Lagos State
Ministry of Health

Lagos State Family Planning Costed Implementation Plan, 2016–2018

March 2016

Suggested citation: Lagos State Ministry of Health. 2016. *Lagos State Family Planning Costed Implementation Plan, 2016–2018*.

Contact:
Lagos State Ministry of Health
The Secretariat
Alausa, Ikeja
Lagos, Nigeria
http://www.lsmoh.com

Lagos State Family Planning Costed Implementation Plan, 2016-2018

March 2016

Table of Contents

FOREWARD **5**

PREFACE **6**

ACKNOWLEDGEMENTS AND CONTRIBUTORS **8**

ABBREVIATIONS **100**

SECTION I: INTRODUCTION **111**

1.1 Nigerian Context 111

1.2 Lagos State Context 12

1.3 Lagos State Family Planning Landscape 14

1.3.1 Service Delivery *15*

1.3.2 Supplies and Commodities *166*

1.3.3 Demand Generation and Behaviour Change Communication *16*

1.3.4 Regulation and Policy *188*

1.3.5 Financing *18*

1.3.6 Supervision, Monitoring, and Coordination *19*

Section 2: Integrated Family Planning Plan **20**

2.1 Goal 20

2.2. Strategic Priorities 20

2.3 Structure of the CIP 20

2.3.1 Demand generation and behaviour change communication (DBC) *21*

2.3.2 Service delivery (SD) *23*

2.3.3 Supplies and commodities (SC) *24*

2.3.4 Policy and environment (PE) *25*

2.3.5 Financing *26*

2.3.6 Supervision, monitoring, and coordination (SMC) *27*

Section 3: Costing **28**

3.1 Assumptions 28

3.2 Cost Summary 28

Section 4: Projected method mix **31**

Section 5: The path forward **33**

5.1 Resource Mobilisation 33

5.2 Ensuring Progress through Performance Management 33

Annex A: Monitoring and Evaluation Summary Table **35**

Annex B: Activity Matrix **38**

FOREWARD

Family Planning has been proven to reduce maternal mortality by 32% and as such qualifies as an important intervention essential for improving the quality of life of women. Nigeria's commitment towards the scaling-up of the uptake of family planning (FP) services in the country is a right step in the right direction.

Following up on the national commitment at the 2012 London Summit on Family Planning, Lagos State Ministry of Health (LSMOH) domesticated the Nigeria Family Planning Blueprint (scale-up plan) to address the peculiarities of the state.

The Nigeria Family Planning Blueprint which essentially contains a 5 year work plan (2014-2018) intends to guide family planning programming and high level commitment through adequate resource allocation is aimed at increasing the national contraceptive prevalence rate (CPR) from the current 15% (NDHS 2014) to 36% by year 2018. Lagos State has been identified as an important source for achieving the national target being the most populous and with proactive governance.

Lagos State with a current CPR of 38% is committed towards achieving the CPR target of 74% target by 2018. Though the target seems a little ambitious in view of the obvious challenges facing the state, the state is poised towards the use of phased result-oriented strategies including the effective engagement of stakeholders at the community level.

This document has been made possible with the financial support of the Bill and Melinda Gates Foundation through Palladium.

The developed Lagos State Family Planning Costed Implementation Plan (2016-2018), will no doubt provide the state with the needed roadmap towards the achievement of the set CPR target of 74% by 2018.

In recognition of the huge expectations and tasks required to accomplish this target, I wish to advocate for the continuous collaboration and support of the various development partners by aligning and designing relevant programs with the developed blueprint.

In conclusion, the efforts and contributions of the various stakeholders in articulating the processes involved in the development of the Lagos State Costed Implementation Plan (2016-2018) is highly acknowledged.

Dr. Olajide Idris

Honourable Commissioner

Ministry of Health

22nd March, 2016

PREFACE

During the 2012 London Summit on Family Planning, Nigeria committed to increasing total contraceptive prevalence rate (CPR) for married women by 2 percent annually to reach an overall CPR of 36 percent by 2018. To realize this commitment, the Nigeria Federal Ministry of Health (FMOH) developed the Nigeria Family Planning Blueprint (scale-up plan), a five-year costed implementation plan that outlines the concrete, detailed programme activities and associated costs and resources required to implement a comprehensive national family planning programme.

The Nigeria Family Planning Blueprint details specific family planning targets for each state to achieve over the five-year period. If each state reaches their share of the blueprint, the country will achieve the national commitment of 36 percent CPR by 2018. Lagos State must increase the overall CPR for married women from 48 percent[1] to 74 percent by 2018 in order to fulfil the state's share of the National Blueprint goal.

Family Planning in Lagos State

The current total CPR (2013) is 48% for married women and the modern CPR is 26% for all married women of reproductive age; there has been a decline in contraceptive use of about 1 percentage point since 2008.

The goal is to increase CPR for all married women to 74% by 2018; this target for Lagos State was announced at the launch of the National Blueprint (2014).

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

Approximately US$91 million is needed to achieve the FP goals in Lagos State.

103,000 child lives and 8,000 maternal lives will be saved by achieving the CPR goal.

The Lagos State Family Planning Costed Implementation Plan (CIP) was developed to guide the state towards meeting the Lagos-specific targets set within the national blueprint. The CIP was developed under the guidance and oversight of the Lagos State Ministry of Health (LSMOH), with support from donors and implementing partners. Consultants from the Nigeria Costed Implementation Plan Technical Support Unit, implemented by Palladium and funded by the Bill & Melinda Gates Foundation (BMGF), worked under the direction of the LSMOH's family planning (FP) unit to define the priorities, activities, and associated costs required to reach the FP objectives of the state. Development of the plan was an iterative process that utilised programme landscaping and assessments to inform the development of family planning activities and costs in Lagos State from 2016 to 2018. The plan incorporates best practices and effective strategies in reproductive health (RH) and family planning to ensure high impact towards the overall objective of increasing CPR for married women to 74 percent by 2018.

Throughout the process, stakeholders have provided significant inputs to ensure that the Lagos State CIP represents the best interests of all women and citizenry of Lagos. The Lagos State CIP Committee, consisting of FP LSMOH officials, development partners, implementing partners, and advocates, advised the entire CIP development process.

The elements of the plan were informed by a comprehensive desk review of the family planning situation in Lagos State. In particular, the CIP builds upon findings from the Lagos State Family Planning Landscape Report funded by BMGF and completed by The Johns Hopkins Center for Communication Programs (CCP), Marie Stopes International Organization Nigeria (MSION), and DKT International Nigeria, The Lagos State Family Planning Situational Analysis led by United Nations Population Fund (UNFPA) consultants and The Performance Monitoring and Accountability (PMA)2014 report prepared under the PMA2020 project and funded by BMGF. The FP situation was further explored through consultations with stakeholders (group meetings, in-person interviews, and electronic communication) to better understand key issues and identify strategic priorities. Key issues were explored across six thematic areas:

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

The Technical Support Team held a series of meetings with the Lagos State CIP Committee and six stakeholder advisory groups representing each thematic area to advise on key issues, appropriate activities, and potential FP strategies that will help the state reach its FP goals. A technical strategy was then developed to address these key issues over the next three years. The technical strategy details concrete, specific activities, categorized by theme. Each activity is linked to associated resource inputs for full implementation and the resulting public sector costs. Drafts of the technical strategy have been reviewed by the Lagos State CIP Committee and revised to incorporate feedback.

ACKNOWLEDGEMENTS AND CONTRIBUTORS

In the strive towards improved Maternal Health in Nigeria, a key strategy is the development of a Lagos State specific Costed Implementation Plan (CIP) for Family Planning Services.

Hence, the Ministry of Health in collaboration with Palladium, sought the input of stakeholders in Family Planning in the State in the development of the CIP in line with emerging issues in the field of Reproductive Health. The CIP document is to serve as an official document in the implementation of all family planning programs and interventions in the State.

Foremost, a special appreciation goes to The Bill and Melinda Gates Foundation (BMGF) for both financial and technical support provided in the course of developing this document.

Special thanks goes to the team of experts, advisors and consultant of Palladium for their valuable time committed towards the development of this important document.

The technical and financial support of United Nations Population Fund (UNFPA) in the development of the State Family Planning situation analysis, which formed the foundation for the document development process is highly recognized and appreciated.

We also acknowledge the input of all the contributors and Family Planning stakeholders especially those who laid the foundation of the development of this document in Lagos State and who continue to ensure that this vision is kept alive, such as Marie Stopes International (MSI), Nigerian Urban Reproductive Health Initiative (NURHI), FHI 360, Lagos Advocacy Working Group (LAWG), Planned Parenthood Federation of Nigeria (PPFN), Pathfinder International, Lagos State University Teaching Hospital (LASUTH), HSC, Lagos State Primary Health Care Board (LSPHCB), Strengthening Health Outcomes through the Private Sector Project (SHOPS), DKT International, Association of General Private Medical Practitioners of Nigeria (AGPMPN), Association of General Private Nurse Practitioners of Nigeria (AGPNPN) and Community Service Organizations (CSOs) working in the State.

Sincere appreciation goes to the entire members of staff of the Directorate of Family Health & Nutrition for their commitment and hard work throughout the process of development of the Costed Implementation Plan.

It is our expectation that the support and contributions of the stakeholders would transcend the document development stage and extend to the implementation of the plan itself as part of efforts to continue to place Lagos State strategically as being foremost among the States in the country.

Dr. Modele Osunkiyesi

Permanent Secretary (Health)

22nd March, 2016

ABBREVIATIONS

AGPMPN	Association of General Private Medical Practitioners of Nigeria
AGPNPN	Association of General Private Nurse Practitioners of Nigeria
BCC	Behaviour Change Communication
BMGF	Bill & Melinda Gates Foundation
CBDs	Community based distribution agents
CCP	The Johns Hopkins Center for Communication Programs
CHEW	Community Health Extension Worker
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CSOs	Community Service Organizations
DBC	Demand generation and behaviour change communication
DFID	UK Department for International Development
DHMIS	District Health Management and Information System
FCT	Federal Capital Territory
FLHE	Family Life and HIV Education
FMOH	Federal Ministry of Health, Nigeria
FP	Family Planning
HEds	Health Educators
HMIS	Health management and Information System
IUD	intrauterine device
LARCs	long-acting reversible contraceptives
LAWG	Lagos Advocacy Working Group
LGA	Local Government Area
LMD	last-mile distribution
LMIS	Logistics Management and Information System
LSMOH	Lagos State Ministry of Health
LSPHCB	Lagos State Primary Health Care Board
MOU	Memorandum of Understanding
MSION	Marie Stopes International Organization Nigeria
NDHS	Nigeria Demographic and Health Survey
NGN	Nigerian Naira
PHC	Primary Healthcare Centre
PMA	Performance Monitoring and Accountability
PMTCT	prevention of mother-to-child transmission
PPMV	Proprietary Patent Medical Vendor
RP	reproductive health
SAG	Stakeholder advisory groups
SHOPS	Strengthening Health Outcomes through the Private Sector
SMC	Supervision, monitoring, and coordination
TBAs	Traditional birth attendants
TFR	Total Fertility Rate
TOR	terms of reference
TOT	training of trainers
UNFPA	United Nations Population Fund
WHCs	Ward Health Committee
WRA	Women of Reproductive Age
YFHC	Youth Friendly Health Clinics

SECTION I: INTRODUCTION

1.1 Nigerian Context

Current estimates suggest the population of Nigeria totals 182 million people (2015), ranking the nation as the seventh most populous country in the world and the largest country in Africa.[ii] With an estimated annual growth rate of 3.2 percent, Nigeria is projected to become the third most populous country in the world by 2050, with an estimated increase of approximately 216 million people over the next 35 years. Nigeria has a youthful population; approximately 44 percent of the population is under the age of 14.[iii] Nearly 50 percent of the population lives in an urban area and projections suggest 67 percent of the population will reside in urban areas by 2050.[iv]

Nigeria comprises 36 states and one Federal Capital Territory (FCT). Each state is controlled by a government led by a governor who is elected via popular vote. Governors oversee the state executive branch and execution of state-level laws. The State House of Assembly presents all revised and new legislation to the governor for approval before officially passing legislation into law. Thus, advocacy to governors for any family planning (FP) legislative initiative is critical to ensure full support and implementation of FP policies at the highest level.

States are further divided into 774 local government areas (LGAs). Each local government area is governed by a Local Government Council, which is headed by a chairman and councillors. LGAs are further divided into wards, each possessing a Ward Health Committee. LGAs are responsible for the provision and maintenance of primary healthcare centres (PHC). Great inconsistencies exist regarding the quality, staffing, funding, and maintenance of PHCs by LGAs. To ensure effective implementation of FP programming, intervention strategies must consider the role of LGAs in service delivery.

The Federal Ministry of Health oversees the entire Nigerian healthcare system through creation and monitoring of policies, strategies, and guidelines. The Family Health department, in particular, coordinates health programming related to reproductive health, maternal, neonatal, and child health. In regards to family planning, the state ministries of health implement national FP guidelines and coordinate family planning service delivery, while the local governments monitor the FP workforce serving primary health clinics.

According to the 2013 Nigeria Demographic and Health Survey (NDHS), 15.1 percent of married women of reproductive age (15–49) are using some kind of contraceptive method; however, only 9.8 percent of these women are using modern FP methods. 68.1 percent of unmarried sexually active women of reproductive age (15–49) are using some kind of contraceptive method, and 54.9 percent of these women are using modern FP methods. The national rate has largely remained at this level since the late 1990s. The modern method mix in Nigeria is predominantly comprised of short-term methods, notably condoms, pills, and injectables.

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

Married women using a contraceptive method, Percent CPR

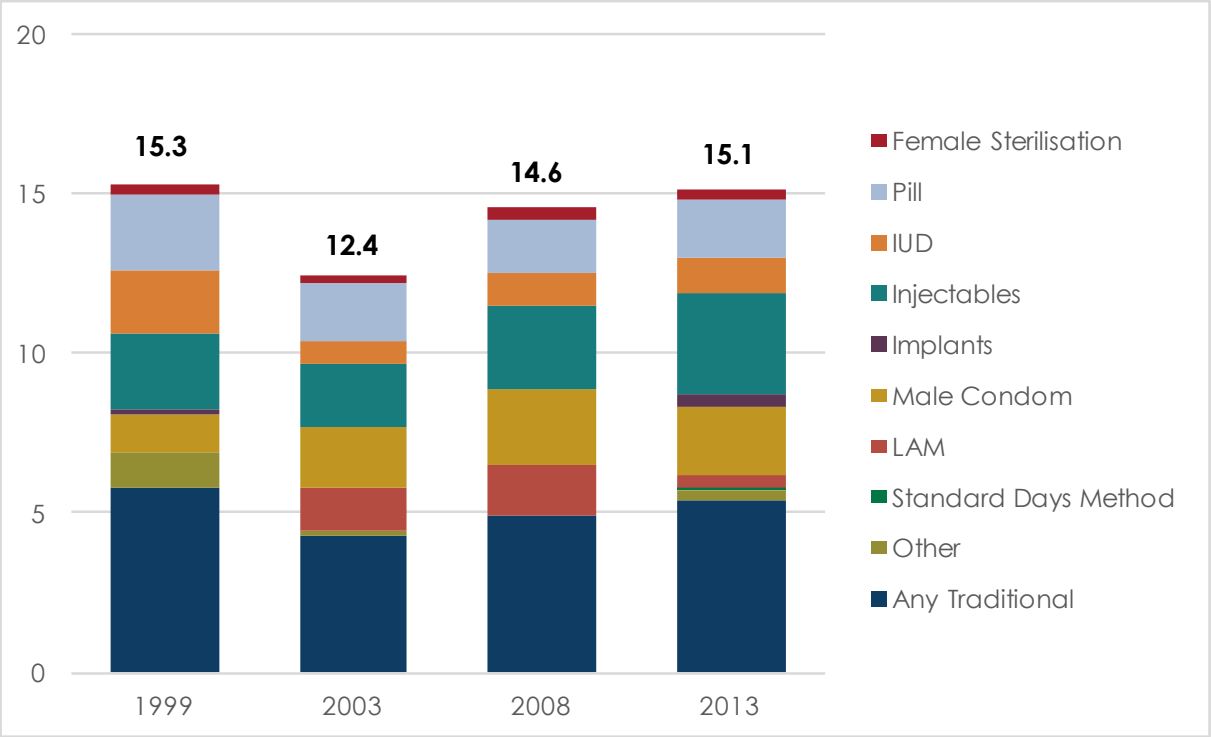
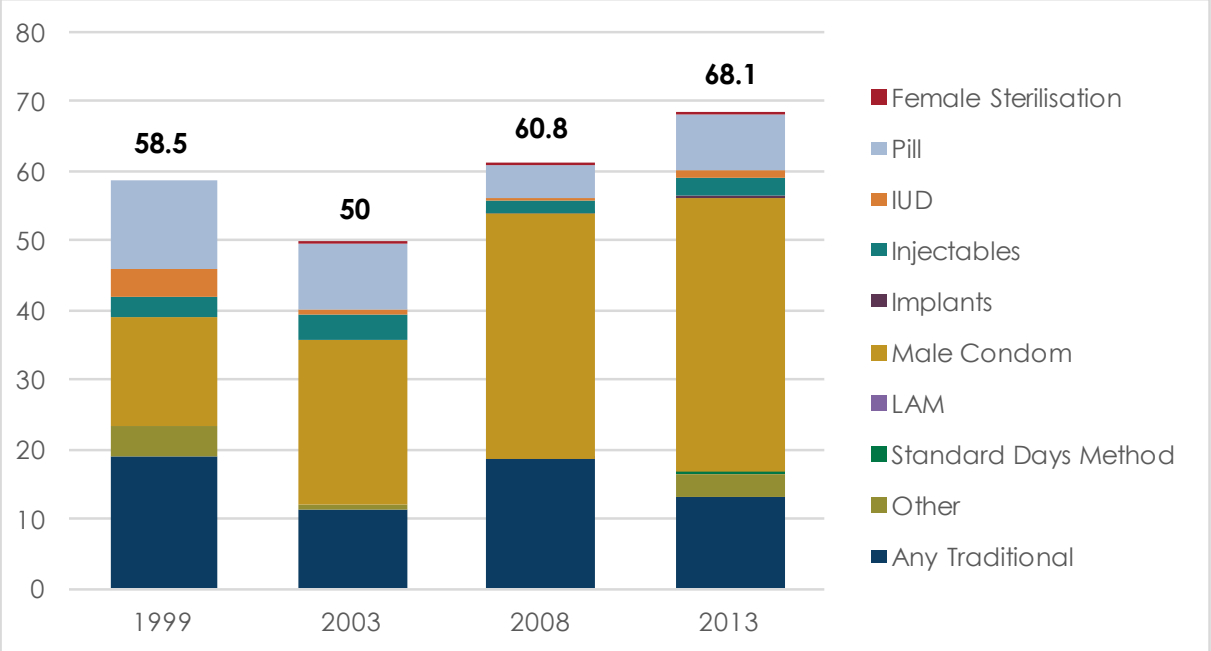


Figure 2: Nigeria Method Mix 1990–2013[vi]

Sexually active unmarried women using a contraceptive method, Percent CPR



1.2 Lagos State Context

While Lagos State holds the smallest land area of 356,861 hectares, it has the largest population size of all of the states. The last state population census (2006) estimated the total population at 17.5 million people with a growth rate of 3.2 percent. Therefore, the projected population in 2015 was 23 million people.[vii] Frequent rural-urban migration occurs in Lagos State, generally in pursuit of economic and educational opportunities. Population density in Lagos

State stands at about 4,193 people per square kilometre, far above the national average of 195 people per square kilometre.[viii]

The Lagos State Ministry of Health (LSMOH) falls under the leadership of the Honourable Commissioner for Health and the Special Adviser to the Governor on Public Health. Each directorate within the LSMOH reports to the Permanent Secretary, who serves as the head of the Ministry's civil service. Family planning programming is the responsibility of the Family Health and Nutrition Department, specifically the Reproductive Health Unit, and is led by the Reproductive Health Coordinator. Within the unit, the Family Planning Coordinator is responsible for monitoring family planning logistics and service delivery for public facilities at the state level.

