Policy Analysis of the Family Planning Landscape in Lagos and Kaduna States

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Nigerian Family Planning Landscaping

NURHI Nigerian Urban Reproductive Health Initiative | Johns Hopkins Bloomberg School of Public Health | Center for Communication Programs | Marie Stopes Nigeria | dkt International Nigeria | Bill & Melinda Gates foundation

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ACRONYMS AND ABBREVIATIONS

APCON	Advertising Practitioners Council of Nigeria
BMGF	Bill and Melinda Gates Foundation
CBD	Community-Based Distribution (of Family Planning)
CHEWs	Community Health Extension Workers
CHO	Community Health Officer
CORPs	Community Resource Persons
CSO	Civil Society Organisation
FBO	Faith-based Organisation
FMoH	Federal Ministry of Health
FP	Family Planning
HEFAMAA	Healthcare Facilities Monitoring and Accreditation Agency
HSDP	Health Sectors Partners' Development Forum
HSPDF	Health Sectors Partners' Development Forum
HSR	Health Sector Reform
IMNCH	Integrated Maternal, Newborn, and Child Health
ISSA	Initiative for Social Sector Advocacy
IUD	Intra-uterine Device
JHU·CCP	Johns Hopkins Bloomberg School of Public Health Center for Communication Programs
KDSG	Kaduna State Government
KESSP	Kaduna Essential Service Package and Systems Policy
LARC	Long Acting Reversible Contraceptives
LASG	Lagos State Government
LCDAs	Local Council Development Areas
LGA	Local Government Authority
MCH	Maternal and Child Health
MNC	Maternal and Newborn Care
MNCH	Maternal and Child Health
MoH	Ministry of Health
MRA	Men of Reproductive Age
MSION	Marie Stopes International of Nigeria
MTSS	Medium Term Sector Strategy
NAFDAC	National Agency for Food and Drug Administration and Control
NAPPMED	National Association of Patent and Proprietary Medicine Dealers
NPSCMP	National Product Supply Chain Management Programme

NDHS	Nigeria Demographic and Health Survey
NPC	National Population Commission
NURHI	Nigeria Urban Reproductive Health Initiative
PATHS2	Partnership for Transforming Health Systems 2
PHC	Primary Health Care
PPMVs	Patent and Proprietary Medicine Vendors
PPP	Public-Private Partnership
SHOPS	Strengthening Health Outcomes through the Private Sector
SMoH	State Ministry of Health
SSHDP	State Strategic Health Development Plan
TWG	Technical Working Group
UNFPA	United Nations Population Fund
USAID	United States Aid for International Development
VHW	Village Health Workers
WRA	Women of Reproductive Age

1. INTRODUCTION

The Johns Hopkins Center for Communication Programs (CCP), Marie Stopes International of Nigeria (MSION), and DKT International Nigeria are partnering to conduct a family planning landscaping exercise in Lagos and Kaduna states on behalf of the Nigerian government and the Bill and Melinda Gates Foundation. The purpose of the analysis is to better understand state-specific family planning supply and demand barriers and identify key solution levers to accelerate contraceptive use. The landscaping exercise, covering urban and rural areas in both states, entails data collection and analyses and solicits inputs from family planning clients and potential clients, service providers, community leaders, and key stakeholders from government, donors, and the private sector.

This report focuses on the policy analysis and regulatory aspect of the FP landscaping study. Broadly, this policy analysis study aims to describe the policy and regulatory environment as it affects contraceptive use, marketing, and service delivery in Kaduna and Lagos States. Specifically, it aims to identify the relevant policies and regulations affecting family planning (FP) services at the state level as well as assess the funding of FP by state government. Among others, the analysis covers regulations that facilitate or hinder provision of FP by different cadres of health workers, including administration of injectables by Community Health Extension Workers (CHEWs); policies that specifically apply to the private sector, both for-profit and not-for-profit, including any restrictions on advertising of branded contraceptive methods; and, the availability and effectiveness of FP coordination structures. The analysis also describes advocacy efforts and structures that exist in each state, whose interests they represent and the activities they undertake to influence policy.

2. OVERVIEW OR BACKGROUND

Nigeria is the most populous country in Africa with a population of over 170 million presently, and the tenth most populous in the world. Evidence from the Nigeria Demographic and Health Surveys (NDHS) suggest that Nigeria's has not recorded any improvement in its family planning uptake over the last 10 years. Presently, the contraceptive prevalence rate for modern contraceptives (m-CPR) stands at 10%, while the contraceptive prevalence rate for all methods (CPR) is 15%. Nigeria has set the target of increasing its CPR from the 2013 figure to 36% by 2018.

The low level of contraceptive use contributes significantly to Nigeria's poor maternal and child health status. It also accounts for the high total fertility rate of almost six children per woman and the high population growth rate of 3.18 percent as reported by the National Population Commission (NPC) based on the 2006 national census. While the proportion of married women who have demand for family planning is just 31%, the level of unmet needs for family planning is 16%. Thus, if all currently married who desire family planning have met their needs met, Nigeria's mCPR would have been more than double its present value. There is the need to understand specific barriers and potential issues to address in order to achieve Nigeria's set target for 2018.

This study, carried out with the support of the Bill and Melinda Gates Foundation (BMGF), focuses on the FP situation in Kaduna and Lagos – two areas where BMGF proposes to engage deeply over the coming years. The purpose of the analysis is to better understand state-specific barriers and identify key solution levers to accelerate contraceptive use. This study particularly focuses on the policy and regulatory environment for FP.

3. METHODOLOGY

Broadly, this policy analysis entails descriptive and analytical review of: (a) current policies and regulations as they affect FP service delivery and use, and (b) advocacy efforts and structures and their influence on policy

3.1 INSTRUMENTS

The guide for the in-depth interview was developed through interaction of experts, based on the objectives of the study and prior experience in the family planning and policy analysis arena.

3.2 TRAINING AND SUPERVISION

The data collection for the study was carried out solely by the Consultant.

3.3 RESPONDENT SELECTION

Purposive sampling was used in selecting the respondents. Respondents were selected based on the stakeholders' group they belong to; their official position and knowledge of the family planning field in Nigeria and/or the focal states vis-à-vis their relevance to the study. The list of interviewees was originally developed by MSION, and refined through interactions with, and input from the Consultant. Furthermore, in some cases, other respondents were also included in the interview list through referrals from interviewees who are familiar with such individuals and believe that their contribution would enrich the study (a modified "snowball approach")

3.4 INFORMED CONSENT

The purpose and process of the study was explained to each interviewee, as well as possible risks and benefits. It was made clear to the interviewees that participation was free, and they would not be adversely affected in any way if they declined to participate, and that they are free to discontinue with the interview at any point. Potential interviewees who agreed to participate were further asked for permission to audio-record the interview; audio-recording was not carried out in

any case when such permission was not given, and recording was only done by writing. The information collected from the interviewees were kept safe by the Consultant and was not shared to any other person outside the study.

3.5 DATA COLLECTION

Data collection employed two approaches:

(a) Desk review and internal consultation, which involved review of existing data and information sources (including the Nigeria Demographic and Health Survey [NDHS]) as well as policies and policy instruments at all levels, and,

(b) Interviews with key informants in partner organisations as well as policy makers, programme managers, practitioner and consumer representatives. The interviews were carried out using a standardized guide, and were recorded in note and with audio recorders when the interviewees granted permission for such. Research ethical standards were observed in carrying out the interviews, and informed consent was obtained from all interviewees.

3.6 DATA ANALYSIS

Data analysis was based on the thematic areas, and involved the use of deductive analysis approach. Data generated from different sources was triangulated in the process to enable interpretive analysis.

4. RESEARCH FINDINGS FOR LAGOS STATE

4.1 CHARACTERISTICS OF RESPONDENTS

In-depth interviews were conducted for the following groups of stakeholders: representatives of key partner organisations as well as other international development partners; FP-related policy makers and programme managers in relevant government ministries, departments and agencies; representatives of the private health sector, including private sector health workers and officials of civil society organisations. The list of interviewees is included as part of the appendixes.

4.2 FINDINGS

4.2.1. Context

Demographic and socioeconomic

Lagos State is the economic nerve centre of Nigeria. With an area of 3,577 square km, 22% of which consists of lagoons and creeks, Lagos State is the smallest state in the country, but has the most dynamic population with representation of practically every ethnic group. The 2006 National Population and Housing Census conducted by the National Population Commission (NPC) reported a population of 9,113,605 (4,719,125 males and 4,394,480 females), which places Lagos State second behind Kano State with 9,401,288 population (NPC, 2009). With the growth rate of 3.2% per annum reported by NPC in 2006, the 2015 estimated population of Lagos State population is 12,252,970. However, Lagos State government has contended these figures as gross underestimate; the state government reported a population of 17.6 million for 2006 (Lagos State Ministry of Health, 2010) and 20.4 million for 2011 (Lagos State MoH, 2011b). The state government puts the annual population growth rate of the state as 8% (Adeshina, 2013).

