Federal Government
of Nigeria

Nigeria Family Planning Blueprint (Scale-Up Plan)

October 2014

Federal Ministry of Health

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FOREWORD

The Federal Government of Nigeria (FGON) since the late 1980s adopted and implemented many policies and strategic plans, including the National Population Policy for Development, National Reproductive Health Policy and Strategic Plans, National Reproductive Health Commodity Security Strategic Plans, and National Guidelines on Contraceptive Logistics Management System.

The FGON also signed up and has been implementing programmes aimed at achieving the Millennium Development Goals (MDGs) alongside other nations of the world. In all of the above, the government and people of Nigeria have fully enjoyed the unparalleled support of various stakeholders at national, regional, and international levels.

These efforts were aimed at addressing the high level of maternal and child morbidity and mortality rates, the poor quality of health of Nigerians due to poor health care infrastructure, inadequate human resources for health, and the inadequate availability of contraceptives and other life-saving maternal/reproductive health (RH) commodities. However, there are other outstanding issues that need to be addressed, and these include limited financial and physical access to high-quality health services and commodities, low level of awareness about various health services, and the high prevalence of STIs, including HIV. The ultimate goal in developing and implementing these policies, programmes, and strategic plans is to facilitate a continuous improvement in the health status and quality of lives of Nigerians.

In more recent times, the FGON took urgent steps towards creating the required favourable and conducive environment for the delivery of and access to high-quality health services by Nigerians in their different localities. Some of these steps included the Midwife Service Scheme (MSS), the policy on free contraceptives and life-saving maternal/RH commodities, accelerated implementation of activities around the long-acting reversible contraceptive (LARC) methods, task shifting with appropriate supervision of the community health extension workers, creation of budget lines and increased funding for key activities such as the procurement and distribution of required RH commodities, as well as an increase in collaboration with the private health sector in health care delivery, among other interventions.

The Nigeria Family Planning Blueprint (Scale-Up Plan), as a continuation of aforementioned steps, represents the avowed determination of the FGON to put in place a broad but well-articulated strategy that holistically addresses existing gaps in the provision of high-quality FP services to Nigerians of reproductive age. I am convinced that the proper implementation of the Blueprint would definitely result in the achievement of the contraceptive prevalence rate (CPR) of 36 percent by 2018—a target which Nigeria has committed to—from the present CPR of 15 percent. This is an achievable task but requires the concerted effort of not only governments at the Federal, State, and Local Government Area (LGA) levels but from the communities themselves, civil society organizations, and the organised private sector. The continued support of our key development partners in the successful implementation of the Blueprint is still solicited. While using this opportunity to appreciate all stakeholders for their contribution to this effort towards increasing the CPR in Nigeria, I wish to reassure all that the FGON shall continue to provide an enabling environment for the delivery of high-quality FP services to Nigerians of reproductive age.

I call on all current and prospective stakeholders to adopt the Blueprint as the reference document in the planning and implementation of all programmes or interventions intended to contribute to increased access to FP services in the country—as doing otherwise will greatly undermine the implementation process and the expected outcomes. It is my sincere belief that there will be broad collaboration among stakeholders as we look towards fast-tracking the process of accomplishing the set goal and objectives of the Blueprint while at the same time avoiding duplication, conflicts of interest, and the waste of scarce resources.

While reassuring the general public that the government shall continue to bring remarkable improvements in FP services and improve the health status of women and their children, I wish to thank all our partners and other stakeholders who have contributed immensely to this process.

Prof. C. O. Onyebuchi Chukwu
Honourable Minister of Health

PREFACE

Following Nigeria's commitments made at the 2012 London Summit on Family Planning, the Federal Ministry of Health (FMOH) developed the Nigeria Family Planning Blueprint (Scale-Up Plan). The FMOH has incorporated existing plans with additional strategic planning and consultation to draft the comprehensive, five-year costed scale-up plan. The Blueprint is intended to guide programming, resource allocation, and commitments to achieve the national objective of a contraceptive prevalence rate (CPR) of 36 percent by 2018.

This Blueprint was developed under the guidance and oversight of the FMOH, with support from donors and implementing partners. Consultants from the Health Policy Project (HPP), implemented by Futures Group and funded by the United States Agency for International Development, and other consultants supported by the Bill & Melinda Gates Foundation (BMGF) worked under the direction of the FMOH's family planning (FP) team to define the priorities, activities, and associated costs required to reach the FP objectives of the country.

Family Planning in Nigeria

The current CPR (2013) is 15% and the modern CPR is 10%; however, relatively little progress has been made over the past five years.

The goal is to increase CPR to 36% by 2018; this target was announced at the London Family Planning Summit (2012).

400,000 infant and 700,000 child deaths will be averted by achieving the CPR goal.

1.6 million unintended pregnancies will be averted by achieving the CPR goal.

Approximately US$600 million is needed to achieve Nigeria's FP goals.

Increased commitments from federal, state, and local governments; donors; and all stakeholders are needed to meet these ambitious goals and achieve these enormous benefits.

Throughout the process, stakeholders have provided significant inputs to ensure that the Blueprint represents the best interests of the women and citizenry of Nigeria. The elements of the Blueprint were developed based on a landscaping exercise completed by BMGF consultants as well as on content from existing plans, including the National Long-Acting Reversible Contraceptive Strategy; the Reproductive Health Commodity Security Strategy; the Maternal, Newborn, and Child Health Strategy; and the National Strategic Health Development Plan. These elements were further refined in working sessions to ensure the achievement of the national target of 36 percent CPR by 2018. Interviews with more than 20 partners, donors, and other government departments highlighted each organisation's concerns and current role. Consultative meetings provided revisions and feedback.

ACKNOWLEDGEMENTS

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LIST OF CONTRIBUTORS

The following stakeholders made valuable contributions to the development of the National Family Planning Blueprint (Scale-Up Plan):

- National Reproductive Health Technical Working Group
- Association for Reproductive and Family Health
- Association of Public Health Physicians of Nigeria
- Bayer Health Care
- Bill & Melinda Gates Foundation (BMGF)
- Clinton Health Access Initiative (CHAI)
- Evidence for Action (E4A)
- Family Health International (FHI360)
- Futures Group/Health Policy Project (HPP)
- International Post-Abortal care Services (Ipas)
- Johns Hopkins Programme for International Education for Gynecologists and Obstetricians (JHPIEGO)
- John Snow, Inc. (JSI)
- Marie Stopes International (MSI)
- Medical and Dental Council of Nigeria
- Merck Sharp Dohme (MSD)
- National Primary Health Care Development Agency (NPHCDA)
- Nigerian Urban Reproductive Health Initiative (NURHI)
- Nursing and Midwifery Council of Nigeria (NMCN)
- Partnership for Reviving Routine Immunization in Northern Nigeria, Maternal Newborn, and Child Health Initiative (PRRINN-MNCH)
- Partnership for Transforming Health Systems-2 (PATHS 2)
- Pathfinder International
- Planned Parenthood Federation of Nigeria (PPFN)
- Population Council
- Society for Family Health (SFH)
- United Nations Population Fund (UNFPA)
- United States Agency for International Development (USAID)
- United States Agency for International Development (USAID)/DELIVER Project

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
BMGF	Bill & Melinda Gates Foundation
CHAI	Clinton Health Access Initiative
CHEW	community health extension worker
CIDA	Canadian International Development Agency
CYP	couple years of protection
DBC	demand generation and behaviour change communication
DFID	UK Department for International Development
DHIS	District Health Information Software
DHS	Demographic and Health Survey
E4A	Evidence for Action
FCT	Federal Capital Territory
FGON	Federal Government of Nigeria
FHI360	Family Health International
FLHE	Family Life and HIV Education
FMOH	Federal Ministry of Health, Nigeria
FP	family planning
GDP	gross domestic product
HCW	healthcare worker
HIV	human immunodeficiency virus
HPP	Health Policy Project
HRH	Human Resources for Health
Ipas	International Post-abortal Care Services
IUD	intrauterine device
JCHEW	junior community health extension worker
JHPIEGO	Johns Hopkins Programme for International Education for Gynecologists and Obstetricians
JSI	John Snow, Inc.
LARC	long-acting reversible contraceptive
LAM	lactational amenorrhea method
LGA	Local Government Area
LMIS	Logistics Management and Information system
M&E	monitoring and evaluation
mCPR	modern contraceptive prevalence rate
MNCH	maternal, newborn, and child health
MOU	memorandum of understanding
MSD	Merck Sharp Dohme
MSI	Marie Stopes International
MSS	Midwives Service Scheme
NDHS	Nigerian Demographic and Health Survey
NGO	nongovernmental organisation
NHMIS	National Health Management Information System
NMCN	Nursing and Midwifery Council of Nigeria
NOA	National Orientation Agency
NPHCDA	National Primary Healthcare Development Agency
NPI	National Programme on Immunization
NRHTWG	National Reproductive Health Technical Working Group
NURHI	Nigerian Urban Reproductive Health Initiative
PATHS-2	Partnership for Transforming Health Systems-2
PE	policy and environment
PHC	Primary Healthcare Centre
PMTCT	prevention of mother-to-child transmission of HIV

PPMV	Proprietary Patent Medicine Vendor
PPFN	Planned Parenthood Federation of Nigeria
PRRINN-MNCH	Partnership for Reviving Routine Immunization in Northern Nigeria—Maternal Newborn, and Child Health Initiative
PSM	Procurement and Supply Chain Management Group
RHCS	reproductive health commodity security
RH	reproductive health
SC	supplies and commodities
SD	service delivery
SDP	service delivery point
SFH	Society for Family Health
SMC	supervision, monitoring, and coordination
SMOH	State Ministry of Health
SMOLG	State Ministry of Local Government
SMS	short message system (texting)
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WG	working group
WHO	World Health Organization
WRA	women of reproductive age

SECTION 1: INTRODUCTION

1.1 The Global Context

Family planning (FP) is one of the most cost-effective ways to prevent maternal, infant, and child mortality. It can reduce maternal mortality by reducing the number of unintended pregnancies, the number of abortions, and the proportion of births at high risk.[1] It has been estimated that meeting women's need for modern contraceptives would prevent about one-quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives per year.[2] Family planning offers a host of additional health, social, and economic benefits; it can help slow the spread of HIV, promote gender equality, reduce poverty, accelerate socioeconomic development, and protect the environment.

Among women of reproductive age in developing countries, 867 million (57%) are in need of contraception because they are sexually active but do not want a child in the next two years. Of these, about 222 million (26%) do not have access to modern methods of contraception, resulting in significant unmet need.[3] In 2006, unmet need for family planning was added to the fifth Millennium Development Goal as an indicator for tracking progress on improving maternal health.[4]

In Nigeria, according to the population census of 2006, there were, at that time, 44,152,637 women of reproductive age. The Nigerian Demographic and Health Survey (NDHS) 2013 reported that only 15.1 percent of married women of reproductive age were using any contraceptive. Ten percent of currently married women reported using a modern method, and 5 percent use other methods of contraception. In addition, there is a significant unmet need for family planning in Nigeria; 16 percent of married women have an unmet need for family planning (NDHS 2013).

1.1.1 London Summit on Family Planning

On July 11, 2012, FP stakeholders worldwide assembled for the London Summit on Family Planning. The UK government, through its Department for International Development (DFID), and the Bill & Melinda Gates Foundation (BMGF) partnered with the United Nations Population Fund (UNFPA) to host a gathering of leaders from national governments, donors, civil society, the private sector, the research and development community, and other interest groups.

The meeting deliberated on the renewal and revitalisation of the global commitment to ensure that women and girls, particularly those living in low-resource settings, have access to contraceptive information, services, and supplies.

The objective of the summit was to "mobilize global policy, financing, commodity, and service delivery commitments to support the rights of an additional 120 million women and girls in the world's 69 poorest countries to use contraceptive information, services, and supplies without coercion or discrimination by 2020." Doing so would prevent a staggering 100 million unintended pregnancies,

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[1] Lule, E., R. Hasan, and K. Yamashita-Allen. 2007. "Global Trends in Fertility, Contraceptive Use and Unintended Pregnancies." Pp. 8–39 in *Fertility Regulation Behaviors and Their Costs: Contraception and Unintended Pregnancies in Africa and Eastern Europe & Central Asia,* edited by E. Lule, S. Singh, and S.A. Chowdhury. "Health, Nutrition & Population Discussion Paper. Washington, DC: World Bank. Retrieved from http://go.worldbank.org/BZSBNC53A0.

[2] Singh, S., J.E. Darroch, M. Vlassof, and J. Nadeau. 2003. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care.* New York: Alan Guttmacher Institute. Retrieved from www.guttmacher.org/pubs/addingitup.pdf.

[3] Singh, S., and J.E. Darroch. 2012. *Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2012.* New York: Guttmacher Institute. Retrieved from www.unfpa.org/webdav/site/global/shared/documents/publications/2012/AIU%20Paper%20-%20Estimates%20for%202012%20final.pdf.

[4] Bernstein, S., and L. Edouard. 2007. "Targeting Access to Reproductive Health: Giving Contraception More Prominence and Using Indicators to Monitor Progress." *Reproductive Health Matters* 15(29):186–191.

50 million abortions, 200,000 pregnancy/childbirth-related maternal deaths, and 3 million infant deaths.[5]

The London Summit on Family Planning committed to the following:

- Increase demand and support for family planning by removing barriers to its access and use
- Improve supply chains, systems, and service delivery models and procure more affordable high-quality contraceptives through better global coordination, including new methods for expanded choices
- Improve market dynamics, including country forecasting capacities and increased availability and quality of a range of FP methods
- Promote accountability at the global and country levels through improved monitoring and evaluation (M&E)
- Advocate for sustained government and donor funding

Nigeria was represented at the London Summit by a team of experts led by the Federal Ministry of Health (FMOH). At the summit, they committed to increasing domestic funding for family planning. The Federal Government of Nigeria (FGON) committed to disbursing an additional $8.35 million per year specifically for family planning and reproductive health (RH), which translated to about a 300 percent increase.

1.1.2 Country response to the London Summit

After the summit's conclusion, the FMOH team of experts identified the following key steps to ensure the increased uptake of FP services:

- Support advocacy
- Strengthen accountability
- Improve supply chains
- Increase contraceptive supply
- Promote best practices
- Support new innovations

This Nigeria Family Planning Blueprint (Scale-Up Plan), hereafter referred to as the "Blueprint," evolved from the commitments made at the London Summit; it provides a roadmap for achieving the FGON's goals for improving access to family planning and reducing maternal mortality through a concerted national effort to scale up family planning over five years (2013–2018).

1.2 The Nigerian Context

With more than 175 million people, Nigeria is the most populous country in Africa and the seventh most populous country in the world. Annual population growth is 3.2 percent, and the total fertility rate is 5.5, with variations across states and regions (NDHS, 2013). Most projections place Nigeria as the third most populous country behind India and China by 2050. There are approximately 35 million women of reproductive age in Nigeria, and the country had nearly 7 million births in 2012 alone.

Nigeria's gross domestic product (GDP) has grown consistently at above 6 percent per year since 2001. However, GDP per capita has grown more slowly at around 4 percent. Income inequity remains a key issue. The top 10 percent wealth bracket in Nigeria receives 34 percent of the income share, whereas the lowest 10 percent receives less than 2 percent. This pattern has been relatively stable for the past 20 years. These inequities persist along regional lines, with oil revenues concentrated in the South.