The Lagos State Primary Health Care Board (LSPHCB) oversees all primary healthcare service delivery in the state, covering all 20 Local Government Areas and 37 Local Council Development Areas. Family planning service delivery is thereby regulated within the primary healthcare framework. The state also has alternative and traditional healthcare delivery systems, which are regulated, in part, by the Ministry of Health through the Traditional Medicine Board.

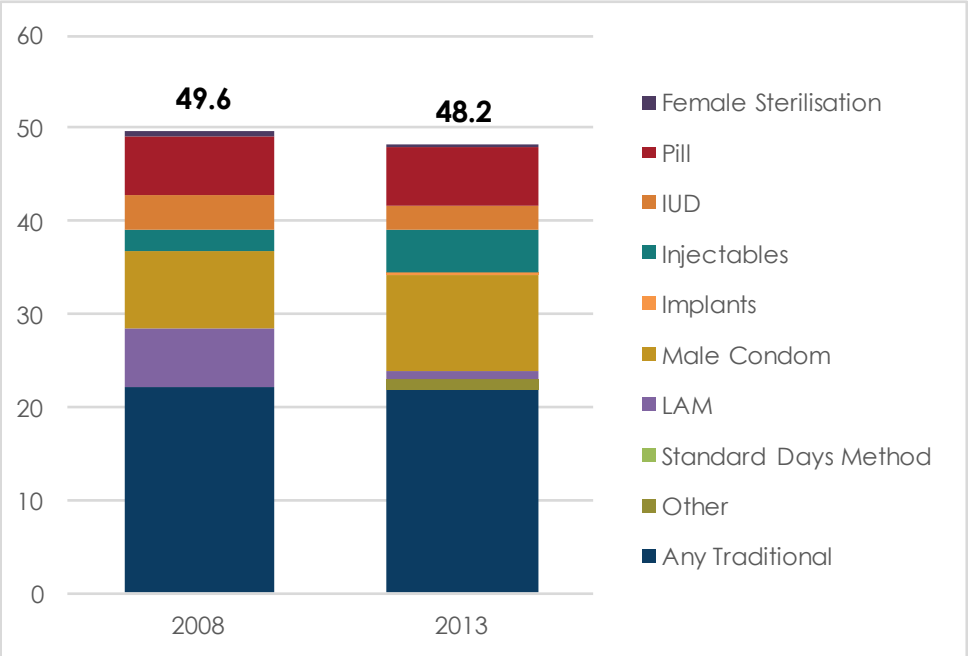
At the local level, each LGA health department is led by the Medical Officer of Health. In addition, while the Primary Healthcare Coordinator supervises primary healthcare activity and the Maternal and Child Health Coordinator supervises maternal and child health, both positions are jointly responsible for coordinating family planning activities in each LGA.

Lagos State has the highest state contraceptive prevalent rate in Nigeria, currently estimated at 48.3 percent for all married women in the state.[1] However, only 26.4 percent of contraceptive users who are married women are using a modern method and less than 3 percent are long-acting methods. Married women using modern methods primarily rely on short-acting methods such as pills, condoms, and injectables. Alarmingly, contraceptive use amongst married women, including modern contraceptive use, in Lagos has dropped slightly since 2008 by approximately one percentage point.

[1] PMA2015 Lagos reports a much lower total CPR for married women of reproductive age in Lagos, 34.6[xiii] compared to 48.3 percent (NDHS 2013). Modern CPR estimates are the same in both reports, however.

Figure 3: Lagos Method Mix 2008–2013[ix]

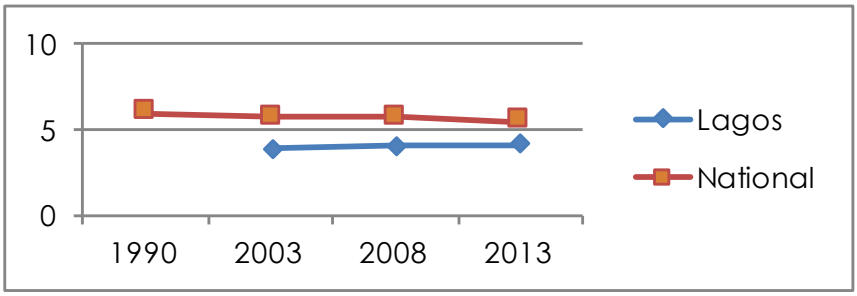
Married women using a contraceptive method, Percent CPR



As Lagos maintains a significantly higher CPR than the national average, it follows that the total fertility rate (TFR) in Lagos would remain lower than the national standard. The total fertility rate has remained relatively stable in Lagos at around four births per woman since 2003; it is currently estimated at 4.1 while the national TFR estimate is 5.5.[x]

Figure 4: Lagos vs National TFR 1990–2013[xi]

Total Fertility Rate Trends, All women of reproductive age



The median age at first birth in Lagos State is 24.5, which is much higher than the national median age of 20.2. The median age for marriage for Lagos State is also higher than the national average at 23.8 years. However, the median age of first intercourse in Lagos for women is 20.4 years and the teenage pregnancy rate is 3.5%, indicating a need to ensure strong FP access for young, unmarried women.

1.3 Lagos State Family Planning Landscape

The family planning situation comprehensively addresses critical dimensions of family planning across both the public and private sectors. Accordingly, the Costed Implementation Plan (CIP) began with a Lagos FP situational analysis across six components:

- Service access and delivery
- Supplies and commodities
- Demand generation
- Regulation and policy
- Financing
- Supervision, Monitoring, and Coordination

1.3.1 Service Delivery

Source of modern contraception: By and large, the private sector provides the majority of modern contraception to the population of Lagos State, filling the need of over 70 percent of modern contraceptive users **(Figure 5).** In particular, pharmacies and proprietary patent medicine vendors (PPMVs) are the primary point of access for modern contraceptive users. However, these providers can only lawfully sell pills and condoms (some are illegally providing injectables, as well). Private providers do not view offering long-acting methods as a profitable service provision. As such, intrauterine devices (IUDs), implants, and injectables are more readily accessed from public clinics **(Figure 6**). According to the LSMOH, 283 public facilities currently offer at least one family planning method and family planning counselling; however, many public facilities do not offer a full method mix of short-term and longer-acting and permanent methods.

Figure 5. Source of Total Modern Contraception in Lagos State, Percentage, 2013[xii]

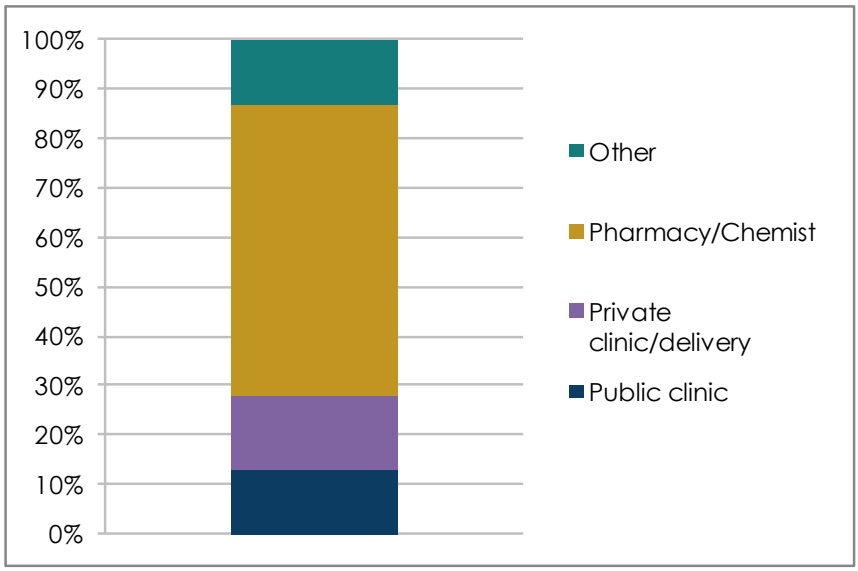
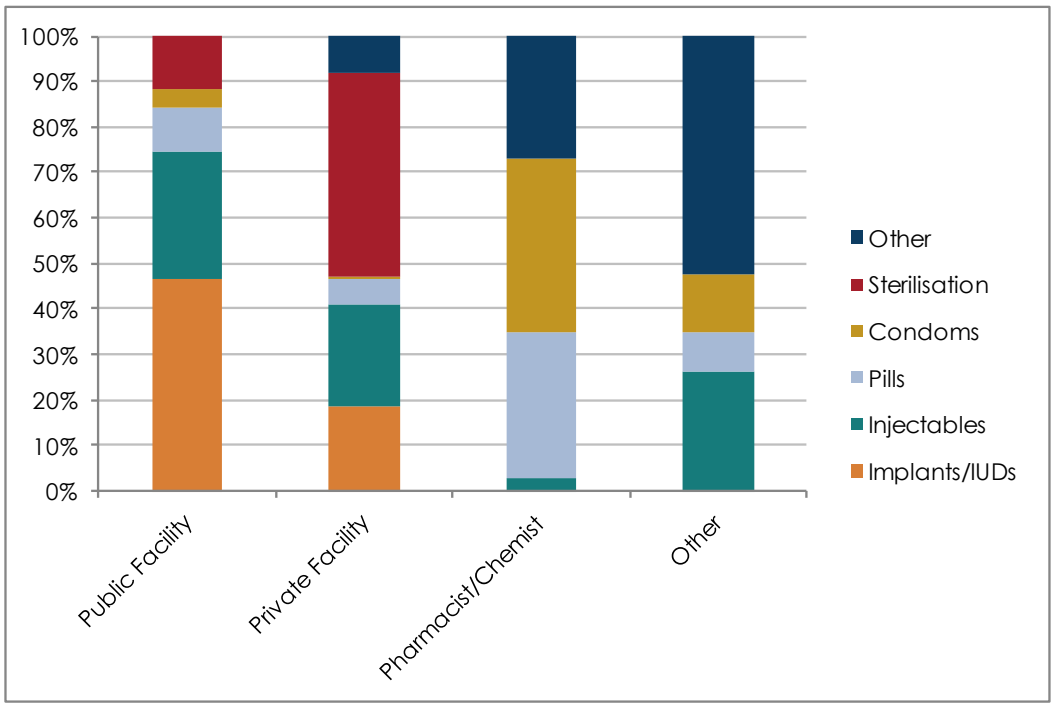


Figure 6. Source of Modern Contraceptive by Method in Lagos State, Percentage, 2015[xiii]



Staff skills and training: FP service delivery suffers from a major gap in the availability of trained FP providers, particularly for injectables and long-acting reversible contraceptives (LARCs). The national policy to allow community health extension workers (CHEWs) to deliver injectable contraceptives was approved in 2012; however, more effort is necessary to formally train an adequate number of CHEWs to properly deliver a range of methods (i.e., how to provide the necessary counselling, screen for pregnancy, deliver the injection, and safely handle waste products). Implants, a significant LARC method, were introduced on a larger scale in the public sector in 2006, and it is likely that many providers who received training in 2006 are no longer practicing in the public system. Plans for increasing implant insertion skills are covered in the National LARC Strategy.[xiv]

As a result of staff shortages in PHCs, providers must balance high patient loads and competing clinical demands and, in turn, are less likely to spend the necessary amount of time counselling patients in the full range of family planning methods and provide a full range of methods. Additionally, limited staff training on FP long-acting reversible methods (implants and IUDs) leads to providers biasing provision of certain methods (pills and injectables) over LARCs, further limiting clients' rights to free and informed choice. LSMOH recognised these challenges and initiated a state-wide initiative to provide in-service training to providers on LARCs who are required to insert 10 safe LARC methods before full certification. The latest training took place in March 2015.

Staff retention is a challenge for the healthcare sector, across Nigeria and in Lagos State. Doctors, nurses, and midwives frequently seek better professional opportunities or higher pay elsewhere, contributing to high staff turnover.

1.3.2 Supplies and Commodities

Procurement of contraceptive commodities is managed at the national level by the Reproductive Health Division of the Family and Health Department of the Federal Ministry of Health. The United Nations Population Fund (UNFPA) coordinates all national commodity procurement, with funding support from the Federal Government of Nigeria and development partners, including USAID, the UK Department for International Development (DFID), and the Canadian International Development Agency.

The state receives commodities stock from the Central Contraceptive Warehouse. At the state level, commodities logistics for contraception are managed via the CHANNEL software.

Prior to 2015, the state relied on the review and re-supply method for logistics management and distribution. Under this model, service providers or LGA maternal and child health coordinators would attend quarterly meetings with the state FP coordinator and provide commodities data (registers, daily consumption records/tally cards, and requisition, issue, and report forms). The data would be reviewed and validated at the meeting and the requisite amount of commodities would be supplied to the service provider or LGA coordinator.

Beginning in October 2015, UNFPA supported the LSMOH to roll out the integrated last-mile distribution system of commodities, whereby malaria, family planning, and reproductive health commodities would be supplied simultaneously through the information capture and direct delivery commodity distribution model. Under this system, LGA personnel visit each facility to collect Logistics Management and Information System (LMIS) reports, which are reviewed by the state central level staff and used to develop distribution plans. Thereafter, a third party vendor conducts bi-monthly delivery visits to each public health facility. In January 2016, UNFPA completed the pilot of this new model for commodity distribution and there are plans to scale up the system over the next three years throughout Lagos State, in conjunction with the LSMOH.

1.3.3 Demand Generation and Behaviour Change Communication

Over the last seven years, the Lagos State family planning programme, including donor-led activities, focused heavily on contraceptive procurement, warehousing, and distribution; monitoring and supervision; and training and re-training providers. Far less effort has gone towards demand generation for family planning.

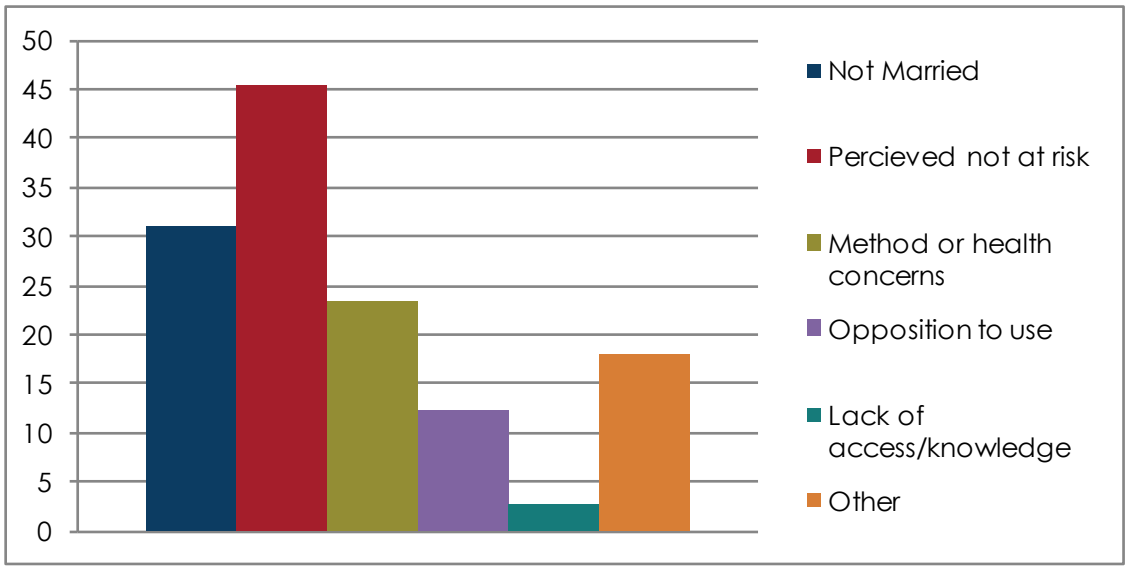
Knowledge of contraception. The NDHS 2013 reports nearly all (99.9 percent) women have heard of at least one modern contraceptive method. Similarly, it is estimated that all men in Lagos state know about at least one modern contraceptive method. Approximately 63 percent of women (age 15–49) in Lagos reported hearing an FP message on the radio, 58 percent on TV, and 23 percent from a newspaper or magazine.

Counselling on Family Planning. Low levels of counselling on family planning limit individuals' rights, including rights to agency and autonomy, empowerment, equity and non-discrimination, informed choice, and voice and participation. In particular, disparities exist regarding counselling on family planning methods, which particularly

affect the poorest women. While on average 25 percent of current family planning users in Lagos State were counselled on the side effects of contraception, only 6 percent of women in the lowest wealth quintile received such counselling. In addition, while on average 41 percent of current family planning users in Lagos were told about other methods, only 24 percent of women in the lowest wealth quintile were told about additional methods.[xv]

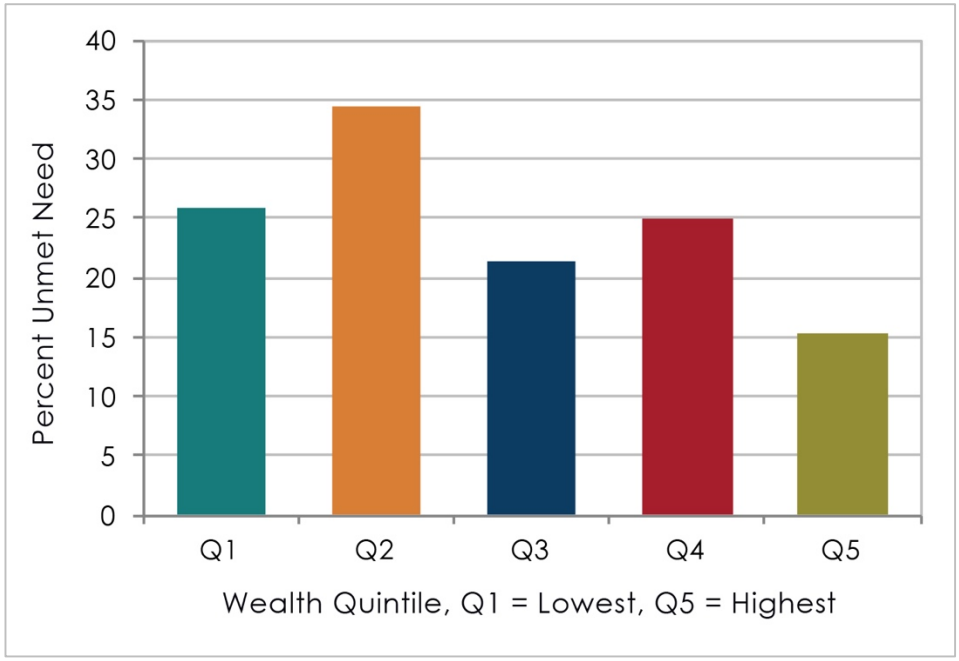
Reasons for non-use. For women wanting to delay their next birth for at least two years, the most common reason reported for not using contraception was perceived not\at risk or lack of need (**Figure 7**). In addition, many women report concerns about FP methods and/or health concerns, which can be potentially addressed through improved education and communications. These reasons for non-use indicate a significant need for a comprehensive social behaviour change communication programme to educate potential users about fertility, child spacing, and the benefits of family planning.