Lagos State experiences a high level of rural-urban migration annually, and witnesses a large influx of population from other states for economic activities. The city of Lagos itself is reputed as one of the most densely populated and fastest growing cities in the world, with the attendant challenge of urban slums (UN, 2011). Lagos State is reported to have over 100 slum communities, which are heavily populated by poor and socially disadvantaged people (Beysolow-Nyanti, 2012). Of the 2,269,345 households reported by NPC to be dwelling in Lagos State in 2006, almost 1% were reported to be homeless (6,915 homeless households and 12,922 homeless persons) while of the 2,195,482 regular households, 284,666 (13.0%) have no sleeping room (NPC, 2009). Women of reproductive age (15-49 years) constitute 58.3 % of females and 28.1% of the state population (NPC, 2009). More than four-fifths of both the male (95.1%) and female (89.3%) population aged 15-49 years are literate (NPC & ICF International, 2014).

Political system

Lagos State traditionally has five administrative divisions, which are further divided into twenty (20) Local Government Areas (LGAs). In 2003, many of the existing 20 LGAs were split for administrative purposes into Local Council Development Areas (LCDAs) with additional 37 LCDAs created, making a total of 57 administrative units. As is true of the rest of Nigeria, Lagos state has a three-tier political system consisting of the executive, the legislative and judicial arms. Since Nigeria's return to democratic rule in 1999, the same political group – which is the main opposition party at the federal level – has primarily ruled Lagos State, although the group has experienced changes in name as a political party in different dispensations.

Health system structure

Lagos State operates a pluralistic health system with public, private and traditional health care operating side-by-side. The state has one state-owned University Teaching Hospital, 26 General Hospitals, 256 primary health care (PHC) centers, 2, 886 private healthcare facilities (hospitals,

specialist clinics and laboratories or diagnostic centers) and 160 registered trado-medical centers (HEFAMAA, Undated). In addition, the following federal healthcare institutions are in Lagos State: a University Teaching Hospital (at Idi-Araba), a Federal Medical Centre (at Ebute-Meta), a National Orthopaedic Hospital (at Igbobi), and a Neuro-Psychiatric Hospital (at Yaba). Several faith-based organisations also operate health programmes or/and own health institutions in the state.

Dating back to 1999, when Nigeria returned to democratic rule, several initiatives have been set in motion to improve the health care service delivery system in Lagos State. These attempts culminated in the introduction of the Health Reform Agenda that took root in 2004, with the main aim of improving the performance of the health system. The reform agenda is backed by a legislation – the Health System Reform Law (HSR) of 2006.

The objects of HSR Law are *"to regulate health services within the State and to provide uniformity in respect of health services across the state by: (1) establishing a State health system which – (a) encompasses public and private providers of health services; (b) provides the population of the State with the best possible health services that available resources can afford; and (2) setting out the rights and duties of health care providers, health workers, health establishments and users"* (Lagos State Government, 2006). Among others, the HSR Law specifically spells out the roles and responsibilities of the Ministry of Health (MoH) and Health Service Commission, and the establishment of various structures and institutions aimed at addressing gaps with the coordination of service at all levels of care. The structures and institutions include the following: Hospital Governing Boards, Hospital Management Committees, Health Facilities Monitoring and Accreditation Agency, State Primary Health Care Board, Local Government Health Authority, Ward Health Committee/Health Facility Management Team, and the State Traditional Medicine Board.

The current health system structure that is in place in Lagos State is based on the 2006 HSR Law as the current administration, which came into power in 2007, has sustained the reform agenda. In addition, the health development of the state in the current era is guided by a well-defined three-pronged health policy thrust of free primary health care services; provision of comprehensive secondary healthcare services; and institution of health sector reforms including the health insurance scheme and private sector participation.

The MoH, as stipulated by the HSR Law, is responsible for the formulation, monitoring, evaluation of policies, strategies, plans of action and supervision of health services in the state. The vision of the Ministry is "*To attain excellence in health service delivery by applying best practices at all levels of care*," and its mission is "*To deliver qualitative, affordable and equitable healthcare services to the citizenry applying appropriate technology by highly motivated staff*." The State Health Service Commission, on the other hand, has overall responsibility for health personnel management for the secondary health facilities. There is decentralization of activities and autonomy of each hospital as the State University Teaching Hospital as well as each of the secondary health care facilities has its own Governing Board, with the MoH having oversight functions over them as well as the Health Service Commission.

Lagos state operates the Ward Health System in line with the extant law. The State Primary Health Care Board (established in 2009) has the overall responsibility for Primary Health Care Management in the State. As part of the state structure for PHC, each LGA has a Local Government Health Authority headed by the Medical Officer of Health, Ward Health Committees, and PHC Facility Committees. As part of the agenda for revitalising the PHC, the government programmed for the scaling-up of one PHC Center per Local Government administrative unit (LGAs and LCDAs), mainly from already existing facilities to become model comprehensive facilities that operate 24 hours a day and are labelled "Flagship PHC Centers". Family Planning is

one of the key services that the 57 Flagship Centers are expected to provide. The current leadership of the State PHC Board has expressed strong intention to strengthen community extension and outreach programme as part of the agenda to improve coverage of PHC services. The State Traditional Medicine Board has the responsibility for the overall supervision of traditional medicine, health care facilities, and traditional institutions owned by traditional herbalists or healers, or other practitioners in traditional medicine, including traditional birth attendants. The Traditional Medicine Board has been active in training and supervising TBAs in maternal health services.

The Health Facilities Monitoring and Accreditation Agency (HEFAMAA) has the primary responsibility to set up relevant standards for both public and private health facilities as well as monitor the facilities to ensure strict compliance with set standards. HEFAMAA plays important roles in the registration and accreditation of private health facilities in the state. Most private sector operatives view the role and activities of HEFAMAA as positively influencing the quality of their services.

In line with its health policy thrust, the Lagos State Government (LASG) initiated a Community Based Health Insurance Scheme in July 2008. The programme targets people working in the informal sector and aims at increasing the reach of the people to health services, particularly at the local government level. The scheme involves regular monetary contribution by individuals and households and offers primary healthcare services to all enrolled members of the community. The scheme is currently operating in Ikosi-Isheri and Ibeju-Lekki LCDAs, and there is plan to scale up the scheme to other LGAs (LASG, undated). In addition, the state government is working on the development of the State Health insurance Scheme to ensure a wider coverage of its populace. Overall, the free health scheme and the insurance scheme will significantly decreases the out-of-

pocket mode of payment and increase the access of people, particularly those at the grassroots, to health services.

The Free Medical Mission programme is a distinct element of the Free Health policy of the state government, which targets rural communities and poor people in the three senatorial districts of the state. The programme is organised on regular and rotational basis from one community to the other and compliments the normal health delivery services of the state, and expand access of the grassroots to health services. The mission particularly focuses on vulnerable populations such as the elderly, children, pregnant women and those with pressing medical and surgical problems. The scope of services offered during medical missions include: general medical consultation and nutritional assessment of the children, general basic/ uncomplicated surgeries, basic, uncomplicated obstetrics/gynecological surgeries, simple dental procedures, eye consultation and screening (with provision of glasses), and eye surgeries (such as cataract extraction with intra ocular lens implantation and pteryguim excision) (Lagos State MoH, undated). The MoH partners with Health & Missions International, local communities, faith-business organisation and other civil society organisations in the implementation of the medical mission programmes.

Family Planning indicators

The FP indicators for Lagos State, as shown in Table 1, are among the best in Nigeria. The total wanted fertility for Lagos State is 3.6, while the total fertility rate (TFR) is 4.1 and the mean ideal number of children for all women age 15-49 years is 6.87 (NPC & ICF International, 2014). The contraceptive prevalence rate (CPR) for all FP methods is 48.3% and 26.4% for modern methods (mCPR). The percentage of married women using long acting reversible contraceptives (LARC) is just 2.7%, which is about 10% of married women using FP. The total demand for FP among married women is 60.1%, and only 43.9% of that demand is met by modern methods. The unmet contraceptive need level is 8.1% for married women and 11.8% for all women of reproductive age

(aged 15-49 years) (NPC & ICF International, 2014). In general, FP indicators are worse for those in the lower economic and educational groups, rural-based women, and young people.

Table 1: Lagos State: Select Family Planning Indicators

	All women	Married women
% of women using contraceptives		
All methods	40.5	48.3
Modern methods	24.8	26.4
Long acting methods	1.9	2.8
Total unmet need	8.1	11.8
Unmet need for Limiting	2.2	3.5
Unmet need for Spacing	5.9	8.3
Total demand for contraceptives	48.6	60.1
% Demand satisfied	83.4	80.4
% Demand satisfied by modern method	51.1	43.9

Source: NPC & ICF International, 2014.

4.2.2. Diagnostic

Government FP stewardship and upcoming elections

The goal of the Lagos State health sector is "*To protect promote and restore the health of Lagosians and to facilitate their reasonable access to health services without financial or other barriers*". The Lagos State HSR provides the legal framework to reinforce the stewardship functions of government in the delivery of quality health services, including family planning. Lagos State has enjoyed continuity in government policies in the area of health care and other social sectors since 1999. The Lagos State government has shown clear commitment to promoting FP as evidenced in the structure of its MoH, policies, programme actions and budgetary provisions.

Irrespective of the results of the coming election, there is very low likelihood that the government policy in terms of family planning and the health sector as a whole would change dramatically. The well-established structure and functions of the health system backed by an appropriate legal framework assures the likelihood of continuity in the public health sector agenda and operations,

and provides some guarantee that very little changes with negative impact on FP would occur in the short- and medium-term.

