Federal Government
of Nigeria

NIGERIA FAMILY PLANNING BLUEPRINT 2020-2024

Federal Ministry of Health

Address:Federal Ministry of Health, Federal Secretariat, Phase III, Ahmadu Bello Way, Central Business District, PMB 083, Garki Abuja, Nigeria.

Email: info@health.gov.ng

Website: www. health.gov.ng

Suggested citation: Federal Ministry of Health, Nigeria National Family Planning Blueprint, Abuja, Nigeria, June 2020

Table of Contents

Acronyms

BHCPF	Basic Health Care Provision Fund
CCW	Central Contraceptives Warehouse
CHAI	Clinton Health Access Initiative
CPR	Contraceptive prevalence rate
DFID	Department for International Development
DKT	Dharmendra Kumar Tyagi
DMPA-SC	Depo-Medroxyprogesterone Acetate Sub-cutaneous
DPH	Department of Public Health
DPRS	Department of Health Planning, Research and Statistics
DPS	Department of Pharmaceutical Services
FCT	Federal Capital Territory
FGON	Federal Government of Nigeria
FHD	Family Health Department
FMOH	Federal Ministry of Health
FP	Family Planning
GHSC-PSM	Global Health Supply Chain – Procurement and Supply Management Project
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMB	Hospital Management Board
JSI	John Snow Inc.
KPI	Key Performance Indices
LGA	Local Government Area
LHD	Long-Haul Distribution
LMD	Last Mile Distribution
LMIS	Logistics Management Information System
MOH	Ministry of Health
MSD	Merck Sharp & Dohme Corp

MSION	Marie Stopes International Organization of Nigeria
MSV	Monitoring and Supportive Visits
NDHS	Nigeria Demographic and Health Survey
NHLMIS	National Health Logistic Management Information System
NSCIP	Nigeria Supply Chain Integration Project
PMA	Performance Monitoring and Accountability
PSM	Procurement and Supply Management
NRHTWG	National Reproductive Health Technical Working Group
NBS	National Bureau of Statistics
NPopC	National Population Commission
NURHI	Nigerian Urban Reproductive Health Initiative
SDP	Service Delivery Point
SLMCU	State and Logistics Management Coordinating Unit
SMOH	State Ministry of Health
SOML	Saving One Million Lives
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Foreward

The Federal Government of Nigeria prioritizes Family Planning (FP) as part of an overall strategy to reduce maternal morbidity and mortality rate in our country. In line with the foregoing, Nigeria aims to achieve modern Contraceptive Prevalence Rate (mCPR) target of 27 percent by the year 2020.

The Nigeria Family Planning Blueprint (Scale-Up Plan) developed, launched and disseminated in 2014 represents the determination of the FGON to put in place a broad and well-articulated strategy that holistically addresses gaps in the provision of high-quality FP services to Nigerians of reproductive age.

The revision of the Nigeria Family Planning Blueprint became necessary in view of many emerging issues since its development, such as the rebasing of the mCPR target from 36% by year 2018 to 27% by year 2020, the introduction of Depo medroxy progesterone acetate subcutaneous (DMPA-SC) injection and the revision of the Task Shifting and Task Sharing Policy, an others.

The set targets cannot be achieved by government alone but through collaboration and commitment by all stakeholders. It is my hope that the revised Nigeria Family Planning Blueprint will provide adequate guidance in the implementation activities of service delivery; supplies and commodities managements; demand generation, social and behaviour change communication, regulation, policy and financing.

I therefore present this revised National Family Planning Blueprint 2019-2023 as the next step towards improving Family Planning services, Partners' support, harmonisation and coordination of efforts towards accelerated improvement in the health and well-being of Nigerians. Continued support from our Development Partners in the implementation of the Nigeria Family Planning Blueprint is desirable.

Finally, I encourage all stakeholders to make use of the Revised Nigeria Family Planning Blueprint, 2019-2023 to benefit from the commitment of financial and technical inputs to the revised version of this important document. I assure all and sundry of the Government's commitment to provide the enabling environment for delivery of quality family planning services to Nigerians of reproductive age and solicit the support of all stakeholders to ensure a successful implementation of this Blueprint.

Dr. Osagie E. Ehanire *MD, FWACS*
Honourable Minister

Acknowledgements

The Federal Ministry of Health is hugely delighted with the successful Review of the Nigeria Family Planning Blueprint (Scale-Up Plan): 2014 – 2018 which has resulted in the production of the current version, the Nigeria Family Planning Blueprint (Scale-Up Plan) spanning the period of 2020 – 2024. The Ministry recognizes the key roles played by a good number of individuals and organisations in making this very important accomplishment possible and wishes to express due appreciation to these stakeholders.

Our sincere appreciation therefore goes to the Mid-Space Project funded by the Bill and Melinda Gates Foundation for the tremendous financial and technical support extended to facilitate the review process including the engagement of the Lead Consultant.

We are also happy to express our deep gratitude to the Clinton Health Access Initiative (CHAI); Marie Stopes International Organisation Nigeria (MSION; Pathfinder International; United Nations Population Fund (UNFPA); and development Research and Projects Centre/Society of Obstetrics and Gynaecology in Nigeria (dRPC/SOGON-PAS) for the engagement of the supporting Consultants and provision of other forms of support that hugely contributed to the successful review of the FP Blueprint.

The Ministry acknowledges the expertise and commitment which the Department for International Development (DfID), Society for Family Health (SFH), Rotary International (RI) and John Snow Incorporated (JSI) brought to bear on the review process and wishes to say a big thank you to them. Special thanks go to the Lead Consultant, Dr. Muktar A. Gadanya, MFR, whose expertise and coordination of the review process enhanced the achievement of the new document.

The leadership and members of the Nigeria Reproductive Health Technical Working Group (NRHTWG) are very much appreciated for their critical review and input that made possible the finalization and validation of the revised FP Blueprint.

Finally, we deeply appreciate the Director and Head, Reproductive Health Division, Dr. Kayode Afolabi and his team for their role in coordinating the implementation of the various tasks involved in the review and validation process.

It is my sincere hope that the revised Nigeria Family Planning Blueprint will be used by all stakeholders to bring about the much needed change in Nigeria's family planning space.

Dr. Salma Anas-Kolo (MBBS, FMCPH, MWACP)
Director and Head, Family Health Department
Federal Ministry of Health

SECTION 1:

Background

1.1 The Global Context

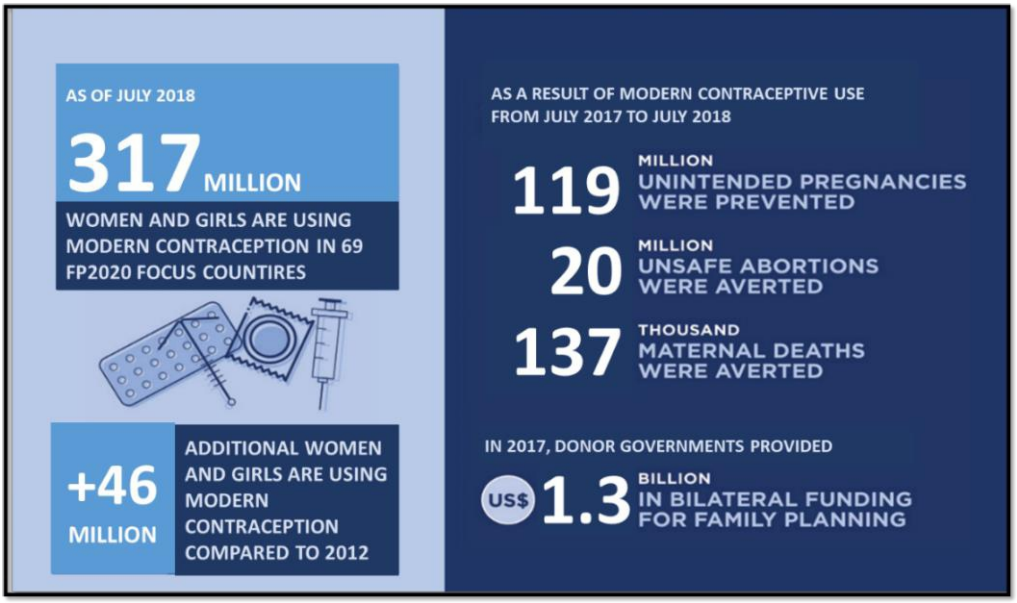
The maternal mortality ratio (MMR) in developing countries is estimated at 239 per 100 000 live births and there are 214 million women of reproductive age (WRA), especially among young people, poorest in populations or unmarried women – who want to avoid pregnancy but are not using any modern contraceptive method due to limited access to contraception. This high MMR and unmet need are compounded by a growing population, cultural or religious beliefs, and a dearth of quality right based family planning (FP) services.[1,2] Family planning (FP) is one of the most cost-effective and beneficial investments in global health. Addressing unmet need by providing FP to women who do not wish to become pregnant dramatically reduces the number of unwanted pregnancies and abortions. This in turn decreases maternal and child deaths, reduces the spread of HIV and increases women's empowerment, all of which improves the overall health and well-being of women, children, and families.

The London Family Planning Summit

In July 2012, a global community of FP stakeholders came together for the London Summit on Family Planning in pursuit of an ambitious yet essential goal; *ensuring 120 million additional women and girls in the world's 69 poorest countries have access to effective family planning information and services by the year 2020*. Achieving this goal would prevent 100 million unintended pregnancies, 50 million abortions, 200 thousand pregnancy/childbirth-related maternal deaths, and 3 million infant deaths.[3] At the summit, national governments, donors, civil society, the private sector and other interested party committed to tackle the numerous policy, financing, delivery and socio-cultural barriers that prevent many women from using contraceptives. As an outcome of this commitment, a global partnership 'Family Planning 2020' (FP2020) was formed to support the rights of women and girls to decide freely, whether, when, and how many children they want to have.

As of July 2018, 46 million additional women and girls in the 69 focus countries were using a modern method of contraception than in 2012, when FP2020 was launched. From July 2017 to July 2018, the use of modern contraception in the focus countries prevented 119 million unintended pregnancies, 20 million unsafe abortions, and 137,000 maternal deaths. In 2017, Africa accounted for almost half of the additional users of contraception with 16 million additional women and girls using a modern method of contraception in the FP2020 countries of Africa as compared to 2012. The modern contraceptive prevalence rate (mCPR) among all women in the region has increased from 19.5% to 23.4% since 2012[4]. Equally, new global initiatives are emerging and some donors are increasing their investments (*Figure 1*). There is broader recognition of rights-based family planning as a development priority with 25 new partners to FP2020 and 74 new and revitalized FP2020 commitments generated during the 2017 Family Planning Summit.

Figure 1: FP2020 indices summary



Source: FP2020 progress report 2018

Family Planning 2020 and Sustainable Development Goals

The range and depth of commitments announced at the FP Summits reflect the growing understanding that rights-based family planning is essential to global development. FP2020 is aligned and committed to extending the lifesaving benefits of modern contraception in contributing to the achievement of the Sustainable Development Goals (SDGs). Contraceptive access is incorporated in the SDGs, and FP2020's goal of reaching 120 million women and girls, and is a critical benchmark on the global path to universal access by 2030.

The SDGs 2030 Agenda includes targets and references to gender equality and women's and girls' empowerment, sexual and reproductive health and reproductive rights which go well beyond the commitments of the Millennium Development Goals (MDGs). The SDGs make specific references to family planning in Goal 3 on health and Goal 5 on gender equality and women's empowerment *(Table 1) – these goals are linked to family planning*. It will be impossible to end poverty and hunger, ensure quality education for all and promote sustained economic growth without ensuring that every woman has access to quality, rights-based family planning services. Countries have used their multi-year FP Costed Implementation Plans (CIPs) to strengthen advocacy for the implementation of both the SDGs and FP2020 commitments. Similarly, The FGON has been implementing programmes aimed at achieving the previous MDGs and now SDGs alongside other nations of the world through its FP Blueprint.

Table 1: SDGs family planning targets

Goal 3: Ensure healthy lives and promote well-being for all at all ages	
Targets	
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Goal 5: Achieve gender equality and empower all women and girls	
Targets	
5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

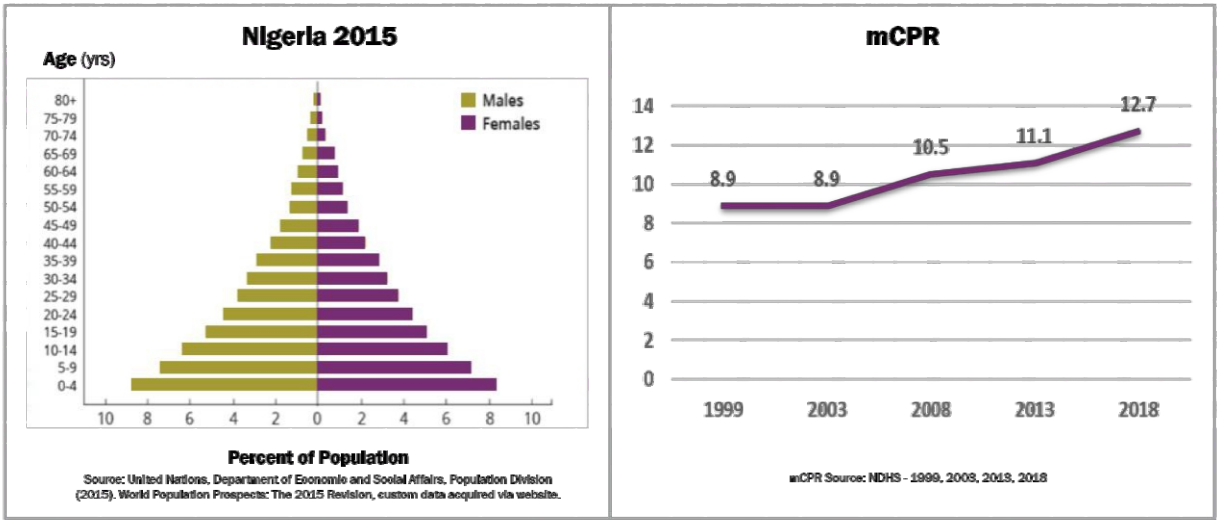
1.2 The Nigeria Context

Nigerian Family Planning Landscape

Nigeria has a rapidly growing population, with current population estimates at over 180 million, out of which about 46 million are women of reproductive age (WRA). With a total fertility rate (TFR) of 5.3, Nigeria's population is likely to hit 379 million by 2050, becoming the fourth most populous country on earth.[5] (NDHS 2018) It would take only about 30 years for population of Nigeria to double itself. Fertility and mortality patterns have resulted in a young population structure, where more than 40% of the current population are children under the age of 15 years *(Figure 2)*. Low level of FP is a major factor in the fertility pattern and population growth rate.

The current family planning method mix shows condoms and injectable contraceptive as the most popular method. The modern method mix predominantly comprises condoms, pills, and injectables *(Figure 2)*. Factors associated with the low contraceptive prevalence level include; cultures that are highly supportive of large family size, myths and misconceptions about contraception, gender inequity, inadequate access to FP services, poor quality of services and inadequate demand creation efforts.[3]

Figure 2: Nigeria Population Pyramid and mCPR Trend



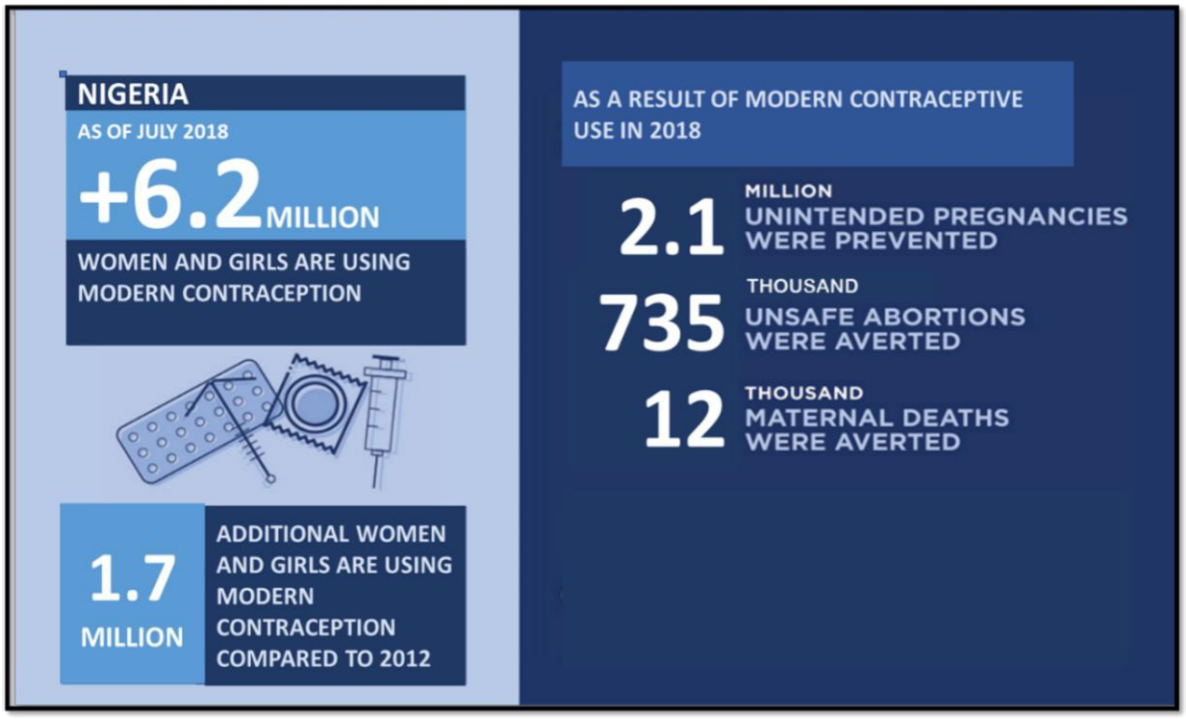
mCPR Source: NDHS - 1999, 2003, 2013, 2018

Nigeria Family Planning Blueprint

The previous FP Blueprint (2014-2018) is a well-articulated CIP that holistically addresses these existing gaps in the provision of high-quality FP services to Nigerians of reproductive age and was developed in view of Nigeria's commitments at the London FP summit. The overarching goal of the previous Blueprint was increasing CPR from 15% to 36% by 2018. The goal set for the revised National Family Planning Blueprint (2020-2024) is 27% mCPR by the year 2024 which represents a projected 3% annual growth from the present national mCPR.

The NDHS (2018) report showed a national CPR of 18% and mCPR of 13% for all women and CPR and mCPR of 17% and 12% among married women respectively. On average, this is a 2%-point increase in CPR and mCPR among both married and all women since the NDHS 2013. As of 2018, more than 6.2 million women are using a modern method of contraception, out of which over 1.7 million are additional women since 2012, when FP2020 commitments were made. In 2017, over 2 million unintended pregnancies, 735,000 unsafe abortions, and 12,000 maternal deaths were averted *(Figure 3).* In the light of the advances made in the National FP indices since 2012, the FGON in collaboration with its partners, updated its commitment at the 2017 FP Summit; to achieve a mCPR of 27% among all women by 2020 and increase its annual allocation for contraceptives to US$4M

Figure 3: Nigeria FP indices summary



Source: Track20 report on core FP indicators, 2018

A landscape analysis of the current national FP situation, using the Blueprint as a reference point was conducted to identify enabling factors and challenges around the recent advancement, and propose recommendations to achieving the revised National mCPR target of 27% by 2024. The landscape report analysed key thematic areas from the Blueprint. These areas include; policy and governance, service delivery, supply and commodity logistics, demand generation, finances, and monitoring and evaluation.

SECTION 2:

Situation Analysis

2.1 Demand Generation

Low demand for FP services remains a significant barrier to increasing CPR in Nigeria. Due to the low use of FP services, there is a general recognition of the value of demand generation in FP programming in Nigeria. In repositioning and increasing utilization of FP services in line with the Family Planning Blueprint and other health promotion related policies, the FMOH has taken some urgent initiatives to increase demand for FP in the country. These initiatives include: development of the National Family Planning Communication Plan (NFPCP), resuscitation of the National Health Promotion Forum and the launch of the new FP logo 'The Green Dot'.

The rollout of the National Family Planning Communication Plan along with the launch and promotion of a new national FP *Green Dot* logo in 2017 increased public awareness and demand for FP services for all women in Nigeria through the dissemination of accurate information and standardized messages on the quality and safety of modern contraceptive methods. The Green Dot logo serves as a site identifier of FP services that are affordable, safe and reliable. The National Health Promotion Forum serves as the platform where stakeholders in health communication harness resources, share best practices and take key decisions regarding the health of the nation including the revision and finalization of the National Health Promotion Policy in 2019. In addition, FMoH is working to strengthen partnerships with media organizations to promote FP as a corporate social responsibility. Each media organization is encouraged to use their structures and systems to promote FP services through discounts, free airtime and incorporation of FP into their routine broadcasts. The FMoH is also collaborating with the National Orientation Agency (NOA) and other government-owned communication entities to use their channels to promote FP in Nigeria. Working closely in partnership with donors and their implementing agencies, FMoH mobilizes resources to scale-up positive behavioural change for increased demand for FP services in the communities. Setting up the demand generation subcommittee of the NRHTWG to provide strategic guidance on demand generation component of the national RH/FP programs has helped to increase FP awareness, knowledge and positive behaviours. One strategic priority of the subcommittee is to provide technical support to strengthen demand generation for FP services through resource mobilization, guidelines for message development and implementation of demand generation interventions to all key segments of the population. Members of the subcommittee include the RH Division of the FMoH, key FP partners, CBOs and Faith Based Organizations (FBOs) involved in demand generation.

The National Primary Healthcare Development Agency (NPHCDA) with support from partners and other government institutions launched the Community Health Influencers, Promoters and Services (CHIPS) programme to streamline the efforts of community-based volunteers (also known as the Village Health Worker) across various health programmes on maternal, new-born and child health. A key role of CHIPS is to create demand for FP among women of reproductive age, as well as garner support for FP services at the community level to the extent that FP becomes a social

norm. As a result of these collaborations and initiatives, FP is promoted as an informed voluntary decision and right for all women of reproductive age.

At the state level, there have been some limitations in implementing demand generation programmes due to resource constraints, inadequate skills and socio-cultural issues. There have also been missed opportunities to leverage on other state programs for cost-effective roll out. However, there have been noticeable improvement for demand generation environment.

Within the private sector, there have been initiatives to utilize new media to increase reach to people of reproductive age, especially the adolescents and youth. Music Television (MTV) in partnership with PEPFAR, Bill and Melinda Gates Foundation and Marie Stopes (South Africa) produced an internet-based TV series called MTV Shuga with 2 seasons based in Nigeria. A World Bank evaluation of the Nigeria-based season 3 revealed that six months after viewing, participants were twice as likely to get HIV-tested, chlamydia infections dropped by 58% among women and people were 14% less likely to have concurrent sex partners, suggesting that this form of edutainment can be more effective than traditional means.[i] Other local based initiatives that routinely address health issues among large viewership should be supported to scale-up demand and use of modern FP methods.

In terms of demand generation outcomes, there has been an increase in the total demand for FP among WRA from 29% to 38% between 2013 and 2018 (NDHS 2018). Unmet need for family planning has increased from 13% in 2013 to 20% in 2018 (NDHS 2018). This implies that 38% of the 46 million WRA (section 1.2), approximately 17.5 millio n women now demand for FP because of demand generation activities. However, among these women only 34% (6 million) are estimated to have their demand satisfied by modern FP methods (NDHS 2018); a decrease from the 39% in 2013. Surprisingly, there has been an increase in the percentage of married women with demand satisfied for modern FP methods from 31% to 34% between 2013 and 2018 respectively. However, there is a significant drop from 61% to 33% among sexually active unmarried women with demand satisfied for modern FP methods. This indicates that the majority of unmarried but sexually active women have unmet demand for modern FP methods.

In addition, while there is a general increase in mCPR from 10% in 2013 to 12% in 2018, the 15-19 and the 20-24 age groups actually experienced a decrease from 4.8% to 2.3% and 13.2% to 8.2% respectively. This population also recorded marked decrease in demand satisfied than other age groups. There is therefore a need to expand access to youth-friendly centres. On the positive side, there has been an increase in unmet need in both the 15-19 and the 20-24 years' age groups, indicating more demand for family planning services. There has also been an overall reduction in teenage pregnancy from 15.8% to 14.8%, though teens who live in rural areas and those with no education are disproportionately affected.

[i] https://www.worldbank.org/en/news/feature/2017/02/23/mtv-shuga-soap-opera-turns-edutainment-into-a-tool-to-fight-hiv-and-gender-based-violence

Table 2: Summary of demand generation challenges.

