

COUNTRY CASE STUDY

MID-TERM EVALUATION OF THE UNFPA SUPPLIES PROGRAMME

(2013-2016)

NIGERIA

EVALUATION OFFICE

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Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2016)

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ABBREVIATIONS AND ACRONYMS

3PL	Third Party Logistics Provider
AFPC	Access to Family Planning Commodities Project
AFRH	Association for Family and Reproductive Health
ANC	Ante Natal Care
BCC	Behaviour change and communication
BMGF	Bill and Melinda Gates Foundation
CCW	Central Commodity Warehouse
CHAI	Clinton Health Access Initiative
CHEW	Community Health Extension Worker
CIP	Costed Implementation Plan
CMS	Central Medical Stores
CO	Country Office
COMBI	Communication for Behavioural Impact Approach
CPR	Contraceptive Prevalence Rate
DDIC	Direct Delivery and Information Capture
DFID	UK Department for International Development
DHIS	District Health Management Information Systems
DMPA-SC	Depo-Provera Sub-cutaneous
EmONC	Emergency Obstetric Neonatal Care
EMTCT	Elimination of Mother to Child Transmission of HIV/AIDS
EVA	Education as Vaccine Initiative
FCT	Federal Capital Territory
FDS	Federal Department of Food and Drugs Services
FGoN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
FP	Family Planning
FP-TWG	Family Planning Technical Working Group
GFF	Global Financing Facility
GHSC-PSM	Global Health Supply Chain Program – Procurement Supply Management
GoN	Government of Nigeria
GPRHCS	Global Programme for Reproductive Health Security
IDP	Internally Displaced Person
IEC	Information, Education and Communication
iLMD	Integrated last mile distribution
IP	Implementing Partner
IUD	Intra Uterine Device
JSI	John Snow Inc.
LARC	Long-Acting Reversible Contraception
LGA	Local Governmental Authority
LLMCU	Local Logistics Management Coordination Unit
LMCU	Logistics Management Coordination Unit
LMD	Last mile distribution
LMIS	Logistics Management Information System
mCPR	Contraceptive Prevalence Rate, modern methods
MEC	Medical Eligibility Criteria
MSIoN	Marie Stopes International of Nigeria
NDHS	Nigeria Demographic and Health Survey
NGO	Non-governmental organisation
NMCN	Nurse-Midwife Council of Nigeria
NPHCDA	National Primary Health Care Development Agency
NPSCMP	National Products Supply Chain Management Programme
NSCIP	Nigeria Supply Chain Integration Project

NURHI	Nigeria Urban Reproductive Health Initiative
PHC	Primary Health Centre
PMA	Performance, Monitoring and Accountability
PPFN	Planned Parenthood Association of Nigeria
PPH	Post-partum Haemorrhage
PSB	Procurement Services Branch (of UNFPA)
PSM	Procurement and supply management
PSM-TWG	Procurement and Supply Management Technical Working Group
RBA	Rights-based approach
RIRF	Request Issue and Report Form
RH	Reproductive Health
RH/FP	Reproductive Health/Family Planning
RHCS/FP	Reproductive Health Commodity Security/Family Planning
RHCS-TWG	Reproductive Health Commodity Security Technical Working Group
RHSC	Reproductive Health Supplies Coalition
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
R&R	Review and Resupply
SCM	Supply chain management
SDP	Service Delivery Point
SMoH	State Ministry of Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
The Global Fund	Global Fund for Aids, Tuberculosis and Malaria
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAN	Visibility Analytics Network
WHO	World Health Organisation
YFC/YFS	Youth Friendly Centre/Youth Friendly Services

GLOSSARY OF MEDICAL TERMS

BEmONC	Basic emergency obstetric and newborn care (BEmONC) is defined as seven essential medical interventions, or 'signal functions', that treat the major causes of maternal and newborn morbidity and mortality and should be available as close to the community as possible. These signal functions include antibiotics to prevent puerperal infection; anticonvulsants for treatment of eclampsia and preeclampsia; uterotonic drugs (e.g., oxytoxics) administered for postpartum haemorrhage; manual removal of the placenta; assisted vaginal delivery; removal of retained products of conception; and neonatal resuscitation.
CEmONC	Comprehensive emergency obstetric and newborn care (CEmONC) includes all the signal functions of BEmONC plus blood transfusions, surgery (e.g., caesarean section), and advanced neonatal resuscitation. The skills, equipment and conditions for these functions should be made available at the referral level such as a district hospital.
EmONC	Emergency obstetric and neonatal care is a package of services provided to the mother-baby couple that includes urgent services to prevent maternal death (e.g. access to essential pharmaceuticals, including antibiotics, anticonvulsants, and uterotonics) and life saving measures for newborns (e.g. clean cord care and neonatal resuscitation).
Fistula	Fistula is a hole between the vagina and rectum or bladder that is caused by injury, leaving a woman incontinent of urine or faeces or both. It requires a surgical repair. Obstetric fistula is a childbirth injury caused by prolonged or obstructed labour.
Infant mortality	The death of a child between one and twelve completed months of life.
Magnesium Sulphate	Magnesium sulphate is used to prevent seizures in a woman with moderate to severe preeclampsia. It is also used to stop seizures (eclampsia) when they are occurring. When magnesium sulphate is used during labour and delivery, it is usually continued for at least 24 hours after delivery. Magnesium sulphate is given intravenously or by injection. It is stable at room temperature and does not need refrigeration.
Maternal death	The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes.
MDSR/ MNDSR	Maternal Death Surveillance and Response/ Maternal and Neonatal Death Surveillance and Response: A continuous action and surveillance cycle of identification, quantification, notification and review of maternal deaths followed by the interpretation of the aggregated information on the findings and the avoidability of the maternal deaths which is used for the recommended actions that will prevent future deaths. The primary goal of MDSR/ MNDSR is reducing future preventable maternal (and neonatal) deaths.
Misoprostol	A uterotonic medicine used to induce the uterus to contract and thus to control post-partum haemorrhage or initiate labour. Misoprostol is on the WHO Essential Medicines List and comes in tablet form. It has a

	long shelf life and is stable at room temperature (so does not need refrigeration).
Neonatal death	The death of an infant during the first month of life.
Oxytocin	A uterotonic medicine given to a woman to cause contraction of the uterus. It may be given to start or increase the speed of labour, and/or to stop bleeding following delivery. Oxytocin is given through injection or intravenously. It requires refrigeration and cannot (currently) be stored at room temperature.
Perinatal death	The perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth. Perinatal mortality refers to the number of stillbirths and deaths in the first week of life (early neonatal mortality).
Stillbirth	Stillbirth is the death of foetus before birth. A macerated stillbirth is one where the foetus has died in utero some hours or days before the delivery. Fresh stillbirths are those where the foetus was alive going into labour but died in the course of the delivery. Both types of stillbirth are largely preventable. Numbering about 2.5 million annually across the world, stillbirths have only recently begun to be counted systematically and data is difficult to interpret as a result. A declining number of stillbirths is the direct result of better maternity care (both antenatal and during delivery).

1 INTRODUCTION

This note presents the results of the field country case study of Nigeria, undertaken for the mid-term evaluation of the UNFPA Supplies programme (referred to as UNFPA Supplies). It is one of four field country case studies carried out during the evaluation (the Lao People's Democratic Republic, Nigeria, Sierra Leone and Sudan). Another five of the 46 countries in which UNFPA Supplies operates were covered by desk-based country case studies (Haiti, Madagascar, Malawi, Nepal and Togo).

1.1 The mid-term evaluation of UNFPA Supplies

The purpose of the mid-term evaluation of UNFPA Supplies is to assess the progress made in implementing the programme since 2013. The objectives of the evaluation are to provide an independent and valid assessment of:

- The relevance and approach of UNFPA Supplies
- Results achieved across all output areas and sustainability
- Gender equality, social inclusion and equity
- Coordination and synergy with partners
- The catalytic role of UNFPA Supplies.[1]

1.2 Objectives of the field country case studies

The country case studies aim to provide insights into the evaluation questions and a comprehensive, nuanced picture of programme actions and their results. They cover nine of the 46 programme countries of UNFPA Supplies and serve to illustrate programme results in a wide range of contexts. They do not form a statistically valid or representative sample of all programme countries.

Table 1: Field and Desk-Based Country Case Studies

Mid-Term Evaluation of UNFPA Supplies: Case Study Countries	
Field-Based Country Case Studies	**Desk-Based Country Case Studies**
Lao People's Democratic Republic	Haiti
Nigeria	Madagascar
Sierra Leone	Malawi
Sudan	Nepal
	Togo

The specific purpose of the field-based country case studies is to allow the evaluation to explore the evaluation questions in greater depth than would be possible in desk studies.

[1] Evaluation Office, UNFPA. *Mid-term Evaluation of the UNFPA Supplies Programme (2013-2020): Terms of Reference,* October, 2016. p. 9. https://www.unfpa.org/sites/default/files/admin-resource/ToR_Mid_Term_evaluation_of_UNFPA_SUPPLIES_2013-2020_F_I_N_A_L.pdf

Box 1: Evaluation Questions

Evaluation Questions

1. To what extent has UNFPA Supplies **contributed to creating and strengthening an enabling environment for RHCS/FP** at global, regional and national level?
2. To what extent has UNFPA Supplies contributed to **increasing demand for reproductive health and family planning commodities and services,** including demand by poor and marginalized women and girls in keeping with their needs and choices (including in humanitarian situations)?
3. To what extent has UNFPA Supplies, through its global operations and advocacy interventions, **contributed to improving the efficiency of the procurement and supply of reproductive health and family planning commodities** for the 46 target countries?
4. To what extent has UNFPA Supplies contributed to **improved security of supply, availability and accessibility of reproductive health and family planning commodities and services** in programme countries, especially for poor and marginalized women and girls, **in keeping with their needs and choices**, including in humanitarian situations?
5. **To what extent has UNFPA Supplies contributed to improving systems and strengthening capacity for supply chain management for reproductive health and family planning commodities in programme countries?**
6. To what extent have the **governance structures** (UNFPA Supplies Steering Committee) **management systems and internal coordination mechanisms** of UNFPA Supplies **contributed to overall programme performance**?
7. **To what extent has UNFPA Supplies played a catalytic role by leveraging increased investment by other actors and supplementing existing programmes in RH/FP at global, regional and national levels?** [2]

The country case studies are not individual programme evaluations at country level. They:

- Provide input for answering the evaluation questions and assumptions for verification
- Triangulate data collected from other sources and respondents with qualitative and quantitative information collected in country
- Identify lessons learned.

The evaluation also uses other methods, including an online survey of key stakeholders, interviews undertaken at global and regional level and a comprehensive global document and data review to ensure coverage of all UNFPA Supplies programme countries.

1.3 Approach and methodology

Each field country case study uses a theory-based evaluation approach which builds on the theory of change (ToC) and key causal assumptions developed for the UNFPA Supplies programme described in detail in the Inception Report of the mid-term evaluation.[3]

[2] Evaluation questions and related key causal assumptions are provided in the *Inception Report of the Mid-Term Evaluation of UNFPA Supplies*: UNFPA, September, 2017.
[3] UNFPA, 2017. *Inception Report*: p. 31-40. https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_Supplies_Mid-Term_Evaluation_-_Draft_INCEPTION_REPORT_Volume_1_-_121017.pdf.

These assumptions (Annex 1), when tested using contribution analysis, allow each evaluation question to be addressed and, ultimately, provide the basis for assessing the contribution of UNFPA Supplies to outcomes in Reproductive Health and Family Planning (RH/FP) in Nigeria.[4]

The main data collection methods used in each field country case study are:

- Identification and review of core documents at country level including: annual workplans; results frameworks and results reports; minutes of planning, review and steering committee meetings; programme review and evaluation documents; monitoring mission reports, national plans and programmes in family planning and Reproductive Health Commodity Security (RHCS); and reports and documents produced by other bilateral and multilateral agencies supporting RH/FP
- Review and profiling of quantitative data, including financial data on programme investments and data on availability and use of family planning commodities
- Key informant interviews with a wide range of stakeholders at national level (Annex 3)
- Site visits at district and local levels including: interviews and discussions with provincial and district health (or in the case of Nigeria, State and Local Government Authority (LGA) teams and group and individual interviews with staff of district hospitals, rural health centres and health posts, and static and mobile health clinics
- Interviews with staff of warehouses and medical stores facilities at national and district level and observation of conditions for storage, monitoring and distribution of RH/FP commodities at national, provincial, district and local levels
- Focus group discussions and group interviews with girls and young women accessing RH/FP services and using commodities supported by UNFPA Supplies
- Debriefings of key informants at national level in order to present preliminary findings and receive feedback on any gaps in the data used, and on factual errors or misinterpretation of the available data.

In each field country case study, the draft field country case study note was submitted to the UNFPA Supplies team in the Country Office (CO) for review and comments prior to submission to the UNFPA Evaluation Office.

1.4 Carrying out the Nigeria field country case study

1.4.1 Data collection activities

The country case study mission was carried out by a team of three evaluators working in Nigeria from November 6 to 17, 2017.

Document reviews

The case study mission was preceded by a review of relevant documents provided by the Nigeria CO. These were supplemented by documents gathered during the case study mission from key informants interviewed. For a list of documents referred to during the case study see Annex 4.

[4] For a full discussion of the analytical approach and methodology used in mid-term evaluation see the *Inception Report,* Sections 3 and 4.

Key Informant interviews
The case study team carried out extensive interviews with key stakeholders for UNFPA Supplies in Nigeria. These included:

- The UNFPA Supplies team, including technical advisors and the UNFPA Country Representative, in the UNFPA CO in Abuja and in the sub-Country Offices in Kaduna and Lagos
- Senior officials at the Federal Ministry of Health (FMoH) in Abuja, including Family Health Department and RH Division, and the National Primary Health Care Development Agency
- Senior officials in the Kaduna and Lagos State Ministries of Health (SMoH)
- Staff at federal and state medical stores in Abuja, Lagos and Kaduna
- Senior staff of non-governmental implementing partners
- Staff of development partners supporting RH/FP programming and commodity security, in particular the United States Agency for International Development (USAID) and the United Kingdom's Department for International Development (DFID)
- Group discussions with implementing partners in Kaduna and Lagos
- Logistics Management Coordination Unit (LMCU) staff in Kaduna
- Staff of Primary Health Centres (PHCs) in Federal Capital Territory (FCT), Kaduna and Lagos; youth-friendly facilities in Lagos.

Site Visits
The case study included site visits and observations (along with key informant interviews and group discussions) at a range of facilities relevant to the operation and effectiveness of UNFPA Supplies. These included:

- The FCT Medical Store (Area 2 Clinic, Garki), Kaduna State Central Medical Store (Drug and Medical Supplies Management Agency, Kaduna State), Lagos State Central Medical Stores, and Warehouse-in-Box (Abuja).
- Five service delivery points (PHCs) in FCT, Kaduna and Lagos

During visits to PHCs, the case study team interviewed facility-in-charge officers and service providers; however, there was neither opportunity to interview clients nor to observe clinical or counselling sessions (see figure 3, p.8).

1.4.2 Limitations

While data collection activities during the case study were intensive and the evaluation team was able to access many of the key informants they had identified in advance, the sample of key informants interviewed and facilities visited was, necessarily, limited. This is especially true in light of the vast size and diversity of the country, the decentralized nature of the administrative structure (in 36 states, plus the FCT), and the very large network of healthcare facilities in Nigeria. Because of the limited time, the evaluation conducted group interviews with partner organizations in Kaduna and Lagos.

In addition, UNFPA Supplies is not the only source of support to activities in RH/FP funded through UNFPA. DFID supports the Access to Family Planning Commodities (AFPC), a 5-year project which provided 3 million GB Pounds on an annual basis (2011/12 - 2016/17) to contribute to the basket fund that includes pooled resources from the Federal Government of Nigeria (FGoN), DFID, the Government of Canada and UNFPA. In addition, bilateral and multilateral development partners have also provided significant funding for RH/FP, including the USAID and the Bill and Melinda Gates

Foundation (BMGF). USAID supports a major effort to address contraceptive supply chain management through the Global Health Supply Chain Programme-Procurement and Supply Management Project (GHSC-PSM) operated by Chemonics International Inc. The Nigerian Urban Family Health Initiative (NURHI), supported by BMGF, is especially active in Lagos and Kaduna, and undertakes major activities to advance the supply, demand and enabling environment for family planning.

Given extensive support to the health sector in general and to RH/FP programming (and the supply chain) in particular from other sources of funding and other partners, care must be taken in identifying the contributions made to results in RH/FP by UNFPA Supplies. The case study findings presented in Section 4 distinguish wherever necessary and possible between contributions made directly by the UNFPA Supplies programme and those that arise from working in combination with other sources of support, both financial and technical.

None of the limitations noted seriously undermine the validity of the findings reported in Section 4.