Policy and regulation and their implementation

The overarching "policy" guides for the health system in Lagos State, against which the FP agenda is juxtaposed, are the State Health Reform Law, the State Strategic Health Development Plan (SSHDP), and The Medium Term Sector Strategy (MTSS) of the Lagos State MoH particularly as the state does not have a separate FP policy/costed operational plan. The Reform Law provides the legal and institutional framework to drive the state health policy whereas the SSHDP (Y2010 – 2015) identifies the priority actions in the health sector (on the part of the state government and LGAs), based on the eight thematic areas specified in the National Strategic Health Development Plan (LASG, 2010).

The SSHDP lists FP among the essential package of health care of high impact intervention and specifies the percentage of service delivery points (SDPs) with at least one FP service provider as one of its indicators. However, whereas the SSHDP specifies maternal and newborn care (MNC) as part of the Minimum Package of Care, the elements specified as part of MNC are antenatal care, emergency obstetric and neonatal care, and skilled delivery but omits FP. This, perhaps, reflects inadequate focus of FP in the context of the overall MCH agenda, which will affect its implementation as part of the integrated package. The State Integrated Maternal, Newborn, and Child Health (IMNCH) Strategy, however, duly positions FP as an integral part of MNC.

The MTSS along with the Medium Term Fiscal Framework constitute the components of the government's Medium-Term Expenditure Framework (MTEF) to planning and implementation of the reform process for the public service. Specifically, MTSS identifies the goals and objectives for the key sectors of Government and translates these, within the confines of Sectoral Expenditure

Envelopes, into an affordable fully-costed and well-defined set of initiatives over the same period The MTSS for the health sector aims, among others, "*To revitalize Integrated service delivery towards a quality, equitable and sustainable healthcare*", with focus on improving access to services; improving quality of services; improving demand for health services; and ensuring financial access for vulnerable groups (Lagos State Ministry of Health, 2012). In 2010, the SSHDP document was aligned with the MTSS for the health sector with a view to devise a seamless link between the two policy documents. The MTSS forms the basis for the generation of the MoH Annual Budget and is updated annually. The MTSS for the health sector gives recognition to FP as it lists the percentage of service delivery points without stock-out of FP commodities as one of its three indicators for its Reproductive Health (RH) program.

In general, the Lagos State FP programme is guided by national policy documents and the development agenda of the State government and no specific FP (written) policy or costed plan have been developed. Yet, as evidenced from the overarching policy documents and the FP operational structure and budgetary activities, Lagos State government clearly give priority to FP in its health and developmental agenda. The State MoH has a FP unit as part of its Family Health and Nutrition Department, and with a qualified and committed health professional as the State FP Coordinator. The Primary Health Care Board also has a Family Planning Coordinator and Family Planning Officers exist in each of the 20 LGAs.

Overall, Lagos State government stands as a trailblazer in women's health and family planning in Nigeria in terms of its commitment and initiatives. For example, in 2013, Lagos was one of 12 states documented to have a dedicated budget line for FP. Furthermore, Lagos was the only state documented to have officially disbursed monies directly for FP services in 2014. In 2014, the state introduced the innovative package of 10 working day paternal leave for male employees of the

state government whose wife had just had a child and extended the period of maternity leave for its female employees from three months to six months with full pay for the first two deliveries.

The FP programme design in Lagos State recognises unique local factors such as myths affect family planning activities in some selected geographical locations and/or among selected groups, particularly in the hard-to-reach areas and the slum communities such as Maroko and Ibeju-Lekki. Interestingly, the report of the study on health disparities in Lagos State noted that whereas many health workers felt that the key reason for low uptake of health services in disadvantaged communities is the people's lack knowledge and information, the opinion of people differed significantly. The reasons given included the hidden costs embedded in the free health care programme, poor and rude attitudes of health workers and long waiting queues at health facilities. Clearly, the government and its agencies need to improve their efforts to reach these underserved groups.

The State MoH and the PHC Board officials are enthusiastic about the July 2012 task-shifting decision of the National Council on Health, which approves the provision of injectable contraceptives by CHEWs. The officials view the decision as an opportunity to strengthen community-based FP activities and improve FP coverage in underserved areas of the state if the capacity of CHEWs can be developed to provide those services in quality manner. The National Task-shifting and Task-sharing Policy of 2014 stipulates that CHEWs can provide injectables, IUDs and implant.

Lagos State MoH also recognises the need for greater advocacy in support of FP. International development partners constitute a major advocacy block in Lagos State and have been instrumental to the advancement of the FP agenda in the state. While civil society organisations (CSOs) constitute a potential powerful advocacy group, only a few local CSOs have a strong FP

focus: substantial opportunities to raise FP champions from this sector exists. Currently, Pathfinder International, with support from the Advance Family Planning programme of the Johns Hopkins Bloomberg School of Public Health, is implementing an advocacy programme in Lagos State. The programme, which is still in its early phase, specifically focuses on raising family planning champions. The programme holds promise and is receiving strong collaboration from the MoH. In addition, the wife of the State Governor, Dame Abimbola Fashola, is readily recognised and applauded as a FP champion with particularly strong interest in demand creation issues. There is the need to direct more efforts to raising champions among the political class, leading religious figures and other highly influential citizens who will likely be able to impact the state FP more than health professionals and technocrats. Together, the international development partners, CSOs and women advocate groups, and individual FP champions constitute key influencing levers for FP policy/regulation in Lagos State.

Private sector involvement, operations and regulations

Broadly, Lagos State government shows high interest in private sector involvement in its development agenda. Among others, the state has clearly defined policies and legislation regarding public-private partnership (PPP) – the Lagos State PPP Law of 2011. The government has also established The Office of PPP as an entity within the Office of the Executive Governor and is accountable to the Executive Council. Within the health sector, the government and its partners have used the PPP arrangement in areas such as improving infrastructure and the operations of laboratories and mortuaries.

In the area of FP, there is a harmonious relationship between the government and the private sector but the overall involvement of the private sector in FP service delivery in Lagos State is not satisfactory. In a study carried out by the USAID-supported Strengthening Health Outcomes through the Private Sector (SHOPS) project, only 55% of private facilities (excluding community

pharmacies) were reported as offering FP services and the median monthly client load for each method is very low – five IUDs, four Depo Provera, two Noristerat, and one combined oral pill . Among those offering the services, only 22% offer hormonal implants while vasectomy is offered by 13% and tubal ligation by 24%. The two most common reasons cited for not offering family planning services were lack of demand (mentioned by 25% of facilities that are not offering FP) and lack of family planning knowledge or skills (mentioned by 25% of facilities). Although only 2% of facilities not offering FP mentioned the non-profitability of the service as their main reason in the SHOPS' study15, that reason featured very prominently in interviews conducted with various stakeholders in Lagos during this consultancy.

There are presently pockets of activities targeted at improving private sector involvement in FP service delivery, mainly initiated by international NGOs and bilateral agencies but with strong support of the state MoH. The most prominent of these is led by the SHOPS Project, include training of private sector health workers in family planning service delivery, supply of seed stock and linkage of facilities with a private sector source from which future stock can be purchased at a subsidized rate (through Planned Parenthood Federation of Nigeria and Society for Family Health). Some stakeholders consider the free FP policy in public sector facilities as likely to serve as a further disincentive for private sector FP services, particularly as it relates to patronage by financially disadvantaged individuals and communities. An ongoing initiative by SHOPS is currently examining the potential for operating the free FP service in the private sector in the state.

No barrier exists concerning private sector involvement from the side of the state government specifically. In general, apart from the standards specified by HEFAMAA for quality health services and for accreditation purposes such as the number of staff and facilities for each category of services, the main policies guiding the operation of FP services are those put in place nationally by federal agencies and which are upheld in the state. Some of the federal regulations and policies

could constitute some barriers to some dimensions of FP programme. For example, Patent and Proprietary Medicine Vendors (PPMVs) are restricted to stocking and supply of condoms and the resupply of oral contraceptives – based on the classification and regulations of National Agency for Food and Drug Administration and Control (NAFDAC) and the Pharmacists Council of Nigeria.

Another area where such restriction poses some challenge is in the area of advertisement of specific or branded FP products in the media, which is regulated by the provisions of both NAFDAC and the Advertising Practitioners Council of Nigeria (APCON). The Nigerian code of advertising practice stipulates that advertisement of branded contraceptives be restricted to night hours – from 8.00pm on radio and 10.00pm on television (but some organisations have been able to get those products mentioned on media at different periods of the day using the vehicle of edutainment such as radio drama). Some stakeholders also indicated some delays in the processing of registration of FP products with relevant authorities, and with clearing of imported FP products at the ports and obtaining duty waivers – which all have to do with federal agencies.

One of the key issues highlighted in the Nigeria Reproductive Health Commodity Security (RHCS) Strategic Plan, 2011-2015 (FMOH, 2012) is that of local production of contraceptive commodities. Specifically, objective 2 of the second component of the Strategic Plan is *"To ensure local production of contraceptive commodities in order to increase their availability".* The specific activities under that objective are: (i) Engage prospective local manufacturers of contraceptive commodities; and, (ii) Provide an enabling environment with policies that support local manufacturing of contraceptives (in response to critical barriers identified). While the Lagos State environment is conducive, conceptually, for local production of contraceptives and many people consider the idea of having such local companies as "noble and ideal", stakeholders are quite divided on the need for such initiative at present. Most stakeholders in the manufacturing and pharmaceutical sector consider the FP demand as rather low and the potential profit margin

unattractive to embark on setting up such production lines in the short- and possibly medium-term period. Others cite the issue of the competitiveness of such potential products (in terms of price, quality and client preference) with currently imported and highly subsidized products. Issues of getting the commitment of international development partners to support such an initiative, or fund even their social marketing are also pertinent.