Challenges	
Low Demand & high unmet need for modern FP	Myths and misconceptions about modern methods of contraception
	Low awareness on benefits of FP among traditional and religious leaders
	Fear of side effects
	Reduction in demand satisfied users, (marked in young persons)
	High unmet need and demand among unmarried population
	Poor availability of youth-friendly information channels and services
	Weak implementation of FLHE by key stakeholders
	Limited structured approaches to reach out-of–school youth (Rural – dwelling, low-educated and youth in lowest poverty quintiles more affected).
	FP health promotion activities still largely driven by donors/partners
	Limited government capacity and commitment to implement NFPCP (especially at state level)
	Ineffective integration of FP messaging into other health SBC interventions
	Low commitment of government at all levels to make SBC a priority and mobilize resources through strategic partnerships FP provider bias Spousal opposition among WRA Low socio-cultural status of women

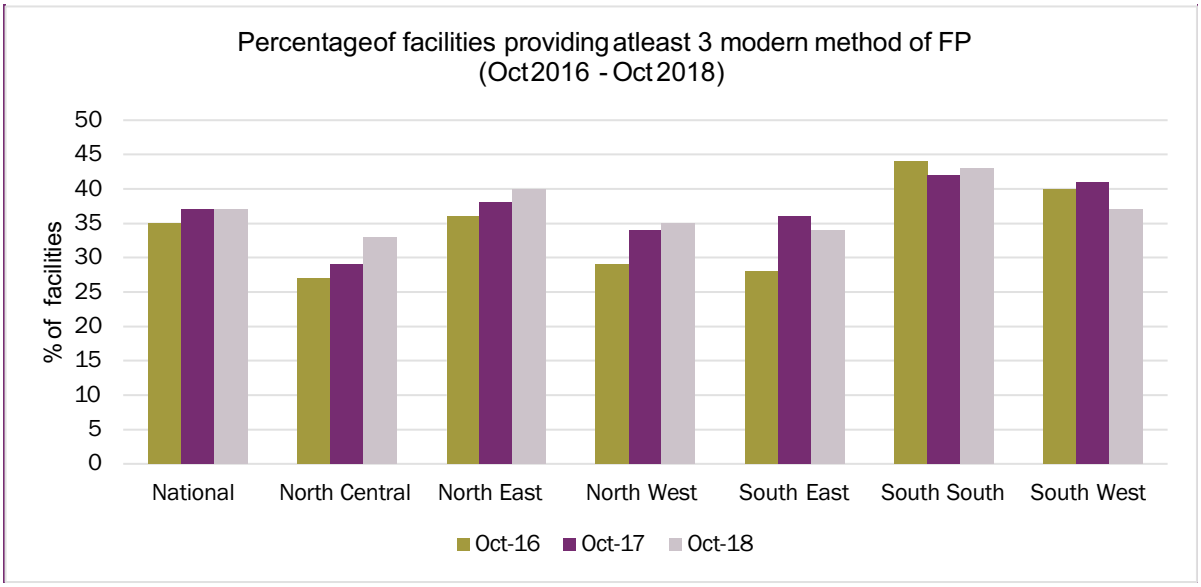
2.2 Service Delivery

As articulated in the previous Blueprint, delivering high-quality FP services across Nigeria depend on providers' competence, human and material resources availability at service delivery points in public and private facilities. These two factors alongside the availability of commodities largely affect the source of contraceptive by users.

Inadequate health facilities providing FP services

Generally, there has been a slight change in the number of health facilities offering at least 3 modern methods of contraception across the 6 geo-political zones. Based on the national FP dashboard reports, as of October 2018, 37% facilities provided at least 3 modern methods of contraception as against 35% in October in 2016 *(figure 4).* However, it is important to note that many facilities may offer service but not report on the HMIS. The low percentage of health facilities offering modern FP methods in the public sector can largely be attributed amongst other issues, to lack of adequately trained service providers at most facilities, biases in service provision, lack/inadequate equipment and infrastructure to support service delivery

Figure 4: Trend in facilities providing at least 3 modern methods of contraception



Source: National FP dashboard

Provider Skills and Training

The FMOH, with support from partners, has facilitated trainings of service providers on the provision of injectables and LARC among other methods of contraception nationwide. However, there is still a major shortage of skilled providers for delivering FP services, especially for injectables and LARCs. As at October 2018, 65% of facilities have a LARC-trained service provider.[6] Comparing this to the 36% of facilities providing LARC at the same period, it is possible that many providers who received training are no longer practicing in the public sector, commodities, tool and job aids for delivering services are unavailable or trained providers are not confident to offer services. If a provider has been trained and does not feel confident and/or comfortable about a method, s/he is less likely to offer that method. This contributes to provider bias for certain methods over others. In the case of injectables and LARC, the Task Shifting and Sharing Policy has been approved to allow community health extension workers (CHEWs) provide this method. With this, the FMOH is currently conducting training for CHEWs to deliver injectables and LARC properly (i.e., provide the necessary counselling, screen for pregnancy, and deliver the actual injection, implants or IUD).

Service Provision Bias

Service providers can increase the odds of continued contraceptive use or contribute to barriers to uptake. In Nigeria, recent literature shows that many providers contribute to barriers to contraceptive use by restricting access to FP methods based on their respective cultural/social norms or client's personal characteristics (i.e. age, parity, and marital status).[7,8] In a 2017 study on service provider imposed restrictions to contraceptive access, providers (nurses/midwives, CHEWs, pharmacists and PPMVs) across six states were recorded to have given service preference to clients who were married or older than 24yrs [6]. Similarly, PMA2020's (2017) Adolescents and Young Adults Health Brief indicates that unmarried individuals might be able to access information and services for male condoms and emergency contraceptives – but have much lower chances accessing same for more effective user-controlled methods (i.e. implants, IUDs, or injectables).[9] As

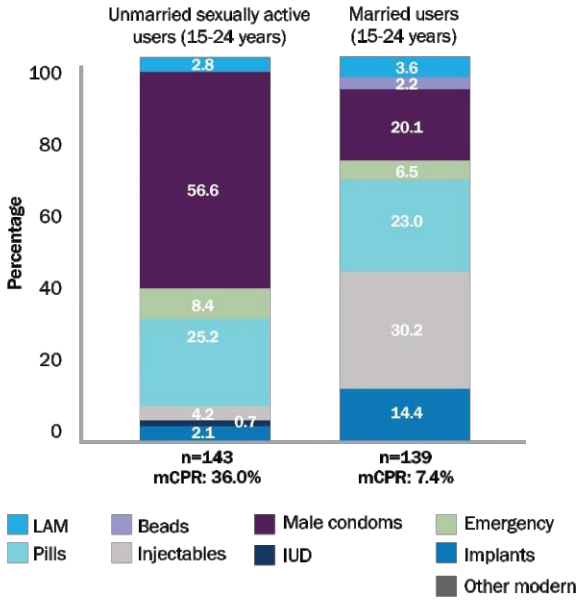
a result, unmarried individuals might choose not to use contraceptives or opt for methods that are more likely accessible but less effective, e.g. condoms *(Figure 5),* as equally shown in the NDHS 2018. The unavailability of adequate youth-friendly FP service points may be the biggest factor in preventing adolescents from accessing contraception. Attention needs to be given to attitudes and perceptions of adolescent and youth access to high quality reproductive health services.

Figure 5: Young and Unmarried sexually active women access to FP

Unmarried sexually active women are less likely to use highly effective methods.

The modern contraceptive prevalence rate (mCPR) among women age 15-24 is 8.8%.

Method mix among modern users, by marital status



Young unmarried users are less likely than married users to access methods from public facilities and to receive counseling services.

A higher percentage of married modern users (28%) obtain their methods from public health facilities than unmarried users (7%).

A higher percentage of married modern users than unmarried modern users receive counseling on other contraceptive methods (41% versus 25%) and side effects (42% versus 22%).

Source of contraceptives and counseling among modern contraceptive users by marital status

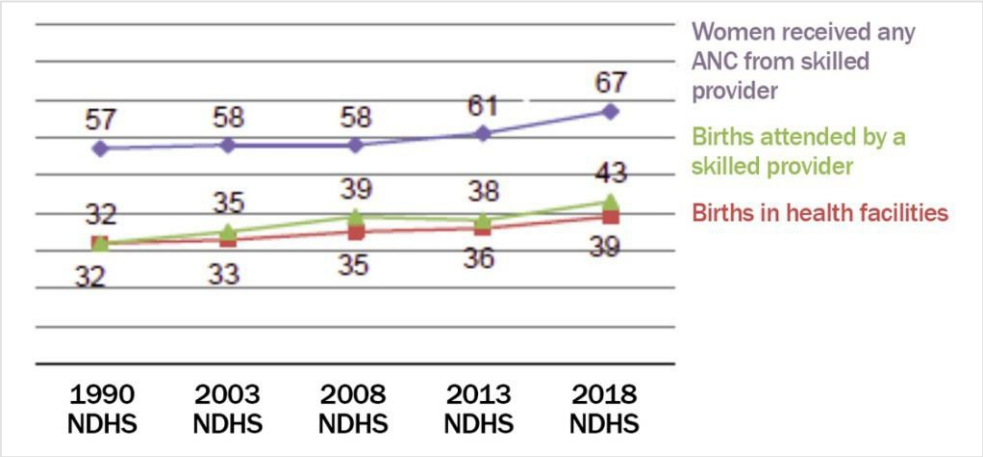
	Unmarried Users, %	Married Users, %
Source of Current Contraceptive Method		
Obtained method from public facility	6.7	28.4
Counseling		
Counseled on other contraceptive methods	25.1	41.0
Counseled on possible side effects	21.8	41.8
Counseled on what to do if experiencing side effects	67.9	76.0

From the study on provider imposed restriction, overall bias score was lower for providers who received in-service training for pill, injectable, and IUDs.[6] The introduction of DMPA-SC could be an opportunity to expand access for young persons and hence the need to revise the in-service and pre-service training curricula to emphasis a more rights based FP service provision and thus increase demand for services among youth.

Integration of FP With Existing MNCH Programs

Despite evidence of increased FP uptake when FP is integrated with maternal and new-born health, childhood immunisation, nutrition programmes and prevention of mother-to-child transmission of HIV (PMTCT) services, opportunities for integrated service delivery are largely missed. There has been an increase in women accessing MNCH services over the past years (see figure 6). Around the time of pregnancy, women may not seek family planning (FP) information or services, yet they often engage with the healthcare system during antenatal care, delivery, postnatal care, and first year infant immunizations.

Figure 6: Percentage of WRA accessing maternal care

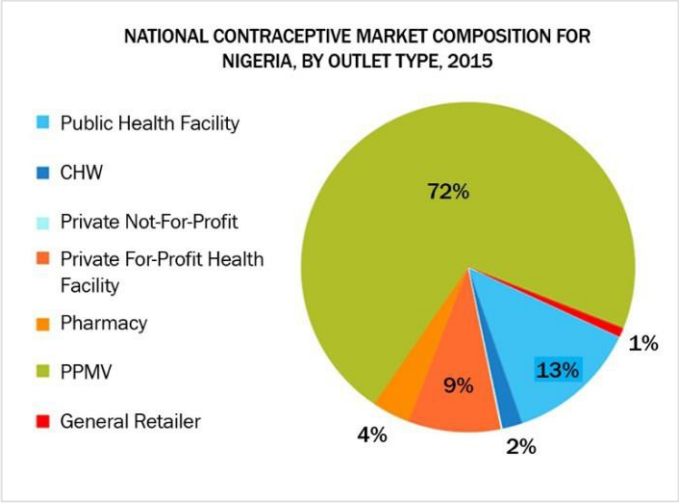


Source: NDHS 2018

These contact points offer valuable, reliable opportunities for healthcare providers to reach women at risk of closely spaced pregnancies with FP counselling and services. Some of the challenges of integration of FP with MNCH included resistance within the separate health programme responsible for FP and MCH services, and facility or community-based workers who are not trained or have inadequate staff time to address both MNCH and FP needs. The postpartum period represents a significant opportunity for reaching women with effective FP. Track 20 (2018) estimates that 17% of WRA in Nigeria are postpartum in a given year and only 2% are using a modern method of contraception.[10]

Private Sector Services

Figure 7: Nigerian Contraceptive market composition



Source: FP Watch Outlet Survey, 2015

The FP Watch Outlet Survey (2015) report[11] shows that over 80% of modern contraception is provided by the private sector *(figure 7).* The private sector ranges from non-governmental and faith-based organizations, usually providing free or subsidized services, to for-profit medical providers, pharmacies and PPMVs . These outlets are important sources of health care, particularly in rural areas or urban slums with few public clinics and account for most of the private sector provision of contraception in Nigeria, especially for condoms, pills, injectables and emergency contraception. However, Most FP training opportunities are focused around the public sector. Recent evidence shows that these cadre of providers can safely provide injectables and significantly expand access to contraception, especially with the introduction of DMPA-SC.

A large part of the recently launched DMPA-SC plan focuses on increasing access to FP through a total market approach, particularly through the community pharmacies and PPMVs. However,

current regulations do not permit pharmacists or PPMVs to administer injectable contraceptives because they are not yet regarded as sufficiently trained to initiate hormonal contraceptives or to provide any type of injection. Instead, they can only refer clients to health facilities. Nevertheless, reports like the NDHS (2013) have shown that almost 13 percent of injectables are provided by PPMV shops. As part of a total market approach, the FMOH is working to ensure regulations support private sector provision of contraceptives and that the private sector complies with public sector health standards.

Table 3: Summary of Service delivery challenges

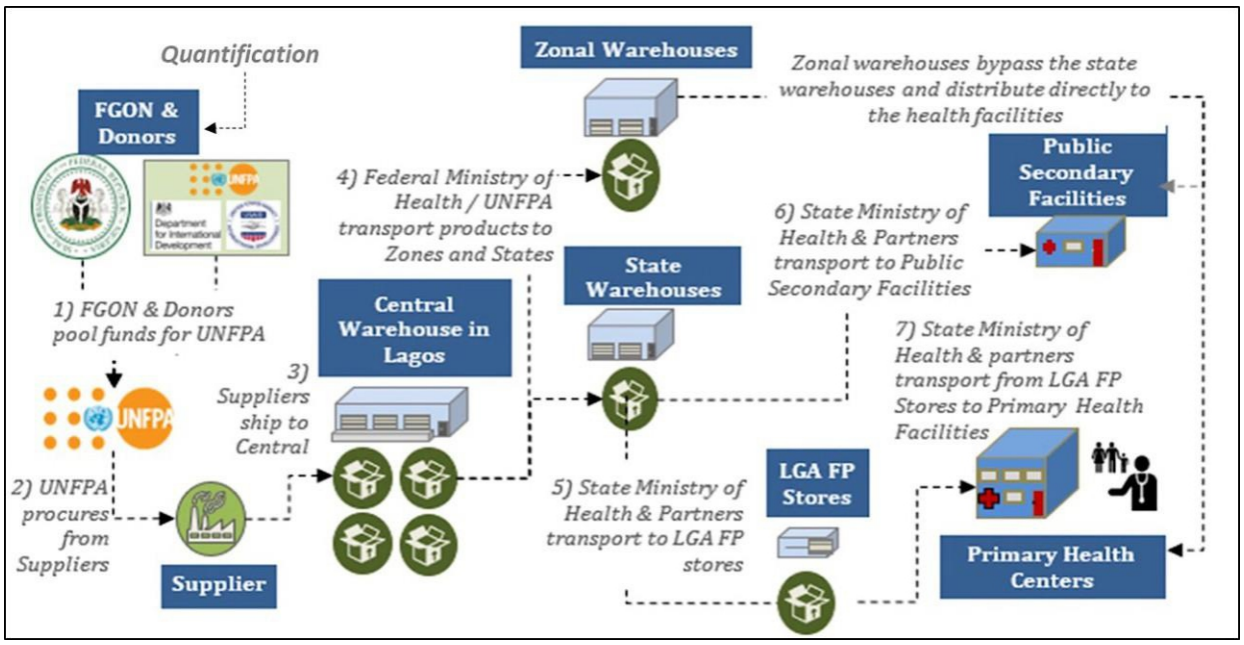
Challenges	
Limited access to modern FP methods	§ Inadequate health facilities providing FP services
	§ Low number of trained and skilled service providers
	§ Poor integration of FP with other maternal health programs
	§ Provider bias in service provision to youth and sexually active unmarried women
	§ Underutilized private sector community service delivery points (e.g. CPs and PPMVs)

2.3 Supply Chain Management

The key aim of this component is to ensure uninterrupted availability of commodities (commodity security) to support quality and affordable FP services across the country.

The FMOH monitors FP supply chain through the Procurement and Supply Management (PSM) subcommittee; which includes the Reproductive Health (RH) Division of the FMOH and partners involved in FP supply chain. This subcommittee is responsible for the contraceptive commodity security through annual forecasts, tracking and reviewing annual forecasts, contraceptive procurement progress, distribution to states and service delivery points. A depiction of the FP Supply Chain flow is shown in Fig *8.* Key components of the FP commodity supply chain in Nigeria are commodity quantification, procurement, distribution and storage.

Figure 8: FP Supply Chain flow



Source: PwC Analysis

The major challenges in the FP supply chain are related to increased stock-outs of commodities due to unavailability or poor quality of actual consumption data to determine the true commodity need, poorly implemented annual supply plans and irregular last mile distribution mostly due to lack of funding. The relatively high rate of stock outs *(figure 9)* limits the provision of quality FP services.

2.4 Quantification

National FP commodity quantification (i.e. forecasting and supply planning) is carried out annually by the PSM subcommittee (quantification task team) and reviewed biannually. The quantification task team is responsible for developing a rolling 3-year forecast that is updated annually. UNFPA[ii] and GHSC-PSM[iii] provide further technical assistance to the quantification task team in forecasting and supply planning, procurement monitoring, inventory management, storage and distribution; all of which is driven by a logistics management information system. A supply plan is developed and submitted to the FMOH for approval. It is important to note that although a rolling 3-year forecast is generated, the supply plan covers a period of one year.

Logistics Data management

Quantification of FP commodities considers demographic and logistics-based forecasts as key inputs into the final demand forecast. However, the national FP commodity quantification has been faced with poor or inaccessible data from service delivery points (SDPs). Ideally, consumption data which is based on the quantity of a product dispensed or consumed during past periods is the "gold standard" for forecasting. It deals with actuals rather than assumptions on FP commodity use and considers the capacity of the system (service delivery and supply chain) to get the product

[ii] UNFPA United Nations Population Fund
[iii] USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) program

into the hands of the client. However, due to delayed, inaccurate or incomplete reporting from SDPs and multiple levels up the reporting chain such data is unavailable or inadequate to support quantification. In addition, the lack of access to private sector data for modelling and forecasting due to its proprietary nature has resulted in greater focus on public sector forecasting, rather than applying a total market approach that will give a national picture of the true demand.

FP logistic data reporting is carried out using the Nigeria Health Logistics Management Information System (NHLMIS). The NHLMIS is a recently deployed integrated data visibility system for health supply chain in Nigeria which is expected to improve the quality and availability of data for quantification. However, at the state level there have been reports of lack of required LMIS tools and where available, limited capacity to use the available tools. All SDPs use hard copies of a standardized Requisition Issue and Report Forms (RIRF) forms to replenish their stocks based on validated usage figures. Calculations done manually into the RIRF at SDPs increase the chances of man-made errors in consumption figures, which has an impact on resupplies decision. This, along with the poor reporting rates, equally affects the use of consumption data for quantification.

2.5 Procurement

The FMOH engaged UNFPA to serve as the procurement agent for FP commodities using a Basket Fund which is guided by a signed memorandum of understanding between the Federal Government of Nigeria (FGN) and UNFPA. UNFPA, Department for International Development (DFID) and United States Agency for International Development (USAID) contribute *(see figure 8).* UNFPA places procurement orders on behalf of the FGN in accordance with approved supply plans developed by the PSM subcommittee and delivers to the national warehouses Central Contraceptives Warehouse (CCW). This procurement arrangement by the FMOH and partners has been beneficial in improving contraceptive commodity security. This is due to a pooled procurement mechanism that the UNFPA Supply Program uses to procure commodities for 46 countries (including Nigeria) at the most competitive negotiated prices with manufacturers, whilst ensuring the highest quality and standards of contraceptives.

Some of the challenges in the procurement process include the delays in approving the supply plan to commence procurement, timely release of funds, recent global shortages of some FP commodities which has led to increasing lead-times and difficulty getting necessary waivers for customs clearance and administrative bottlenecks at the ports. All these occasionally cause depletion of emergency stock levels (i.e. below minimum of 9 months of stock) at the national warehouses.

2.6 Distribution and Storage

Storage

Storage of FP commodities is a critical component of the Nigerian FP supply chain. The country has a central contraceptive warehouse (CCW) in Lagos into which all FP commodities procured for the public sector is stored. For maximum efficiency and to ensure uninterrupted commodity supply to states with minimum wastage, a minimum of 9 months and maximum of 18 months stock is stored centrally at any given time. All Nigerian states have warehousing facilities, which serve as storage units for securing and distributing FP commodities. However, state warehouses are still congested

and in suboptimal conditions in most cases. The country in line with integration of health disease programs is deploying six zonal hubs to ensure integrated commodity LMD distribution with other programs.

Distribution

Distribution of FP commodities can be divided into two categories: Long-haul distribution (LHD) from CCW to state stores and Last Mile Distribution (LMD) from state stores to service delivery points (SDPs). The FMOH is responsible for long-haul distribution, while the state and local governments are tasked with the LMD. The long-haul distribution while largely effective is still plagued with bottlenecks related to delayed state reports, limited funding and commodity unavailability and delay in implementing scheduled distributions.

Similarly, there are challenges with the last mile distribution to the SPDs. Presently, LMD of contraceptives across the 36 states and the FCT are saddled with sustainability challenges as they are majorly donor/partner driven. Key challenges in the state-level commodity distribution include inadequate resources; particularly funding for commodity transportation. Previously, States raised money for distribution using a cost-recovery model derived from user fees charge for proving Family Planning services in public health facilities. However, the removal of user fees in 2011 resulted in a loss of this income at state level. This limitation in funds to support distribution costs to health facilities has stalled distribution and increased stock out rates.

Ensuring the regular distribution of contraceptive commodities to SDPs in the long-term, requires each state to establish and fund its own process for the LMD of contraceptive commodities. There is an ongoing effort by the FMOH to promote and support state ownership of and responsibility for LMD of contraceptives via integrated distribution. Part of these efforts include system wide strengthening interventions, such as the formation of a State Logistics Management Coordination Unit and the planned integration of parallel health supply chains in the country through the National Product Supply Chain Management Program (NPSCMP).

Below is a summary of the identified challenges across the FP PSM thematic area

Table 4. Summary of supply challenges

	Sub Areas	Challenges
High Stockout rates at health facilities	Quantification	§ Incomplete or non-reporting from public and private sector health facilities § Poor quality of available consumption data § Non-availability and limited capacity to use LMIS reporting tools at some HFs
	Procurement	§ Insufficient government counterpart funding (for contribution to the Basket Fund)
		▪ Delay in obtaining various waivers required for clearing of commodities ▪ Administrative bottlenecks at the ports
		▪ Long lead-times resulting from global manufacturer's capacity (Limited product options)
	Distribution & Storage	§ Inadequate funding for last mile distribution by state governments
		▪ Poor warehousing conditions at state level

2.7 Policy and Environment

In recent times, FP issues have been at the forefront of discussions on population and development in Nigeria as reflected in the revised National Population Policy (2018) This informed FGN investment in *family planning and other relevant sectors of the economy to accelerate economic growth and achieve the demographic dividend. (see Figure 2).* Though some decision makers have been sensitised and have contributed to family planning, more work needs to be done to ensure that family planning receives the attention and support it requires.

Enabling environment for Family planning

The FMOH has made great strides in improving the enabling policy environment for FP, these include;

- Revitalizing its commitment in the 2017 Summit on Family Planning,
- Development of a national guideline to scale-up private providers' access to government's free FP commodities.
- Review of the National Reproductive Health Policy and The Reproductive Health Strategic Framework
- Revision of the Task Shifting/Task Sharing Policy (TSP) for Essential Health Care Services
- Development of the accelerated introduction and scale-up plan for DMPA-SC to increase access to injectable contraceptives.

These are in addition to several service protocols/guidelines that have equally been developed or reviewed to address relevant FP issues.[iv] However, there are still some gaps in policies, particularly around adolescents and young people access to family planning services and rights. Reproductive health policies do not presently indicate unrestricted access to FP services for youth, without being subject to parental consent, spousal consent, or provider discretion[v]. Most policies and national documents leave ambiguity in the scope of service provision for youth (i.e. age of consent)[12]. These documents do not explicitly mention youth's legal right to freely and independently access a full range of contraceptive services, including LARCs. Hence, health providers choosing to provide service to adolescents and youth are not protected by any policy statement that legally authorizes health providers to offer contraceptive services to these age group.