Figure 7: Reasons for non-use among women wanting to delay their next birth for 2 years, 2015[xvi]



Unmet need among married women of reproductive age. The total unmet need for married women in Lagos State is 24 percent.[xvii] In addition, significant disparities exist; women in the two lowest wealth quintiles have the highest unmet need at 26 and 34 percent, respectively, while women in the highest wealth quintile have the lowest unmet need at 15 percent. (**Figure 8**).

Figure 8. Unmet need amongst married women of reproductive age, by wealth quintile, 2015[xviii]



1.3.4 Regulation and Policy

Family planning priorities have been well incorporated into policies and guidelines at the national level. In April 2011, the FMOH instituted a policy that provides free family planning commodities at primary health clinics. In addition, the FMOH recognised the need to extend services for family planning closer to the community by permitting Community Health Extension Workers to provide injectables.

The following four plans, instituted at the national level, incorporate components of family planning into their strategy: The National LARC Strategy; the Reproductive Health Commodity Strategy; the National Strategic Health Development Plan; and the Maternal, Newborn, and Child Health Strategy. Relevant policy or guideline changes from these plans have been addressed in the National Blueprint and subsequently in the Lagos CIP.

The Maternal and Child Mortality Reduction Programme in Lagos recognises the importance family planning plays in improving the health of women and children throughout the state. The programme incorporates family planning information in maternal health promotional material distributed at primary health clinics and in trainings for healthcare providers on the provision of essential maternal and newborn services.

1.3.5 Financing

In Lagos State, 11 percent of the total government budget in 2015 was allocated to health (Nigerian Naira (NGN) 44.619 billion). The Lagos State government allocation for health was proportionally higher than the national allocation of 6.1% to health.

Family planning commodities are funded at the national level and service provision funding is the responsibility of the state. Out of all 36 states, Lagos State is the only state to officially disburse budget monies directly for FP services. The state established an NGN 16.8 million FP budget line in 2013; however, the allocation has not increased since then.

In January 2016, the Honourable Commissioner officially required all LGA governments to fund the cost of consumables for family planning. Actual release of funds has yet to be tracked. In addition, the LGA budgetary committees have not established a separate line item for FP service; however, they do fund maintenance of primary health facilities.

1.3.6 Supervision, Monitoring, and Coordination

The Family Planning Coordinator at the LSMOH oversees monitoring and evaluation of FP programming in the state. The FP unit within the LSMOH leads bi-monthly supervisory meetings to assess the status of FP service delivery in primary healthcare facilities. The Lagos FP Technical Working Group meets regularly to coordinate FP activities. Members of this group include LSMOH representatives, implementing partners, donors, and other ministries.

At the local level, service providers report key FP indicators to the LGA Reproductive Health Coordinator on a bi-monthly basis. The LGA Reproductive Health Coordinator feeds data up to the State FP coordinator each quarter and the State FP Coordinator reports to the central system every four months. Key FP indicator categories tracked include clients counselled, contraception (including long-acting methods) distributed or inserted, and commodity availability. Data is maintained in the National Health Management Information System. In addition, CHANNEL, an electronic LMIS, currently tracks the supply chain of reproductive health commodities.

SECTION 2: INTEGRATED FAMILY PLANNING PLAN

2.1 Goal

The overarching goal of the Lagos State CIP is to increase the uptake of family planning services, thereby raising the contraceptive prevalence rate from 48 percent to 74 percent by 2018. In doing so, Lagos State will contribute to the national goals of increasing women's use of family planning services (CPR to increase from 15 percent to 36 percent) and reducing maternal mortality by 75 percent and infant mortality by 66 percent across Nigeria by 2018.

2.2. Strategic Priorities

Based on recommendations from the Lagos State FP Situational Analysis and Lagos FP Landscape reports, as well as insight from partners' experiences implementing FP programming, the task force outlined the following strategic priorities as a means to highlight the critical activities needed to reach the target of a 74 percent CPR by 2018.

- **FP demand generation and behaviour change:** Strengthen demand for a full range of contraceptive methods and FP services by delivering targeted, accurate FP information to men and women and addressing common FP myths and misconceptions.
- **Targeting the youth population:** Ensure youth are well informed on reproductive health issues and FP services available, and increase youth access to accurate FP counselling and safe and reliable service provision.
- **Private sector delivery channels:** Increase coverage and access to high-quality integrated FP services and commodities through the private sector, including faith-based organizations, private hospitals/clinics, pharmacies and PPMVs as appropriate for some methods.
- **Staff and training:** Strengthen the capacity of healthcare workers to provide safe, high-quality FP services, including counselling, provision, and removal of long-acting reversible contraception.
- **Monitoring and Evaluation:** Develop a comprehensive monitoring and evaluation plan for family planning logistics and service provision, including community-based distribution systems, such as pharmacies and paramedical vendors.

2.3 Structure of the CIP

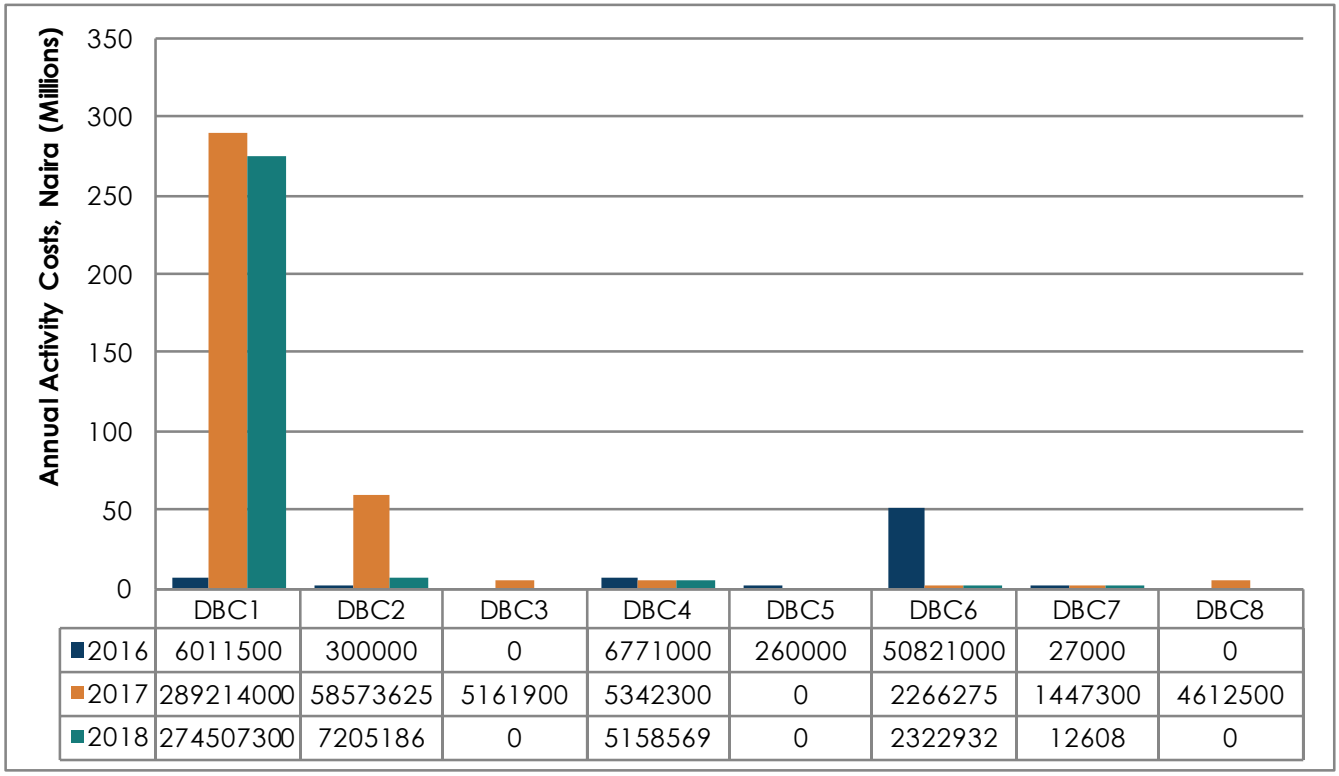
The CIP's activities are structured around six basic areas of the health system for family planning:

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

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

2.3.1 Demand generation and behaviour change communication (DBC)

Figure 9: Demand Generation and Behaviour Change Communication Activity Costs per Year, Naira



	DBC1	DBC2	DBC3	DBC4	DBC5	DBC6	DBC7	DBC8
2016	6011500	300000	0	6771000	260000	50821000	27000	0
2017	289214000	58573625	5161900	5342300	0	2266275	1447300	4612500
2018	274507300	7205186	0	5158569	0	2322932	12608	0

a. Justification

Demand generation for family planning is necessary to address the stigma, myths, and misconceptions surrounding family planning in Lagos State. Through the provision of accurate family planning information, men and women can make more informed, rights-based decisions regarding their reproductive needs. Behaviour change communication strategies foster an enabling and supportive environment surrounding family planning within communities and encourage leaders at all levels to champion uptake of family planning services within their spheres of influence.

b. Strategy

The behaviour change communication strategy emphasises the critical role of family planning in the health of women and the economic development of the state. The primary intervention promotes uptake of a full range of family planning methods through traditional media channels (radio, television, and print media) to the general population. The strategy hopes to gain support at the community level from gate-keepers (community and religious leaders, traditional healers, and male advocates) to champion family planning within their communities. Targeted interventions intend to reach specific segments of the population (adolescents, poor women, and people with disabilities) and address their unique challenges and barriers to FP use.

c. Activities

DBC1. Develop and roll out the Lagos State behaviour change communication strategy. A state-level family planning behaviour change communication landscape analysis will be conducted to better understand the existing opportunities and barriers for use in family planning throughout the state. The findings from this study will influence development of a comprehensive family planning behaviour change communication strategy, which shall include tailored and tested messaging towards targeted audiences and incorporate FP messaging into ongoing newspaper, radio, and television communications. The communications strategy seeks to address myths and misconceptions surrounding family planning use, encourage male involvement in family planning, and promote safe and consistent use of a mix of family planning methods, including long-acting contraception.

DBC2. Train CHEWs and male advocates to provide FP information to the community. The state will train a cadre of CHEWs to integrate family planning messaging and information provision into their existing protocols. CHEWs will provide contraceptives (condoms, pills, and injectables), inform community members on the range of methods available for family planning, including long-acting reversible contraception, refer community members to local PHC for FP services, provide post-natal family planning counselling to recent mothers, and train advocates on evidenced-based family planning messaging and promotion. A cadre of male advocates for family planning will receive training to champion the uptake of family planning in their community.

DBC3. Engage religious and community leaders as FP champions. A series of meetings will be held with influential religious and community leaders to discuss the benefits and potential impacts of family planning. These meetings will serve as an opportunity to address questions about family planning methods, including myths or misconceptions these leaders may have about family planning methods. The meetings will further serve to encourage religious and community leaders to champion family planning within their respective spheres of influence and encourage them to promote family planning as a health and human right within their communities.

DBC4. Educate adolescents in the state about benefits of family planning and birth spacing. In- and out-of-school youth will participate in a life planning curriculum intended to assist them with life goal-setting (including financial, professional, familial, health, and other goals) and preparation towards achieving set goals. Participants are matched with career mentors as an added support mechanism towards reaching their goals. As a part of the curriculum, youth will learn how family planning can contribute to achieving life goals. Participants involved in the programme will be encouraged to spread family planning messaging to their peers.

DBC5. Develop partnerships with state and private media stations to promote FP as a social responsibility. A media engagement strategy will be developed and implemented, which outlines approach of engagement, suggested media activities, and recommended key messages. The strategy seeks to develop partnerships with public and private media stations in support of subsidised promotion of family planning information across various media platforms (radio, television, print, and internet media providers).

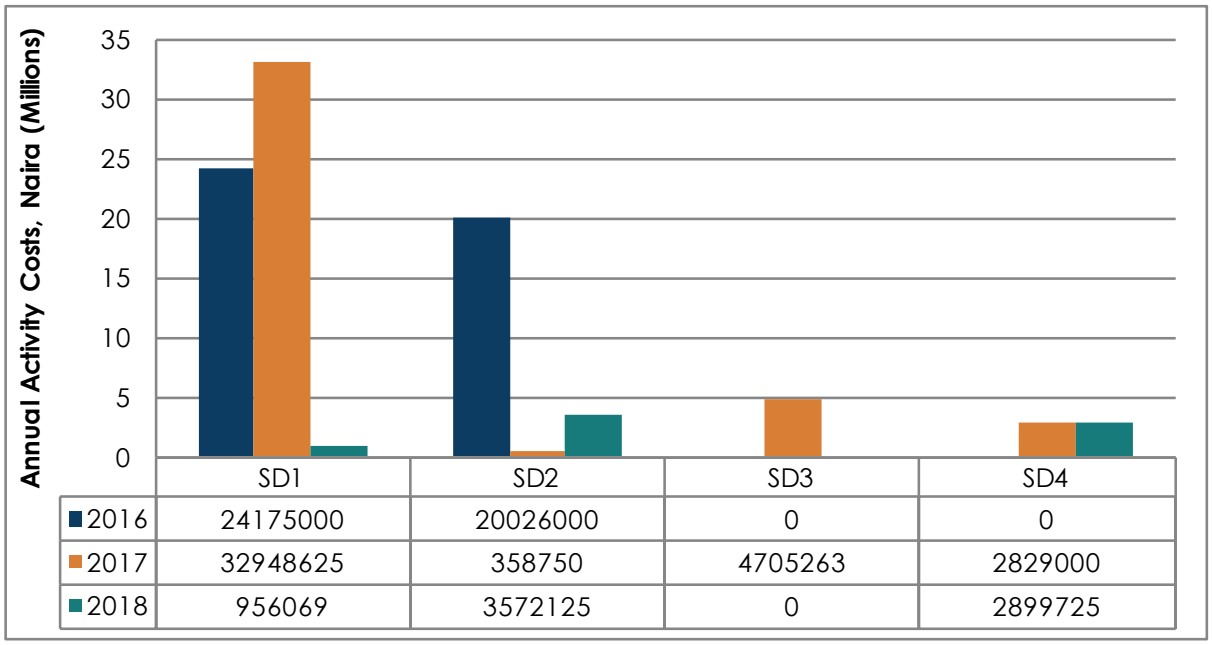
DBC6. Spread awareness about FP and where to access services among the general population. A visual symbol of FP will be developed and rolled out throughout the state to advertise locations where FP services are available. Additionally, a directory of FP service delivery points will be developed to assist men and women with accessing FP service provision. Lagos State will involve community organisations and professional associations to roll out promotional activities at the community level. A family planning hotline will be created to counsel contraceptive users and address any concerns with proper contraceptive use and side effects. A social media campaign targeting adolescents will be rolled out to increase adolescent uptake of family planning.

DBC7. Involve disability rights organizations in FP behaviour change strategy. To address the barriers people with disabilities face accessing FP services, the LSMOH will partner with human rights organisations working with the disabled population. Additionally, teachers of disabled youth will receive training on FP promotion.

DBC8. Sensitise and train traditional healers on modern FP promotion. Traditional healers are well respected by community members in certain segments of the population. This intervention seeks to honour the status of traditional healers in the community by recognizing their role in providing essential health services, and encouraging them to promote choice in selection of family planning methods, including referral for modern FP services.

2.3.2 Service delivery (SD)

Figure 10[2]: Service Delivery Activity Costs per Year, Naira



	SD1	SD2	SD3	SD4
2016	24175000	20026000	0	0
2017	32948625	358750	4705263	2829000
2018	956069	3572125	0	2899725

a. Justification

Family planning service provision in Lagos State is weakened by inadequate staffing levels, frequent turnover of trained FP staff, and low prioritisation of FP service delivery within primary health clinics. Few private clinics offer long-acting contraception due to low profitability of these services. Therefore, innovative programming is necessary to increase service delivery points for FP and ensure high-quality service provision.

b. Strategy

Programming will prepare service providers to offer a full range of family planning services. In-service and pre-service trainings will reach both public and private sector providers. Meanwhile, task-shifting and integration of FP services into other programme areas will expand the number of providers who are able to provide FP services. The majority of women in Lagos access their family planning services from pharmacists and PPMVs; therefore, it is vital to include the private sector in FP service delivery initiatives. A new intervention will train pharmacists and PPMVs to provide proper FP counselling and refer women for long acting methods. Enabling environments to access FP services will be fostered for adolescents, as well as for people with disabilities.

c. Activities

SD1. Train public and private service providers on National Service Delivery Integration Protocol. Primary care providers in both the public and private sector will be trained on comprehensive FP counselling, insertion, and removal as a part of an integrated service delivery approach. The training will highlight the critical need of family planning to improve health outcomes for women and children and support development in Lagos.

SD2. Expand FP service delivery through the private sector. A pool of pharmacists and PPMVs will receive training on FP information provision, counselling, and referrals for long-acting methods. Opportunities to leverage untapped private sector resources will be explored.

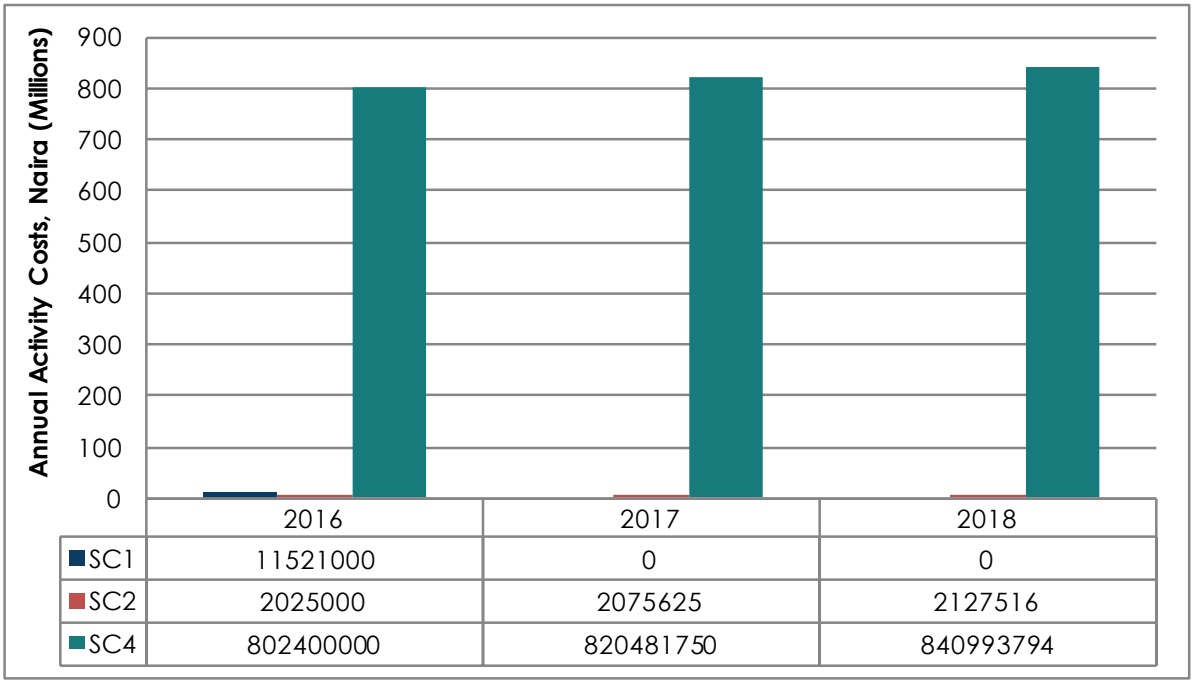
SD3. Increase access to FP services at Youth Friendly Health Centres (YFHC). Clinic hours at YFHCs will be extended to cover evenings and weekend to address youth-specific barriers to accessing FP services. Two youth-friendly health rooms will be designated in existing PHCs. Additionally, public and private service providers will be sensitised on youth-friendly service provision of FP.