Stakeholders in support of the idea of local FP production see a potential for using the products of such companies to meet local needs, thereby avoiding port-related issues and reducing lead times, as well as improving commodity availability and security. The recent WHO-certification of some drug production facilities and the success in the production of Zinc for childhood diarrhoea are viewed as encouraging signs for future local contraceptive companies. Overall, significant challenges exist with regards to local production of contraceptive in the short- and medium-tem, and will take a course of sustainable, bold and complementary actions among various stakeholders to make such a reality, including government regulations and incentives (such as tax relief, basic protection and financial guarantees to local producers).

The proposed Lagos integrated supply chain PPP, which is to cover essential life-saving commodities, present an emerging opportunity for greater private sector involvement in the FP activities and the health sector in the state. Training of health workers (including CHEWS and Community Resource Persons as well as formal health workers) and supply of FP logistics are two key areas for strengthening FP collaboration between public and non-government stakeholders (including private-for-profit, NGOs, and development partners). The current classification of health facilities and organisational approach, where a number of private health facilities are recognized as Basic Emergency Obstetric Care Facilities and some as Comprehensive Emergency Obstetric Facilities alongside public health facilities, provide opportunity for greater collaboration in community-based FP services and outreaches.

Coordination mechanisms

Lagos State has a well-defined coordination mechanism for donor-supported activities and for family planning programming. The Lagos State Health Sectors Partners' Development Forum (HSPDF) was established in 2011 as a coordination platform for partners' in the health sector (Lagos State MoH, 2011a). Its structure includes a General Assembly with all development partners as members; the Steering/Executive Committee, which is responsible for the overall guidance of the HSPDF and provides leadership on broader health issues; and Thematic/Technical Working Group (TWG), through which the HSPDF largely executes its mandate. The various structures include private sector representatives, CSOs, professional associations and other relevant interest groups. The membership of the General Assembly, for example, includes five Medical Officers of Health, Association of General and Private Medical Practitioners, Association of General and Private Nurses, and professional groups as well as the Private Sector Alliance. The Private Sector Alliance is also a member of the Steering Committee. TWGs are charged with the technical oversight for various disease areas/health subsystems, and are generally structured around the key line departments of the State MoH, including a TWG on Family Health.

An Implementing Partners Forum has also been established, drawn from the TWGs, and headed by the Special Adviser to the Governor on Health to deal with matters that are not resolved at the TWG level. The Commissioner for Health chairs the HSPDF's General Assembly (which meets twice a year) and the Steering Committee (which meets quarterly and is co-chaired by a bilateral/multilateral agency on a rotating basis). Each TWG is constituted by institutional members of the HSDPF working in the area of focus, meets quarterly, and is chaired by a senior government official and co-chaired by representative of a development partner. The HSDPF is expected to have a secretariat, which is supposed to be under the Office of the Permanent Secretary of the

State MoH, but this has not been established, and is one of the challenges that the HSDPF experiences in its functioning.

Also, there is no vote allocated to the various meetings of the HSDPF by the State government, and the meeting therefore is held when a Development Partner is available to fund it. With the support of Partnership for Transforming Health Systems 2 (PATHS2) and some other partners, however, the meeting holds regularly. A sub-group on family planning has been established under the Family Health TWG in 2014. The State RH Coordinator and United Nations Population Fund (UNFPA)'s representative co-chair the sub-group. The FP subgroup review FP data consumption and is currently working towards the development of operational plans for FP. The State FP Coordinator holds a coordination meeting with the 20 LGA-based Family Planning Managers annually, and the group also meets during the two-monthly FP Review and Re-supply Meeting.

Overall, the existence of the various coordination mechanisms has contributed significantly to improvement in donors' coordination, relationship between development partners and the state government and its agencies, and effectiveness and efficiency in managing resources provided by development partners. Among others, mapping of donors has been undertaken, and there is now a better distribution of partners across the LGAs in the state, and harmonisation of plan of actions.

Budget and health financing

As presented in the MTSS, Lagos State government's budgetary allocations to the health sector though significant in absolute figures, when compared with other states, is much lower than the often-quoted benchmark of 15%. Significantly, the health budgetary allocation has been increasing in absolute terms and budgeted funds are often fully released. The health budget allocation was N26.2 billion in 2010 (6.38% of the total state budget), N35.8 billion in 2011 (7.95%), N37.3 billion in 2012 (7.57%). The report of the "Investment Case" launched by the Lagos state government in

2010 shows that an investment of 15 dollars per capita is needed annually for the health sector to achieve a reduction of 50% in the under-5 mortality, 33% in the maternal mortality ratio and also reduce the impact of HIV/AIDS, tuberculosis and malaria by year 2020. However, the per capita expenditure on health by the state government is $4 (MTSS).

Lagos State has the distinction of being the only state in Nigeria that funded FP distribution within its geographical boundary (from State to LGA and PHC facilities) in 2013 and 2014. The overall budgeted allocation for Reproductive Health in 2014 was N45 million and this was fully released. Among others, the fund catered for the FP review and resupply meetings and for service delivery training, with a special focus on LARC.

4.3 CONCLUSIONS AND RECOMMENDATIONS

4.3.1. Conclusions

This policy analysis showed that the Lagos State Government has demonstrated keen interest in and support for FP programme, and annually provides significant amount for it in its budget, and the allocations are usually fully released. Among others, the policy and regulatory environment in Lagos State is supportive of family planning, and permits the operation of various groups of stakeholders in the FP sector without any restrictive state-specific law or regulation. However, extant federal regulations that are operative in Lagos and all other states of Nigeria affect the advertisement of branded FP commodities on the media, as well as certain areas of contraceptive marketing and service delivery

Lagos state government maintains cordial relationships with the private sector and positively engage the private sector in its family planning and related health agenda. There is a well-

structured coordination mechanism for family planning activities in Lagos State, and private sector practitioners and groups are well represented in the coordination structure. The involvement of private-for-profit health service providers in FP service provision leaves some rooms for improvement in Lagos State. Against the background that most mothers (56.1%) in Lagos State deliver in private health facilities (NPC & ICF International, 2014), the utilisation of FP from FP sector is rather low. Among others, the proportion of mothers that deliver in private health facilities signals that a huge number of potential clients for postpartum FP services are available to that sector. Interestingly, a high proportion of private facilities has indicated desire to introduce FP services or additional products within the next 12 months. This intention provides a window of opportunity that government and development partners could take advantage of.

As the 2013 NDHS shows, only 17.6% of non-contracepting women of reproductive age (WRA) in Lagos State who visited a health facility within the 12 months preceding the survey had FP discussed with them. If effective family planning information and counselling are given to all women of reproductive age (WRA) and men of reproductive age (MRA) that had sought for care on any issue at a private facility, the statistics of FP message reach (and most likely uptake) would be dramatically different. Promoting greater involvement of the private sector should involve efforts to build the capacity of private health workers on quality FP service delivery, particularly LARC, which will improve the contraceptive rate and the couple-year protection considerably as well as have greater potential for reasonable financial rewards for their services.

In addition, there are other channels whereby FP service delivery and utilisation can be strengthened in Lagos State going by the pattern of the overall reproductive health service delivery and uptake, including the private and proprietary medicine vendors (PPMVs), traditional birth attendants, and community-based FP promotion and service delivery approaches. For example, chemist/patent medicine stores constituted the most common source for users of male condom

(58.3%) and pills (51.8%) in 2013. PPMVs are very well established across the length and breadth of Lagos State, particularly the rural areas, and provide health services to a high proportion of Nigerians who are underserved by the formal health system. However, PPMVs' involvement in FP services often receives little official government recognition, and attracts very little partnership from various development organisations. Consequently, PPMVs have generally had few training targeted at them, and the quality of their service may be doubtful (Ujuju et al., 2014; SFH & Global Health Group, 2015).

Extant policies limit PPMVs to motivation and counselling of FP clients, supply of barrier methods of contraceptives, and resupplying of oral pills (FHI 360, 2013). However, a high proportion of PPMVs stock other types of contraceptives beyond those permitted by extant regulations, including injectables; this practice often sets the PPMVs on collision course with relevant regulatory agencies. One of the interesting trends in the PPMV sector is that of their changing demographics with many young graduates joining the group in the face of unemployment. Many graduates of Pharmacy Technician Community Health Courses from Schools of Health Technology are also joining their fold; these categories may be able to offer more FP services than currently permitted by relevant regulations. Overall, PPMVs have good potentials for expanding the reach of the contraceptives approved for them, and their knowledge and capacity need to be built for quality services and referral linkages between them and the formal health system.

Evidently, community-based FP promotion and service delivery is weak in Lagos State. As the 2013 NDHS shows, 77.3% of non-contracepting women of reproductive age did not discuss FP either with a fieldworker or at a health facility. A combination of effective facility-based FP education and counselling and vigorous community-based FP promotion would change these statistics, and likely impact FP uptake significantly. In addition to government community-based services, outreaches (Marie Stopes International, 2014) and social marketing of FP by private

sector organizations (DKT, 2014), including CSOs and international NGOs will be important elements in the overall scheme of advancing FP agenda. As argued in a fairly recent Lancet article, “In a world that is increasingly urbanised and exposed to mass media, the potential contributions of social marketing will steadily rise and this mode of service delivery should be a routine component of overall family-planning provision” (Cleland, 2006). Social franchising has also been posited as a mechanism for improving private sector involvement and quality service delivery in FP (SFH, 2014).

