself.
- In some states, lack of coordination mechanisms between the SMOH and the RH or FP partners to discuss programs, issues, and challenges.
- No budget line for national stakeholders' meeting or for some state-level meetings (donor dependent).

- Poor feedback mechanisms in both directions (national and state level). Reporting rates are low, feedback on the reports that are received is not regularized, and feedback does not occur in the absence of face-to-face supervision.
- Weak monitoring and supervision between LGA and SDP levels.
- Weak coordination with private sector at all levels.
- Inadequate staff and funding for supervision at all levels.

Key Recommendations

- Make the national RHCS meetings occur on a regular schedule: Meet two times per year. Include a budget line, and ensure an ability to access the budget.

  Discuss and disseminate the RHCS Situation Analysis report at the meeting.

  Establish RHCS committee terms of reference (guidelines, activities, and indicators).

  Make sure state focal people attend for cross-sharing experiences and for starting the process for a counterpart in state-level meetings.

  Form additional TWGs to address all key areas of RHCS.

- Reinitiate and regularly schedule FP coordinators' meetings to share challenges, to troubleshoot, and to maintain and improve supervision skills. Earmark funds in federal and state budget to support travel to the meetings.
- Disseminate an annual report on RHCS (situation, progress, and coming months activities).
- Increase coordination with commercial sector to leverage resources and expertise in demand-creation, training, and awareness-raising in FP.
- Create a state-level RHCS coordination committee to include all major stakeholders at the state level.
- Dedicate one FP coordinators' meeting to discussing how to formalize a coordination mechanism—including strategies to form and keep committees invigorated, joint work planning and budgeting, and development of targets and indicators— as well as to reporting results to key state-level decisionmakers.
- The SMOH should take the lead in coordinating activities among NGOs and IPs.
- The SMOH, along with partners, should hold joint biannual work planning and progress meetings.
- The SMOH and partners should map out coverage of FP facilities, identify those facing challenges in following CLMS guidelines, and provide appropriate technical assistance to those facilities.

Commitment

The existence of supportive policies and a dedicated budget line for reproductive health in general—with emphasis on contraceptive commodities security specifically—are the surest sign of commitment that a government can show for RHCS. This commitment also provides an enabling environment for all stakeholders, including donors, development partners, NGOs, and relevant civil society organizations (CSOs) working in the area of RH within a country. Continuous, focused advocacy for

RH and FP is the vehicle that ensures that the subject remains on the forefront of a country's critical issues and that it allows for sensitization of both national policymakers and the community in general.

Commitment in the Public and Private Sectors

Nigeria currently has a National Policy on Population for Sustainable Development, a National Reproductive Health Policy and Strategy, a National RHCS Strategic Plan, and Guidelines for Integration of HIV/AIDS and RH. The support by the FMOH for a second commodity security assessment, which is the first among any country to do two assessments, demonstrates the continuing commitment and attention toward RHCS. All of those efforts are evidence of significant commitment that has empowered the public sector—the FMOH and the development partners—to take leadership in improving RH service delivery in general, as well as in striving to ensure commodity security.

The existence of those policies serves as a means and a platform for highly visible private sector involvement. The private pharmacies all carry FP commodities. Even though they come at a higher cost than the subsidized price at public sector health facilities, they are readily accessed by the clients with confidence in sustained supply and confidentiality. The NGO, CSO, and the private sector—with their parallel logistics systems—ensure availability of a wide range of commodities in the private sector. They also provide services in a socioculturally appropriate context that is significant in Nigeria, where religious concerns makes FP a touchy subject.

In the six sample states, varying degrees of commitment were observed:

- The state of Abia showed no evidence of political commitment and had no budget line for RH; however, commodities were readily available in the private sector.
- Although no explicit state policies exist for the state of Akwa Ibom, the SMOH provided imprest to support RH and FP logistics. The state allocated 4.5 million naira for training in 2007 but did not release the funds.
- The state of Bauchi has no stated policies on RH and FP, but FP services are provided under the maternal mortality reduction (MMR) umbrella.
- In 2008, the state of Kano established a budget line for RH of 5 million naira.
- The state of Nasarawa has an RH specific policy that includes adolescent health with RH education that is integrated into the school curriculum. However, no budget line exists for commodity security, and there is a dire shortage of skilled staff members to provide RH and FP services.
- The state of Ogun was the most engaged of those visited, with more nurses and midwives available to provide FP services. Funds have been made available for commodity procurement and support of logistics activities.

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

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

Advocacy

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

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

Health Sector Reform and Development Assistance

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

Strengths

- An increasing awareness at the federal level for RH and FP issues.
- Funds from the MMR budget to be used for logistics and capacity-building.
- Continued support for commodity procurement, logistics, and capacity-building from development partners.
- An increasing in private-public partnerships in RHCS (successful social marketing strategy).
- Government-allocated funds from the MMR budget to support some RHCS initiatives.
- Significant civil society engagement, with high involvement in providing FP services, training, and increased demand in some states.
- An improvement in media engagement .
- Various levels of support for RH and FP at the state level.

Weaknesses

- No dedicated budget line for FP and RH programs at national and state levels (except in Kano state).
- All FP commodities donated, creating a donor-driven program.
- Weak political commitment at the national, state, and LGA levels.
- RH funds not readily disbursed and made available because of bottlenecks in accessing funds.
- Inadequate advocacy to increase profile of RH and FP within the FMOH and other line ministries.
- Weak collaboration between FMOH and civil society.
- Low priority for FP within state-level programs.
- No financial support from the state level for purchase of contraceptives, supervision, or transportation.
- No strategic advocacy plan focused on either the decision makers or the community for awareness-raising of FP at state and national levels.
- High attrition and transfer rates among public sector employees.

Key Recommendations

- Create a line-item budget for RHCS at the federal and state levels.
- Create a two-pronged national strategic advocacy and awareness-creation plan targeted toward (a) decision makers and (b) the community, to increase awareness on importance of RH and create demand for FP.
- Continue evidence-based advocacy to the relevant committees at the National Assembly on the importance of FP and the need to ensure RHCS.
- Strengthen the capacity of the health promotion branch at federal and state levels.
- Advocate to commissioners of LG and Chieftaincy Affairs, chairpersons of LGA Service Commission, LGA directors of personnel, and LGA chairpersons to reduce staff attrition and allocate funds in support of RHCS.

Financing

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

Government and Donor Funding

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

- UNFPA donates through the global thematic trust fund and CIDA trust fund for contraceptives procurement.

- DFID purchases condoms and injectables for social marketing provided to SFH.
- USAID procures Depo-Provera, Duofem, and IUCDs for SFH.

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

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

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

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

In the six sample states visited, funding dedicated to RHCS did not exist; however, all states practice cost recovery:

- Abia has no budget line for RH, and funds generated from the cost-recovery system were not adequate for supporting the commodity logistics activities.
- Akwa Ibom does not have an RH budget line, but the SMOH approves imprest to support the cost for RH and FP logistics.
- Bauchi has no budget line, and because of low-uptake cost recovery, income generation is insignificant and does not cover the logistics needs of the program.
- A separate account for cost recovery funds has been established in Kano state, but the funds have never been used for ordering contraceptives.

- In Nasarawa state, the cost-recovery system works well, but income generated is not adequate to support the transportation needs of the LGA RH and FP supervisors and providers, and no funding support is provided for the team by the state.
- Ogun has a more robust income-generating cost-recovery system, and despite having no specific budget line for RH, the state provides additional funding for commodity procurement and support of logistics activities.

Current and Future Funding

Obtaining future commitments from the government for contraceptive spending is not yet a reality, although a budget line for MMR has been created. Continued donor funding alone will not be adequate to support all contraceptive procurement, to fund CLMS, or to ensure RHCS on a long-term basis. A funding gap for contraceptive commodities exists; even social marketing and NGOs depend on the donors for commodity procurement. Accurate consumption data are not available, which adversely affects forecasting capacity and thus affects the ability to determine future financing needs. Future funding also depends heavily on the commitment of the government because current total dependency on donors is not sustainable.

In the short term, funding from UNFPA, CIDA, DFID, and USAID seems to be stable for at least one to two years. However, to increase leadership, to demonstrate true commitment, and to generate financial sustainability of contraceptive security, the government of Nigeria should start contributing its own funds to the purchase of contraceptives and other RHCS initiatives.

Strengths

- FMOH spent 20 million naira between 2005 and 2007 from the MMR budget for capacity-building, supervision, and RHCS meetings.
- A functional cost-recovery system is being used at all levels.
- Some states have budget allocation for training, transport, and supervision through MMR funds.

Weaknesses

- FMOH does not finance the procurement of any commodities, thereby creating over-dependency on development partners.
- No financial sustainability plan or diversity exists for FP commodities.
- No state-level budget for FP services or commodities exists.
- Difficulty exists when accessing both budgeted and cost-recovery funds.
- Because of low demand and uptake, income generated through cost recovery is insufficient to cover both logistics costs and purchase of significant quantities of commodities.
- Separate accounts do not exist in all states for cost-recovery income, which further creates difficulty in accessing funds as intended.
- The government allocated funds for procurement of FP commodities in 2007, but that allocation was not taken advantage of.