Also, as mentioned earlier, there is a large resource pool of providers within the healthcare system that evidence has shown can offer FP services (e.g., injectables) but are not adequately recognized by the Task Shifting/Task Sharing Policy (TSP). These include; the junior community health extension workers (JCHEWs), the community pharmacist, community midwives and PPMVs. Inclusion of these providers in the TSP is vital as these cadre could play important roles in providing contraception to women since in a large proportion of rural facilities, they may be the only available healthcare providers.

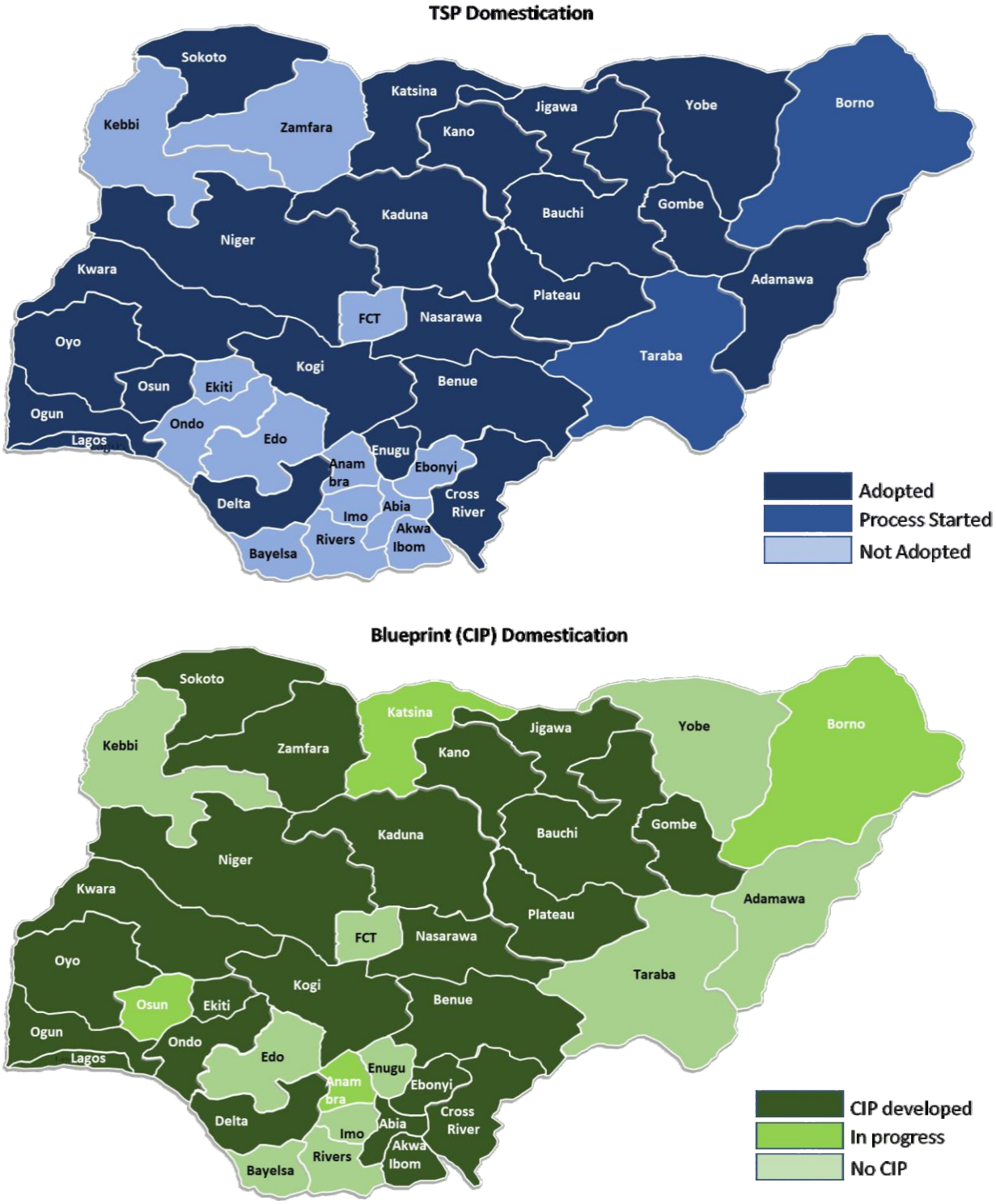
Policy to action

Given the nature of the three-tier government, autonomy falls on the SMOH to adopt and implement policies developed by the FMOH. This has been a recurrent challenge with the timely and effective implementation of most policies/guidelines as the FMOH can only advocate for the domestication of these policies. Since the approval of the TSP in 2012, 13 states are yet to begin domestication *(figure 10).* Likewise, for the national FP Blueprint, 14 states are yet to domesticate the plan to state level costed implementation plans since its launch in 2014. *(figure 10)*

[iv] http://www.health.gov.ng/index.php/resources/policy-documents/family-health

[v] Provider discretion is understood to be any legal provision that allows a provider to determine eligibility for youth to access contraception apart from medical eligibility criteria, such as the provider's personal belief.

Figure 10: TSP and CIP domestication across states as at April 2019



Source: Partnership and coordination Subcommittee Report April 2019

Furthermore, with the self-injection component of DMPA-SC approved by the National Agency for Food, Drug Administration and Control (NAFDAC), relevant guidelines and an implementation plan for self-injection have been developed by the FMOH. Considering that DMPA-SC will be

administered within the community and at home, visits to health care providers may likely reduce. Therefore, adherence to guidelines is necessary to ensure proper care and safety for clients administering DMPA-SC at home or for self. Such guidelines clarify how to monitor and report any possible adverse reaction and modalities to ensure proper disposal of the used DMPA-SC. In addition, there is the need for the inclusion of DMPA-SC in the FMOH approved pre- and in-service training curricula for injectable contraceptives.

Table 5: Summary of Policy environment challenges

Challenges	
Inadequate enabling policy environment for FP	§ Inadequate policies supporting Adolescent and Youth FP
	§ Ambiguities in existing FP policies (especially around adolescent and youth)
	§ Poor translation of existing policies to action

2.8 Financing

In Nigeria, financing for health and by extension for FP, is the responsibility of all the three tiers of government. Although FP a lot of investment in FP funding has been made by government and donors, it still remains inadequate. Overall FP funding, outside funding for contraceptive commodities, has largely been financed by external donors. This however excludes the costs for equipment, infrastructure and human resources, which is borne jointly by the three levels of government. In addition, the federal government has been paying for the purchase of contraceptives through a 'basket-funding' mechanism with external donors and in line with the nation's policy of free contraceptives at all public facilities. In the past three years, the federal government has augmented its share of the 'basket funds' in line with its FP 2020 commitment to increase its share to $4m annually. This progress was however cut short in 2019 when no amount was allocated to the 'basket'. This translated to close to 90% reduction in the overall budget for the year, a situation that calls for more advocacy and engagement with the executive arm, legislative arm of the federal government with states government on FP and health financing. .

Related to the problem of low level of allocation to FP, there is a more prevalent issue of poor and late release of funds. This leads to significant delays in purchase of commodities and recurrent need for external donors to fill the gaps. Establishing mechanisms that enable sustainable domestic financing for FP, including leveraging private sector networks to deliver FP services and information, represents a bold new approach to meeting the health needs of women and girls. Companies that have not traditionally been involved in health or FP nevertheless have a significant role to play.

Table 6: Summary of Finance challenges.

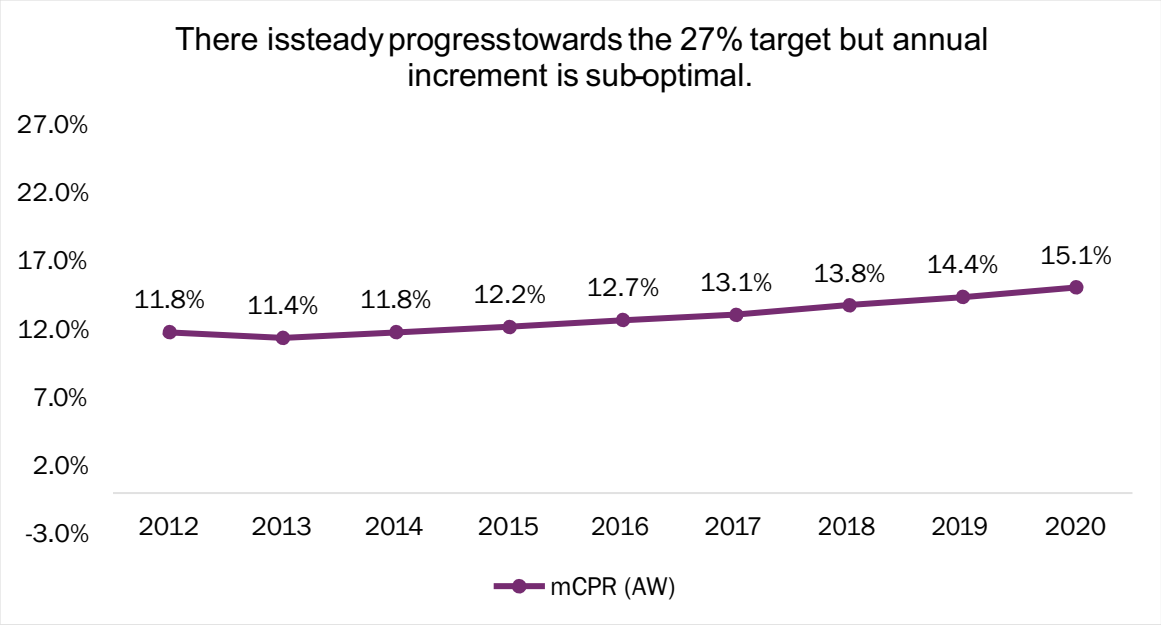
Challenges	
Inadequate funding for FP activities	§ Inadequate domestic funding for FP
	§ Untimely releases of budgeted funds for FP
	§ Lack of FP budget lines at subnational level

2.9 Supervision,Monitoring and Coordination

Monitoring

Following the country's FP2020 commitments in 2012, there has been an increased awareness of the importance of M&E in FP among stakeholders. This informed the development of the national CIP with a set of objectives and indicators. Thus, the indicators are aligned with the strategic objectives of the national FP Blueprint. The Blueprint, which marks out strategies needed to achieve the FGN FP goal of 36% CPR was used in developing a 5-year Activity Matrix by the FMOH though this target has been rebased to 27% mCPR by 2024. However, progress towards mCPR target has been slow but progressive *(see figure 11).*

Figure 11: FP2020 Projected Trend in mCPR: 2012-2020.



Source: FP2020: Catalysing collaboration 2017-2018.

The Blueprint Activity Matrix forms the basis for the development of the annual National Unified FP Workplan; an annually costed workplan developed by the NRHTWG to guide national FP activities. The Workplan is used to track the implementation of planned FP activities through the NRHTWG quarterly meetings and is reviewed annually. Equally, with support from partners, FMOH developed a CIP Map - a strategic tool that articulates 15 priority objectives from the Blueprint. These priority objectives have key indicators, which were selected out of the 61 Blueprint indicators to track the Blueprint's execution and performance. These priority indicators as well as the FP2020 core indicators were tracked by the FMOH with support from Track20.

The FGN, with support from CHAI, has developed the National FP Dashboard to monitor routine program activities including training activities, commodities utilization and stock status at Federal, State and facility levels. The Dashboard is used to inform program planning and resource allocation to ensure effective FP service delivery. The FP Dashboard has also been linked and integrated with the National DHIS2.0 platform as part of measures to fulfil the "One M&E system" principle of the FMOH. The FP Dashboard, which draws data from the NHMIS and program reports has been a very helpful platform for tracking and analysing FP human resource and routine data. The FMOH has

so far trained all state RH/FP coordinators and partners on using the dashboard. The key challenges in monitoring national FP programs include;

Over-reliance on periodic survey data: Reliance on periodic survey data such as the NDHS, is heavy, thus data is needed more frequently to track indicators that monitor the Blueprint execution process. PMA2020's bi-annual surveys provides a rapid-turnaround source of information that can be used for various FP data needs but is limited to 8 states, hence does not provide a full national representation for some indicators. Prioritization and re-categorization of the indicators into output, outcome and impact levels will be required to ensure effective data management. This will generate appropriate indicator datasets that can assist routine program planning and annual workplan reviews.

Low reporting rate of routine program indicators: The FP dashboard currently captures only 8 Blueprint indicators and suffers similar challenges to LMIS tools due to the low reporting rates on consumption data in the NHMIS and training data from programs. Low reporting rates are further compounded by the limited capacity of health workers on M&E data management, poor supportive supervision as well as the difficulty in capturing private sector data.

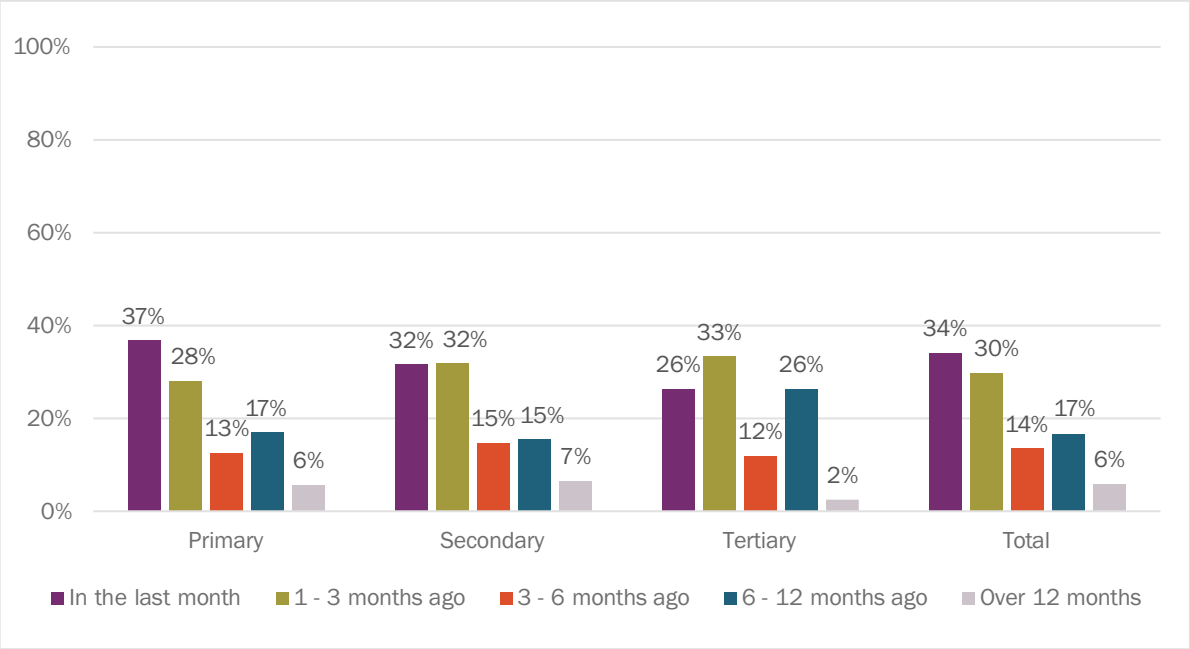
Limited access to data sources: Despite several efforts to strengthen the data collection processes including establishment of the DHIS2.0 and FP Dashboard, most program managers and FP coordinators still have limited access to DHIS2.0. Thus, data analysis and interpretation for use in tracking program performance and planning is limited.

Poor FP data quality: There are differing levels of capacity in data management at national, state and LGA levels. The factors contributing to poor data quality include low facility reporting rate, inadequate data analysis and supervision.

Supervision

Supervisory visits of SDPs should be conducted within a 3-month period. According to the 2018 UNFPA Supplies Survey report, an average of 64% of facilities across all levels reported they had been visited by a supervisor within the last 3 months before the survey was carried out. However, about 6% of facilities have gone more than a year without a supervisory visit.

Figure 12. Time since facilities received a supervised visit



Source: 2018 UNFPA supplies survey report

Another issue is the availability and inadequate use of supervisory checklist and tools. These tools are meant to be used to collect information and help supervisors to decide what corrective action can be taken during the visit, and what issues need to be followed up for action in the longer term. Reports have shown that checklist and other supervisory tools are not effectively used during supportive supervisory visits to facilities.

Coordination

Effective strategic partnership and coordination is necessary for the attainment of the goal and set targets in the FP blueprint. The multi-sectoral nature of the FP program makes it essential for different actors in public and private sector, including civil society organizations and the community to pool together their expertise, spread, resources and influence for an impactful response. Similarly, the necessary government agencies at all levels that have responsibility for bringing together and managing inputs of all critical stakeholders for effective response must recognize, harness and leverage on the comparative advantages of all actors. In the last 4 years of implementation of the blueprint, the Coordinating Unit at the national level has been able to expand the partnership network by bringing into the response a mix of partners across the various sectors.

These partners have individually and collectively made significant contributions that have impacted positively on the national response. Similarly, the coordination structure and mechanism have been repositioned to create harmony and give the response a sense of direction, maximizing the input and resources available within the internal and external environments. There has been a reinvigoration of the efforts by the NRHTWG considering that meetings are held regularly, partners' efforts are focused on the plan; while it also serves as veritable platform for linking, information sharing and learning and innovative ideas are being harvested and applied to the extent possible.

It is also important to note that the emergence of a new leadership to head the Coordinating Structure is a strong factor in some of the turnaround recorded following the adoption of the first FP blueprint.

While many successes have been achieved, there are still some challenges that need be addressed for a response that is not only comprehensive but also yielding results. Some donor assistance is not evenly distributed across the country and there have been some challenges in aligning some partners' activities with the goals of the government. There are also issues relating to the line ministries not linking and collaborating sufficiently, inadequate infrastructure and training for staff, insufficient technical support to the state, weak documentation, and inadequate funding by government, leading to high dependence on aid from partners.

There is therefore the need for an approach that enables stronger cooperation and collaboration among partners and critical stakeholders and transformative approach to coordination with government driving and taking charge of the process. This will ensure a sharper focus on anticipated result and all available resources well directed and channelled for a response that is not only effective but sustainable overtime. The partnership and coordination strategy of the plan aligns with SDG 17 and will pilot the nation's family planning in the direction of contributing directly and indirectly to Sustainable Development Goals.

Table 7: Summary of supervision, monitoring and coordination challenges.

	Sub Areas	Challenges
Inadequate use of data for decision making	Monitoring	§ Poor FP data quality: § Over-reliance on periodic survey data § Low reporting rate on routine program indicators § Limited access to data sources
	Supervision	§ Irregular ISS
		▪ Inadequate or non-use of ISS tools
	Coordination	§ Duplication of resources
		▪ Poor alignment of partner and government priorities

SECTION 3:

Family Planning Blueprint Strategies

3.1 Goal

The FP Blueprint (2020 – 2024) identified an overriding goal of achieving a mCPR of 27% by 2024.

3.2 Strategic Objectives

1. Raise demand and reduce Unmet Need for FP through strengthened Implementation of the National FP Communication Strategy
2. Expand Access to FP Methods through renewed focus on new opportunities, products and service delivery channels
3. Strengthen commodity security and reduce the high rates of stock-outs at service delivery points through improved logistics data quality and resource mobilization
4. Improve the national and sub-national policy environments for FP expansion with special emphasis on youth policy environment
5. Improve domestic funding to adequately cover FP costs countrywide through mobilizing resources from new public and private sector funding sources
6. Increase the use of evidence to manage and coordinate national FP program

3.3 Demand Generation

The demand generation component of the Blueprint will anchor on usage of consumer lens to promote positive behavioural change, design and implement interventions, that address the bottlenecks which hinder youth and adolescents from access and uptake of FP information and services. The implementation of the proposed activities will align with NFPCP, FLHE and other community structures

The demand generation component of the Blueprint will utilise opportunities in the Public and Private Sectors, in both Health and Non-Health sectors, with joint engagements and integration of youth friendly services, which will include gender mainstreaming into provision of youth friendly FP services.

Beyond plans at the National level, the Blueprint will encourage partners to assist states to review operational guidelines for Family Planning, with deliberate inclusion of SBC activities for FP in states CIP, ensuring that interventions are specific to the state needs, with priority 'catch-up' interventions for states that are experiencing marked decline in FP outcomes.

Cognisant of the current widespread myths and misconceptions regarding Family Planning, the Blueprint will leverage on existing opportunities to harvest and document success stories, experiences and adapt this to the various contexts in Nigeria. New media channels, in addition to the traditional approaches, will be utilized for wide and cost-effective reach to host and

disseminate success and human-interest stories. Data suggests that television viewing is increasing at a higher rate than radio among young persons. In addition, young persons in the 15-24 age group, especially males in the 20-24 years' age group have overall good access to internet with as high as 62% of males and 54.8% of females in some states having accessed internet at least once a week in the past month (MICS 2017).

The Blueprint, cognisant of the reach of new media, and for the need for enhanced access to the youth, will utilise websites and other appropriate social media platforms to target and engage young persons, and provide information on youth-friendly service sites.

This Blueprint will promote effective partner coordination for demand generation activities as well as effective monitoring and feedback to inform on-going alignment with changing social needs.

3.4 Strategic outcomes:

DC1: Ensure effective implementation of the NFPCP2017-2020. The National Family Planning Communication Plan outlines the country's strategy for reaching various populations with appropriate messaging and quality services under a uniform brand. Ensuring effective implementation is critical for family planning gains. This outcome will: (1) strengthen the Health Promotion Unit of the Federal Ministry of Health to effectively lead the implementation of the NFPCP; (2) ensure that interventions are specific to the various state needs; (3) promote effective integration of demand generation activities into state programs; (4) increase engagement of traditional and religious leaders on family planning; (5) expand the NFPCP champions to include social influencers and on-air-personalities; (6) develop audience specific life planning SBC interventions for adolescents and young persons; and (7) strengthen the nationwide implementation of FLHE while ensuring increased access to e-FLHE materials.

DC2: Expand young persons' access to information by leveraging new media. New media has an undisputedly wide reach in Nigeria. It is also more cost-effective than traditional mass media approaches. Taking cognisance of this, the strategic outcome will: (1) establish framework for new media program delivery (and monitoring) within the FMOH to drive this new initiative and provide oversight and support for state roll out; (2) develop and implement approaches to increase awareness and reach of young persons on social media platforms and (3) develop and implement interactive approaches to address specific information needs of individual young persons, integrating service delivery directories for access to youth friendly service points via applications, interactive messaging and multilingual call centres.

DC3: Improve partner coordination through the DG sub-committee of RHTWG.Partners are integral to the successful delivery of demand generation activities in Nigeria. In order to create synergies and avoid duplications (and therefore ineffective use of resources), effective coordination is essential. This strategic outcome will: (1) expand private sector partnership to all partners considered instrumental to achieving the plan including new media, organizations interested in CSR and those who gain from increased FP demand (such as pharma organizations); (2) Ensure effective partner engagement through regular meetings and communications and (3) Ensure effective regular monitoring of the demand generation activities specifically.

The Blueprint, cognisant of the reach of new media, and for enhanced access to the adolescents and youth, will utilise websites and other social media platforms to host and disseminate success and human-interest stories.

3.5. Service Delivery

Achievement of the goals of the Blueprint to a large extent depends on trained providers and material resources to deliver high-quality and rights-based FP services at service delivery points in public and private facilities across the country. The low percentage of health facilities offering modern FP methods especially for injectables and LARCs in the public sector can be attributed amongst other issues, to a lack of adequately trained service providers at most facilities. The objectives of the strategies for service delivery are to expand access to FP Methods at facilities and within communities. A rights-based approach to provision of family planning information will be adopted by ensuring that uptake is voluntary and based on informed knowledge, choice and consent, confidentiality, equity, non -discriminatory and avoiding provider bias. Providers will receive comprehensive FP training and be adequately deployed to locations where they are most needed.

3.6 Strategic Outcomes

SD.1. Develop and Roll-out national FP training plan. The country continues to experience inadequate number of health facilities providing FP services due to the short supply of trained and skilled (especially LARC) service providers. In-service training materials will be reviewed and updated as necessary. There will be scale-up of in-service training, prioritizing providers working at facilities without any trained provider, with focus on quality and long-acting reversible contraceptive (LARC) methods. Quarterly meetings will be conducted to review training plans and reporting on the dashboard. Also, to be reviewed and updated are in-service training materials for each cadre (doctors, midwives/nurses, and CHEWs). This will also improve coordination of trainings by all implementing partners. Quarterly supportive supervision and mentoring will also be conducted to ensure that the health workers are providing quality and rights-based information and services.