2 COUNTRY CONTEXT AND PROGRAMME RESPONSE

2.1 Demand, supply and unmet need for family planning in Nigeria

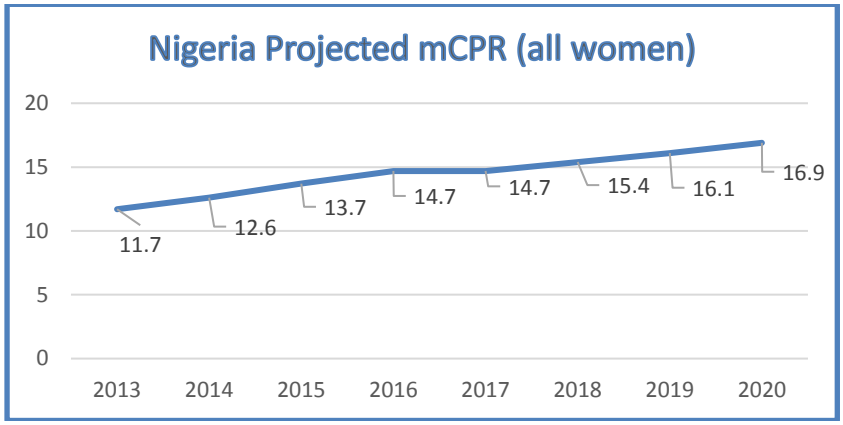
2.1.1 Trends in contraceptive prevalence and demand

Nigeria has an estimated total population of 190 million in 2017 with an estimated annual growth rate of 2.6 percent.[5] If population growth is maintained at this rate, Nigeria is on track to become the world's third most populous country in 2050, behind China and India. "Nigeria's youth-dominated age structure, with approximately 44 percent of the population younger than 15, will have a significant effect on the growth rate, as almost half will be at or reaching reproductive age within the next 15 years".[6] Nigeria accounts for more than 14 percent of all maternal deaths worldwide, resulting in 40,000 deaths annually.[7] Thirty percent of these deaths can be averted by increasing uptake of modern family planning methods.[8]

Family Planning 2020 (FP2020) on its web-site (Track 20) estimates the current Contraceptive Prevalence Rate for the use of modern methods (mCPR) among all women in Nigeria stood at 16.9 percent at the end of 2016. The Track20 model estimates that mCPR has increased steadily in the four years from 2013 to 2016.

[5] United Nations, DESA Population Division. *World Population Prospects, 2017.* Accessed from https://esa.un.org/unpd/wpp/DataQuery/ on January 5, 2018.
[6] Tien, Marie, Sylvia Ness, Ugochukwu Amanyeiwe, Echendu Adinma, Uzo Ebenebe, and Azubike Nweje. 2009. *Nigeria: Reproductive Health Commodity Security Situation Analysis*. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1.
[7] World Health Organization (WHO) (2014); 'Global causes of maternal death: a WHO systematic analysis'; Lancet Global Health 2: e323–33. Accessible at: http://dx.doi.org/10.1016/S2214-109X(14)70227-X
[8] Singh S and Darroch JE, (2012) Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA) Accessible at: http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf

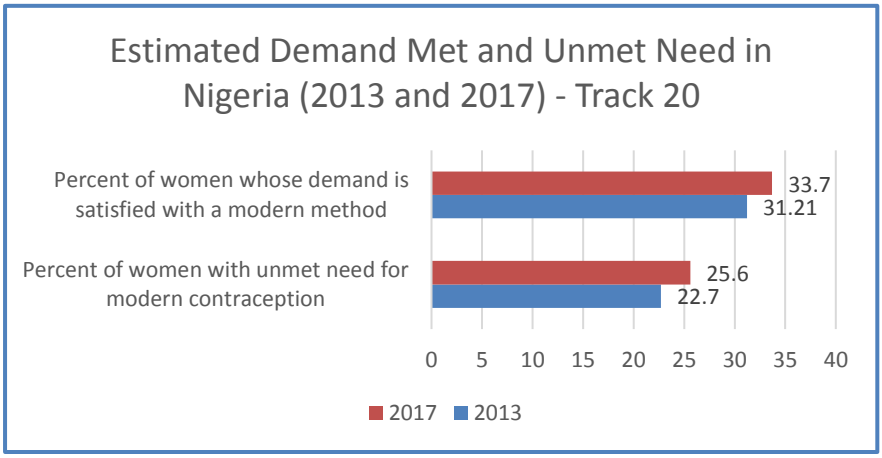
Figure 1: Past and projected modern method CPR for all women: Nigeria



Source: FP2020: Track 20[9]

The FP2020 commitment statement by the GoN is to achieve a contraceptive prevalence rate of 27 percent among all women by 2020.[10] (The original goal announced at the London Family Planning Summit in 2012 was to increase contraceptive prevalence rate (CPR) from 15 percent in 2013 to 36 percent in 2018, but was revised downward as part of its revitalized FP2020 commitment in 2017). At the current rate of annual increase of 1.1 percent at the national level, it is unlikely that Nigeria will achieve this overall goal. However, there has been an improvement in the percent of women whose demand for modern methods has been met. In addition, Track20 estimates that approximately 1.89 million *additional* users were served in 2017 as compared to 2012.[11]

Figure 2: Estimated demand met and unmet need for family planning



Contraceptive prevalence varies widely by state, with mCPR as high as 32 percent in Osun (South West region) and as low as .5 percent in Kano (North West region).[12] Contraceptive use is

[9] Accessible at: http://www.familyplanning2020.org/entities/61

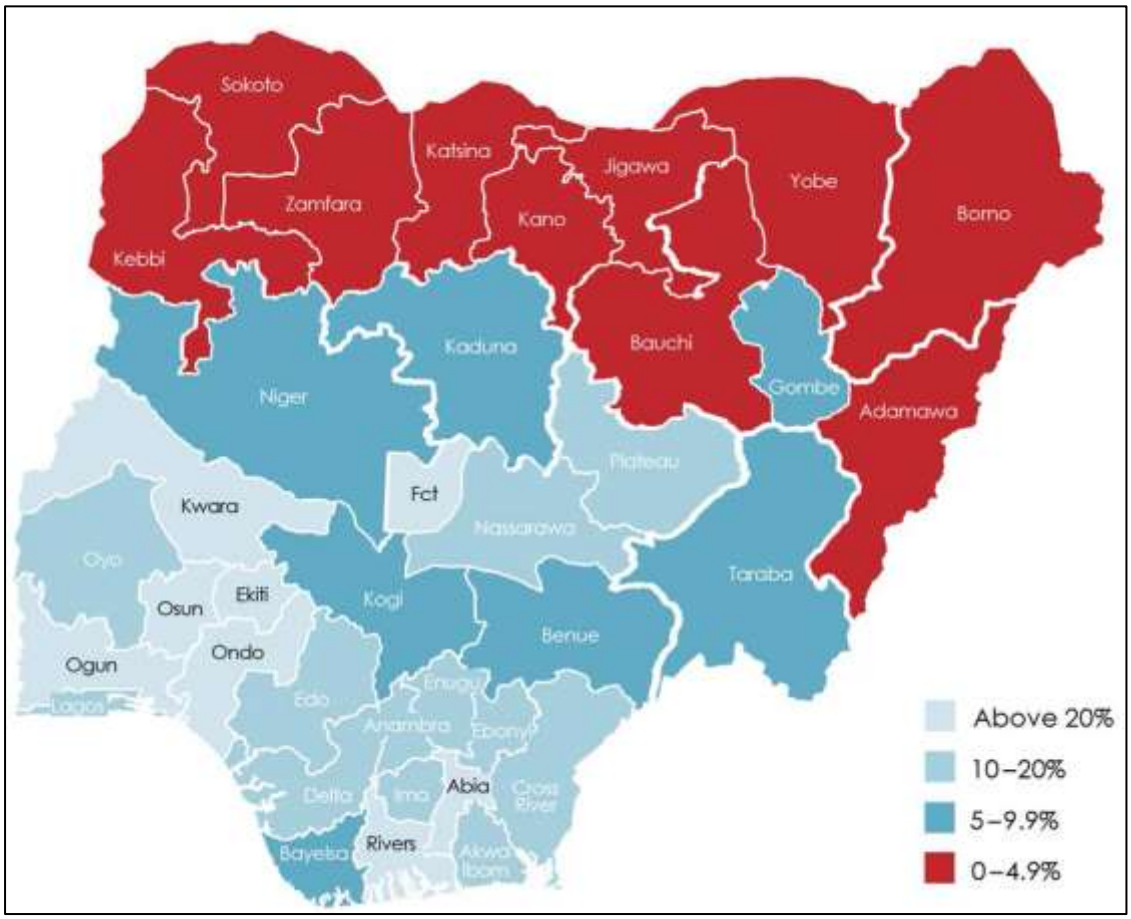
[10] Government of Nigeria*: FP2020 Commitment.* July 2017. Accessible at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/08/Govt.-of-Nigeria-FP2020-Commitment-2017-Update-SO1.pdf

[11] FP2020. Nigeria Commitments. Accessible at: http://www.familyplanning2020.org/entities/61

[12] Track20. *Nigeria: Exploring sub-National Opportunities in Family Planning Programming.* Accessible at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/11/Nigeria-Subnational-Opportunities-Handout-2.pdf

concentrated largely in the southern states where levels of wealth and education tend to be higher than in the North. Not surprisingly, there are also regional differences in knowledge of modern contraceptives, with the lowest levels found in the North-West and North-East regions. Overall, low demand for family planning services and commodities is a significant barrier to increasing CPR, due to a lack of awareness about the benefits of family planning and because of common misconceptions about efficacy and side effects.[13] Demand creation is a key strategic priority; the national Family Planning Blueprint (which serves as the costed implementation plan (CIP) for family planning) calls for strengthening demand for family planning services by developing targeted, tailored, and accurate information and delivering it through accessible communication channels to all key segments of society.[14]

Figure 3: CPR across Nigeria, 2011



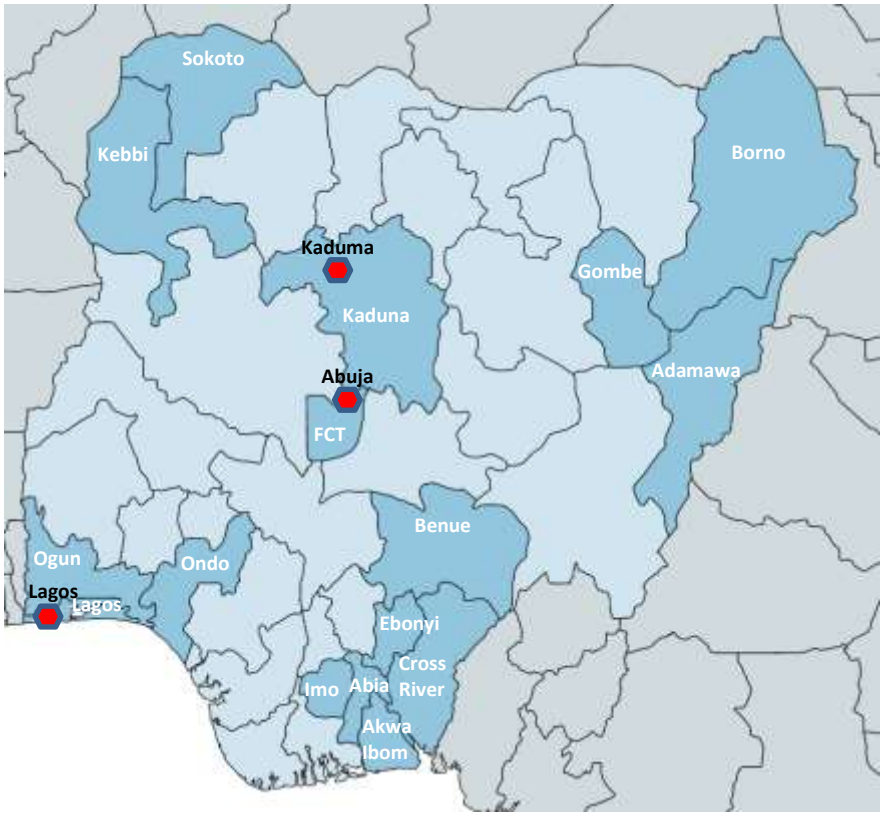
Source: Nigeria CIP, National Blueprint, 2014

In the states visited by the evaluation team, contraceptive prevalence rates have shown increased momentum, with an annual increase of 2.3 percent in Kaduna and 3.3 percent in Lagos. In the case of Kaduna, much of this rise is the result of increased use of long-acting/reversible contraception, notably implants.

[13] Federal Government of Nigeria, Federal Ministry of Health, 2014. *Nigeria Family Planning Blueprint (Scale-up Plan),* October 2014. Accessible at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2015/09/CIP_Nigeria.pdf

[14] Ibid, p.14.

Figure 4: Map showing UNFPA Supplies Focus States and sites visited



UNFPA Supplies Focus States (15 states + FCT)

The evaluation team visited the following states/LGAs and city districts (in Abudja):

- Federal Capital Territory/**Abuja**:
  - Garki District of Abuja City
  - Dutse in Bwari District of Abuja City
- **Kaduna** State/Kaduna City:
  - Kujama town in Chikun LGA
  - Badarawa LGA
- **Lagos** State/Lagos City:
  - Agege LGA
  - Lagos Island

Table 2: **CPR 2013, 2016 and 2017 (All women, Age 15-49) for All Methods, Modern Methods and Long-Acting Reversible/Permanent Methods, National level, Kaduna State and Lagos State[15]**

Geographic Area	Type of method	N-DHS 2013	PMA2016	PMA2017[16]
National	All methods	16.0	19.8	21.0
	Modern methods	11.1	14.9	14.7
	LARC/PMs	1.4	2.8	3.1
Kaduna State	All methods	20.9	15.1	17.4
	Modern methods	19.4	13.9	15.6
	LARC/PMs	4.0	5.6	13.9
Lagos State	All methods	40.5	26.4	29.7
	Modern methods	24.8	19.7	20.6
	LARC/PMs	1.9	2.6	4.2

[15] PMA2020.org. *Briefs Family Planning, PMA2017/Nigeria-R2; PMA2014/Kaduna-R1; PMA2017/Kaduna; PMA2014/Lagos-R1; and PMA2017/Lagos.* Accessible at: https://pma2020.org/fp-briefs

[16] PMA2020 is a project housed at the Gates Institute at the John Hopkins Bloomberg School of Public Health which uses innovative mobile technology to support rapid-turnaround surveys to monitor key health and development indicators from a nationally representative sample of population-based and service delivery data on an annual basis in 11 FP2020 countries.

This increased momentum is seen by the GoN as a sign of its efforts to roll out several mutually reinforcing policies and actions that aim at making sure that family planning services and commodities reach the people that need them. These include the development of the national family planning CIP entitled the *National Family Planning Blueprint* as well as the abolishment of user fees for contraceptive services.[17] The GoN also estimates that the cost of delivering family planning services between 2016 and 2020 is 97 million USD, but only has commitments to date of 32 million USD. The funding gap for commodities between 2016 and 2020 is estimated at 22 million USD.[18]

2.1.2 Institutional arrangements

Nigeria is a federal republic with 36 states plus the FCT, together referred to as "36+1" states, across six geopolitical regions or zones (North-Central, North-East, North-West, South-East, South-South, and South-West). States are led by governors who wield significant influence in health and other matters, it is estimated approximately 50 percent of all government revenue is controlled by states. The national government sets policy which must be "domesticated" at the state level for implementation to occur. There are also 774 LGAs, each led by a government council. LGAs run the primary health care system with the support of Ward Development Committees and other community groups. Therefore, for policies and programmes to be scaled, there must be strong linkages from the national to state to LGA levels. Given the country's sheer size and diversity, this devolution is challenging.

Delivery of RH/FP Services

The health system in Nigeria is organized in a three-tiered structure. At the ***federal level***, the FMoH is responsible for policy and technical support to the overall health system, including coordination of international assistance, national health management information systems, and provision of services through tertiary and teaching hospitals (at least one per state). At the ***state level***, SMoHs are responsible for secondary general hospitals which serve as referral facilities for PHCs. SMoH also provide technical support and oversight to PHCs. The LGA is responsible for service delivery at the ***primary health care level***, and is overseen by the National Primary Health Care Development Agency.

As of December 2011, there were over 34,000 health facilities across 36 States and the FCT; 88 percent are primary health care facilities and 66 percent are government owned.

Table 3: Number of health facilities in Nigeria by type[19,20]

	Primary	Secondary	Tertiary	Total
National	30,098	3,992	83	34,173
• **Public**	21,808	969	73	22,850
• **Private**	8,290	3,023	10	11,323
Kaduna (public & private)	1,524	33	4	1,561
Lagos (public & private)	1,785	460	7	2,252

[17] Government of Nigeria, 2017. *FP2020 Meeting Nigeria Country Brief* (final Government certified version).
[18] Ibid.
[19] Federal Ministry of Health, 2016. *National Health Policy 2016.* Accessible at: http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/1212_2016_National_Health_Policy_Draft._FMoH_1283.pdf
[20] OA Makinde et al, 2014. "Development of a master health facility list in Nigeria," *Online Journal of Public Health Informatics.* Vol6(2): e184. Published online 2014 Oct 16. doi: 10.5210/ojphi.v6i2.5287

The private medical sector is the most common source for users of modern contraception; less than one-third (29 percent) of current users obtain their contraception from public facilities.[21] Contraceptive implants and intra Uterine devices (IUDs), or long-acting, reversible contraception (LARCs) and injectables require trained personnel, and are usually sourced by the public sector, whereas condoms and pills are available from a wide variety of sources, such as proprietary patent medicine vendors, pharmacies, informal drug sellers and pharmacies.