Key Recommendations

- Create a dedicated budget line for RHCS.
- Have FMOH use its own internally generated funds to procure commodities to demonstrate commitment toward increasing sustainability of FP programming.
- Advocate for legislative backing for a percentage of funds from the annual FMOH budget for procurement of RH commodities and other logistics activities.
- Create a counterpart funding scheme in addition to cost-recovery funds to support capacity-building, transportation, monitoring and supervision, and storage at the state level.
- Use the regular program budgeting process to earmark funds for RH, including FP commodities, services, and activities.
- Develop strategies to remove bottlenecks in accessing cost-recovery funds and create separate bank accounts at state, LGA, and tertiary facilities.

Commodities

The public sector offers 10 types of contraceptive commodities. Short-term methods include male and female condoms, combination and progestin-only oral contraceptives, and injectables. Long-term methods include IUCDs and implants (see table 3). All of the methods are donated to the FMOH by UNFPA. DFID is also a major contributor, procuring Gold Circle condoms and Noristerat for SFH. USAID currently procures Depo-Provera, Duofem, and Copper T 380 IUCDs for SFH and may also begin procuring Jadelle.

Table 3. Contraceptives Offered by the FMOH Program

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

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

SFH distributes the largest amount of contraceptives in Nigeria through social marketing programs. It provides all short- and long-term methods except female condoms. PPFN also provides FP services and commodities; it provides the same contraceptives as the public sector, plus emergency oral contraceptives and vaginal foaming tablets (VFTs). (See table 4 for contraceptive sources.)

Table 4. Source of Contraception

Source	Pill	IUD	Injectables	Male Condoms	Total
Public Sector	**18.6**	**65.5**	**48.4**	**4.1**	**22.8**
Hospital	10.9	47.0	22.9	3.1	13.1
Health center	4.9	12.9	19.0	0.4	6.5
FP clinic	1.3	5.6	6.0	0.5	2.4
Private Sector	**74.0**	**32.5**	**48.0**	**59.2**	**57.7**
Hospital or clinic	2.3	30.3	17.9	0.6	7.5
Pharmacy	71.6	0	25.1	58.3	48.8
Private doctor	0	0	4.3	0.3	1.0
Other	**5.5**	**0**	**1.0**	**29.1**	**14.3**

Source: NDHS, 2003.

Established public sector contraceptive prices are standardized throughout all public sector facilities in the country.

Team members found variations in contraceptive prices during the field visits. (See table 5.) Service providers do not adhere to established prices and charge more when commodities they purchase are bought on the open market.

Table 5. Contraceptive Unit Costs at SDP Level

	Method	Unit	Unit Cost
1	Condom, female	Piece	20
2	Condom, male	Piece	1
3	Depo-provera 150 mg inj+ syringe	Vial	60
4	Exluton	Cycle	15
5	IUCD	Piece	100
6	Lo-femenal	Cycle	15
7	Microgynon	Cycle	15
8	Noristerat 200 mg inj + syringe	Ampoule	60
9	Implanon implant	Piece	2,000
10	Jadelle implant	Piece	2,000
11	Gloves, disposable latex medium	Pair	10

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

No manufacturing of contraceptives takes place in the country.

Table 6 illustrates the sources, methods and brands, and costs of contraceptives provided by some of the developing partners in Nigeria. If one looks at total contributions, DFID, USAID, and UNFPA finance the largest share of contraceptives, with DFID—through SFH—accounting for the greatest proportion of male condoms. This table is a sample of contraceptive financing sources.

Table 6. Sources and Costs of Contraceptives

Source	2004	2005	2006	2007	2008[a]	Total
IPPF						
Condoms, female	$803	0	$8,995	0	0	$9,798
Condoms, male	$5,850	0	$50,680	0	0	$56,530
Implants (Norplant)	$1,328	0	$1,569	0	0	$2,896
Injectables (Noristerat)	$9,641	0	$15,804	0	0	$25,445
COC (Microgynon, Lo-femenal)	$14,238	$801	$35,446	$7,704	0	$58,189
EOC (Postinor)	0	0	$1,075	0	0	$1,075
Orals (Exluton/Microlut)	0	0	$3,830	0	0	$,3830
IUCD	$3,375	0	$709	0	0	$11,078
VFT	0	$2,033	$9,045	0	0	$4,084
IPPF total	*$35,235*	*$2,834*	*$127,153*	*$7,704*	*0*	*$172,926*
DFID (SFH)						
Condom, male (Gold circle)	$6,116,031	$6,471,556	$6,358,270	$7,169,029	$7,565,600	$33,680,485
Injectables (Noristerat)	$577,898	$652,631	$913,577	$1,265,761	$1,623,000	$5,032,867
DFID total	*$6,693,930*	*$7,124,187*	*$7,271,847*	*$8,434,790*	*$9,028,600*	*$38,553,353*
UNFPA (FMOH)						
Condom, female	0	0	0	$390,000	0	$390,000
Condom, male	$56,160	$77,090	$424,920	$150,003	$360,003	$1,068,176
Implants (Implanon, Jadelle)	0	0	$300,000[b]	$300,000[c]	0	$600,00
Injectables (Noristerat, Depo-Provera)	0	$484,200	$170,000	0	0	$654,200
IUCD	0	$16,781	0	0	0	$16,781
COC (Microgynon, Lo-femenal)	0	0	0	$40,000	0	$40,000
Orals, Progestin only (Exluton/Microlut)	$120,000	0	0	0	0	$120,000
UNFPA total	*$176,160*	*$578,071*	*$894,920*	*$880,003*	*$360,003*	*$2,889,157*
USAID (SFH, FHI, USAID)						
Condoms, male	0	$227,492	0	$73,137	0	$300,629
Implants (Jadelle)	0	0	0	$46,472	0	$46,472
Injectables (Depo-Provera)	$811,960	$991,199	$518,722	$1,077,397	$546,789	$3,946,067
COC (Duofem)	$1,271,568	$1,518,245	$917,090	$1,502,067	$573,442	$5,782,412
IUCD	0	$155,306	$85,430	$172,641	0	$413,377
USAID total	*$2,083,528*	*$2,892,241*	*$1,521,242*	*$2,871,714*	*$1,120,231*	*$10,488,957*
TOTAL	$8,988,853	$10,597,333	$9,815,162	$12,194,211	$10,508,834	$52,104,393

Sources: RHInterchange, SFH (figures confirmed by SFH).

a. The 2008 figures are not complete; 2008 SFH figures are projections.

b. Implanon.

c. Jadelle.

Client Use and Demand

As shown in table 7, between 1999 and 2003, the contraceptive prevalence rate (CPR) stagnated at 8.9 percent among all women currently using contraceptives. The results from the 2003 DHS showed that male condoms were the most commonly used method mix (38 percent), followed by pills (22 percent) and injectables (18 percent). Additionally, a comparison between 1999 and 2003 rates showed decreases in CPR in all methods except for male condoms, with an increase from 26 percent to 38 percent.

Table 7. Contraceptive Prevalence Rate by Method among All Women, 1999 and 2003

Family-Planning Methods	Percentage of Current Use (1999)	Percentage of Method Mix (1999)	Percentage of Current Use (2003)	Percentage of Method Mix (2003)
Pills	2.6	29	2.0	22
IUCD	1.7	19	0.6	7
Injectables	1.9	21	1.6	18
Condoms (male)	2.3	26	3.4	38
Sterilization (female)	0.2	2	0.2	2
Implants	0	0	0	0
Vaginal method (1999) LAM, emergency contraception (2003)	0.1	1	1.1	12
Total use of modern methods	8.8	100	8.9	100

Source: NDHS, 1999, 2003.

The decreases, shown in table 7, follow the same trend among currently married women and will be the focus of discussion because that group is most at risk of pregnancy. CPR declined from 8.6 percent to 8.2 percent from 1999 to 2003 for married women. There was a decline in injectable use from 2.4 to 2.0 percent among married women. One of the reasons this method is popular is the discretion it provides among married women. The reasons behind the decline should be addressed because it can be an indicator that a woman's ability to protect herself from pregnancy is decreasing. Oral contraceptives also became less popular, with a decline in CPR from 2.6 percent to 2.0 percent. Both injectables and orals were available at health facilities during the field visits. The only increase in CPR was in the use of male condoms (2.3 to 3.4 percent).

Although these short-term methods have declined in use, there should be a corresponding increase in long-term methods such as implants and female sterilizations. However, the data show virtually no additional uptake among these two methods. Even sharper decreases in IUCD use occurred between 1999 and 2003 (see table 8), with CPR currently at less than 1.0 percent. Virtually no use of implants is evident. Very little demand for implants exists, which can be partly attributed to the low number of skilled, qualified service providers, coupled with the high cost of receiving the methods. Low demand for implants may continue because of the recent introduction of Jadelle and the transition time needed to train service providers to offer and counsel on this brand.

Table 8. Contraceptive Prevalence Rate among Currently Married Women

Family-Planning Methods	Percentage of Current Use (1999)	Percentage of Method Mix (1999)	Percentage of Current Use (2003)	Percentage of Method Mix (2003)
Pills	2.4	28	1.8	22
IUCD	2.0	23	0.7	9
Injectables	2.4	28	2.0	24
Condom (male)	1.2	14	1.9	23
Sterilization (female)	0.3	3	0.2	2
Implants	0.1	1	0	0
Vaginal method (1999)	0.2	2	1.5	18
LAM, emergency contraception (2003)				
Total use of modern methods	8.6	100	8.2	100

Source: NDHS, 1999, 2003.