SD.2. Accelerate training of lower level providers and CIHPsthrough support to TSPand CIHPs roll-out. Harnessing all channels for the delivery of FP information and services is necessary for the achievement of the mCPR goal. As part of the implementation of the TSSP, lower level/Private sector Providers (CPs and PPMVs) will be trained including the referrals from the community to PHCs. Current CBDA training materials will be reviewed to identify those requiring updates and to ensure that full FP rights-based information is available to clients. The training of CBDAs will be scaled up to provide information on the full method mix in the community.

SD.3. Integrate FP into other PHC/MCHopportunities – PPFP,Child Health Services.Inadequate interventions focused on addressing PPFP has been recognized by stakeholders as a challenge in service delivery. As part of the integration of FP into other MNCH opportunities, the capacity of HCW providing ANC, L&D, Post-natal and Immunization services will be improved to provide PPFP services. They will be trained on PPFP and PAC, to target implementation and integration of PPFP and Post-PAC FP along the continuum of care. Training materials on PPFP and PAC will be developed and integrated into FP in-service and pre-serve training curriculum.

SD.4. Strengthen strategy for introduction of new contraceptives. Expansion of the method mix will accelerate progress towards achieving the national mCPR target. This will include the implementation of the strategic scale-up plan for DMPA-SC including its the self-injection component approved by the National Agency for Food, Drug Administration and Control (NAFDAC). Accelerated training of FP providers in both the public and private sectors will be conducted across the country. This will include PPMVs and CPs.

SD.5. Expand access to Rights based Youth Friendly FP Services. Provider bias in service provision to youth and sexually active unmarried women remains a barrier to the delivery of a right based non-discriminatory FP services. Service provider bias as a result of training being more skill-focused with inadequate emphasis on value clarification and youth-friendly services is an identified challenge in service delivery. The Quality of counselling and attitudinal skill-building will be improved by revising FP training materials/curriculum to emphasize right-based approach. IPCC modules will be made mandatory as a component of FP trainings to ensure it is reinforced as a way of addressing provider attitude and bias as well as institutionalizing rights-based counselling.

3.7 Supply Chain Management

To achieve the Blueprint goals, it is essential to ensure a sustained supply of commodities and consumables to SDPs across both rural and urban areas, thus, preventing stock-outs and ensuring contraceptive security.. The supply chain strategies of the Blueprint seek to promote adherence by all stakeholders to a consistent timeline for preparation, approval and implementation of supply plan to expedite procurement process, as well as ensure better warehousing and last mile distribution of commodities to SDPs. It also focuses on increasing the pool of funds through the basket fund for procurement and distribution.

3.8 Strategic Outcomes

SC 1: Improve LMIS data quality for accurate forecast. The LMIS data will be improved through capacity building and adherence to standardized SOPs for reporting in both private and public sectors. The capacity at the national and subnational level for forecasting will be built through structured regular training with various software and forecasting methods, and necessary equipment procured. FP data should be embedded at the national level and LMCU to improve visibility and analysis which would inform quantification, procurement and quality assurance. Quantification for full method mix will be conducted annually using improved LMIS data. When available, data from surveys, program evaluations, program plans, service statistics will also be used to strengthen supply planning. Data quality assurance exercises will also be carried out in line with national guidelines.

SC 2: Engage federal and state governments to mobilize resources for procurement, warehousing & distribution of commodities. FMOH will sustain effective Long-haul distribution (LHD) from CCW to zonal/state stores and engage states to mobilize domestic resources to support LMD from zonal/state stores to SDPs. Existing subnational resources such as BHCPF and SOML, and others private/public sector resources will be identified and explored as potential opportunities to increase funding for LMD of FP commodities and improving warehousing conditions at zonal/state levels. Warehousing infrastructure and logistics capacity and efficiency will be improved through

training supply chain officers in logistics management, advocating for full refurbishment of warehouses where necessary.

SC 3: Strengthen procurement process through PSM sub-committee. The FMOH will ensure efficient procurement and supply planning through the PSM sub-committee of the RHTWG. This committee which consist of government, donors and implementing partners involved in FP commodity security will work to build commodity logistic and management capacity at all levels. The committee will meet regularly to monitor and coordinate the implementation and review of the national procurement and supply plan.

3.9 Policy and Environment

A conducive policy environment is essential for effective implementation of FP activities across all spheres. This blueprint will guide the review of key policies to address any ambiguities that affect the implementation of FP services, including those for adolescents and young people. This blueprint will also promote effective policy implementation across all states for maximum effect and access by ensuring capacity to domesticate and implement policies within the states. However, where critical policy frameworks are absent, they will be developed.

3.10 Strategic Outcomes

P1. Repositioning AYSRH through Revision of all Policies and Training Manuals that Restrict Adolescent and Youth from Accessing a Full Range of FP Methods. This strategy will involve the review of selected RH policy and guideline documents to address inconsistencies between these documents and adolescent policies. These documents include: (1)National Guidelines for the Integration of Adolescent and Youth Friendly Services into PHC Facilities in Nigeria 2013"; (2) Increasing Access to Long Acting Reversible Contraception in Nigeria: National Scale-up Strategy and Implementation Plan 2013 - 2015; (3) National Family Planning Training Manual for Physician, Nurse and Midwife 2015; (4) RH/FP Service Protocol 2015; (5) National Policy on Health and Development of the Young People 2007; and (6) National Training Manual for the Health and Development of adolescent and young people in Nigeria 2011.

P2. Develop policy to increase indigenous private sector investment for FP in Nigeria. There is a need to increase domestic funding for FP in order to reduce over-dependency on donor funding and ensure ownership. In order to harness this potential, this strategic outcome will involve the development of a policy framework for private sector investment in family planning.

P3. Advocate for policy implementation at State level. Widespread policy implementation is necessary for national improvement in FP indicators. This strategy will focus on supporting states with gaps in policy implementation to advocate at the state level. Particular emphasis will include advocating for an enabling environment for young persons' FP service delivery and access.

P4. Improved focus on technical support to states on policy development and adaptation. While the national level provides policy guidance, states are to adapt policies and develop new ones for issues peculiar to the state context to support state implementation. This strategy will build capacity of states to critically identify policy issues and bottlenecks and develop or adapt polices to address them.

3.11 Financing

The GoN is committed to ensuring sustainable financing for FP to tackle the perpetual funding gap and reliance on external donors through mobilizing domestic funds and better accountability. Consistent advocacy by government and its partners in the civil society made the current government commit to paying for all previous pledges and continue to pay until the end of the commitment period, the year 2020. With the recent removal of counter-part funding in 2019 budget, these advocacy efforts have become more necessary to ensure that the government pays up to 2020 and thereafter for the next five years. The recent widening of the health fiscal space from implementation of the Health Act the new programs and better funding of the LGAs and facilities, have provided new opportunities to increase domestic funding for FP. This also calls for a renewed vigour to ensure accountability and responsibility in expenditure.

3.12 Strategic Outcomes

F 1: Increase FP financing through fulfilling the old and creating new financial commitments to FP beyond 2020. The national RH TWG through its advocacy sub-committee will facilitate coordinated efforts to engage the national assembly, the executive through the office of the Vice President and other relevant MDAs to ensure the government has re-committed to providing additional resources into the basket funds for commodities.

F 2: Mobilize resources from new avenues/programs, the private and other sources. Concerted efforts will be exerted to identify and engage new sources for FP funding at all the levels of governance. With government implementation of policies that widen the fiscal space including the National Act and National Financial Intelligence Unit (NFIU), more money will be generated to fund FP at all levels of government (states, LGAs and facilities).

F 3: Improve accountability and tracking of FP funding. Given the shortage of funds for FP interventions nationally, it is critical to ensure any available finances are spent efficiently. The new Blueprint outlines initiatives to ensure finances are tracked and institutions are accountable to the people. Activities that will ensure efficient expenditure will include tracking of budgeted funds, release of budgeted funds and regular expenditure analysis to be facilitated by CSOs at various levels. Key CSOs involved in budget tracking will be trained to conduct these activities.

3.13 Supervision, Monitoring and Coordination

In view of the country's commitment, there is a need to ensure strong monitoring and measurement system that provide clear understanding of progress over time. In addition, the diverse number of stakeholders contributing to the national FP response must be coordinated if progress is to be meaningful. On the background of weak data management, the revised National FP Blueprint has proposed several important interventions to ensure achievements of its set out objectives.

A strengthened National Health Management Information System (NHMIS) provides the best foundation to manage progress and address service delivery challenges in good time. Competent M&E officers managing good quality data inputs from lower public and private facilities; regular tracking and course correction of the use of the system and improved supportive supervision will improve visibility and quality of FP programming in the country.

In a vastly diverse country with like Nigeria, stringent coordination on many fronts is necessary to avoid duplication of resources and better align efforts with national aspirations. Coordination must be strengthened not just between non-governmental and government partners, but also among

government agencies operating both within and between national and sub-national governments. The role of re-vitalized NRHTWG must also continue to be improved as a key coordination structure for the national FP program.

3.14 Strategic Outcomes

SMC 1: Strengthen the NHMIS to guide FP programming in the country. Capacity of the M&E human resources will be built continuously by simplifying the training curricula of the NHMIS system including its foundational software, the DHIS 2.0 and the associated FP Dashboard. This will make regular training easier to be conducted at all the levels of the health care system and together with improved supply of tools including guidelines for data collection and quality checks, will improve the system's capacity to produce quality data. Private sector sources will also be included in these efforts and better tracking will result from establishing and managing state-level dashboards to track and share FP reports, wherever possible.

SMC2: Improve the quality and performance of FP programs at sub-national and facility level. National Integrated Supportive Supervision (ISS) plan has a component of FP that will be revised to better align with current performance requirement at sub-national level due to anticipated increased funding and implementation activities at that level. Once reviewed, relevant officers at states and LGAs will be trained and supported to develop plans and conduct quarterly supervision visits and follow-up activities. Partners and CSOs will also be encouraged to track the supervision plan and ensure it is being carried out and serving the purpose of improving performance at those levels.

SMC3: Strengthen national structures for coordination of FP activities. The initiative of developing annual FP workplan from the FP Blueprint ensures that all resources are aligned to the Blueprint. Going forward, quarterly progress on implementation of the plan normally discussed at the NRHTWG meetings will be shared with donors to ensure implementing partners are responsive to this national coordination effort. In addition, the outputs of the National FP dashboard will be used to produce quarterly newsletter and annual performance report to show progress on key coverage indicators. This will also be shared widely as a way to ensure all key stakeholders are aware of the progress that is being made. In order to improve national visibility and alignment, the NRHTWG will also invite external stakeholders such as the media, private companies, traditional leaders and entertainment industry actors to participate in FP review activities.

Coordination will also be stimulated through regular review of state FP activities and providing feedback by the NRHTWG leadership, assigning and encouraging technical partners to take on support to individual states and ensuring they develop state-specific CIPs. Regular tracking through mapping of CIP development and implementation as well as using that information to understand where donor-supported programs are currently being implemented will provide good opportunity to achieve equitable distribution and coordination of FP interventions. All these will further reinforce the role of RHTWG in coordination of FP activities and ensure better harmonisation of FP activities and national governance.

SECTION 3:

Operationalization

The revised blueprint and its eventual implementation are coming at a time that the Nigeria's economy is growing at less than 2% and from the pronouncements of the Government, it is evident that there is a serious concern on the growth of Nigeria's population and the need for a concerted effort to avoid an explosion. Consequently, the Government in the Economic Recovery and Growth Plan (ERGP) highlights strategies for addressing population growth considering that even in a situation of positive economic growth, the achieved GDP may be unable to keep pace with the needs of a population that is expanding exponentially. The Federal Government commits to the review and implementation of the National Population Policy with National Planning Commission and Federal Ministry of Health as responsible agencies for the review.

With Family Planning being a strategy in the policy, the National Family Planning blueprint is the strategy document for the operationalization of the family planning strategy of the revised policy. The blueprint recognizes partnership and collaboration as essential to the implementation of the plan with the participation of agencies from all sectors. It is expected that the implementation will be driven to leverage on the resources available in the various Line Ministries and others (Education, Women Affairs, Youth, National Planning Commission, NPHCDA, NOA, NHIS etc.), Faith based community, traditional and religious institutions constituencies, community structures, local and international development partners, the private sector (health, drug vendors, business), media (traditional and social), entertainment industry, professional associations in health and research institutions. The operationalization of this plan and the impact it will make rests strongly on the effective mobilization and deployment of the resources available in all these actors for expanded coverage (information and services). The Coordinating agency will provide the required leadership in creating awareness, sensitise the various agencies to their roles in the implementation, provide support to them where required to enable them play these roles and monitor their response to the National Blueprint. Specifically, the Federal Ministry of Health (Reproductive Health Division) will design and implement the following

- Presentation of the approved blueprint to all actors in the constituencies identified above either through an integrated meeting with the various constituencies represented or focused presentation (dissemination) to representatives of each community
- Media engagement (traditional and social) to present the Blueprint, highlight their roles and responsibilities and overtime provide the necessary training that enable them acquire the capacity needed to actively participate in the implementation.
- Dissemination to the various line ministries and other relevant agencies (listed above) and engaging them on the strategies for their active involvement in implementation
- Dissemination to international donors and development partners to mobilise their support (financial, technical, materials etc.) to the implementation of the plan. The FMOH (RH Division) will evolve and implement a capacity building plan for the various line ministries

and Agencies to enable them develop the capacity needed to implement activities relating to their Ministries/Agencies

- Engagement with the National Economic Management Team to position the blueprint and its implementation within the EGRP and other policies and plans of the Federal Government of Nigeria with a view to secure their buy-in and integration of family planning into government priority agenda and resource allocation
- Development of Harmonized Annual Family Planning Operational Plan based on the blueprint with participation of strategic actors from various constituencies – development partners, Line Ministries and Agencies, media, entertainment industry, faith based, Interfaith and private health sector. The RHTWG and its various sub-committees will keep this plan in focus and use the platform of its meetings to review implementation and advice on re-energizing the operationalization.
- FMOH (RH Division) will implement an effective mechanism that enable an alignment between international assistance to family planning and the National Blueprint
- The RHTWG will keep the plan in focus, putting in place strategies that enable all actors focus on and align their various programs with the Blueprint. Deviations will be identified and necessary actions taken to ensure that all responses target the country's priorities and CPR target. If possible, new country programs will be presented to the RHTWG for input that align such country program to the Blueprint
- The RHTWG will undertake a bi-annual review of the implementation of the plan while an Expanded 2-day Annual Review meeting with strategic partners and stakeholders in attendance to review the implementation of the blueprint and develop operational plan for the following year
- The Federal Ministry of Health will also on annual basis make presentations at the Annual National Council on Health (NCH) with a view to raise awareness and draw attention of the various sub-sectors in the health sector to their roles in the implementation of the Blueprint
- Annual Performance Report/Score card will be developed and disseminated to provide update on progress and impact to enable various partners keep track, design and implement their improved response strategies
- The operationalization strategy of the plan will also include mid-term and end-line evaluation of the plan with the RHTWG RDME sub-committee leading the process
- The various reviews will also include using available data to determine progress and the extent to which the blueprint is achieving the desired objectives.

SECTION 3:

Impact

The projected impacts for the Nigerian FP blueprint 2020 -2024 are indicated in *table 8* below[vi]. See also *figures 13-20.*

Table 8: Projected impacts 2020 -2024

Total annual impacts	2019	2020	2021	2022	2023	cumulative for 2019-2023
Demographic impacts						
Unintended pregnancies averted	226,443	184,161	144,049	105,538	68,186	728,377
Live births averted	100,712	81,907	64,067	46,939	30,326	323,951
Abortions averted	93,786	76,274	59,661	43,711	28,241	301,673
Health impacts						
Maternal deaths averted	1,175	943	727	525	334	3,704
Child deaths averted*	5,644	4,590	3,591	2,631	1,700	18,156
Unsafe abortions averted	79,762	64,869	50,740	37,175	24,018	256,564
DALYs and economic impacts						
Maternal DALYs averted (mortality and morbidity)	68,159	54,671	42,168	30,458	19,396	214,852
Child DALYs averted (mortality)	477,224	388,116	303,581	222,420	143,700	1,535,041
Total DALYs averted	545,384	442,787	345,748	252,878	163,097	1,749,894
Direct healthcare costs saved (2018 USD)	12,600,190	10,247,449	8,015,463	5,872,578	3,794,130	40,529,809

[vi] The impact of this Blueprint was modelled using "Michelle Weinberger, Anisa Berdellima, Rhian Stephens, George Hayes, Erik Munroe. Impact 2 (v5), Marie Stopes International, 2019https://www.mariestopes.org/what-we-do/our-approach/our-technical-expertise/impact-2/"