According to the FMoH, health service delivery in Nigeria is characterized by "inequitable distribution of services, decaying infrastructure, poor management of human resources for health, negative attitude of health care providers, weak referral systems, poor coverage of high-impact cost-effective interventions, lack of integration and poor supportive supervision".[22] These challenges carry over into family planning service delivery. Family planning is accorded less priority as it is not a "disease" programme and its long-term benefits less visible to stakeholders. A major challenge is the overall shortage of providers for family planning service delivery, exacerbated by high turnover and inadequate skills and training for existing staff.[23]

Institutional structures for supply chain management

UNFPA is the official procurement agent for the FMoH and works directly with the Family Health Division of the Ministry in collaboration with DFID, USAID and other donors to support the Federal Government of Nigeria in ensuring access to reproductive health commodities in public health facilities. This arrangement takes advantage of a centralized pooled of procurement funds accessible via UNFPA using pre-qualified vendors which ensure that manufacturers of the commodities maintain quality standards. The arrangement also enables price advantages through bulk purchases.

The Nigerian institutional structure for supply chain management is in flux. In 2012, the National Products Supply Chain Management Programme (NPSCMP) was created within the Food and Drugs Services Department (FMoH) to strengthen supply chain management across several programmes, including RH, HIV/AIDS, Malaria, TB and Vaccine/immunization programmes. It was established to address the challenges related to fragmented supply chains and resource constraints across the different programmes and states. In the case of contraceptive commodity logistics management, different systems exist for "last mile delivery" depending on which donor/implementing agency was supporting distribution efforts in the states. More detail regarding the supply chain is provided in Section 3.5.

To support the capacity of NPSCMP, the Nigeria Supply Chain Integration Project (NSCIP) was created in 2014 with funding from The Global Fund, USAID, UNFPA and other partners. NSCIP is managed by NPSCMP and its implementation partner, the i+solutions-led consortium; its purpose is to expedite the integration of supply chains across the various disease programmes while building capacity at federal, state, and local government level for enhanced visibility, control and efficient last mile distribution (LMD) of health commodities. A main component of the NSCIP aims to establish functional LMCUs and deploy Logistics Management Information Systems (LMIS); first within the 36+1 states and then down to the local logistics management coordination units (LLMCUs) at the LGA level. The plan also calls for the establishment of zonal warehouses, bypassing state warehouses going directly to service delivery points (SDPs) through third party logistics providers (3PL). The system is in the process of being rolled out and is in different stages of operation depending on a variety of factors at the state level. While NSCIP is moving forward, existing and parallel systems are

[21] Nigeria Demographic and Health Survey, 2013.
[22] Federal Ministry of Health, 2016. *National Health Policy 2016,* p. 12.
[23] Federal Government of Nigeria, Federal Ministry of Health, 2014. *Nigeria Family Planning Blueprint (Scale-up Plan),* October 2014. Accessible at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2015/09/CIP_Nigeria.pdf

being maintained, leading to a continued patchwork of supply chains. The complexities of rolling out an integrated supply chain across a large number of autonomous states with differing levels of capacity and resources cannot be overstated.

2.2 The UNFPA Supplies programme in Nigeria

2.2.1 UNFPA Supplies support to Nigeria 2013-2015

Value and distribution of allocations for UNFPA Supplies in Nigeria, 2013 to 2015

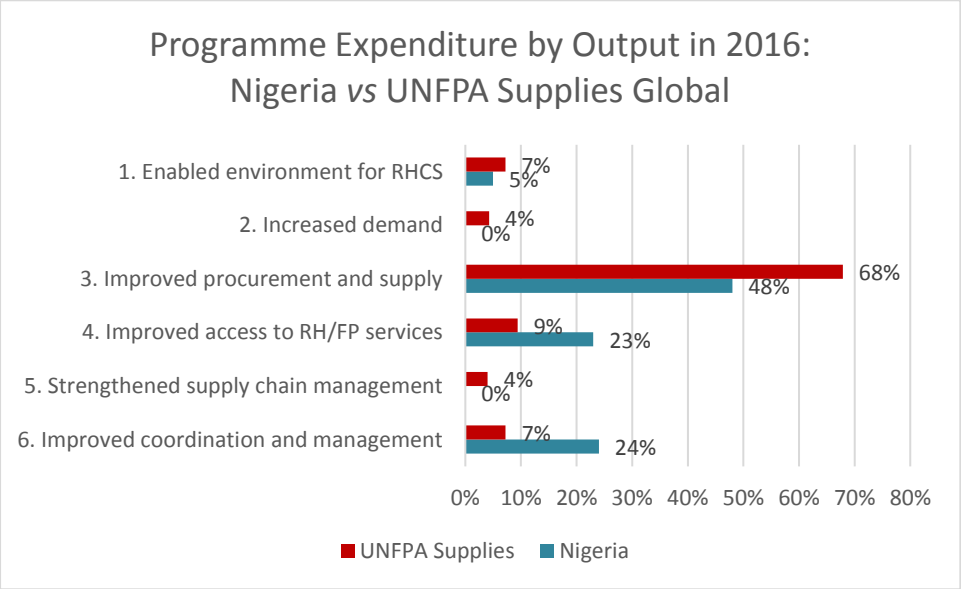
From 2013 to 2015, the total value of UNFPA Supplies support allocated to the programme in Nigeria was 34.8 million USD.[24]

Table 4: Budget allocations for GPRHCS/UNFPA Supplies to Nigeria, 2013-2015

Budgets (Annual Progress Reports)	2013	2014	2015
Programme Support	4,354,900	6,242,550	3,358,734
Commodities	5,760,884	6,992,758	8,141,844
Total:	10,115,784	13,235,308	11,500,578

Table 4 illustrates the allocation of those funds across the six programme outputs. Output three, improved efficiency of procurement (global) refers to the value of commodities procured. It is the largest single category of funding, accounting for over 48 percent of all the funds allocated to UNFPA Supplies in Nigeria in 2015-16. However, this is less than the amount procured globally. Expenditures for access to RH/FP services and programme coordination are significantly higher for Nigeria than globally.[25]

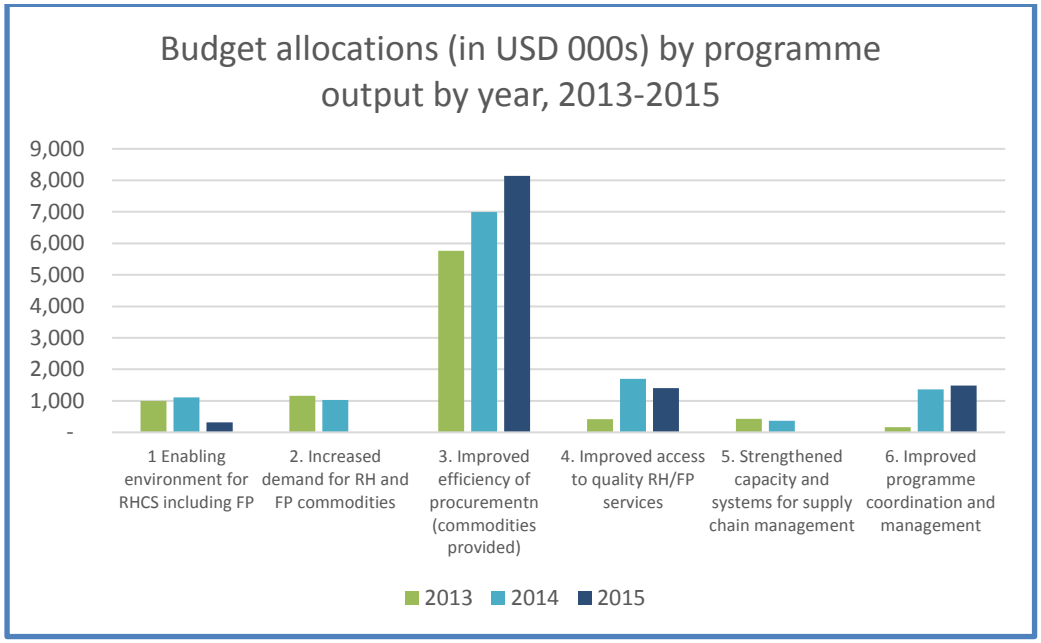
Figure 5: UNFPA Supplies fund allocations (by percent) by programme output in Nigeria and globally, 2016



[24] Data on the allocation of resources to UNFPA Supplies is taken from UNFPA Nigeria CO Annual Progress Reports for 2013, 2015 and 2015.

[25] Data for UNFPA Supplies Programme Globally: See UNFPA, *UNFPA Supplies, Annual Report 2016*. P. 86-92.

Figure 6: UNFPA Supplies budget allocations (in USD 000s) by programme output by year, 2013-2015



Budget allocation for commodities (output 3) increased over the three years, from 5.7 million USD in 2013 to 8.1 million USD in 2015. However, as seen in Table 4, the *overall* budget allocation to Nigeria decreased between 2014 and 2015. In order to maintain the important role that UNFPA plays in Nigeria for the provision of family planning commodities, all other programme categories experienced reductions in funding allocations, with no funds allocated for output 2 (demand creation) or output 4 (strengthened capacity and systems for supply chain) in 2015.

2.2.2 Key implementing partners

The Nigeria 7th Country Programme (2014-2017) supports the 36 States and FCT with distinct programming activities in 15 States (Abia, Adamawa, Akwa Ibom, Benue, Borno, Cross River, Ebonyi, Gombe, Imo, Kaduna, Lagos, Ogun, Ondo, Sokoto and Kebbi) and FCT (see figure 3).[26] The key implementing partner for UNFPA Supplies in Nigeria is the FMoH. Within the FMoH, the Department of Family Health is responsible to develop and coordinate the implementation of policies and programmes that promote the health of the family through integrated health services in Nigeria. The RH Division oversees family planning services and logistics at all levels of healthcare delivery and its functions include training of service providers, development and review of training manuals, guidelines and protocols on family planning services, production of information education communication (IEC)/behavioural change communication (BCC) materials, working in partnership with development partners, and forecasting, procurement and distribution of family planning commodities, coordination of State implementers on family planning, and monitoring and evaluation of family planning programmes in the states.[27]

Other key federal implementing partners include the NPHCDA, a parastatal agency of the FMoH responsible for providing technical and programmatic support to states and LGAs in the planning, supervision and monitoring of primary health care services in Nigeria. UNFPA also works with the Central Commodity Warehouse (CCW) and Central Medical Store (Oshodi). In addition, UNFPA has established direct relationships with select State governments where programmatic efforts exist, including SMoH and State Central Medical Stores.

[26] UNFPA Nigeria, 2015. *Annual Progress Report, Joint Thematic Trust Funds Jan to Dec 2014.*
[27] http://www.health.gov.ng/index.php/department/family-health

Other key implementing partners and their activities supported by UNFPA Supplies are described in table 5.

Table 5: Other implementing partners of UNFPA Supplies[28]

Implementing Partners	Main Activities Supported by UNFPA Supplies
Association for Reproductive and Family Health (ARFH)	ARFH works in partnership with other organizations to promote best sexual and RH practices and to reduce the disease burden, particularly sexually transmitted infections (STI), HIV and AIDS, Malaria and Tuberculosis. UNFPA supports ARFH to train Community Health Extension Workers (CHEWs) to expand access to *Sayana Press*.
Planned Parenthood Federation of Nigeria (PPFN)	PPFN, an affiliate of the International Planned Parenthood Federation, has a large network of service delivery points and delivers around 10% of all family planning services in Nigeria. PPFN operates a national commodity store which serves itself and other private sector organizations. UNFPA supports PPFN in two major areas: 1) to provide services to internally displaced persons (IDPs) in Adamawa, Yobe and Borno States and 2) as a pass-through funding mechanism to support Review and Resupply (R&R) cluster meetings of LGA coordinators to ensure LMD of contraceptive commodities. It also supported PPFN to introduce Sayana Press in FCT, Benue and Kaduna through training of CHEWs and community mobilizers.
Marie Stopes International of Nigeria (MSIoN)	MSIoN collaborates with UNFPA on the training of 3,000 public sector providers on LARCs (IUDs and implants). Activities included the development of standardized training manual which has been adapted by the Federal Government, clinical and counselling skills training and mentoring and supervisory follow-up.
John Snow Inc. (JSI)	JSI provides technical assistance to UNFPA on logistics and in conducting the annual facility survey. UNFPA also supported JSI to conduct an assessment of the two different LMD systems in four states – R&R and Direct Delivery Information Capture approaches to inform future RHCS strategy.
Education as Vaccine Initiative (EVA)	EVA uses child and youth friendly approaches to strengthen the capacities of children, young people and other stakeholders to facilitate and sustain social change in the area of health, protection and education. UNFPA has supported EVA to improve access to SRH services by adolescents in Benue, Cross River and FCT. Training was provided for peer educators (25 per each of the three states where EVA works) as well as for healthcare providers in youth-friendly services (20 per state).
Nursing and Midwifery Council of Nigeria	UNFPA supported the Council to develop six modules for the Mandatory Continuing Professional Development Programme, a prerequisite for maintaining a license, training of trainers (2 from each of the 36 states), and materials (including anatomic models) for training on LARCs at 80 midwifery schools.

In terms of commodity support, UNFPA Supplies accounts for an estimated 70 percent of all family planning supplies shipped to Nigeria, with the remainder supplied by USAID. Most of that support is provided for public sector programmes (including those implemented by NGOs such as PPFN and MSIoN. USAID supports mainly the private sector as well as public sector activities in six states not covered by UNFPA.

[28] The information in table 3 is compiled from three sources: interviews with staff of the implementing partners; annual reports of UNFPA Supplies; and monitoring reports by the implementing partners.

3 CASE STUDY FINDINGS

The documented evidence for the findings reported in this section can be found in detail in the Evaluation Matrix (Annex 1).

3.1 The enabling environment for RHCS and family planning

Since 2012, considerable progress has been made in strengthening the family planning and reproductive health commodity services enabling environment as a result of more prominent support from the Government of Nigeria in the wake of the London Summit. With coordinated support from UNFPA and others, the National family planning Blueprint and state-level Costed implementation plans in some states (including Kaduna and Lagos) guide family planning priorities, including actions for strengthening the supply chain. UNFPA is regarded by stakeholders as a key player in supporting the enabling environment for reproductive health and commodity security at national level through its programme of technical assistance to the Federal Ministry of health and at state level, where it has focused its programme efforts.

For details of the evidence supporting findings in Section 4.1 see Annex 1: Assumptions 1.1, 1.2, and 1.3

3.1.1 UNFPA Supplies and the enabling environment

UNFPA plays an important role in Nigeria in supporting the FMoH to develop national plans, priorities and strategies for moving family planning, and in particular RHCS, forward. It is considered by stakeholders as the partner with the most leverage and influence with health officials, due to its role in procuring 100 percent of the contraceptive commodities for the public sector programme (and 70 percent of all contraceptive commodities procured). UNFPA was instrumental in catalysing the GoN commitment to FP2020 in 2012, and thereby revitalizing family planning efforts after many years of political neglect.

In particular, UNFPA has contributed to a positive policy environment for family planning. Prior to 2013 UNFPA supported the development of key national policies including the Free Contraceptive Commodity Policy in 2011, which abolished user fees; the Nigeria RHCS Strategy 2011-2015; and the Task Shifting policy in 2012, allowing the provision of IUDs and implants by CHEWs. Since 2013, UNFPA has contributed to the development of the following strategies and plans to support the expansion of family planning access to commodities and services:

- The National Family Planning Blueprint or CIP in 2014
- Updated GoN FP2020 commitment in 2017, with plans to update the National Family Planning Blueprint to align with revised goals and priorities
- State level CIPs in Kaduna, Lagos and Cross Rivers, including situational analysis based on analysis of NDHS 2013 data to inform the Kaduna and Lagos CIPs
- National LARC Strategy and Implementation Plan 2013-2015 linked to RHCS supply, commodities and demand
- National Family Planning Communication Plan (Green Dot) launched in 2017, to brand PHCs as trusted providers of quality family planning services
- Midwife Service Scheme, including pre-service curriculum reform and certification of midwives in family planning and LARCs.

One of the major contributions made by UNFPA Supplies was the initiation of a pooled basket of funds to support the financing of contraceptive commodities for public health facilities. The basket fund was necessitated by the Free Contraceptive Commodity Policy in 2011; prior to this, local

financing for commodities came from a drug revolving fund supported by user fees. UNFPA coordinated the establishment of the fund and supported advocacy efforts, including a review of GoN resource flows for population activities that resulted in counterpart contribution from the Government of approximately 3 million USD annually. It is estimated that approximately 75 percent of the total pledged from the Federal Government counterpart cash contribution was released between 2011 and 2016. And while UNFPA advocacy has mainly focused at national level for funding commodities through the basket, more work is needed to advocate for sub-national financing for programme costs related to training, supervision, and LMD to ensure commodities are used in service delivery.

UNFPA plays an important coordination role (Section 3.6.1) for family planning through its technical support to the FMoH in implementing its leadership of the overall programme within the public and private sectors. When asked about efforts to promote a total market approach in Nigeria, stakeholders, including UNFPA Nigeria, lacked consensus about what this means as a strategy for market shaping.