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

Women with higher education who live in urban areas and are between the ages of 20 and 39 are more likely to use contraceptives. Those living in urban areas are more than twice as likely to use contraceptives as women in rural areas (13.9 percent versus 5.7 percent, respectively). Although the prevalence rate is higher in the urban areas, CPR declined between 1999 and 2003 from 15.7 to 13.9; in the rural area, CPR stagnated at 5.7 percent (see table 9). The South-West region has the highest CPR of 23.1 percent, followed by the South-South (13.8) and the South-East (13.0 percent). Education is also a factor in use of modern methods, showing contraceptive use of 2.3 percent for women with no education and 21.7 percent for those with higher education. As the number of living children increases, use of contraception also increases, from 1.4 percent for those with no children to 11.0 percent for those with five or more children (see table 9).

Additional activities are needed to increase awareness, but increased resources are especially needed to better target the rural and disadvantaged population. Although many national policies include

strategies to improve RH, those policies should be updated to include specific, explicit language targeting the poor.. For example, the National Reproductive Health Strategic Framework and Plan addresses equitable access to quality health services and capacity-building, with specific activities to (a) create and support FP from SDPs to the community level and (b) train additional service providers. That part of the plan would be an ideal place to insert specific language about increasing service for the poor and placing service providers in rural settings to increase access. For statistics on currently married women, see table 9.

Table 9. Contraceptive Prevalence by Background Characteristics (Currently Married Women)

Contraceptive Prevalence	1999	2003
By Age		
15–19	1.2	3.8
20–24	2.6	6.6
25–29	6.7	10.0
30–34	12.7	9.5
35–39	13.3	10.9
40–44	12.1	8.8
45–49	9.4	5.4
By Residence		
Urban	15.7	13.9
Rural	5.6	5.7
By Region		
North-Central	n/a	10.3
North-East	2.2	3.0
North-West	2.5	3.3
South-East	9.1	13.0
South-West	15.5	23.1
South-South	n/a	13.8
Central	10.9	n/a
By Education		
No education	3.1	2.3
Primary	10.1	11.2
Secondary	16.2	18.3
Higher	28.0	21.7
By Wealth Quintile		
Lowest	n/a	3.6
Second	n/a	2.9
Middle	n/a	6.7
Fourth	n/a	9.2

Contraceptive Prevalence	1999	2003
Highest	n/a	20.5
By Number of Living Children		
0	1.3	1.4
1_2	3.5 (1), 7.8 (2)	7.4
3_4	8.7 (3)	9.6
5+	12.5 (4+)	11.0

Source: NDHS, 1999, 2003.

n/a = not available.

Total unmet need has decreased slightly from 17.5 to 16.9 percent (see table 10). A slight increase was evident in unmet need for limiting births from 4.6 to 5.1 percent. However, total demand satisfied (unmet need plus current users) has decreased from 46.7 to 42.7 percent among currently married women. Unmet need is very similar for urban and rural women (17.3 and 16.7 percent, respectively). Unmet need is highest for women between the ages of 20 and 44, which is the same age group with the highest use of contraception, indicating a high need for contraceptives that is not being met. Geographically, wide differences in unmet need exist among the North-West region (11.1 percent), North-East (18.1 percent), and South-South (24.5 percent). The North-East and North-West also have the two lowest CPR rates (3.0 and 3.3 percent) in the country. See table 10 for unmet needs.

Table 10. Unmet Need for Contraception

Unmet Need	1999	2003
For Spacing Births	12.9	11.8
For Limiting Births	4.6	5.1
Total Unmet Need	**17.5**	**16.9**
By Age		
15–19	14.8	14.6
20–24	22.7	16.4
25–29	17.0	17.1
30–34	17.9	19.1
35–39	18.1	18.1
40–44	15.4	19.3
45–49	11.9	11.4
By Residence		
Urban	16.6	17.3
Rural	17.9	16.7
By Region		
North-Central	n/a	21.8
North-East	12.2	18.1
North-West	24.4	11.1
South-East	20.9	18.9

South-West	15.7	24.5
South-South	n/a	17.2
Central	16.3	n/a
By Education		
No education	15.6	14.1
Primary	21.7	21.0
Secondary	19.5	20.7
Higher	10.7	14.7
By Wealth Quintile		
Lowest	n/a	14.9
Second	n/a	15.6
Middle	n/a	16.7
Fourth	n/a	19.9
Highest	n/a	18.0

Source: NDHS, 1999, 2003.

n/a = not available.

The fact that the North-East and North-West have the lowest CPR rates can be attributed to a number of reasons that influence service access and use of contraceptives. The North-East and North-West are more religiously conservative, and knowledge of FP is the lowest in those two regions among the six geopolitical areas. The implication is that less awareness for FP generates low demand. Religious groups, both Catholic and Islamic, have a strong influence on contraception practices and on the type of FP media messages disseminated to the public. In some instances, the church has stopped the broadcasting of FP messages. In the north, restrictions exist against male providers serving female clients.

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

As mentioned earlier, an inadequate number of trained personnel exists at all levels, including doctors, nurse midwives, and CHEWs. Coupled with this lack of trained personnel is a high attrition and transfer rate, as well as an inadequate number of female workers. Furthermore, the shortage in skilled health workers also plays a role in access to specific methods, such as long-term and permanent methods, because training and services for implants, for instance, takes place only at secondary and tertiary health facilities. Adolescents as a specific population are addressed through strategies, frameworks, and policies. However, in practice, adolescents in some regions do not have the same access to public-sector facilities because of (a) cultural and religious biases and misconceptions and (b) the fact that health workers can refuse to provide services. This lack of access could also caused by infrequent supervision at the LGA and SDP level, poor supervision practices, insufficient monitoring, weak accountability, and lack of transportation to the more-rural SDPs.

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

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

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

Strengths

- Availability of most popular methods (injectables and orals) at health facilities
- Provision of alternative outlets for FP services by NGOs
- Outreach FP services provided to communities and rural areas by NGOs

Weaknesses

- Lack of unified, national strategy for IEC and BCC about FP
- Inadequate number of trained personnel (doctors, midwives, nurses, CHEWs, CBDs)
- Lack of current FP training or knowledge for many health workers
- High attrition rate and transfers among health workers
- Low public awareness of FP among some populations
- Existence of provider bias and spousal, religious, and cultural barriers
- Training on implants being restricted to secondary and tertiary health facilities because of inadequately trained personnel.

Key Recommendations

- Provide a second health staff (nurse midwives) to work in underserved and rural areas.
- Revisit Nursing Council guidelines to increase student enrollment in an effort to graduate more health workers annually.

- Revisit national health and education policies to increase enrollment, graduate larger numbers of health workers annually, and hire additional skilled service providers.
- Institutionalize FP and RHCS training into basic nursing and medical school curricula.
- Increase partnership and collaboration with NGOs, FBOs, and CBOs on FP-related activities to leverage resources and expertise.
- Engage the media (increase involvement) in RHCS issues.
- Develop functional strategies to increase male involvement in FP at the community and decision-making levels.

Capacity

Product Use

SOPs, or standing orders, exist for RH and FP and logistics management. Those orders include the FP service provision SOPs, the monitoring and supervision of dispensing practices, the universal safety precaution guidelines, and the CLMS guidelines and job aids. Some health facility workers are aware of these SOPs, but they were not sighted or available in many of the health facilities. In some facilities, there were outdated SOPs from 1992. All service providers encountered had undergone training in disposal of sharp objects. Universal safety precautions were generally observed, such as the disposal of syringes, through the provision of immunizations and immunization campaigns that take place at health facilities during National Programme on Immunization (NPI). Printed copies of safety precautions were not always at the facilities. Some of the SDPs had posters displaying the full range of FP or birth-spacing methods, but none had any type of standard treatment guidelines.

In general, health workers at the SDP level did not have current training on FP. The health workers may have had training during their education, but many had not received any recent training. Only a few said they had attended the six-week FP course. Provision of IUCD insertion services is limited as a result of human resource shortages and inadequacy of IUCD insertion kits.

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

Aside from stockouts and limited availability of all contraceptives, other reasons for the low demand for contraceptives are due to cultural, social, and religious factors. The field visits revealed that husbands' consent plays a strong factor in the women's use of contraceptives. The use of male condoms among married couples was reported to be lower than use among singles. The low number of doctors and nurse midwives trained in implant insertion is a barrier to women using long-term methods of contraception.

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

Strengths

- Some service providers are aware of standing orders or SOPs.
- Some clinical service providers (CSPs) are trained in IUCDs at the SDP level.
- Most facilities adhere to proper procedures for disposal of hazardous material.

Weaknesses

- Both availability and knowledge of guidelines, service protocols, and manuals at facilities are inconsistent.
- Long-term methods (e.g., IUCDs and implants) are not in high demand because of a limited number of SPs trained in their insertion.
- Dissemination of service protocols and posters to the LGA and SDP levels is inadequate.

Key Recommendations

- Disseminate SOPs, STGs, and job aids to all facilities.
- Update skills of providers at all levels, both state and LGA.
- Develop a national IEC and BCC campaign strategy in collaboration with key development partners and the private sector.
- Conduct and update a market segmentation analysis to better target public-sector resources.

LMIS (Logistics Management Information System)

The information on daily consumption, the stock on hand, and the quantities and costs of contraceptives are managed through the contraceptive logistics management system (CLMS), which is a paper-based system. The RIRF, RIF (which is used in the redesigned CLMS states), daily consumption record (DCR), tally cards, and Cost Recovery Record are used to record and manage logistics information. In 2003, the CLMS was redesigned to improve the efficiency and effectiveness of the system. Also in 2003, the cost-recovery system was introduced as part of the redesign, thereby acting as a revolving drug fund to provide (a) funds for resupply (b) margins used to cover the costs of transportation and supervision, and (c) incentives to health workers. In 2006, the CLMS was streamlined to simplify the inventory control system, as well as to reduce the number of forms. The new CLMS was piloted in three states: Bauchi, Kano, and Nasarawa.