SD4. Create an enabling environment for the disabled population's to access FP services. FP services will be made more easily accessible to the disabled population by providing a sign language interpreter at two designated PHCs. In addition, a mobile outreach campaign will seek to provide FP care directly to people with disabilities.

[2] SD3 Activity costs are linked to SD1 and DBC2 and, therefore, not included in Figure 10

2.3.3 Supplies and commodities (SC)

Figure 11[3]: Supplies and Commodities Activity Costs per Year, Naira



	2016	2017	2018
SC1	11521000	0	0
SC2	2025000	2075625	2127516
SC4	802400000	820481750	840993794

a. Justification

A consistent and sustainable supply of contraceptive commodities and consumables is imperative in order to meet the needs of all FP clients in Lagos state. The 2018 method mix goals aspire to increase uptake of IUDs and implants; as a result, the supply of these methods must also increase over the next three years to meet demand. The foremost challenge in regards to the supply of commodities in Lagos is timely and adequate distribution of these supplies to the last mile (reaching from the LGA all the way to the health facilities).

b. Strategy

The supplies and commodities strategy focuses on addressing issues with last-mile distribution of FP commodities through implementation of the information capture and direct delivery distribution approach. In addition, the strategy seeks to involve private sector providers in FP commodity distribution and prepare a resource mobilization strategy for future funding of commodity logistics and distribution in the state.

c. Activities

SC1. Improve state capacity for FP commodity logistics and management. FP commodities and logistics officers will receive training on how to accurately forecast commodity needs and manage supplies and logistics at the local and facility level.

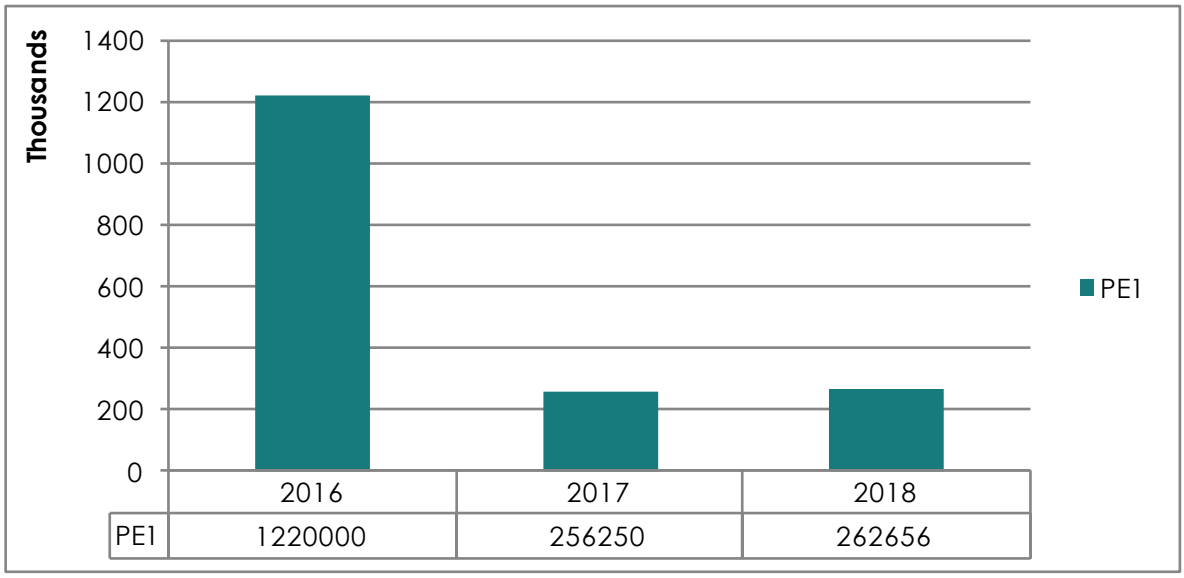
SC2. Ensure availability of FP commodities in the private sector. The LSMOH will engage with the private sector in Lagos State to align goals in commodity distribution and identify opportunities for public-private partnerships in commodity distribution.

SC3. Enhance last-mile distribution (LMD) of FP commodities to promote service delivery at the LGA level. A pilot intervention, funded by UNFPA, will replace the existing review and re-supply model for FP commodity distribution with the integrated last mile distribution of malaria, family planning and reproductive health commodities.

[3] SC3 Activity costs are linked to SD1 and, therefore, not included in Figure 11

2.3.4 Policy and environment (PE)

Figure 12: Policy and Environment Activity Costs per Year, Naira



a. Justification

Ensuring a supportive and enabling policy environment surrounding family planning programming throughout multiple levels and divisions of the government is necessary to fully reach the state FP goals. In particular, it is vital to advocate to non-health governing bodies, such as the Ministry of Education and Financing Committee, regarding the significant impact family planning can have on the population and development. Properly institutionalizing new guidelines will further validate and champion the criticality of FP programming at the highest levels of government in the state.

b. Strategy

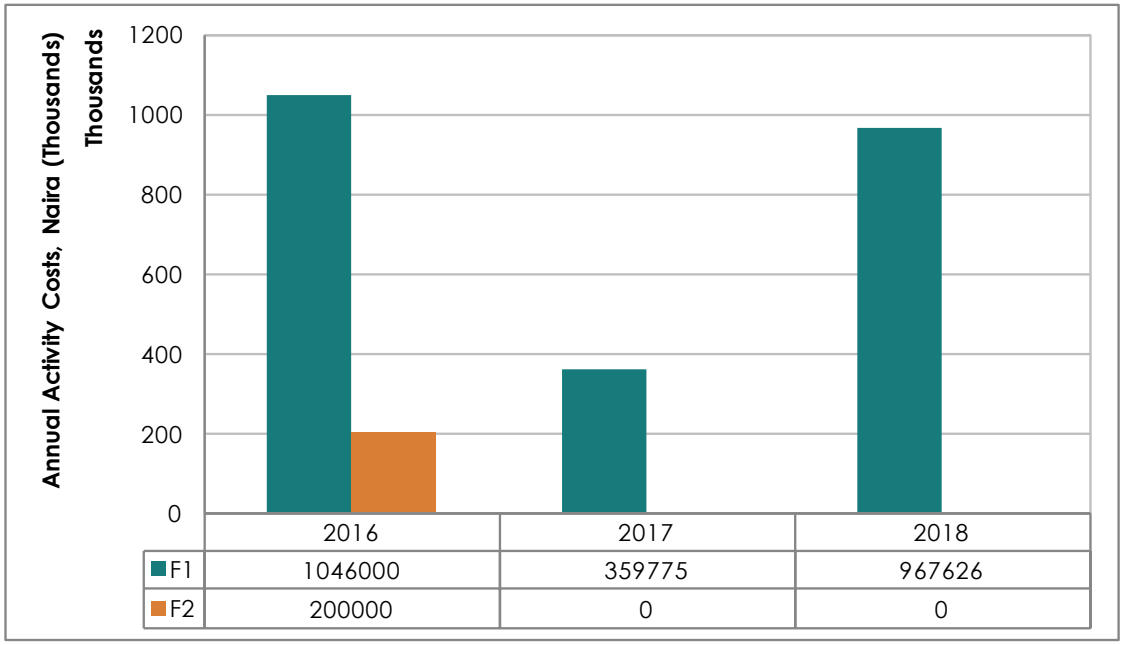
An advocacy campaign will be rolled out to garner political and financial support for family planning, including promotion of the Demographic Dividend, at the state and LGA levels. This campaign seeks to address stigma surrounding FP at the policy level and highlight the widespread benefits and impact a strong family planning programme might have in the state. Advocacy efforts will also encourage policymakers to update relevant guidelines and protocols, such as task-shifting.

c. Activities

PE1. Include family planning in relevant policies at all levels. Relevant policies will be reviewed and updated to support full implementation of the FP programme, such as task-shifting protocols. Additionally, advocacy groups will be supported to build coalitions and support for family planning within non-health governing and legislative bodies in the state. Advocacy activity seeks to engage decisionmakers by highlighting annual projected costs, cost savings, impact analysis, and the other benefits of FP.

2.3.5 Financing

Figure 13: Financing Activity Costs per Year, Naira



a. Justification

The FP budget line has not increased in Lagos since 2013 and does not sufficiently meet the needs of the full FP programme. Additional existing funding streams for family planning, primarily donor-supported FP programming, are unsustainable in the long-term. Therefore, it is paramount that government financial bodies are sensitised to the extreme importance of family planning and release additional funds to support FP activities in the state.

b. Strategy

The LSMOH and advocacy groups will conduct advocacy towards the LSMOH Budget Committee to increase the FP budget line. Additionally, advocacy will be conducted towards the Ministry of Local Government and Community Affairs to prevail on LGA authorities for creation of an FP budget line at the local level. New funding streams will be explored through potential public-private partnerships.

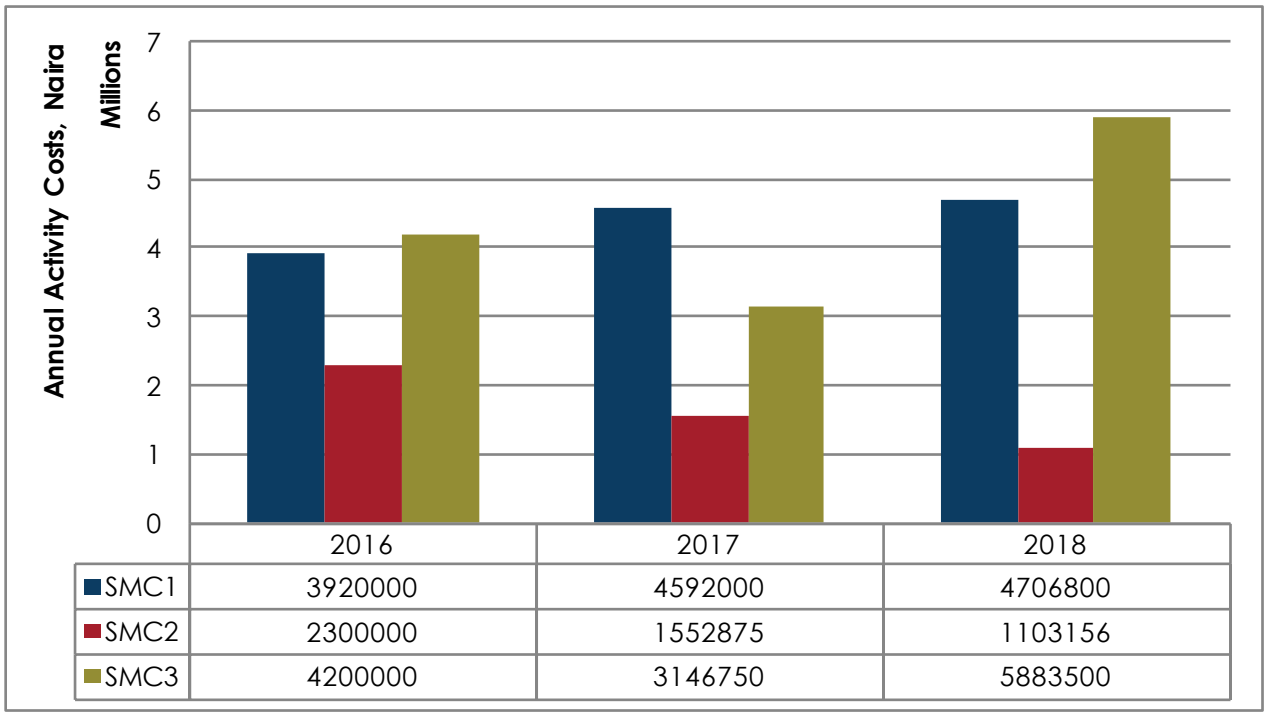
c. Activities

F1. Initiate FP advocacy to support the increase of funding for FP. Civil society organisations and existing advocacy groups will be supported to develop and implement an advocacy campaign to increase support and funding for FP at the state and local level. The LSMOH will further advocate to private businesses and enterprises for the establishment of public-private partnerships in support of family planning activities.

F2. Leverage the social corporate responsibility of private companies to support FP information and service delivery through in-kind contributions. To further foster private sector engagement in family planning, this activity seeks to involve corporations in commodity delivery and public messaging through engaging companies to voluntarily initiate corporate responsibility initiatives.

2.3.6 Supervision, monitoring, and coordination (SMC)

Figure 14: Supervision, Monitoring, and Coordination Activity Costs per Year, Naira



	2016	2017	2018
SMC1	3920000	4592000	4706800
SMC2	2300000	1552875	1103156
SMC3	4200000	3146750	5883500

a. Justification

Harmonisation of supervision efforts at the state and local level are needed to more efficiently and effectively manage FP activities. Better coordination between the LSMOH and partner activities will ensure the FP programme is sufficiently implemented in the allotted time period to reach the state FP goals. A widespread data management system is vital to track the progress of FP programming and identify bottlenecks.

b. Strategy

Current mechanisms for FP data collection will be evaluated and updated, accordingly. The LSMOH will involve reproductive health coordinators and/or FP Managers at the LGA-level in supportive supervision activities to ensure timely implementation of recommendations between supportive supervision visits. Coordination mechanisms between the LSMOH, local government officials, donors, and private sector representatives will be institutionalised to facilitate execution of the Lagos State CIP.

SMC1. Integrate LGAs into supportive supervision of health facilities. The LSMOH seeks to enhance supervision and quality assurance for FP service delivery at every level of the health system by conducting integrated joint supportive supervision in public facilities. This will create a more rapid feedback loop to track compliance and implementation of recommendations at the facility level.

SMC2. Conduct research on progress towards the state FP goals. The LSMOH will generate and disseminate FP service provision and programmatic data to assess progress towards the Lagos part of the National Blueprint goal. The effectiveness of the two existing monitoring software systems will be evaluated and integrated into one tracking system.

SMC3. Effectively, plan, coordinate, and execute the Lagos State CIP. Coordination mechanisms will be developed and institutionalised to facilitate execution of the Lagos State CIP. This includes creation of a donor coordination group to track donor-supported FP activities and encourage alignment and support for the CIP.

SECTION 3: COSTING

3.1 Assumptions

The costing process was informed and supported by the LSMOH and partners. FP programme activities were individually costed by estimating the unit costs for each necessary input and the quantity needed for implementation, as well as the frequency of the activity in the CIP. Costing inputs were derived from existing LSMOH standard rates, partners programming activities, and direct estimates from vendors. National estimates were used when state estimates were unavailable. Sources for each costing input are noted in the costing tool for general reference. Programme activities costs can be updated and modified as the CIP evolves.

The cost of contraceptives and consumables was estimated based on estimated annual shifts in method mix and growth in the population of women of reproductive age. The 2015 baseline method mix projections for Lagos State were drawn from the National Blueprint, which used the 2008 and 2013 NDHS data to project the 2015 method mix for each state. The annual rate of change in method use was calculated from 2008 to 2013 and applied to baseline projections. The 2018 CPR goal was extrapolated for each intermediate year between 2016 and 2018. The method mix used for costing should not be used for forecasting or procurement purposes; rather, this should be considered a guiding framework for the estimated costs of commodities and consumables in the state.

The costing strategy builds upon similar costing processes in other countries and at the national level to comprehensively estimate the full implementation costs of the FP programme. Unless otherwise noted, all costs (such as salaries, per diem rates, fuel costs, venue hire, etc.) are based on current costs as of January 2016. We have made assumptions for inflation based on available economic predictions. All costs have been calculated in U.S. dollars and converted to Naira.

3.2 Cost Summary

The costs of the CIP were calculated using an Excel-based costing tool with methodologies borrowed from the costing of other FP plans in the region. The cost estimates consider total resource requirements for contraceptive commodities, contraceptive consumables, and programme activities over the three-year CIP period. The CIP costs were estimated based on inputs derived from government rate documents, relevant Lagos vendors, partners implementing programmes, and national estimates when necessary. In addition to total costs, the tool categorises costs by programme areas and strategic priorities per year. The CIP factors in investment costs as well as sustainability/inflation costs over the three years. This should be considered as only a broad costing of the Blueprint, not a budgeting tool to be used on an activity-by-activity basis to allocate funds.

The total cost of the CIP from 2016–2018 is Naira 18 billion (US$91 million).

The vast majority of the cost of the plan, Naira 14 billion (US$72 million), or 79 percent of the total costs are for contraceptive commodities alone. An additional Naira 373 million (US$1.8 million) is necessary to cover the costs of consumables for the three years, contributing to 2 percent of the full FP programme costs. Thirteen percent of the FP programme costs are needed to fund supplies and commodity distribution, 4 percent for demand generation, and the remaining 2 percent for service delivery and access, finance, policy and environment, and supervision and monitoring activities.

Costs are spread over the duration of the CIP, with commodity costs increasing over time as more women are reached. There are heavier upfront investments in 2016, and not all interventions are designed to incur costs in every year.