3.1.2 Implementation hindered by diversity of "36+1" States (commitment, financing, cultural, political, etc.)

UNFPA appropriately focuses on creating an enabling environment at the national level as a necessary pre-condition for supporting appropriate actions at sub-national levels. In Nigeria, however, the devolving of policies and strategies for any programme is a complex and daunting undertaking, given the country's size and diversity. This is even more so for family planning which is dependent on cultural and political acceptability among stakeholders at the policy, service delivery, community, and individual levels. The implementation of health policies requires political support from state governors; likewise, LGAs (n=774) are responsible for managing the primary health care system. With many states the size of other West African countries, there is a structural challenge to rolling out and supporting adoption and adaptation of policies in 36 semi-autonomous states.

Parental consent is an example of the challenge regarding "domestication" of policies from national to local levels. Interviews with many stakeholders at the policy and service level indicated that providers continue to discourage young people from accessing services, in part due to a misunderstanding of parental consent policies. Many facilities leave to the discretion of the individual service provider the decision of which contraceptive methods can be provided without parental consent (most often condoms and pills but sometimes injectables) resulting in barriers to access.

Despite the challenges related to scaling up the implementation of federal policies into practice at the state level, UNFPA Nigeria nevertheless receives high marks from other implementing partners for maintaining strong relationships with SMoH officials, and many look to UNFPA to increase its efforts to leverage its influence to support positive change in the policy and programme environment.

3.2 Increasing demand for reproductive health commodities and services

UNFPA Supplies has contributed to demand creation efforts, especially at policy level, and through its work to engage religious and traditional leaders on benefits of family planning and with partners working at community level. Intensive, well-resourced and evidence-based demand interventions (coordinated with improved supply), have proven successful, yet coverage is limited to select urban areas. Achieving the FP2020 goal will require consistent investment and action in demand creation by other partners with expertise and resources not available from UNFPA Supplies.

For details of the evidence supporting findings in Section 4.2 see Annex 1: Assumptions 2.1, 2.2, 2.3.

3.2.1 Importance of demand in advancing Nigeria Family Planning Blueprint

Demand generation is a priority issue in Nigeria given the slow progress in mCPR growth as measured in the period leading to the Nigeria Demographic and Health Survey in 2013. Current levels of demand are low, given that the mean ideal number of children in Nigeria is very high at 6.5. These levels vary by state, e.g., in Kaduna and Lagos States the ideal number of children is 4.1. Nevertheless, low latent demand in many states will inhibit progress. Demand creation was highlighted in the 2014 National Family Planning Blueprint as an essential component for accelerating progress towards achieving the FP2020 goal.

Desk reviews conducted by the FMoH with UNFPA support indicate that the key demand-related barriers to acceptance and use of family planning in Nigeria relate to fertility; method-related side effects; myths and misconceptions; resistance and opposition due to socio-cultural, religious and spousal objections; and, poor treatment by unfriendly health care providers. Formative research conducted for the BMGF-funded NURHI project in several states (including states visited during this evaluation) identified key challenges which need to be addressed in order to strengthen demand efforts; among them: fear of family planning methods persists and decisions remain in the control of husbands even though women carry the burden for lack of access to contraception. They also identified possible issues to inform strategies, such as education is considered a key benefit for family planning promotion and provider advice is important as choosing family planning is seen as a medicalized decision.

Concerted effort and coordination is required regarding demand creation, even if UNFPA Supplies no longer supports demand activities by design. UNFPA Nigeria understands this, and is prepared to undertake resource mobilisation from other donors to enable it to contribute to meeting this need. For example, Canadian funding has supported adolescent programming in Kaduna, in an effort to "make up" for the discontinuation of funding for demand under UNFPA Supplies. Nevertheless, interviews with implementing partner agencies identified the need for better coordination of demand activities, in order to take advantage of the different techniques employed by the various partners. For example, in Kaduna State NURHI covers mass media for family planning; however, implementing partners noted that there is lack of clarity about which facilities are covered by which partners, including what techniques are used for demand creation at community level especially in rural areas not covered by NURHI. Demand creation for male involvement is also seen as a challenge, IPs indicate there is a role for UNFPA to play in coordinating a stronger response for addressing constructive male involvement in family planning.

3.2.2 UNFPA Supplies support for demand creation in policy and advocacy

UNFPA Supplies has addressed demand mainly at the policy level, as part of its role to support the FMoH to coordinate overall family planning priorities and programme strategies. Under the GRPHCS programme, UNFPA supported the development of the RHCS Strategic Plan, which included demand creation priorities that were followed through during the period under evaluation. Aligned with this strategy, UNFPA Supplies supported the training of state health educators on effective demand creation (2013); commissioned the aforementioned desk review on barriers to contraceptive uptake (2014); trained family planning government and development partners on the Communication for Behavioural Impact (COMBI) approach (2014); and assisted the FMoH in developing the Family Planning Communication Plan for 2017-2020, which includes a new family planning logo and brand (ongoing). The new brand, *The Green Dot,* will be displayed at public and private facilities, and will connote quality services with the tagline: *"Safe and Trusted."*

Figure 7: Green Dot logo for Family Planning Communication Plan, 2017-2020

In addition, UNFPA supported partners in family planning sensitization activities, for example, TV dramas, billboards, community engagement, and promotion in conjunction with outreach services. A major focus of these activities was targeting youth. UNFPA developed a campaign to promote condom use among youth aged 15-24, with the hash tag *#NoHoodieNoHoney*, which reached over 9,300 youth on social media and 5,000 youth through interpersonal communication. UNFPA Supplies also supported an NGO implementing partner, Education as Vaccine (EVA), to improve adolescents' access to sexual and reproductive health (SRH) services in Benue, Cross River, and FCT through peer education, community mobilization and training of providers in youth-friendly services. (See Section 3.4.2 for information on EVA efforts in service delivery access aligned to demand creation.)

UNFPA tailors its demand strategies to the context. For example, in Northern states of Kebbe and Sokoto, UNFPA employs a "whole of society" approach in addressing SRHR, including access to contraception, which integrates efforts to advance gender equality, female education and empowerment, and an end to early marriage. Interviews with UNFPA suggest that barriers to family planning are being reduced by engaging with a broad range of partners, including traditional leaders. However, with respect to its position in the demand creation arena, UNFPA considers that it is not a major player, but instead conducts limited activities linked to outreach services and during global observances, such as safe motherhood week.

3.2.3 Changing norms to support demand for family planning and to sustain contraceptive use

There are signs that demand is increasing in geographic areas where efforts to promote family planning demand have been closely tied to provision of service delivery. Endline findings from the NURHI project in Kaduna include a significant increase in mCPR, particularly from the use of implants. The NURHI strategy sought to develop "consumer first" interventions for creating demand and sustaining use of contraceptives among marginalized urban populations using an evidence-based approach. The strategy aimed to prove that significant investment in demand, based on formative research, can drive supply, and eventually result in family planning becoming a social norm so that products and services are supported by a sustained and healthy level of demand. This research implies that moving the needle on demand in a significant way requires a concerted high level of investment which is not possible using UNFPA Supplies support, given the 2016 programme decision to eliminate demand creation as a programme output.

3.3 Improved efficiency of procurement – forecasting and quantification

At national level, UNFPA Supplies, with other donors and implementing partners, has contributed to improved forecasting and quantification of commodity needs and coordination of resources. The creation of a commodity basket has supported improved and consistent availability of contraceptives, including long-acting, reversible contraception, since 2012. There remain continuing challenges and bottlenecks, given parallel supply chain systems and logistic management information systems across different programmes and states.

For details of the evidence supporting findings in Section 4.3 see Annex 1: Assumptions 3.1, and 3.3

3.3.1 Access to adequate funding to meet the need for RH/FP commodities

To be effective, UNFPA Supplies needs to be able to access the funding necessary to procure the RH/FP commodities required in focus countries.[29] In Nigeria, UNFPA procures **family planning** commodities using funds from the basket fund set up in 2012 to procure family planning commodities with donations from DFID, UNFPA, BMGF and the GoN. USAID does not contribute directly to the basket fund but provides commodities for the activities it supports in six states (these commodities go directly in to the CCW.) As noted in Section 3.1.1, UNFPA advocacy resulted in improved coordination and commitment to fund RH/FP commodities through the creation of the basket fund, leading to increased and consistent availability of contraceptive methods. The process of establishing the basket fund raised the profile of commodity security as an important issue for national focus and resulted in the GoN committing resources. However, the challenge is that the Government does not release the funds, resulting in delays. Recently, USAID provided 6.4 million USD in commodities to bridge the gap arising from the failure of the GoN to fund its commitment.

Stakeholders consider UNFPA procurement an essential contribution to the family planning programme in Nigeria: without it, there would be no programme. Over the period 2013 to 2016, UNFPA Supplies procured 26.6 million USD in commodities and equipment. Contraceptives made up 86.1 percent of the cost of items procured, followed by 10.3 percent for other pharmaceuticals, medical kits, and equipment. The remaining percentage accounted for educational materials and shipping/courier costs. The amount of funds fluctuated from year to year, with the largest amount spent in 2015 at 9 million USD (compared to 6.6 million in 2013, 4.9 million in 2014 and 6 million in 2016). When funds were at their peak in 2015, procurement included 3.8 million USD to procure implants and 2.9 million for injectables in line with efforts to expand access to these methods (Section 3.4.1). Assuming the trend towards increased demand for family planning will continue, the total allocation for procurement in 2016 at 6 million USD is not enough to cover the level purchased for just injectables and implants in future years. Efforts to support resource mobilization locally will become even more important in responding to increased demand.

3.3.2 Quantification has improved; methods vary with different donor-driven systems

The Family Health Department of the FMoH is responsible for annual quantification and forecasting of contraceptive commodities, with the technical assistance and support of UNFPA in close coordination with USAID and its implementing partner for commodity security, the GHSC-PSM project (previously managed by JSI and now implemented by Chemonics). The process is done through annual stakeholder meetings where contraceptive needs are estimated, resources compared with needs, and gaps identified to be addressed by FMoH and UNFPA. The process is mainly for public health facilities; however, INGOs are part of the process to ensure that their

[29] UNFPA, *Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2016): Inception Report.* September, 2017. p.37.

community intervention/outreach needs for activities conducted in coordination with the public sector are taken into consideration.

Interviews with stakeholders indicate that there has been an improvement in quantification and forecasting for public sector facilities as a result of the "R&R model" of distribution supported by UNFPA in 30 states since 2013. (The remaining states are supported by USAID which utilizes the Direct Delivery Information Capture (DDIC) model, an informed push system which collects consumption data at time of commodity distribution.) This R&R model supports hands-on review of consumption and needs at the SDP level during periodic LGA cluster meetings (for more detail see Section 3.5.1) with the State Family Planning Coordinator and monitoring and evaluation officer. It helps determine what volumes will be required and guides the development of more accurate forecasts at LGA and state levels. UNFPA facilitated the deployment of CHANNEL Software in 9 states (Lagos, Ondo, Ogun, Kaduna, Kebbi, Sokoto, Gombe, Benue, Adamawa and FCT) as well as the CCW to ensure logistics data capture of contraceptive commodities from 2012 to 2017. In addition, UNFPA supported FMoH to document logistics data from the states using the Request Issue and Report Form (RIRF) database.

3.3.3 Logistics Management Information Systems in flux

Both the R&R and DDIC systems will be phased out once the integration of the national supply chain becomes operational. Even with the hands-on support through R&R meetings, there are continued capacity issues that relate to poor understanding of LMIS, leading to quantification and ordering problems at state level. Efforts will be needed to ensure that ground is not lost when the DDIC and R&R methods systems are replaced.

At present, there is no nationwide end-to-end visibility although the NSCIP is expected to provide more visibility across the system. There are plans for an integrated LMIS to be based on Navision, a platform introduced by UNICEF and currently in use by the National Primary Health Care Development Agency for the vaccines programme and compatible with DHIS so as to enable synchronization of LMIS and HMIS data. CHANNEL will be phased out when this becomes operational (for more details refer to Section 3.5.4).

3.4 Improving access for poor and marginalized women and girls

UNFPA Supplies and partners have successfully increased access to commodities and services, especially in areas where there have been major programme investments, i.e., Kaduna. Family planning is being "mainstreamed" through public and private networks, with commodity supply keeping pace. Major investment in long-acting reversible contraception has broadened the method mix and improved choice. While there is no explicit defined strategy for reaching marginalized populations, UNFPA Supplies supports programmes for vulnerable youth and those displaced by the Boko Haram insurgency in Borno.

For details of the evidence supporting findings in Section 4.2 see Annex 1: Assumptions 4.1, and 4.2

3.4.1 Improving family planning service access and capacity, especially for long-acting reversible contraception

The 2014 Family Planning Blueprint identified several key priorities in service delivery, including to build the capacity of providers and training institutions and support delivery of high-quality family planning services, especially at the PHC level. Aligned with this priority, UNFPA Supplies engaged in a range of partnerships to support the scale-up of health worker capacity to provide injectables and LARCs, and to reach rural and underserved populations. This included working with MSIoN to support the implementation of the National LARC Training Plan through the development of a

standardized, competency-based LARC Training Curriculum which included both clinical and counselling skills, and used it to train master trainers and conduct in-service training of staff in over 800 health facilities in 12 states and the FCT. The training focused on the importance of good client-provider interaction and high-quality screening and counselling and included supervision and mentoring to trainees to further support skills development. UNFPA also supported the FMoH to update the National RH/FP Clinical Protocol, based on the updated WHO Medical Eligibility Criteria in 2015. Although competency-based protocols exist at the national level, states do not support adequate levels of training to ensure capacity at all appropriate SDPs.

To address sustainability of training efforts, UNFPA also worked with the Nursing and Midwifery Council of Nigeria in 2012, and supported 12 teaching institutions to upgrade capacity for pre-service education. UNFPA assisted with the launch of a re-certification process which included family planning training, including LARCs, with technical support and supervision from MSIoN. Midwives must be recertified every three years by selecting from a choice of six mandatory modules. UNFPA helped to develop the modules on family planning as well as Emergency Obstetric and Neonatal Care (EmONC), Elimination of Mother to Child Transmission of HIV/AIDS (EMTCT), Rape, and effective treatment of Postpartum Haemorrhage (PPH).

Further, UNFPA Supplies supported partners PPFN and ARFH to train CHEWs in injectables, including the piloting of *Sayana Press* (Subcutaneous Depo or DMPA-SC), a new, lower-dose, easy-to-use injectable contraceptive that is administered every three months under the skin rather than in the muscle. PPFN reported that in the states supported by UNFPA to train CHEWs (FCT, Benue and Kaduna), most of those receiving the *Sayana Press* were new users, and had not used *Depo-Provera* previously. The task shifting policy approved in 2015 allows for CHEWs to insert IUDs and implants; and documentation indicates that pilots conducted by CHAI and MSI with FP2020 funding have been successful. However, stakeholder interviews suggest that while initial training may be possible, there are operational issues since this must be done in the presence of a trained midwife. In addition, supervisory systems are not well resourced at the state and LGA level, indicating that on-going monitoring may be difficult to ensure quality.

3.4.2 Targeting marginalized women and girls (adolescents and IDPs)

In countries like Nigeria, with slow mCPR annual rates of growth, efforts are needed to normalize family planning to establish it as an acceptable health service for women and families, while also strengthening the health system to provide quality family planning services and reduce barriers. Strategies to address equity among different sub-groups are generally introduced once family planning has been established as a legitimate health service. Within the UNFPA Nigeria CO, there was not a well-defined or shared agreement about which groups were considered “marginalized.” Nevertheless, UNFPA has undertaken important efforts to reach marginalized youth, as well as to address the needs of IDPs as a result of the conflict in the North from the Boko Haram insurgency. Regarding the latter, the UNFPA Supplies response in the Northeast included routine distribution and resupply of commodities to facilities where feasible. It also included partnering with PPFN to provide RH services in IDP camps where facilities were destroyed, as well as outreach services where facilities still existed in Adamawa, Yobe and Borno States.

The UNFPA Nigeria Country Programme includes the establishment of Youth Friendly Centres as a priority activity to support the development of life skills among male and female youth. UNFPA partners with EVA Initiative to improve adolescent access to SRH services in Benue, Cross River, and FCT through the training of peer educators (25 per state) and providers in youth-friendly services (YFS) (20 per state). Capacity building in YFS was based on formative research with young people which revealed some of the challenges associated with accessing with family planning services, i.e., confidentiality and apprehension dealing with older providers.

In Lagos, UNFPA supported the establishment of several YFS centres. One, on the grounds of the PHC Sango, sees approximately 77 to 100 youth every day and provides life skills training (including exploration of gender norms), RH counselling, and family planning referrals. Another centre, Okwu-Awo YFC, was located adjacent to a large slum on Lagos Island to support easy access to its activities and services for marginalized youth, including unmarried teen mothers. Services include pregnancy testing, ante natal care (ANC), malaria testing, HIV/AIDS testing, and referrals for sexual violence. In Kaduna, UNFPA appropriately pursued a different youth strategy given the young age of marriage and childbearing. UNFPA supported a programme to integrate adolescent SRH content within the educational curriculum, which included additional components related to community engagement, mentors' clubs and reduced school fees, resulting in a reported increase in the number of girls who enrolled and were retained in school.

While youth-focused activities observed in both states were appropriate, it is not clear whether and how they can be scaled either within the states or nationally. Moreover, observations at PHCs in both states indicate that there is a need to undertake efforts to reduce biases of healthcare providers regarding contraceptive service provision to unmarried women.