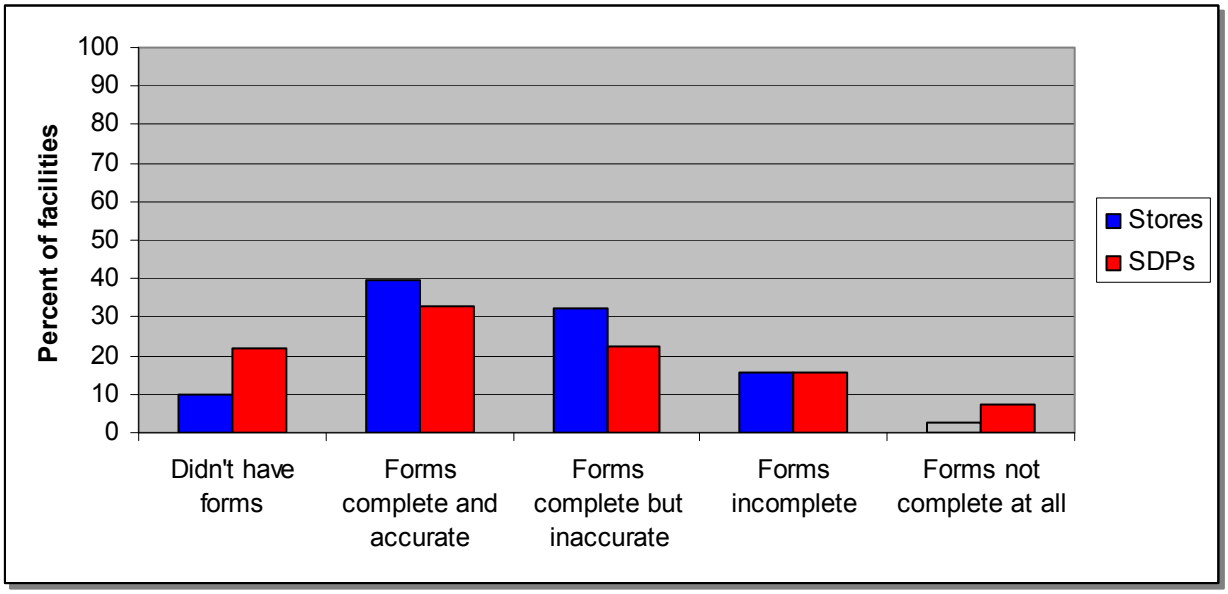
The teams found that—to some degree in all the sites visited—the staff had difficulty understanding and completing the RIFs, RIRFs, and cost-recovery forms on their own. That difficulty may be due to several reasons, such as nonadherence to reporting and request schedules so that use of forms is infrequent. Since the inception of the program, there has been a high staff turnover, and some of the existing staff members either have had no training in CLMS or have gained their knowledge through OJT. The supervision of CLMS has been inadequate because of a lack of commitment by coordinators; where quality supervision was done, there was accuracy and understanding of filling out the RIRFs. In some states, supervision is being carried out and led by development partners.

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

of the stores and SDPs had complete and accurate RIF and RIRF forms (see figure 4). The RIF and RIRF are completed at the state, LGA, and SDP levels and capture stock status as well as average monthly consumption, losses, and quantity ordered for each level. Consumption data are available from the data collected from the SDP RIF and RIRF; however, those data are not used to forecast and procure at the central level, because of inaccurate and weak reporting. Within each state were facilities that either were not using the CLMS forms or lacked some forms. An improvement in logistics data would allow the central level to start using consumption data to forecast and procure commodities.

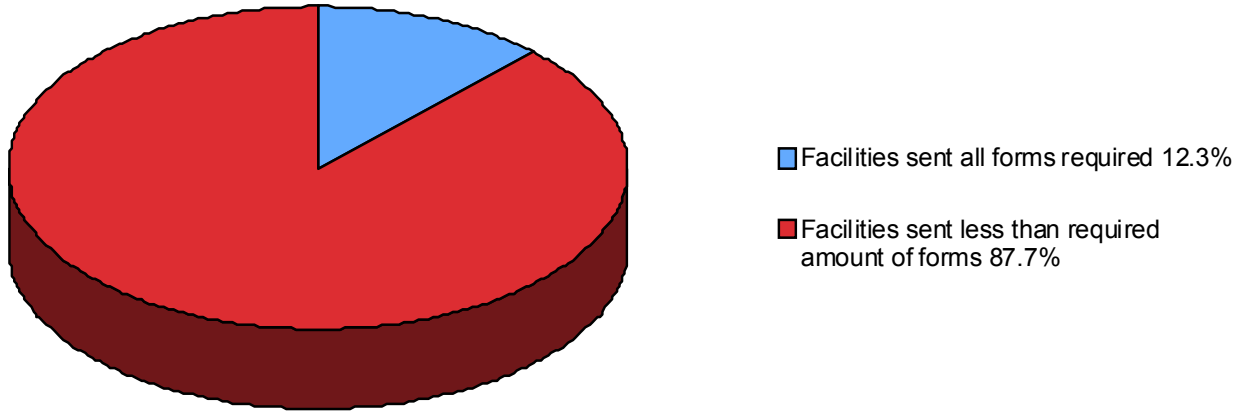
The DCR tracks client consumption by method for each day and tallies the information at the end of each month. It also tracks the amount dispensed to CBDs, as well as losses in inventory. Most of the facilities and the health staff did not report having difficulty completing the form. Tally cards are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

Figure 4. Percentage of Facilities with Complete and Accurate RIFs and RIRFs



The quality and frequency of feedback and reporting of the CLMS forms varied among the states visited. Only 12.3 percent of facilities sent in all required forms. Feedback from the upper level to the lower levels is also lacking, which may contribute to the low reporting levels (see figure 5), especially if lower levels are not being held accountable for late or incomplete reports by the central level. In most states, supervision and monitoring occur in conjunction with development partners through a supervision schedule. In addition, regular review meetings of the LGA and state coordinators do take place to review the CLMS forms. A general finding from the field visits was that supervision, especially at the lower levels, needed improvement by the SMOH. Some maternal and child health (MCH) coordinators were not aware that (a) CLMS forms were not being used, (b) there were stockouts, (c) health staff members were charging different prices for contraceptives, and (d) other issues that would normally have been found during regular supervisory visits existed.

Figure 5. Percentage of Facilities That Send RIFs and RIRFs



Source: LIAT, 2007.

Strengths

- CLMS forms are generally available.
- Stronger supervision visits are reflected in accuracy of CLMS forms.

Weaknesses

- Some health workers find it difficult to fill out request forms.
- Weak monitoring, supervision, and feedback exist between LGA and SDP levels.
- There is high attrition of trained staff on CLMS.
- Providers show a lack of capacity to consistently complete forms.
- A low number of CLMS forms reach the central level for decision-making purposes.

Key Recommendations

- Provide refresher training on CLMS, and establish cascade training to reach all service providers.
- Establish standard mechanisms for regular feedback on completing forms and compliance with CLMS procedures.
- Regularly share current practices and issues, as well as troubleshoot among LGAs and SDPs.
- Reintroduce supervisory skill training for FP and MCH coordinators.

Forecasting

Forecasts are conducted together twice a year by the Forecasting and Procurement Committee on behalf of UNFPA and the FMOH. The FMOH and UNFPA use the Country Commodity Manager (CCM) software, which is largely a forecasting tool, to forecast and quantify public-sector contraceptive requirements using issues data. Using quantity received, expiry date, average monthly consumption, and stock-on-hand data, CCM can forecast commodity requirements for up to five years. However, because

reliable consumption data are not available (as a result of low reporting, late reporting, and inaccurate completion of the CLMS forms), there could be an inaccurate estimation of actual demand using issues data. CCM can use demographic data to validate forecasts. A need exists for improvement in reporting rates before accurate consumption data and stock status can be achieved and used for forecasting. CHANNEL software is being considered as a method for better capture of data down to the SDP level.

Once a forecast is completed, the FMOH makes a request to UNFPA to procure the contraceptives. A comprehensive, national forecast is not conducted with USAID, DFID, and SFH. SFH provides an estimated 74 percent of the condoms in Nigeria. Given the large role of those organizations in the supply of contraceptives, conducting a joint national-level forecast with SFH and with all of the major suppliers of contraceptives would be a worthwhile exercise to determine the extent to which the public sector is meeting demand for contraceptives and to identify any gaps.

Strengths

- A functional forecasting and procurement committee exists.
- Improvements in capturing facility-level data are being considered.

Weaknesses

- Poor coordination exists among FMOH, development partners, and SFH.
- No comprehensive national forecasting exercise exists between FMOH and development partners on procurement of contraceptives.
- The procurement committee does not meet regularly because of a lack of funds.
- Consumption data are not available at the central level for forecasting purposes.

Key Recommendation

- Conduct a comprehensive national forecast with all development partners to determine future needs, to identify gaps and secure commitment for the short term (2–3 years), and to coordinate procurement schedules.