While CBD, community outreaches and social marketing have potentials to address some of the challenges regarding FP services in underserved communities, they have limited impact on expanding LARC and offer no opportunities for surgical FP procedures. Outreach camps, which usually last 2-3 days in a specific location, have been used successfully in some East African countries to promote the insertion of IUD and implants and perform tubal ligation and vasectomy in underserved communities. Interestingly, outreach camps are not uncommon in Nigeria – organized by governments as well as non-governmental organisations – and are organized for a variety of surgical and non-surgical conditions. Also, mobile health clinics are organized to rural and underserved areas by Lagos State government as well as by faith-based organisations and other groups of stakeholders. However, health camps and mobile health services in Lagos State and other parts of Nigeria have included FP in only limited cases. In addition to the idea of organizing specifically designed integrated health outreaches, of which FP is at the center, outreach camps for FP can be integrated into the existing platforms.

While some FP advocacy efforts are ongoing in Lagos State, driven mostly by international development partners, there are gaps in these efforts and opportunity for strengthening current efforts exist. Overall, FP advocacy programmes and activities generally need to be improved in

terms of approach, content, and intensity in order to sustain the current momentum as well as gain new grounds in FP services.

4.3.2. Recommendations

A. Policy and Advocacy Issues at Federal Level

Role of VHW and CORPS in FP Service Delivery: The National Task-shifting and Task-sharing Policy of August 2014 represents a paradigm shift in FP service provision vis-à-vis the responsibility of CHEWs. However, the policy seems to have limited the role of Community Resource Persons/village health workers to the provision of education and counselling and promotion of dual protection (i.e. simultaneous protection against unwanted pregnancy as well as sexually transmitted infections using condoms), but not the actual provision of condoms. Secondly, the policy did not specify roles for various groups of health workers as regards oral contraceptive pills. These issues are certainly omissions, and should be addressed appropriately. Communication and advocacy to the Federal Ministry of Health would be needed in this respect.

The Role of Patent and Proprietary Medicine Vendors in FP Service Delivery: There is a need to re-examine the current provisions regarding FP services to be offered by PPMVs in the light of the changing demographics of practitioners, the global knowledge base and emerging discourse on viewing oral pills as over-the-counter drugs. In addition, issues regarding the additional training that PPMVs may need to improve the quality of current service delivery and to position them for a greater role in the provision of FP should receive focus. Relevant stakeholders to engage on this issue include the Federal Ministry of Health, the Pharmacists Council of Nigeria, the School of Health Technologies, and the National Association of Patent and Proprietary Medicine Dealers (NAPPMED).

Advertisement of FP products in the electronic media: The current regulation on FP products is unnecessarily restrictive and advocacy is needed to both NAFDAC and the Advertising Practitioners Council of Nigeria (APCON) on the issue.

National Product Supply Chain Management Programme: As part of the effort to ensure the security of the life-saving commodities for women and children, which also fits into the Saving One Million Lives initiative of the Federal Government, the Federal MoH is attempting to set up the National Product Supply Chain Management Programme (NPSCMP). There is need for greater advocacy for the effective take-off and operation of the programme.

B. Policy and Advocacy Issues at Lagos State Level

Sustaining Funding of Family Planning Programme and Improving Its Coverage: There is need for advocacy to ensure continued good funding for the FP programme in Lagos State and also for the establishment and operationalization of the proposed Lagos integrated chain PPP, which will improve life-saving commodity security (LASG, 2014; PATHS, 2014). In addition, advocacy efforts will be important to enable the state strengthen the coverage of its FP programme, particularly with community-based deployment of CHEWS and building the capacity of all FP service providers for improved services.

Capacity-building for Community Health Workers and other FP Providers: To take the full advantage of the policy that now permits CHEWs to administer injectables, IUD and implants, it is important to build the capacity of CHEWs to provide these contraceptives particularly as their initial training did not cover these materials. Lagos State needs to develop a detailed operational plan

for in-service training of the huge number of CHEWs in government employment as well as other CHEWs who may potentially play roles in community-based FP distribution or social marketing programmes. Strengthening the capacity of FP providers across board – including both public and private sector providers and all categories of health workers – is an important task, and advocacy to the government will be important in that respect.

Development of a Costed FP Strategic/Operational Plan: Lagos State needs to develop a costed FP strategic/operational plan that will provide a roadmap to the future, and also guide appropriate allocation of funds to FP services.

C. Under-utilised Delivery Channels for Family Planning that should be strengthened

Private Sector involvement: Promoting greater involvement of the private sector should involve efforts to build the capacity of health workers in the private sector on family planning services, particularly LARC, which will improve the contraceptive rate and the couple-year protection considerably as well as have greater potential for reasonable financial rewards for their services. One critical FP issue that needs to be vigorously promoted to private sector providers is postpartum family planning, considering the high proportion of deliveries that take place in the private sector. There is also the need to strengthen demand generation efforts so that the volume of FP clients for the private health facilities will also increase thereby, also making FP services more profitable.

Community-based FP outreaches and community-based FP distribution: community-based approaches, including community-based distribution of FP, need to be strengthened as part of the overall agenda of improving both FP demand generation and service coverage. The leadership of Lagos State PHC Board is quite keen on strengthening community-based health activities, including integrated outreaches that will involve FP; partnering with the Board for enhanced FP

coverage is very promising. Community-based approaches are particularly important in underserved communities such as rural areas and urban slums of Lagos State. In addition, they will also be important in settings with predominantly low-income informal workers and small-scale traders, who can ill-afford to leave their work to visit family planning clinics; such locations include motor parks and markets.

Private and Proprietary Medicine Vendors: PPMVs have good potentials for expanding the reach of the contraceptives approved for them, and their knowledge and capacity need to be built for quality services and referral linkages between them and the formal health system. It will be important to work with the National Association of Patent and Proprietary Medicine Dealers (NAPPMED) as most PPMVs are registered with this association and not with the required regulatory body (Pharmacists Council of Nigeria) or the Ministry of Health

D. New delivery channels to be explored for family planning service delivery

Traditional Birth Attendants: With the proportion of mothers that deliver with traditional birth attendants (TBAs), the strong trust of community women and leaders in them, TBAs have good potentials to serve as social and community mobilisers for FP, service dispensers for barrier methods, and educators on the importance of FP in maternal and child health. Thus, broadening the activities of TBAs to include FP promotion and services can be strategic to advancing FP particularly in rural communities and highly traditional settings. TBAs now have associations at various levels, and working with their associations as well as their supervisory bodies (such as the Lagos State Traditional Medicine Board) can pave the way for forming good and fruitful working partnerships with TBAs.

Developing Community Resource Persons for FP Services: The approach of "Community Resource Persons" (CORPs) has been used successfully in various areas of public health and in

settings in Nigeria and beyond. These areas include integrated management of childhood illnesses, malaria prevention and treatment, and mobilizing pregnant women to use health facilities for antenatal care and delivery. However, this promising approach has hardly been explored in any significant manner in the FP circle in Nigeria. Suitable persons, particularly trusted community members, can be trained and equipped to be CORPs – and can include TBAs. CORPS could also serve as FP champions in their various communities.

Outreach camps for long-acting and surgical methods of FP: Organisation of FP outreach camps that offer surgical as well as other forms of FP offers opportunity for improving the uptake of permanent as well as LARC, and provide support to other regular facility-based and community-oriented approaches. Lagos State, luckily, has an active mobile health unit that undertake a wide range of activities, including some surgical procedures. Outreach activities for FP (both surgical and non-surgical) should be integrated into the existing platforms of health camps and outreaches that take place in the state from time to time.

5. RESEARCH FINDINGS FOR KADUNA STATE

5.1 CHARACTERISTICS OF RESPONDENTS

In-depth interviews were conducted for the following groups of stakeholders: representatives of key partner organisations as well as other international development partners; FP-related policy makers and programme managers in relevant government ministries, departments and agencies; representatives of the private health sector, including private sector health workers and officials of civil society organisations. The list of interviewees is included as part of the appendixes.

5.2 FINDINGS

5.2.1. Context

Demographic and socioeconomic:

Located in the North West geo-political zone, Kaduna State is the twelfth largest state in Nigeria and accounts for about 5% of Nigeria's total landmass. According to the 2006 national census, the population of Kaduna State was 6,113,503 in 2006 (3,090,438 males and 3,023,065), making it the third most populous state in Nigeria (NPC, 2009). Using the 3% growth rate reported by the National Population Commission, the 2015-projected population for Kaduna State is 8,068,761. Of the 1,160,633 households in the state in 2006, 23,549 (2%) are nomadic households while 15,850 are institutional/census functionary households. Women of reproductive age (15-49 years) constitute 47.6% of females and 23.5% of the state population. The poverty level in Kaduna State, though lower than the zonal average, is high.

Women constitute about half the population of Kaduna state, and are recognised breadwinners of about three-quarters of rural population (KDSG, 2013). However, the level of women empowerment is low: in 2013, only 54.1% of women of reproductive age (WRA) reported making specific decisions either by themselves or jointly with their husband as regards their own health

care (NPC & ICF International, 2014). Furthermore, the proportion of WRA who participated in making the following three groups of decisions – the woman's own health care, making major household purchases, and visits to her family or relatives – either by themselves or jointly with their husbands was 41.9%, while 34.7% did not participate in making any of the three decisions (NPC & ICF International, 2014).