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[5] Family Planning Summit 2012. "Technical Note: data sources and methodology for calculating 2012 baseline, 2020 objectives, impacts and costings." Family Planning Summit Metrics Group, 2012.

Constitutionally, Nigeria is divided into 36 States and one Federal Capital Territory (FCT). State governments are led by governors who strongly influence budgets and wield significant political power. States effectively control 50 percent of all government revenue. As a result, the implementation of many health policies, including family planning, benefits significantly from the support of state governors.

Each State is divided into Local Government Areas (LGAs). There are 774 LGAs, each run by a local government council comprising a chairman (the chief executive) and elected councilors. LGAs ultimately are responsible for managing and implementing the primary healthcare system, which is the most extensive channel for healthcare in the country. Ward development committees and other community groups often support their primary healthcare centres (PHCs). As a result, there are disparities in the way PHCs are funded, staffed, and stocked across the country.

From an RH perspective, the federal government is charged with developing policies, strategies, guidelines, and plans that provide direction for the Nigerian healthcare system. However, implementation of these guidelines ultimately falls on the State Ministry of Health (SMOH). Each SMOH is responsible for health programme direction and coordination in its State. The State Ministry of Local Government (SMOLG) is responsible for hiring, managing, and paying health workers at the primary healthcare level (as part of the civil service). Each State also has an FP coordinator who helps facilitate commodity ordering and transportation as well as advocacy. Effecting change in reproductive health requires a concerted effort and clear alignment from the federal government down to the LGAs.

According to the 2013 NDHS, 15.1 percent of married women of reproductive age (15–49) are using any contraceptive method; however, only 9.8 percent of these women are using modern FP methods. This national rate has largely remained at this level since the late 1990s. The modern method mix predominantly comprises condoms, pills, and injectables.

Figure 1: Nigeria Method Mix 1990–2013[6]

Married women using a contraceptive method, percent CPR
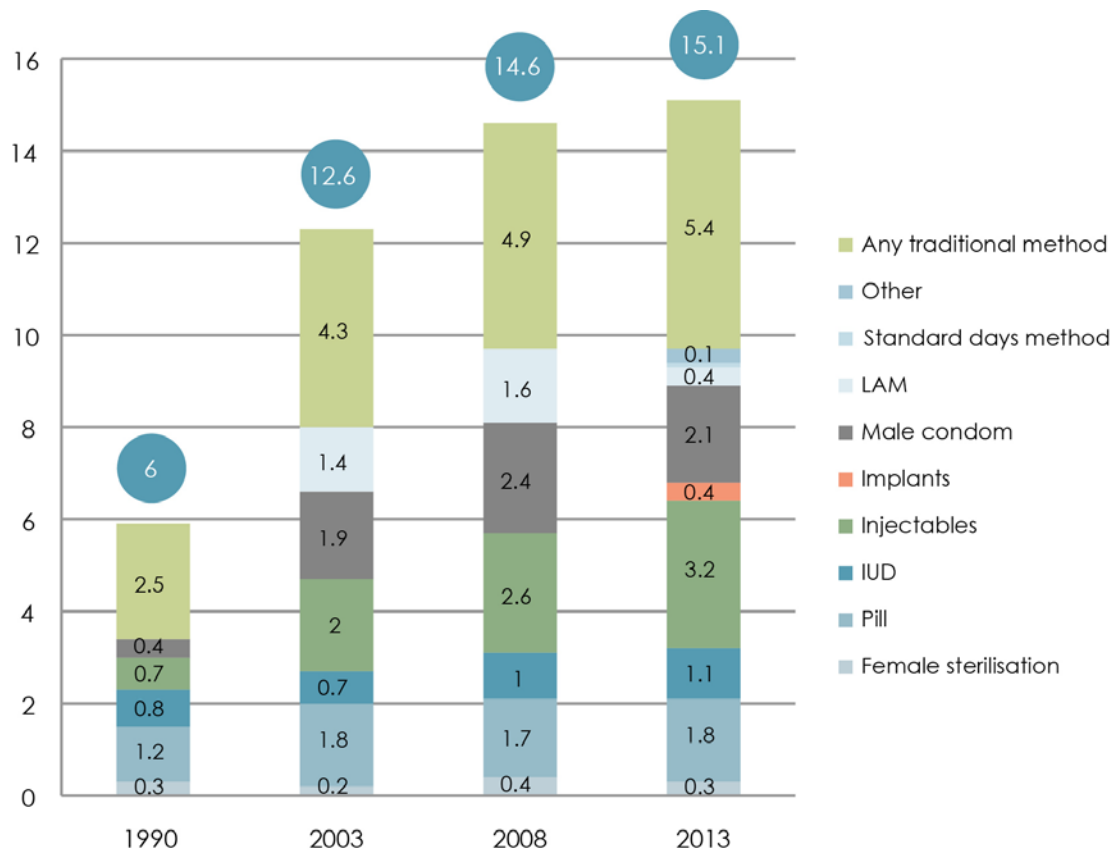
As part of its FP2020 commitment, the Nigerian government has set a target of reaching a 36 percent CPR by 2018. To achieve this goal, the government pledged additional funds to be provided over the next four years, starting from 2014; and several donors and nongovernmental organisations (NGOs) are currently committed to supporting FP/RH efforts in Nigeria.

1.3. Nigeria Family Planning Landscape

Those who developed the Blueprint analysed the FP situation in Nigeria across five components:

- Service delivery
- Supplies and commodities
- Demand generation and behaviour change communications
- Regulation and policy
- Financing

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[6] 1990 NDHS, 2003 NDHS, 2008 NDHS, 2013 NDHS. National Population Commission (NPC), Federal Republic of Nigeria and ICF International. 2014. *Nigeria Demographic and Health Survey (NDHS) 2013*. Abuja, Nigeria: NPC; and Rockville, MD: ICF International.

1.3.1 Service delivery

Nigerian women seek FP services from both the public and private sectors. Because intrauterine devices (IUDs), implants, and injectables require trained service delivery, they are usually sourced via the public sector. Condoms and pills are available from a wide variety of sources, including proprietary patent medicine vendors (PPMVs), informal drug sellers, pharmacies, and private and public health clinics.

Figure 2: Sources of Contraception[7, 8]

Source of modern contraception

Source of modern contraception, by method
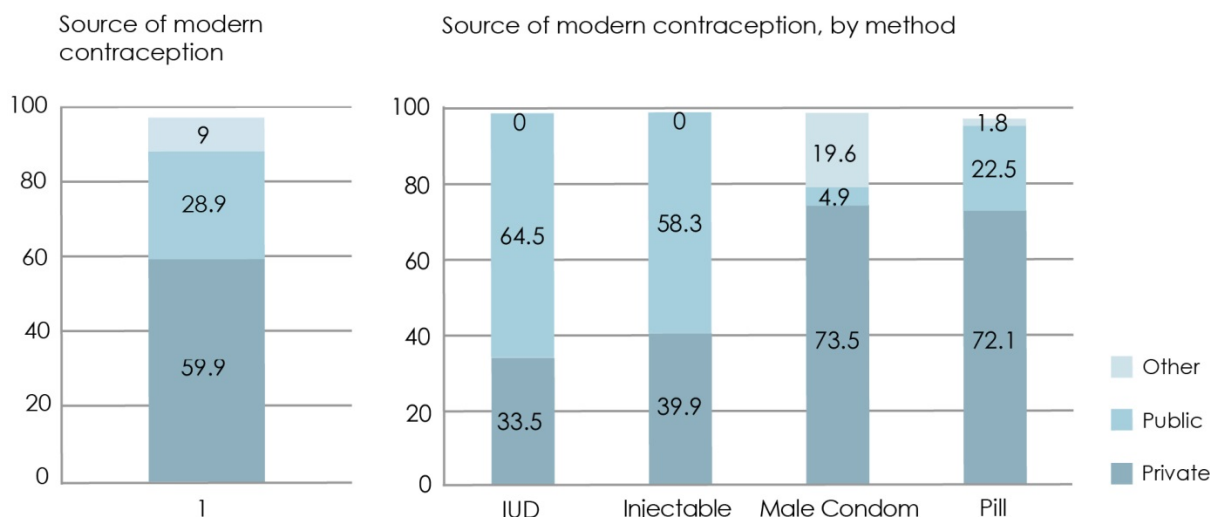
Delivering high-quality FP services across Nigeria depends on the providers' skills and training, as well as human resource availability at public and private points of care.

Staff skills and training: There is a major shortage of skilled providers for delivering FP services, especially for injectables and long-acting reversible contraceptives (LARCs). In the case of injectables, the policy to allow community health extension workers (CHEWs) to deliver them was approved in 2012, but few CHEWs have received formal training on how to deliver the method properly (i.e., provide the necessary counselling, screen for pregnancy, and deliver the actual injection). Regarding LARCs, implants were introduced on a larger scale in the public sector only in 2006, and it is possible that many providers who received training are no longer practicing in the public system. Plans for increasing insertion skills are covered in the National LARC Strategy.

In addition to limiting overall access to family planning, inadequate staff skills and training contribute to other challenges. If a provider has not been trained and does not feel confident and/or comfortable about a particular method (e.g., inserting an IUD or giving an injectable), s/he is less likely to offer that method. This contributes to provider bias for certain methods over others. UNFPA estimates that 63 percent of state hospitals in Nigeria are not offering implants.

High turnover also persists in the healthcare sector. Turnover among providers can be as high as 40 percent per year in some areas of Nigeria. Doctors, nurses, and midwives choose to leave their posts each year due to opportunities abroad, interest in other fields, or retirement. Many experienced FP providers also cite the lack of continuing education and training as a challenge, pointing to the 1980s as the last time that large-scale FP training efforts were in place. Given the substantial time that has passed since then, it is likely that many of these learned skills no longer remain in the system.

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[7] National Population Commission (NPC), Federal Republic of Nigeria and ICF International. 2014. *Nigeria Demographic and Health Survey (NDHS) 2013*. Abuja, Nigeria: NPC; and Rockville, MD: ICF International.

[8] "Other" sources refer to shop, friend/relative, and other.

Staffing levels: Nigeria suffers from low staffing levels across all cadres of health workers. According to the World Health Organization (WHO) Health Workforce Survey (2008), the country has approximately 0.4 doctors, 1.6 nurses, and 0.2 CHEWs per 1,000 people. Moreover, these averages mask regional differences. To compound the problem, many States have frozen new recruitment, citing high recurrent expenditures. As trained staff retires, they are often not replaced.

In the North, Nigerians rely on CHEWs as the primary point of care. These workers have at least two years of post-secondary school education. They often work as the only staff members of PHCs, providing all the care in the community and sometimes delivering services for which they are not properly trained.

CHEWs recently became legally permitted to provide injectable contraception to women. However, they are still restricted from providing IUDs and implants. In practice, this means that access to the full complement of LARCs in the North is limited to secondary health facilities and larger primary care sites.

Figure 3: Density of Human Resources for Health (HRH) in the States[9]

South-East	Nurses/Midwives		CHEWs	
Abia	1,376	18	1,262	16
Anambra	1,214	11	1,000	9
Enugu	1,906	21	2,996	33
Ebonyi	199	4	551	10
Imo	4,588	43	1,682	16

South-South	Nurses/Midwives		CHEWs	
Rivers	1,001	7	2,715	19
Adwa Ibom	2,311	22	1,556	15
Edo	1,427	17	1,531	18
Cross River	409	5	1,542	20
Delta	1,949	18	1,000	9
Bayelsa	255	6	1,000	22

South-West	Nurses/Midwives		CHEWs	
Osun	1,428	16	3,071	34
Ondo	908	10	2,550	28
Ogun	988	10	1,205	12
Ekiti	421	7	1,535	24
Oyo	1,650	11	1,255	9
Lagos	5,506	21	870	3

North-Central	Nurses/Midwives		CHEWs	
FCT	1,508	41	1,000	27
Kwara	501	9	1,323	23
Plateau	1,772	23	2,319	30
Nasarawa	1,106	25	1,111	25
Kogi	2,850	36	971	12
Benue	368	4	2,803	28
Niger	1,192	13	1,573	17

North-East	Nurses/Midwives		CHEWs	
Taraba	908	17	1,111	20
Gombe	577	11	900	17
Adamawa	981	13	1,245	17
Borno	1,190	13	2,362	25
Yobe	259	5	1,084	21
Bauchi	519	5	1,457	14

North-West	Nurses/Midwives		CHEWs	
Kaduna	2,120	15	5,249	36
Zamfara	232	3	580	8
Kebbi	582	8	1,000	13
Sokoto	1,407	16	423	5
Katsina	1,431	11	1,751	13
Kano	1,392	7	1,912	9
Jigawa	395	4	897	9

X Per 10,000 WRA   X Higher density

1.3.2 Supplies and commodities

Ensuring the uninterrupted availability of high-quality FP commodities and consumables in the public sector continues to be a major problem in Nigeria. There have been improvements in recent years under the direction of the FMOH, with assistance from UNFPA, the United States Agency for International Development (USAID), and other donors. However, fully addressing this issue will require aligning forecasting, procurement, and distribution to consumer needs.

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[9] Labiran, A., M. Mafe, B. Onajole, and E. Lambo. 2008. *Health Workforce Country Profile for Nigeria*. Brazzaville: Africa Health Workforce Observatory.

Forecasting: FP commodity forecasting is currently run through the John Snow, Inc. (JSI) DELIVER Project using a mixture of logistics data and a demographic-based framework. However, there are problems with ordering in States due to a poor understanding of logistics management and information system (LMIS) tools.

Procurement: FP commodity procurement is carried out solely through UNFPA, with funds contributed by the FGON and development partners, including UNFPA, USAID, the UK Department for International Development (DFID), and the Canadian International Development Agency (CIDA). Pipeline problems are common due to delayed shipments, which occasionally cause depletion of emergency stock levels.

Distribution: Distribution from the Central Contraceptive Warehouse in Lagos to the State stores across the country is functioning in most cases. UNFPA, other donors, and implementing partners have begun to coordinate State to LGA to service delivery point (SDP) distributions in the States. While distribution has improved significantly in recent years, it is still an ad hoc system with inherent sustainability concerns.

1.3.3 Demand generation

Low demand for FP services and commodities remains a significant barrier to increasing CPR. Many women are not aware of the various methods of contraception or the relative benefits and side effects of each. In addition to lack of awareness, common misconceptions about side effects and efficacy persist among many men and women. Furthermore, the overall health and economic benefits of birth "spacing" and "limiting" are not well understood among families or even providers. This seems to translate into a low motivation to use family planning and low usage patterns. To address this situation, all stakeholders and influential leaders should be encouraged to provide correct and appropriate information on birth spacing.

Knowledge: There is a low knowledge of contraceptives, especially LARCs, across Nigeria. The NDHS (2013) reported that 84.6 percent of married women of reproductive age have heard of at least one method. However, this average masks critical differences related to method type, age, wealth, and other factors. For example, only 25.9 percent of women have heard of implants in Nigeria—a much lower rate of knowledge than in other countries. From a geographical perspective, knowledge is significantly lower in the North, as is contraceptive prevalence.