Procurement of Supplies

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

The LGA level orders on a quarterly basis from the state, and the SDP level orders every two months. An ordering and distribution plan exists but is not being followed because a formal transport system does not exist. There have been delays in distributing contraceptives down to the state level despite stock at the Central Contraceptive Warehouse (CCW).

Previously, private transporters were hired to send contraceptives out to the states, but this system was modified in 2006 to use UNFPA and CIDA trucks to transport commodities to the states. In the meantime, when UNFPA and CIDA trucks are not available, or when emergency orders are made, a formal or defined means of (or funds for) transportation is set up by the public sector;

however, bottlenecks often cause delays. Contraceptives were scheduled to be distributed to the states in February 2008, but this distribution did not occur as a result of the reasons stated earlier.

At the LGA level, service providers that enjoy proximity to the LGA headquarters receive their products quickly.

The RIFs and RIRFs serve as a proxy mechanism to determine the amount of supplies needed using established maximum and minimum guidelines. In one state, some health staff members did not understand how to use the forms or did not follow the reporting and ordering schedule, which often led to rationing of the commodities. Rationing also occurred in the past because some states had not been regularly receiving supplies from the central level.

NGOs such as PPFN, ARFH, and StopAID access and purchase public-sector contraceptives through direct request to the central level.

The most recent shipment of Microlut has been delayed since August 2007 because of registration issues. The fact that only manufacturers can register products prolongs the process. However, a waiver for Microlut was finally obtained in January 2008. Between the registration delay and shipment, stockouts of Microlut have occurred nationwide.

SOPs ensure that contraceptives meet quality standards. NAFDAC is the body responsible for monitoring the quality of contraceptives, as well as all other health commodities imported into the country.

Strengths

- Commodities are available at a central warehouse.
- NAFDAC provides quality control of products.
- The lead time between LGAs and SDPs is generally one day.

Weaknesses

- A long lead time exists between the federal and state levels.
- Maximum and minimum levels are not closely followed.
- Stockout of Microlut occurred.

Key Recommendation

- Strengthen the capacity at state level to collect quality data.

Inventory Control Procedures

The CLMS has established maximum and minimum stock levels for each level as shown in table 10. State stores have a minimum stock level of five months or a maximum stock level of eight months. Using a pull system, each level orders from the next level up. The field visits revealed inconsistent knowledge and lack of adherence to the established inventory control procedures (minimum stock levels and maximum or minimum levels) by health workers. Some states had facilities that adhered to minimum guidelines (Akwa Ibom and Ogun—100 percent) and maximum guidelines (Bauchi—90 percent, Nasawara—60 percent). Other states did not keep products at the established levels (Kano, Abia).

Lack of adherence to guidelines is due to a shortage of health facility workers who have had training on CLMS, inadequate supervision to reinforce proper record keeping practices and concepts, and insufficient resupply funds to order the amount needed. Another reason for not following minimum stock levels is the low use rate of contraceptives, a fact which has made some staff members reluctant to order more because they believe the commodities may expire before the products are used (as a result of low demand).

Table 10a. Maximum and Minimum Stock Levels for Contraceptives for Streamlined States

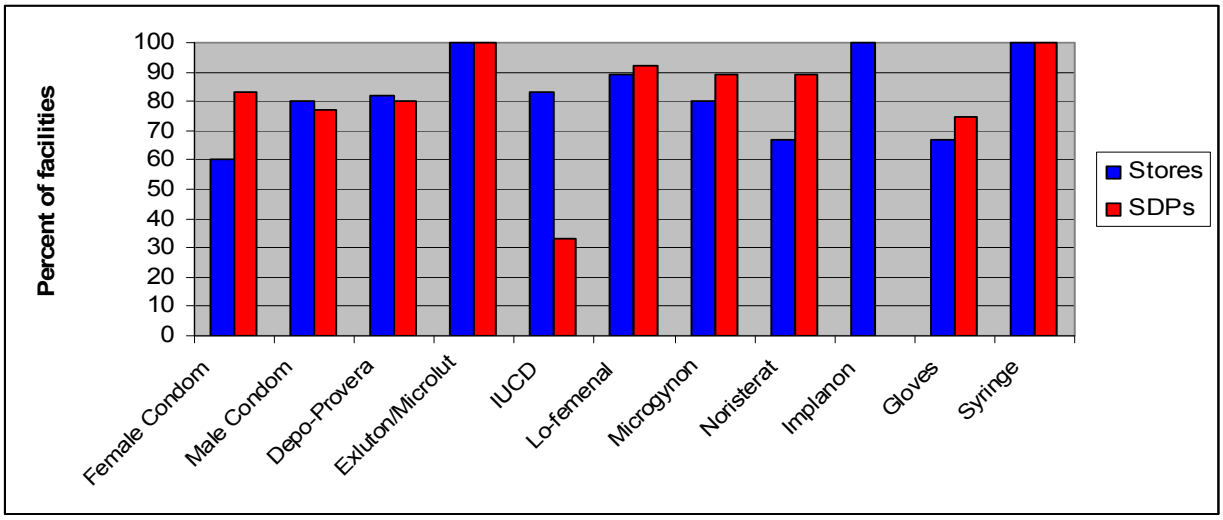
	Reporting and Ordering Cycle	Minimum	Maximum
State	4 months	4 months	8 months
LGA	3 months	3 months	6 months
SDP	2 months	2 months	4 months
CBD	1 month		

Table 10b. Maximum and Minimum Stock Levels for Contraceptives for Redesigned States

	Reporting and Ordering Cycle	Minimum
State	4 months	5 months
LGA	3 months	4 months
SDP	2 months	3 months
CBD	1 month	

There are no formal guidelines for the redistribution of supplies in the system. However, a few examples were sighted during the field visits. In those examples, coordinators redistributed among one another any stock they may have needed or had excess amounts of. Overall, communication and reporting are poor from the central and state levels, leading to inadequate data and lack of a general knowledge as to what is going on at different levels of the system. As an example, some facilities had requested female condoms when theirs expired, but at the state level, the FP coordinator did not order them because she did not know a new shipment had arrived at the central level.

Figure 6. Percentage of Facilities Stocking below Minimum Stock Levels



Source: LIAT, 2007.

Currently, there is a nationwide stockout of Microlut in the public sector. Because of procurement regulations, only manufacturers can register products. Those regulatory issues are reflected in the 2007 LIAT. Also, in the 2007 LIAT, SDP-level findings showed Exluton/Microlut and Microgynon with stock below minimum levels (100 and 90 percent, respectively) and with stockouts lasting more than three months in the previous six months (Exluton/Microlut: 98 days; Microgynon: 111 days). Lo-Femenal also had a high percentage of SDPs below minimum stock levels (more than 90 percent) and lengthy stockout periods in the previous six months at the SDP level. Depo-Provera has also experienced low stock levels (80 percent). With the central level currently out of stock of Exluton/Microlut and Microgynon and with the less than optimal stock levels of Depo-Provera, ensuring the availability of other choices such as Noristerat and Lo-femenal is extremely important. Apart from injectables, oral contraceptives are among the top three most popular modern methods among married women. Information made available revealed that there was adequate stock of Noristerat (600,000 units) at the central level.

Table 11. Average Frequency and Number of Days of Stockouts of Contraceptive Products in the Past Six Months

Contraceptive Products	Stores		SDPs	
	Average frequency of stockout	*Average number of days of stockout*	Average frequency of stockout	*Average number of days of stockout*
Female condom	1.0	137	1.0	130
Male condom	1.1	121	1.2	110
Depo-Provera©	1.1	85	1.0	103
Exluton/Microlut	1.1	116	1.0	98
IUCD	1.1	103	1.0	86
Lo-femenal	1.0	98	1.0	104
Microgynon	1.1	107	1.1	111
Noristerat	1.0	57	1.1	74
Implanon	1.0	67	1.0	128

Source: LIAT, 2007.

Stockouts occurred for a variety of contraceptives in the past 12 months in every state during the field visit, either at the store, LGA, or SDP. The 2007 LIAT found that rural stores and SDPs experienced a greater number of stockouts than urban stores and SDPs, with the exception of Noristerat, Exluton/Microlut, and Implanon.

A policy for first-to-expire, first-out (FEFO) was part of the CLMS storage guidelines. It was found that most health workers understood the concept and were putting this in practice at the stores, LGAs, and SDPs. Within each state however, there were facilities that were not following FEFO by not arranging commodities according to expiry dates and not separating expired stock. Additionally, they were not aware of guidelines on how to deal with expired products. It was also found that expired or damaged goods were not always correctly accounted for in the tally cards.

A large amount of Microgynon has expired as a result of the use of issues data in forecasting contraceptive requirement. Products within one year of expiration are tagged and quarantined. Steps

are being taken so that products close to expiration will be identified and pushed out for use rather than removed from inventory.

Strengths

- An increase in FMOH capacity in logistics management has occurred.
- Inventory control systems for maximum and minimum are in place.
- Informal redistribution of commodities is taking place in some states.
- The concept of FEFO is understood.

Weaknesses

- A nationwide stockout of Exluton/Microlut and Microgynon exists.
- Reliance is on donor procurement systems.
- Many facilities order when supplies are low rather than following minimum and maximum guidelines.
- FEFO is not always implemented.
- Expired products are not appropriately managed.

Key Recommendations

- Reinforce, through improved supervision, adherence to inventory control procedures and FEFO guidelines.
- Use data from CLMS forms for decision making, and consider automation to allow for analysis of logistics data, monitoring stock status, and forecasting and procurement.
- Establish formal redistribution system among states, LGAs, and SDPs to avoid stockouts, expiration of products, and rationing.
- Disseminate guidelines for storage of products and for destruction of damaged and expired products from central level.