Figure 13. Impact on unwanted pregnancies

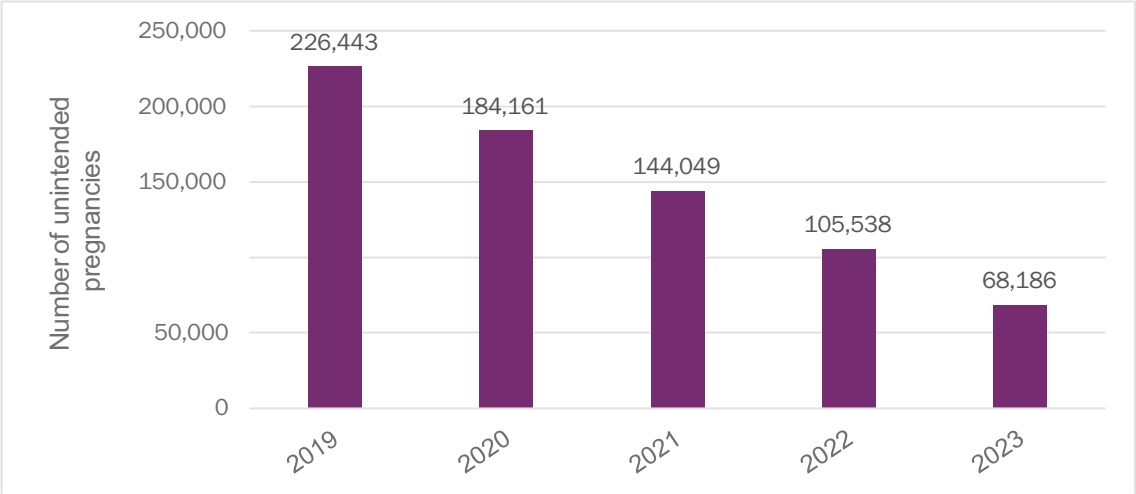


Figure 14. Estimated abortions averted

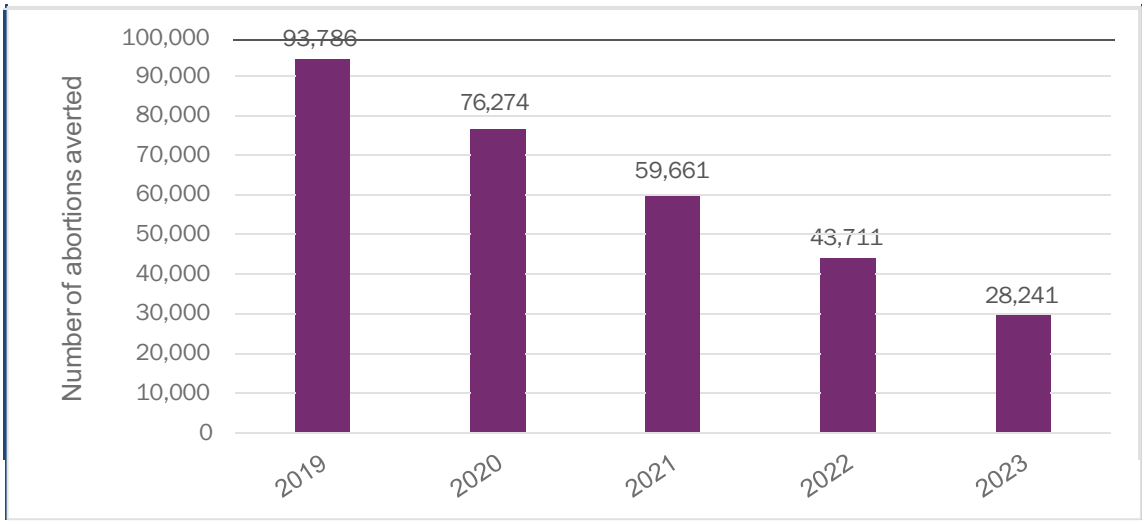


Figure 15. Unsafe abortion averted

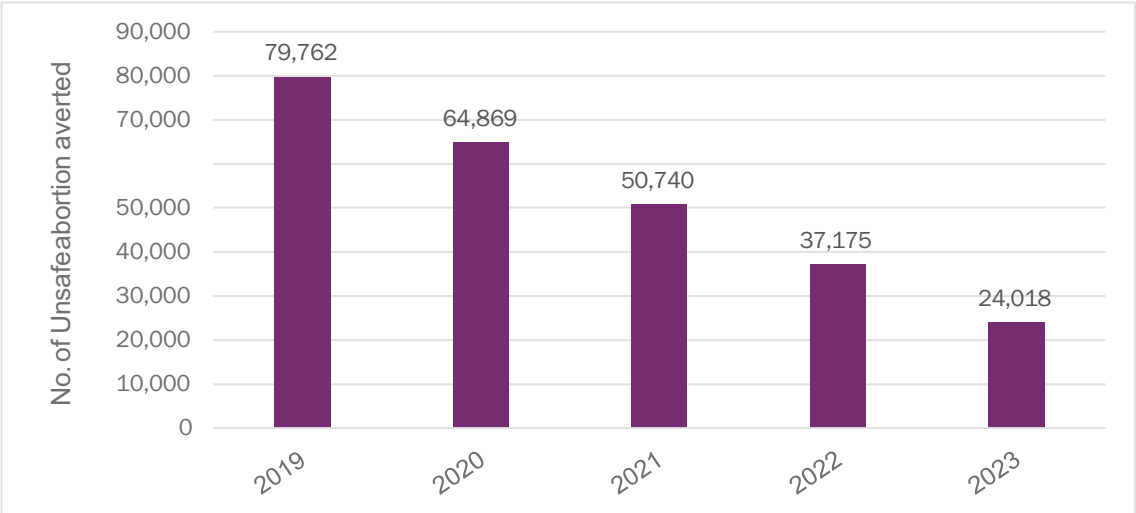


Figure 16. Estimated annual child death averted

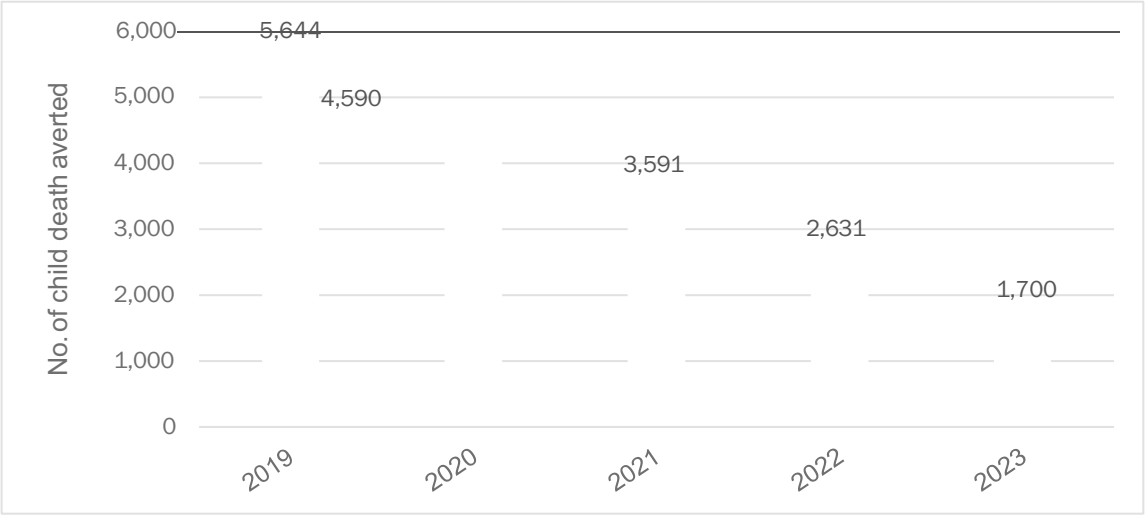


Figure 17. Estimated maternal DALYS annually averted

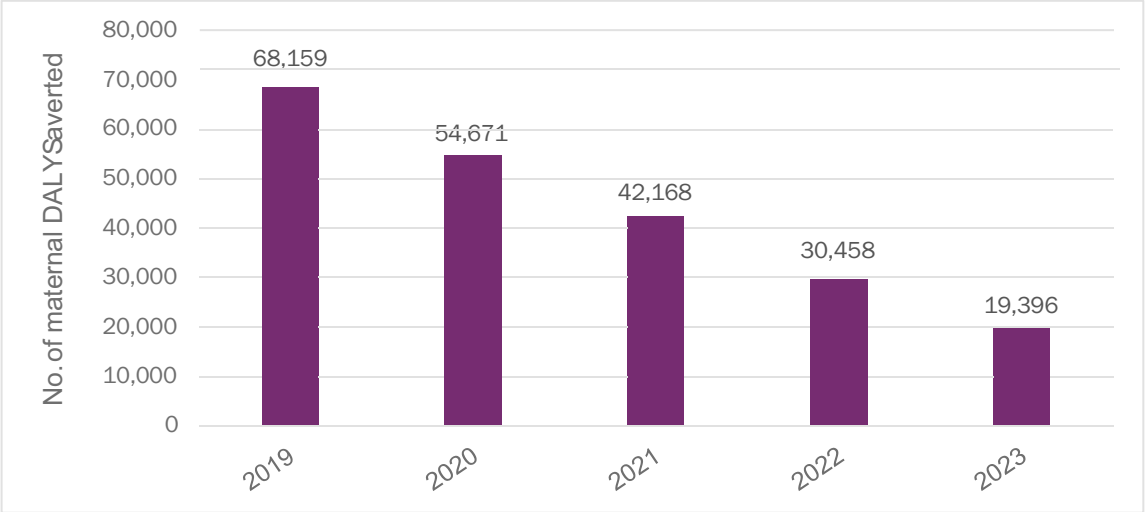


Figure 18. Estimated child DALYS annually averted

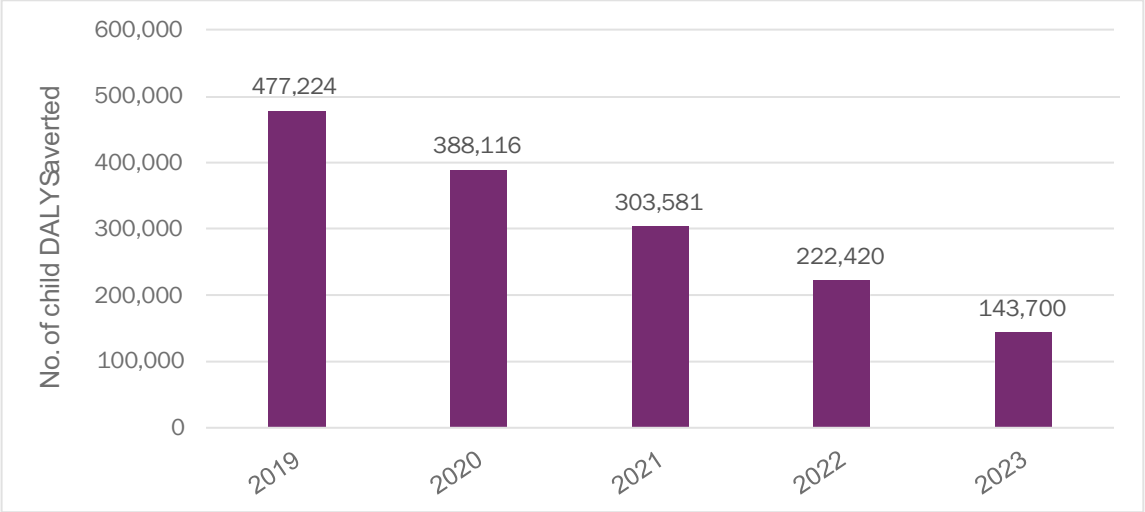


Figure 19. Estimated total DALYS annually averted

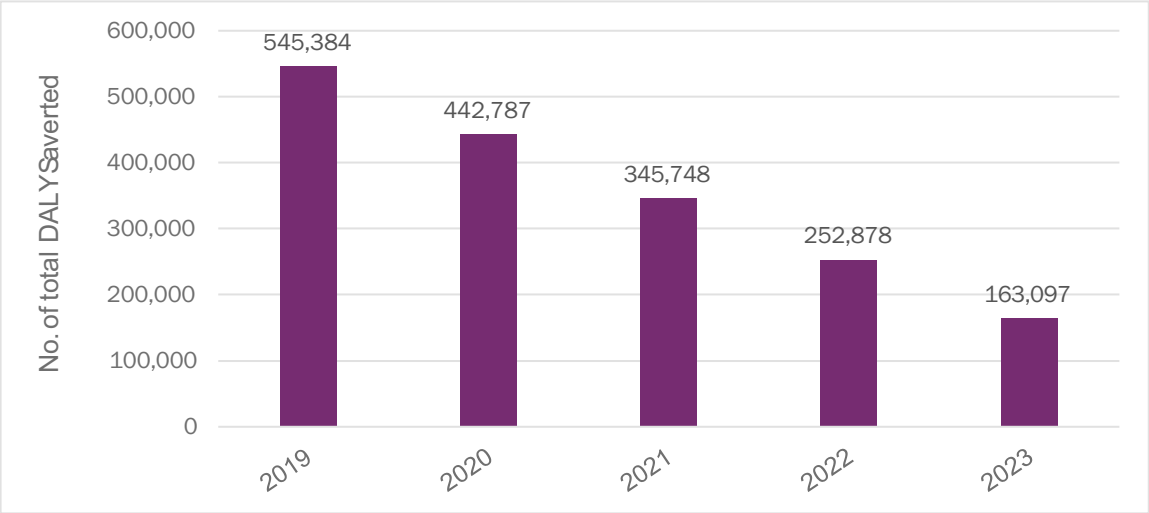
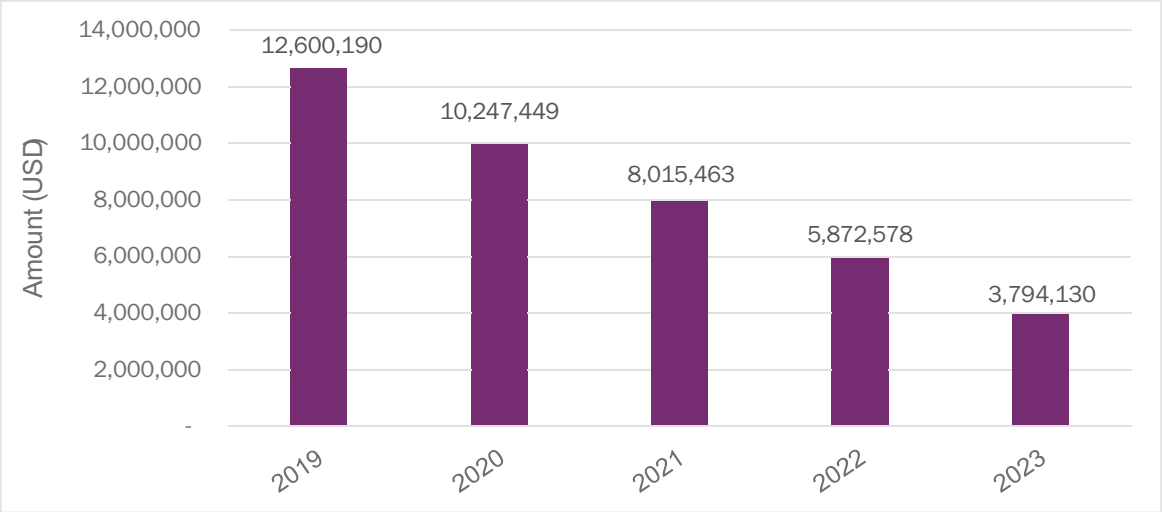


Figure 20. Estimated healthcare cost saved



SECTION 6:

Costing

6.1 Assumptions

The assumption of these estimates are in 2 broad categories- 1) The assumption of cost per activities which were overly dependent on the validated FP blueprint 2020 -2024 adequately matched figures from the cost input that were independently verified to mirror the present realities and 2) The procurement and supply chain management (PSM) commodities projection and cost implication by PricewaterhouseCoopers (PwC)- with focus on contraceptives only.

The contraceptives costs were estimated using various techniques which are based on costing done by PwC. These costs of contraceptive have been estimated from 2019 to 2023, based on the present (2019) product prices based on the most recent price surveys by Federal Ministry of Health (FMoH), PwC and others, and 2023 CPR aim for women of reproductive age (married and unmarried), through which the estimates for each intermediate year were forecasted. The technique utilized in providing the cost analysis for this FP 2020 -2024 blueprint will not be used for predicting or procurement objectives. It is developed to create a structure for pragmatic pricing of commodities and consumables.

A practicable inflation rate for the pricing was deduced using the average value for the last 5 years which would be more consistent with the realities and experiences in Nigeria- this is set at 13.04%. Although, this rate did not apply to the commodities since they are procured independently from the international market. Exchange rate of N360.00/US$1.00 was used as against N306.00/US$1.00 per CBN rate. This is to bridge the reality between the parallel market rate and the official rate in Nigeria, and potential change in government policies and flux.

The number of participants, meeting/event days, volume of commodities, etc. was as approved per Validated National FP Blueprint 2020 -2024. For trainings, a cohort is between 1 to 65 participants. Consequently, activities will be implemented in the quarter/year intended, otherwise, these will move to the next quarter/year.

It should be noted that all costs (such as salaries, per diem rates, transportation costs, venue hire, etc.) are estimated based on present costs as of August 2019. All costs were calculated in U.S. dollars and equivalent Naira; some sets of indicators were considered in the breakdown of cost at the states level, they include: number of women of reproductive age (WRA), number of health workers, population, number of facilities, number of LGAs, and uniform costs distribution.

This costing is aimed to achieve a high-level etimate of materials needed to realize the national objective of increased CPR by 2023. It is expected that the Federal government's efforts to stabilize the economy and reduce insecurity will begin to yield the desired results as soon as possible, to enable implementation of planned activities, without other extra costs, e.g. security expenses.

6.2 Cost Summary

The estimated expenditures in this FP plan have been specially done with the use of specific technique that was created for this purpose, with strategies borrowed from other FP blueprints that were done in the neighboring countries. The instrument enables for the estimation of the total costs of the FP plan, and also divides the costs by area of activity, State and year. It comprises

both preliminary (expenditure) costs and continuing or maintenance costs for the period covered by the FP plan. Nevertheless, this blueprint should be seen only as general costing of the FP plan, not a financial statement to be used for distribution of funds for the day-to-day activities.

This FP Blueprint from 2019 to 2023 is estimated at a total cost of US$252,004,187. Given that the scope of the FP Blueprint has been changed from 2019-2023 to 2020-2024, the adjustment in costing will be carried out during the Mid-Term Review of the document.

Generally, US$125,693,775, representing 50 percent of the total costs, are for procurement & supply chain management, comprising the consumables and contraceptives. Another 38.8 percent is for service delivery; 4.9 percent for supervision, monitoring & co-ordination; and 4.6 percent for financing including logistics, venue rent etc. another 1.4 percent are for demand creation while policy advocacy account for the remaining costs at 0.5 percent of the overall costs. These costs are expected to cover the period of the FP Blueprint, with costs of commodity increasing over time as more women are reached.

Table 9: Costs by Category and Strategic Priority
The Blueprint will cost a total of $252 million, with the highest costs in procurement & supply chain management

Category	Total
Demand creation	3.5
Service delivery	97.7
Procurement & Supply Chain Management	125.7
Policy Advocacy	1.2
Finance	11.7
Supervision, Monitoring & Co-ordination	12.2
Total	*252.0*

Figure 21: Costs by Category and Strategic Priority
The Blueprint will cost a total of $252 million, with the highest costs in procurement & supply chain management

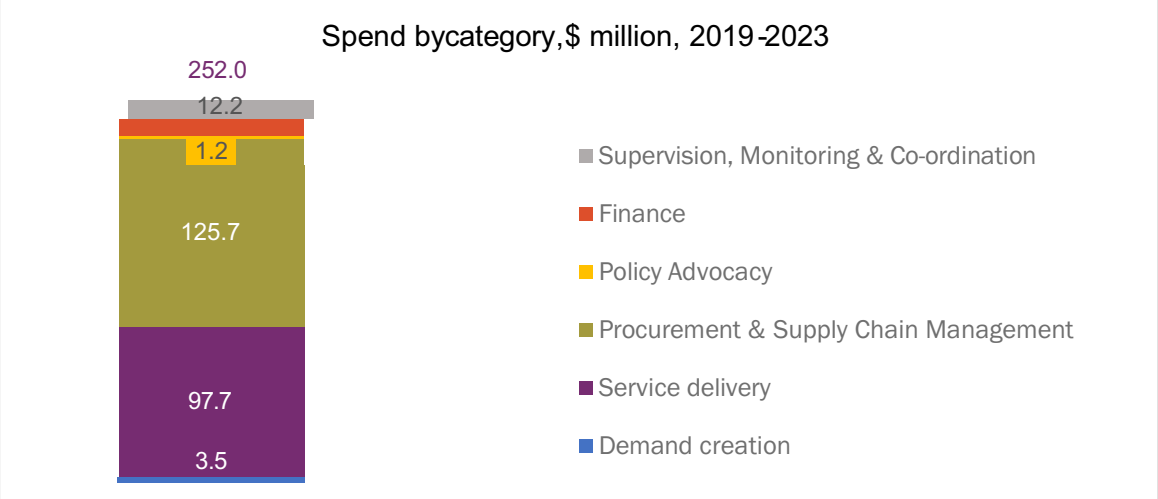


Table 10: Costs per year, by category in USD Millions

Category	2019	2020	2021	2022	2023	Total
Demand creation	1.71	1.23	0.25	0.16	0.18	3.52
Service delivery	8.09	20.44	20.28	22.92	25.91	97.66
Procurement & Supply Chain Management	27.42	25.42	23.27	24.22	25.36	125.69
Policy Advocacy	0.63	0.07	0.51	0.00	0.00	1.20
Finance	1.21	2.42	2.55	2.88	2.65	11.70
Supervision, Monitoring &Co-ordination	1.79	2.19	2.42	2.74	3.09	12.23
	40.84	51.77	49.27	52.92	57.20	252.00

Figure 22: Costs per year, by category in USD Millions

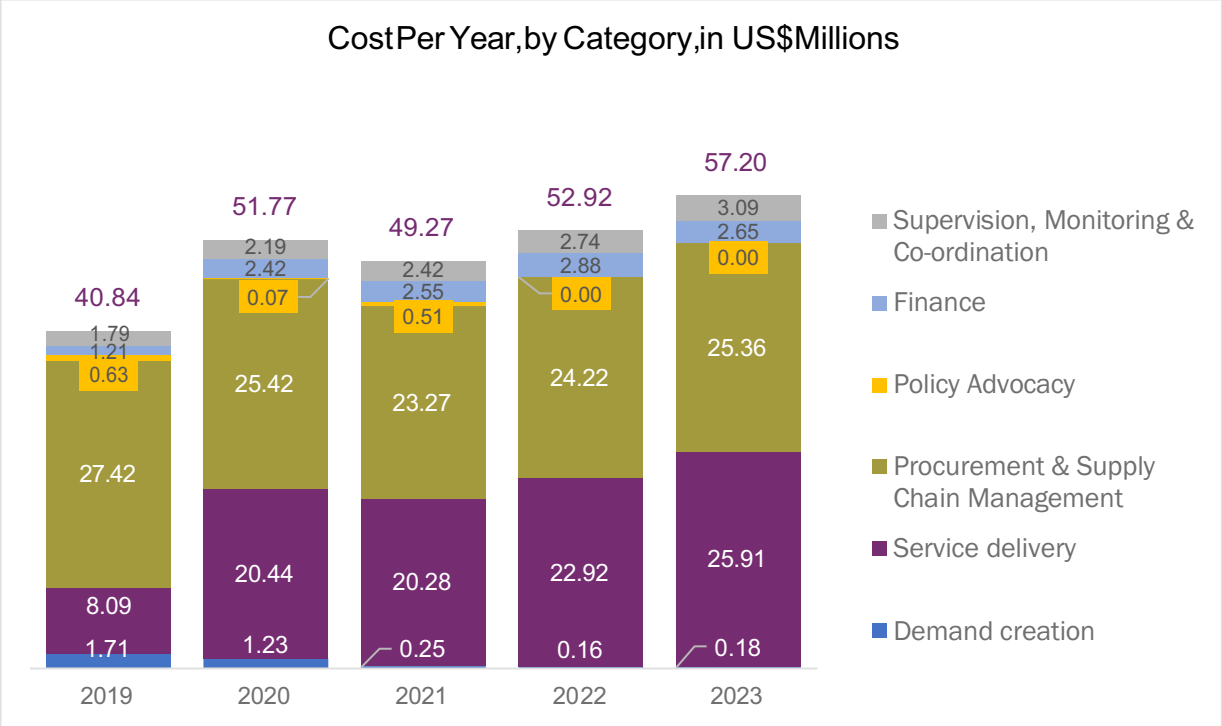


Figure 23: Cost per year by Programme Activities

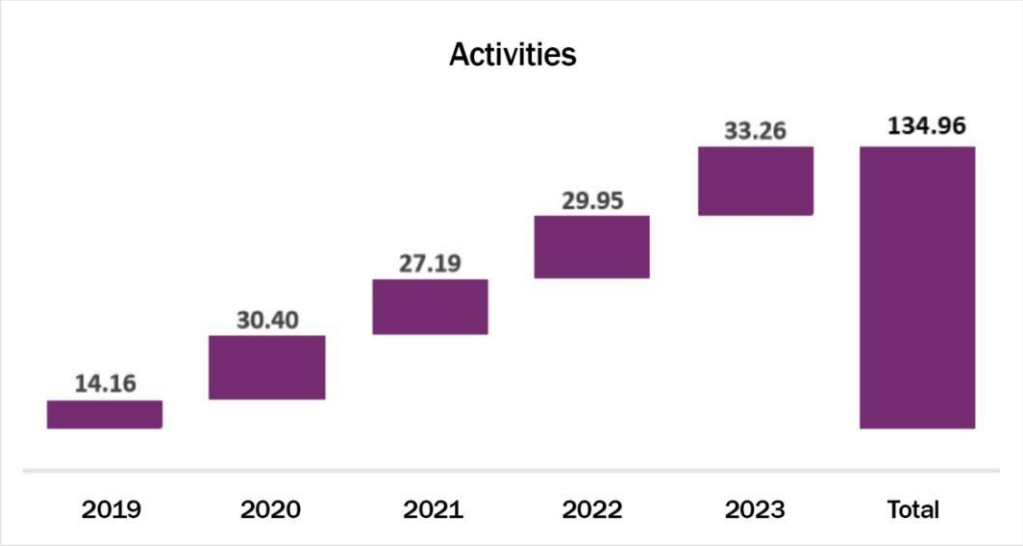


Figure 24: Cost per year by FP Commodities

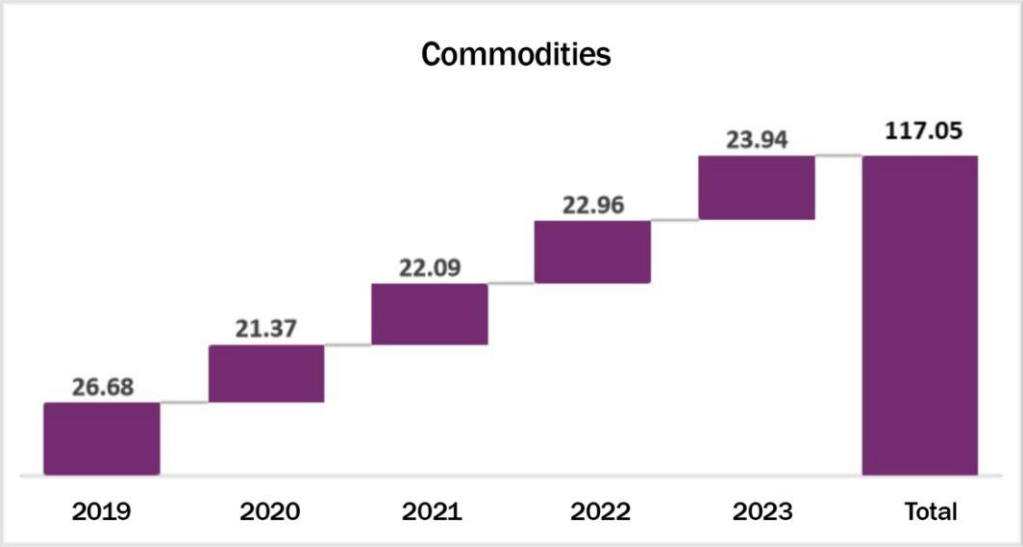


Table 6.3:

Cumulative Cost Comparison by Category in US (Expired vs. Current Blueprint)					
CATEGORY	2013- 2018 (USD)			2019-2023 (USD)	
Demand	133,000,000			3,524,274	
ServiceDelivery	131,000,000			97,657,103	
Commodities and Consumables	183,000,000				
Policy advocacy				1,204,965	
Finance				11,696,533	
Supply Chain	23,000,000			125,693,775	
Supervision,Monitoring and Coordination	133,000,000			12,227,538	
Total	*603,000,000*			*252,004,188*	
Cost per year, Categories in US $ 2014 – 2018					
CATEGORY	2014	2015	2016	2017	2018
Demand	28.5	22.1	29.3	23	30.5
ServiceDelivery	29.7	24.9	25.4	25.1	25.6
Commodities and Consumables	21	28.1	35.9	44.4	53.6
Policy Advocacy	-	-	-	-	-
Finance	-	-	-	-	-
Supply Chain	4.4	4.4	4.5	4.6	4.6
Supervision,Monitoring and Coordination	26.8	25.7	27.8	25.6	27.7
Total	*110.4*	*105.2*	*122.9*	*122.7*	*142*
Cost Per Year, Categories in US $ 2019 – 2023					
CATEGORY	2019	2020	2021	2022	2023
Demand	1,706,766	1,230,489	251,592	157,448	177,979
ServiceDelivery	8,094,683	20,444,824	20,279,770	22,924,252	25,913,574
Commodities and Consumables	-	-	-	-	-
Policy Advocacy	632,516	67,332	505,117	-	-
Finance	1,205,151	2,420,050	2,545,245	2,877,145	2,648,940
Supply Chain	27,416,054	25,420,958	23,269,735	24,222,437	25,364,592
Supervision,Monitoring and Coordination	1,787,825	2,188,207	2,421,071	2,736,779	3,093,655
Total	*40,842,995*	*51,771,860*	*49,272,530*	*52,918,061*	*57,198,740*

Annex 1: CIP Matrix

DEMAND GENERATION

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
DG 1	Ensure effective implementation of the NFPCP 2017-2020					
DG 1.1	Strengthen the HPD of FMoH to lead the implementation of NFPCP	DG 1.1.1. Strengthening the HPD as the secretariat, equip and train staff, cascade training to state for successful implementation. DG 1.1.2. Ensure a framework for regular monitoring and review of data. DG 1.1.3. Capacity building for planning, programming (e.g. HCD) and monitoring implementation	I) Communication support equipment including audio-visual aids II) 10 days consultant's time, Hall, DSA, Transport, Training materials II) 5X37 States days consultant, Halls, DSA, Transport, Training materials X 36 states + FCT	M&E framework??, I) No. of HPD staff trained Functional HPD secretariat (Outcome) II) No. of states HPD capacity built	Y1, Q1 – Y2	FMOH, Partners (SFH, BA, MSION, TCI,DKT)
DG. 1.2	Devolve interventions to states, addressing challenges that are peculiar to the target population	DG 1.2.1. Identify state specific challenges and support formulation of targeted interventions, taking cognizance of current state data DG 1.2.2. Support states to develop state-specific operational plans. DG 1.2.3. For states with large negative changes (e.g. greater than 5% points from NDHS 2018), plans should include priority 'catch-up' actions	60 days consultant's time Hall, DSA, Transport & Meeting materials	Proportion (%) of states with specific plans developed	Y1, Q2	SMOH, Partners (SFH, BA, MSION, TCI,DKT)