Figure 4: Knowledge of Different Methods[10]

Women's knowledge of contraceptive methods, percent of married WRA
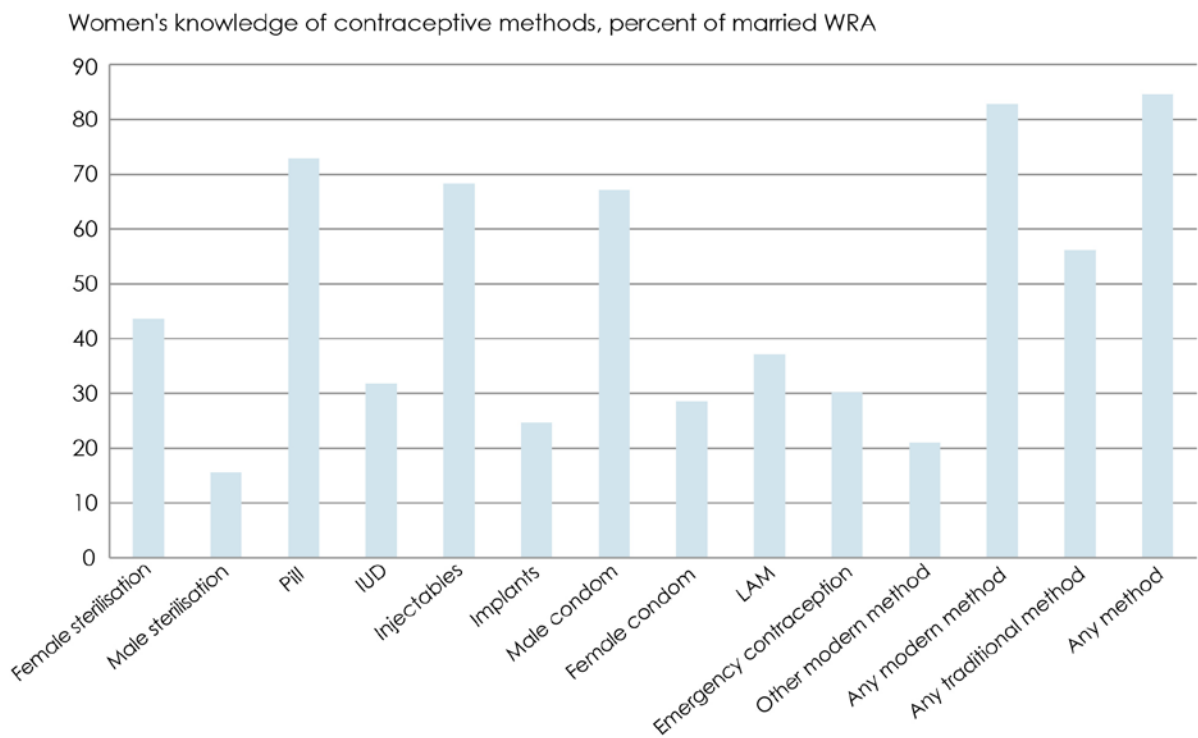
Figure 5: Regional Differences in Knowledge of Modern Contraceptives[11]

Women's knowledge of contraceptive methods, percent of married WRA
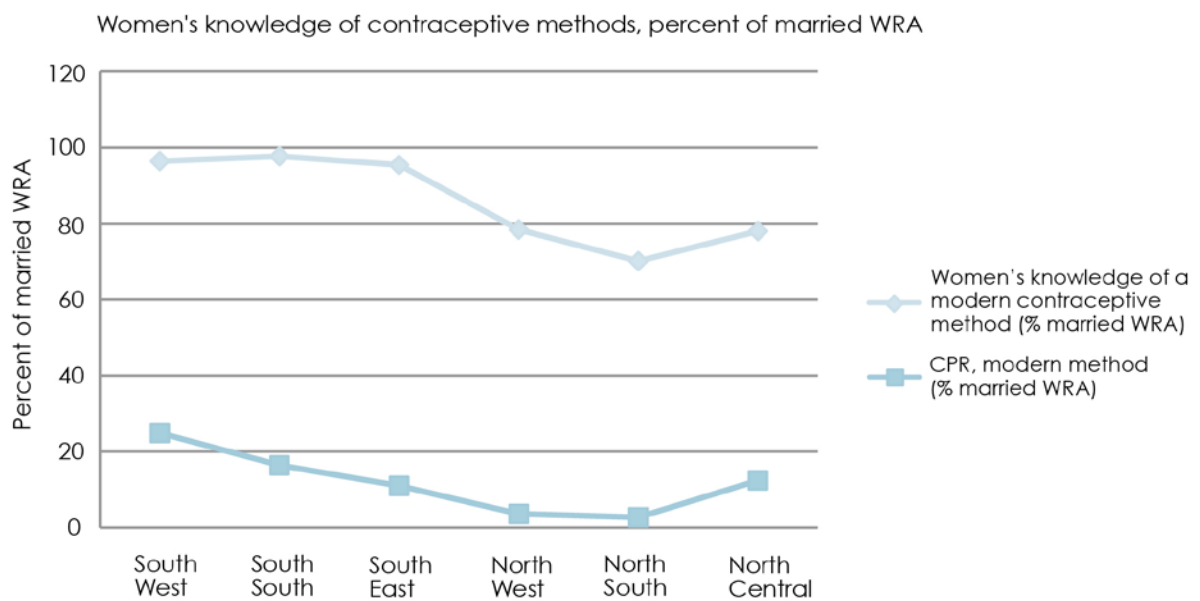
Not surprisingly, lower levels of education and wealth show the same patterns of lower knowledge and lower use of contraception.

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[10] NDHS 2013.

[11] NDHS 2013.

Figure 6: Education and Wealth Differences in Knowledge of Modern Contraceptives[12]

Awareness of at least one modern contraceptive method
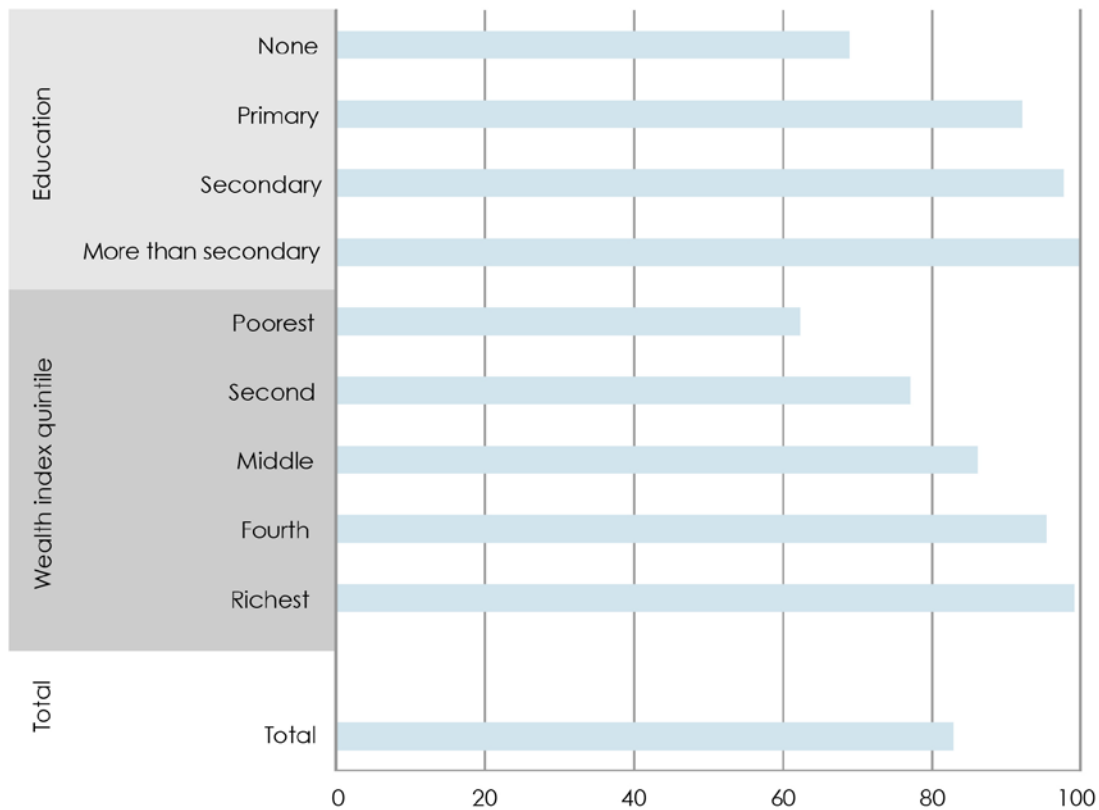
Motivation to use: "Unmet need" can be used as an indicator of a population's motivation to use contraception. This measures the proportion of women who have expressed a desire to either space or limit their childbearing but are not using an FP method. In Nigeria, 16 percent of currently married women have an unmet need for FP services (12% for spacing and 4% for limiting births). Unlike knowledge, unmet need does not seem to follow any geographical patterns but instead shows varying levels across States and regions. Education or wealth levels also do not seem to drive the level of unmet need.

"Intention for future use" is another indicator of motivation. Among currently married nonusers, 23.3 percent intend to use FP methods in the future. An additional 10.2 percent were unsure. Finally, more than 63 percent of women stated that they did not intend to use contraception in the future. The reasons cited included being opposed to using contraception, partner opposition, lack of knowledge, a fear of side effects, and religious prohibitions. This indicator applies to a broad future timeframe as opposed to one point in time, meaning that the figures cited above are too low to achieve the CPR target of 36 percent by 2018. These statistics confirm that demand generation will be a critical component of meeting the national CPR goal.

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[12] NDHS 2013.

Figure 7: Intention for Future Use Among Nigerian WRA[13]

Intention for future use of contraception

■	Missing
■	Unsure
■	Intends to use
■	Does not intend to use

3.2%
10.2%
23.3%
63.3%

Percent of married WRA
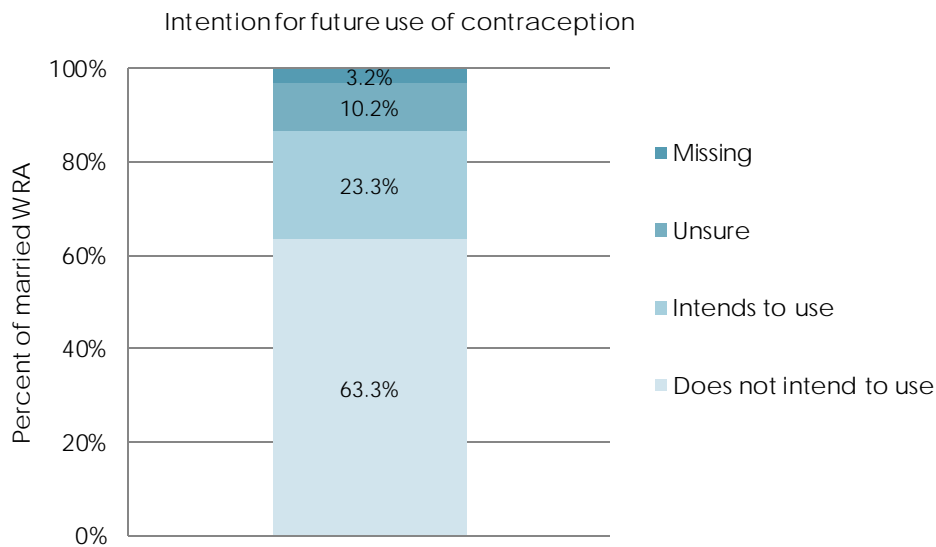
Figure 8: Additional Contraceptive Users Required to Reach National Goal of 36%

Contraceptive use for all methods

15.1% — 2013 CPR, any method
16.1% — 2013 unmet need
31.2% — Potential future CPR
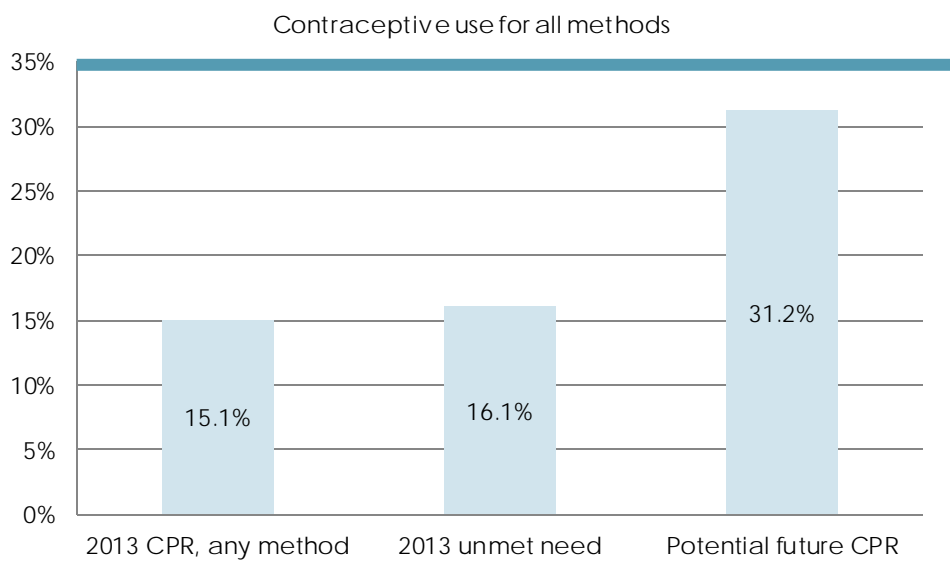
Usage: National CPR figures mask the significant range in contraception use patterns across Nigeria. State-level modern contraceptive prevalence rates (mCPRs) range from <1 percent to 27 percent, with usage concentrated largely in the southern States. Usage patterns also follow traditional education and wealth lines, with higher levels of each equating to higher usage.

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[13] NDHS 2013.

Figure 9: CPR Across Nigeria

% Women married or currently in union ages 15–49 using any modern method (2011)

Legend:
- Above 20%
- 10–20%
- 5–9.9%
- 0–4.9%
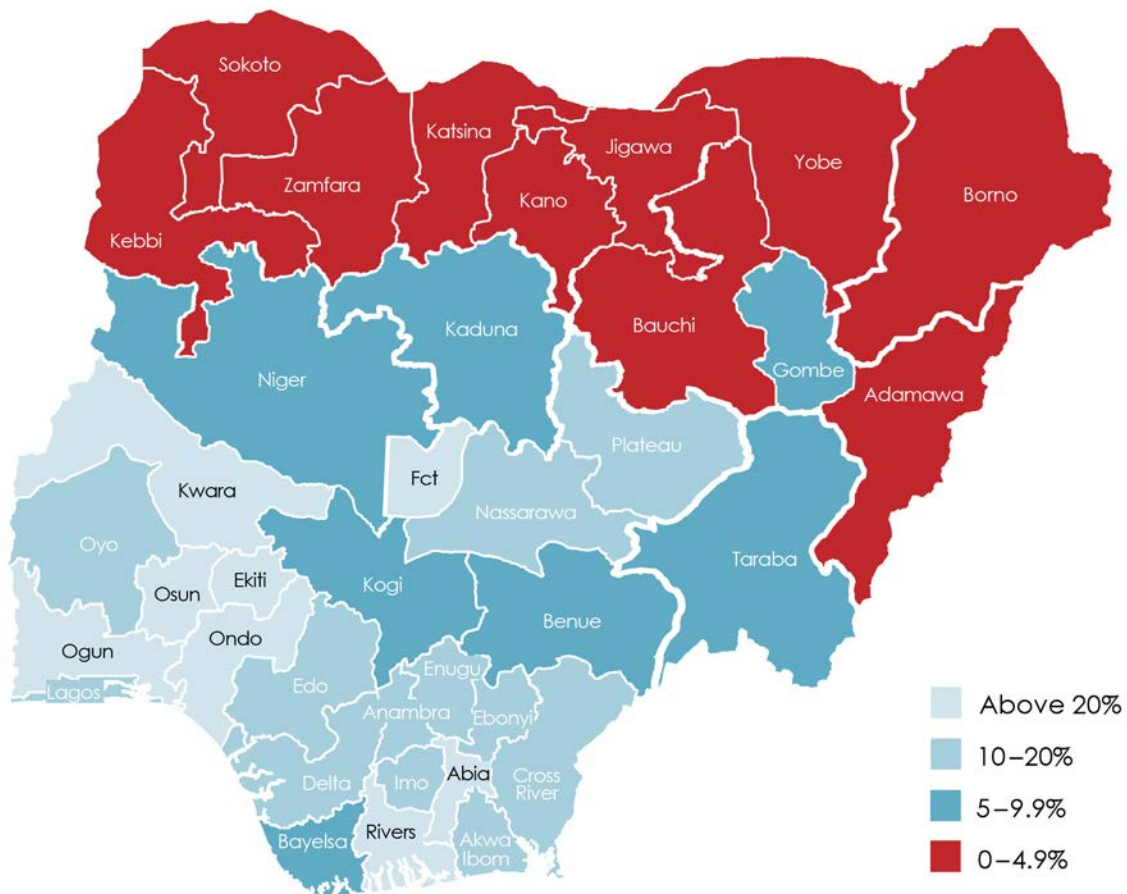
1.3.4 Regulation and policy

The FGON has made great strides in improving the enabling policy environment for family planning. These include participation in the 2012 London Summit on Family Planning and its announced commitment to increase domestic funding for family planning. In addition, the FMOH adopted a free commodity policy in April 2011, making all FP commodities at public facilities available free of charge to all women. Finally, the policy to permit injectable provision by CHEWs greatly expanded the potential number of service providers across the country for this key method.