Storage and Warehousing

Guidelines for storage and handling of products do exist, but availability varied widely from state to state, with availability noted in Abia, Akwa Ibom, and Nasarawa. In Kano, Bauchi, and Ogun, few staff members could demonstrate evidence of knowledge of the existence of guidelines. Although no guidelines were seen, the staff seemed to be following procedures for disposal of sharp objects; at many facilities, a disposal box for sharps was prominent in the dispensary. Facilities do not have uniform standard guidelines for destruction of damaged products.

Only in Abia were physical inventories and visual inspections carried out with any regularity. The staff members at the various other facilities visited seem to conduct physical inventories either when they know a supervisory visit will occur or just prior to ordering. The CCW performs a physical inventory two times per year and is part of the CCM forecasting exercise. Physical inventory should

be conducted every six months or annually in large storage facilities, quarterly in medium-sized ones, monthly in small facilities, and weekly for dispensing cupboards.

A comprehensive assessment of the central warehouse at Oshodi and the NPHCDA zonal warehouses in Kaduna and Ibadan was carried out in November 2007. This assessment indicated that the zonal warehouses were in poor physical condition—with roof and ceiling damage—and were not connected to a source of power. The Ibadan warehouse had evidence of termite infestation, obsolete forms, and expired bed nets. The central warehouse was generally in good physical condition, although roof leaks and termite encroachment were identified. The warehouse currently has suitable space, but this space may not be adequate for expected program expansion, and the current dispatch bay is not sufficient for proper product handling. The staff at the central warehouse has basic store management skills, but none of the systems are automated, leading to human error. There is inadequate knowledge of modern warehousing principles and management practices. In addition, expiry dates and batch numbers were not tracked on bin cards, and there were no SOPs or stock reports in place. No personnel protective gear was available, and security was inadequate, with no cameras or alarms and only one security guard on duty (Central Contraceptive Warehouse Assessment, 2007).

At the state level, storage conditions varied considerably. Abia, Nasarawa, and Kano were observed to have adequate state storage facilities, although the Kano facility was dusty and disorganized. Bauchi and Akwa Ibom had inadequate facilities in terms of both space and storage conditions. In Bauchi, new storage space has been set aside for renovation (pending funding).

From the state-level down, storage space was mostly adequate, with needs not anticipated to change much in the near future. In some facilities where security or space was an issue, commodities were not stored in cabinets but were kept in the office or the home of the service provider. State FP coordinators and LGA MCH pr RH coordinators need to distribute storage guidelines and to make training a priority in the next work plan.

Expired products should be separated from other commodities. NAFDAC witnessed the burning of expired products. In one instance, it was observed that an SP did not know how to read expiration dates correctly and had, admittedly, dispensed this product, while being unaware that it had expired. In another state, several SPs reported that their state FP coordinator told them to take back expired stock when they brought it to the state level (as per guidelines), and one even reported that the coordinator said to destroy the product. In Abia, state SPs were following protocol to send damaged and expired products to the central warehouse through the state store.

Some facilities kept cleaning products such as bleach together with commodities, and some products were stored upside down. No fire extinguishers were seen at any facility. Service providers were generally motivated, but in states with poor warehousing practices, SPs had not received training or adequate supervision. SOPs and guidelines on (a) warehousing and storage and (b) destruction of damaged and expired products need to be distributed in those facilities where there has not been any training on those procedures.

Strengths

- A varying degree of adequacy exists at state- and LGA-level stores. Some states, like Abia, are following very good warehousing procedures and have adequate space, policies, and trained personnel in place.
- Motivated service providers were found at all levels in all states.

Weaknesses

- In most states, there is poor availability of warehousing guidelines and of guidelines for destruction of damaged or expired products at any level, as well as of personnel trained on those principles.
- No automated system is in place for warehouse and inventory management at the central level.
- Current storage space is inadequate for expansion at the CCW.
- Some commodities are improperly stored (e.g., upside down, taken home, in loose paper or plastic bags).
- Teams noticed a leaking roof at the central store, roof damage at zonal stores, and signs of termite infestation. Some state and LGA stores need refurbishment.
- A lack of reliable power supply exists at Ibadan and Kaduna warehouses.
- No fire extinguishers are available in any states and LGA stores.

Key Recommendations

- Upgrade the warehouses at Ibadan and Kaduna to support the central warehouse at Oshodi so as to improve access to the states and to increase storage capacity.
- Establish a budget line at state and LGA levels for store refurbishment. The state FP coordinator should work with LGA coordinator to prioritize urgency of refurbishment.
- Establish stakeholder task force to partner with warehouse improvements.
- Design and implement SOPs at the CCW level, train staff members, and establish key performance indicators.
- Automate the CCW with a warehousing information management system.
- Employ more security guards at the CCW.

Transport and Distribution

At the central level, the CLMS section is responsible for coordinating distribution of supplies to the state level. In principle, a schedule exists so that supplies are sent to the states three times per year, according to the order placed by the state FP coordinator. In the past, distributions were made through private transporters using cost-recovery funds. States reported that having placed their orders several months back, they had yet to receive supplies. Currently, the arrangement is to work with UNFPA to use its transportation when the government and UNFPA schedules are in consonance. Presently, there is no transport for public sector contraceptives. SOPs for transport and distribution do not exist at the national level. The cost-recovery system has funds in its account, but the funds are not regularly accessed to provide transport and distribution for supplies.

The LGAs and SDPs use funds from cost recovery, where sufficient, to collect products from the higher level and to transport them using public transportation. Products are supplied on an established schedule that is tied to reporting. Products are generally available the same day they are requested, as long as the product itself is available in the store. This system works satisfactorily

except where the cost-recovery margin is insufficient; some SPs use their own funds, rely on sporadic supervisory visits to collect their supply, or do not collect it at all.

No budget line exists, at any level, for transport and distribution. Although the cost-recovery system may be able to provide enough margin in the future to fund transportation and distribution of commodities, the system as a whole is not yet at that point. In addition, lack of a well-thought-out distribution schedule and system of transportation from the central level has created a situation countrywide in which facilities and LGA and state storerooms are understocked or stocked out of certain products. Where there is low demand, products have expired with no resupply or with no coordination to reallocate them to where there is higher use. Where possible, state and LGA coordinators could coordinate with other departments or with development partners who make regular, scheduled visits to (a) drop supplies for—and collect reporting forms from,—facilities and (b) conduct supervisory visits.

Strengths

- Some LGAs and SDPs use cost recovery for transport of commodities.
- Distribution schedule follows reporting and ordering at state level and below.
- Lead time is short at state level and below for receiving stock (one day).

Weaknesses

- Delays exist in delivery from CCW in transporting commodities to the state.
- No defined or formal means of transporting public-sector commodities is in place.
- There are no standard guidelines for transportation.
- Funds from cost recovery for transportation and distribution of commodities at all levels are insufficient.

Key Recommendations

- Reassess current transportation arrangement ,and identify an efficient, sustainable distribution plan to provide timely distribution of commodities to the states.
- Develop SOPs for transportation of commodities.
- Have FMOH and SMOH establish a counterpart budget for transportation and distribution to fill any financing gaps not covered by the cost recovery margin.
- Encourage public private partnerships to assist with distribution of commodities.

Conclusions

This situation analysis is one step in a process to improve reproductive health (RH) commodity security so that all people can choose, obtain, and use quality contraceptives whenever they need them. After the finalization of this report, the next step will be to update, fund, disseminate, and adapt the reproductive health commodity security (RHCS) strategy nationwide. Continued effort and joint advocacy by the RHCS stakeholders committee are keys to ensuring that family planning (FP) is seen as an important health priority in Nigeria. Strengthening the supply chain and the corresponding human resources required will help ensure the availability of contraceptives for all.

This second RH assessment demonstrates the commitment by the Federal Ministry of Health (FMOH) to generating additional momentum for RHCS. Implementing and financing the activities in the next RHCS strategy will show explicit commitment for RH and FP in Nigeria.