Kaduna is a highly pluralistic state and culturally very diverse with over 60 ethnic groups. In particular, there are distinct differences in religion, ethnicity, traditions and social norms between the predominantly Hausa/Moslem population in the northern part of the state and Christians of a variety of ethnic groups in the southern part. Kaduna town, the state capital, was the administrative and military capital of the defunct Northern Region and remains the unofficial political capital of the northern region. Hausa language is widely spoken across the state, and as true generally for northern Nigeria, traditional leaders have significant influence on the government and people in Kaduna. The state has 32 autonomous traditional institutions in the form of Emirate councils mostly in the northern part and chiefdoms, in the southern part.

The majority of the people in Kaduna State live in the urban and semi-urban centres including Kaduna, Zaria, Kafanchan, Kagoro, Zonkwa, Birnin Gwari, Makarfi and Zangon Kata. Almost all the industries in Kaduna State are located in Zaria and Kaduna, and nearly two million people live in the two towns. Agriculture is the main stay of the economy of the state. The majority of employed people are self-employed while the second largest employer is the private sector (27%), which is dominated by informal operators and small enterprises, while about 13% of the labour force works in the public sector (KDSG, 2013). Kaduna State has a high number of educational institutions and one of the highest number of tertiary institutions in the country including the Ahmadu Bello University Zaria, the National Institute of Transport Technology, Zaria, and the Civil Aviation

Training College, Zaria. Yet, only 51.8% of women and 77.8% of males aged 15-49 years and sampled in the 2013 NDHS were literate (NPC & ICF International, 2014).

Political system

Kaduna state has 23 Local Government Areas, which were restructured into 46 Development Areas in 2004 to facilitate increased development. Politically, Kaduna State is one of the most volatile states in Nigeria and has witnessed a number of violent community clashes over the years fuelled largely by political and/or religious factors. Since Nigeria's return to democratic governance in 1999, the same political party, which also is the ruling party at the federal level, has ruled the state. However, the main opposition party has, grown considerably in strength in the last few years and has a high chance of winning the next election.

Health system structure

Kaduna State, like the rest of Nigeria, has a pluralistic health care system, comprising a wide range of service providers – public, private-for-profit and not-for-profit including faith-based organisations. The health care providers are also very heterogeneous, varying from traditional birth attendants, medicine hawkers to specialists in teaching hospitals. Kaduna State has over 1,000 PHC facilities, 31 secondary care facilities, 656 private health facilities and 2,500 registered PPMVs. In addition, the state hosts five tertiary health facilities belonging to the federal government, and all based in Kaduna/Zaria: four of these provide specialised care, while the Ahmadu Bello University serves as the apex reference tertiary health care facility. There are also two hospitals belonging to the armed forces in Kaduna State. Furthermore, there are several health professions training institutions in the state, including eight Schools of Nursing, four Schools of Midwifery and two Schools of Health Technology in addition to the Ahmadu Bello University and Ahmadu Bello University Teaching Hospital's units and programmes for the development of human resources in health.

The state-owned General Hospitals have been categorized as either rural hospitals, general hospitals or specialist hospitals, with the range of services and skills available for service delivery improving as one moves from the rural to the specialist hospitals. The primary health care facilities are owned by LGAs and classified into health clinics and PHC Centers with the PHC Centers expected to provide the full complement of PHC services. The State MoH is responsible for the provision of secondary health care, development of human resources for health, and supporting and supervising the effective delivery of primary health care. Excluding PPMVs, the private sector constitutes 40.2% of health facilities in the state, and the majority of them provide primary care (Kaduna State MoH, 2011).

The goal of the state health sector is to ensure that all citizens of Kaduna state have quick and easy access to improved and affordable curative, preventive, rehabilitative and promotive health services. The state health policy thrust centres on reducing the level of mortality and the prevalence rates of HIV/AIDS and other key preventable diseases through PHC delivery services targeting the most vulnerable groups of the society, including pregnant women and children under five years (Kaduna State MoH, 2011). The State Government has initiated a number of pro-poor programmes including Free Maternal and Child Health (MCH) services. Fee for service at point of service delivery is the dominant method of financing health care services in the state. However, with the introduction of free MCH programme, a total of 115 public PHCs and 28 secondary health facilities provide some components of MCH care and services free of charge. In addition, through the Sustainable Drug Supply Programme, drug revolving funds have been revamped in 55 facilities in an effort to ensure availability of drugs in public primary and secondary health facilities (Kaduna State MoH, 2011). The government plans to increase the number of facilities involved in the free MCH programme.

Family planning indicators

The total wanted fertility for Kaduna State is 3.8, while the total fertility rate is 4.1 and the mean ideal number of children for all women age 15-49 years is 4.17. Kaduna State also has a high rate of adolescent childbearing, with the proportion of adolescent girls (15-19 years) that have begun childbearing, according to 2013 NDHS, as 33.2% (20.9% have had a live birth while 12.2% are pregnant with their first child) (NPC & ICF International, 2014). The contraceptive prevalence rate (CPR) for all FP methods is 20.2% and 18.5% for modern methods (mCPR). The percentage of married women using LARC is just 3.8%, which is about 20% of married women using modern FP methods. The total FP demand among married women in Kaduna is only 25.9%; however, 71.3% of that need is met by modern methods. The unmet contraceptive need level is 5.8% for married women and 5.5% for all women of reproductive age (aged 15-49 years). In general, FP indicators are worse for those in the lower economic and educational groups, rural-based women, and young people. In a 2012 survey, only 70% of FP service delivery points were found to have modern contraceptive in stock at the time of the survey (Johnson et al, 2014). Poor attitudes to and myths about FP most likely play a major role in the low contraceptive rate: as a 2013 survey showed, most women of reproductive age (54.9%) and men of reproductive age (53.3%) were of the opinion that those who use FP end up with health problems (Measurement, Learning & Evaluation & NPC, 2013).

Table 2: Kaduna State: Select Family Planning indicators

	All women	Married women
% of women using contraceptives		
All methods	20.9	20.2
Modern methods	19.4	18.5
Long acting methods	4.0	4.8
Total unmet need	5.5	5.8
Unmet need for Limiting	1.2	1.6
Unmet need for Spacing	4.3	4.2
Total demand for contraceptives	26.3	25.9
% Demand satisfied	79.2	77.7
% Demand satisfied by modern method	73.8	71.3

Source: NPC & ICF International, 2014

5.2.2. Diagnostic

Government FP stewardship and upcoming elections

The Kaduna State Government has shown some commitment to FP particularly in creating an enabling environment for development partners working in the area of FP to operate, but significant challenge exists in terms of the budgetary input of the government itself into the FP programme. In the discharge of its stewardship responsibilities, the state government, in the past few years has initiated a number of policies and legislation with positive bearings on FP activities. These include the Kaduna Essential Service Package and Systems Policy (KESSP), which defines the minimum human resources, equipment needed and services to be rendered by each category of public health facility while the Sustainable Drug Supply Policy aims at ensuring availability of good quality drugs in all public health facilities in the state. The State Primary Health Agency has also been established although it is just finding its feet.

The operationalization of these laudable policies has, however, not been optimal; this presents an opportunity in that future government and partners can work towards strengthening the implementation of these and related policies. In addition, two draft bills presently under consideration – the draft Free MCH Bill and the PHC Under one Roof Bill – have potentials to also contribute to improved FP programming and will provide strong legal framework and support. In addition, the integrated supportive supervision being implemented in over 200 facilities by the MoH. The community health volunteers' project being supported by PATHS2 in six LGAs to track pregnant women and mothers to improve health care utilisation and childhood immunisation also offers some opportunities for improved stewardship of FP activities.

While the political terrain of Kaduna remains unpredictable vis-à-vis the upcoming election, it seems unlikely that there will be a reversal of government effort in the area of FP and related MCH

agenda judging from the opinions of stakeholders, the continued challenge of MCH burden, and the analysis of historical trends of development work in the state. The availability of written policy and related legislations that could support FP activities is also reassuring in this regard.

Policy and regulation and their implementation

Having a "healthier and more educated population" is one of the four pillars of the Kaduna State Development Plan 2015-2018 (KDSG, 2013). The Results and Performance Measurement Framework for the Plan specifies reduction in maternal, infant and under-five mortality rates as well as reducing HIV prevalence as some of the key performance indicators. These goals and the indicators present stakeholders in the FP sector a potential rallying point and platform to proactively engage the government for greater investment in FP programmes.

Kaduna State also has a number of other relevant policy documents, including:

- Kaduna State Strategic Health Development Plan (2010-2015): based on the framework and thematic areas developed at the federal level, the SSHDP outlines key priority health actions for the state, and FP is recognised as one of the essential individual/clinical oriented as well as population-oriented high impact services
- Kaduna State Maternal Newborn and Child Health Strategic Plan (2012-2015)
- Kaduna state and LGAs Annual Operational Plan: Family planning plan activities at state and LGA level are prioritised in these plans
- Kaduna State Human Resource for Health Policy (2011 -2020): this makes provision for recruitment and training of skilled health workers to provide certain services, including FP
- Kaduna State Essential Drug List 2014 – the document stipulates the FP commodities expected to be use in various health facilities, pharmacist shops and other health outlets.