In setting the national CPR target at 36 percent, the FMOH has shown its strong commitment to family planning. The Blueprint originated from the FMOH's desire to improve coordination among FP stakeholders to achieve a common goal. Currently, there are at least four plans with FP/RH goals associated with them. These are the National LARC Strategy, the Reproductive Health Commodity Strategy, the National Strategic Health Development Plan, and the Maternal, Newborn, and Child Health (MNCH) Strategy. Components relating to family planning from each of these plans were included in the Nigeria FP scale-up plan exercise.

1.3.5 Financing

Financing for family planning comes from all three levels of government in Nigeria as well as external donor sources.

Federal: The FGON contributes US$3 million for contraceptive procurement annually.

State: FP provision (excluding commodity costs) ultimately falls to the States. To date, out of the 36 States, only Lagos has officially disbursed budget monies directly for FP services. This means that for many States, the funds required to transport commodities and consumables to SDPs are not available. Those States lacking donor projects are severely limited in providing FP services and commodities through the public health system.

LGA: While LGAs are responsible for managing PHCs, they depend on budgets released by the States. No LGAs have received released funds dedicated to family planning.

Securing additional funding for family planning at the federal, state, and LGA levels will be a critical part of expanding access to and use of contraception across Nigeria. A key goal for the Blueprint is to detail the costs at the national level to provide clarity on the fiscal requirements for meeting Nigeria's CPR target.

SECTION 2: INTEGRATED FAMILY PLANNING PLAN

2.1 Goal

The overarching goal of this Blueprint is to increase women's use of FP services (CPR to increase from 15% to 36%) and contribute to the reduction of maternal mortality by 75 percent and infant mortality by 66 percent across Nigeria by 2018.

2.2 Objectives

By 2018, Nigeria intends to accomplish the following:

- Provide accurate and comprehensive knowledge of FP methods to every segment of the population through easily accessible channels to generate demand and change behaviour.

- Ensure that every State in Nigeria contributes at least 50 percent of the funds it requires for adequate FP service delivery every year.

- Ensure that every health facility (including PHCs and private and faith-based clinics) has an adequate number and category of trained staff—according to national guidelines—to provide LARC services throughout the country.

- Strengthen contraceptive logistics management systems to ensure continuous contraceptive availability at all health facilities.

- Improve routine data management (including collection, collation, reporting, and use) at all levels of the healthcare delivery system in the country to allow for smooth tracking of FP progress.

2.3 Strategic Priorities

As part of the Blueprint's development, the FMOH, in conjunction with key stakeholders, has prioritised a set of issues most relevant to achieving Nigeria's target of a 36 percent CPR. These issues surfaced based on existing FP/RH planning work, a diagnosis of the FP landscape in Nigeria, and partner experiences working in FP programming across the country. Based on these inputs, seven issues emerged as priorities, including one focusing on M&E.

Figure 10: Seven Priority Issues
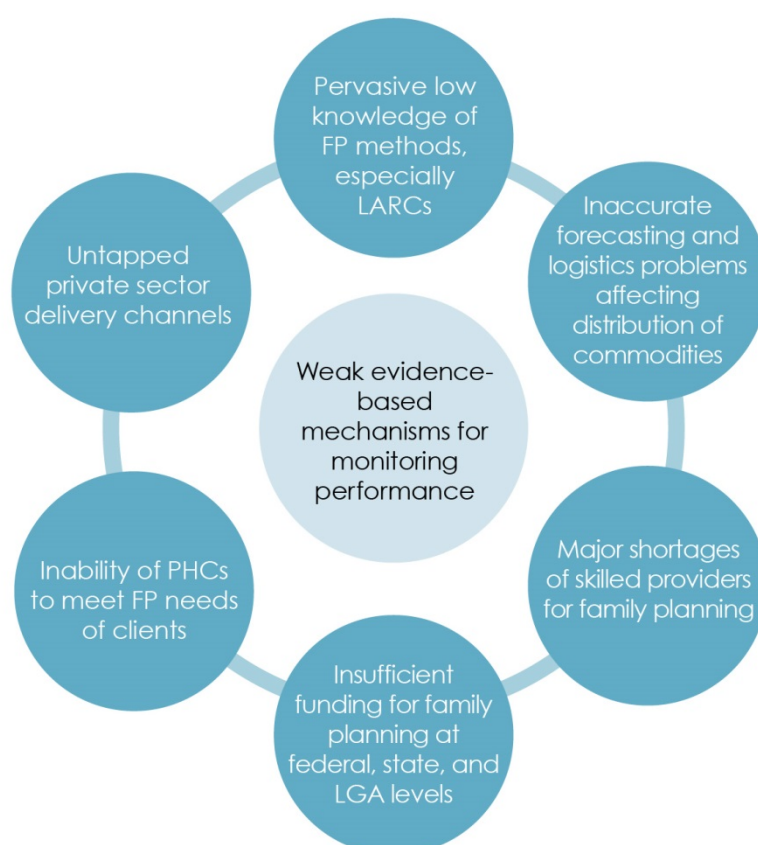
The following strategic priorities are intended to help align activities across the FP landscape going forward:

- **FP demand generation and behaviour change communication**: To strengthen demand for FP services by developing targeted, tailored, and accurate information and delivering it through accessible communication channels to all key segments of the population.

- **FP financing**: To set up standard budget lines in federal, state, and LGA budgets to cover FP services, commodities, consumables, and distribution all the way to the service delivery points.

- **Staff and training**: To build capacity of providers and training institutions and support the health system in delivering high-quality FP services.

- **Private sector delivery channels**: To increase coverage and access to high-quality integrated FP services and commodities through the private sector, including faith-based organisations, private hospitals/clinics, and pharmacies and PPMVs as appropriate for some methods.

- **FP coverage in the PHC system**: To improve access to high-quality integrated FP services by the PHC system, including the provision of counselling and delivery of all methods except sterilisation.

- **Forecasting and distribution logistics**: To strengthen the federal, state, and LGA FP structures to better coordinate and monitor all supply chain activities to deliver commodities and consumables promptly and to efficiently use innovative technologies (e.g., health platforms).

- **Fact-based decision making and performance management**: To improve FP knowledge and performance management (e.g., research, data collection, collation, analysis, feedback, and use) at all levels.

2.4 Structure of the Blueprint

The Blueprint's activities are structured around six basic areas of the health system for family planning:

- Demand generation and behaviour change communication
- Service delivery
- Supplies and commodities
- Policy and environment
- Financing
- Supervision, monitoring, and coordination

Across the six categories, several activities exist—some of which are further subdivided into sub-activities, with descriptions for costing purposes. The full details of these activities can be found in Annex B: Detailed Costing.

2.4.1 Demand generation and behaviour change communication (DBC)

a. Justification

Public awareness of family planning can be enhanced by increasing its public visibility. Knowledge and demand will come from the wide dissemination of accurate information about FP methods and their availability, as well as the encouragement of FP use to promote the health of women and their families. Advocates at the federal, state, and LGA levels can increase interest in family planning within communities, producing a supportive environment, reducing normative barriers, and mobilising community support.

b. Strategy

The key proposed interventions aim to sustain support for family planning from the highest policy levels and promote public dialogue at all levels—from the national through to the community—about the important role of family planning in promoting health and supporting development. They include high-impact, demand generation activities to close the knowledge-use gap by addressing myths and misinformation about family planning and the fear of side effects and health concerns that impede its adoption and use.

Specific demand generation efforts will be targeted at identified high-priority segments (e.g., adolescents/young people, unmarried women). FP education will be incorporated into classroom settings, and teachers will be equipped to adequately support the sexual and RH needs of youth and adolescents. Peer educators shall be trained to help with disseminating information and linking young people to service delivery points if and when they need the services. Provision of adolescent- and youth-friendly services shall be mainstreamed into pre-service and in-service training of healthcare providers at all levels.

c. Activities

DBC1. Develop and roll out targeted, national, multimedia FP advocacy and demand generation campaigns. A national FP communications strategy will be developed. Based on this strategy, a national multimedia campaign—including television, radio, print media, and short message service communications—will be rolled out. Key messages will include information on general FP promotion, choosing an FP method (e.g., short- vs. long-term), the importance of methods safety, dispelling false beliefs and myths about specific FP methods, and promoting male involvement. The strategy and messages will ensure that the campaigns reach the majority of Nigerians, including those from vulnerable populations. Promotional and instructional materials will be produced for wide

distribution at healthcare facilities and within communities. FP messaging will be integrated into ongoing health campaigns.

DBC2. Develop and deploy national, state, and community-level FP champions. A network of national-, state-, and community-level FP champions will be established and supported to promote family planning. These three types of champions will engage in advocacy, ensure an enabling environment, share information, and improve service delivery and uptake.

DBC3. Fully integrate family planning into school health programs. The Family Life and HIV Education (FLHE) curriculum will be updated to support the goal of increasing appropriate FP messaging to adolescents and youth. Support will be provided for this roll-out, including liaising with the ministries of education and the teachers unions and training teachers and updating training materials. Training of peer educators will further complement this activity. Finally, youth development organisations will be briefed on the merits of including FP and Family Life Education in their programming and will be linked with Family Life Education partners that can provide support in including this programming in their activities.

DBC4. Develop partnerships with federal, state, and private media stations to promote family planning as a social responsibility. The FMOH will explore plans to sensitise media owners and executives in Nigeria and sign a memorandum of understanding (MOU) with them to devote more time to the promotion of family planning as part of their organisations' social responsibility. Each media organisation will be encouraged to freely air messages promoting FP service use in Nigeria. The FMOH will also explore collaborative options with the National Orientation Agency (NOA) and other federal government-owned information agencies to use their channels to promote family planning in Nigeria.

2.4.2 Service delivery (SD)
a. Justification
The current staffing and skill levels in the public and private sectors of the Nigerian healthcare system do not provide adequate and equitable FP services to the population. It is necessary to both bolster the current delivery system through improving skills and deploy new FP service approaches to improve availability and accessibility.

b. Strategy
To ensure wide availability of family planning, it is essential to identify the health system's current FP service delivery capabilities and develop modalities for updating the gaps. The core of FP service availability is ensuring that FP health workers at each level have the appropriate training to provide FP services.

FP training of health workers will be increased—both in general and based on immediate scale-up needs for particular methods (i.e., injectables and LARCs). A training plan will be developed based on a situation analysis of health worker skills. The training plan will undergo annual reviews to meet the country's human resource needs. Standardised curricula will be developed and implemented for both pre-service and in-service trainings. All partners involved in training will work in coordination with the FMOH to reach training goals. Mentorship and supervision following formal training will be a key activity of the FMOH going forward. Pre-service education will be strengthened under the direction of the FMOH and Ministry of Education, such that providers entering the healthcare workforce are competent to provide all FP methods.[14]

Integrating family planning into other health services should also be explored as a key strategy to enhance its availability at higher-level facilities with sufficient staff; for example, there is a need to

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[14] This intervention assumes that there will be an adequate client load at FP sites to train all relevant cadres of students in PSE schools. In reality, unaffordable user fees in many teaching hospitals discourage clients from coming. The enforcement of user fee removal will lead to an increase in client load.

build capacity for postpartum IUD services in labour wards. Referral for FP services will be stressed in the training and supervision of all healthcare workers who do not themselves provide these services.

Several other innovative approaches to enhancing FP availability will be piloted, including training staff at pharmacies and PPMVs throughout the country to provide high-quality counselling and services for those methods they are legally permitted to provide.

In addition to these activities, innovative solutions to reach rural and under-served populations will be employed. Although mobile clinics and community-based outreach programmes may in some cases prove difficult to establish, and usually are more expensive than stand-alone clinic-based services, these initiatives will help to ensure more equitable access to FP services.[15]

c. Activities

SD1. Improve pre-service training for family planning by updating current curricula. Pre-service curricula for nurses, midwives, doctors, and CHEWs will be reviewed to ensure that they include adequate coverage of family planning, including LARCs, and appropriate levels of practical training.

SD2. Train the trainers for pre-service training to the States. A pool of FP trainers for nurses, midwives, and CHEWs will be trained on all methods in each State to serve as state-based trainers for both the state and LGA FP trainings.

SD3. Procure FP equipment and anatomic models for training. Determine the package of equipment, models, commodities, and consumables required for successfully training FP workers. These will be procured (e.g., IUD insertion kits, plastic uteruses for IUDs, or plastic arms for implants) based on locational needs.

SD4. Develop and disseminate an in-service training plan and single standardised curriculum for each type of service provider. Prepare a plan for in-service FP training of Nigerian health workers. The various in-service training curricula and materials used in Nigeria will be reviewed and standardised.

SD5. Train CHEWs in comprehensive family planning, with an emphasis on injectables. Train CHEWs and put in place mechanisms for regular supportive supervision for quality assurance; training will be extended to the unemployed as well as those in the private sector.

SD6. Train nurses and midwives in comprehensive family planning, with an emphasis on LARC methods. Suitable nurses and midwives will be selected for training on comprehensive FP methods, with an emphasis on LARC methods for expanding access. An on-the-job training approach will be instituted to reduce the period of absence and ensure high-quality training based on the provider's capability needs and the community's/facility's service needs.