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Appendix A

Reproductive Health Commodity Security National Stakeholders Workshop

Agenda

Wednesday, March 5–Thursday, March 6, 2008

Abuja, Nigeria

Day 1: Wednesday, March 5		
8.00–9.00am	• Registration	Facilitators
9:00–10:00am	• Opening prayer • Welcome remarks • Goodwill message by partners • Opening remarks • Participant introductions • Review purpose, objectives, and output of the workshop. Adopt the agenda.	Dr. Ngozi Njepuome head of Department of Public Health, FMOH • UNFPA • USAID Prof. Adenike Grange, Honorable Minister of Health Facilitator Mr. Greg Izuwa, CLMS,FMOH
10:00–10:30am	• Introduction to the concept of RHCS	• Consultants
10:30–11:15am	• Introduction to Reproductive Health Commodity Security and Update of RHCS Situation in Nigeria (2003–2007) • UNFPA Global RHCS Strategy • Questions and answers	Dr. Bose Adeniran, head CLMS, FMOH Dr. Chris Oyeyipo, UNFPA
11:15–11:30am	*Break*	

11:30–12:30pm	• Technical presentations – RH policy assessment – CLMS assessment report – Contraceptive warehouse assessment report	 Prof. Adekunle, ENHANSE consultant Mr. Musa Odiniya, CLMS,FMOH Mr. L.C.C. Anyanwu, CLMS, FMOH
12:30–1:30pm	*Lunch*	
1:30–3:00pm	Introduce tool, and review Context and Coordination in plenary.	• Consultants
3:00–4:45pm	• Small group instructions – Organize groups by components. – Break out into focus groups – Assign note-taker and group presenters • Focus group tool review (take break as needed) – Review questions in tool. – Identify strengths and weaknesses. – Prioritize strengths and weaknesses. – Identify information gaps.	• FMOH and consultants • Participants and facilitators
4:45–5:00pm	• Wrap-up and briefing about Day 2	• Consultants

Day 2: Thursday, March 6		
9:00–9:15am	• Opening and introduction to Day 2	• FMOH and consultants
9:15–11:00am	• Continue focus group work. – Continue review of tool. – Identify strengths and weaknesses. – Prioritize strengths and weaknesses. – Identify information gaps.	• Participants and facilitators
11:00–11:15am	*Break*	•
11:15–12:30pm	• Finish focus group work. – Identify strengths and weaknesses. – Prioritize strengths and weaknesses. – Identify information gaps or suggestions to modify tool for assessment. – Develop recommendations. – Prepare summary on findings, and prepare presentation for large group.	• Participants and facilitators
12:30–1:30pm	*Lunch*	
1:30–3:00pm	• Plenary: Group presentations and discussion	• Designated group presenters
3:00–3:15pm	*Break*	

3:15–5:00pm	Plenary: • Discussion and agreement on any needed changes to tool • Identification of next steps	• FMOH and consultants
5:00–5:15pm	• Wrap-up and closing remarks	• Consultants • FMOH

RHCS National Stakeholders Workshop Participant List

S/No.	Name	Organization
1.	Grace J. Ekong	SMOH, Akwa Ibom
2.	Nneka Oteka	FMOH
3.	Dr. A. B. Garba	NPHCDA, Minna
4.	Salako Adebusola	FMOH
5.	Kalu Francisca	SMOH, Abia
6.	Ugochukwu Alex	FMOH
7.	Alabi O. Oladapo	NPHCDA, Bauchi
8.	Yaya Tijjani	SMOH, Bauchi
9.	Gbenga Ijaodola	FMOH
10.	Izuwa Greg	FMOH
11.	Ortonga Gabriel	FMOH
12.	Olayele Ralph	FMOH
13.	Ononose Judith	FMOH
14.	Larabah Asalakah	SMOH, Nasarawa
15.	Dr. Ashiru Rajab	SMOH, Kano
16.	Mrs. Elsie Esara	National Population Commission
17.	Kayode Morenikeji	USAID
18.	Kale Feyiseran	USAID, Washington
19.	Chris Oyeyipo	UNFPA
20.	Charity Ibeawuchi	ENHANSE
21.	Amonia Standfast	Federal Ministry of Finance
22.	O. E. Eta	Federal Ministry of Women's Affairs
23.	A. A. Olaoye	National Population Commission
24.	Liyatu P. Esubili	FCTA Health Department
25.	Fadele E. O. (Mrs.)	NPHCDA, Ibadan
26.	Chris Elemuwa	NPHCHA, Benin
27.	Dr. Adenike Adeyemi	FMOH
28.	Dr. Moji Odeku	FMOH
29.	C. Enenche	SFH
30.	Dr. Onuekwusi	FMOH

31.	Ileuma S. A.	NPC
32.	Kofo Kolawole	COMPASS
33.	Bright Ekweremadu	SFH
34.	Kwakfut P. S. M.	CHAN
35.	Dr. Chris Agboghoroma	SOGON
36.	Mrs. Nafsat Adamu	PPFN
37.	Dr. Celina Asuelinmen	PSN
38.	Obi Oluigbo	SFH
39.	Dr. R. Kajang	NACA
40.	Ahmed Sa'ad	NHIS, Abuja
41.	L. C. C. Anyanwu	FHD FMOH
42.	Dr. Jide Coker	FMOH
43.	Somoye Olaronke Mrs.	SMOH, Ogun
44.	Bombata Temitope	FMOH
45.	Aishatu Lawan	SMOH, Kano
46.	Zubaida Abubakar	FHI-GHAIN
47.	Ladipo E. O.	FMOH
48.	Johnnie Amenyah	JSI
49.	Mrs. Okodugha M. O.	FMOH
50.	Ogungbami Abiodun	PPFN
51.	Eric Iful	NAFDAC
52.	Akua Kwateng Addo	USAID
53.	Christian Ibeh	UNFPA
54.	Mrs. C. L. I. Okechukwu	Ministry of Defense
55.	Dr. Bose Adeniran	FMOH
56.	Prof. O. A, Ladipo	ARFH
57.	Dr. Leku Ador	Nigerian Medical Association
58.	Dr. Adewuye B. R.	Nigerian Medical Association
59.	Dr. Agboghoroma	SOGON
60.	Echendu Adinma	UNFPA
61.	Uzo Ebenebe	UNFPA
62.	Azubike Nweje	UNFPA
63.	Igharo Elizabeth	USAID | DELIVER
64.	Sharon Simpa	JSI
65.	Elizabeth Ogbaje	JSI
66.	Sylvia Ness	USAID | DELIVER
67.	Ugo Amanyeiwe	Abt Associates
68.	Marie Tien	USAID | DELIVER

Appendix B

Reproductive Health Commodity Security Stakeholders Workshop Agenda

Tuesday, March 18–Wednesday, March 19, 2008

Kano State, Nigeria

Dates and times	Activities	Responsible agents/Remarks
Day 1: Tuesday, March 18		
9:00–10:00am	• Opening prayer • Welcome remarks	Dr. Daiyabu Mohammed, Director PHC/DC
	• Welcome address	Hajiya Aishatu Isyaku Kiru, Honorable Commissioner of Health, SMOH
	• Participant introductions • Review purpose, objectives, and output of the workshop. Adopt the agenda.	Dr. Ashiru Rajab, Deputy Director PHC
10:00–10:30am	• Commodity Insecurity Game and discussion	Consultants
10:30–11:15am	• Introduction to Reproductive Health Commodity Security Methodology and Objectives	Consultants
11:15–11:30am	*Break*	
11:30–12:00pm	• Reproductive Health Situation Update in Kano State—The Story So far	Hajiya Aishatu Lawan, FP Coordinator Dr. Ashiru Rajab, Deputy Director, PHC/DC
12:00–1:30pm	*Lunch/Afternoon prayers*	
1:30–3:00	• Introduce tool, and review context and coordination in plenary.	• Consultants

3:00–4:45	• Small group instructions – Organize groups by components. • Break out into focus groups. – Assign notetaker(s) and group presenters. – Identify strengths and weaknesses. – Identify information gaps.	• Participants & consultants
4:45–5:00	• Wrap-up and briefing about Day 2	• Consultants

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

Kano State RHCS Stakeholders Workshop Participant List

S/No.	Name	Organization
1.	Auwalu Ibrahim	SMOH
2.	Kayode Morenikeji	USAID
3.	Aishatu Lawan	SMOH
4.	Ahmad Garba Zango	SMOH
5.	Nura Ibrahim	SFH
6.	Fatima Abdu	FOMWAN

7.	Abdulrazaq Alkali	YOSPIS, Kano
8.	District Head	Tarauni Local Government
9.	Baba Isa Mohammed	National Population Commission
10.	Mairo Bello	AHIP
11.	Rep. Nasarawa District Head	Kano Emirate
12.	Maryam Musa	PPFN Kano
13.	Dr. Aminu Magashi Garba	Community Health and Research Initiative
14.	Abdullahi Y. Sule	YEDA
15.	Inuwa Idris Yakassai	Minister of Information, Kano
16.	Dr. Ashiru Rajab	SMOH
17.	Ummi Wada Waziri	ACCESS/JHPEGO, Kano
18.	Dr. F. Hassan-Hunga	AKTH
19.	Dr. Amir Imam Yola	SMOH, Kano
20.	Pharm. Gali Sule	SMOH, Kano
21.	Asmau Mohammed	SMOH
22.	Dr. Ibrahim Ibn Muhammad	NMA, Kano Branch
23.	Hon. Commissioner A. I. Kiru	SMOH
24.	A. S. Daurawa	SMOH
25.	Dr. B. A. Umar	Kano State Shariah Commission
26.	Salamatu Ibrahim	Muslim Sisters Organization
27.	Alh. Kabiru Garba	Rep. Nasarawa District Headquarters
28.	Dr. Bashir A. Umar	Shariah Commission Kano
29.	Bashirat L. Giwa	USAID | DELIVER
30.	Elizabeth Ogbaje	JSI
31.	Sylvia Ness	USAID | DELIVER
32.	Ugo Amanyeiwe	ABT Associates Inc.
33.	Marie Tien	USAID | DELIVER
34.	Elizabeth Igharo	USAID |DELIVER
35.	Sharon Simpa	JSI

Appendix C

Field Visits

Abia State

Team members

Lawrence Anyanwu, FMOH

Temitope Bombata, FMOH

F. M. Kalu, Abia State Family-Planning Coordinator

Azubike Nweje, UNFPA

State Level, State Store

Contact	Position
Dr. C. N. Oluoha	Director, Public Health and Disease Control
Mrs. V. Chigbu	Director, Finance, MOH
Chief Mrs. Nnenna Onwusoroh	Executive Chairman, Local Government Service Commission
Mrs. F. M. Kalu	State Family-Planning Coordinator
Mrs. Maria Okeh	State Safe Motherhood Coordinator
Federal Medical Centre, Umuahia	
Mrs. Nkechi Ogbulafor	Chief Nursing Officer-in-Charge, FP Clinic
Dr. Onuoha	Medical Director