3.4.3 Applying elements of a human-rights based approach

UNFPA promotes human rights-based approach in its programming, as evidenced by the joint implementation guide developed with WHO.[30] UNFPA Supplies in Nigeria programmes in several key areas outlined in the implementation guide, such as promoting availability and access, including in humanitarian context, and addressing non-discrimination to remove barriers to achieve access for all. The annual GPRHCS/UNFPA Supplies facilities surveys include an exit interview of clients in a sample of health facilities providing contraceptive service delivery. The categories of responses relate to the elements of a rights-based approach that are critical to service delivery, such as informed choice, autonomy, (limited aspects of) quality, privacy, and non-discrimination ("courtesy and respect"). However, there are several other principles that constitute rights-based family planning, such as participation and accountability; these have not been explicitly assessed or addressed by UNFPA in service delivery activities.

Table 6 illustrates the results of surveys carried out in 2014 and 2015.

Table 6: GPRHCS/UNFPA Supplies Facilities Survey Exit Interview Responses

GPRHCS/UNFPA Supplies Survey Findings on Exit Interviews: Nigeria (primary, secondary and tertiary; public and private)		
	2014	**2015**
Provided with the method of their choice	93.5	96.6
Provider took clients preferences and wishes into consideration	94.5	95.7
Client taught how to use the method	93.9	97.0
Client told about common side effects of the method	91.8	95.1
Provider informed client about what can be done re: side effects	90.4	94.2
Provider informed client what to do in case of serious complications	86.7	92.1
Client given date to return to the SDP for check-up and/or supplies	91.4	92.8
Client satisfied with cleanliness of health facility	88.1	93.6
Client satisfied with privacy of exam room	89.8	94.0

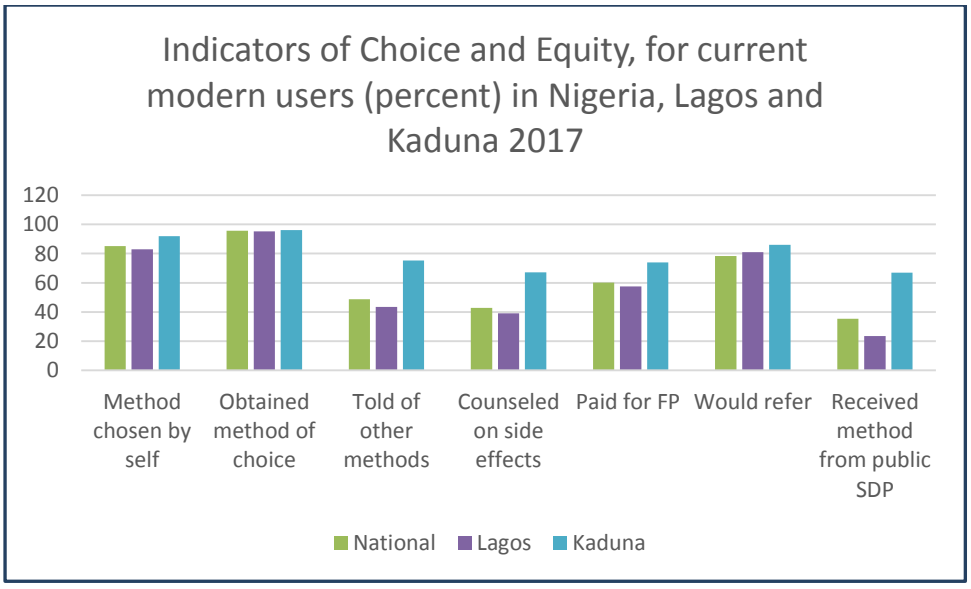
[30] UNFPA and World Health Organization, 2015. *Ensuring human rights within contraceptive service delivery: implementation guide.* Accessible at: http://apps.who.int/iris/bitstream/handle/10665/158866/9789241549103_eng.pdf

GPRHCS/UNFPA Supplies Survey Findings on Exit Interviews: Nigeria (primary, secondary and tertiary; public and private)		
Client indicated he/she was treated with courtesy and respect by staff	94.1	96.4
Client would recommend SDP to friends and relatives	n/a	97.0
Client responded no to "*forced to accept*" family planning method	**n/a**	**87.4**

For the most part, the exit interviews conducted during annual facilities surveys report a high level of satisfaction on the part of the women interviewed. Across nine of the ten questions concerned with different aspects of the quality of service, reported results are highly positive, in the two surveys where this information was available. With the exception of one (client given date to return to SDP) all questions where there are two data points show improvements from 2014 to 2015. The lowest percentage (87.4) is for "client responding no to 'not forced to accept' family planning method," although the definition is not clear regarding what constitutes coercion. In addition, the 2015 survey indicates that the percentage of those clients responding no was much lower in tertiary facilities (72 percent) meaning that almost 30 percent of clients felt they were forced to accept a method that was not their choice. It is not clear whether or how this information was followed-up or used to address potential rights issues.

Other datasets report somewhat lower levels of choice and satisfaction than seen in the UNFPA facility surveys (Figure 8). While women are getting their methods of choice, less than 50 percent were informed of other methods or counselled on side effects. Findings from Kaduna indicate that clients report higher quality experience with family planning, in part reflecting the programmatic attention by several donors and implementing partners over the past several years to expand access to quality contraceptive services in the state, including UNFPA. Contraceptive discontinuation, while lower than in some other countries, is significant in Nigeria, e.g., 23.1 percent for injectables and 9.1 for IUDs in 2013.[31] UNFPA has been encouraged by stakeholders to guide research priorities to ensure that client concerns and decisions related to discontinuation can be addressed.

Figure 8: PMA2020 Choice and equity Indicators for Nigeria (national), Lagos and Kaduna



[31] Data for discontinuation of implants is not available in NDHS 2013 as implant availability was limited at that time.

3.5 Strengthening systems and capacity for supply chain management

UNFPA Supplies has contributed to efforts to strengthen supply chain management for last mile distribution of family planning commodities in 30 states in Nigeria (the others are supported by USAID). Stock-outs have decreased overall from high levels in 2013; however, there is concern that gains are fragile as the national supply chain transitions towards integration, bringing together the currently fragmented systems for public health commodities. UNFPA has supported efforts by Nigerian Supply Chain Integration Project and others to build capacity for the integrated supply chain. While progress has been made towards integration, there is lack of buy-in and confusion due to limited efforts to communicate progress and develop sound strategies to transition from the current to the new, integrated system.

For details of the evidence supporting findings in Section 4.5 see Annex 1: Assumptions 5.1, and 5.2.

3.5.1 Efforts to strengthen supply chain management and last mile distribution of contraceptive commodities

Identifying areas of supply chain management needing support

Interviews with stakeholders indicate appreciation for the role UNFPA plays in providing critical information regarding RH/FP service delivery access issues, including those related to commodity security. The annual facility surveys supported by UNFPA provide important information on the prevalence of stock-outs at the primary, secondary and tertiary levels of the system, the availability of a range of contraceptive methods and life-saving maternal health/RH medicines, as well as the utilization of logistics forms, frequency of training in logistics management and supervisory visits. Information from the facility surveys support data for decision-making related to progress and challenges in family planning commodity and service delivery. Performance, Monitoring and Accountability (PMA)2020 annual population-based rapid surveys also include important information on stock-outs, method mix and client indicators related to choice, which provide additional data to triangulate with the UNFPA facility surveys to get a more complete picture in selected states (including Lagos and Kaduna).

UNFPA Supplies support to strengthening supply chain management

During the evaluation period 2013-2016, UNFPA has provided extensive support to strengthen systems related to RHCS, including mentoring FMoH staff on using tracking tools to monitor procurement and supply chain management (PSM) and state-level LMD of contraceptives to SDPs. As mentioned in Section 3.3, UNFPA Supplies has supported nine states with computers and other IT equipment to facilitate the deployment of CHANNEL Software to ensure logistics data capture of contraceptive commodities from 2012 to 2017. With the impending transition to an integrated supply chain, UNFPA also supported training for national- and state-level programme officers to build capacity for Logistics Management Coordination Units (LMCUs) tasked with implementing LMD under the integrated system. Stakeholders suggest that it is important for UNFPA to continue to strengthen supply chain management at state level, as LMCUs will require on-going support in a range of functions, including quantification, forecasting, warehousing, integrated LMD, reporting and data analysis.

Current challenges with last mile distribution

In Figure 8 the process steps for information flow and distribution of commodities are laid out for the Review and Resupply process for the LMD to public sector facilities supported by UNFPA in states (such as Kaduna and FCT) where family planning commodities have yet to be integrated within the work of NSCIP or in the six states where USAID supports the DDIC process. Process steps shaded in green and marked with green arrows on the chart represent flows of information. Process steps shaded in blue represent the actual shipment and delivery of RH/FP commodities.

There are some bottlenecks at each step of the supply chain cycle. These include:

a) *Quantification and estimation of demand and need* for the upcoming year which, though improved, is based on "issues" data (what was provided to the SDP) and not on actual consumption at the SDP and thus may over or under-estimate actual needs.

b) *Commodity procurement levels* are based on what is funded via the basket and may not match projected need.

c) *Customs clearance procedures* are lengthy and waivers take approximately five months to obtain. Change in the administration responsible (from Ministry of Finance to Ministry of Budget and Planning) resulted in additional delays due to capacity to manage the process, although this should improve with time.

d) *R&R meetings* to review data and distribute commodities occur less frequently than planned due to budget constraints, resulting in stock shortages or surpluses.

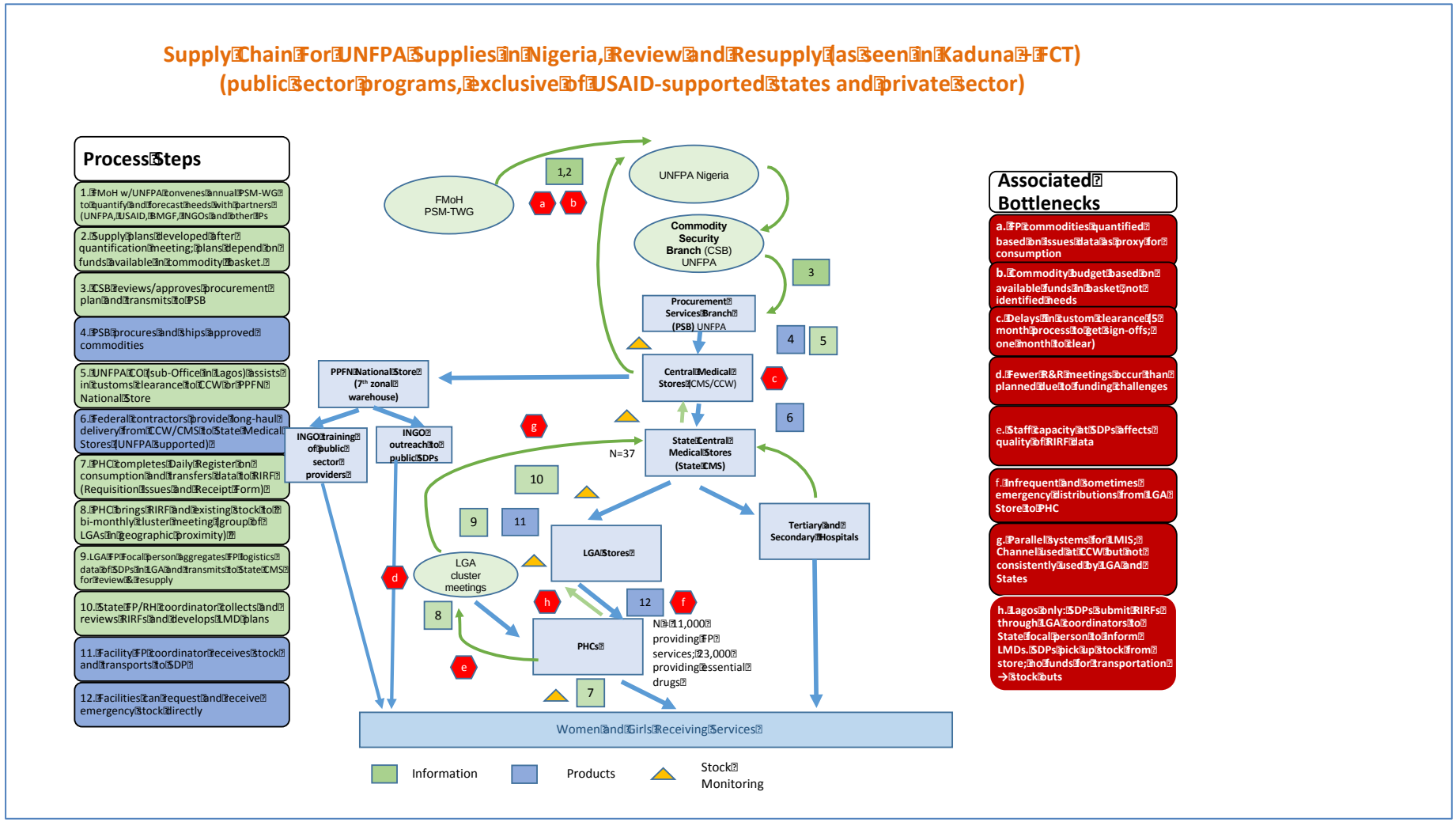
e) *Capacity of staff at SDP* affects quality of data on RIRFs.

f) Infrequent, intermittent and occasionally *emergency distributions* from the LGA to the PHCs due to lack of funds for fuel, drivers and other transport costs.

g) Inconsistent use of *CHANNEL* at LGA and SDP levels due to lack of capacity, infrequent technical assistance and management of computers.

These identified bottlenecks in the supply chain for RH/FP commodities arise from some key structural factors operating in Nigeria, such as the inability to operate a human resource intensive LMD process at scale given the lack of adequate human and financial resources to do so. The system requires a strong public health system with a supervisory structure in place to serve the large number of SDPs across several states and LGAs. UNFPA Supplies has contributed to improvement of LMD throughout this system, however, programme support was always meant to be a stop-gap measure and is neither intended to be, nor is it remotely, sustainable.

Figure 9: Supply Chain for UNFPA Supplies in Nigeria, Review and Resupply



3.5.2 Reduction of contraceptive commodity stock-outs

Data in table 7, taken from the annual GPRHC/UNFPA Supplies facilities survey (2013 to 2016), show an improved situation for stock-outs of modern methods of contraception between 2013 and 2016, although the situation slightly worsened between 2015 and 2016 for male and female condoms.

Table 7: Stock-outs of Modern Methods

Percent of Service delivery points reporting a stock-out of a modern contraceptive method on the day of the survey (2013-2016)				
Year	**2013**	**2014**	**2015**	**2016**
Male condoms	10.4	7.8	1.9	5.8
Female condoms	13.4	9.6	0.6	7.1
Oral contraceptives	5.2	4.4	7.8	2.9
Injectables	8.7	3.2	5.7	4.7
IUDS	5.7	5.2	6.2	5.0
Implants	10.4	5.1	6.5	4.5
Female sterilization	5.9	4.1	28.8	11.1
Male sterilization	10.0	5.3	46.7	11.5
Emergency Contraceptives	13.0	13.2	13.8	8.7

Source: GPRHCS/UNFPA Supplies Facilities Surveys: 2013 to 2016

The data show that the overall situation for stock-outs of modern methods of contraception was notably worse in 2013 than in 2016 or almost all commodities, with stakeholder interviews crediting UNFPA (and USAID) efforts to support LMD as the key factor in this turnaround. While interviews at facilities indicated stock-outs had decreased overall, group discussions with implementing partners suggested that stock-outs still occurred, mainly due to delays in distribution from higher levels (federal and state) rather than because of LMD from state levels to facilities. Stakeholders indicated concern that the coming transition to an integrated supply chain may negatively affect family planning commodities, especially once the R&R cluster meetings are phased out.

3.5.3 Logistics Management Information Systems

The supply chain for public health commodities is fragmented, as are the LMIS systems that support the chain for each type of commodity. The NSCIP is intending to address the unification of LMIS as part of the integration process (Section 3.5.4); although this will be a challenge given that each programme uses different reporting tools and systems as well as reporting frequencies. For family planning commodities, the LMIS systems currently used are CHANNEL for UNFPA-supported states and mSupply for USAID-supported states although these are now considered interim until the new system is in place.

UNFPA introduced CHANNEL in 2012 to improve the capture of inflow and outflow of commodities and data, including stock issuance data, stock expiry data, losses and adjustments and automated reports by health facility and by levels in the system. As noted earlier, UNFPA also supported capacity-building in the use of CHANNEL at the Central Warehouse and in nine states; however, it is a standalone system and not connected online which limits its ability to provide real-time updates. Moreover, UNFPA was unable to provide adequate levels of technical assistance to ensure its consistent use, and the team visited facilities where the capacity to use CHANNEL and/or the computers provided was limited. UNFPA Nigeria is supportive of Government efforts to transition to the Navision platform for the integrated supply chain rather than continuing to invest in CHANNEL, a more sustainable strategy in the long run.

3.5.4 Towards an integrated supply chain

In 2012, the Federal Department of Food and Drugs Services within the FMoH, established the NPSCMP to address the problems arising from the fragmented system across the five main public health programmes – RH/FP, HIV/AIDS, TB, Malaria and vaccines. Stakeholders spoke of well-known challenges in the current fragmented system including include financial and human resource limitations; uneven capacity for implementation across 36+1 states; and fragmented donor interest and competing priorities for FMoH.