SD7–SD9. Expand access to FP services through new access points, including outreach, mobile clinics, and public-private partnerships. Access will increase with the establishment of periodic outreach to health centres from hospitals. There will also be piloting of periodic FP-only clinics at locations such as large urban markets, as well as innovative ways to serve rural

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[15] A 2006 study found that community-based distribution programmes cost US$4.85 to US$35.37 per CYP, with a weighted average of US$12.55. Clinic-based services, excluding sterilisation, ranged from US$4.44 to US$16.65 per CYP, with a weighted average of US$7.93. A mix of access through clinics and community-based distribution is the most expensive mode of FP service delivery, ranging from US$4.44 to US$19.38, with a weighted average of US$18.21. (These study estimates do not include costs to users.) Levine, R., A. Langer, N. Birdsall, G. Matheny, M. Wright, and A. Bayer. 2006. In Chapter 57, *Contraception. Disease Control Priorities in Developing Countries*. 2nd edition. Edited by D. T. Jamison, J. G. Breman, A. R. Measham, G. Alleyne, M. Claeson, D. B. Evans, P. Jha, A. Mills, P. Musgrove. Washington, DC: World Bank.

communities. The FMOH and its partners will explore opportunities to expand FP access within work settings.

SD10. Scale up distribution of family planning through pharmacies. Establish an FP-focused training programme for pharmacists and pharmacy employees. Pharmacies are legally permitted to sell pills, condoms, and injectables. Training will focus on basic FP information, counselling skills, and referrals for service; their practice limitations will be emphasised throughout the training to curb possible abuse.

SD11. Scale up community-based distribution of short-acting methods through PPMVs and informal drug sellers. Establish FP-focused training programmes for PPMVs/informal drug sellers; their practice limitations will be emphasised throughout the training to curb possible abuse. Because women source pills and condoms from these channels, improving the knowledge of their proprietors and staff would improve women's access and choice.

SD12. Provide and maintain necessary FP equipment. An initial needs assessment will be conducted and regularly updated. Any needed equipment will be procured for each facility and FP programme (e.g., PHCs, mobile clinics, etc.).

SD13. Integrate FP services with other health services. Protocols for counselling and referral for FP services by providers of other health services will be developed and institutionalised (e.g., routine immunization, postnatal care, STI clinics, etc.).

SD14. Retain skilled providers at SDPs for reasonable periods to allow for optimal service provision. Advocate to LGA health managers to be mindful of the FP human resource need at SDPs by retaining trained providers for a period sufficient to allow for transferring skills and building FP service provision capacity. Given high attrition rates, this will ensure that training stays within the system.

SD15. Explore opportunities for public-private partnerships. Review current public-private partnerships across the entire FP landscape (e.g., service delivery, supply chain, demand generation, etc.). Initiate conversations with the private sector for support when possible.

SD16. Make PHCs youth-friendly. FP providers will be given adequate orientation to enable them to provide youth-friendly FP services. Part of making FP youth-friendly requires providing places where youths can have adequate privacy to receive FP services. When possible, private, youth-friendly service points will be established in existing PHCs. These rooms will be closed off so that the identity of the person inside cannot be viewed from the rest of the facility. The rooms will be furnished with FP materials and necessary supplies. Peer educators trained to dispense pills and condoms will staff the service points.

2.4.3 Supplies and commodities (SC)

a. Justification

This category addresses the sustainable supply of contraceptive commodities and related consumables. It is aimed at ensuring that they are adequate and available to meet the needs and choices of FP clients. The activities of this strategic priority will be implemented in line with the Reproductive Health Commodity Security (RHCS) Strategic Plan.

Providing a choice of FP methods to meet the changing needs of clients throughout their reproductive lives increases overall levels of contraceptive use and enables individuals and couples to meet their reproductive goals. The method mix available influences not only successful client use and satisfaction, but also has implications for provider skills, confidence, and competence. In addition, specific activities will ensure that the contraceptives available in the country are of high quality. Currently, significant distribution challenges are a limiting factor in ensuring the availability of high-quality FP services at SDPs. Specific activities will be undertaken to ensure that contraceptives are

delivered over the "last mile" to health facilities to ensure RHCS throughout the country, including rural areas.

b. Strategy

As the central-level supply no longer poses a significant challenge for FP commodities, the focus will be on resolving distribution challenges from state stores to the LGA stores and SDPs. A key focus will be on improving the distribution of commodities, ensuring that the last mile of the supply chain is strengthened.

c. Activities

SC1–SC2. Forecast and procure FP commodities and consumables. Based on the expected method mix, the forecasting and procurement of FP commodities will continue to be carried out centrally, and state and LGA capacities for forecasting and procuring accompanying consumables will be strengthened. The method mix will be reviewed consistently in line with consumer preferences.

SC3. Coordinate FP commodity procurement and distribution. The FMOH will organise procurement and supply management (PSM) coordination meetings with donors and implementing partners across the system to ensure that correct quantities are procured and distributed.

SC4. Build FP commodity logistics and management capacity at all levels. To ensure the improvement of distribution from State to LGA to SDP, logistics and management training at the national, state, LGA, and facility levels will be expanded.

SC5. Identify area-specific needs for commodity distribution. The FMOH will work with States and LGAs to identify and provide for area-specific needs (including equipment and logistics) for commodity distribution.

SC6. Procure and distribute equipment identified as needed for commodity distribution.

SC7. Ensure that storage facilities are sufficient in quantity and quality. Review existing commodity storage facilities nationally. Develop a plan for increasing capacity if required. Review the state of current storage facilities and develop standards for commodity/consumable warehousing. Procure additional equipment required and upgrade as necessary.

2.4.4 Policy and environment (PE)

a. Justification

Although the Nigerian government is increasing efforts to establish supportive policies around family planning, additional support will be paramount in achieving national FP goals. There is still insufficient allocation of human and financial resources to achieve these goals. Therefore, the priority area of policy and environment focuses on advocacy for family planning within various levels of government and the private sector, including faith-based organisations and civil society and private providers to ensure that the best policies are both present and fully implemented.

b. Strategy

To improve the enabling environment for family planning, government policies and strategies will be reviewed to ensure that family planning is integrated appropriately. Specific advocacy will also be conducted to ensure that policies and guidelines for family planning promote rather than hinder access to it, especially by under-served populations, faith-based groups, and youths. The FMOH and partners will create and support advocates at all levels who can play key roles—both publicly and behind the scenes—in ensuring that family planning remains in the limelight for both policy making and domestic funding.

c. Activities

PE1. Include family planning in relevant policies at all levels. The FMOH and other stakeholders will review existing policies to ensure they adequately address relevant FP issues; they will advocate for any necessary changes and incorporate them into relevant policies.

PE2. Build advocacy momentum through international events. Ensure that high-level Nigerian FP supporters continue to participate in national and international FP-related events (e.g., national family planning conferences, women deliver conferences, international conferences on family planning, etc.).

PE3. Create a central consortium for all advocates for family planning. Networks of FP champions and promoters at all levels will be identified and brought under a national consortium to be coordinated by the FMOH. This consortium will be broadened to include influential institutions such as NOA, the National Institute of Policy and Strategic Studies (NIPSS), the Nigeria Defence Academy (NDA), faith-based institutions, and the Administrative Staff College of Nigeria (ASCON). This arrangement will be reflected at the state and LGA levels for maximum outcome and impact. In addition, FP advocates will work within the government to emphasise the importance of family planning, especially as it relates to policies and budgeting, including in meetings within the FMOH and external stakeholders, such as donors and implementing partners.

2.4.5 Financing

a. Justification

While the overall policy environment for family planning is increasingly positive, the government's strong policy and strategic commitment has not been accompanied by a commensurate dedication of national-, state-, or LGA-level financial resources.

b. Strategy

To address the limited financial commitment to family planning within the various government budgets commensurate to need, the FMOH and partners will advocate for increased funding within national budgets, in addition to funding secured from development partners and the private sector. The FMOH will also cultivate advocates within other ministries to ensure that the national budget includes a line item for family planning that increases over time to meet the growing demand for FP services.

c. Activities

F1. Develop an FP advocacy package highlighting annual projected costs, potential cost savings, impact analysis, and the other benefits of family planning as shown in the RAPID[16] presentation, and adapt it accordingly for the various target groups.

F2. Orient the various advocacy groups, networks, and champions on the use of the packages developed.

F3. Advocate for increased funding for family planning at all levels of the government. Support civil society organisations and the consortium to undertake advocacy visits to governments at all levels to solicit for the establishment of a budget line for family planning where none exists and for regular release of funds for FP activities.

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[16] RAPID (Resources for the Awareness of Population Impacts on Development) is a model that illustrates the impact of demographic change on social and economic development. It can be used to apply projected population growth under different scenarios to project future resource requirements in the health, economy, education, agriculture, and urbanization sectors.

F4. Advocate for increased funding for family planning from donors and the private sector.
The FMOH will organise advocacy to donors to seek more FP funding and to the organised private sector to support FP activities as part of the sector's corporate social responsibility programs.

2.4.6 Supervision, monitoring, and coordination (SMC)

a. Justification
Effective management and governance of FP activities at all levels is needed to ensure that the country reaches its FP goals. Better systems are needed to improve coordination among partners and the FMOH and ensure that activities are implemented as a harmonised national effort. Current bottlenecks in supervision, monitoring, and coordination include inadequate dedicated staffing and financial resources at the federal, state, and LGA levels, as well as limited data management.

b. Strategy
The National Reproductive Health Technical Working Group (NRHTWG) is a crucial body in coordinating partners and managing work at the central level. Efforts will be undertaken to make the NRHTWG more effective and efficient by ensuring a standardised schedule of meetings and list of meeting attendees.

Existing data collection, supervision, and monitoring tools will be revised, and new tools will be developed to consistently and closely track a revised list of FP indicators. An executive dashboard will be developed to easily track progress across the key FP indicators jointly managed by the Department of Planning, Research & Statistics (DEPRS) and Department of Family Health (DFH) at the federal level and to monitor progress towards the national goal. The dashboard will be tracked as part of regular NRHTWG meetings.

The National Health Management Information System (NHMIS). The NHMIS consists of tally sheets (registers) with associated summary forms, MIS matrix forms, and sentinel surveillance form registers for occupational/environmental and communicable diseases as routine sources of data from facilities. These are complemented by community-based activity forms and non-routine sources of data, such as specialised surveys, baseline surveys, and health surveys such as the National AIDS & Reproductive Health Survey and the NDHS. NHMIS is used by all public sector facilities, whereas its adoption among private sector facilities is emerging. The NHMIS collects information on all diseases and services, including FP services. To track achievement of the Blueprint, the use of routine data from the NHMIS is key to the M&E strategy.

In recent times, the NHMIS has adopted the use of District Health Information Software (DHIS) for reporting HIV-related service data. All facility-based information systems feed into the DHIS. It is a database adaptive to different levels such as the LGA, state, and national. The DHIS empowers health workers at facilities and all levels to use information to improve health services. Data elements used in DHIS could be routine data (submitted routinely, whether annually, monthly, or quarterly); survey or audit data (collected infrequently, but reflecting the situation at the time of data collection); and semi-permanent data that do not change frequently (typically census data). Data elements are grouped as data sets, and a data set is equivalent to a reporting form. In 2013, the implementation of DHIS as a web-based programme was launched. Implementation of the Blueprint shall be integrated into it.

Mentorship and supervision are key strategies for improving the quality of implementation. Supervisory tools will be revised to include key FP quality standards, such as youth-friendly service provision. Supervisors will receive training in conducting supportive supervision. Mentoring and supervisory tools for family planning will be developed as part of the training curriculum for use in post-training mentorship sessions.

Figure 11: Summary of M&E Indicators, by Blueprint Category

Impact											
Demand		Service Delivery			Supplies and Commodities		Policy and Environment	Financing		Supervision, Monitoring, and Coordination	
Awareness of FP methods	Targeted FP advocacy	CYP	Modern FP WRA users	Providers trained in FP, by type	Difference between forecasted and actual consumption	Trained persons in forecasting and LMIS	Review and update of FP policies	National and state budget line for FP	Annual expenditure on FP	Capacity to supervise, coordinate, and monitor blueprint	

c. Activities

SMC1. Enhance supervision and quality assurance for family planning at every level of the health system. There will be additional relevant training for existing staff as part of strengthening the FP units at all levels, along with the provision of necessary equipment for ongoing operations. The coordination of FP activities will be improved nationally by identifying existing institutions coordinating FP activities at the state level, strengthening them by supporting regular meetings of FP/RH focal persons with LGA FP focal persons, and institutionalising biannual national meetings with all state-level FP coordinators under the aegis of the RH unit of FMOH. The meetings will provide materials or discussions on data quality assurance and supervision. The head of RH will have the responsibility of documenting and reporting all FP activities nationwide to all relevant bodies, especially the NRHTWG.

SMC2. Create a core of master trainers at the state level for supervisory training at both the state and LGA levels. Identify suitable FP providers to be trained as master trainers as well as supervisors at LGA levels, and train them using the tools developed.

SMC3. Develop supervision tools, including data collection tools and a dashboard. Data collection and supervisory tools will be revised to ensure adequacy and relevance to the successful implementation of the Blueprint. These data will then be summarised in a dashboard for monitoring.

SMC4. Support supervisory and technical backstopping visits to States and LGAs regarding FP activities. Trained supervisors will be supported in undertaking technical backstopping visits from States and LGAs to SDPs on a regular basis and make reports to the relevant authorities.

SMC5. Conduct surveys/investigations and strategic research to collect relevant complementary data. The NDHS is conducted too infrequently to provide the data required to monitor progress and shift priorities. Survey instruments will be designed to collect FP data as necessary.

SMC6. Review progress of the Blueprint regularly. The FMOH will monitor and adjust the Blueprint as needed. A midway review should be used to course correct any issues that develop. Best practices will be documented and successes will be scaled up. The final Blueprint review will help codify learning and build a sustainable FP system to maintain progress.

SECTION 3: COSTING

3.1 Assumptions

The method mix used to estimate the costs of contraceptives are based on the same inputs as those calculated by Marie Stopes International (MSI)'s Impact 2 Model in Section 4: Projected Method Mix.

These contraceptive costs have been calculated from 2013 to 2018, based on the current (2013) estimated mix and 2018 CPR objective for married women of reproductive age and extrapolated for each intermediate year. The method mix is based on the current mix in Nigeria but adjusted for the national scale-up focus on LARCs. The method mix in this document will not be used for forecasting or procurement purposes. It is designed to provide a framework for realistic costing of commodities and consumables.

Costing elements are described and costed based on knowledge of similar FP programmes in other countries and input from the FMOH and partners as to the specifics in Nigeria (e.g., per diems, media costs, etc.).

Costing inputs came from a variety of sources and include standards from the FMOH, partner budgets, and true quoted costs (e.g., from the radio stations). Where specific costs were not available, estimates from other countries have been adjusted for Nigeria. Commodity costs for both contraceptives and consumables come from AccessRH.

Unless otherwise noted, all costs (such as salaries, per diem rates, fuel costs, venue hire, etc.) are based on current costs as of December 2013. We have made assumptions for inflation based on available economic predictions. We calculated all costs in U.S. dollars; the cost breakdown at the state level is based on a set of six factors: number of facilities, number of health workers, number of women of reproductive age (WRA), population, number of LGAs, and equal distribution of costs.

This costing sets out to provide a high-level estimate of resources required to reach the national goal of 36 percent CPR by 2018. It is not meant to be an exact list of activities and timing. It is expected that many costs will be revised once the planning for specific areas is completed, as innovations and other requirements may cause the Blueprint to change.

3.2 Cost Summary

The costs of this Blueprint have been specifically calculated using a tool developed for this purpose, with methodology borrowed from other FP plan costings regionally. The tool allows for a calculation of the overall costs of the Blueprint, as well as a split of the costs by activity area, state (indicative), and year. It includes both initial (investment) costs and ongoing or sustainability costs for the duration of the Blueprint. However, this should be considered as only a broad costing of the Blueprint, not a budgeting tool to be used on an activity-by-activity basis to allocate funds.