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
DG. 1.3	Integrate NFPCP into state programs	DG 1.3.1. Identify on-going, related, funded state programs and MDAs (e.g. SOML PfR that financially rewards the states for increase in CPR and programs in related sectors e.g. YSD, WA, Agric, NOA, SHIA) for wider, cost-effective reach DG 1.3.2. Support states to develop and implement simple work plans for integrated messaging and activities.	60 days consultant's time Hall, DSA, Transport & Meeting materials	Percentage of state programs with FP SBC activities integrated	2019, Q2, ongoing	SMOH, MDAs, partners(SFH, BA, MSION, TCI,DKT)
DG. 1.4	Increase engagement of traditional & religious leaders(link to advocacy)	DG 1.4.1. Identify key traditional &religious leaders in all states DG 1.4.2. Conduct advocacy and engagement meetings to secure buy-in for their roles as gatekeepers and champions for FP in their communities.	20 days consultant's time Hall, DSA, Transport & Meeting materials	Increased number of political leaders ,traditional ,religious and decision makers in Nigeria who openly speak in support of Family Planning . Number of FP champions (outcome)	2019, Q3 – ongoing	SMOH, Partners(SFH, BA, MSION, TCI,DKT)
DG. 1.5	Expand NFPCP influential/champions to include social influencers, on air personalities and bloggers	DG 1.5.1. Identify key influencers specific to different population groups (e.g. religious leaders with large following), general population influencers, social media influencers (youth influencers Nollywood influencers, etc. to champion issues around family planning and related economic development. DG 1.5.2. Conduct engagement meetings and workshops for selected influencers to secure buy-in and enlighten them on the NFPCP, branding and their potential roles as champions.	10 days consultant's time, advocacy visits, 3 Hall, DSA, Transport, Workshop materials. honorarium and travels.	Increase number 'influentials' engaged Identified FP influencers equipped /skilled in SRH FP messaging	2019, Q3 - ongoing	FMOH, New media team,partners(SFH, BA, MSION, TCI,DKT)

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		DG 1.5.3. Formalize relationship with agreeable champions and provide on-going support for content and messaging as required.				
DG. 1.6	Develop audience-specific life planning SBC Interventions (validated by the demand generation subcommittee of the NRHTWG) for youth and adolescents	DG 1.6.1. Identify/map the key sub-groups within this population to be prioritized based on situation analysis to include: out of school, in-school, rural dwellers, young persons with low literacy, etc. DG 1.6.2. Develop specific approaches and roll-out plans for each sub-group DG 1.6.3. Implement and track roll out	20 days consultant's time	Audience specific life planning intervention developed& implemented . Number of states implementing the plan. Number of tracked reports from states.	2019, Q3	FMOH, SMOH, Partners(SFH, BA, MSION, TCI,DKT)
DG. 1.7	Strengthen implementation of FLHE	DG 1.7.1. Conduct a rapid assessment of status of current FLHE implementation and quality of content received by students to inform strategies for strengthened implementation DG 1.7.2. Implement a specific FLHE dashboard, integrating existing MIS tools, in collaboration with the relevant MDAs and stakeholders to keep FLHE implementation and monitoring DG 1.7.3. Develop a simple quality assurance system for spot checks on quality of teacher delivery and student learning on FLHE issues DG 1.7.4. Explore the inclusion of specific examination questions pertinent to FP issues in relevant	60 days' consultant's time, DSA, other assessment costs. IT firm for dashboard and web-access development. Printing and replication costs for handbook and CDs.	Percentage coverage of FLHE implementation Percentage coverage of distribution of FLHE materials Existence of a dashboard to monitor & track performance. FLHE quality assurance system developed	2019, Q1 ongoing	FMOH, FMOE, Partners (UNESCO, UNICEF,UNFPA SFH, BA, MSION, TCI,DKT)

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		routine school subject examinations as a means of strengthening correct knowledge, in collaboration with Ministry of Education, UBE and other relevant stakeholders				
		DG 1.7.5. Liaise with states and stakeholders to ensure adequate reproduction and distribution of FLHE handbooks and instructional tools e.g. handbook, models, eFLHE CDs to teachers				
		DG 1.7.6. Develop web-access platform for FHLE materials to increase teacher reach and access.				
DG2	Leverage new media to expand youth access to information					
DG. 2.1	Establish framework for new media program delivery	DG 2.1.1. Engage key stakeholders in a multisectoral forum (relevant FMOH units such as RH, HPU, ICT and selected relevant MDAs) to establish the need for new media delivery, secure buy-in and support, and oversight	60 days consultant's time Hall, DSA, Transport & Meeting materials	New media operation plan	2019, Q1	FMOH, New media team (NMT)
		DG 2.1.2. Establish a secretariat within the suitable structure (e.g. HPU), specifically tasked with oversight of e new media program delivery through FMOH portals, and support state-roll out as applicable. Ensure technical and financial support for the new media unit through Partner support and or function out-sourcing				

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		DG 2.1.3. Conduct rapid assessment to adequate map the new media terrain to identify suitable entry points and channels for delivery and high impact				
		DG 2.1.4. Develop and implement operational plan for programming, with clear indicators for monitoring reach, coverage and end-user feedback				
DG. 2.2	Develop and implement approaches to increase awareness and reach of young persons on social media platforms	DG 2.2.1. Design and develop mini (less than 10mins) episodes/series using local realistic, age-appropriate storylines to promote success stories, dispel myths and misconceptions, etc. for internet viewing	20 days consultant's time	Percentage of target population (15-24) reached through social media platforms	2019, Q2 - ongoing	FMOH, NMT
		DG 2.2.2. Design and develop mini (less than 10mins) episodes/series using local realistic, age-appropriate storylines to promote success stories, dispel myths and misconceptions, etc. for internet viewing				
		DG 2.2.3. Increase access to eFLHE content through web-based access				
DG. 2.3	Develop and implement interactive approachesto address specific information needs of individual young persons	DG 2.3.1. Develop a directory of FP advisors, resource persons and other persons who can be scheduled to lead chat sessions	30 days consultant's time Promotion costs Support for call center	Percentage of target population engaged	2019, Q2 – ongoing	FMOH, NMT
		DG 2.3.2. Define guidelines/process for chat discussions, including issues of confidentiality, guidelines on postings and train resource persons in line with this				

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		DG 2.3.3. Schedule and implement regular interactive chat or group sessions (e.g. WhatsApp, telegram), anchored by FP advisors/resource persons	Resource persons honorarium, data Promotion cost Monitoring cost App development and promotion Advocacy to NCC and telecommunication companies and promotion of toll free line	% of targeted audience reached % of targeted audience reached % of target group aware of utilizing toll-free centre	2019, Q4-ongoing 2019, Q4-ongoing 2019, Q1	FMOH, NMT FMOH, NMT FMOH, NMT
		DG 2.3.4. Liaise with stakeholders to publicize sessions on all social media channels for increased attendance				
		DG 2.3.5. Promote (paid promotion) schedule on Instagram and other similar platforms				
		DG 2.3.6. Develop interactive branded (in line with NFPCP) app for FP information, reminders and youth-friendly service directory information				
		DG 2.3.7. Establish a toll-free multi-lingual call center and or interactive SMS system for FP information and youth-friendly service directory information				
DG.3	Improve partner DGcoordination through the DGsub-committee of RHTWG					
DG. 3.1	Expand private sector partnership	DG 3.1.1. Identify key private sector partners that are instrumental to effective implementation of the plan – both as CSR and those that stand to benefit from increased FP demand e.g. pharma industry and the bank eg GTB (supports Ndani TV)	20 days consultant's time	Mapping report	2019, Q1-2	RHTWG
		DG 3.1.2. Include identified organizations in partnership forums				

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
DG. 3.2	Effective partner engagement	DG 3.2.1. Ensure specific focal person(s) with clear roles and responsibilities for partner engagement and coordination. DG 3.2.2. Map all partners implementing in the RH/FP demand generation space for inclusion into partnership forum. DG 3.2.3. Ensure regular partnership form engagement through structured update emails/circulars, regular meetings, etc.	10 days consultant's time, Hall and meeting costs	Minutes of quarterly meetings	2019, Q2 – ongoing	RHTWG, Partners (SFH, BA, MSION, TCI,DKT)
DG. 3.3	Effective monitoring of DG implementation	DG 3.3.1. Work with M&E TWG to harmonize monitoring tools and formats to cover plan monitoring needs (including new social media) and partner monitoring needs. DG 3.3.2. Hold regular (bi-monthly) partner meetings, including HPU, specifically for the tracking of DG activities within the blueprint. DG 3.3.3. Conduct periodic reviews/evaluations to inform the evolution of messaging and approaches to meet changing social and target population needs.	60 days consultant's time Hall, DSA, Transport & Meeting materials Hall, DSA, Transport & Meeting materials 40 days consultant's time , Hall, DSA, Transport & Meeting materials	Bi-monthly M&E reports on DG Annual program review reports with recommendations for subsequent year	2019 , Q2 – ongoing 2019, Q2- bimonthly Year 2, Q2- bimonthly	RHTWG

SERVICE DELIVERY

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
SD1.	Develop and Roll-out national FP training plan					
SD1.1.	Scale up in-service training for providers working at public health facilities without any trained provider	SD 1.1.1. Conduct a Mapping to develop Database of all facilities and available trained FP providers in each geopolitical zone	60 days Consultants time, DSA & Transport	Database of all facilities showing Proportion of trained HCWs who currently provide FP services	Q3 2019	FMoH
		SD 1.1.2. Review and update the National in-service training material for each cadre (doctors, midwives/nurses, and CHEWs) to reflect current rights and evidence-based practice	30 days of consultant time Hall, Lunch and tea breaks, transportation Printing 500	Updated In-service training materials	Q3 2019	RHTWG
		SD 1.1.3. Review and update pre-service training materials as necessary for each cadre (doctors, midwives/nurses, and CHEWs)	30 days of consultant time Hall, DSA, Transport & Meeting materials	Updated pre-service training materials	Q3 2019	FMoH, FME and Regulatory Councils
		SD 1.1.4. Conduct Training of trainers for doctors, midwives/nurses, and CHEWs in 6 geopolitical zones	60 days Consultants time Hall, DSA, Transport & Meeting materials	State-level trainers trained (target: 370 each of doctors, midwives/nurses, and CHEWs trained)	Q4, 2019	FMoH, SMoH and Regulatory Councils
1.2	Review training plans and reporting on the dashboard	SD 1.2.1. 2 day Quarterly national meetings for 60 people	Hall, DSA, Transport & Meeting materials	Quarterly review meetings conducted and states upload trainings on the database.	Q4 2019 and ongoing on quarterly basis	RHTWG

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
1.3	Conduct quarterly ISS at States and LGAs levels	SD 1.3.1. Harmonize and update the FP component of integrated supportive supervision (ISS) tools	60 days Consultants time Hall, DSA, Transport & Meeting materials	Improvement of data into method information index	From Q4 2019 and ongoing on quarterly basis	SMoHs, FMoH
SD.2	Accelerate training of lower level providers (incl. CPs & Tier 2 &3 PPMVs) and CIHPs through support to TSP and CIHPs roll-out					
2.1	Scale up training of Tier 2 & 3 PPMVs	SD 2.1.1. Revise guidelines for CPs & Tier 2 & 3 PPMVs	10 days of consultant time Hall, DSA, Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp	Guidelines revised	Q 4 2019	FMoH
		SD 2.1.2. Conduct training of trainers at zonal level for CPs & Tier 2 & 3 PPMVs	30 days Consultants time Hall, DSA, Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp	State-level master trainers on paramedical training trained (target: 740	Q2 2020	FMoH
2.2	Scale up training of CBDAs to provide information on the full method mix	SD 2.2.1. Review current training materials to identify what CBDA training materials require updates and to ensure that full FP rights-based information is available to clients	2day review meeting for 30 people Hall, Lunch and Tea break and Transport	training materials updated	Q4 2019	FMoH

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		SD 2.2.2. Conduct training of trainers for CPs & Tier 2 & 3 PPMVs	30 days Consultants time Hall, DSA, Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp	State-level master trainers on paramedical training trained (target: 740	Q2 2020	FMoH
SD.3	Integrate FP into other PHC/MCH opportunities – PPFP, Child Health Services					
3.1	Develop and roll out FP integration protocol	SD 3.1.1. Develop integration protocol	2-day meeting for 30 people 10 days Consultant's time Hall, DSA, Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp		Q1 2020	FMoH
		SD 3.1.2. TOT of FP Coordinators on integration protocol	3 day meeting for 60 people 10 days Consultants time Hall, DSA, Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp	FP Coordinators Trained	Q2 2020	FMoH

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
3.2	Scale up PPFP and Post-PAC FP	SD 3.2.1. Review and update all existing training guidelines, protocols, policy document, quality of care standards, checklists and job aids to include PPFP	30 days of consultant time Hall, DSA, Transport Meeting materials	PPFP and PAC training materials updated	Q1 2020	
		SD 3.2.2. Conduct training of trainers on PPFP and PAC	30 days Consultants time Hall, DSA, Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp	State-level trainers trained (target: 370 each of doctors, midwives/nurses, and CHEWs trained)	Q2 2020	
		SD 3.2.3. Conduct counselling and competency-based training for In-service, Pre-service settings including health care workers from Labour and delivery wards and ANC	Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp	NO. / % of HCWs trained - counselling & competency-based training No. of providers who achieve 80% of PPFP quality of care standards	Q2 2020 and ongoing	SMoHs
SD.4	Strengthen strategy for introduction of new contraceptives					
4.1	Increase in number of public SDP providing DMPA-SC services	SD 4.1.1. Conduct training of trainers DMPA-SC	30 days Consultants time Hall, DSA, Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp	State-level trainers trained (target: 370 each of doctors, midwives/nurses, and CHEWs trained)	Q4 2019	FMoH

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		SD 4.1.2. 1-day training (experienced providers)/ 2 days training (limited providers) on DMPA-SC/SI	Hall, DSA, Transport Meeting materials	Providers Trained (target: 37,000 each of doctors, midwives/nurses, and CHEWs trained)	From Q4 2019	FMoH and SMoHs
4.2	Increase in number of private sector SDPs providing DMPA-SC services	SD 4.2.1. Conduct training of PPMVs and CP and CHIPs following legislative approval	Hall DSA Transport Meeting materials	PPMVs and CP Trained. (Target 37,000 each of PPMVs and CP)	From Q1 2020	SMoHs and FMoH
SD.5	Expand access to Rights based Youth Friendly FP Services					
5.1	Develop more facilities to provide Youth Friendly FP Services	SD 5.1.1. Develop a health facility youth-friendly service standard	40 days consultant's time, Hall DSA Transport Meeting materials	Service standard developed	Q2 2020	FMoH
		SD 5.1.2. Conduct Assessment of facilities based on youth-friendly service standard annually	40 days consultant's time, Hall DSA Transport Meeting materials	National health facility youth friendliness assessment conducted	Q3 2020	SMoHs and FMoH
5.2	Conduct youth friendly FP service provision training for providers	SD 5.2.1. Develop a YFHS manual	20 days Consultants time, Hall, DSA, meals	YFHS manual developed	Q3 2020	FMoH and partners
		SD 5.2.2. Conduct training of trainers on	30 days Consultants time Hall	% of trainings conducted as planned and %	Q3 2020	FMoH and partners

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		youth friendly FP service provision and counselling	DSA Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing: 100 pages pp	change of pre and post-tests scores		
5.3	integrate IPCC into all FP training materials	SD 5.3.1. Update all FP training materials to include IPCC modules and Institutionalize rights-based counselling	20 Days Consultant's time Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for consultant	FP training materials updated to include IPCC	Q2 2020	FMoH and partners
5.4	Train peer educators to distribute condoms	SD 5.4.1. Develop Peer Educator Manual	20 Days Consultant's time Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for consultant	National Peer Educator Manual developed	Q2 2020	FMoH and partners
		SD 5.4.2. Train peer educators	Hall, DSA, Transport Meeting materials Travel per diem for participants Transport refund for trainers Printing:	Peer educators (Target 37,000)	Q3 2020 and ongoing	FMoH and partners

SUPPLY CHAIN MANAGEMENT

	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
SC 1	Improve LMIS data quality for accurate forecast					
	Coordinate LMIS data reporting by private and public sector health facilities through the LGA and State LMCU	SC 1.1.1. Develop/adapt SOPs for data reporting/collection by private and public health sector facilities	30 days consultant time, Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for consultant	SOPs for data collection developed	Q1 2020	FMoH
		SC 1.1.2. Train trainers on SOP at state level	Hall DSA Transport Training materials Travel per diem for trainers Transport refund for consultant	Trainers trained on SOP	Q1 2020	
		SC 1.1.3. Disseminate SOPs to facilities, FP coordinators, and data managers	Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators	SOPs disseminated	Q2 2020	
		SC 1.1.4. Engage regulatory authorities (Department of Hospital Services/ Health Management Board) on incentives and penalties for non-submission of data	Central meeting with 36 States+ FCT stakeholders Hall	Meetings with stakeholders	Q4 2019	SMoHs and FMoH

	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
			DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators	Facility list updated Facility list % completeness and DQA result % of State and LGAswith situation room	Q4 2019 Q1 2020	
		SC 1.1.5. Engage with State Ministries of Health to update the health facility list on the NHLMIS				
		SC 1.1.6. Conduct data quality assurance exercises in line with national guidelines	FMOH/SMOH teams and their DSA with a team of 24 in each state and the FCT spending 4 days			
		SC 1.1.7. Provide technical and operational support for the conduct of NHLMIS situation rooms at state and LGA level	30 days consultanttime and DSA			
SC 1.2	Develop comprehensive annual contraceptive forecast and procurement plan	SC 1.2.1. Conduct annual quantification, forecasting, and procurement workshops for FP commodities	30 days consultant time Central meeting with 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators and consultant	Workshop completed in Q4 for the coming year Approved supply plan	Q4 2019 and ongoing	
		SC 1.2.2. Circulate forecasting, supply plans, and procurement plan to	e-circulation		Q4 2019 and ongoing	

	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		stakeholders (PSM subcommittee for ratification) to FMOH for approval				
		SC 1.2.3. Review and update commodity supply plan	30 days consultant time Central meeting with 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators and consultant	Workshop completed in June/July in the implementing year	June/July annually	FMoH and partners
SC 1.3.	Build capacity at national and subnational level for data collation to guide forecasting	SC 1.3.1. Conduct assumption-building workshops and training of master trainers on commodity logistics and management to guide forecasting	Central training for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting trainer/consultant and consultant 30 days consultant time	% of stakeholders in attendance	September annually	FMoH and partners
		SC 1.3.2. Conduct structured training for FP sub- quantification team using various software and forecasting methods	Central training for 36 States+ FCT stakeholders Hall DSA	% of stakeholders trained	Q3 2020 and then annually	FMoH and partners

	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
			Transport Meeting materials Travel per diem for participants Transport refund for meeting trainers/facilitators			
		SC 1.3.3. Procure necessary equipment and tools (computers/software) to strengthen FMOHs coordination of quantification/procurement process	Needs assessment by consultant Computers Softwares			FMoH and partners
SC 2	Engage federal and state governments to mobilize resources for procurement, ware-housing & distribution of commodities					
SC 2.1	Mobilize resources from states for the last mile distribution of contraceptives by leveraging on existing resources (e.g. BHCPF, SOML)	SC 2.1.1. Review current distribution system and mechanisms and conduct options analysis, including financial analysis, to identify alternative LMD strategies	5 days central meeting for 37 states stakeholders and PSM Sub-Committee members including FMoH officials		Q3 2019	FMoH and partners
		SC 2.1.2. Develop and implement recommendations for strengthening LMD	PSM Sub-Committee members		Q3 2019	FMoH and partners
		SC 2.1.3. Establish a national FP commodity resource mobilization task team (This should be moved to Finance to collaborate with PSM)	3 days central meeting for 37 states stakeholders and 5 FMoH officials		Q4 2019	NRHTWG
		SC 2.1.4. FP commodity resource mobilization team to advocate to State governors, HoAs and donors to create budget lines and release funding for last mile distribution (This should be moved to Finance to collaborate with PSM)	Attendance of 10 members of RHTWG at the National Governors' Forum State level ACGs to advocate to HoAs	Attendance and presentation at the Governors' Forum	Once annually	NRHTWG

	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		SC 2.1.5. Develop guidelines for state and private sector procurement of FP contraceptives	10 days consultant's time with 2 days validation meeting for 40 participants Hall DSA Travel Costs Refreshment	No of States and private sector organisations procuring contraceptives in line with existing guidelines	Q2 2020	FMoH and partners
		SC 2.1.6. Engage state level partners to contribute resources to the LMD	Attendance of 10 members of RHTWG at the National Governors' Forum State level ACGs to advocate to HoAs	% of States contributing to the LMD	Q2 2020	
SC 2.2.	Scale-up integrated commodity distribution in states	SC 2.2.1. Fast-track effective integration of FP into the NSCIP zonal model	Six zonal two day-meetings for 30 stakeholders including halls, DSA and workshop materials		Q1 2020	FMoH and partners
		SC 2.2.2. Engage states to utilize pre-existing systems (e.g. joint pick-ups with other programmes and general hospitals (integrated transportation of commodities) from regional stores)	Six zonal one day meeting for 30 stakeholders including halls, DSA and workshop materials		Q1 2020	FMoH and partners
SC 2.3	Enhance warehousing infrastructure and conditions at national and state level	SC 2.3.1. Train supply chain officers in warehousing and logistics	Central training for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants	% of officers trained	Annually	FMoH and partners

	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsble
			Transport refund for meeting trainer/consultant and consultant 30 days consultant time			
		SC 2.3.2. Advocate for full refurbishment of warehouses at national and subnational levels	Attendance of 10 members of RHTWG at the National Governors' Forum State level ACGs to advocate to HoAs	% of warehouses refurbished	Q2 annually	FMoH and partners
SC 3	Strengthen the procurement process through PSM sub-com.					
SC 3.1	Build FP commodity logistics and management capacity at all levels	SC 3.1.1. Conduct assessment on state and local level challenges to logistics and commodity management	10 days consultant time and validation in a two days meeting of 40 stakeholders	Assessment report validated	Q4 2019 and Q4 2021	FMoH and partners
		SC 3.1.2. Disseminate findings from assessment and advocate for state and local government authorities to take up recommendations	Central meeting of 40 stakeholders		Q4 2019 and Q4 2021	FMoH and partners
		SC 3.1.3 Update commodity logistics and management training based on assessment findings	10 days consultants time and 3 days validation meeting	Training plan updated	Q1 2020	FMoH and partners
SC 3.2	Ensure that government and all development partners implement procurement and shipment per the procurement plan	SC 3.2.1. Hold national-level review meeting of commodity distribution system	Central review for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants	% of meetings held on time	Q2 annually	FMoH and partners

	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
			Transport refund for meeting facilitators /consultant and consultant 10 days consultant time			
		SC 3.2.2. Procure commodities per the quantification and procurement plan	As per FMoH/UNFPA quantification cost	% of quantified commodities procured on time	Q3/Q4 annually	FMoH and partners
		SC 3.2.3. Regularly review implementation of procurement plan and monitoring of shipment pipelines and take action	At PSM and NRHTWG Meetings		Quarterly from Q4 2019	FMoH and partners

POLICY ADVOCACY

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
P1	Repositioning AYSRH through Revision of all Policies and Training Manuals that Restrict Adolescent and Youth from Accessing a Full Range of FP Methods					
P1.1	Review the following RH documents: (1)National Guidelines for the Integration of Adolescent and Youth Friendly Services into PHC Facilities in Nigeria 201"; (2Increasing Access to Long Acting Reversible Contraception in Nigeria: National Scale-up Strategy and Implementation Plan 2013 - 2015; (3) National Family Planning Training Manual for Physician, Nurse and Midwife 2015; and (4)RH/FP Service Protocol 2015	P 1.1.1. Engage consultants to support the review processes P 1.1.2. Conduct three broad-based Stakeholders' meeting P 1.1.3. Conduct validation meeting to finalize the documents P 1.1.4. Print sufficient copies of the reviewed documents P 1.1.5. Launch by HMH and Dissemination	30 days consultant's time Hall, DSA, Transport & Meeting materials Hall, DSA, Transport & Meeting materials Printing of 5000 copies Hall, MC, and DSA Meals for 47 including media	Review and finalization of the 4 RH policies/documents	2019, Q4[i] 2020 Q2	FMoH and partners
P1.2	Revise National Policy on Health and Development of the Young People and the National Training Manual for the Health and Development of adolescent and young	P 1.2.1. Engage consultants to support the review processes P 1.2.2. Conduct three broad-based Stakeholders' meeting P 1.2.3. Conduct validation meeting to finalize the documents	20 days consultant's time Hall, DSA, Transport & Meeting materials	Review and finalization of the policy on health and development of young people	2019, Q4	