Figure 15: Costs by Category and Strategic Priority

The CIP will cost a total of Naira 18 billion, with the highest costs in contraceptive commodities

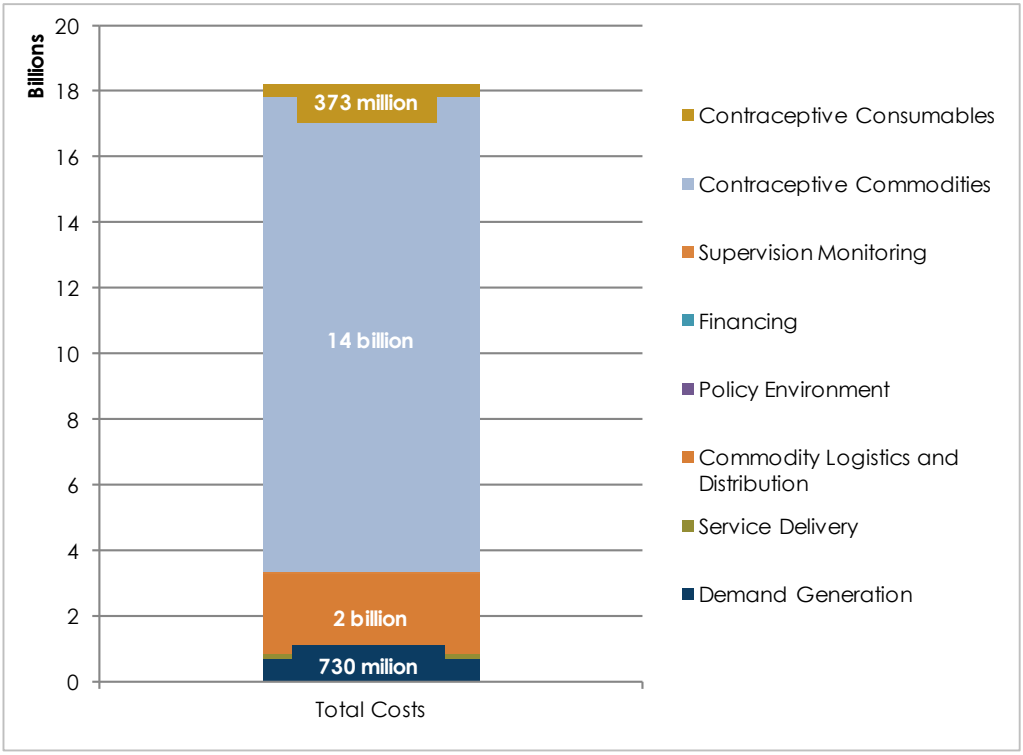
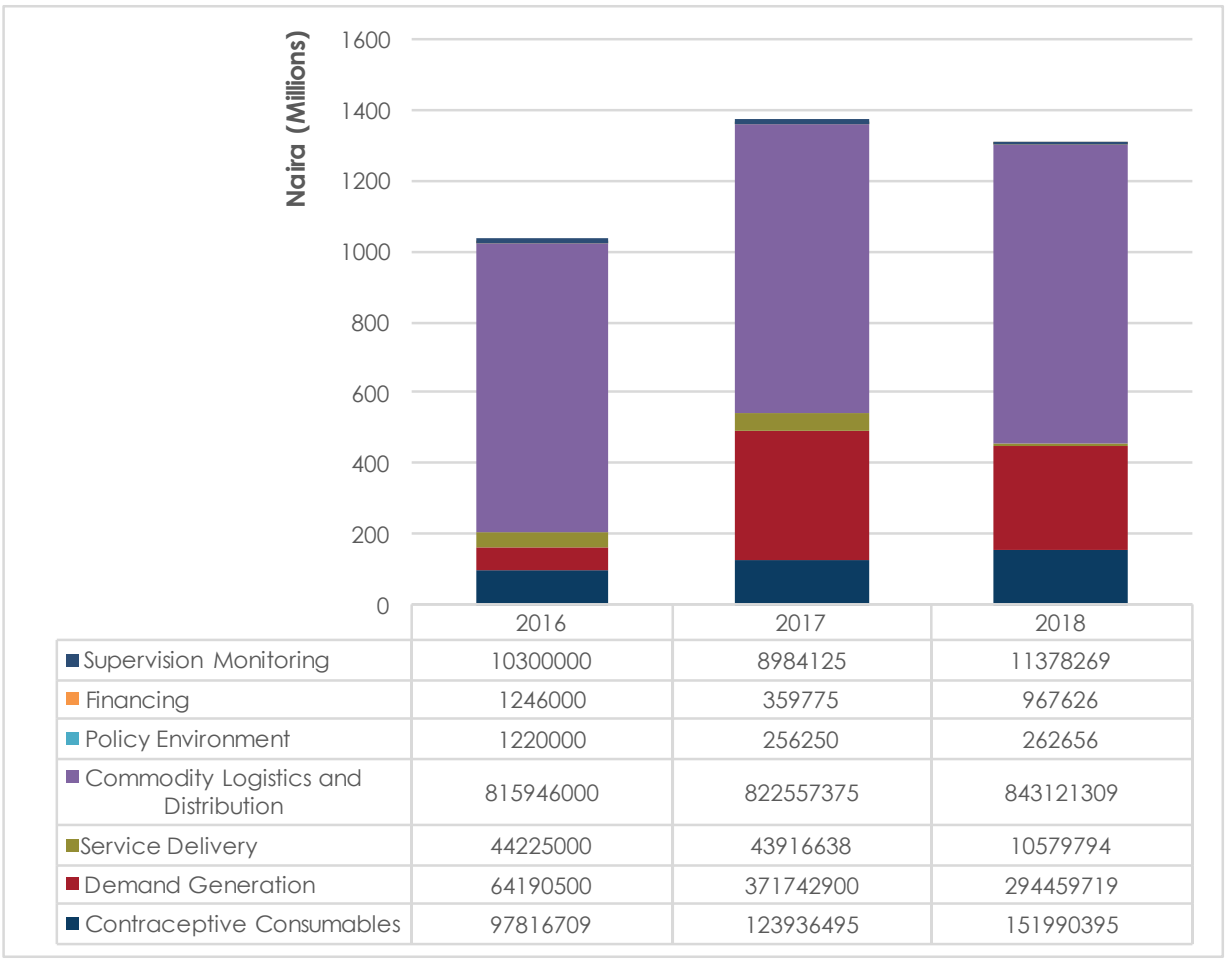
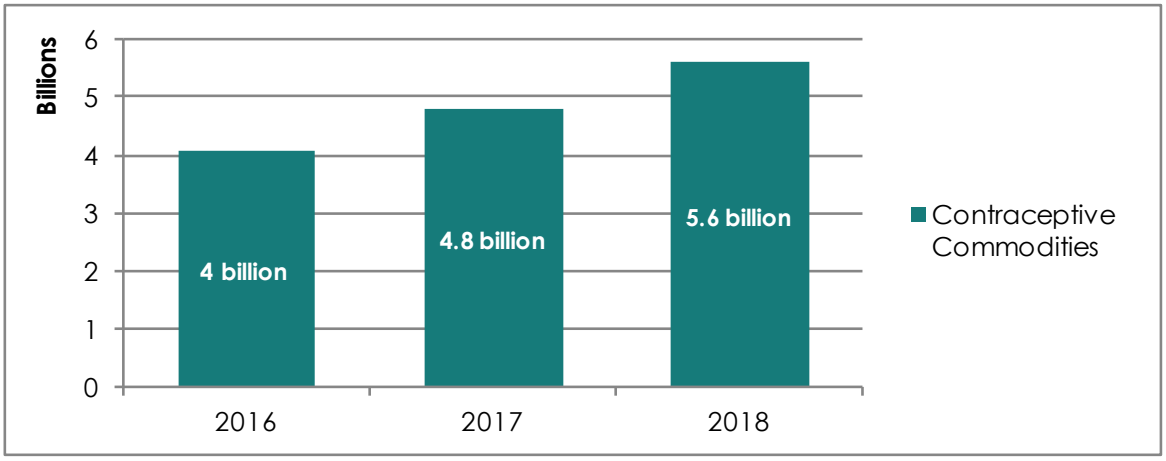


Figure 16: Cost per Year, by Category, Excluding Contraception Commodity Costs, in Naira (millions)



	2016	2017	2018
Supervision Monitoring	10300000	8984125	11378269
Financing	1246000	359775	967626
Policy Environment	1220000	256250	262656
Commodity Logistics and Distribution	815946000	822557375	843121309
Service Delivery	44225000	43916638	10579794
Demand Generation	64190500	371742900	294459719
Contraceptive Consumables	97816709	123936495	151990395

Figure 17: Total Contraceptive Commodity Costs, in Naira (millions)



SECTION 4: PROJECTED METHOD MIX

CIP activities are designed to increase the CPR from 48 percent to 74 percent and increase the modern CPR from 27 percent to 43 percent by 2018 amongst married women. The principle of the CIP is to provide a broad choice of FP methods to users to meet their preferences and needs.

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

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

- Use of LARCs (i.e., IUDs and implants) will grow faster than in previous years due to increases in trained healthcare providers and improved facilities.
- Use of injectables will also grow faster than in previous years due to a policy change allowing CHEWs to administer injections, as well as experience from other countries indicating that injectables are typically a preferred method as CPR increases.
- Traditional methods will continue to grow at the same rate, but their share of the total CPR will decrease due to higher rates of growth for modern methods.

Figure 18: Contraceptive Prevalence by Method, Married Women, 2015 baseline and 2016-2020 projections

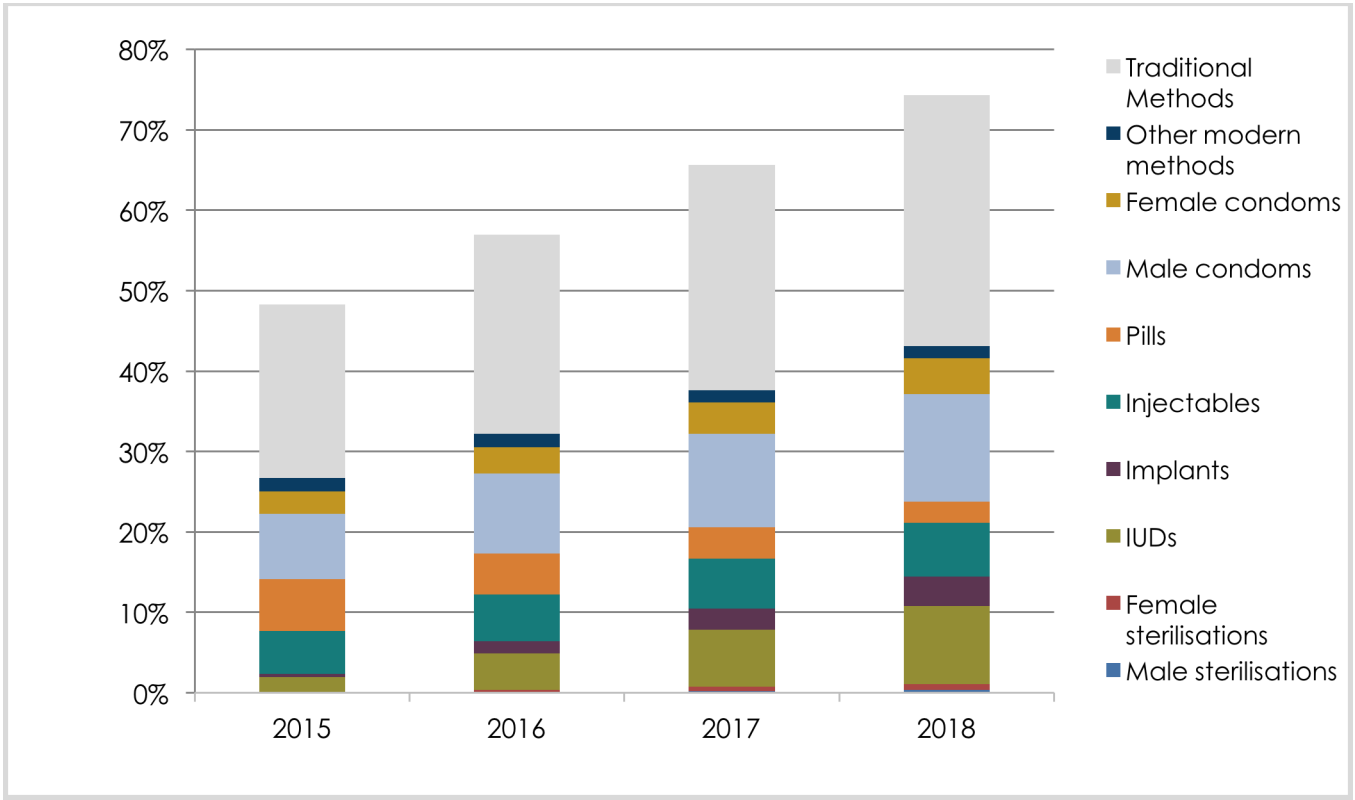
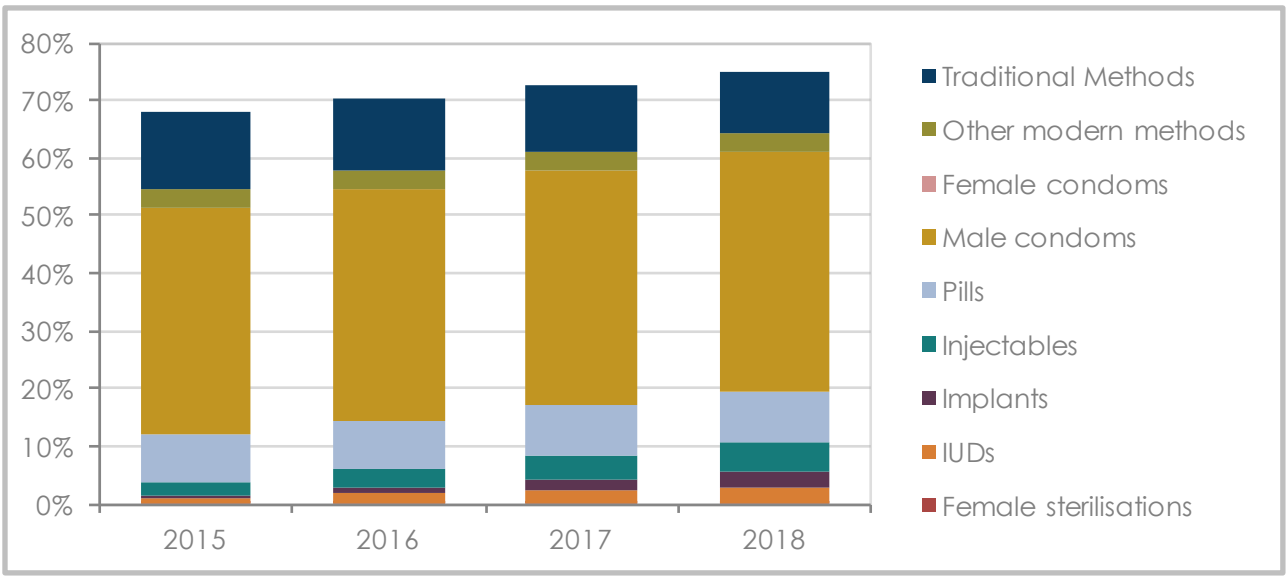


Figure 19: Contraceptive Prevalence by Method, Unmarried Women, 2015 baseline and 2016-2020 projections



SECTION 5: THE PATH FORWARD

5.1 Resource Mobilisation

This document can serve as an excellent tool to mobilise adequate funding for FP in Lagos State to reach the state CPR goal. Nearly 80 percent of the estimated funding needed for FP programming in Lagos State will go towards contraceptive commodities alone. Considering that Lagos State has the highest density population of all states in Nigeria, it follows that the costs to cover the specific contraceptive needs for women of reproductive age would require significant investment. Currently, the FMOH holds the responsibility for covering these costs and providing adequate contraceptive commodities to meet the family planning needs of women in Lagos State. However, that does not guarantee sufficient supplies of commodities will be provided during the three-year time period. To ensure full support of the Lagos State CIP by the FMOH, the state may consider using this document as an advocacy and accountability mechanism for sufficient procurement of contraceptive commodities.

A severe funding gap exists between allocated state funding for FP and the projected costs. The current budget line of 16.4 million (stagnant since 2013) covers less than 15 percent of the estimated 2016 state-responsible programme activity costs. To address this gap, the state should fully allocate and release already committed FP funds to support the programme activity costs outlined over the three years. In addition, the state may consider using the outlined activities and associated spending requirements to advocate for additional federal, local and donor support to fill the funding gap.

Additional attention should go towards sustainable finance planning for commodity logistics and distribution at the state level. Currently, UNFPA fully funds the estimated 13 percent share of the FP programming in the state for commodity logistics and distribution. The newly implemented last-mile distribution approach has proven outcomes to improve efficient and timely distribution of commodities directly to facilities thereby addressing previous shortages at clinics. The programming costs to implement the new system represent a significant portion of the overall FP programme activity budget. Therefore, the LSMOH might consider further using this document as a tool for continued stakeholder engagement and future resource mobilization for these costs.

5.2 Ensuring Progress through Performance Management

In order to reach the 74 percent CPR goal set by the Federal Ministry of Health, Lagos State must make a concerted effort to fully implement the CIP in a timely fashion. In doing so, the state and partners must remain cognisant of progress along the way through stringently tracking the status of implementation, measuring outputs and estimating impacts where possible.

The Family Planning CIP in Lagos State is meant to serve as a living document that can evolve over the three-year period based on measurements of progress and feedback from implementers. High-quality, timely, and comprehensive data collection is necessary to inform the evolution of the plan to improve performance and institutionalisation and scale-up of best practices. Therefore, uptake of the performance management plan (Annex A) is encouraged for all stakeholders as a guiding tool towards progress.

Since Lagos is a priority CIP state, the indicators outlined purposely align with the national Performance Management Plan to encourage harmonisation where possible with the National Blueprint and allow the state to efficiently feedback implementation progress to the FMOH.

To support successful implementation and achievements of CIP goals and objectives, the following four interlinked M&E components will be implemented systematically:

- Routine data collection through DHIMS (District Health Information Management System)
- Performance review and quality improvement
- Integrated supportive supervision
- Evaluation and operations research

The framework calls upon quarterly, bi-annual or annual reporting of key indicators to measure output or impact. The data source noted serves as a marker for the responsible data collection system. As a part of the supervision, monitoring, and coordination strategy in the CIP, the LSMOH will lead coordination of this data collection and request feedback, where necessary, from implementing partners.

The full framework is available in Annex A.