The total cost of the Blueprint from 2013–2018 is US$603 million.

Overall, US$183 million, or 30.3 percent of the overall costs, are for commodities, including contraceptives and consumables. Another 21.7 percent is for service delivery and access; 22.1 percent for supervision, including research and M&E; and 22.1 percent for demand creation. Procurement and supply chain management account for the remaining costs at 3.8 percent of the total.

Costs are spread over the duration of the Blueprint, with commodity costs increasing over time as more women are reached. There are heavier upfront investments in 2014, and not all interventions are designed to incur costs in every year.

The costs of the Blueprint are comparable to other similar FP plans. The annual cost per WRA for activity costs (cost of the Blueprint without commodities, US$420 million) is US$1.8; this is slightly lower than costs in other countries in the region of approximately US$2–5. The annual cost per user for FP commodities (total of US$183 million) is US$4.10, in line with the costs of US$4.00–4.20 seen in other countries.

Figure 12: Costs by Category and Strategic Priority

The Blueprint will cost a total of $603 million, with the highest costs in commodities

Spend by category, $ million, 2014–2018
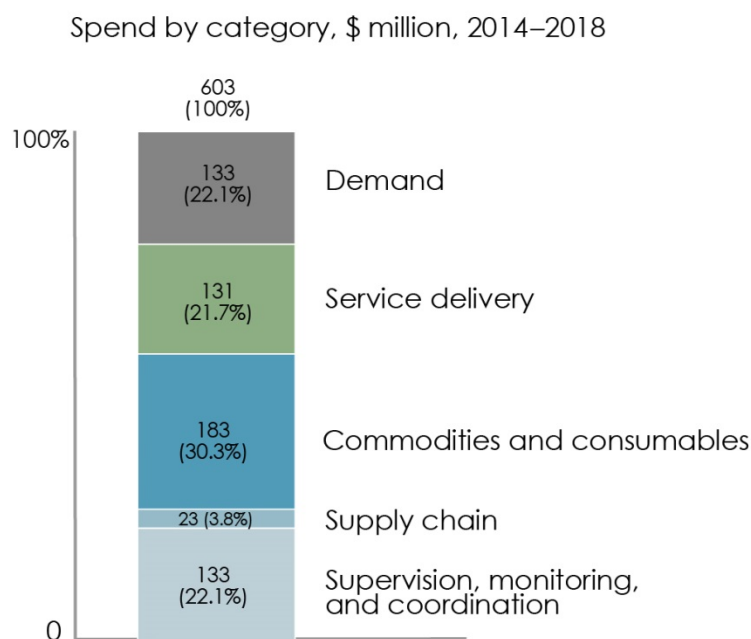
Figure 13: Cost per Year, by Category, in US$ Millions

	2014	2015	2016	2017	2018	
	5.6	7.1	8.6	10.3	12.0	Total users of modern methods[1], millions
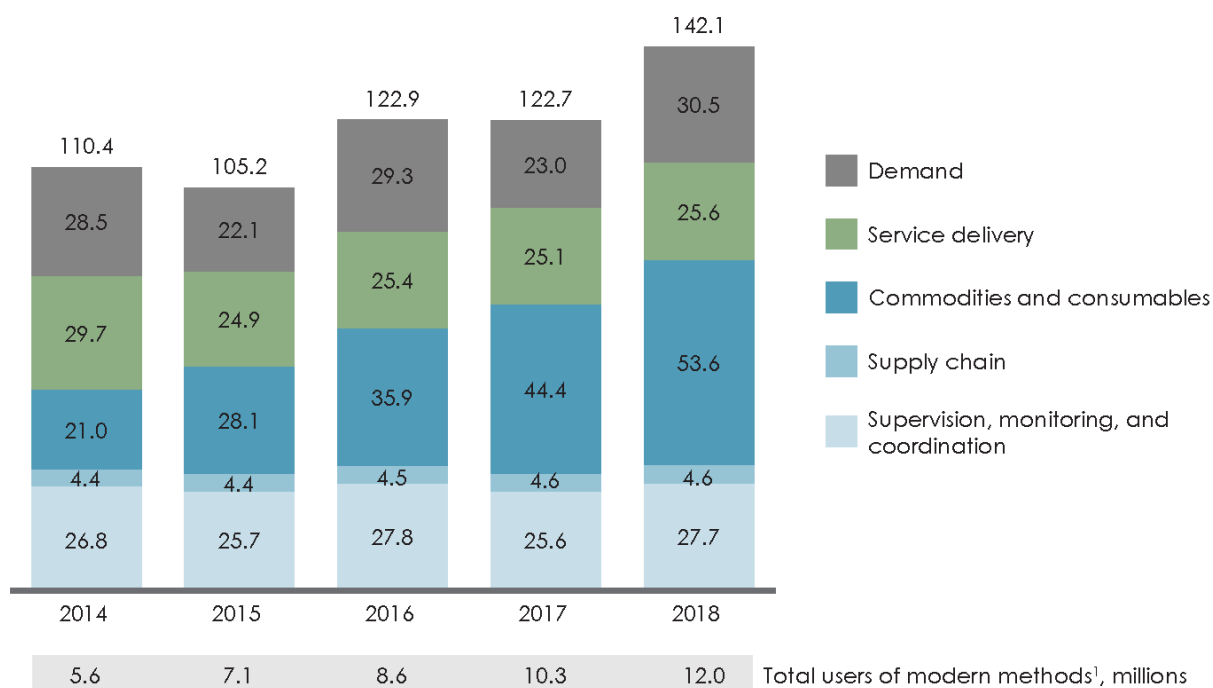
[1] Includes married and unmarried WRA, even though CPR target includes only married WRA

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Figure 14: Cost per Year, by Programme Activities and FP Commodities

Costs increase over time as more women are reached, with heavier up-front investments in training

Activities

| 89 | 77 | 87 | 78 | 88 | 420 |

FP Commodities

| 21 | 28 | 36 | 44 | 54 | 183 |

| 2014 | 2015 | 2016 | 2017 | 2018 | Total |
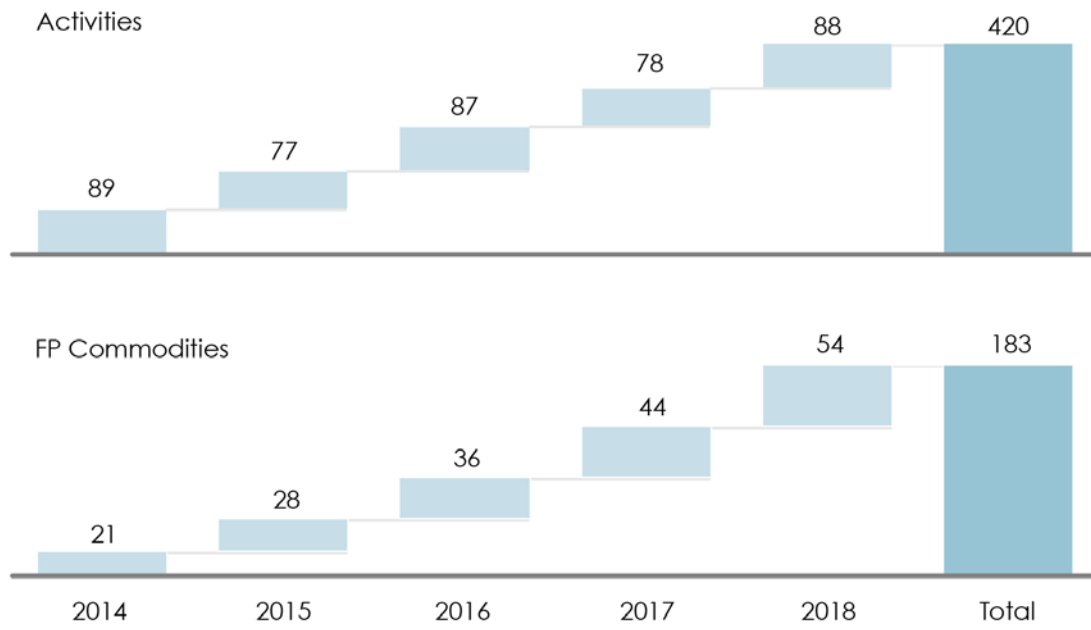
SECTION 4: PROJECTED METHOD MIX

Blueprint activities are designed to enable 6.5 million new users to access contraceptives between 2014 and 2018. This equates to an increase in the CPR from 15.2 percent to 36 percent and increase in the mCPR from 9.8 percent to 28.4 percent by 2018. The principle of the Blueprint is to provide a broad choice of FP methods to users to meet their preferences and needs.

For purposes of costing and planning, a method mix projection was developed. Thus, these figures are meant to be directional, not stand-alone targets. The current method mix was derived from the 2013 NDHS.

The 2018 method mix was estimated based on three core assumptions:

- Use of LARCs (i.e., IUDs and implants) will grow faster than in previous years due to increases in trained healthcare providers and improved facilities based on the National LARC Strategy.

- Use of injectables will also grow faster than in previous years due to a policy change allowing CHEWs to administer injections, as well as experience from other countries indicating that injectables are typically a preferred method as CPR increases.

- Traditional methods will continue to grow at the same rate, but their share of the total CPR will decrease due to higher rates of growth for modern methods.

Figure 15: Current and Projected Method Mix[17]

	2013 method mix, %	2018 projected method mix, %	Married WRA using contraceptives in 2018, 000s	Additional users, 000s
Traditional methods	36	21	2,717	396
Modern methods	67	79	10,299	6,130
Pill	12	12	1,562	788
Male condom	14	16	2,082	1,180
LAM	5	3	439	95
Injectables	21	33	4,230	2,854
IUDs	7	10	1,301	829
Implants	3	4	521	349
Female sterilisation	2	1	165	36
Total	100	100	13,016	6,526

The growth of each method is calculated as a linear progression, and the trajectory for each method can be seen in Figure 16.

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[17] NDHS 2013 Current Method Mix; 2014–2018 Projected Method Mix: Calculated from data derived from consultations with FMOH, UNFPA, CHAI, NURHI, and other key stakeholders.

Figure 16: Method Mix Changes Over Time [18,19]

CPR by method, %

Traditional		Injectables
Pill		IUD
Male condom		Implants
LAM (and other)		Female sterilisation

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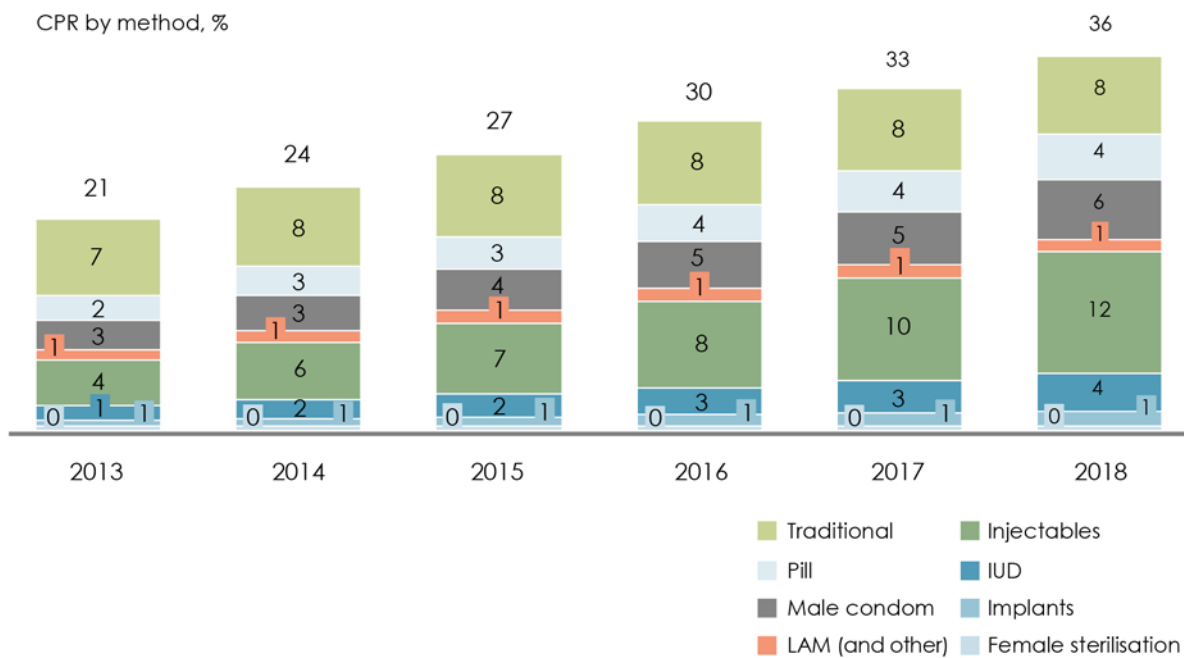
[18] NDHS 2013 Current Method Mix; 2014–2018 Projected Method Mix: Calculated from data derived from consultations with FMOH, UNFPA, CHAI, NURHI, and other key stakeholders.

[19] Using the national CPR as derived from state-by-state CPRs in the NDHS 2013, weighted by population; NDHS national CPR is not population weighted by State.

SECTION 5: THE PATH FORWARD

5.1 State-level Planning

The FMOH developed the Blueprint to provide a framework for reaching Nigeria's overall CPR target of 36 percent. Reaching this goal will also require significant state-level leadership and coordination in the planning and implementation process. This document is designed to serve as a foundation and set of principles for designing state-level implementation plans across the country.

This undertaking will be challenging and require partner participation and support. The 36 States and the FCT are at different stages of FP uptake and require tailored intervention packages to increase FP acceptance and use. For example, States with a relatively high CPR and high unmet need will require a different strategy than those with a lower CPR and lower unmet need. Beyond FP statistics, other factors differentiate States and how family planning must be positioned for successful uptake. For example, States have varying levels of mass media exposure, which will inform demand generation approaches. Further, the care-seeking behaviour and available health channels, such as PHCs, differ across regions, States, and LGAs. Thus, it is likely that northern States will require different strategies from southern States.

Ultimately, States will need to follow a similar process to that of the FMOH in creating the national Blueprint. Each State will engage the appropriate stakeholders, diagnose its specific priorities, set a state-wide goal for CPR, define the most appropriate interventions, and create a detailed and costed plan. This process will require substantial leadership at the state level from the FMOH as well as other government agencies and, crucially, the support of the governor/other key stakeholders and champions.

Engage stakeholders: It will be vital to engage, align, and coordinate a strategically selected set of stakeholders around the costed plan process. Beyond SMOHs, stakeholders from the States' primary healthcare agencies, Ministry of Local Government and Chieftaincy Affairs, LGA departments of health, religious leaders, and the private sector are intended to participate. Technical assistance from partners can help catalyse action, sustain momentum, and help build capabilities. The process should be led by the State and jointly owned with partners.

Identify priorities: Based on the national Blueprint, States will reflect on the specific priorities for scaling up family planning in their particular contexts. Consideration should be given to elements of the health system that require attention, including service delivery, the supply chain, demand generation, policy, and financing. Technical assistance from the FMOH/partners would be provided for the data gathering and analysis to support the priority areas.

Set a CPR objective: Reaching the national target of 36 percent will require gains across all States. However, given the diversity of FP landscapes, there will be no one growth expectation for all States. Rather, some States are expected to grow faster than others (i.e., States that already have made recent FP progress versus those just starting out on this journey). The FMOH can propose an initial state CPR objective, but each State will ultimately be responsible for setting its own targets.