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
	people in Nigeria 2011.	P 1.2.4. Print sufficient copies of the reviewed documents P 1.2.5. Launch by HMH and Dissemination		Review and finalization of the National training Manual for the Health and Development of adolescent and young people in Nigeria		
P2	Develop policy to increase indigenous private sector investment for FP in Nigeria					
P2.1	Develop Private Sector Engagement Strategic Plan	P 2.1.1. Engage consultant(s) to facilitate the strategy development process P 2.1.2. Desk review of evidences of FP service provision and support in the private sector P 2.1.3. Mapping of all relevant private sector actors including obtaining perspectives of stakeholders P 2.1.4. Convene two stakeholders' meetings to further review the draft P 2.1.5. One Stakeholders' meeting to validate the draft P 2.1.6. Print and disseminate document P 2.1.7. Support development of strategic and operation plans for implementation	20 days consultant's time Hall, DSA, Transport & Meeting materials, Printing	Completed and finalized private sector engagement strategic plan Proportion of private sector facilities that benefitted from the implementation of the private sector engagement strategic plan	2019, Q4 Y3, Q1[i]	FMoH and partners
P3	Advocate for policy implementation at State level					
P3.1	Provide technical support to states to advocate for policy implementation at state level (e.g. TSP)	P 3.1.1. Identify states with substantial gaps in policy implementation P 3.1.2. Approach Partners to provide support for states	20 days consultant's time to conduct situation analysis and recommendation of partners that can support the states.	Proportion of states with substantial gaps in policy implementation	2019, Q1	FMoH and partners

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
P3.2	Advocate for a more enabling policy environment for youth FP use	P 3.2.1. Identify states with substantial gaps in policy implementation P 3.2.2. Provide support for advocacy to relevant officials in targeted states.	20 days consultant's time to conduct situation analysis and recommendation of partners that can support the states.	Proportion of states with substantial gaps in the implementation of policies that ensure enabling environment for youths	2019, Q1	FMoH and partners
P4	Improved focus on Technical Support to States on Policy Development and Adaptation					
P4.1	Assess Capacity of FMOH, SMOH and the Policy Makers/Program Managers at State Level to develop and or adapt relevant Policies for SRHR in Nigeria	P 4.1.1. Consultant Engagement P 4.1.2. Mapping of existing TA and gap identification.	20 days consultant's time	Assessment of the capacity of National and state level FP officials to develop and or adapt relevant Policies for SRHR in Nigeria	2019, Q4	FMoH and partners
P4.2	Capacity Building based on the Gap identified above	P 4.2.1. Develop and implement training plan	20 days consultant's time to develop the training plan, Printing of training plan	Completion and implementation of training plan	Completion of training plan (2019, Q4) Implementation of training plan (2019, Q1)	FMoH and partners

FINANCING

S/N	Main Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
F 1	Increase FP funding through fulfilling the old and creating new financial commitments to FP beyond 2020					
F1.1	Develop a comprehensive advocacy strategy to recover previous government financial commitments and make new ones.	F.1.1.1 Hold a 3-day strategy meeting to determine advocacy objective, target audience, advocacy messages and a workplan of who and when to do it.	Hall, DSA, transport for 37 stakeholders and 10 FMoH officials for 3 days	Number of meeting helds	Q4 2019 and annually	FMoH and partners
		F.1.1.2 Print and disseminate advocacy briefs and plans	Printing of 5000 copies each about 15 pages		Q1 annually	FMoH and partners
		F.1.1.3 Train FP champions on FP budget process and on how to conduct finance and policy advocacy	Central training for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators /consultant and consultant 30 days consultant time	% of identified champions trained and are active	Q2 annually	FMoH and partners
F1.2	Conduct coordinated advocacy to the national assembly, the office of the president and vice	F.1.2.1 Plan coordinated advocacy with key advocates and senior officers of FMOH	10 RHTWG members needing 10 days each for planning and follow-up visits	% of planned advocacies conducted	Q3 2019 and quarterly thereafter till 2023	

	president and the state governments (through the Nigeria Governors' Forum) and donors to solicit for financial commitment to FP according to the strategy	F.1.2.2 Conduct one advocacy visit each to the executive, the legislature and donors per quarter	10 RHTWG members needing 10 days each for planning and follow-up visits		Q3 2019 and quarterly thereafter till 2023	
F 2	Mobilize resources from new avenues/programs, the private and other sources					
F2.1	Engage with SPHCDAs in states already receiving the BHCPF and NHIS funds to ensure FP services are fully covered at PHCs	F 2.1.1 Develop a guide to engaging with the 2 gateways for BHCPF and NHIS at the national, state, LGA and PHC levels and disseminate to advocates and FP champions	20 days consultants time and 2 days validation meeting for 37 stakeholders from the States	% of SPHCDAs successfully engaged	Q1 2020	FMoH and partners
		F 2.1.2 Develop a plan and conduct meetings with national and state organs (NPHCDA, NHIS, SPHCDAs, SHISs, LGAs, Steering Committees, LGAs etc) to agree on how to fund and track FP services	Central plan development for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators /consultant and consultant 30 days consultant time	Planned developed on time	Q4 2019	FMoH and partners
F2.2	Identify and engage other sources of government funds to fund FP	F 2.2.1 Map out other government sources of funds such as the NDDC, North-east Development Commission etc and explore inclusion of FP	20 days consultant time 2 days validation meeting with 37 state stakeholders		Q2 annually	

		F 2.2.2 Plan and conduct meetings with identified organizations	10 RHTWG members needing 10 days each for planning and follow-up visits	% of planned meetings conducted	Q1 and Q3 annually	FMoH and partners
F 3	Improve accountability and tracking of FP funding					
F3.1	Revise the National Financial Sustainability Plan and develop an FP financial accountability plan to track FP funding and expenditure	F.3.1.1 Engage an expert to review the National Financial Sustainability plan as it relates to FP	40 days consultant time 3 days validation meeting with 47 stakeholders	National Financial Sustainability plan reviewed	Q3 2019	FMoH and partners
		F.3.1.2 Hold a 3-day meeting to develop a plan to track FP funding and expenditure, including indicators, targets and how to conduct the activity.	Central meeting for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators /consultant and consultant 30 days consultant time		Q4 2019 and thereafter annually	FMoH and partners
F3.2	Track FP budgets, releases and expenditure using the financial accountability plan at various levels	F.3.2.1 Identify and engage organizations involved in budget tracking at national and state level and train them to conduct FP financial tracking.	20 days consultant time and presented at the quarterly NRHTWG meetings	% of identified organizations successfully enaged	Q4 2019 and annually	FMoH and partners
		F.3.2.2. Develop a scorecard for family planning services	40 days consultant time 3 days validation meeting with 47 stakeholders			

		F.3.2.3 Develop a plan and conduct tracking activities	20 days consultant time and 2 days validation meeting of 60 stakeholders Tracking to be conducted by NRHTWG		Q4 2019 and then quarterly till 2023	FMoH and partners
F3.3	Map out and track donor commitments and spending on FP	F.3.3.1 Develop a tool to map out donor investments (in financial terms) through the RH Division of FMOH	20 days consultant time and 2 days validation meeting of 60 stakeholders	Tool developed and validated	Q4 2019	FMoH and partners
		F.3.3.2Update plan regularly and present at RHTWG meetings	10 days consultant time annually		Q4 2019 and then quarterly	FMoH and partners
F3.4	Conduct studies to rank FP interventions based on their cost-effectiveness in the Nigerian context and encourage development of FP CIPs around these interventions to remove inefficiencies	F 3.4.1 Develop a ToR and engage an expert to assess key interventions for efficiency and cost-effectiveness	40 days research consultant time Research assistants (40) for 20 days Printing of 1000 copies Dissemination meeting involving 60 including media		Q4 2019	FMoH and partners
		F 3.4.2 Rank interventions based on their cost-effectiveness			Q4 2019	FMoH and partners
		F 3.4.3 Print and disseminate ranking to guide prioritization of activities in Nigeria			Q1 2020	FMoH and partners

SUPERVISION, MONITORING AND COORDINATION

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
SMC 1	Strengthen the NHMIS to guide FP programming in the country					
SMC 1.1	Build capacity of M&E Officers on the revised NHMIS/DHIS2.0 tools	SMC 1.1.1. Simplify training curricula for NHMIS and DHIS 2.0 for use at lower levels	30 days expert time and 2 days validation meeting for 40 stakeholders	Training curricula simplified	Q2 2020	FMOH
		SMC 1.1.2. Conduct training and refresher for M&E Officers on revised NHMIS & DHIS2 Tools and FP Dashboard at all levels	Central training for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators /consultant and consultant 30 days consultant time	36 states + FCT stakeholders trained on revised NHMIS & DHIS2	Q1 2020, 2021, 2022	FMOH
		SMC 1.1.3. Print and disseminate revised NHMIS Tools		Revised NHMIS tools printed and disseminated nationwide Proportion of states nationwide that revised NHMIS tools has been disseminated to	Q1 annually	FMOH
SMC 1.2		SMC 1.2.1. Develop and disseminate training/OJT guidelines to improve the	40 days consultant time and 3 days validation meeting	Training/OJT guidelines developed and	Q4 2020	FMOH and partners

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
	Improve quality of data inputs into the NHMIS	capacity of field staff to collect, validate and transmit FP data	Dissemination meeting for 40	disseminated to states		
		SMC 1.2.2. Develop and disseminate guidelines for monitoring data quality at facility, LGA, state and federal level	40 days consultant time and 3 days validation meeting Dissemination meeting for 40	Data quality monitoring guidelines developed & disseminated	Q4 2020	FMOH and partners
		SMC 1.2.3. Support the conduct of quarterly DQA and mentoring at the state and LGA levels	Two FMoH officials spending 3 days per state annually	State DQA activity supported by FMOH officials quarterly Number of states supported by FMOH officials for DQA in the quarter	Q4 2019 and then quarterly	FMOH and partners
SMC 1.3	Incorporate private sector providers into the NHMIS system	SMC 1.3.1. Map private sector facilities including CPs providing FP services	40 days consultant time and 3 days validation meeting		Q4 2019 and then annually	FMOH and partners
		SMC 1.3.2. Train or orient identified private sector providers on FP and NHMIS tools				
		SMC 1.3.3. Link identified private sector facilities to M&E Officer for tracking	Half-day orientation meeting in 36 States and FCT		Q2 2020 and then annually	FMoH and partners
		SMC 1.3.4. Update the DHIS 2.0 to include mapped private sector facilities for reporting				
SMC 1.4	Increase tracking of progress in data	SMC 1.4.1. Conduct refresher training for 36 states on FP dashboard to frequently monitor and track progress	20 days consultant time	Proportion of trainings conducted	Q3 2020	FMoH and partners

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
	reportage through DHIS 2.0		Central two days training for 36 States and FCT			
		SMC 1.4.2. Disseminate FP dashboard reports quarterly	At NRHTWG meetings quarterly and via email and website	Number of disseminations conducted	Q4 2019 and then quarterly	FMoH and partners
SMC 2	Improve the quality and performance of FP programs at sub-national and facility level					
SMC 2.1	Strengthen supportive supervision (including to the private sector)	SMC 2.1.1. Review and disseminate current ISS tool to all states and LGAs	20 days consultant time and 2 days validation of40 stakeholders	Reviewed ISS tool disseminated	Q2 2020	FMoH and partners
		SMC 2.1.2. Support states/LGAs to conduct quarterly supportive supervision of facilities	Two FMoH officials spending 3 days per state annually		Q4 annually	
		SMC 2.1.3. Train and re-train RH/FP Coordinators on ISS and follow up meetings	Central 3 days training for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators /consultant and consultant 30 days consultant time		Q2 annually	FMoH and partners
		SMC 2.1.4. Develop scorecard and track regular conduct of supervisors' follow up visits	Scorecard and recommendations for States using 30 days consultant time		Quarterly 2019-2023	FMoH and partners

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
		SMC 2.1.5. Hold quarterly meeting of partners & CSOs to track conduct of supervision	Central 3 days meeting for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators and consultant 30 days consultant time	% of quarterly meetings held on time	Quarterly fromQ4 2019 (but at no cost since to be done at RHTWG meetings)	FMoH and partners
SMC 3	Strengthen national structures for coordination of FP activities					
SMC 3.1	Further reinforce the role of RHTWG to coordinate all stakeholders and strengthen its role in the national FP response	SMC 3.1.1. Develop Annual FP Workplan and share implementation progress quarterly with donors/partners to understand how projects are supporting governments.	Central 5 days meeting for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants	Number of annual plans developed by 1st January	Q3 annually	FMoH and partners
		SMC 3.1.2. Conduct quarterly NRHTWG meeting and invite external partners (private sector, media, companies) to make presentation and participate in review of annual FP workplan.	Three days quarterly National RHTWG meeting involving all 36 states and FCT and the media and private sector	Number of NRHTWG meetings conducted on time	Q4 annually and then quarterly	FMoH and partners
		SMC 3.1.3. Use the FP Dashboard and other sources to produce quarterly newsletter and an Annual Performance Report on FP progress and disseminate to a wide audience.	20 days consultant time Printing of 5000 copies		Q4 2019 and then quarterly	FMoH and partners

S/N	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Responsible
			One day dissemination involving 60 stakeholders			
SMC 3.2	Strengthen coordination between national and state level institutions involved in FP implementation	SMC 3.2.1. Support linkages between state and national planning and performance system through regular review of national FP dashboard and feedback to states on status of coverage.	Central 2 days review meeting for 36 States+ FCT stakeholders Hall DSA Transport Meeting materials Travel per diem for participants Transport refund for meeting facilitators /consultant and consultant 30 days consultant time	Number of states supported	Q4 2019 and then every six months till 2023	FMoH and partners
		SMC 3.2.2. Assign states to technical partners and track development and implementation of CIPs at states	To be presented at NRHTWG meeting		Quarterly from Q4 2019	FMoH and partners
		SMC 3.2.3. Conduct and present annual mapping of donor projects to strengthen nation-wide mechanism for equitable distribution of FP interventions	20 days consultant time To be presented at NRHTWG meeting		Quarterly from Q4 2019	
		SMC 3.2.4. Hold bi-annual inter-governmental meetings between RHTWG and other agencies including NPHCDA, NHIS, NGF etc to discuss and align strategies on FP and other areas	2 days meeting of 60 stakeholders Hall		Bi-annual from 2020 till 2023	

Results Framework

Thematic areas	Short term Outcomes	Intermediate Outcome	Impact
Demand Generation	§ Effective implementation of the NFPCP 2017-2020 § Increased access to young persons on FP information and services through new media § Improved partner DG coordination	▪ Increase demand for FP ▪ Decrease in unmet need for FP	- Increased CPR - *728,377 Unintended pregnancies averted* - *323,951 Live births averted* - *301,673 Abortions averted* - *3,704 Maternal deaths averted* - *18,156 Child deaths averted* - *256,564 Unsafe abortions averted* - *214,852 Maternal DALYs averted (mortality and morbidity)* - *1,535,041 Child DALYs averted (mortality)* - *£32,567,666 Direct healthcare costs saved (2018 GBP)*
Service Delivery	§ Increased availability of services and information through trained lower level providers (incl. CPs & Tier 2&3 PPMVs) and CIHPs § Improved integration of FP into other PHC/MCH opportunities – PPFP, Child Health Services § Improved contraceptive choices from introduction of new contraceptives § Expanded access to rights, based youth friendly FP services	▪ Expanded access to information and services on family planning during visit with health service provider ▪ Increased proportion/percentage of women and youth whose demand for contraception is satisfied	
Policy Advocacy	§ Improved implementation of adolescent and youth RH/FP policies § More states are developing and implementing better policies due to improved technical support on policy development and adaptation	▪ Improved enabling policy environment for the provision of FP to women and youth	
Financing	§ Increased indigenous private sector investment for FP in Nigeria	▪ Increased domestic FP financing	
Procurement and Supply Chain Management	§ Improved quality of LMIS data for forecasting procurement § Increase in number of states with resources for procurement, warehousing and distribution of commodities § Strengthened supply/procurement planning through PSM	▪ Reduced stock out of contraceptives at facilities	
Supervision, Monitoring and Coordination	§ Strengthened NHMIS to guide FP programming § Improved capacity for supervision, coordination management, or M&E of family planning § Strengthened national structures for coordination of FP activities	▪ National FP program is better coordinated and supervised	

Indicator Table (Demand Generation)

S/N	Indicator	Level	Baseline	Target	Information source
1.	Percentage of women of reproductive age who have heard about at least one method of family planning	Outcome	82.3% (2013) 2018 pending[7]	50% increase by end Y2[8] 75% increase by end Y4	NDHS
2.	Percentage of young women and young men age 15-24 with knowledge of a source of condoms,	Outcome	45.5% (2013) 2018 pending	50%increase by end Y2 70% increase by end Y4	NDHS
3	Demand for family planning	Outcome	36% married, (2018)	30% increase by end Y2 50% increase by end Y4	NDHS
Ensure effective implementation of the NFPCP 2017-2020					
4	Proportion (%) of state-specific plans developed[9]	Output	0%	80% by end of Y1 100% by end of Y2	State reports
5	Percentage of state programs with FP SBC activities integrated[10]	Output	N/A[11]	40% by end Y1 80% by end Y2	State reports
6	Percentage coverage of FLHE implementation (disaggregated by state, public and private sector)[12]	Output	To be inputted from rapid assessment report	50% coverage by end Y1 75% coverage by end Y2 85% coverage by end Y4	FLHE implementation reports FHLE dashboard[13]
7	Percentage coverage of distribution of FLHE materials (disaggregated by state, public and private sector)[14]	Output	N/A	50% coverage by end Y1 75% coverage by end Y2 85% coverage by end Y4	FLHE implementation reports FHLE dashboard[15]

[7] To be updated on release of full NDHS 2018 report
[8] End Y2 assumed to correlate to mid-term
[9] Numerator: No of states with completed operational plans for implementing NFPCP (for "watch[9]" states, priority activities must be included for plan to be considered complete). Denominator: 37 (states + FCT)
[10] Numerator: No of programs with SBC integrated. Denominator: Total number of relevant existing state programs mapped
[11] As a guide, programs to be mapped in denominator include: 1. SOML PfR, 2. Agric outreach programs, Women Affairs, Youth and Social development, etc. Assume a minimum of 6 per state.
[12] Numerator: No of schools with documented evidence of FLHE implementation (defined as 1. Teachers trained and 2. At least 3 months of student learning). Denominator: Total number of registered schools (public and private – primary (Pry1-JSS3) and secondary (SS1-3))
[13] Scheduled for development under this blueprint (Y1Q2)
[14] Numerator: No of schools with teaching materials (defined as minimum of 1. FLHE handbook and 2. FLHE teaching aid (combined) or 3. eFLHE materials and student computer access (combined). Denominator: Total number of registered schools (public and private)
[15] Scheduled for development under this blueprint (Y1Q2)

S/N	Indicator	Level	Baseline	Target	Information source
8	FLHE quality assurance system developed and validated by stakeholders	Output	N/A	Developed by end Y1 Implemented in 40% of covered schools by end Y2 80% by end of Y4	FLHE implementation reports FHLE dashboard[16]
Expanded access of young persons to FP information and services though new media					
9	New media operational plan developed	Output		Plan developed and finalized by end of Y1	
10	Percentage of target population (15-24) reached through social media platforms disaggregated by sex, age, platform)[17]	Output	Target population[18] 15-19 years: 2.05m M, 1.14F 20-24 years: 3.02m M and 1.27m F.	50% coverage by end Y1 75% coverage by end Y2 85% coverage by end Y4	Social media analytics tracking
11	Proportion of persons reached (total and disaggregated by age and medium)[19]	Output	Target population: 46m[20]	30% coverage by end Y1 45% coverage by end Y2 50% coverage by end Y4	Social media analytics tracking and radio and TV broadcast/viewer tracking mechanisms
12	Percentage of target population engaged[21]	Output	Target population[22] 15-19 years: 2.05m (M,), 1.14F14m (F) 20-24 years: 3.02m (M) and 1.27m (F.).	35% coverage by end Y1 65% coverage by end Y2 80% coverage by end Y4	Social media analytics tracking

[16] Scheduled for development under this blueprint (Y1Q2)

[17] Numerator: total number of views, likes, etc. in this age group. Denominator: Target population aged 15-24 years = population aged 15-24 male and female multiplied by % viewed internet at least once a week in past month male and female

[18] 15-19 years is approximately 11.2% and 20-24 years is approximately 9.6% of total population (using data from 2015 pyramid in background section) applied to total population of 180m = 20.1m 15-19 and 17.3m 20-24 years' target population with approximately 50% male and 50%m female, with national internet level use (Applied from MICS 2016) for 15-19 years at 20.3% male and 11.3% female and for 20-24 years at 35% male and 14.7% female). States to apply state values.

[19] Numerator: Total number of views, likes, including television shows and radio, etc. in reproductive age (15-49years). Denominator: Population of reproductive age

[20] Population of reproductive age (using data from background section above)

[21] Numerator: total number of young persons (15-24 years) (requesting information, participating in chats, referred to services), disaggregated by age, sex and platform) Denominator: Target population aged 15-24 years = population aged 15-24 male and female multiplied by % viewed internet at least once a week in past month male and female

[22] 15-19 years is approximately 11.2% and 20-24 years is approximately 9.6% of total population (using data from 2015 pyramid in background section) applied to total population of 180m = 20.1m 15-19 and 17.3m 20-24 years' target population with approximately 50% male and 50%m female, with national internet level use (Applied from MICS 2016) for 15-19 years at 20.3% male and 11.3% female and for 20-24 years at 35% male and 14.7% female). States to apply state values.