- Essential Service Package and Systems Policy (2008): A costed plan that aims to domesticate the Minimum Health Care Package of the National Primary Health Care Development Agency.
- State PHCDA Act - aims to strengthen the coordination and management of PHC across the state

The state has also developed a Medium Term Sector Strategy. A review of the MTSS, however, shows variances between the MTSS costs and the approved budget for MoH (SPARC, 2014).

Kaduna State does not have a state specific policy for the FP programme but efforts to develop a costed FP strategic/operational plan were initiated in January 2015 with support from Futures Group – this represents an opportunity that future players can buy into. Kaduna State has no budget line for the FP programme at the state level (but has for the free MCH programme), and any funding of FP activities is from the State MoH recurrent budget. The State government and the MoH have not been providing funds for distribution of contraceptives within the state (from State level to LGA level and facilities).

So far the Contraceptive Review and Resupply Meeting, which holds every two month and provides the platform for distributing FP commodities to the LGA focal person, has been fully funded by UNFPA over the last two years. Yet, the distribution of the commodities to facilities from LGA level has been very problematic as funds are not provided by the state government or LGAs for that purpose, and it is left for individual family planning service providers to find the funds and means to get FP commodities to the facility. In addition, the cost of consumables (such as cotton wool and injection for administration of injectables) are not borne by the government. As such, the health workers end up passing the associated costs to the client, and these constitute part of the hidden costs (alongside personal gains embedded by service providers) of the otherwise government's pronounced free FP policy in public sector facilities . Without quick and concerted

action, contraceptive security issue will likely worsen in the immediate future as UNFPA has indicated its discontinuation of funding of the Review and Resupply meeting.

The state government fully subscribes to the task-shifting and task-sharing policy that now permits CHEWs to administer injectables: this policy particularly favours the state (and other northern states) as a high proportion of the health facilities in the state are manned by CHEWs. However, there will be the need to build the capacity of CHEWs to deliver these services safely, satisfactory and in a quality manner.

The MoH duly recognizes the need to address various myths that are pervasive in the state through community-based interventions that are culturally sensitive and responsive to the needs of the various population segments. Among others, FP providers have identified that the notion of "child spacing" is more acceptable to the majority of people in Kaduna State compared to the language and notion of "family planning" as the former accords with their traditional values as well as religious beliefs. Stakeholders had also identified the need to raise advocates and champions to address specific FP issues in the state, and the potential of religious and traditional rulers as key influencers are well noted. For this reason, the MNCH and advocacy groups strategically have representatives of traditional rulers and religious leaders as members.

The Nigeria Urban Reproductive Health Initiative (NURHI) project has particularly done a lot of work in Kaduna State regarding strengthening FP advocacy efforts. Among others, NURHI facilitated the formation of Advocacy Core Groups, comprising of various key stakeholders, including community members, state FP coordinators and LGA FP supervisors, and CSO operatives. Furthermore, NURHI built up the capacity of the members in terms of advocacy skills and FP messaging to enable them to become pro-active frontrunners in driving policy change and

actions for improved access to FP. The Advocacy Core Group has now transformed to a civil society organisation, the Initiative for Social Sector Advocacy (ISSA).

Private sector involvement, operations and regulations

Kaduna State government has shown significant interest in working with different stakeholders in its family planning and related health agenda, including development agencies and the private sector, and has created a conducive environment for their operations. Among others, the MoH collaborates with religious organisations and their health institutions/programmes, professional groups, and private-for-profit health institutions. A high proportion of private sector facilities in Kaduna State – 81% of the facilities excluding community pharmacies – offer family planning services, but the median monthly client load is low (10) (Johnson et al, 2014). While almost all the facilities provide injectable contraceptives (95%), only 63% offer combined oral pills, 23% offer hormonal implants while tubal ligation is offered by 22% and vasectomy by 6%. Low demand is a major deterrent to the provision of the FP services.

The MoH and the State government, as a whole, has shown significant interest in PPP. The MoH has established a desk for PPP in the Directorate for Planning, and is expected to develop a PPP operational plan. The government has also established a PPP office under the office of the State Governor. The state health sector has witnessed some specific initiatives regarding private sector involvement in FP. One of them is the signing of Memorandum of Agreement (MoA) between the MoH and 10 selected private-for-profit health institutions, facilitated by PATHS2. The initiative involved the supply of some equipment and drugs relating to Emergency Obstetric Care to the facilities to improve their quality of service and coverage, with the understanding that the facilities will initiate appropriate pro-poor pricing system whereby services are provided at reduced or no cost to poor people who are identified based on pre-stated criteria. SHOPS project is also working with some private providers in Kaduna State.

The actions and policies of Kaduna State government and its agencies have posed no barrier to the activities of private sector operatives in the FP arena in the state. But, as is true for Lagos State, there are regulations by federal agencies on issues ranging from stocking and administration of various contraceptives, to advertisement and registration of products, custom inspection of imported contraceptives and clearing at the port, as well as obtaining duty waivers. Similarly, the arguments canvassed in the case of the potential for local production of contraceptive commodities in Lagos State holds true for Kaduna State.

Coordination mechanisms

A donor collaboration mechanism exists but not specifically for family planning, although the platform also discusses family planning programme, MCH and other project activities. The meeting and functionality of the group had been mostly donor-driven and completely dependent on the funding by development partners. Maternal, Newborn and Child Health (MNCH) Coordination Meeting holds periodically, and many of the activities revolve around the MNCH week: the meeting involves many development partners that are involved in FP activities,

There is no structured meeting of FP coordinators at state level but the coordinators use the opportunity of the regular contraceptive review and re-supply meetings to come together and deliberate on programme implementation and service delivery issues. This meeting has yielded a number of benefits, including an increase in the number of facilities participating in the FP cluster distribution system, reduction in FP stock-outs, and improved competence of FP officers to correctly complete the statutory forms for FP supply and reporting. There is also no coordination meeting in the State that involves private sector FP providers; however, the MoH endeavours to involve many groups of stakeholders in its activities, including professional groups such as the Nigerian Association of Nurses and Midwives and the Association of Community Pharmacists.

Budget and health financing

Kaduna State has gradually increased its funding of the heath sector in absolute terms between 2007 and 2012, from ₦6.7 million to ₦11.2 million. However, in terms of the proportion of the state budget allocated to the health sector, the percentage has remained almost stable but below the 15% benchmark. The proportion of the state budget allocated to the health sector was 12% in 2010, 8-10% subsequently, and 11% in 2015. About two-thirds of the allocation to the health sector is for recurrent costs (Kaduna State MoH, 2011).

There is poor funding for family planning activities at both state and LGA levels. As indicated earlier, there is no budget line for family planning at state level and the funding of any family planning activities is from the grossly inadequate MoH recurrent budget. As a stakeholder indicated, the MoH even finds it difficult to provide the ₦15,000 - ₦20,000 required to pay casual workers to off-load contraceptives brought from the federal level to the state store! The MoH has also not provided funding for any supervisory visits to facilities and for training in FP service delivery for several years – the only activities carried out in these areas in recent years were all donor-funded. Overall, FP funding in Kaduna State is heavily donor-dependent. On the other hand, there is a budget line for the government's Free MCH services, and that is expected to integrate FP, but in practice, that is not the case. For the LGAs, the Ministry for Local Government approve budget as to the amount to be spent on family planning programmes each year. Between 2012 and 2015, the Ministry's allocation for FP for each LGA is as follows: 2012 – ₦500,000; 2013 – ₦1,000,000; 2014 – ₦1,000,000; and, 2015 – ₦2,000,000. Only one LGA was reported to have released the funds allocated, and that was in 2012.

From 2014, Kaduna State initiated the use of a new accounting system – the International Public Sector Accounting System (IPSAS). This system does not allow budgeting per programme head,

but rather uses some standard heads that cut across various programmes such as personnel and travel. This new system may make it difficult to track government funding for FP in the future.

5.3 CONCLUSIONS AND RECOMMENDATIONS

4.3.1. Conclusions

Kaduna State government has shown significant interest in working with different stakeholders in its family planning and related health agenda, including development agencies and the private sector, and has created a conducive environment for their operations. Among others, the MoH collaborates with religious organisations and other non-for profit groups, private-for-profit health institutions, and professional groups. However, the government has not created budget line for FP activities but some funds that could support some FP activities exist under the free MCH programme budget. Overall, the government funding of FP at both state and LGA levels have been quite poor. In addition, there is no structured meeting of FP coordinators at state level but the coordinators use the opportunity of the regular contraceptive review and re-supply meetings to come together and deliberate on programme implementation and service delivery issues

The actions and policies of Kaduna State government and its agencies have posed no specific barrier to the activities of private sector operatives in the FP arena in the state. But, as it is true for Lagos State, there are regulations by federal agencies on issues ranging from stocking and administration of various contraceptives, to advertisement and registration of products that pose as barriers to contraceptive advertisement, marketing, and access.

While a high proportion of private sector facilities in Kaduna State offer FP services, less than a quarter offer LARC (Johnson et al, 2014). The available data, showing that only 6.1% of non-contracepting women of reproductive age (WRA) in Kaduna State who visited a health facility

within the 12 months preceding the survey had FP discussed with them (NPC & ICF International, 2014), This indicates that considerable gap exists in term of FP promotion even by facility-based health workers. Poor attitudes to, and myths about FP constitute major barriers to contraceptive uptake about FP. There is also a degree of suspicion about the family planning agenda, particularly at the grassroots: consequently, stakeholders generally favour the idea of promoting "child spacing" (rather than the use of the term, "family planning"). The low level of women empowerment, including limited opportunity to participate in decision-making about their own health care, is also contributory. Males, traditional and religious leaders hold important position in the scheme of things, including health issues in Kaduna State, and should be considered as important stakeholders in the FP agenda.