Create a costed plan: Each State will develop a clear implementation plan based on its identified priorities and the state-level CPR objective. State-level plans will lay out the critical activities and associated costs of fulfilling them. This process will be completed in conjunction with key stakeholders in the State and the FMOH.

State plans should build on existing FP planning and programming and identify other health initiatives for coordination or integration; for example, some States have already developed costed plans (e.g., Gombe). These plans should serve as an advanced starting point and be harmonised with the national Blueprint when necessary. When possible, States should coordinate with other programs, such as

reproductive, maternal, newborn, and child health, to ensure the effective use of resources and leveraging of opportunities to take advantage of successful interventions.

Achieving the 36 percent CPR objective in Nigeria is a large-scale endeavor. The FMOH will implement a phased implementation process.

5.2 Resource Mobilisation

The planning phase is just the starting point for the national Blueprint. The target date of 2018 for achieving 36 percent CPR is fast approaching. Effective implementation of priority activities is crucial to making a real difference in the access to and uptake of FP methods across Nigeria and achieving the country's maternal and child health goals.

The national Blueprint estimates that more than US$600 million is required to support Nigeria's FP goals through 2018. Although current and exact figures are not available for donor activity for all FP activities in the country, it is clear that significant additional funds will need to be mobilised.

This funding gap will need to be addressed in two ways. First, when possible, already committed FP funds should be allocated to the priority activities identified in the Blueprint whenever possible. This will help ensure that current donor funding and partner activities are aligned to the greatest areas of need. Second, additional sources of funding will be required from federal, state, and local governments, as well as donors.

The national- and state-level plans will be used as key advocacy tools to demonstrate both the needs for and potential impacts of new funding. The plans outline clear activities, spending requirements, and performance management/tracking indicators as the basis for advocacy messaging and funding requests. In addition to seeking additional commitments, the FMOH and SMOHs will ensure that funding is released in accordance with all commitments.

5.3 Ensuring Progress through Performance Management

The primary purpose of developing the plans is to spur and accelerate impact and progress towards the 36 percent CPR target. This can only occur if the plans are quickly and effectively translated into real programming and activity on the ground.

The national and state Blueprints must be living tools to set direction and measure progress towards concrete milestones, outcomes, and impacts. To ensure that proper information is collected, a performance management framework will be developed, consistent with ongoing M&E initiatives.

This framework will allow States to track their performance against their own goals, as well as provide a national-level dashboard for the FMOH that aggregates gains across the country into a clear and up-to-date picture of FP progress and gaps. This information will allow policymakers, advocacy experts, donors, and ministry officials to reflect on what is working and what is not and to correct the latter as appropriate while also documenting best practices. Further, progress can be communicated to the global level to facilitate learning and build advocacy and support.

The current data collection system for FP-related metrics is predominantly the NDHS. Given the multiyear gap between surveys, it will be important to develop a quicker and more nimble data-gathering structure. This should leverage current and planned programs, including Track2020, DHIS, SMART surveys, and Saving One Million Lives.

Regardless of the vehicles for data collection, FP metrics must be collected in a systematic fashion across all States that have enacted Blueprints. The initial metrics to track would include the following:

- Current contraceptive use (the CPR), by method
- Future intention to use, by method

- Unmet need
- Age at first childbirth
- Total number of children

Over time, additional metrics would be added based on programmatic choices in each State.

The FMOH and SMOHs would lead the process for performance management, with technical assistance from partners. As mentioned above, an important initial step will be to identify and coordinate with ongoing performance management initiatives. The ministries would also track progress against the plans on an ongoing basis and periodically convene partners to update plans and costing. Incorporating a fact base into ongoing planning, decision making, and resource allocation will be a major output of the Blueprint.

ANNEX A: MONITORING AND EVALUATION SUMMARY TABLE

No	Indicator No	Indicators	Indicator Type	Data Source	Level of Reporting	Frequency
1.	FP1	Modern contraceptive prevalence (all women) [CPR]	Impact	NDHS/NARHS	National/State	Annually
2.	FP2	Contraceptive continuation rates	Impact	Special study	National/State	Annually
Demand Generation and Behaviour Change Communication						
3.	D1	Percentage of women of reproductive age who have heard about at least three methods of family planning	Outcome	NDHS/NARHS	National/State	Annually
4.	D2	Percentage of the population who know of at least one source of modern contraceptive services and/or supplies	Outcome	NDHS/NARHS	National/State	Annually
5.	D3	Percentage of population with a favourable attitude towards an FP product, practice, or service	Outcome	NDHS/NARHS	National/State	Annually
6.	D4	Percentage of audience who believes that spouse, friends, relatives, and community approve (or disapprove) of the practice	Outcome	NDHS/NARHS	National/State	Annually
7.	D5	Number of targeted national multimedia FP advocacy and demand generation campaigns	Output	Programme report	States/Region	Quarterly
8.	D6	Number of national, state, and community-level FP champions, identified by type of level (i.e., national, state, and community)	Output	Programme report	State	Quarterly
9.	D7	Number of key national/state leaders who have spoken in favour of family planning	Output	Programme report	National, regional, or state level	Annually
10.	D8	Number of dissemination sessions of the revised and updated Adolescent Family Life Education curriculum, by State	Output	Programme report	National, regional, or state level	Annually
11.	D9	Number of teachers trained in the revised curriculum, by State	Output	Programme report	State	Quarterly
12.	D10	Number of peer educators trained in the curriculum, by State	Output	Programme report	State	Quarterly
13.	D11	Percentage of women who make FP decisions alone or jointly with husband/partner/provider	Output	Programme report	State	Quarterly
14.	D12	Percentage informed of permanence of sterilisation	Output	Programme report	State	Quarterly

No	Indicator No	Indicators	Indicator Type	Data Source	Level of Reporting	Frequency
Service Delivery						
15.	SD1	Couple years of protection (CYP)	Outcome	NHMIS	National/State	Quarterly
16.	SD2	Percentage/total number of modern method users (all women)	Output	NHMIS	State	Quarterly
17.	SD3	Percentage of women whose demand for contraception is satisfied	Outcome	NARHS/NDHS	National	Annually
18.	SD4	Percentage of women with an unmet need for contraception	Outcome	NHMIS	State	Annually
19.	SD5	Number of unintended pregnancies averted due to contraceptive use	Outcome	NHMIS	State	Annually
20.	SD6	Number of unsafe abortions averted due to contraceptive use	Outcome	NHMIS	State	Annually
21.	SD7	Number of maternal deaths averted due to contraceptive use	Outcome	NHMIS	State	Annually
22.	SD8	Percentage of women who were provided with information on family planning during last visit with health service provider	Outcome	Facility assessment	State	Annually
23.	SD9	Development of in-service training plan and single standardised curriculum, by type of service provider	Output	Programme report	State	Annually
24.	SD10	Number of dissemination sessions of revised and updated pre-service training curriculum for family planning, by national, regional, or state levels	Output	Programme report	State	Quarterly
25.	SD11	Number of FP trainers trained in updated pre-service training curriculum, by State	Output	Programme report	State	Quarterly
26.	SD12	Number of trainers trained in in-service FP practices	Output	Programme report	State	Quarterly
27.	SD13	Number of training sessions conducted by trainers, disaggregated by regions and State	Output	Programme report	State	Quarterly
28.	SD14	Proportion of recruited CHEWs trained for comprehensive FP (emphasis on injectables) training, disaggregated by level (national, regional, or state)	Outcome	Programme report	State	Quarterly
29.	SD15	Proportion/number of nurses and midwives trained in comprehensive family planning (emphasis on LARC methods)	Outcome	Programme report	State	Quarterly
30.	SD16	Number of training sessions conducted for pharmacists and pharmacy employees at the national, regional, and state levels	Output	Programme report	State	Quarterly

No	Indicator No	Indicators	Indicator Type	Data Source	Level of Reporting	Frequency
31.	SD17	Number of pharmacies where at least one person has been trained in FP methods and counselling, by level (state and community)	Output	Programme report	State	Quarterly
32.	SD18	Number of training sessions conducted for PPMVs and informal drug sellers, by level (national, regional, and state)	Output	Programme report	State	Quarterly
33.	SD19	Quantity of FP training equipment, materials, and anatomical models procured and disbursed to trainers, by State	Output	Programme report	State	Annually
34.	SD20	Number of new access points for FP service provision (hospital, clinic outreach, mobile FP clinics, and community venues where FP outreaches are conducted), by State	Outcome	Programme report	State	Quarterly
35.	SD21	Number of facilities at which FP equipment assessments were conducted, by State	Output	Facility assessment	State	Quarterly
36.	SD22	Number of facilities in which family planning is integrated with other healthcare services (i.e., sites where family planning is integrated with routine immunization, HIV counselling and testing, prevention of mother-to-child transmission (PMTCT), and STI services)	Output	Facility assessment	State	Quarterly
37.	SD23	Development of national CHEW database	Output	Programme report	State	Annually
38.	SD24	Number of public-private partnerships for increasing FP service delivery, supply chain, demand generation, etc., by State per year	Output	Programme report	State	Annually
39.	SD25	Proportion of identified PHCs renovated for service delivery, by State	Output	Programme report	State	Annually
Supplies and Commodities						
40.	SC1	Percentage difference between forecasted consumption and actual consumption	Outcome	Programme report	Federal/State	Annually
41.	SC2	Existence of a government budget line item for the procurement of contraceptives	Output	Programme report	State	Annually
42.	SC3	Contraceptive or other RH commodity forecasts updated at least annually	Output	Programme report	State	Annually

No	Indicator No	Indicators	Indicator Type	Data Source	Level of Reporting	Frequency
43.	SC4	Costing of forecasted (quantified) contraceptive or other RH commodity needs conducted and incorporated into budget planning by FMOH and/or donors	Output	Programme report	State	Annually
44.	SC5	Number of persons trained to manage and produce commodity forecast reports, by region or State	Output	Programme report	State	Quarterly
45.	SC6	Number of commodity forecast reports, by region or State	Output	Programme report	State	Quarterly
46.	SC7	Number of procurement and forecast meetings conducted at national, regional, and state levels	Output	Programme report	National/State/Region	Quarterly
47.	SC8	Number of commodity logistics trainings conducted at national, state, and LGA levels	Output	Programme report	State	Quarterly
48.	SC9	Number of storage facilities in which commodity quantity and quality reviews are conducted, by region or State	Output	Programme report	State	Quarterly
Policy and Environment						
49.	PE1	Completion of review of FP-related policies and policy updates, disaggregated by level (national and state)	Outcome	Programme report	State	Annually
50.	PE2	Number of international events in which national- and state-level policymakers and programme managers attend	Output	Programme report	State	Annually
Financing						
51.	F1	Annual expenditure on family planning from government domestic budget	Outcome	Programme report	State	Annually
52.	F2	Number of States with costed FP plans	Output	Programme report	State	Annually
53.	F3	Number of States with an FP budget line item	Output	Programme report	State	Annually
Supervision, Monitoring, and Coordination						
54.	SMC1	Capacity for supervision, coordination management, or M&E of family planning	Outcome	Programme report	State	Annually

No	Indicator No	Indicators	Indicator Type	Data Source	Level of Reporting	Frequency
55.	SMC2	Number of existing staff trained in either supervision, coordination management, or M&E of FP programme at the national and state levels	Output	Programme report	State	Annually
56.	SMC3	Number of state- and LGA-level assessments of staff capacity to conduct supervision, coordination management, or M&E of FP programme at the national and state levels	Output	Programme report/OCAT report	State	Annually
57.	SMC4	Number of new staff hired to supervise, coordinate, and conduct M&E of FP programme at the national and state levels	Output	Programme report	State	Annually
58.	SMC5	Assessment meeting to identify and prioritise FP indicators and sources for M&E and completion of a strategy for data collection and analysis	Output	Programme report	National	Annually
59.	SMC6	Number of supervisory visits conducted at the state level	Output	Programme report	State	Quarterly
60.	SMC7	Development of the M&E plan and dashboard	Output	Programme report	National	Annually
61.	SMC8	Annual report to NRHTWG, listing results for each M&E indicator	Output	Programme report	National	Annually

ANNEX B: DETAILED COSTING

Activities: 1 of 13

	Category		Costed Items	Quantity and Frequency	Total cost, $
Demand	D1 Communications Strategy	D1.1	Development	4 (# of consultants); 90 (# of days each)	298,062
		D1.2	Review and approval	37 (# of participants; 2 (# per year)	
	D2 Radio and TV	D2.1	Radio broadcasting	12 (# of programmes); 365 (# of broadcasts per year)	37,405,234
		D2.2	TV broadcasting	6 (# of programmes); 312 (# of broadcasts per year)	
		D2.3	Radio broadcasting	67,525 (# of broadcasts per year)	
	D3 Radio listening	D3.1	Comp to discussion leaders	3,700 (# of groups)	1,381,512
		D3.2	Discussion materials		
		D3.3	Other materials		
	D4 Advertising and printed materials	D4.1	Promotions	4 (promotions/campaigns)	24,531,796
		D4.2	Billboard	370 (billboard units per promotion/campaign	
		D4.3	Poster	45,388 (poster units per promotion/campaign	
		D4.4	Flyers/pamphlets/brochures	4,538,800 (flyer units per promotion/campaign	

Activities: 2 of 13

	Category		Costed Items	Quantity and Frequency	Total cost, $
Demand (continued)	D5 Press	D5.1	Press release	4 (# of press releases)	125,257
		D5.2	Publication	12 (# of articles published)	
	D6 Telecom and Internet	D6.1	Helpline	24 (# of phone lines); 2 (# of counselors per line); 0 (# of SMS lines)	6,844,085
		D6.2	Mass SMS	3 (# of SMS campaigns); 10,000 (000s reached via SMS)	
		D6.3	Website	0 (# of websites)	
	D7 In-person health campaigns	D7.1	Campaigns	45,388 (# of t-shirts per campaign); 45,388 (# of hats per campaign); 3,870 (# of CHEWs per campaign); 4 (# of days per CHEW); 774 (# of *criers* per campaign); 2 (# of campaigns per year, nationally)	24,915,507

Category	Costed Items	Quantity and Frequency	Total cost, $
D8 Champions programme – national training	D8.1 National training	111 (# of participants); 3 (# per year) Level 2 meeting (meeting level) 4 (meeting length (days))	7,668,658
D9 Champions programme – state training	D9.1 Train FP promoters	25 (# of participants); 64 (# per year) Level 4 meeting (meeting level) 4 (meeting length (days))	6,290,734
D10 Champions programme – ongoing	D10.1 Support for change champions	111 (# of change champions)	503,910
	D10.2 Support for FP promoters	1,600 (# of FP promoters)	
D11 Family life education in programme – curriculum review	D11.1 Curriculum review meeting	40 (# of participants); 1 (# per year) Level 2 meeting (meeting level) 4 (meeting length (days))	35,674
	D11.2 New curriculum	3 (# of documents)	
D12 Training teachers in new curriculum	D12.1 School teachers	20 (# of participants); 744 (# per year) Level 4 meeting (meeting level) 2 (meeting length (days))	20,128,945
D13 Peer educators	D13.1 Peer educators	30 (# of participants); 50 (# per year); Level 3 meeting (meeting level); 1 (meeting length (days))	2,350,748
D12 Faith-based dialogue	D14.1 Meetings	20 (# of participants); 37 (# per year); Level 4 meeting; (meeting level); 1 (meeting length (days))	879,563