ANNEX A: MONITORING AND EVALUATION SUMMARY TABLE

Indicators	Indicator Type	Data Source	Level of Reporting	Frequency
Modern contraceptive prevalence (all women) [CPR]	Impact	NDHS/NARHS	National/ State	Annually
Demand Generation and Behaviour Change Communication				
Percentage of women of reproductive age who have heard about at least three methods of family planning	Outcome	NDHS/NARHS	National/ State	Annually
Percentage of the population who know of at least one source of modern contraceptive services and/or supplies	Outcome	NDHS/NARHS	National/ State	Annually
Percentage of population with a favourable attitude towards an FP product, practice or service	Outcome	NDHS/NARHS	National/ State	Annually
Percentage of audience who believes that spouse, friends, relatives, and community approve (or disapprove) of the practice	Outcome	NDHS/NARHS	National/ State	Annually
Number of targeted multimedia FP advocacy and demand generation campaigns	Output	Programme report	States/ Region	Quarterly
Number of FP champions (trained and active)	Output	Programme report	State	Quarterly
Number of dissemination sessions of the revised and updated Adolescent Family Life Education curriculum	Output	Programme report	state	Annually
Number of teachers trained in the revised curriculum	Output	Programme report	State/Ministry of Education (MoE)	Quarterly
Number of peer educators trained in the curriculum	Output	Programme report	State	Quarterly
Service Delivery				
Couple years of protection (CYP)	Outcome	NHMIS	National/ State	Quarterly
Total number of modern method users (all women)	Output	HMIS (public and private)	State	Quarterly
Percentage of women who were provided with information on family planning during last visit with health service provider	Outcome	Health Management Information System (HMIS)	State	Annually

		(public and private)		
Development of in-service training plan and single standardised curriculum, by type of service provider	Output	Programme report	State	Annually
Number of dissemination sessions of revised and updated in-service training curriculum for family planning	Output	Programme report	State	Quarterly
Proportion of identified PHCs renovated for service delivery	Output	Programme report	State	Annually
Number of FP trainers trained in updated pre-service training curriculum, by state	Output	Programme report	State	Quarterly
Number of trainers trained in in-service FP practices	Output	Programme report	State	Quarterly
Number of training sessions conducted by trainers,	Output	Programme report	State	Quarterly
Proportion of recruited CHEWs trained for comprehensive FP (emphasis on injectables) training	Outcome	Programme report	State	Quarterly
Proportion/number of nurses and midwives trained in comprehensive family planning (emphasis on LARC methods)	Outcome	Programme report	State	Quarterly
Number of training sessions conducted for pharmacists and pharmacy employees on FP counselling	Output	Programme report	State	Quarterly
Number of pharmacies where at least one person has been trained in FP methods and counselling, by level (state and community)	Output	Programme report	State	Quarterly
Number of training sessions conducted for PPMVs and informal drug sellers, by level (national, regional, and state)	Output	Programme report	State	Quarterly
Quantity of FP training equipment, materials, and anatomical models procured and disbursed to trainers	Output	Programme report	State	Annually
Number of new access points for FP service provision (hospital, clinic outreach, mobile FP clinics, and community venues where FP outreaches are conducted)	Outcome	Programme report	State	Quarterly
Number of facilities at which FP provider/equipment assessments were conducted, (skills, competence)	Output	Supportive Supervision (public and private)	State	Quarterly

Number of facilities in which family planning is integrated with other healthcare services (i.e., sites where family planning is integrated with routine immunization, HIV counselling and testing, prevention of mother-to-child transmission (PMTCT), and sexually transmitted infection (STI) services)	Output	Facility assessment	State	Quarterly
Development of state FP-trained CHEW database	Output	PHC Board	State	Annually
Number of public-private partnerships for increasing FP service delivery, supply chain, demand generation, etc.	Output	Programme report	State	Annually
Supplies and Commodity Distribution				
Percentage difference between forecasted consumption and actual consumption	Outcome	Programme report	Federal/State	Annually
Number of LGAs/LCDAs providing consumables for FP services		LSMOH/PHC Board		
Contraceptive or other RH commodity forecasts updated at least annually	Output	Programme report	State	Annually
Number of persons trained to manage and produce commodity forecast reports	Output	Programme report	State	Quarterly
Number of commodity logistics trainings conducted	Output	Programme report	State	Quarterly
Policy and Enabling Environment				
Uptake of FP-related policies and policy updates, disaggregated by level	Outcome	Programme report	State	Annually
Financing				
Annual expenditure on family planning from government domestic budget	Outcome	Programme report	State	Annually
Total FP budget line item	Output	Programme report	State	Annually
Supervision, Monitoring, and Coordination				
Capacity for supervision, coordination management, or M&E of family planning	Outcome	Programme report	State	Annually
Number of existing staff trained in either supervision, coordination management, or M&E of FP programme at state levels	Output	Programme report	State	Annually
Number of supervisory visits conducted at the state level	Output	Programme report	State	Quarterly

ANNEX B: ACTIVITY MATRIX

Priority Area: Demand Generation and Behaviour Change Communication (DBC)

DBC1. Men and women access accurate, rights-based, information about birth spacing, including information about the full mix of effective and safe family planning methods, and the benefits and potential side effects

DBC1.1. Gather evidence and data to inform the FP Behaviour Change Communication (BCC) strategy

- Identify FP myths/misconceptions
- Identify existing FP communication channels
- Identify gatekeepers (religious leaders, traditional/community leaders, etc.)
- Identify target audiences (women of reproductive age, adolescents, men, people with disabilities, etc.)
- Identify FP communication opportunities and barriers

Sub activity	Inputs	Output Indicators	Timeline	Responsible
DBC 1.1.1. Outline terms of reference (TOR) for research firm that will identify the major objectives for FP BCC Landscape Analysis ▪ Meeting at the LSMOH with key RH/FP LSMOH personnel to develop primary objectives for BCC strategy and landscape study ▪ Develop TOR for research firm based off of primary objectives	No inputs	TOR developed for research firm	2016 Q1	LSMOH

	DBC1.1.2. Hire communications firm to prepare an FP BCC Landscape Analysis ▪ Conduct secondary analysis of national FP BCC strategy and Lagos-specific FP BCC programmes and research ▪ Conduct five Formative Research Rapid Assessments (one assessment conducted at each administrative region–Ikeja, Badagry, Ikorodu, Lagos Island, and Epe) Develop preliminary FP BCC Strategy with recommendations for communication of FP messages to targeted audiences	Communications Firm ▪ 90 days (includes DBC 1.1.2-1.1.5) Graphic Designer 15 days	▪ FP BCC Landscape Analysis Report developed ▪ Preliminary FP BCC Strategy developed	2016 Q2-Q3	LSMOH
	DBC1.1.3. LSMOH and key stakeholders validate preliminary Lagos FP BCC Strategy ▪ Meeting to validate FP BCC Landscape Analysis Report and FP BCC Strategy	2-day meeting ▪ Lagos hotel ▪ 45 people ▪ Printing 25 pages pp (1125 total) ▪ Lunch ▪ Tea break ▪ Transport per diem *Linked to DBC 1.1.2*	Lagos FP BCC strategy draft validated	2016 Q2	State RH/FP Coordinator

		DBC1.1.4. Test and revise key communication messages ▪ Communications firm tests communication messages in 5 administrative districts ▫ 4 focus groups per administrative district, each targeting a specific audience bracket (youth, males, people living with disabilities, and traditional FP method users) ▪ Communications firm revises key communication messages based off of focus group feedback	20 focus group meetings ▪ 8 people per focus group ▪ Small meeting hall ▪ Lunch ▪ Transport per diem *Linked to 1.1.2*	Key messages revised (target: 40)	2016 Q2	State RH/FP Coordinator
		DBC1.1.5. Develop a package to guide recruitment, orientation, and monitoring of FP champions[4] ▪ Communications firm creates evidenced-based messaging tailored towards specific FP Champions (religious/community leaders, traditional healers, and male advocates) ▪ Communications firm develops Facilitators Guide ▪ Communications firm develops FP Champion promotional material *Linked to DBC2.2.1, DBC3.1.1, DBC3.2.1*	*Linked to 1.1.2*	FP Champion package produced	2016 Q3	State RH/FP Coordinator

[4] FP Champions are community members who will be sensitised to the importance, potential benefits, and availability of various methods of family planning. FP champions are tasked with further spreading FP messaging for community uptake through their scopes of influence. FP champions are not authorised to provide family planning methods or counselling services.

		DBC1.1.6. Finalise Lagos state FP BCC strategy ▪ FP TWG Meeting ▪ Communications firm presents revised key messages ▪ Approve and finalize key messages	1 half-day validation workshop: ▪ @ LSMOH ▪ 15 people ▪ Tea break ▪ Lunch ▪ Printing: 20 pages pp (300 total)	Lagos FP BCC strategy finalized	2016 Q3	State RH/FP Coordinator
		DBC1.1.7. Print and disseminate strategy ▪ State RH/FP coordinator will hold one-on-one meetings with key partners to disseminate strategy and clarify LSMOH expectations for partnership in strategy execution (@ LSMOH) ▪ Strategy will be presented at Annual Family Planning Coordination Meeting (*linked to SMC 1.2.1)* ▪ Strategy will be presented at RH/FP TWG meeting (*linked to SMC4.1.2)*	▪ Printing: 200 copies strategy (4,000 pages total) ▪ 800 FP Champion Booklets (for training) ▪ 5000 FP Advocacy Booklets (for community distribution)	Lagos State FP BCC strategy disseminated through existing stakeholders meetings	2016 Q3	State RH/FP Coordinator
	DBC1.2. Develop and implement an FP mass media campaign based on the Lagos State BCC strategy					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**
		DBC1.2.1. Develop TV, radio, and print ads in pidgin and predominant local languages ▪ Hire a media firm to develop: o 30-second TV ads (4) o 30-second radio spots (4) o Poster designs (10) o Billboard designs (2) ▪ Validation meeting to finalise communication material designs	▪ Media firm (2530 days)-TV/Radio) ▪ Media firm (15 days)-Print ▪ 1 half-day validation workshop: o @ hotel in Lagos o 25 people o Lunch o Tea break o Printing: 20 pages pp (500 total)	▪ Radio spots developed (target: 4) ▪ TV ads developed (target: 4) ▪ Posters developed (target: 10) ▪ Billboards developed (target: 2)	2017 Q1	State RH/FP Coordinator

		DBC1.2.2. Purchase airtime for radio and TV, and areas to put up posters and billboards	▪ Purchase radio airtime: 4 major state radio stations for 24 months ▪ Purchase TV airtime: 4 major TV channels for 24 months ▪ Print posters and support CHEWs through allowances and per diems to put up posters in health facilities, community gathering areas, and schools (once) ▪ Purchase 4 billboards for 6 months per year (2 years)	▪ Radio spots aired daily (target: 4) ▪ TV ads aired daily (target: 4) ▪ Posters printed (target: 40,000) ▪ CHEW support (75) ▪ Travel allowance ▪ Billboards put up (target: 4) ▪ BRT bus signage (target: 25)	2017-2018	State RH/FP Coordinator
		DBC1.2.3. Train media spokespeople on accurate, effective messaging on FP ▪ Half-day training workshop (40 media spokespeople—TV, radio, and internet reporters) ▪ 2 TWG members lead workshop	▪ 1 half-day training workshop o Meeting Halls o Lunch o Travel per diems o Printing: 420 copies	40 Media spokespeople trained	2017 Q1	State RH/FP Coordinator
DBC2. Increase awareness of and interest in FP promotion through interpersonal communication and male involvement						
	DBC2.1. Leverage CHEWs (posted at PHCs) to increase FP awareness and information provision skills					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**

		DBC 2.1.1. Consultant adapts National Service Delivery Integration Protocol to develop training materials that integrate FP messaging (LARC counselling/ information provision, post-natal FP counselling, etc.) into CHEW's daily protocols and develop job aides *Linked to SD1.1.1 (Consultant adapts National Service Delivery Integration Protocol to include updates for nurses and midwives)*	▪ Consultant, 30 days	Lagos State CHEW Service Delivery Integration Protocol created	2016 Q4	
		DBC2.1.2. Two consultants conduct CHEW trainings at each of the 5 administrative zones ▪ CHEWs will be trained on the adapted Integration Protocol (*linked to DBC2.1.1*) ▪ CHEWs will be trained on how to facilitate FP Champion trainings for male advocates, traditional healers and religious/community leaders (*linked to DBC1.1.5*) ▪ Consultant conducts 1-week training at zonal level to build a cadre of state-level CHEWs (5 trainings)	▪ 2 consultants (30 days each) ○ Travel per diems ▪ 5 training of trainers (TOT) Workshops (40 people per training) ○ @hotel in zone ○ Travel per diem ○ Hotel accommodations ▪ Printing: 15 pages pp (3,030 total)	200 CHEWs trained in the integration protocol and facilitating FP Champion trainings	2017 Q1	State RH/FP Coordinator
	DBC 2.2. Involve males in FP promotion					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**

		DBC 2.2.1. Orient 10 male FP Champions in each of the 40 LCDA in Lagos state ▪ CHEWS recruits volunteer male champions through their wives who adopt contraceptives at PHCs ▪ 1 CHEW per LCDA assigned to orient FP Champions ▪ Hold half-day orientation for male FP champions in each LCDA	40 half-day orientations ▪ @PHC ▪ Lunch ▪ Transport refund	400 Male FP Champions identified and given orientation	2017 Q2	State RH/FP Coordinator
		DBC 2.2.2. Conduct 2-day FP Champion training for male volunteers using FP Champion package in 5 administrative zones *Linked to DBC 1.1.5*	▪ 2-Day training o @ hotel in administrative zone o 2 facilitators per training o 80 participants per training o Hotel Accommodations o Tea break o Lunch o Travel per diem Printing: 20 pages pp	400 Male FP champions trained	2017 Q2	CSO & CHEWS
		DBC 2.2.3. Male FP peer promoters hold quarterly community dialogue with other men on FP promotion	▪ @PHC/Local meeting spot ▪ Refreshment ▪ Transport refund	Males advocated on FP benefits and encouraged to continue dialogue with other males	2017 Q 2 - 2018 Q4	State RH/FP Coordinator

		DBC2.2.4. Hold annual FP Champion advocacy planning meeting	▪ 1-Day meeting o @ hotel located in state o 2 facilitators o 40 participants o Tea break and lunch o Travel per diem ▪ Printing: 20 pages pp ▪ No hotel accommodation	Advocacy plan developed	2017 Q3 2018 Q3	Lagos State Advocacy Working group (LAWG)
	DBC 2.3. Engage influential men to be spokespersons for male involvement in FP					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**
		DBC 2.3.1. Recruit influential men in sports, politics, and the media/arts to be champions for male-involvement in FP ▪ LSMOH/IP contacts influential men and proposes involvement in FP campaign	Entertainment Stipend (5 entertainers)	Influential men identified as potential FP ambassadors and contacted	2016Q3	LSMOH Artist guild
		DBC 2.3.2. Engage influential men in FP promotional campaign	DBC 1.2.1-1.2.2	Influential men engaged as FP ambassadors	2016 Q3	LSMOH Artist guild
DBC3. Establish and sustain engagement with religious and community leaders on FP						
	DBC3.1. Identify potential FP advocates among religious leaders					

		Sub activity	Inputs	Output Indicators	Timeline	Responsible
		DBC3.1.1. Hold a series of workshops with religious leaders to discuss FP and the health of women and families. Leaders discuss their concerns, interests and pathways for FP incorporation in religious practices. Facilitators use the FP Champion package ▪ Linked to DBC 1.1.5 ▪ Meetings with leaders of 12 religious mother bodies, 2 half-day meetings each ▪ Religious leaders assign two representatives for FP religious advocacy activity (linked to DBC 3.1.2)	▪ 2 rounds of 12 half-day workshops (24 total) ▪ @ LAWG or religious body site ▪ 10 people per meeting ▪ Lunch ▪ Tea break ▪ Travel per diem ▪ Printing (10 pages pp, 1200 total)	120 religious leaders engaged in FP	2017 Q2	LAWG
		DBC 3.1.2. Identified FP advocates within each religious community prepare appropriate, evidence-based FP messages to incorporate into religious practices ▪ 12 one-day meetings to prepare appropriate FP religious messaging	▪ 12 one-day meetings with religious advocates ○ @ LAWG or religious body site ○ 4 people per meeting (2 religious advocates and 2 AWG facilitators) ○ Lunch ○ Tea break ○ Transport per diem	Religion-specific advocacy messages developed	2017 Q2	LAWG
		DBC 3.1.3. FP religious messaging reviewed, updated, approved, and supported by religious leaders ▪ FP religious advocates report messaging to religious leaders to review and approve FP messaging ▪ 1 round of half-day meetings	▪ 2 rounds of 12 half-day workshops (24 total) ○ @ LAWG or Religious body site ○ 10 people per meeting ○ Lunch ○ Tea break ○ Travel per diem	FP Religious messaging approved by religious leaders	2017 Q2	LAWG

		DBC 3.1.4. FP religious messages disseminated by religious leaders to local religious bodies ▪ Religious leaders send official letters to religious bodies advocating for the incorporation of appropriate FP religious messaging	No inputs	FP religious messaging disseminated to local religious bodies	2017 Q3	LAWG
		DBC 3.1.5. Public advertising of religious leaders willing to publically support FP messaging	*Linked to DBC 1.2.2*	Religious media ad developed	2017-2018	LAWG
	DBC3.2. Identify FP advocates among community leaders					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**
		DBC3.2.1. Hold a series of awareness-raising events with community leaders using the FP Champion package ▪ 5 full-day FP Champion workshops at each administrative zone (20 participants each)	▪ 5 one-day meetings with community leaders (100 participants total) o @ hotel located in administrative zone o Lunch o Tea break o Transport per diem	Community leaders engaged as FP champions (target: 100)	2017 Q2	LAWG
		DBC 3.2.2. Community leaders incorporate FP Champion training into their community practices	Incentive/Cap (100 participants)	FP messaging disseminated by community leaders	2017 Q2	LAWG
DBC 4. Educate adolescents in the state about benefits of family planning and birth spacing						
	DBC4.1. Increase FP awareness and contraceptive utilization among youths/ adolescents in Lagos State					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**

		DBC 4.1.1. Develop a life planning programme for youth ▪ Life (career, family, health, and finances) Goal-setting interactive activity ▪ Peer educator structure ▪ Career mentor involvement ▪ Integration of FP benefits and service information	▪ Conduct 1-day life-planning programme development workshop o 2 facilitators o 5 university students o 5 youth representatives from priority vocational trades o 10 pre-identified career mentors o @ hotel o 22 people o Lunch and tea break o Travel	Life-planning programme developed	2016 Q3	State RH/FP Coordinator
		DBC 4.1.2. Train peer educators and mentors in the life-planning curriculum ▪ 2 universities	▪ Conduct 1-day meeting with student representatives and mentors (1 per university) o 2 facilitators o @ 2 universities o 25 people each o Lunch and tea break o Travel	50 student representatives and mentors trained in life-planning curriculum	2016 Q3	State RH/FP Coordinator & CSO
		DBC 4.1.3. Train peer educators and mentors in the Life-planning curriculum ▪ Conduct 1-day TOT training for peer educators (2) and mentors (2) representing 5 priority trades per LCDA ▪ 3 trainings (5 LCDAs per training) ▪ 5 facilitators per training	▪ @ 3 hotels located centrally to each cluster of LCDAs ▪ 100 people per training ▪ Lunch ▪ Tea break ▪ Transport per diem	150 peer educators and 150 mentors trained in the life-planning curriculum	2016 Q3-Q4	CSO
		DBC 4.1.4. Roll out life-planning programme at 2 universities ▪ Create student clubs ▪ Hold bi-annual one-on-one mentorship meetings	▪ Start-up and maintenance funds for student clubs (100 students per club) ▪ Transport per diem for mentors	200 university students participated in life-planning programme	2017 Q1 - 2018 Q4	State RH/FP Coordinator & CSO

		DBC 4.1.5. Roll out life-planning programme for 5 priority trades ▪ Partner with local trade associations in each LCDA to integrate life-planning programme into vocational training centres ▪ Create peer groups by trade ▪ Hold bi-annual one-on-one mentorship meetings	▪ Start-up and maintenance funds for peer groups (25 students per peer group) ▪ Transport per diem for mentors	1,875 youth participated in life-planning programme	2016 Q4 - 2018 Q4	State RH/FP Coordinator & CSO
		DBC 4.1.6. Review progress of programme ▪ FP Programme monitoring team holds review and revise meeting o 2 facilitators o 2 representatives from each university programme (4 total) o 2 representatives from each LCDA (30 total)	▪ @ hotel ▪ Lunch ▪ Tea break ▪ Transport per diem	Update on progress documented and support provided by team	2017 Q1	LSMOH
DBC 5. Develop partnerships with state and private media stations to promote FP as a social responsibility						
	DBC5.1. Plan and execute a media engagement strategy					
	Sub activity		**Inputs**	**Output Indicators**	**Timeline**	**Responsible**
	DBC5.1.1. Develop an engagement strategy that outlines approach of engagement, suggested media activities, and recommended key messages ▪ Consultant or IP develops engagement strategy based on key informant interviews ▪ Hold a half-day vetting workshop with RH TWG (Linked to SMC 3.1.2)		20 days of consultant time	Media engagement strategy developed	2016 Q2	State RH/FP Coordinator