Other existing and potential channels for promoting need to be strengthened in Kaduna State, including TBAs as more than two-thirds of the mothers (67.5%) in the state deliver at home. PPMVs are well established across the state and well patronised, particularly in the rural areas. However, PPMVs and their association have been involved in a long-drawn legal battle with the State Ministry of Health, and this limits their participation in the government health agenda. Opportunities for resolving existing disputes and forging new relations as well as capacity development initiatives are needed to strengthen PPMV's involvement in FP services in the state and improve the quality of services they provide. As argued earlier, current regulation limiting PPMVs to supplying condoms and resupplying of oral pills deserves to be critically reviewed on the basis of current evidence.

Clearly, community-based FP promotion and service delivery activities are weak in Kaduna State. As the 2013 NDHS shows, 91.1% of non-contracepting women of reproductive age did not discuss FP either with a fieldworker or at a health facility (NPC & ICF International, 2014). A combination of effective facility-based FP education and counselling and vigorous community-based FP promotion

are therefore important to improve FP uptake significantly. In addition to government community-based services, outreach and social marketing of FP by private sector organisations including CSOs and international NGOs are also important.

While community outreaches and social marketing have potentials to address some of the challenges regarding FP services in underserved communities, they have limited impact on expanding LARC and offer no opportunities for surgical FP procedures. Outreach camps, which usually last 2-3 days in a specific location, have been used successfully in some East African countries to promote the insertion of IUD and implants and perform tubal ligation and vasectomy in underserved communities. Interestingly, outreach camps are not uncommon in Nigeria – organized by governments as well as non-governmental organisations – and are organized for a variety of surgical and non-surgical conditions. Also, mobile health clinics are organized to rural and underserved areas by Kaduna State government as well as by faith-based organisations and other groups of stakeholders. However, these health camps and mobile health services generally exclude FP. In Kaduna State, it will be best to organise the FP outreach camp as part of integrated health camp/outreaches rather than stand-alone camps in view of the sensitivity of FP in the environment.

While considerable FP advocacy efforts are taking place in Kaduna State with international development partners as well as civil society organisations playing major roles, there are still considerable work to do given the poor funding support of the government to FP issue, and poor acceptance of the FP agenda by many stakeholders, including some religious leaders. Thus, FP advocacy efforts needs considerably strengthening in Kaduna State.

4.3.2. Recommendations

A. Policy and Advocacy Issues at Federal Level

Role of VHW and CORPS in FP Service Delivery: The National Task-shifting and Task-sharing Policy of August 2014 represents a paradigm shift in FP service provision *vis-à-vis* the responsibility of CHEWs. However, the policy seems to have limited the role of Community Resource Persons/village health workers to the provision of education and counselling and promotion of dual protection (i.e. simultaneous protection against unwanted pregnancy as well as sexually transmitted infections using condoms), but not the actual provision of condoms. Secondly, the policy did not specify roles for various groups of health workers as regards oral contraceptive pills. These issues are certainly omissions that need to be appropriately addressed. Communication and advocacy to the Federal Ministry of Health leadership and relevant would be needed in this respect.

The Role of Patent and Proprietary Medicine Vendors in FP Service Delivery: There is a need to re-examine the current provisions regarding FP services to be offered by PPMVs in the light of the changing demographics of practitioners, the global knowledge base and emerging discourse on viewing oral pills as over-the-counter drugs. In addition, issues regarding the additional training that PPMVs may need to improve the quality of current service delivery and to position them for a greater role in the provision of FP should receive focus. Relevant stakeholders to engage on this issue include the Federal Ministry of Health, the Pharmacists Council of Nigeria, the School of Health Technologies, and the National Association of Patent and Proprietary Medicine Dealers (NAPPMED).

Advertisement of FP products in the electronic media: The current regulation on FP products is unnecessarily restrictive and advocacy is needed to both NAFDAC and the Advertising Practitioners Council of Nigeria (APCON) on the issue.

National Product Supply Chain Management Programme: As part of the effort to ensure the security of the life-saving commodities for women and children, which also fits into the Saving One Million Lives initiative of the Federal Government (Jonathan & Stoltenberg, 2013; FMOH, 2013), the Federal MoH is attempting to set up the National Product Supply Chain Management Programme (NPSCMP). There is need for greater advocacy for the effective take-off and operation of the programme.

B. Policy and Advocacy Issues at Kaduna State Level

Improved Funding of Family Planning Programme and Improving Its Coverage: There is the need for improved and adequate funding of FP at both the state and LGA level. In order to improve the coverage of services, there is also the need for advocacy for the effective funding and full operationalization of the State Primary Health Care Board and the "Primary Health care under One Roof" agenda.

Capacity-building for Community Health Workers and other FP Providers: To take the full advantage of the policy that now permits CHEWs to administer injectables, IUD and implants, it is important to build the capacity of CHEWs to provide these contraceptives particularly as their initial pre-service training did not cover these materials. Kaduna State needs to develop a detailed operational plan for in-service training of the huge number of CHEWs in government employment as well as other CHEWs who may potentially play roles in community-based FP distribution or social marketing programmes. Strengthening the capacity of FP providers across board – including both public and private sector providers and all categories of health workers – is an important task, and advocacy to the government will be important in that respect.

Development of a Costed FP Strategic/Operational Plan: Kaduna State needs to finalise the development of its costed FP strategic/operational plan, and to operationalise it with fidelity when completed to ensure effective implementation of the state family planning agenda.

C. Under-utilised Delivery Channels for Family Planning that should be strengthened

Private Sector involvement: Promoting greater involvement of the private sector should involve efforts to build the capacity of health workers in the private sector on family planning services, particularly LARC, which will improve the contraceptive rate and the couple-years of protection considerably as well as have greater potential for reasonable financial rewards for their services. One critical FP issue that needs to be vigorously promoted within the private sector is postpartum family planning, considering the high proportion of deliveries that take place in the private sector. There is also the need to strengthen demand generation efforts so that the volume of FP clients for the private health facilities will also increase, thereby also making FP services more profitable.

Community-based FP outreaches and community-based FP distribution: community-based approaches, including community-based distribution of FP, need to be strengthened as part of the overall agenda of improving both FP demand generation and service coverage. Kaduna State PHC Board, though in its early stages, provides a promising platform for advancing and strengthening the community-based FP agenda as it plans to operationalise the "PHC under one roof" agenda as well as community outreach approaches. Community-based approaches are particularly important in underserved communities such as rural areas.

Private and Proprietary Medicine Vendors: PPMVs are widespread all over Kaduna State and have good potentials for expanding the reach of the contraceptives approved for them. There is the need, however, to establish and strengthen partnership between the MoH and the National Association of Patent and Proprietary Medicine Dealers (NAPPMED). There is need to train

PPMVs in order to improve their knowledge and capacity for quality services, as well as strengthen referral linkages between them and the formal health system.

D. New delivery channels to be explored for family planning service delivery

Traditional Birth Attendants: With the high level of home deliveries in Kaduna State, TBAs have good potentials to offer FP counselling and relevant services. They can serve as social and community mobilisers for FP, service providers for barrier methods, and educators on the importance of FP in maternal and child health issues. Overall, broadening the activities of TBAs to include FP promotion and services can be strategic to advancing FP particularly in rural communities and highly traditional settings.

Developing Community Resource Persons for FP Services: The approach of "Community Resource Persons" (CORPs) has been used successfully in various areas of public health in settings in Nigeria and beyond. These areas include integrated management of childhood illnesses, malaria prevention and treatment, and mobilising pregnant women to use health facilities for antenatal care and delivery. However, this promising approach has not been explored in any significant manner in the FP circle in Nigeria. Suitable persons, particularly trusted community members, can be trained and equipped to be CORPs – and can include TBAs. CORPS could also serve as FP champions in their various communities. The community health volunteers trained with the support of PATHS2 and working in safe motherhood area such as the tracking of pregnant women to improve health care utilisation constitutes a good group to serve as CORPs. Males, religious leaders and traditional rulers particularly will have great potentials as CORPs in Kaduna State.

Male-targeted FP initiatives: The cultural and social dynamics make involvement of men critical to advancing the FP agenda in Nigeria, particularly in Kaduna and other northern states. With men's

traditional role as family and community leaders as well as religious leaders remaining consistent and prominent in Kaduna State setting, there is the need to revive and intensify programmes to promote male involvement in FP, male acceptance and use of FP products, as well as male recruitment and positioning as FP champions. A multi-media communication intervention as well as interpersonal and community-based approaches will be needed, and careful targeting of various groups are needed. Programmes to attract and develop traditional and religious leaders as FP champions is especially called for in Kaduna State, given the socio-cultural landscape.

Outreach camps for long-acting and surgical methods of FP: Organisation of FP outreach camps that offer surgical as well as other forms of FP offers opportunity for improving the uptake of permanent as well as LARC, and provide support to other regular facility-based and community-oriented approaches. Integrated health camps with strong FP component will likely be useful in Kaduna State.

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