The NSCIP, a three-year effort, was begun in 2015 with funding from the Global Fund, USAID and other partners, including UNFPA. The aim of NSCIP is to accelerate the integration of supply chains for the five public health programmes and build efforts in 14 "pilot" states for eventual national scale-up. Its vision is to improve access to commodities through an efficient and harmonized LMD system, with visibility at all levels (Federal, State, LGA and SDP) and for all commodities across donors/programmes, within both the public and private sectors. Commodities will be privately managed by 3PLs through a zonal arrangement of six axial warehouses which will bypass State warehouses and distribute directly to SDPs. NSCIP has established LMCUs in all 36+1 states and rollout to the LGAs has recently begun. LMCUs will assume responsibility for data collection from SDPs and will collate and review LMIS reports for submission to NPSCMP. A standalone tool is currently being used for data collection, with plans to step down its use to local LLMCUs at LGA level and to make it cloud-based to enable its concurrent use by multiple individuals. UNFPA supported the pilot of integrated LMD in Lagos, Ogun and Ondo States. It also supported a five-day training of trainers in integrated SCM. The State trainers are expected to conduct step-down training to LGA staff.

There is widespread recognition and a consensus in Nigeria regarding the need to move towards an integrated supply chain. At the same time, there is confusion about the current status of implementation and the extent to which progress has been made. Several stakeholders indicated that there was insufficient advocacy with states to ensure buy-in at the beginning, nor has there been adequate on-going communication. For example, a meeting of the national Health Council (comprised of State Health Commissioners) held during the evaluation team's visit proposed State rather than Zonal management of warehouses – a significant policy change. Exit strategies for the current LMD systems are not in place, leading to added confusion. In States and LGAs visited, there were varying interpretations of NSCIP progress, with some assuming it had failed as evidenced by the fact that the current R&R system was still in place. Supply chain experts in Nigeria noted that the project requires continued large-scale investment to ensure that capacity exists at all levels of the system to manage the integrated supply chain. They also noted that UNFPA is in a unique position to advocate for this given its important role in the programme.

3.6 Improved coordination and management

UNFPA Supplies has contributed to improved coordination of the overall family planning effort in Nigeria through the provision of technical support to the Federal Ministry of Health (and selected State Ministries of Health) to carry out their roles as conveners and organizers of reproductive health and family planning activities. As an active and engaged "focal point" for FP2020, UNFPA country office has contributed to the revitalization of technical working groups which has resulted in improved supplies forecasting and quantification.

For details of the evidence supporting findings in Section 4.6 see Annex 1: Assumptions 6.1 and 6.2.

3.6.1 Coordinating action in support of Family Planning in Nigeria

UNFPA Supplies has provided the CO with a robust platform which it has used to successfully advocate for revitalized commitment from the GoN for family planning in general and RHCS, in particular. UNFPA is active as a FP2020 "Focal Point" in close coordination with FMoH and USAID and has supported the FMoH to revitalize the RHCS Technical Working Group (RHCS-TWG) and Procurement and Supplies Management Technical Working Group (PSM-TWG). These TWGs are critical for coordinating the range of implementing partners engaged in family planning interventions across the 36+1 states. At the state level in Kaduna and Lagos, UNFPA also supports the respective SMoH to coordinate FP-TWGs.

The TWGs include the private sector partners that are critical to the family planning effort, and stakeholder interviews indicate that UNFPA has contributed to improved overall coordination of family planning by providing technical support to the FMoH to carry out its convening role. This has been purported to improve forecasting and quantification (Section 3.3.1) as well as to reduce duplication of programmatic activities undertaken by implementing partners.

3.6.2 Capacities of the UNFPA country office

Interviews with Federal and State officials, development partners and implementing partners indicate that the UNFPA CO was able to provide a high level of technical support through the UNFPA Supplies Programme. In particular, they noted that the CO provided strong technical and strategic support for family planning, as well as for the overall quantification and planning processes related to the supply chain. Partners have high expectations of UNFPA to address important issues related to government commitment and sustainability for family planning in Nigeria.

3.7 The catalytic role of UNFPA Supplies

Development partners consider UNFPA central to the reproductive health and family planning effort in Nigeria. In addition to procuring all the family planning commodities for the publics sector, UNFPA has appropriately leveraged its role and bilateral resources to strengthen both commitment and capacity to improve access to family planning commodities and services both at national and state level. However, the needs in Nigeria are well beyond what UNFPA Supplies can support, and recent gains are at risk without increased buy-in and commitment to address funding gaps at state level.

For details of the evidence supporting findings in Section 4.7 see Annex 1: Assumption 7.1

3.7.1 UNFPA Supplies as a key partner with FMoH in family planning programming

There is a general agreement among all key stakeholders interviewed in Nigeria that the UNFPA Supplies programme is essential to the operations of RH/FP services across the country. As already noted the programme is the major source of RH/FP commodities for the public health facilities and activities and supports efforts to ensure access to RH/FP commodities and services in 30 states. In the states where UNFPA has resources to undertake a broader programme focus, it has been critical in engaging State governments through advocacy and capacity-building for family planning efforts beyond commodity supply management, including but not limited to, youth and gender and expanding capacity for an expanded method mix. UNFPA Nigeria uses its convening power to hold annual Family Planning Stakeholders' Consultative meetings in 2013, 2014 and 2015 which led to significant resolutions and contributed to rallying support from sub-national government and other development partners. UNFPA has also leveraged its resources (and that of the bilateral DFID project, Access to Family Planning Commodities) to obtain the commitment of the GoN to the commodities basket (Section 3.1.1).

3.7.2 The challenge of sustainability

UNFPA recognizes that the gains made in the past several years to improve access to family planning commodities and services will be stalled by limited buy-in and funding gaps at the state level. UNFPA contributed to the development by the FMoH of a draft Sustainability Plan for the Family Planning Programme including incremental funding from Government at national and sub-national levels as well as innovative financing mechanisms. In addition, efforts were made to ensure family planning funding was included in the Global Financing Facility (GFF) Investment case for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). The Federal Government has renewed its agreement to continue to contribute to the Basket Fund for the period 2017-2020 (this is done every four years). It is expected that this will also encourage partners to renew commitment to the basket fund in the next four years. Continued advocacy is needed to ensure that commitments are realized and funds are actually released.

4 CONCLUSIONS

4.1 Strengths and Challenges

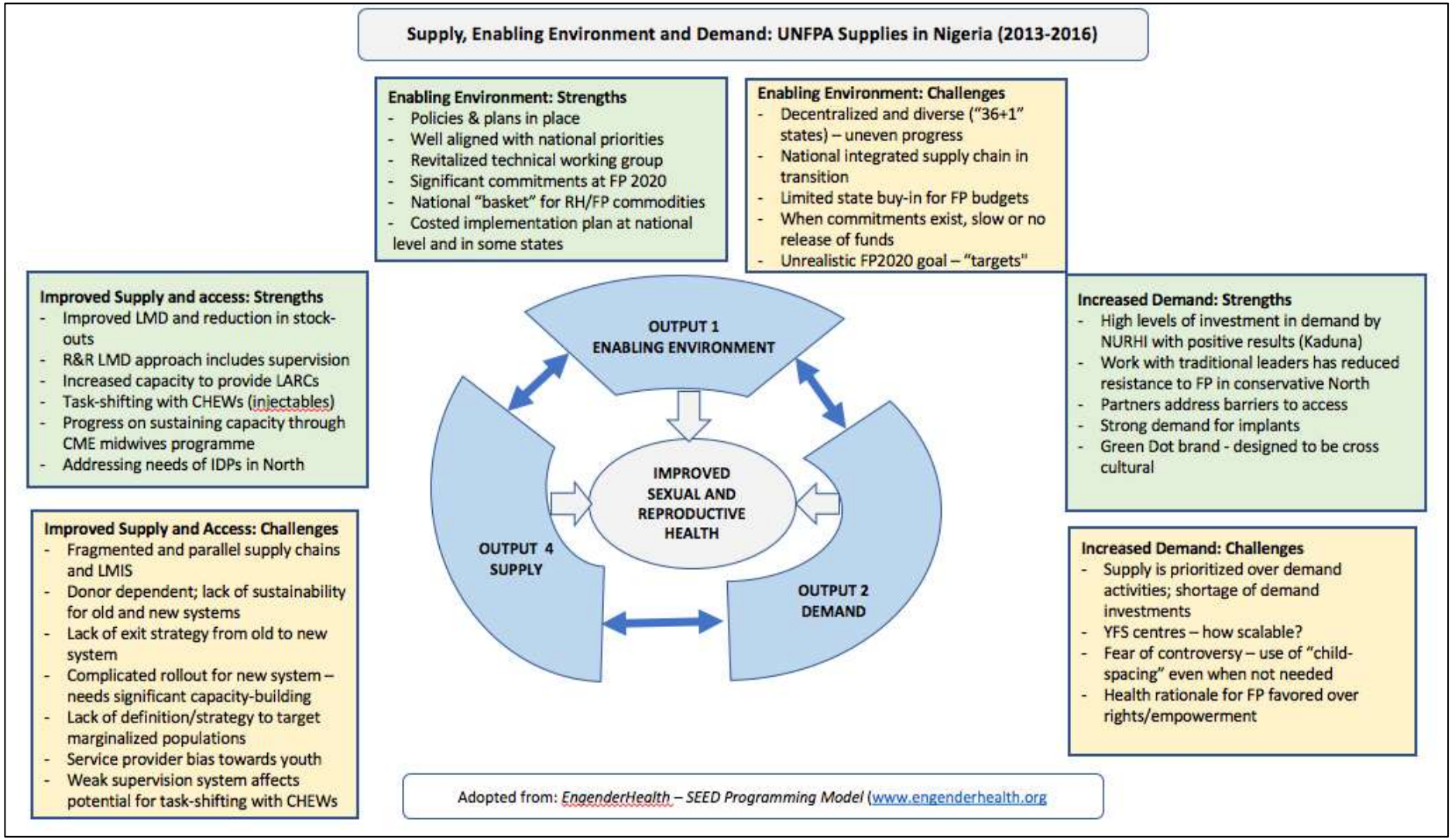
The conclusions presented here are based on findings reported in Section 3. The conclusions are intended to provide an overall summary of the contribution made by UNFPA Supplies in Nigeria from 2013 to 2016 and to point out some of the most important strategic choices facing the programme going forward. The ToC for UNFPA Supplies[32] (Annex 2) illustrates how the different activities supported by the programme (from 2013 to the end of 2016) can be organized under three inter-locking and inter-related outputs necessary to achieve the programme goals:

1. Improved **supply and availability** of reproductive health and family planning commodities and services (including improved access for poor and marginalized women and girls) contexts)
2. An **enabling environment** for reproductive health commodity security and family planning in Nigeria
3. **Increased demand** for reproductive health and family planning commodities by poor and marginalized women and girls.

These three outputs constitute the main components of the Supply, Enabling Environment and Demand (SEED) model of effective reproductive health and family planning programming first advanced by EngenderHealth.[33] Of course, it is not necessary for the UNFPA Supplies programme to address all three components of the SEED model in any one country. Other sources of both funds and technical expertise, whether from national or external sources, may well address one or more of the three components. Indeed, from 2017 onwards, increased demand is not a designated output of the programme. However, because all three outputs were included in the design and operation of UNFPA Supplies in Nigeria during the evaluation period, it is useful to examine the overall effectiveness of the programme through the lens of the three-component SEED model.
Figure 10 provides an overview of the strengths and challenges of the UNFPA Supplies Programme in Nigeria in relation to improved supply, a strengthened enabling environment and increased demand for RH/FP commodities and services.

[32] UNFPA, *Mid-Term Evaluation of UNFPA Supplies: Inception Report.* 2017, p.17.
[33] UNFPA, *Mid-Term Evaluation of UNFPA Supplies: Inception Report.* 2017, p.15. Original model accessible at:www.engenderhealth.org

Figure 10: Strengths and Challenges: UNFPA Supplies in Nigeria



The situation for RH/FP services and commodities in Nigeria at the end of 2016 and into 2017 indicates the continuing need for a strong UNFPA Supplies programme of support to the country. As figure 10 illustrates, the recent strengthening of demand for RH/FP commodities and services presents an important opportunity to solidify gains and accelerate progress towards national commitments and goals updated in 2017 under FP2020. However, there is an urgent need to "domesticate" the national commitment to family planning to States' level and to ensure that there is frequent communication and consultation with States about the status of NSCIP and planning for rollout. A one-size-fits-all strategy is not possible in Nigeria given the challenges of programme implementation across "36+1" states, with great cultural, geographic and socio-economic (including humanitarian) diversity.

A strategy which prioritizes advocacy for resource mobilization as well strong coordination and planning to ensure smooth implementation and transition from parallel to integrated systems is required to protect gains that have been made thus far.

4.2 Contributing to reproductive health and family planning (2013-2016)

1. UNFPA Supplies has been an essential component of RHCS and has been vital to the operations of family planning, in particular, coordination and strategy development in Nigeria from 2013 to 2016.
2. There is a strong framework of policies, strategies and national commitments in place to support a strengthened enabling environment in RH/FP programmes and services in Nigeria. The FMoH, with support from UNFPA Supplies and other partners, has increased its commitment to family planning in the wake of the 2012 London Summit, signifying a major turnaround from previous years.
3. UNFPA catalysed commitment and financing of the commodities "basket" by the Federal Government and other development partners, resulting in consistent availability of a range of contraceptive options at favourable terms. However, advocacy is still needed to ensure that funds committed by the Federal Government are released, and adequate budgeting and release of funds occurs at State level to cover RH/FP commodities and services.
4. UNFPA Supplies support for R&R cluster meetings contributed to improve LMD from 2013 to 2015, resulting in a reduction of stock-outs at PHC facilities. However, stock-outs increased in some areas in 2016 due to the transition to a new method of integrated distribution (see next point) and need for continued communication and capacity-building to support the change-over to the new system.
5. While there is strong consensus at Federal level among the GoN, donors and implementing partners regarding the need for an integrated supply chain, this is not consistently seen at the state and LGA levels. Lack of communication about the transition adds to confusion and lack of buy in, resulting in the need for increased attention and investment to address change management in order for the integrated system to be successful.
6. UNFPA Supplies has contributed to increased access to an expanded contraceptive method mix, including implants and *Sayana Press*, via its partnerships with private sector partners such as MSIoN, ARFH, PPFN and others. In addition, it has supported the development of sustainable service capacity through a continuing education programme for midwives' recertification which includes modules on family planning counselling and LARCs in collaboration with Nurse-Midwife Council of Nigeria (NMCN). However, while there are efforts underway to support task-shifting of LARC service provision to CHEWs, it is not clear that the health system is ready to support the supervision and mentoring by midwives needed to ensure quality of services.

7. UNFPA Supplies has contributed to demand activities at the policy and strategy level. Evidence-based demand activities are critical to advance contraceptive uptake in Nigeria; however, this requires a level of resources that is neither possible nor desirable under UNFPA Supplies, given the critical role it plays in ensuring commodity security. The UNFPA CO has a role to play in advocating for programming that addresses supply and demand components holistically, even if it is not responsible for direct implementation.
8. UNFPA Supplies has worked with NGO implementing partners to successfully target marginalized youth and to reach under-served populations, including internally displaced populations in the Northeast. However, its focus is to "mainstream" family planning as a norm, therefore, the main target population for UNFPA Supplies are women of reproductive age served by the public sector. Nevertheless, there remain barriers for unmarried youth to access contraceptive services as a result of provider biases. Furthermore, while there are components addressing some of the principles in a rights-based approach to family planning, a rights perspective is not fully or explicitly considered in assessing or designing family planning interventions. In particular, there is a lack of systematic attention to meaningful participation, quality of care, and supporting accountability mechanisms within service delivery. An opportunity exists for UNFPA leadership in this area, as there is a move to integrate rights-based family planning into the upcoming revision of the Costed Implementation Plan.

4.3 Strategic choices

9. The move to an integrated supply chain presents an opportunity for UNFPA to shift resources from supporting the R&R LMD system to advocacy and communication efforts to ensure a smooth transition, particularly in states where it has heavily invested.
10. The trend towards decreasing financial resources available to the global programme suggests that UNFPA Supplies in Nigeria will continue to face a challenge regarding the level of funding available it can commit to the basket for RH/FP commodities. This is especially true given the share of the method mix devoted to implants. The GoN has committed to providing 3 million USD/year over the next four years, yet it is also critical to work with state and local governments to secure complementary budgets for RH/FP service delivery. UNFPA has been especially effective in providing support to output one (the enabling environment for RHCS and family planning commodity security), and continued support is essential to address domestic resource mobilization in order to meet the family planning commitment.
11. UNFPA Supplies procurement of commodities is considered a linchpin for the family planning effort in Nigeria, both for what the programme allows in terms of access to family planning services but also for using its leverage to address strategic policy and programme issues with the GoN at federal and state levels. The 75/25 resource split (commodities/technical assistance) as determined by UNFPA Supplies globally seems appropriate in Nigeria, with the focus for the 25 percent prioritized for those activities that are best implemented by UNFPA given its relationship and role in supporting the government.