Indicator Table (Service Delivery)

S/N	Indicator	Level	Baseline	Target	Information Source
1	Percentage of women whose demand for contraception is satisfied	Outcome	46.9% (NDHS 2018)	30% increase by end Y2[23] 50% increase by end Y4	NDHS
2	Percentage of women who were provided with information on family planning during last visit with health service provider	Outcome	N/A[24]	30% increase by end Y2 50% increase by end Y4	NDHS
3	Number of unintended pregnancies averted due to contraceptive use	Outcome	2,060,000 (Nigeria 2018 CI handout)	25% increase by end Y2 50% increase by end Y4	NDHS
4	Number of unsafe abortions averted due to contraceptive use	Outcome	735,000 (Nigeria 2018 CI handout)	25% increase by end Y2 50% increase by end Y4	NDHS
Development and implementation of national FP training plan					
5	Update of in-service training plan and single standardized curriculum by type of service provider	Output		Updated by Q3 2019	Program reports
6	Number of state-level trainers trained (doctors, nurses/midwives, and CHEWs)	Output		370 each of doctors, midwives/nurses, and CHEWs	Program reports
7	Quarterly review meetings conducted, and states upload trainings on the database	Output		Q4 2019	Program reports
Accelerate training of lower level providers (incl. CPs & Tier 2&3 PPMVs) and CIHPs through support to TSP and CIHPs roll-out.					
8	Number of CPs and PPMVs (Tier 2&3 PPMVs) and informal drug sellers trained, by level (national, regional, and state)	Output		740 CPs and PPMVs (each)	Program reports
Improved integration of FP into other PHC/MCH opportunities – PPFP, Child Health Services					

[23] Assuming the mid-term review will be done by the end of Y2.
[24] Awaiting NDHS 2018 full report

S/N	Indicator	Level	Baseline	Target	Information Source
9	Proportion of facilities in which family planning is integrated with other healthcare services (i.e., sites where family planning is integrated with routine immunization, HIV counselling and testing, prevention of mother-to-child transmission (PMTCT), and STI services)[25]	Output	94.4% of facilities integrated FP into HIV services[26].		Facility assessment
10	Percentage (%) of HCWs trained - counselling & competency-based training[27]	Output			Program reports
11	Number of providers who achieve 80% of PPFP quality of care standards	Output			Program reports
Increase in strengthened strategies for introduction of new contraceptives					
12	State-level trainers trained on the provision of DMPA-SC services (doctors, nurses/midwives, and CHEWs)	Output		370 each of doctors, midwives/nurses, and CHEWs form Q4 2019	Program reports
13	Training of CPs and PPMVs on the provision of DMPA-SC/SI services	Output		37,000 each of PPMVs and CPs from Q1 2020	Program reports
Expanded access to rights, based youth friendly FP services					
14	Number of new access points for FP service provision, including points for young persons	Output			Program reports
15	Number of peer educators trained on AYFS	Output		37,000	Program reports

[25] Numerator: Number facilities in which family planning is integrated with other healthcare services. Denominator: Total number of health facilities (public and private health facilities)
[26] Rapid Assessment of Sexual/Reproductive Health and HIV Integration in Nigeria (2011). The assessment was done in public health facilities across 13 states in the country. The assessment was coordinated by InSiGHt Health Consulting Limited.
[27] Numerator: Number of HCWs trained on counselling and competency-based training. Denominator: Total number of HCWs who currently provide FP services

Indicator Table (Procurement and Supply Chain Management)

S/N	Indicator	Level	Baseline	Target	Information Source
1	Percentage difference between forecasted consumption and actual consumption	Outcome			Program reports
Improved quality of LMIS data for forecasting procurement					
2	Proportion of health facilities (public and private facilities) on the NHLMIS database.[28]	Output			NHLMIS database
3	Proportion of health facilities with the SOPs for data reporting[29]	Output			Facility assessment
4	Number of commodities forecast reports, by region or State	Output			Program reports
5	Number of persons trained (training of maser trainers) on commodity logistics and management to guide forecasting, by region or State	Outputs			Program reports
Engagement of states to mobilize resources for procurement, warehousing & distribution of commodities					
6	Number of states with FP commodity mobilization task team	Output			Program reports
7	Proportion of warehouses refurbished at national and subnational levels[30]	Output			Program reports
Strengthened supply/procurement planning through PSM					
8	Commodity logistics and management training updated (based on the findings from the logistics and commodity management assessment conducted at state level)	Output			Program reports
9	Number of states procuring commodities in line with the procurement plan.	Output			Program reports

[28] Numerator: Number of health facilities on the NHLMIS database. Denominator: Total number of health facilities (public and private facilities)
[29] Numerator: Number of health facilities with SOPs for data reporting. Denominator: Total number of health facilities (public and private facilities)
[30] Numerator: Number of warehouses refurbished. Denominator: Total number of warehouses at national and subnational levels

Indicator Table (Policy Advocacy)

S/N	Indicator	Level	Baseline	Target	Information Source
Improved implementation of adolescent and youth RH/FP policies					
1	Number of FP and youth-related policies and training manuals reviewed and/or revised	Output		All policies reviewed and finalized by end Y2, Q1	Program reports
2	Proportion of states that developed/adapted revised youth RH policy/ies[31]	Output		60% of states by end Y3[32] 100% of states by end Y4	Program reports
More states are developing and implementing better policies due to improved technical support on policy development and adaptation					
3	Proportion of states that have domesticated/operationalized key policies/plans (e.g TSP, FP CIP, DMPA-SC Roll-out etc)[33]	Output		60% of states by end Y3[34] 100% of states by end Y4	Program reports

Indicator Table (Finance)

S/N	Indicator	Level	Baseline	Target	Information Source
Increased indigenous private sector investment for FP in Nigeria					
1	Proportion of private sector facilities that benefitted from the implementation of the private sector engagement strategic plan[35]	Outcome		50% of private facilities by end Y3[36] 70% of private facilities by end Y4	Program reports

[31] Numerator: Number of states with substantial gaps in policy implementation. Denominator: 37 (+FCT)
[32] Assume this will be the period for midterm review of the plan
[33] Numerator: Number of states with substantial gaps in policy implementation. Denominator: 37 (+FCT)
[34] Assume this will be the period for midterm review of the plan
[35] Numerator: Number of private sector facilities that benefitted from the implementation of the plan. Denominator: Total number of private sector facilities
[36] Assume this will be the period for midterm review of the plan

Indicator Table (Supervision, Monitoring and Coordination)

S/N	Indicator	Level	Baseline	Target	Information Source
1	Capacity for supervision, coordination management, or M&E of family planning	Outcome			Program reports
Strengthened NHMIS to guide FP programming					
2	Proportion of private sector facilities (health facilities, PPMVs and CPs) linked to a M&E officer for tracking.[37]	Output			Facility assessment
3	Number of states that submit data/reports to the national level dashboard for progress monitoring and tracking	Output			Program reports
Improved quality and performance of FP programs (sub-national and facility levels)					
4	Number of states with the updated ISS tool	Output			Program reports
5	Number of state- and LGA-level assessments of staff capacity to conduct supervision, coordination management, or M&E of FP programme at the national and state levels	Output			Program reports

[37] Numerator: Number of private sector facilities linked to a M&E officer. Denominator: Total number of private sector facilities

References

[1] WHO FP factsheet http://www.who.int/mediacentre/factsheets/fs351/en/

[2] WHO MMR factsheet http://www.who.int/mediacentre/factsheets/fs348/en/

[3] Nigeria FP Blueprint

[4] FP2020 executive summary 2017

[5] http://www.demographicdividend.org/country_highlights/nigeria/

[6] FP Dashboard

[7] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017 -2223-2

[8] Provider bias in the provision of contraceptives to adolescent girls and young women in South West Nigeria

[9] PMA2020's (2017) Adolescents and Young Adults Health Brief

[10] http://track20.org/download/pdf/2018%20PPFP%20Opportunity%20Briefs/english/Nigeria%20PPFP%20Opportunity%20Brief%202.pdf

[11] The FP Watch Outlet Survey (2015) http://www.actwatch.info/sites/default/files/content/publications/attachments/Nigeria%20FPwatch%2015%20Findings%20Full%20Report%20Final.pdf

[12] https://www.prb.org/youthfpscorecard/en/

Federal Government
of Nigeria

NIGERIA FAMILY PLANNING BLUEPRINT - ADDENDUM ON HEALTH EMERGENCIES INCLUDING COVID 19 RESPONSE

Federal Ministry of Health

Address: Federal Ministry of Health, Federal Secretariat, Phase III, Ahmadu Bello Way, Central Business District, PMB 083, Garki Abuja, Nigeria.

Email: info@health.gov.ng

Website: www. health.gov.ng

1.0 Background

Coronavirus Disease 2019 (COVID-19) is caused by *Severe Acute Respiratory Syndrome CoronaVirus-2* (SARS-CoV-2).[1] The disease was first identified in December 2019 in the Wuhan district of China and has led to an ongoing pandemic.[2] SARS-CoV-2 is a positive-sense single-stranded RNA virus that is highly contagious.[3] As of June 2020, more than 10.3 million cases have been reported across 188 countries and territories, resulting in more than 505,000 deaths.[4] Nigeria reported its index case on February 27th, 2020, and since then, the infection has been on the rise, with all the 36 states and FCT reporting cases, which are on a daily rise.[5]

This document, an addendum to the National Family Planning Blueprint, is meant to highlight the actual and potential effects of COVID-19 on Family Planning services in Nigeria, with documentation of the mitigatory practices that are effective, and a recommendation of some other approaches that can be used as the situation evolves. The addendum has the potentials for application in other pandemic and/or epidemic settings.

2.0 Impact of COVID-19 on Sexual and Reproductive Health (SRH) Services

2.1. Global Impact

The COVID-19 pandemic had significant and mostly deleterious effects on the operations of global and national economies and systems. As an unprecedented and rapidly emerging crisis, most countries are inadequately equipped to tackle the pandemic. The challenges of responding to COVID-19 have led to disruptions of health systems globally, which has affected (consistently, but to a variable extent) the provision of many health services, including Family Planning (FP). The disruption of services pertains to *access* and *quality of care*, including clients' perception of the safety in going to healthcare facilities. Access has four components, namely: *geographic, financial, structural, and cultural access*.

Geographic access (referred to as access to services with 5Km or 30 minutes walking distance) was impacted in many locations when some facilities closed or scaled-down services necessitating longer commute time, thus potentially increasing costs and limiting *financial access*. *Structural access* (which refers to the ability of system and health facilities to provide adequate and qualitative care) is impacted by workers' sickness from COVID-19, and isolation periods when COVID-19 is suspected, among other factors. *Cultural access* refers to the provision of services that are contextually nuanced and acceptable; for example, some programming has gone into ensuring female healthcare workers provide Sexual and Reproductive Health Services in places where they are better accepted. COVID-19 can lead to sickness of healthcare workers and other disruptions, with potential threats to arrangements that are culturally-nuanced and better accepted. In addition to the impact on access to services, quality is often affected in pandemic settings. For example, healthcare workers may be overworked, leading to potential problems in interpersonal communication, longer waiting times, and shorter consultation time, which are a recipe for dissatisfaction and non-adherence to medical advice, which is critical for family planning services.

In a pandemic situation, a decrease in access to reproductive health services usually occurs, as seen in the lessons from the Ebola epidemic response in Sierra Leone, where many individuals exited (in addition to mortalities from unsafer abortion) from the lockdown with a wide range of reproductive health challenges, including unintended pregnancies, sexual and reproductive rights violations, etc.[6,7]

The current COVID-19 pandemic has further exposed the fragility of the international supply chain, with many health commodities production and shipping logistics slowed or stopped altogether. It is estimated that about 47 million clients may lose access to modern contraception if the current global logistics situation persists for six months and could lead to nearly 7 million unintended pregnancies, with consequences on maternal mortality and global and national and sub-national targets for FP and the Sustainable Development Goals.[8] It is also estimated that at the current rate of service and program disruptions, there may be an estimated 10% reduction in the utilization of both short- and long-acting reversible contraceptives and a 50 million increase in clients with unmet need for modern contraceptives, which could result in over 15 million additional unintended pregnancies.[9]

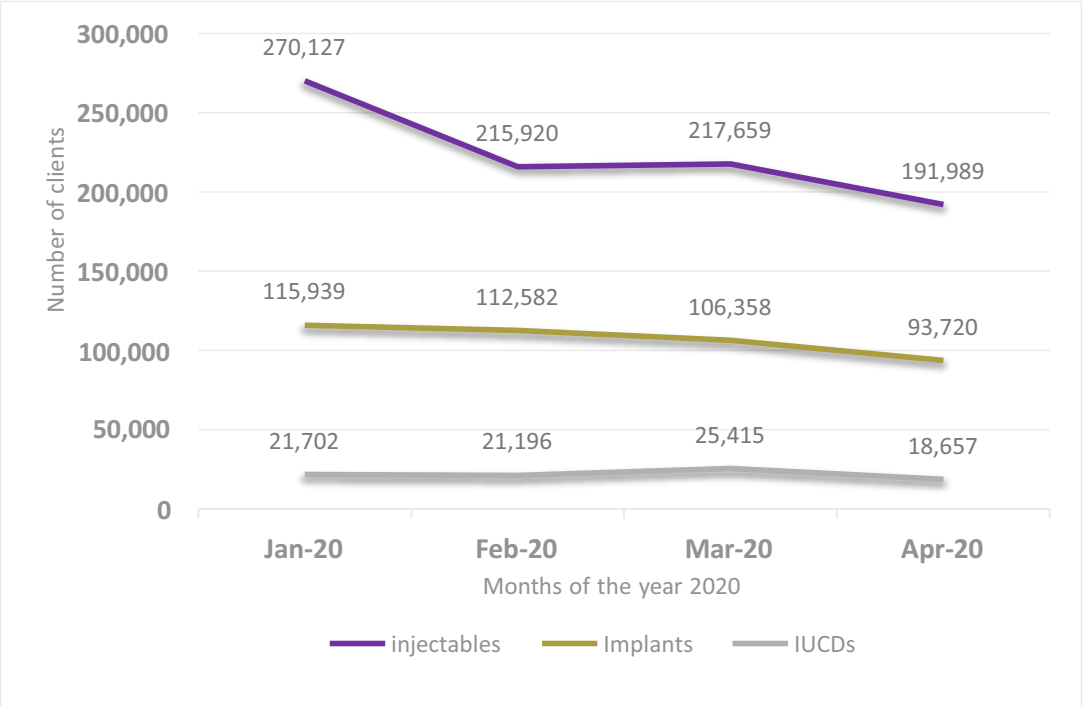
2.2 National Impact

In Nigeria, National COVID-19 guidelines have been developed and are being implemented across sectors. In response to the pandemic, the government implemented lockdown and movement restrictions to control the spread of the virus that led to logistics challenges, which impacted SRH commodity distribution and availability. Equally, safety concerns were ripe amongst health providers because of infection among their colleagues, with over 800 health workers infected as at the end of June 2020.[10]

The first scheduled National distribution of contraceptive commodities to the 36 States and the FCT was delayed, with observed non-prioritization of FP Commodities' Last Mile Distribution (LMD) to Service Delivery Points (SDPs) in some States as a result of the focus on COVID-19 interventions. This had a significant effect on the availability of appropriate contraceptive methods to clients – especially for short-acting contraceptives methods requiring more frequent replenishment.

The unavailability of Personal Protective Equipment (PPE) also confounded access to contraceptives at service delivery points (SDPs), which posed an increased risk of contracting COVID-19 by health workers and FP clients. The actual infection or perception of risk of COVID-19 infection has far-reaching consequences on facilities' ability to provide services of required quality and number.

Figure 1: Decline in the uptake of various contraceptive methods in Nigeria based on DHIS2



data[1]

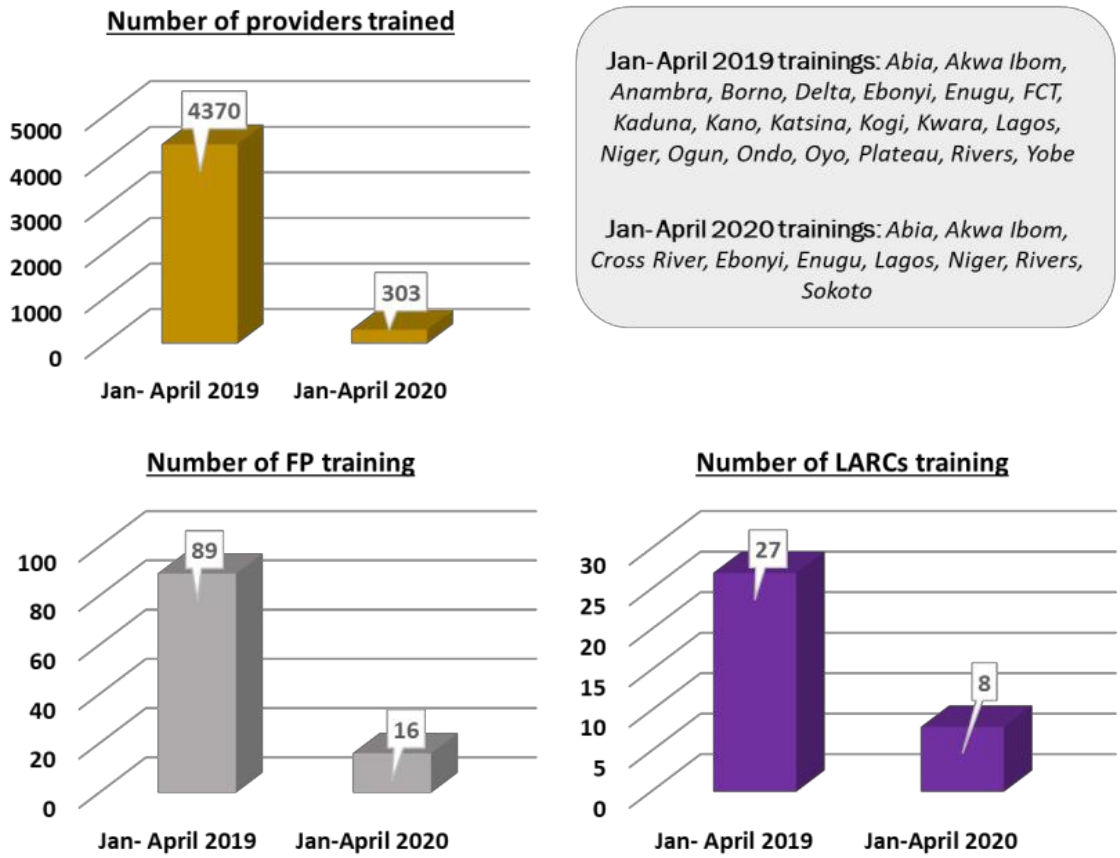
The National Health Information Management System (HMIS), through the DHIS2, showed a decline in uptake of various methods as a result of these challenges to family planning services (Figure 1). The decline in contraceptive methods use was most pronounced for injectables, declining from over 270,000 users per month in January 2020 to only about 190,000 users in April 2020. There was also a decline in the use of implants from 115, 929 clients in January 2020 to 93,720 in April 2020. The use of IUCDs declined over the same period from 21,702 to 18,657.

Training, including for Long-Acting Reversible Contraceptives (LARCs), declined in numbers and geographical spread from the onset of the COVID-19 pandemic with an effect on the quality of services and coordination at states and aggregate National level. See Figure 2 below.

3 Possible Challenges, Emerging Issues, and Suggested mitigations

S.No	Thematic area	Possible challenges/emerging issues	Suggested mitigations
1.	Demand Generation	a. COVID-19 messaging over-shadowing all other forms of messaging in planning, implementation, and reach.	i. As more people increasingly use social media and internet sources for a range of activities, FP messages should be provided through this format, in addition to sustaining and fine-tuning (based on COVID-19 context) the traditional approach of demand generation for Family Planning. It is also essential that FP staff provide health talk on COVID-19 during every engagement for demand generation and service delivery.
		b. Community gatekeepers and champions diverting all energies to COVID-19	ii. Develop, validate, and fine-tune an on-going basis COVID-19 demand creation guidelines that can sustain mobilization of clients for FP and SRH services. There is a greater need for the use of community structures and gatekeepers–town announcers, door to door mobilization while avoiding crowd or clustering
		c. The need for physical distancing preventing physical events and campaigns for FP	iii. Online engagement needs to be enhanced. With the lockdown, people are likely increasingly using online resources, especially those provided by social media. Large group meetings or engagements should (if possible) be held remotely via online platforms unless a physical meeting is necessary, and should then be limited to the maximum number of attendees recommended by Nigeria Centre for Disease Control (NCDC), with appropriate PPEs and other precautions.

Figure 2: Decline in the number and geographical spread of training for FP in Nigeria[2]



Training of healthcare workers for both LARCs and other methods went down drastically compared to the same period last year, with lesser training and geographical spread as a result of COVID-19 disruptions. For the period January to April 2019, a total of 4,370 providers were trained in 89 distinct training (with 27 of those training been for LARCs) and involving 21 states. There was a massive decline for the corresponding period in 2020, with only 303 healthcare workers trained in 16 distinct training (with 8 of those training been for LARCs), and involving only nine states.

With the bulk of health promotion and education programs targeting COVID-19 transmission interruption, the continuing generation of demand for FP services may be impaired in many locations. Notably, there is a disruption of many face-to-face demand generation activities outlined in the National Family Planning Blueprint and states' Costed Implementation Plans for Family Planning/Child Birth Spacing.

While the current allocation to Family Planning for the year 2020 represents a substantial decline from the allocation in 2019, contextual programming and service delivery in the COVID-19 setting pose more significant challenges, as every service encounter or coordination meetings will require appropriate Infection Prevention and Control (IPC) measures. With the budget allocation at ₦1,220,000,000.00, the official devaluation of Naira against Dollar due to the pandemic, rise in inflation compared to the same period in 2019, and probable sub-optimal budget performance from COVID-19-induced macro-economic woes, it is likely that the already inadequate funds for FP will further be grossly inadequate to meet FP targets at National and sub-national levels.

S.No	Thematic area	Possible challenges/emerging issues	Suggested mitigations
		e. Difficulty in training healthcare provider due to funds and COVID-19 restrictions	ix. Web-based & online in-service training methods to be adopted as much as possible.
3.	Supply Chain Management	a. Disruption in supply chain management at all stages	i. Map weak points and levels in LMD and proactively offer support. ii. Assist states in distributing stocks from state stores to facilities when the states received a supply of commodities from FMOH. iii. Increase availability by moving commodities from low volume facilities to high volume facilities within states. iv. Road pass for vendors & truck drivers transporting FP commodities to the various States and FCT are essential.
4.	Policy and Environment	a. COVID-19 sensitive and guidelines that are regularly updated may be lacking	i. Statements and letters are needed regularly to emphasize the relevance of sustaining FP services at all levels. ii. An Action Plan for RMNCAH Service provision (including RH/FP) needs to be developed and included in the National and State levels COVID-19 Response Plan of Action. These need to be updated regularly. iii. FP Commodity supplies & Services should be integrated into the overall National Health Response iv. National Guidelines on self-care need to be developed and implemented in collaboration with all stakeholders.

S.No	Thematic area	Possible challenges/emerging issues	Suggested mitigations
2.	Service Delivery	a. Movement difficulties and delays for service providers, even when they have an official pass during lockdowns b. Lack of coherence in stakeholders' service delivery approach.	i. Secure approvals (Pass) from National and State ministries of Health to enable team members to move and work as essential health workers even in most challenging locations and across states. Advocacies are needed for honouring those passes with a means of their authentication ii. Incorporate COVID-19 guidelines into FP service delivery that will ensure an optimal standard of practice and care across the board, ensuring quality and access.
		c. Shortage of PPE demotivating service providers.	iii. Deploy an ongoing basis appropriate Personal Protective Equipment (PPE) for all team members and service providers.
		d. Difficulties for clients to access services due to movement restrictions	iv. The home delivery system of refills can be explored in collaboration with the private sector. v. Telemedicine can be explored for minor follow-ups, especially as they relate to side-effects and other counselling. vi. Outreaches that take services to the women in their community and closer to their homes are vital where and when facility access is disrupted. vii. Strengthen community-based family planning program to ensure that FP clients receive services and commodities within their immediate communities including in humanitarian settings viii. Plan proactively for National FP Distribution to all states and support for Last Mile Distribution (LMD) in collaboration with states.

S.No	Thematic area	Possible challenges/emerging issues	Suggested mitigations
			v. Virtual meetings are recommended with the State Reproductive Health Coordinators and State Family Planning Coordinators to discuss the status of reproductive health/family planning implementation in the states and to agree on critical tasks to sustain service delivery and uptake
5.	Financing	a. Inadequate funds for FP activities confounded by COVID-19	i. For the fiscal year 2020, the sum of ₦1,220,000,000.00 was captured in the Appropriation Act 2020 and retained in the revised Appropriation Bill[10]. Additional sources of funds need to be identified and tapped immediately, for both regular services and COVID-19 innovation.
6.	Supervision, Monitoring, and Coordination	a. Difficulty in coordination and monitoring and use of data.	i. There is a need to set-up COVID-FP response teams at all levels with real-time responses. Ideally, this task can be apportioned to a subcommittee of the National and State RH/FP TWGs as applicable. ii. Train/sensitize existing NRHTWG sub-committees always to ensure that deliberations are COVID-19 contextual. This is to be achieved by an orientation activity and ensuring that sub-committees/break-out "discussions guides" for all meetings have proceedings guides, including with specific reminders to be COVID-19 cognizant at the outset and a reminder to reflect at the end that COVID-19 context has been captured. iii. There is a need for regular tracking of workload and productivity of healthcare workers to allow for prompt support. iv. Strategic data collation processes are recommended. For example, clustered data collation meetings (applying COVID-19 precautionary standards for meetings), as well as the use of digital data collation to ensure activities are adequately captured.

As COVID-19 epidemiology emerges, plans should be reviewed and updated regularly for the attainment of local, national, and global sexual and reproductive health targets and commitments. With increasing utilization of virtual fora, access, and quality of internet connections must be improved.

References

[1] Hui DS, I Azhar E, Madani TA, Ntoumi F, Kock R, Dar O, et al. (February 2020). "The continuing 2019-nCoV epidemic threat of novel coronaviruses to global health—The latest 2019 novel coronavirus outbreak in Wuhan, China". International Journal of Infectious Diseases. 91: 264–266. doi:10.1016/j.ijid.2020.01.009. PMC 7128332. PMID 31953166.

[2] ibid.

[3] Chan JF, Yuan S, Kok KH, To KK, Chu H, Yang J, et al. (February 2020). "A familial cluster of pneumonia associated with the 2019 novel coronavirus indicating person-to-person transmission: a study of a family cluster". The Lancet. 395 (10223): 514–523. doi:10.1016/S0140-6736(20)30154-9. PMC 7159286. PMID 31986261.

[4] COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)". ArcGIS. Johns Hopkins University. Available https://coronavirus.jhu.edu/map-faq [Accessed 30 June 2020]

[5] Nigeria Centre for Disease Control. COVID-19 Nigeria https://covid19.ncdc.gov.ng/ [Accessed 29th June, 2020]

[6] Bietsch K, Williamson J and Reeves M, Family planning during and after the West African Ebola crisis, Studies in Family Planning, 2020, 51(1):71–86, http://dx.doi.org/10.1111/sifp.12110. [Accessed 28th June, 2020]

[7] Camara BS et al., Effect of the 2014/2015 Ebola outbreak on reproductive health services in a rural district of Guinea: an ecological study, Transactions of the Royal Society of Tropical Medicine and Hygiene, 2017, 111(1):22–29, http://dx.doi.org/10.1093/trstmh/trx009. [Accessed 29th June, 2020]

[8] World Health Organization, COVID-19: operational guidance for maintaining essential health services during an outbreak, 2020, https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak. [Accessed 28h June, 2020]

[9] International Planned Parenthood Federation, COVID-19 pandemic cuts access to sexual and reproductive healthcare for women around the world, 2020, https://www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world [Accessed 26h June, 2020]

[10] Afolabi, K. Sustaining Family a and Sexual and Reproductive Health Services Delivery amid COVID-19 pandemic. MSION webinar. June 13th, 2020


UNITY AND FAITH, PEACE AND PROGRESS