The leftmost vertical label reads: **Demand (continued)**

Activities: 4 of 13

Category	Costed Items	Quantity and Frequency	Total cost, $
S1 Pre-service training – Curriculum review	S1.1 Pre-service training curr review	3 (# of consultants); 30 (# of days each)	68,986
	S1.2 Curriculum review and approval	30 (# of participants); 1 (# per year); Level 1 meeting (meeting level); 2 (meeting length (days));	
	S1.3 New curriculum	30 (# of documents)	
S2 Pre-service training – Training of trainers	S2.1 Training of trainers	20 (# of participants); 8 (# per year); Level 2 meeting (meeting level); 5 (meeting length (days)); 20 (# needed per training)	1,086,069
S3 In-service training – Training plan and curriculum review	S3.1 In-service training curriculum review	3 (# of consultants); 30 (# of days each)	125,704
	S3.2 Curriculum review and approval	30 (# of participants); 1 (# per year); Level 1 meeting (meeting level); 1 (meeting length (days))	
	S3.3 New curriculum	30 (# of documents)	
S4 In-service training – Training of trainers	S4.1 Training of trainers	20 (# of participants); 8 (# per year); Level 2 meeting (meeting level); 5 (meeting length (days)); 20 (# needed per training); 3 (# of days per visit); 5 (# of sites to visit from each training)	1,255,336
S5 In-service training – injectables (CHEWs)	S5.1 Training providers in FP generally	60 (# of participants); 37 (# per year); Level 4 meeting (meeting level); 5 (meeting length (days)); 111 (# of teachers)	17,987,287

The leftmost vertical label reads: **Service delivery and access**

	Category		Costed Items	Quantity and Frequency	Total cost, $
Service delivery and access (continued)	S6 In-service training – LARC training	S6.1	Training providers in LARC	40 (# of participants); 37 (# per year); Level 4 meeting (meeting level); 12 (meeting length (days)); 40 (# needed per training); 74 (# of teachers)	23,197,996
	S7 Training materials – Initial investment	S7.1 S7.2 S7.3	ZOE gynecological simulator Plastic uterus (for IUDs) Plastic arm (for implants)	493 (# needed per procurement) 493 (# needed) 493 (# needed)	1,791,715
	S8 Outreach activities – Initial investment	S8.1 S8.2 S8.3	Site purchase Nurse Cleaner	37 (# of outreach points); 1 (# per outreach point) 0.5 (# per outreach point)	2,314,085
	S9 Mobile clinics – Initial investment	S9.1	Vehicle/truck	37 (# of outreach points)	2,256,488
	S10 Outreach activities and mobile clinics – Ongoing costs	S10.1 S10.2 S10.3	Training providers in FP generally Lunch for doctors and others Retired midwife	1 (# of days per outreach visit) 12 (# of outreach visits per year per outreach point); 37 (# of outreach points) 2 (# of midwives); 1 (# of doctors/clinical officers in outreach); 4 (# of times a year); 22694 (# of health centres)	31,795,295

	Category		Costed Items	Quantity and Frequency	Total cost, $
Service delivery and access (continued)	S11 Knowledge campaign with pharmacies	S11.1	Meetings	20 (# of participants); 37 (# per year); Level 4 meeting (meeting level); 2 (meeting length (days))	1,599,100
	S12 Knowledge campaign with PPMVs	S12.1	Meetings	20 (# of participants); 370 (# per year); Level 4 meeting (meeting level); 2 (meeting length (days))	17,372,514
		S12.2	Meetings	7400 (# of trainees)	
	S13 FP equipment for all health facilities	S13.1	Autoclave	1 (per 10 health centres per year); 3,404 (# of points refurbished)	26,942,899
		S13.2	Towel drape, 46cm x 61cm	30 (per 10 health centres per year); 3,404 (# of points refurbished)	
		S13.3	Forceps, sponge, straight, serrated jaws 24cm	5 (per 10 health centres per year); 3,404 (# of points refurbished)	
		S13.4	Forceps, hemostatic, Halsted- Mosquito, curved 12.5cm	5 (per 10 health centres per year); 3,404 (# of points refurbished)	
		S13.5	Scissors, Mayo, 23cm	5 (per 10 health centres per year); 3,404 (# of points refurbished)	
		S13.6	Forceps, Tissue, 1:2 14cm	5 (per 10 health centres per year); 3,404 (# of points refurbished)	
		S13.7	Handle for surgical blade, no. 3 (minor surgery)	5 (per 10 health centres per year); 3,404 (# of points refurbished)	
		S13.8	Forceps, uterine, Duplay (tenaculum)	5 (per 10 health centres per year); 3,404 (# of points refurbished)	

Category	Costed Items	Quantity and Frequency	Total cost, $
S13 FP equipment for all health facilities (contd)	S13.9 Sound, uterine	2 (per 10 health centres per year); 3,404 (# of points refurbished)	
	S13.10 Speculum, Graves, Medium	5 (per 10 health centres per year); 3,404 (# of points refurbished)	
	S13.11 Privacy screen	1 per 10 health centres per year); 3,404 (# of points refurbished)	
	S13.12 Explanatory kits (condom and IUD demo models)	1 per 10 health centres per year); 3,404 (# of points refurbished)	
	S13.13 Explanatory flyer/handbook	1 per 10 health centres per year); 3,404 (# of points refurbished)	
S14 Integration of FP with other health services	S14.1 Integration guidelines	2 (# of consultants); 60 (# of days each)	71,748
S15 CHEWs registration on national training database	S15.1 Registration costs	1850 (# of CHEWs)	138,169
S16 Explore opportunities for public-private partnerships	S16.1 Meetings with key private stakeholders	20 (# of participants); 5 (# per year); Level 1 meeting (meeting level); 2 (meeting length (days))	53,154
S17 Youth-friendly facilities	S17.1 Renovation	454 (# of facilities renovated) CYP offered (Measure Evaluation PRH)	2,713,764

Service delivery and access (continued)

Category	Costed Items	Quantity and Frequency	Total cost, $
P1 Contraceptives	P1.1 Male condom	120 (units per year)	177,253,282
	P1.2 Female condom	120 (units per year)	
	P1.3 Combined oral pill (COP)	13 (units per year)	
	P1.4 Progestin only pill (POP)	13 (units per year)	
	P1.5 Injectable	4 (units per year)	
	P1.6 Implant Jadelle	3.8 (typical length of coverage before removal); 95% (mix of implants)	
	P1.7 Implant Sinoplant	3.2 (typical length of coverage before removal); 5% (mix of implants)	
	P1.8 Implant Implanon	2.5 (typical length of coverage before removal); 0% (mix of implants)	
	P1.9 Implant consumables		
	P1.10 IUD	4.6 (typical length of coverage before removal)	
	P1.11 IUD consumables		
	P1.12 Female sterilisation consumables	39.7 (avg operation age (to calc coverage prior to age 49))	
	P1.13 Male sterilisation consumables		

Commodities and Consumables

	Category	Costed Items	Quantity and Frequency	Total cost, $
Commodities and Consumables (continued)	P2 Consumables	P2.1 Gloves, Gloves, nonsterile, size Medium (each)	2 (# for implants); 2 (# for IUDs); 4 (# for female ster); 2 (# for male ster)	5,672,046
		P2.2 Betadine solution 500ml	0.01 (# for implants); 0.01 (# for IUDs); 0.01 (# for female ster); 0.01 (# for male ster)	
		P2.3 Gloves, surgical, sterile Size 7.5 (pair)	1 (# for implants); 1 (# for IUDs); 2 (# for female ster); 1 (# for male ster)	
		P2.4 Fenestrated drape, sterile, disposable, 20cmx20cm	1 (# for implants); 0 (# for IUDs); 0 (# for female ster); 0 (# for male ster)	
		P2.5 Lidocaine hydrochloride 1% (20ml)	0.2 (# for implants); 0 (# for IUDs); 0 (# for female ster); 0.5 (# for male ster)	
		P2.6 Syringe, disposable, sterile, 5ml	1 (# for implants); 0 (# for IUDs); 4 (# for female ster); 1 (# for male ster)	
		P2.7 Needle, disposable, sterile, 23-gauge	1 (# for implants); 0 (# for IUDs); 4 (# for female ster); 1 (# for male ster)	
		P2.8 Bandaid (wound plaster, waterproof)	1 (# for implants); 0 (# for IUDs); 0 (# for female ster); 0 (# for male ster)	
		P2.9 Adhesive tape (zinc oxide plaster) nonsterile 2.5cm x 5m	0.1 (# for implants); 0 (# for IUDs); 0.1 (# for female ster); 0.05 (# for male ster)	
		P2.10 Gauze bandage, nonsterile, 10cm x 4.5meters	0.2 (# for implants); 0 (# for IUDs); 1 (# for female ster); 6 (# for male ster)	
		P2.11 Cotton balls (not roll of cotton!), large, nonsterile	6 (# for implants); 0 (# for IUDs); 0 (# for female ster); 0 (# for male ster)	
		P2.12 Blade, surgical, no. 10, sterile, disposable (removal only)	1 (# for implants); 0 (# for IUDs) ; 2 (# for female ster); 0 (# for male ster)	
		P2.13 Suture material (sterile with needle) + 1 pack chromic catgut	0 (# for implants); 0 (# for IUDs); 2 (# for female ster); 1 (# for male ster)	
		P2.14 IV solution x 1000cc	0 (# for implants); 0 (# for IUDs); 2 (# for female ster); 0 (# for male ster)	

	Category	Costed Items	Quantity and Frequency	Total cost, $
Commodities and Consumables (contd)	P2 Consumables (contd)	P2.15 Urethral catheter	0 (# for implants); 0 (# for IUDs); 1 (# female ster); 0 (# for male ster)	
		P2.16 Infusion set with catheter or needle 14-16 gauge	0 (# for implants); 0 (# for IUDs); 1 (# female ster); 0 (# for male ster)	
	P3 Quality testing	P3.1 Cost as % of commodities procured	0.1%	145,290
Supply chain	P1 Procurement and forecasting meetings	P1.1 Procurement forecasting	30 (# of participants); 1 (# per year) Level 1 meeting (meeting level) 2 (meeting length (days)	235,542
		P1.2 Forecasting review meetings	30 (# of participants); 4 (# per year) Level 1 meeting (meeting level); 1 (meeting length (days)	
	P2 FP logistics training	P2.1 Training of trainers	37 (# of participants); 1 (# per year); Level 2 meeting (meeting level); 5 (meeting length (days)	626,396
		P2.2 Training providers in FP logistics and procurement	20 (# of participants); 6 (# per year); Level 3 meeting (meeting level); 3 (meeting length (days)	
	P3 Distribution equipment – Ongoing costs	P3.1 Vehicle renting	148 (# of vehicles); 2 (maintenance visits per year)	20,937,868
		P3.2 Fuel	12 (# of circuit visits per year)	
		P3.3 Driver		
	P4 Storage facilities	P4.1 Infrastructure	0 (# of points refurbished)	864,067
		P4.2 Storage equipment	5 (# of points refurbished); 100 (# needed per point)	

	Category		Costed Items	Quantity and Frequency	Total cost, $
Supervision, monitoring, and coordination	P1 Review FP service guidelines	P1.1	FP guidelines review	30 (# of participants); 1 (# per year) Level 2 meeting (meeting level) 5 (meeting length (days))	72,808
	P2 International advocacy	P2.1	Attending international meetings (e.g., Women Deliver)	4 (# of trips); 4 (# of days) 4 (participants per trip)	107,548
	P3 Procurement and forecasting meetings	P3.1	Coordination meetings	30 (# of participants); 2 (# per year) Level 1 meeting (meeting level) 2 (meeting length (days))	28,915
	P4 FP logistics training	P4.1	Coordination meetings	30 (# of participants); 6 (# per year); Level 2 meeting (meeting level); 2 (meeting length (days));	458,804
		P4.2	Technical and other support		
	P5 Financing advocacy meetings to government	P5.1	Financing advocacy meetings	20 (# of participants); 36 (# per year); Level 4 meeting (meeting level); 1 (meeting length (days))	513,542
	P6 Advocacy strategy and meetings to donors	P6.1	Financing advocacy meeting	25 (# of participants); 4 (# per year); Level 1 meeting (meeting level; 1 (meeting length (days))	26,738

	Category		Costed Items	Quantity and Frequency	Total cost, $
Supervision, monitoring, and coordination (continued)	S1 Data collection books	S1.1 S1.2 S1.3	Patient book Stock book Referral book	1 (per health centre) 1 (per health centre) 1 (per health centre)	1,271,195
	S2 Technical WG/ SteerCo meetings	S2.1	Costed separately as to no per-diems	30 (# of participants); 11 (# of meetings per year)	20,536
	S3 Training in FP supervision	S3.1	Train in FP supervision	30 (# of participants); 37 (# per year); Level 3 meeting (meeting level); 5 (meeting length (days)); 0 (# of days per visit); 0 (# of sites to visit from each training)	3,291,066
	S4 Supervision and quality assurance	S4.1	Central to zones	2 (# of supervisors); 5 (# of days (length of visit)); 2 (# of circuits/routes to make per visit); 1 (# of times per year per site)	120,761,749
		S4.2	Zones to states	2 (# of supervisors); 4 (# of days (length of visit); 1 (# of circuits/routes to make per visit); 6 (# of zones); 1(# of times per year per site)	
		S4.3	States to LGAs	2 (# of supervisors); 4 (# of days (length of visit)); 1 (# of circuits/routes to make per visit); 744 (# of districts); 1 (# of times per year per site)	
		S4.4	LGAs to health centres	2 (# of supervisors); 1 (# of circuits/routes to make per visit); 22,694 (# of health centres); 2 (# of times per year per site)	

Category		Costed Items		Quantity and Frequency	Total cost, $
S5 Supervision/ review meetings	S5.1	Federal supervisory review		30 (# of participants); 2 (# per year); Level 2 meeting (meeting level); 1(meeting length (days))	2,533,186
	S5.2	Zone supervisory review		20 (# of participants); 4 (# per year); Level 3 meeting (meeting level); 6 (# of zones); 1 (meeting length (days))	
	S5.3	State supervisory review		20 (# of participants); 4 (# per year); Level 4 meeting (meeting level); 37 (# of states); 1 (meeting length (days))	
S6 Surveys/investigations (e.g., mid-DHS)	S6.1	SMART survey used as proxy ($16k per state)		0 (# of surveys/investigations)	3,733,816
S7 Plan review – midway	S7.1	Mid-way plan review		30 (# of participants); 1 (# per year); Level 2 meeting (meeting level); 2 (meeting length (days))	15,287
S8 Plan review – final	S8.1	Final plan review		30 (# of participants); 1 (# per year); Level 2 meeting (meeting level); 2 (meeting length (days))	15,905
S9 Hire focal points	S9.1	Zone-level FP coordinator		6 (# of resources); 100% (% of time spent on FP)	448,058
S10 Train zonal focal points	S10.1	Train zonal FP focal points		10 (# of participants); 2 (# per year); Level 2 meeting (meeting level); 5 (meeting length (days))	67,526
S11 Train state focal points	S11.1	Train district FP focal points		20 (# of participants); 6 (# per year); Level 3 meeting (meeting level); 2 (meeting length (days))	110,968

Supervision, monitoring, and coordination (continued)