5 ANNEXES

5.1 Annex 1: Evaluation Matrix

An enabling environment for Reproductive Health Commodity Security and Family Planning	
Evaluation Question 1:	To what extent has UNFPA Supplies contributed to **creating and strengthening an enabling environment for RHCS/FP** at global, regional and national level?
Sub-Questions:	a) To what extent has UNFPA Supplies been effective in **engaging with global and regional partners to secure commitments and mobilize resources** in support of country needs in RHCS/FP? b) To what extent has UNFPA Supplies been effective in **advocating with national partners** so that RHCS and family planning are **integrated into** and **prioritized in national budgets, programmes, and health policies and strategies** (including guidelines, protocols and tools)? c) To what extent has UNFPA Supplies been effective in s**trengthening and participating in coordination mechanisms** at all levels to ensure support and programming aligns with **global and national strategies to expand access to RH/FP commodities and services**, especially (but not exclusively) for poor and marginalized women and girls and other new users? d) To what extent has UNFPA Supplies been effective in a**dvocating for and supporting a total market approach** strategy for marketing of family planning commodities and services?

Question 1: Key Assumptions and Observations	Sources of Evidence
Assumption 1.1: UNFPA Supplies **advocacy efforts** at global, regional and national level **are coordinated and aligned with national and global strategies** to **expand access to RH/FP services and commodities.**	
Supporting the development of national plans, priorities and strategies	
• UNFPA Nigeria plays a **key role** in supporting the enabling environment for RHCS at national level through its programme of technical assistance to FMoH in coordinating the national RH programme. It is considered • UNFPA and USAID provided technical assistance to FMoH to develop the **National RHCS Strategic Plan 2011-2015**, the framework guiding the implementation of the FP/RHCS programme in the last years. The Plan included coordination and monitoring activities as well as quantification/forecasting of contraceptives required for the Public Health.	• UNFPA Nigeria, *Joint Thematic Trust Funds Annual Progress Report*, 2015 p.7
• The FMoH leads the **RHCS Technical Working Group** (RHCS-TWG), the official coordinating body for RCHS, co-chaired by UNFPA with participation of a number of national level stakeholders working in the area of Family Planning. In 2015, the platform of the RHCS TWG continued to be the most important opportunity for monitoring family planning interventions in the 36 States + FCT including identification of gaps and resource mobilization.	• UNFPA Nigeria, *Joint Thematic Trust Funds Annual Progress Report*, 2015 p.7
• In 2015 UNFPA continued its technical assistance to improve **programme coordination and management** at national level. It supported the National Planning Commission (NPC), a federal government agency responsible for formulating and monitoring the implementation of national development plans as well as coordination and management of development cooperation.	• UNFPA Nigeria, *Joint Thematic Trust Funds Annual Progress Report*, 2015 p.17

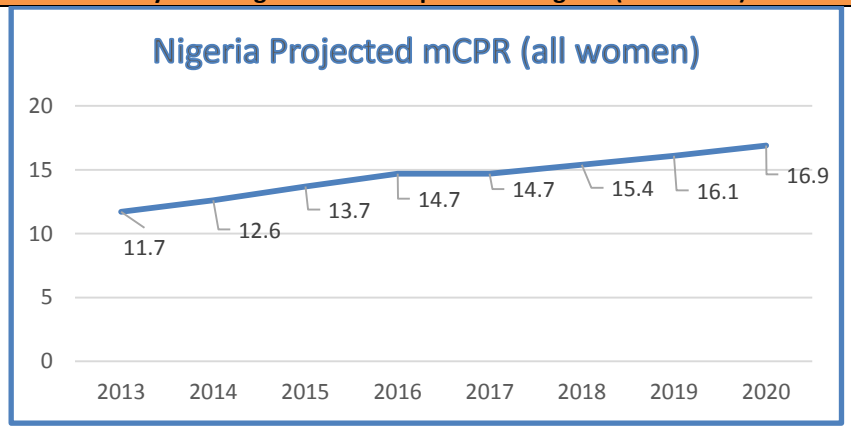
Question 1: Key Assumptions and Observations	Sources of Evidence
• UNFPA was a key supporter in the development of the **Family Planning Blue Print (2014**) to guide family planning programming in Nigeria from 2014 to 2018 (BMGF provided TA and funded the actual plan's development). The Family Planning Blue Print has been developed as a Costed Implementation Plan for the Family Planning Programme to meet the FP2020 goal of reaching 36 percent CPR by 2018 (now revised to 27 percent by 2020) and is the main strategic document for family planning programming.	• FMoH, *Nigeria Family Planning Blueprint (Scale-Up Plan,* 2015 • Interviews: FMoH officials and UNFPA CO staff, Abuja
• **Activities conducted by UNFPA** in Nigeria under the AFPC (and, by inference, UNFPA Supplies) is well-aligned with national health strategies and plans and is responsive to the national development context (which includes the on-going scale-up of PHC facilities to ensure that there is one functional centre per ward): ○ Free commodity policy (2011) abolishing user fees on family planning commodities at pubic health care centres, ○ Task shifting policy (2012) allowing for provision of IUCDs and implants by Community Health Extension Workers (CHEWs) ○ Midwife Service Scheme (2013) which reforms the curriculum and allows the provision of IUCDs and implants by midwives ○ National LARC Strategy and Implementation plan (2013-2015) linked to RHCS supply, commodities and demand components ○ Nigeria RHCS Strategy 2011-2015 ○ National Guidelines for Integration of Adolescent and Youth Friendly Services into Primary Health Care Facilities in Nigeria, 2013.	• Horstman, R. et al, *Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report,* 2017, p. 13-14
• UNFPA Nigeria **supported three states (Kaduna, Lagos and Cross Rivers) to "domesticate" the National Family Planning Blueprint**. The process included convening consultations with stakeholders as well as conducting situational analyses using existing data to inform the development of the Lagos and Kaduna State CIPs.	• Interviews: UNFPA Nigeria, Abuja, Lagos and Kaduna
• "The constructive partnership with other key players in the MNH and SRH field in the country has led to positive collaboration and complimentarily of support to target communities."	• UNFPA, *UNFPA Nigeria 6th Country Programme Evaluation, Final Report,* 2012, p. 55
The evolving institutional architecture for RH/FP Commodity Security in Nigeria	
• In 2014 the Government of the Federal Republic of Nigeria (GoN) through the **National Product Supply Chain Management Programme** (NPSCMP), a unit of the Food and Drugs Department of the Federal Ministry of Health (FMoH), in partnership with USAID, UNFPA, GF and other partners, established the National Supply Chain Integration Project (NSCIP) with the objective of improving **patient access to medicines** through enhanced visibility, control and efficient last mile delivery (LMD) of health commodities. This is to be achieved through the integration of national health commodities supply chain functions between federal, state, donor, public and private sector, as well as across public health programmes – HIV/AIDS, tuberculosis, malaria, reproductive health, vaccines, essential drugs (ATMRHV-Ed) and other health commodities - through the establishment of functional Logistics Management Coordinating Units (LMCUs) and the deployment of Logistics Management Information Systems (LMIS) across the 36 states and the Federal Capital Territory, Abuja.	• Interviews: NSCIP Head Office, Abuja; USAID, Abuja

Question 1: Key Assumptions and Observations	Sources of Evidence
• In 2015, two consultative meetings were convened by FMoH with financial and technical support from UNFPA to communicate progress and challenges on current distribution models as well as the need for the states to fund state distribution and to explore sustainable distribution options. Participants included NPHCDA, National Population Commission, State Directors of PHCs from 36 States + FCT, family planning Coordinators from 36 States + FCT as well as Development Partners – USAID, JSI/DELIVER, Pathfinder International, CHAI, Marie Stopes, PPFN, MSD, SFH, NURHI, JHPIEGO, McKinsey Group, Future Groups, PATHS 2, AXIOS Foundation, and ARFH. The meeting resulted in a consensus that the most **preferred distribution option is the Direct Delivery Information Capture System** (DDIC) which was piloted in Ebonyi, Sokoto and Bauchi States by USAID|DELIVER Programme in 2013-2014. Action plans were developed including interventions to bridge the issues of capacity gaps in states for set up of Logistics Management Coordination Units to supervise implementation of the integrated supply chain as well as resource mobilization efforts to fund the system through Government and Donor contributions.	• UNFPA Nigeria, *Joint Thematic Trust Funds Annual Progress Report*, 2015 p. 16
Assumption 1.2: Drawing on global, regional and national sources for financial support, **national health authorities have been able to achieve (and to varying degrees, sustain) increased budget allocations** and expenditures for RHCS/FP.	
• The political transition in the government has **negatively affected the release of the funds** for the family planning programme in the period before, during and after the elections (in 2015). As of the end of 2015, the Government had outstanding pledged funds totalling to 22.78 million USD for the period 2013 and 2015.	• UNFPA Nigeria, *Joint Thematic Trust Funds Annual Progress Report*, 2015 p.8
• In 2016, an analysis conducted for a DFID review of APFC indicated that of the 37 states, 15 had included RH/FP within their budgets. Yet, 8 had not yet released funding.	• Appleford, G. and Ibeh, C.C., *Access to Family Planning Commodities Programme in Nigeria, Narrative Report,* 2016, p.9
• **All major family planning donors contribute to a basket fund established in 2011** (DFID, UNFPA, BMGF and GoN) at the national level which is used to procure commodities. UNFPA procures the commodities on behalf of this group for public health facilities. Note that USAID does not contribute directly to the basket fund but funds the gap which goes directly in to the CCW. Recently procured about 6.4 million dollars' worth of family planning commodities because of insufficiency of funds from the Nigerian government. • SOML – Saving One Million Lives – World Bank does not contribute to the basket fund, but gives money to states for RBF. Each state receives 2 million USD • Domestic financing for family planning is 4 million USD due to UNFPA advocacy with GoN. • The basket is just **for commodities**.	• Interview: UNFPA CO Staff, Abuja and USAID Staff, Abuja

<table>
<tr><th>Question 1: Key Assumptions and Observations</th><th>Sources of Evidence</th></tr>
<tr><td>
Despite a large pool of donors, only UNFPA, DFID, Global Affairs Canada and CIFF have contributed to the basket for commodities from 2011 to 2016:
<table>
<tr><th>Source</th><th>Total released or disbursed (2011-2016) in USD 000s</th><th>Percent of total pledged (2011-2016</th></tr>
<tr><td>Federal Government Counterpart Cash Contribution</td><td>8.983</td><td>74.86</td></tr>
<tr><td>NPHCDA/SURE-P</td><td>16.7</td><td>11.2</td></tr>
<tr><td>UNFPA Supplies (commodities only)</td><td>22.387</td><td>124</td></tr>
<tr><td>RMNCH Grant (Life-saving commodities)</td><td>23.5</td><td>100</td></tr>
<tr><td>DFID (commodities)</td><td>23.5</td><td>100</td></tr>
<tr><td>Canadian DFATD (FP commodities)</td><td>4.8</td><td>95</td></tr>
<tr><td>CIFF (DMPA-sub-cutaneous)</td><td>.675</td><td>50</td></tr>
<tr><td>BMGF (commodities)</td><td>2.47</td><td>100</td></tr>
</table>
</td><td>Horstman, R. et al, Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report, 2017, p.32</td></tr>
<tr><td>In 2013, the CO had provided financial support to NPC to conduct the 2013 Resource Flow Survey (RFS) that generates data on resources utilised for "Population Activities" including Family planning services, basic reproductive/maternal/adolescent health services and basic research, data and population and development policy analysis.</td><td>UNFPA Nigeria, Joint Thematic Trust Funds Annual Progress Report, 2015 p.17</td></tr>
<tr><td>According to DFID, “the AFPC grant of £18 million and its precursor of £3 million given to the Nigerian Government through UNFPA for commodity procurement were the direct catalyst and advocacy tool that led to the commitment of the 3 million USD annually by the Federal Government of Nigeria (FGON) as both grants were premised on condition that Government provide monetary contribution. Previous efforts by the UNFPA had failed since 2003 when family planning services were reactivated. AFPC has therefore catalyzed FGON financial commitment to family planning as part of its FP2020 commitments.”</td><td>Appleford, G. and Ibeh, C.C., Access to Family Planning Commodities Programme in Nigeria, Narrative Report, 2016, p.4</td></tr>
<tr><td>UNFPA efforts at improving financing for commodities have mainly focused at federal level through the commodity basket fund. Sub-national level financing should be explored by UNFPA and partners. For example, with the planned Basic Health Care Provision Fund (BHCPF), states should be able to allocate for family planning commodities and services through state Primary Health Care Development Committees (PHCDCs), based on their forecasted need and demand creation plans.
The Global Financing Facility (GFF) presents an additional opportunity. Currently, it has planned a pilot in three states - Niger, Osun and Abia, with financing for the BHCPF of which 45 percent will be directed to the state PHCDAs for operations and commodities, including family planning. Another 50 percent of financing will be allocated to the National Health</td><td>Horstman, R. et al, Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report, 2017, p.32</td></tr>
</table>

Question 1: Key Assumptions and Observations	Sources of Evidence
Insurance Scheme (NHIS) to support the development of state social health insurance schemes, including case rates for packages of services (which may include family planning).	
• According to the UNFPA Nigeria SWOT analysis in 2015, **out of pocket expenditures rank highest at 70 percent of the total health expenditure**. • GFF is a window of opportunity for government to prioritize RMNCAH, which are core mandates of UNFPA. However, a major risk is the increasing security threat in Nigeria with its **attendant poor investment climate**. • UNFPA supported the government to lay the **groundwork for the inclusion of Reproductive Health funding in the national health account**; encouraged an approach to improve pro-poor access to RH services through the **Conditional Cash Transfer and Community Based Health Insurance**. UNFPA has assisted in the government efforts to improve human resources for health, pushed for **task shifting policy** and strengthened the **data management system** for tracking results and expenditures in health.	• UNFPA West and Central Africa Regional Office, 2015, *SWOT Analysis: UNFPA Family Planning Interventions in West and Central Africa 2013-2015 (Nigeria)*, p. 16-17
Assumption 1.3: • National **programmes, policies and strategies** (including guidelines, protocols and tools **prioritize improving access** to RH/FP services and commodities, including access **for poor and marginalized women and girls**.	
• See evidence under Assumptions 1.1 and 1.2 above.	
• The **portfolio of UNFPA Nigeria is a big and massive undertaking**. UNFPA works on LMD in 30 states. UNFPA is also conducting Federal level advocacy with Senators and aspires to setting a legislative framework to include family planning financing and a credit line for commodities.	• Interviews: UNFPA Nigeria, Abuja
Assumption 1.4: National authorities are receptive to a **total market approach strategy for RH/FP services and commodities** which encourages **increased participation by NGOs, civil society and the private sector** and potentially can contribute to **improved marketing and increased demand**.	
• There is a clear consensus about the importance of partnering with **private sector** and coordinating both private and public sector family planning activities. This seen as critical to the implementation of the costed implementation plan and overall to reaching FP2020 commitment for Nigeria. However, when asked about total market approaches, **there wasn't a well-articulated notion of what is meant by a total market approach** or whether/how it should be applied in Nigeria.	• Interviews: UNFPA Nigeria Abuja.
• Per Society for Family Health, a social marketing organization, **a total market approach is in place for condoms and emergency contraception**. With a grant from DFID, SFH enforced generic marketing and promoted condoms as dual protection. This effort reduced barriers in the market. There were over 200 brands of condoms in the market and market share for generics dropped. However, it has since stabilized. **For implants and IUDs, building up a brand is important** as methods are getting introduced. It is important to ensure that planning includes the private market, especially in Nigeria where the programme is donor dependent. There should be medium term and long term framing for planning. Donors broadly need to look at growing the private market in terms of branding, so the system does not crash if donors pull out.	• Interview: Society for Family Health, Abuja

Increased demand for RH commodities by poor and marginalized women and girls	
Evaluation Question 2:	To what extent has UNFPA Supplies **contributed to increasing demand for RH/FP commodities and services,** including demand by poor and marginalized women and girls in keeping with their needs and choices (including in humanitarian situations)?
Sub - Questions:	a) Has UNFPA Supplies **advocated effectively for policies and programmes to strengthen demand and address barriers to access** (including but not limited to harmful socio-cultural norms) while taking account of the needs of marginalized women and girls? b) Has UNFPA Supplies been effective in **supporting engagement by community leaders, service providers, adolescents and women to build demand and address barriers to access**? c) To what extent have policies and programmes supported by UNFPA Supplies contributed to **improving knowledge and attitudes, reducing barriers and improving the capacity** of women and girls **to demand services and exercise choice** in accessing RH/FP commodities in a range of settings? d) **From 2017**, with UNFPA Supplies **no longer providing direct support to increasing demand**, what processes and mechanisms have been/will be used to **ensure that improvements in supply complement and are coordinated with demand generation actions of partners**?