Umuahia North LGA

Contact	Position
Sir Linus Oti	Head of Administration/Secretary
Comrade Eze Idika	Treasurer
Umuahia North Urban Clinic	
Mrs. Ichi	RH Supervisor
Mrs. E. A. Eleke	CNO/HOD, Health

Ohafia LGA

Contact	Position
General Hospital, Ohafia	
Dr. Onyemachi	Chief Medical Officer-in-Charge
Mrs. H. O. Udeaagha	CNO/FP Supervisor
Health Centre, Isiama-Elu	
Mrs. C. N. Huomah	SN/M
Mrs. Ugo Idika	FP Supervisor

Aba South LGA

Contact	Position
Family Planning Clinic, Health Office	
Lady N. L. Anuruegbe	Director of Nursing
Mrs. Ngozi Eke	RH Supervisor
Mrs. Chinyere Nwankwo	PNO-in-Charge
Family Planning Clinic, Abia State University Teaching Hospital	
Mrs. G. O. Chuku	CNO/FP Supervisor

Akwa Ibom State

Team members

Uzo Ebenebe, UNPFA

G. F. Ekong, Akwa-Ibom State Family-Planning Coordinator

E. O. Ladipo, FMOH

Adebusola Salako, FMOH

Contact	Position
University of Uyo Teaching Hospital (UUTH)—Offot Edina	
Prof. E. Ekanem	Chief Medical Director
Mrs. Arit Udofia	Chief Nursing Officer
Mrs. Theresa Eyo	Chief Nursing Officer
Mrs. Peace G. Udo	Assistant Chief Nursing Officer
Dr. A. Umoiyoho	Chief Consultant (HOD), Obst./Gynecology
Dr. Bassey Emen	Chief Consultant Obst./Gynecology

Nsit Ibom LGA

Contact	Position
Nsit Ibom PHC – Afahaeffiong	
Mrs. Mercy Eyo	Deputy Director, Health Services
Mrs. Grace P. Ajuzie (Mbiokporo)	Deputy Director, Health Services
Model PHC Nsit Ibom – Afahaeffiong	
Mrs. Eme G. Oyong	Deputy Director, Health Services
Mrs. Eno Okon Mtuen	Junior Chew

Oron LGA

Contact	Position
Operational Base Oron LGA	
Mrs. Arit Enekere	Deputy Director, Health Services
PHC Oron	
Mrs. Enebong Solomon	Deputy Director, Health Services
General Hospital Oron – Iquita	
Dr. Etuk Essien	Medical Superintendent
Mrs. Hannah Akan	Deputy Director, Health Education

Ikono LGA

Contact	Position
Operational Base Ikono LGA—Ibiaku Ntok Okpo	
Mrs. Efioanwan Umoh	FP Supervisor/Chief Nursing Officer
PHC Operational Base Ikono—Ibiaku Ntok Okpo	
Mrs. Diaka Udoh	Chief Matron
General Hospital Ikono—Ibiaku Ntok Okpo	
Dr. David Essien	Medical Superintendent
Mrs. Anthonia Iyang	FP Provider-in-Charge, Asst. Chief Nursing Officer

Bauchi State

Team members

Sylvia Ness, DELIVER

Elizabeth Ogabe, DELIVER

Judith Ononose, FMOH

Nneka Oteka, FMOH

Hauwa Othman, PHC Deputy Coordinator

Yaya Tijjani, PHC Coordinator

State Level

Contact	**Position**
Yaya Tijjani	PHC Coordinator
Hauwa Othman	PHC Deputy Coordinator

Dass LGA

Contact	**Position**
Husseina Othman	MCH Supervisor
Town Maternity	
Deborah G. Abbas	Service Provider
Wandi Health Centre	
Maryam Hashim	Service Provider

Ganjuwa LGA

Contact	**Position**
Hulda Barnabas	RH Supervisor
Kafin-Madaki—Town Maternity	
Naomi Giddeon Kamakam	Service Provider
Sabon Kariya Primary Health Center	
Patricia Iroja	Service Provider
Soro Primary Health Centre	
Halima Mai	Service Provider

Katagum LGA

Contact	**Position**
Amina Bappa	MCH Supervisor
Urban Maternity	
Helen Gizo	Service Provider
Town Maternity	
Helen Philemon	Service Provider

Kano State

Team Members

Elizabeth Igharo, DELIVER

Greg Izuwa, FMOH

Aishatu Lawan, Kano State Family-Planning Coordinator

Kayode Morenikeji, USAID

Marie Tien, DELIVER

SMOH

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

Kumbotso LGA

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

Gwale LGA

Contact	Position
Zainab Hussein	MCH Coordinator
Kabuga Health Clinic	
Yahuze Tshohu	Deputy PHC
Halima Muazu	Staff Midwife
Filimushe MCH Center	
Hadiza Garba	SCHEW
Planned Parenthood Federation of Nigeria	
Mariam Musa	State Project Coordinator, Clinic Officer
Community-Based Distributor	Male Motivator
Community-Based Distributor	Market-Based Distributor
Community-Based Distributor	Peer Educator

Takai LGA

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

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

Contact	Position
Abdulrazak S. Alkali	Executive Director

COMPASS Project

Contact	Position
Fatima M. Bunza	State Team Leader FCT
Habib M. Sadauki	Senior Advisor Reproductive Health

Nasarawa State

Team members

Ugo Amanyeiwe, Abt Associates Inc.

Laraba Asalakah, Nasarawa State Family Planning Coordinator

Sharon Simpa, JSI

Gabriel Ortonga, FMOH

State Level

Contact	Position
SMOH, Lafia	
Dangana Musa	Permanent Secretary
Christopher Umbugadu	Director, PHC

Obi

Contact	Position
Obi LGA Secretariat	
J. E. Amirikpa	Director, PHC
Isiaka Osuza	Director, Personnel Management
General Hospital, Obi	
Amudat Babatunde	Staff Nurse/Midwife in charge
PHC, Tudu Adabu	
Talatu Agbo	Reproductive Health Supervisor
State Store, PHC, Akunza	
Laraba Asalakah	Family Planning Officer

Toto LGA

Contact	Position
Toto LGA Secretariat	
Hauwa Danjuma	Director, PHC
Toto LGA Store	
Lucy Shafa	Reproductive Health Supervisor
Basic Health Centre, Gadabuke	
Rifkatu Azaki	Community Health Extension Worker (CHEW)
National Model PHC	
Pauline Eke	Registered Nurse/Midwife in charge

Nasarawa/Eggon & Toto LGA

Contact	Position
Nasarawa Eggon LGA Secretariat	
Bawa Ajegena Alh	Director, PHC
Danladi Y. Alh	Assistant Director, PHC
Mairo T. Bashayi	Monitoring /Supervision Officer
Stephen Y. Ebuga	Assistant Coordinator HIV/AIDs
Nasarawa Eggon LGA Store	
Paulina Agushaka	Reproductive Supervisor
PHC, Wowyen	
Martina Umbugadu	Registered Nurse/Midwife in charge

Ogun State

Team members

Echendu Adinma, UNFPA

Ralph Olayele, FMOH

Olaronke Somoya, Ogun State Family-Planning Coordinator

Alex Ugochukwu, FMOH

State Level

Contact	Position
Dr. M.T. Olowonyo	Permanent Secretary
Mr. Yomi Bajele	Director Finance and Admin.
Dr. E. A. Ogunsola	RH Coordinator
Mrs. O. Somoye	FP Coordinator

Ijebu Ode LGA

Contact	Position
Giwa M. Oseni	Executive Chairman
Femi Dehinbo	Vice Chairman
Adegboyega Kuku	Secretary to LGA
Mrs. I. E. Lawal	Supervisor Community Dev
A. A. Omosanya	Special Adviser Revenue Gen
Alhaji F.O. Adeyemi	Director General Special Activities
Mr. L .A. Olaibi	TR/Director Finance
Dr. A. A. A.Talabi	PHC Coordinator
Mrs. V. O. Ogunbanjo	RH/FP Coordinator
State Hospital, Ijebu	
Mrs. Aiyedun Afusat Salami	FP Coordinator
Family Health Clinic, Oke Oyinbo	
Mrs. A. K. Sote	Chief Nursing Officer
Mrs. M. O. Ottun	Chief Health Officer

Imeko Afon LGA

Contact	Position
Mr. L. A. Sunmola	Principal Executive Officer
Mr. G. A. Balogun	Supervisor Health
Mrs. M. E. Odukate	RH Coordinator
Dr. J. A. Bakare	PHC Coordinator
PHC Imeko	
Mrs. A. Adewolu	FP Coordinator
General Hospital, Imeko	
Mrs. M. A. Keunele-Adeniyi	Chief Matron/CNO
Mr. M. O. Ayilana	CNS
Health Clinic, Ilara	
Mrs. L. A. Olatunde	Chief Nursing Officer
C. R. Fagbemi	

Abeokuta South LGA

Contact	Position
Alhaji Ade Idris	Head of Local Government Administration
Mr. B. A. Owolabi	Director General, Services and Administration
Mr. E. O. Oyedele	Director of Finance
Chief Mrs. O. Majekodumi	Chief Matron, HMB
Mrs. E. O. Adekunle	Chief Matron, HMB

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