		DBC 5.1.2. Execute media engagement strategy ▪ FMOH reach out to individual media houses to hold 20 small-group outreach meetings (5 participants per meeting ▪ Sign Memorandum of Understanding (MOU) with media outlets	▪ @ media office ▪ Transport per diem	▪ Media engaged ▪ MOU signed (target 2)	2016 Q3 – 2017 Q2	State RH/FP Coordinator
DBC 6. Increase awareness about FP and where to access services among the general population						
	DBC 6.1. Develop FP promotional materials					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**
		DBC 6.1.1. Adopt, print, and distribute the National Logo as a state FP service symbol/ Logo	Hold 1-day launch of National FP logo ▪ Hall ▪ 100 people ▪ Lunch and tea breaks ▪ Transport refund ▪ Print 10,000 copies of fliers and 5,000 copies of posters ▪ 3,000 copies of state FP logo/symbol ▪ List of FP service delivery points (public and private) in the state— 2,000 copies printed	National/State FP Logo adopted and printed	2016 Q2	UNFPA/ LSMOH/ MLGCA
		DBC 6.1.2. Develop a directory of FP service delivery points (public & private)	*Linked to DBC 6.1.1 above*	Directory of FP developed and printed	2016 Q1/Q2	LSMOH/ SHOPES/ MION/ PARTNERS

		DBC 6.1.3. Distribute state FP service posters with agreed upon logo to show where people can access services ▪ Linked to DBC 6.1.1	Print and distribute ▪ 250,000 copies of flyers ▪ 750 copies of posters ▪ 500 copies of list of FP service delivery points (public and private) in the state	Flyers and posters developed and printed	2016 Q1-Q2	LSMOH/ PARTNERS
	DBC 6.2. Involve Ward Health Committee (WHCs), Community Service Organizations (CSOs), Health Educators (HEds), Association of General Private Medical Practitioners of Nigeria (AGPMPN), AGPNP and Community-based distribution agents (CBDs) in dissemination of FP messages & service promotion at the community level					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**
		DBC 6.2.1. Involve WHCs, CSOs, HEds, AGPMPN, AGPNP (nurse practitioners), and CBDs CSOs in all the FP promotional activities at the community level ▪ 1-Day Sensitisation and launching at community level on the newly created FP symbol involving all WHCs, CSOs, HEds, AGPMPN, AGPNPN, and CBDs ▪ Integrate FP promotional activity into existing community programming	▪ 10 sensitisation workshops (50 participants each) ○ Local hotel ○ Lunch ○ Tea break ○ Transport per diem ○ Printing: 10 pp (5,000 total)	WHCs, CSOs, HEds, AGPMPN, AGPNPN, and CBDs pare actively engaged in all FP promotional activities	2016 Q2/3	RHFP Unit LSMOH/RH U, HEU (Health Education Unit), NSU (National Surveillance Unit), DMS (Data Management System Commission) of PHCB/MLCCA (Primary Healthcare board)
	DBC 6.3. Create an interactive medium to communicate FP information (including benefits and side effects of FP)					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**

		DBC 6.3.1. Conduct advocacy visits to telecommunication network companies to create a 24-hour toll free hotline for exchange of FP information and complaints	5-person advocacy team visits communication companies for creation of hotline services ▪ 5 people ▪ 10 visits ▪ Lunch ▪ Transport refund	▪ Hotline created	2016 Q3	LSMOH/Partners
		DBC 6.3.2. Maintain 24-hour free hotline for exchange of FP information and complaints ▪ 3 health professionals on call 24/7 to respond to phone hotline and social media queries	▪ Call-in line maintenance fee ▪ 3 nurses part-time salaries	Hotline maintained	2017 Q1-2018 Q4	LSMOH/Partners
		DBC 6.3.3. Create and maintain social media for youth and anonymous message box to ask questions ▪ A communications firm/partner will create a standalone social media campaign targeting youth to inform youth of FP methods and have live discussions in an interactive portal (website, Facebook page, Twitter) ▪ A communications firm/partner will promote the social media campaign in existing youth online spaces ▪ 3 health professionals on call 24/7 to respond to phone hotline and social media queries (*linked to DBC6.3.2)*	Communications firm ▪ 10 days design ▪ 4 days/month for maintenance	Social media page created and maintained	2016 Q3	LSMOH/PARTNERS
DBC 7. Increase people with disabilities' access to a full range of family planning methods and counselling						
	DBC 7.1. Partner with disability human rights groups to promote and increase uptake of FP methods					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**

		DBC 7.1.1. Attend disability human rights group annual meeting and present FP Champion package (LSMOH representative)	▪ Transport per diem	Disability advocates are sensitized to the importance of FP	2016 Q4	LSMOH
		DBC7.1.2. Invite representatives of disability human rights group to FP TWG Meetings to advise on how the LSMOH can more effectively reach target populations ▪ 2 representatives attend once a quarter ▪ *Linked to SMC3.1.2*	▪ Travel per diem (2 participants)	FP TWG sensitised to FP-related needs of people with disabilities	2016 Q2, Q4 2017 Q2, Q4 2018 Q2, Q4	LSMOH
	DBC 7.2. Reach out to the in-school population of youth with disabilities					
		Sub activity	**Inputs**	**Output Indicators**	**Timeline**	**Responsible**
		DBC 7.2.1. Integrate FP awareness messages into curriculum of the physically challenged schools ▪ Advocate to the FMOE to include FP awareness messages in the curriculum of physically challenged schools	▪ 5 visits to the FMOE ○ Transport per diem ○ Lunch	FMOE approves integration of FP awareness in curriculum of physically challenged schools	2017 Q1	LSMOH
		DBC 7.2.2. Conduct a training for teachers at physically challenged schools ▪ 1-day training in Lagos state (30 participants)	▪ 1-day training ○ @ Hotel ○ Lunch ○ Tea break ○ Transport per diem ○ Printing: 600 pages	30 teachers of students with disabilities trained on FP awareness	2017 Q2	LSMOH
DBC 8. Increase use of modern contraceptive methods						
	DBC 8.1. Sensitise and train traditional healers on modern FP promotion[5]					

[5] As traditional birth attendants (TBAs) are officially being phased out, this activity seeks to retain the influence and respect TBAs likely will continue to have in their communities regarding women's choice and access to family planning services. Therefore, this activity targets primarily TBAs but will enlist them in the promotion of modern contraceptives in their community through awareness creation and FP information dissemination and referrals.

		Sub activity	Inputs	Output Indicators	Timeline	Responsible
		DBC 8.1.1. Conduct an FP Champion training for traditional healers ▪ 1 training per administrative district (40 participants each)	▪ 1 consultant, 45 days o Transport per diem o Hotel per diem ▪ 2-day TBA TOT Workshop (5 workshops) o @ Local Hotel o Lunch o Tea break o Transport fund o Printing: 1,500 pages	200 traditional healers trained as FP Champions	2017 Q1	LSMOH

Priority Area 2: Service Delivery (SD)

SD1. Maximise the number of FP service delivery points by increasing the number of health providers at all levels that are trained to provide the full spectrum of FP services appropriate to their cadre.

SD1.1. Scale up in-service training, prioritising providers working at facilities without any trained provider, with focus on quality, provision of long-acting methods, and counselling

Sub activity	Additional detail (Inputs Required)	Output Indicators	Timeline	Responsible
SD 1.1.1. Review National Service Delivery Integration Protocol and adapt updated in-service training materials as necessary for providers (nurses) to be in alignment with the national blueprint ▪ Consultant Adapts National Integration Protocol (*linked to DBC2.1.1)*	• 1-day full-day vetting and finalisation workshop with RH TWG and relevant provider associations (1 meetings) o @LSMOH o 25 people o Lunch and tea breaks o Transportation o Printing 500 (20 pages pp)	In-service training materials updated	2016 Q3	RHTWG
SD 1.1.2. Conduct training of trainers for FP providers ▪ 2 representatives from each LCDA ▪ 5 master trainers (skilled nurse practitioners)	▪ 5-day training o @ Lagos Hotel o 80 people per workshop o Transport per diem o Hotel accommodations o Lunch o Tea break o Printing: 20 pp	25 providers prepared to train other providers on updated FP service provision and counselling guidelines	2017 Q2	MSION/LSMOH/PHCB

		SD1.1.3. Identify training priority facilities, including private providers ▪ LSMOH staff reviews results from mapping activity (SMC 3.1.1.) with input from LGA FP coordinators and develop list of priority facilities and providers to receive FP refresher skills training	No inputs	Priority list of facilities that require FP capacity training identified	2016 Q3	SHOPS/MSION/LSMOH/HEFAMAA
		SD 1.1.4. Trainers are deployed to provide refresher trainings to healthcare workers on updated FP service provision and counselling guidelines ▪ Trainers conduct two rounds of 3-day facility-based in-service trainings per LCDA ▪ 5 participants per training	3-day in-service trainings ▪ Transport per diem ▪ Technical allowance ▪ Lunch ▪ Training materials, 20 pp ▪ Sample commodities and consumables (500 IUDs, 500 Injectables, 500 implants)	State and LGA-level nurses trained (target: 800)	▪ 2016 Q4, 2017 Q3	MSION/LSMOH/PHCB
		SD 1.1.5. Conduct supportive supervision trips bi-annually at each facility (333 facilities total) • 10 days per trip	Supportive supervision visit ▪ 5 LSMOH staff ▪ 5 master trainers (SD 1.1.2) ▪ Transport per diem ▪ Per diem ▪ Accommodations	2 supportive supervision trips conducted	▪ 2017 Q2 ▪ 2018 Q2	LSMOH
	SD 1.2. Address rapid FP-trained staff overturn					
	Sub activity		**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
	SD 1.2.1. Collaborate with board in charge of transfer to ensure trained providers are able to retain their position in a clinic, or are replaced by equally qualified personnel ▪ State FP coordinator and FP TWG representatives to conduct visit to health board in charge of staff transfer		▪ Lunch ▪ Transport ▪ 5 visits	Health board advocated to retain trained staff at facilities	2016 Q3	LSMOH

		SD 1.2.2. Ensure providers selected for trainings are committed to providing FP at their facility after training ▪ Trainees complete pledge forms committing to provide FP services at their facility after training for at least 2 years or agree to train replacement in situations of early departure ▪ Trainees encouraged to train additional providers in facility before relocating position	Print pledge forms (1,000 total)	Trainees commit to staying in position for at least 2 years	2016 Q3-2018 Q4	LSMOH
		SD 1.2.3. Develop a database of provider training in line with the geo-spatial mapping of FP service providers *(linked to SMC2.1.1.)* ▪ LSMOH staff keep database updated when staff are transferred ▪ Coordinate staff placements with PHC	No input	Database developed to track availability of FP providers at each state clinic	2016 Q3	LSMOH
SD2. Expand FP service delivery points through the private sector						
	SD2.1. Scale up distribution of FP service through paramedical service providers (pharmacies, PPMVs, and informal drug sellers)					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SD 2.1.1. Develop new FP training manual for each category of paramedical staff, focusing on FP information provision, counselling skills, and service referrals ▪ Consultant or IP develops new FP service provision training manual for pharmacists, PPMVs, and informal drug sellers ▪ 3 full-day RH TWG meeting with relevant professional associations: initiation, vetting, and finalisation	▪ 60 days of consultant time ▪ @ hotel in Lagos ○ 30 people ○ Lunch ○ Tea break ○ Transport per diem ▪ Printing: 20 pages pp (600 total)	FP service provision training manual for paramedical providers developed	2016 Q1-2	

		SD 2.1.2. Conduct TOT for paramedical providers ▪ Consultants conduct 4-day TOT to build a cadre of state-level paramedical trainers ▪ 2 representatives from each LCDA	▪ 2 consultants to facilitate o @ hotel in Lagos o 80 people per training o Travel per diem ▪ Printing: 15 pages pp (1,200 total)	State-level paramedical trainers trained (target: 80)	2016 Q3	
		SD 2.1.3. Paramedical providers deployed to train paramedical providers in their LCDA ▪ Paramedical provider trainers hold two 2-day training (5 participants each)	▪ 2-day training workshop o @ IP site o Transport per diem o Lunch o Tea break ▪ Printing: 15 pages pp (22,200 pages)	State-level paramedical providers trained (Target: 800)	2016 Q4, 2018 Q1	
	SD2.2. Explore opportunities to leverage untapped private sector resources					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SD2.2.1. Conduct private sector service provision landscape analysis carried out by partners working with private sectors (SHOPS, MSION, and SFH) ▪ Consultant or IP conducts desk review of landscape analysis from partners ▪ Hold 1 half-day workshop with State FP TWG and relevant provider associations: vetting and finalisation	▪ 1 consultant, 30 days ▪ Validation workshop o @ hotel in Lagos o 25 people o Lunch o Transport per diem o Printing: 20 pages pp (500 total) (Note: This meeting is part of monthly RH TWG meetings, but is separately costed from SMC3.1.2 due to larger meeting size)	State-specific private sector service provision landscape analysis developed	2016 Q4	

		SD2.2.2. Engage the private sector to align goals and identify opportunities for public-private partnerships such as Total Market Approach and corporate social responsibility ▪ Hold 5 small group meetings with private sector representatives ▪ Hold 1 full-day strategy session with the private sector representatives to establish coordinating mechanism and identify partnership opportunities	▪ 5 small group meetings o @ office of the private sector organizations o 5 people per meeting o Transport refund o Printing: 20 pages pp (100 total) ▪ 1 private sector strategy meeting o @ LSMOH hall o 25 people o Lunch o Tea breaks o Transport per diem o Printing: 20 pages pp (500 total)	Private sector organizations engaged Public-private coordination mechanism established Partnership opportunities identified	2017 Q1	
SD 3. Increase access to FP information and services through the current 5 Youth Friendly Health Clinics (YFHC) in the state						
	SD 3.1. Extend the hours of service at YFHCs to cover evening and weekends to make service more accessible					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SD 3.1.1. Advocate to the PHC board at the LGA-level to recruit current and retired nurses to service the clinics for an additional salary after hours ▪ Advocate to the PHC board to recruit current and retired nurses to service the clinics for an additional salary after hours (a particular recruitment focus will be on nurses deemed able and appropriate to engage a youth audience)	▪ 2 LSMOH representatives, 2 trips ▪ Transportation ▪ Lunch	PHC agree to recruit current and retired nurses to service after hour clinics	2016 Q4	
		SD 3.1.2. Based on the results of SD 3.1.1, Nurses recruited to offer extended service hours receive refresher training on FP provision and counselling	Nurses receive refresher training *Linked to SD 1.1.2*	Nurses trained on FP provision and counselling	2017 Q2	

		SD 3.2.3. Support the salary/additional benefits of nurses	Salary for 1 nurse at each of the 5 youth friendly health clinics	5 nurses provide extended hour care at YFHCs	2017-2018	
	SD 3.2. Create 2 additional Youth friendly health rooms (in addition to the existing 5) to reach out to underserved communities with adolescent FP services					
		SD 3.2.1. Identify 2 facilities with proximity to youths and integrate youth friendly FP services ▪ LSMOH staff reviews results from mapping activity (SMC 3.1.1.) and identifies priority facilities ▪ Advocacy?	*Linked to SMC2.1.1.*	2 facilities identified to integrate youth friendly FP services	2016 Q4	▪ LSMOH
		SD 3.2.2. 2 identified clinics have an additional room designated or added to the facility for youth friendly health services	▪ Construction of 2 youth friendly health service rooms in existing PHCs ▪ Equipment and furniture procured for youth friendly service rooms ▪ Desk, 2 chairs, couch, blood pressure cuff, scale, posters, job aids etc.	2 new youth friendly health service clinics created	2016 Q4-2017 Q1	
		SD 3.2.3. Conduct youth friendly FP service provision training for providers that will run the 2 newly created centres using existing curriculum ▪ 5-day training workshop on the rights of adolescents and youth, provision of youth friendly health services, including FP service provision and counselling for all FP service providers	▪ 5-day workshop o @LSMOH o 25 participants o Transport per diem o Accommodations o Lunch o Tea break	20 providers receive trainings (some refresher) on youth friendly health service provision	2017 Q1	
SD 4. Create an enabling environment for physically challenged populations to access FP services						
	SD4.1. Make FP services more easily accessible to people with disabilities					

		SD4.1.1. Employ the services of sign language personnel to interpret during FP counselling and service provision at 2 facilities per administrative zone	▪ Sign language interpreter salary part-time for 2 years (10 interpreters)	Sign language services provided at designated facilities	2017-2018	LSMOH RH UNIT
		SD 4.1.2. Conduct FP service outreach services to communities and gatherings of physically challenged population ▪ Designate 15 FP providers in the state to provide quarterly outreach care to people with disabilities	▪ Technical allowance ▪ Transport fees ▪ Lunch	Mobile FP services provided to people with disabilities	2017-2018	LSMOH RH/FP unit

Priority Area 3: Supplies and Commodities (SC)

SC 1. Improve state capacity for FP commodity logistics and management

SC1.1. Ensure adequate training and preparation for FP commodity logistics and management officers

Sub activity	Additional detail (Inputs Required)	Output Indicators	Timeline	Responsible
SC1.1.1. Update commodity logistics and management training based on findings from an assessment on state and local level challenges to logistics and commodity management	▪ Consultant or IP revise and update the commodity logistics and management training curriculum based on assessment findings o 15-day consultant time ▪ 1 half-day validation workshop: o @ hotel o 25 people o Lunch and tea break o Printing: 20 pages pp	Commodity logistics and management training manual update	2016 Q2	National Supply Chain Integration project (NSCIP)/DPS
SC1.1.2, Conduct training of commodity logistics and management officer master trainers	▪ Consultants conduct 3-day TOT to build a cadre of state-level master trainers on logistics and management o 3 consultants, 10 days each o @ hotel o 25 people per training o 3 trainings o Travel per diem for trainers o Transport refund for participants o Printing: 20 pages pp	Master trainers trained on commodity logistics and management training	2016 Q3	NSCIP/DPS

		SC1.1.3, Commodity logistics and management master trainers conduct training at the LCDA level ▪ 4 participants at each training	▪ LCDA-level trainings (5 total) o @ PHC o 4 people per training o Lunch o Refreshments o Printing: 20 pages pp	Commodity logistics and management officers trained	2016 Q4	NSCIP/DPS
		SC2.1.1, Forecast annual FP needs ▪ 1 two-day annual meeting to review annual contraceptive and consumable needs	▪ 2-day meeting (annually) o @ hotel o 25 people o Lunch & tea breaks o Transport refund o Printing: 20 pages pp	Commodity and consumable needs identified	2016 Q3 2017 Q3 2018 Q3	FMOH/NPH CDA/UNFPA
		SC2.1.2, Coordinate FP commodity procurement and distribution among the government and development partners ▪ 1 one-day procurement and supply management coordination meeting annually to confirm budget line with LSMOH and budget supplement from partners	1 full-day meeting annually o @ LSMOH o 25 people o Lunch & tea breaks	LSMOH and supplement budget clarified	2016 Q4 2017 Q4 2018 Q4	FMOH/UNFPA
SC3. Improve quality of private sector FP service by ensuring the availability of commodities at private sector (non-profit and for-profit) service delivery points						
	SC3.1. Engage with private sector to align goals in commodity distribution to the private sector					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**

		SC3.1.1. Identify opportunities for public-private partnerships in commodity distribution	▪ Linked to SD2.1.1.	Conditions for commodity distribution to the private sector clarified	2015 Q3 Q3 2016	LMCU/SHOPS/MION/Mckinsey/UNFPA/
SC 4. Enhance last mile distribution (LMD)of FP commodities to promote service delivery at the LGA level						
	SC4.1. Conduct pilot of the Integrated Last Mile Distribution of Malaria, Family Planning and Reproductive Health commodities					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SC4.1.1. Conduct pilot study of integrated LMD of Malaria, FP and RH commodities in 40% of SDP in Lagos state within 2-months at 200 facilities	▪ 2 Consultants or implementing partners, 45 days ▪ Travel per diem ▪ Dissemination meeting with FP TWG ▪ 40 participants ▪ Lunch ▪ Transport per diem		2016 Q2	LSMOH/UNFPA
	SC4.2. Scale-up the pilot of the Integrated Last Mile Distribution of Malaria, Family Planning and Reproductive Health commodities					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SC4.2.1. Develop a guideline based on the findings of the pilot study and share with stakeholders ▪ IP/Consultant develops guidelines ▪ Dissemination workshop	▪ Consultant or implementing partner, 10 days ▪ Dissemination workshop ▪ Half-Day ▪ @UNFPA site ▪ Tea break ▪ Lunch ▪ Transport per diem ▪ Printing: 600 copies of the guideline	Lagos last mile distribution guidelines developed	2016 Q2	LSMOH/UNFPA

		SC 4.2.2 Roll out the implementation of the integrated LMD strategy to improve FP service provision through prevention of FP commodity stuck out at the LGA level	Official flag-off ceremony of the integrated LMD strategy ▪ Hall ▪ 50 people ▪ Lunch ▪ Tea break ▪ Transport refund	Stakeholders informed of last mile distribution roll-out	2016 Q2	LSMOH/UNFPA
		SC4.2.3. Fund the third party commodity logistics vendor to capture commodity inventory logistics at the facility and re-supply (includes vehicle/travel costs, overhead, mobile warehouse maintenance, and software costs)	▪ Third Party Vendor (DDIC Distribution Model)		2016-2018	LSMOH/UNFPA
	SC 4.3. Provision of budget line the Logistics TWG and LMCU in the annual appropriation					
	SC 4.4. Improve available Human Resources for Health (HRH) available for driving the integrated LMD process in Lagos state					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SC4.4.1. Conduct advocacy to relevant government authority for the engagement of full time Staff for LMCU, Healthcare Providers at the Service Delivery Points and Warehouses	*Linked to SC5.3.1*			LSMOH/UNFPA

Priority Area 4: Policy and Environment (PE)

PE1. Strengthen the enabling environment for FP at the state-level

PE1.1. Advocate for establishment of state-level policies (including task-shifting policy) aligned with national policies on FP

Sub activity	Additional detail (Inputs Required)	Output Indicators	Timeline	Responsible
PE1.1.1. Review national policies relevant to FP and prioritize for state advocacy	▪ Consultant or IP conducts desk review on national policies relevant to FP o 20 days ▪ 1 half-day RH TWG meeting to prioritize policies for advocacy at state-level o This meeting is part of monthly RH TWG meetings	Priority national FP policies selected	2016 Q2	LSMOH/PARTNERS
PE1.1.2. Develop a state-level advocacy plan for policy adoption	▪ Consultant or IP develops advocacy plan o 20 days ▪ 1 half-day RH TWG vetting meeting o This meeting is part of monthly RH TWG meetings	Advocacy plan developed	2016 Q3	LSMOH/PARTNERS
PE1.1.3. Develop evidenced-based advocacy materials for decision-makers (parliamentarians, finance ministers, etc.) highlighting annual projected costs, cost savings, impact analysis, and the other benefits of FP ▪ Consultant or IP designs effective advocacy package (briefs, power points, etc.) ▪ Advocacy package validated *Linked to F1.1.1*	▪ Consultant or IP, 10 days ▪ 1 half-day vetting meeting with RH TWG (This meeting is part of monthly RH TWG meetings) ▪ Printing: 500 pages	Advocacy materials developed to advocate to decision-makers	2016 Q3	LSMOH/Partners

		PE1.1.4. Orient LAWG on advocacy plan ▪ 1-day meeting to review plan, agree on next steps, and assign responsibilities	▪ Hold full-day advocacy plan orientation o @ hotel in Lagos o 30 people o Lunch and tea break o Transport refund o Printing: 20 pages pp (600 pages total)	State advocacy group oriented on advocacy plan and responsibilities allocated	2016 Q3	LSMOH/ PARTNERS
		PE1.1.5. Conduct advocacy campaigns at the state-level with State Advocacy group ▪ Advocate for increased funding to support national guideline updates (*linked to PE 1.1.1*)	▪ Hold small-group meetings at the state-level o @ State Ministry of Health or other state-level government office o 5 people each o Travel per diem for LSMOH reps o Printing: 20 pages pp	Advocacy meetings conducted (Target: 4)	2016 Q3-4	LSMOH/ PARTNERS
		PE1.1.6. Support high-level advocacy meetings to pass key policies affecting FP ▪ Use advocacy package (*linked to PE 1.1.3*) ▪ Hold one half-day advocacy meeting annually to inform parliamentarians of the importance of FP and to influence policy language and budget increases ▪ Key policies will be identified during FP TWG meetings	▪ Half-day advocacy meeting (annually) o @ hotel o 25 people o Lunch and tea break o Travel per diem o Printing: 20 pages pp	Advocacy meetings held (target: 3)	2016 2017 2018	

Priority Area 5: Financing (F)

F1. Build support for increasing FP line item in the Lagos state budget						
	F1.1. Produce and execute an advocacy campaign for FP finance					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		F1.1.1. Develop an FP financing advocacy package *Linked to PE1.1.3*	No inputs	FP financing advocacy package developed	2016 Q3 2017 Q3	
		F1.1.2. Orient state advocacy groups on the package	▪ Consultant conducts orientation o 2 days of consultant time ▪ 1 half-day state orientation meeting o @ hotel in Lagos o 30 people o Travel reimbursement o Printing: 20 pages pp	Advocacy groups oriented on the FP financing advocacy package	2016 Q3-4 2017 Q3-4 2018 Q3-4	
		F1.1.3. Support advocacy visits to the LSMOH Budget Committee to increase/assign FP line item and to release budgets once approved	▪ 2 visits o @ ministry offices o 5 people per meeting o Travel reimbursement o Printing: 20 pages pp	FP Budget line increased and released	2016 Q4 – 2017 Q1 2017 Q4 – 2018 Q1 2018 Q4	

Priority Area 5: Financing (F)

		F 1.1.4. Conduct advocacy to Lagos State Ministry of Local Government and Community Affairs to prevail on LGA for creation of FP budget line (to include commodity logistics and procurement of consumables) in the LGA annual budget	▪ 5 visits ○ @ ministry offices ○ 5 people per meeting ○ Travel reimbursement ○ Printing: 20 pages pp	Local governments ad funding for FP	2016 Q3	LSMOH/LAWG
		F 1.1.5. Hold LGA-FP Stakeholders breakfast meeting with all the 20 LGA Chairmen in Lagos state to promote funding and HRH support for FP service provision	▪ 1-day LGA FP Advocacy Meeting (twice) ○ Hall ○ 60 participants ○ Transport ○ Refreshments ○ Lunch ○ Tea break	LGA chairmen support funding for FP	▪ 2016 Q3 ▪ 2018 Q1	LSMOH and Ministry of Local Government and Community Development
F2. Improve commitment of resources to FP service provision in the state through public private partnership (PPP)						
	F2.1. Leverage the social corporate responsibility of private companies to support FP information and service delivery through in-kind contributions					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		F2.1.1. Solicit for logistic support from companies who operate haulage services to help in commodity logistics/transportation to facilities	▪ 10 Advocacy visits by a team of 5 members	Advocacy conducted for private sector support for logistics/transportation	2016 Q3-Q4	LSMOH/LAWG

Priority Area 5: Financing (F)

		F2.1.2. Solicit for free communication of FP messages via SMS to subscribers and toll free hotline services from telecommunication companies to promote FP uptake with the general public	▪ Linked to F3.1.1			LSMOH/LAWG

Priority Area 6: Supervision, Monitoring, and Coordination (SMC)

SMC1. Enhance supervision and quality assurance for FP service delivery at every level of the health system						
	SMC1.1. Improve the quality of FP service provision through supportive supervision					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SMC1.1.1. Conduct integrated joint supportive supervision to cover FP services in both public and private facilities • 5-member Team providing quarterly supportive supervisory visits to facilities providing FP services (members to include representatives of LSMOH, FP TWG and Partners) and provide feedback to LGA FP Managers	• Lunch • Transport refund • Report printing (1,000 pages) • Hotel accommodation (for distant LGA)	State-level joint integrated supportive supervision conducted	2016 Q3 - 2018Q4	LSMOH RH/FP Unit
		SMC1.1.2 Train LGA FP Managers on supportive supervision	2-day training • 40 participants • Lunch • Tea break • Hotel, Lagos • Transport refund • Hotel accommodation	40 LGA FP Managers trained on how to conduct supportive supervision at PHCs	2016 Q3	LSMOH

Priority Area 6: Supervision, Monitoring, and Coordination (SMC)

		SMC 1.1.3. Create a feedback loop for supportive supervision visits in public facilities • LGA FP managers visit facilities to provide quarterly feedback and ensure timely implementation of recommendations between supportive supervision visits	• Lunch • Transportation refund • 20 LGA FP Managers	Feedback of outcome of supportive supervision provided to the facilities and implementation of recommendations followed up	2016 Q3 - 2018Q4	
SMC2. Generate and disseminate FP service provision and programmatic data to assess progress towards the Lagos part of the national Blueprint goal						
	SMC2.1. Identify the location of all health facilities providing FP services					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SMC2.1.1. Use geo-mapping to locate and track each facility providing FP services (public and private) and associated lists of FP services available, available FP providers, and youth friendly health service centres providing FP services • Database developed of all facilities, services provided, and available FP trained providers	3 Consultants, 30 days • Transport per diem	Map created of all facilities providing FP services and list of service providers	2016 Q2-Q3	

Priority Area 6: Supervision, Monitoring, and Coordination (SMC)

		SMC 2.1.2. Routinely update geo-spatial map of FP service delivery locations • LGA FP manager to update LSMOH staff member of any FP service delivery location or provider changes annually • Consultant updates database annually	1 consultant, 5 days (annually)	Map of facilities providing FP services is up-to date	2017 Q3 2018 Q3	
	SMC2.2. Develop and maintain a dashboard of FP indicators					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SMC2.2.1. Ensure that identified indicators are collected through the DHIS • Consultant or IP to review indicators currently part of DHIS; work with LSMOH RH Department and the M&E Department to integrate core FP indicators if not yet included • Incorporate newly identified indicators into existing dashboard • Review updates with FP TWG	▪ 30 days of consultant time ▪ Monthly FP TWG review meeting	Core FP indicators included in DHIS	2016 Q3	LSMOH RH/FP Unit

Priority Area 6: Supervision, Monitoring, and Coordination (SMC)

		SM2.2.2. Track Blueprint progress through periodic update of the dashboard • LSMOH to gather data on a quarterly basis from the DHIS into the dashboard • Share dashboard every quarter at RH/FP TWG and the donor coordination meetings	No Inputs	▪ Quarterly progress dashboard developed	▪ 2016 ▪ 2017 ▪ 2018	
	SMC2.3. Conduct strategic research to collect programmatic data on indicator progress (including national blueprint indicators)					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SMC2.3.1. Identify key issues areas to target for operational research and evaluation	▪ RH/FP TWG meeting (Linked to SMC 4.1.2)	Key FP topics for further research identified	2016 Q4 2017 Q4 2018 Q4	
		SMC2.3.2. Conduct one operational research study based off of key issues identified in *SMC 2.3.1* ▪ Research firm conducts operational study ▪ Workshop to disseminate findings and discuss ways forward	▪ Research firm, 30 days ▪ Full-day FP TWG workshop ○ @LSMOH ○ 15 participants ○ Lunch ○ Tea break	Results and recommendations from operational study	▪ 2017 Q1	

Priority Area 6: Supervision, Monitoring, and Coordination (SMC)

		SMC 2.3.3. Evaluate the effectiveness of the CHANNEL software versus FP Dashboard and identify ways to integrate or transfer to one system ▪ Consultant or IP to develop a dashboard for use by LSMOH to keep track of the core FP indicators ▪ Results presented at routine FP TWG meeting	Consultant, 10 days	CHANNEL software versus FP Dashboard evaluated and decision reached on way forward	2016Q2	
		SMC2.3.4. Document best practices from programmes contributing to the Blueprint goal ▪ Consultant or IP produces best practice briefs biannually based on RH TWG guidance ▪ Share at RH/FP TWG Meeting (*SMC 3.1.2),* Donor coordination meeting (*SMC 3.1.4),* and LGA FP Advocacy Meetings (*F1.1.5)*	• Consultant, 20 days • Printing: 2,000 pages	Best practices documented and shared	2016 Q2+4 2017 Q2+4 2018 Q2+4	
		SMC2.3.5. Disseminate practical FP data through quarterly newsletters/ fact sheet • LSMOH produces quarterly newsletter/factsheet in collaboration with the RH TWG	▪ Printing: 2,000 pages	Practical FP data disseminated through e-mail and print editions (target 12 issues; 1,000 prints per issue)	▪ 2016 ▪ 2017 ▪ 2018	

Priority Area 6: Supervision, Monitoring, and Coordination (SMC)

SMC3. Effectively plan, coordinate, and execute the Lagos state CIP						
	SMC3.1. Develop and institutionalize coordination mechanisms to facilitate execution of the Lagos state CIP					
		Sub activity	**Additional detail (Inputs Required)**	**Output Indicators**	**Timeline**	**Responsible**
		SMC3.1.1. Develop state annual work plans to progress towards the effective implementation of Lagos state CIP ▪ 2-day annual meeting to develop FP work plan based on the activities outlined in the Lagos State CIP, identify how partners and donors and contribute to these activities, and define annual calendar of meetings, topics, membership, roles and responsibilities including sub-committees, and goals for the FP TWG	2-day work planning meeting (annual) ○ @ Hotel ○ 50 people ○ Lunch ○ Tea break ○ Transport reimbursement for staff travelling from distant LGAs	▪ Annual work plan developed ▪ RH/FP TWG calendar developed ▪ RH/FP TWG membership and their roles and responsibilities reviewed	▪ 2016 Q3 ▪ 2017 Q3 ▪ 2018 Q3	
		SMC3.1.2. Hold RH/FP TWG meetings • Monthly half-day RH/FP TWG meetings based on the calendar and topics defined under activity SMC2.1.1	Half-day RH/FP TWG Meetings ○ @ LSMOH ○ Travel ○ 30 people ○ Tea break and lunch ○ Travel refund ○ Printing: 20 pages pp	▪ RH/FP TWG meetings held	▪ 2016 ▪ 2017 ▪ 2018	

Priority Area 6: Supervision, Monitoring, and Coordination (SMC)

		SMC3.1.3. Set up a donor coordination group ▪ Hold full-day donor coordination start-up meeting to map out and align donor activities (geography, FP topic area, etc.)	Donor coordination meeting o @ hotel in Lagos o 30 people o Travel o Printing: 20 pages pp	▪ Donor priorities and activities mapped	▪ 2016 Q1	
		SMC3.1.4. Maintain dialogue and responsiveness of donor programmes • Hold bi-annual half-day donor coordination meeting to share progresses, update priorities, and respond to emerging issues in a coordinated fashion	Bi-annual donor coordination meetings o @ LSMOH o 20 people o Lunch and tea break o Travel o Printing: 20 pages pp	▪ Donor coordination meetings held	▪ 2016 ▪ 2017 ▪ 2018	
		SMC3.1.5. Conduct an end-point review of the Lagos state CIP ▪ A Consultant or IP to manage the review and new planning process ▪ Full-day meeting to identify best practices and accomplishments over the three years, and identify key issues and barriers to be addressed in the new 5-year planning process	• Consultant or implementing partner, 40 days • Full-day CIP closing out meeting o @ hotel in Lagos o 30 people o Travel per diem o Printing: 50 pages pp	▪ Lagos state CIP endpoint report on achievements and lessons learned report developed	▪ 2018 Q3	

Priority Area 6: Supervision, Monitoring, and Coordination (SMC)

		SMC3.1.7 Develop new 5-year plan in line with new national blueprint for family planning	▪ Consultant or IP to manage the development of a new five year CIP o 90 days of consultant time o 3 half-day meetings of the FP TWG o 2 meetings of each strategic advisory group o Launch of the CIP at by the LSMOH o Dissemination of the CIP to each LGA FP Manager	▪ New five-year CIP launched by LSMOH	▪ 2018 Q4	

REFERENCES

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

[ii] United Nations, Department of Economic and Social Affairs, Population Division.2015. World Population Prospects: The 2015 Revision, Key Findings and Advance Tables. Working Paper No. ESA/P/WP.241. http://esa.un.org/unpd/wpp/publications/files/key_findings_wpp_2015.pdf

[iii] United Nations, Department of Economic and Social Affairs, Population Division. 2015. World Population Prospects: The 2015 Revision, Key Findings and Advance Tables. Working Paper No. ESA/P/WP.241. http://esa.un.org/unpd/wpp/publications/files/key_findings_wpp_2015.pdf

[iv] United Nations, Department of Economic and Social Affairs, Population Division.2014. World Urbanization Prospects: The 2014 Revision, Highlights (ST/ESA/SER.A/352).

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

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

[vii] Lagos State Ministry of Health and UNFPA. 2014. Lagos State Family Planning Situational Analysis. Lagos, Nigeria.

[viii] Lagos State Ministry of Health and UNFPA. 2014. Lagos State Family Planning Situational Analysis. Lagos, Nigeria.

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

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

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

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

[xiii] PMA 2015/Lagos-R2: Performance Monitoring and Accountability 2020 (PMA2020) Project. Centre for Research, Evaluation Resources and Development (CRERD) and Bayero University Kano (BUK). 2015. Available at: http://pma2020.org/sites/default/files/NGR2-LAGOS-FPBrief-v9-2015-12.07.pdf. Retrieved 11 February 2016.

[xiv] Nigeria Federal Ministry of Health. 2014. "Increasing Access to Long-Acting Reversible Contraceptives in Nigeria: National Strategy and Implementation Plan (2013-2015)."

[xv] PMA 2015/Lagos-R2: Performance Monitoring and Accountability 2020 (PMA2020) Project. Centre for Research, Evaluation Resources and Development (CRERD) and Bayero University Kano (BUK). 2015. Available at: http://pma2020.org/sites/default/files/NGR2-LAGOS-FPBrief-v9-2015-12.07.pdf. Retrieved 11 February 2016.

[xvi] PMA 2015/Lagos-R2: Performance Monitoring and Accountability 2020 (PMA2020) Project. Centre for Research, Evaluation Resources and Development (CRERD) and Bayero University Kano (BUK). 2015. Available at: http://pma2020.org/sites/default/files/NGR2-LAGOS-FPBrief-v9-2015-12.07.pdf. Retrieved 11 February 2016.

[xvii] PMA 2015/Lagos-R2: Performance Monitoring and Accountability 2020 (PMA2020) Project. Centre for Research, Evaluation Resources and Development (CRERD) and Bayero University Kano (BUK). 2015. Available at: http://pma2020.org/sites/default/files/NGR2-LAGOS-FPBrief-v9-2015-12.07.pdf. Retrieved 11 February 2016.

[xviii] PMA 2015/Lagos-R2: Performance Monitoring and Accountability 2020 (PMA2020) Project. Centre for Research, Evaluation Resources and Development (CRERD) and Bayero University Kano (BUK). 2015. Available at: http://pma2020.org/sites/default/files/NGR2-LAGOS-FPBrief-v9-2015-12.07.pdf. Retrieved 11 February 2016.