Question 2: Observations	Sources of Evidence
Assumption 2.1: UNFPA COs **advocate effectively for sustainable policies, programmes and investments addressing socio-cultural norms and other barriers** to improve **the knowledge and capacity of marginalized women and girls to demand access to RH/FP commodities**, including through community engagement and use of a total market approach.	
Overview of Family Planning Use and Acceptance in Nigeria (2013-2016)	
 Accessible at: http://www.familyplanning2020.org/entities/61	• Source: FP2020 – Track 20. Accessible at: http://www.familyplanning2020.org/entities/61

Question 2: Observations	Sources of Evidence
• The **GoN set a goal at the London Family Planning Summit in 2012 to reach 36 percent CPR by 2018**. According to Track20 project by Avenir Health, this growth would require an annual increase of 4.2 percent to reach the goal as compared to the current trend of .7 percent. • Ideal number of children is used as a proxy for latent demand. In Nigeria the mean ideal number of children is 6.5. Track20 estimates that at this level it is unlikely that mCPR (married) would go beyond 15 percent, well below the FP2020 goal. There is variation by state, however, in most areas low latent demand will limit future growth. • Ideal number of children in Kaduna = 4.1 (NDHS, 2013) • Ideal number of children in Lagos = 4.1 (NDHS, 2013)	
• For better understanding of the **persistent low CPR in Nigeria**, in 2012 the FMoH with support from UNFPA Nigeria conducted a desk review of studies on Barriers to utilization of Family Planning in Nigeria. The Bill and Melinda Gates Foundation (BMGF) also supported the FMoH to conduct a Landscape Exercise for the Nigeria Family Planning Programme to identify strengths and weaknesses with a view to recommending appropriate interventions for improvements. Based on the findings from the studies, the following were identified as the key barriers to acceptance and utilization of family planning services in Nigeria: ○ Fertility related barriers ○ Method related side effects ○ Myths and misconceptions ○ Opposition to women using Family Planning due to socio-cultural, religion and spousal objections. ○ Health systems barriers such as supply, unskilled and unfriendly health care providers • The studies once highlight the stagnant mCPR rate during the past 24 years and recommended urgent action **to pursue an aggressive Demand Creation strategy** and campaigns to reposition Family Planning and to increase utilization of Family Planning services.	• Source: FMoH, *National Family Planning Communication Plan (2017-2020),* p. 4.
• Based on the **Method Information** Index developed by Avenir Health for FP2020, only 47 percent of women using family planning nationally received: 1) information on other methods, 2) information about side effects, and 3) information about what to do in case of side effects. There is wide variation in the Method Information Index by state, with nearly all states exhibiting an **opportunity to improve the quality of services and counselling**. This ranges from a high of 90 percent in Ogun State and a low of 5 percent in Edo State. In the states visited by the evaluation team the index values are 75 percent for Kaduna and 37 percent for Lagos. Accessible at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/11/Nigeria-Subnational-Opportunities-Handout-2.pdf	• Source: FP2020 –Track20. *Exploring Subnational Opportunities in Family Planning Programming*
UNFPA Supplies Efforts to Improve National Strategies and Focus on Demand Creation	

Question 2: Observations	Sources of Evidence
• **Key areas of intervention supported by UNFPA CO** till date include: contribution to the development of RHCS Strategic Plan (2011-2015); training of state's health educators on effective demand creation on family planning (2013): commissioning and production of desk review on barriers to uptake of family planning in Nigeria (2014); training of family planning government and development partners on Communication for Behavioural Impact (COMBI) 2014; rebranding of the family planning logo and development of Family Planning Communication strategy for the FMOH (ongoing) and targeted family planning sensitization through partners (TV drama, billboards and community engagement). • The CO also developed #NOHOODIENOHONEY campaign specifically targeting adolescents to increase uptake of condoms use among adolescents aged 15-24. The campaign has reached over 9,300 (on YouTube), 639,981 (Twitter) and 5,000 adolescents through Inter-personal communication.	• UNFPA West and Central Africa Regional Office, 2015, *SWOT Analysis: UNFPA Family Planning Interventions in West and Central Africa 2013-2015 (Nigeria)*, p.9
• **Kaduna:** *"**NURHI is the major player in demand creation for family planning** in Kaduna, implementing continuous community engagement, media (TV, radio, print) campaigns and outreach activities. UNFPA does fringe demand creation activities during global observances such as safe motherhood week and during outreaches".*	• UNFPA CO, *Situational Analysis of Family Planning Programme in Kaduna,* PowerPoint Presentation, undated.
• **UNFPA's demand creation strategy** (through 2012) was based on provisions in National policies such as National Reproductive Health Policy (2010), Nigerian Reproductive Health Commodity Security (RHCS) Strategic Plan (2010-2015) and BCC Strategy for National Reproductive Health Policy and Framework (2005-2008). The strategy seeks to increase knowledge and awareness of modern family planning methods, how to access them, and their contribution to improved health and development outcomes. Given the regional disparities in cultural beliefs and practices, women's autonomy and decision making power, sector and educational levels, the strategy attempts to meet the needs of individuals who desire to delay childbearing, space childbirths and limit childbearing.	• UNFPA, *UNFPA Nigeria 6th Country Programme Evaluation, Final Report,* 2012, p.24
• UNFPA supported the FMoH to develop its **National Communication Plan for 2017-2020**. The plan is based on the COMBI strategy, a "*dynamic and proven approach that has been used in over 20 countries **to increase uptake of social and health services**. COMBI strategically blends a variety of communication interventions to engage individuals and families in considering recommended behaviour and to encourage the adoption and maintenance of that behaviour."* • There are three **main audiences for the plan**: 1. Primary audience: Community and individuals 2. Secondary audience: health service providers, CHEWs, pharmacists and Patent Medicine Vendors, etc. 3. Tertiary audience: political leaders and policy makers at all levels of the government	• Source: FMoH, *National Family Planning Communication Plan, 2017-2020),* p. 8, 10.
• UNFPA has supported the FMoH with the development of **The Green Dot Brand Guideline**, which is being introduced in late 2017 as the National family planning logo. The green dot will be displayed at public and private facilities to connote the availability of quality services. The green dot was chosen as logos tend to be	• FMoH, The Green Dot, Brand Guideline, September 2017, p. 8.

Question 2: Observations	Sources of Evidence
misinterpreted in diverse, multi-ethnic and religious societies such as Nigeria. *"It is simple, abstract in nature, easy to describe and recall; its simple colour represents the diversity and oneness of Nigeria."*  	
Assumption 2.2: UNFPA Supplies supports policies and programmes **including effective community** engagement to **directly address socio-cultural barriers to improving the knowledge and ability of marginalized women and girls to demand appropriate RH/FP commodities of their choice**.	
Addressing Barriers and Engaging Communities	
• There is evidence that, through a **broad range of partnerships, including with traditional leaders**, that **barriers to modern contraception were being dismantled**. In contexts such as Kebbi and Sokoto states, a "whole of society" approach is required to address SRHR, particularly for young women. Various initiatives are being undertaken, through UNFPA and development partners, to address gender equality, including female education, empowerment and ending early marriage.	• UNFPA Nigeria, *Annual Review Summary Sheet, Access to Family Planning Commodities (AFPC) Programme in Nigeria,* March 2016, p.5
• **Education as Vaccine Initiative**, an NGO founded in 2002, works with **adolescents and young people**. They have partnered with UNFPA for many years on improving adolescent access to sexual and reproductive health and services in Benue, Cross River, and FCT. States are chosen based on certain indices like adolescent pregnancy rates, HIV prevalence, and geographical distribution across Nigeria. Activities include training young people as peer educators, 25 per state, to carry out activities with their peers, i.e., one-one-one discussions, community activities like rallies and mobilizing for uptake of services at health facilities. Pre-test and post-test tool are used to gauge knowledge change. Programmes has also trained health care providers on youth-friendly services – about 20 per state. This capacity building was based on formative research with young people which **revealed some of the challenges associated with accessing with family planning services**. Some of these include confidentiality, age of providers (young people apprehensive about dealing with older providers). Other activities conducted by EVA are noted below: **1.** UNFPA supported EVA to facilitate the development of an ***Adolescent Health Development plan*** in Benue. There are also plans to develop one for Cross River state.	• Interviews: Education as Vaccine staff, Abuja

Question 2: Observations	Sources of Evidence
2. EVA has another project (not UNFPA-supported) working on ***parental consent*** issues. Providers discourage young people from accessing services. There is a guideline developed by the FMoH and Health council which is not being implemented because of different state level policies, laws and customs. The project advocates for state governments to officially adopt and domesticate the guidelines. Changing the law would take time but a lot can be done to see that there is flexibility in ensuring access to services, ensuring that emancipated young people have access to services. 3. Besides advocacy on parental consent policies, EVA also advocates for ***integration of youth friendly services in PHCUOR (Primary Health Care Under One Roof)*** - under PHCUOR there are plans to renovate about 10,000 PHCs across the country. Advocacy for integration of youth friendly services is both at the national level and state (Benue) level. EVA has met with the NPHCDA and the FCDA (Federal Capital Development Authority) board and the SPHCDA in Benue. It may not be easy or possible to provide all the features of a YFF but it is hoped that, at least in every LGA, there should be one standard/comprehensive YFF with recreational activities, trained health providers on FP, accessible location etc. One TFF has been launched in in an LGA in FCT but staff have not been trained on youth friendly service provision (supported by UNFPA). 4. With UNFPA support, EVA has also distributed male and female condoms, emergency contraceptives to CBD. The CBDs were trained with the support of SMoH and given family planning commodities for distribution. The CBDs are also given a tool for recording age and sex of users. Over 10,000 people in 2 LGAs have received family planning commodities through this programme. UNFPA also supported the EVA with male and female condoms for their routine activities. • Partnership issues with UNFPA: EVA is funded every year by UNFPA. Other funding from UNICEF, IWHC, Peach programme – sub grants to other organisations working in that area, Ford Foundation (ICT, mobile apps for information, UNFPA supported dissemination the apps), Amplify Change (trained young people in Cross River, Ondo, Kaduna on policy advocacy at the state –level and engage with decision makers).	
Effect of UNFPA Supplies Support, Other Programmes and Other Factors on Demand	
• Canadian funding is being used in Kaduna to support adolescent programming and GBV activities. This in part makes up for the **lack of funding from UNFPA Supplies/DFID for demand activities**. In areas where socio-cultural norms are barriers to family planning access, demand is critical, especially when tied to service delivery via mobile outreach. • If we want to achieve the demographic dividend, we cannot drop demand creation for family planning as a strategy. Letting go of this component will seriously affect the health system – 67-70 percent of the population is young people.	• Interview: UNFPA Nigeria, Abuja
• **The "big player" in implementing demand creation activities via mass media is the Nigeria Urban Reproductive Health Initiative (NURHI) funded by BMGF** and managed by Johns Hopkins Centre for Communication Programmes (CCP) with key partners, including the Association for Reproductive and Family Health and CCP Nigeria. The focus of NURHI is on **increasing contraceptive use in selected urban sites** (FCT, Kaduna, Ilorin, Ibadan, Zaria and Benin) with a **focus on the urban poor**. Its strategy sought to develop "consumer first" interventions for creating demand and sustained use of contraceptives among	• Source: NURHI, *Demand Generation Strategy, 2011,* accessible at: www.nurhitoolkit.org.

Question 2: Observations	Sources of Evidence
marginalized urban populations, using an evidence-based approach. It aimed to open a dialogue regarding family planning into everyday life in families and communities, and to increase accurate knowledge about methods and where to access services. *"In addition to simply increasing demand for contraceptives as an end goal, NURHI will test the theory (Proof of Concept) that a significant investment in demand can drive supply, optimally to appoint where family planning is a sustainable social norm so that products and services are supported by market demand."* (p. 2) • Formative research in Kaduna (and Ibadan) offered these key themes: o Education is a key benefit of FP o Women carry the burden of family planning but decisions remain in the **control of husbands** o **FP is difficult to discuss**; it requires a lot of knowledge o Choosing family planning is a **"medicalized" decision**; doctor's advice is seen as key. o Using family planning is seen as very risky in comparison to risks of pregnancy (IUDs are seen as most risky). o **Fear of family planning persists** (fear of discussion/approval of spouse, fear of health consequences and side effects) (p. 7-8) • NURHI developed the **"Get it Together" campaign** which has three main approaches: 1. A branded multi-channel campaign with radio, TV, BCC materials and social mobilization in each of the NURHI cities 2. A popular radio programme with drama and live call-ins tailored to each location and language 3. Community-level family planning promotion and referrals for family planning services by urban youth social mobilizers • **Endline findings from the NURHI Project in Kaduna** included the following key achievements: *1. "A significant increase in modern CPR was seen in Kaduna, particularly use of implants.* *2. A higher percentage of young women, aged 30-34 and women aged 25-29 are using a modern method at endline. Twenty percent of women adopted a modern method while 7 percent discontinued use for an overall increase of 13 percentage points.* 3. *More than half of women living in Kaduna reported hearing NURHI slogans and seeing a family planning message on TV. Nearly quarter of women were exposed to NURHI print media messages."* • Accessible at: http://www.nurhitoolkit.org/sites/default/files/tracked_files/NURHI%20factsheet%20kaduna_9.17.15.pdf	
Assumption 2.3: UNFPA Supplies support to increasing demand **in partnership with governments and others for RH/FP commodities** complements and is coordinated with support from other sources at national and sub-national levels.	
• See data under Assumption 2.1. Most of UNFPA support for increasing demand is in partnership with the Federal GON to develop strategies and plans for BCC.	
• Partners are using different demand creation techniques and there is **poor coordination** on this. Some make good use of ward development committees. Other partners should consider keying in to the facility health committees as a means to address family planning access barriers.	• Interview: Group discussion with Child Spacing Technical

Question 2: Observations	Sources of Evidence
• MNCH2 (DFID project, implemented by Palladium) and NURHI (BNGF project, implemented by JHU-CCP) are the main implementing partners working on demand creation. There is **lack of clarity on what facilities are covered by which partner**, duplication of facilities, orphan facilities, and techniques for demand creation. Some duplication does occur with CHAI and NURHI. NURHI covers the entire state as far as demand creation is concerned with mass media, sports programmes. The state has a demand creation model which is used by both MNCH2 and NURHI are doing. NURHI – 70 high volume sites and adding on 50 PHCs in the future. • **Demand creation regarding male involvement is a challenge**. Messages may not really be targeting men in ways that are conducive to behaviour change. A very high percent of women (from surveys –about 80%) still require permission, consent or approval from male partners. Many cultural/religious practices do not empower women to make these decisions on their own. UNFPA should consider providing support for demand creation as they have capacity to cover a wider area of state/facilities compared to other partners and IPs. • **Youth-friendly services**: There are young women support groups (supported by NURHI) which hold meetings four times a month, made up of 12 persons between 14-21 years. Young women are referred to facilities where services are accessed. UNFPA may also consider support for this and youth-centred demand creation programmes need strengthening. State should also consider adopting a strategy for addressing it. • **NURHI works in urban areas mostly** but not as much in rural areas.	Working Group, Kaduna State

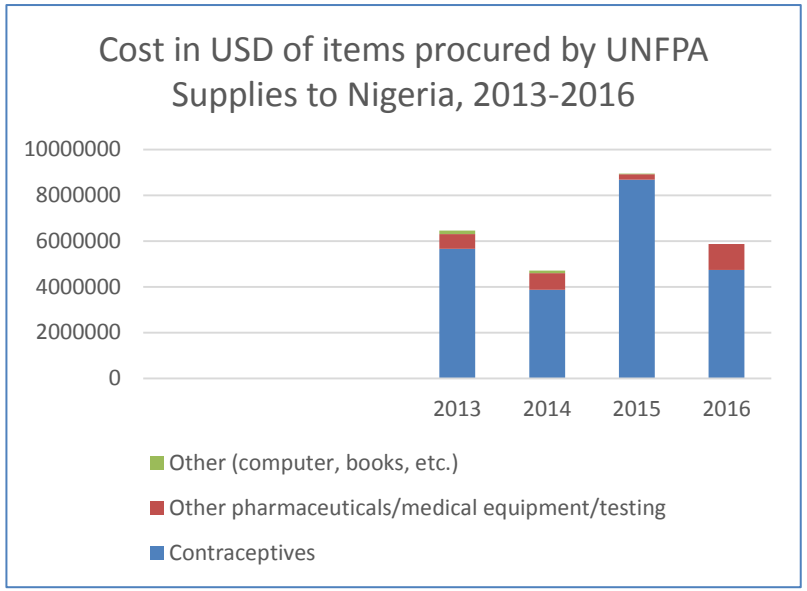
Improved efficiency for procurement and supply of RH commodities (global focus)	
Evaluation Question 3:	To what extent has UNFPA Supplies, through its global operations and advocacy interventions, contributed to **improving the efficiency of the procurement and supply** of reproductive health and family planning commodities for the 46 target countries?
Sub-Questions:	a) To what extent has UNFPA Supplies contributed to improving the **efficiency of global procurement of SRH/FP products** across all critical dimensions of performance (quality, mix, price, lead time, supplier performance, etc.)? b) Is there evidence that UNFPA Supplies has helped to **improve global forecasting, prequalification, pricing** and **long-term agreements** with a variety of suppliers. c) To what extent has UNFPA Supplies, in coordination with national authorities and partners, helped to **avoid global supply disruptions, over-stocking, over-paying, and quality issues**? d) Is there **evidence** of **increased choice** (prequalified suppliers and products), competitive pricing, reduced lead times, and increasing volumes distributed to key populations, including populations experiencing humanitarian crises? e) To what extent has UNFPA Supplies helped to **improve the global supply chain** of these commodities, and to **shape the global market** for them (influencing price, quality, innovation, and availability), using its global reach and purchasing power?

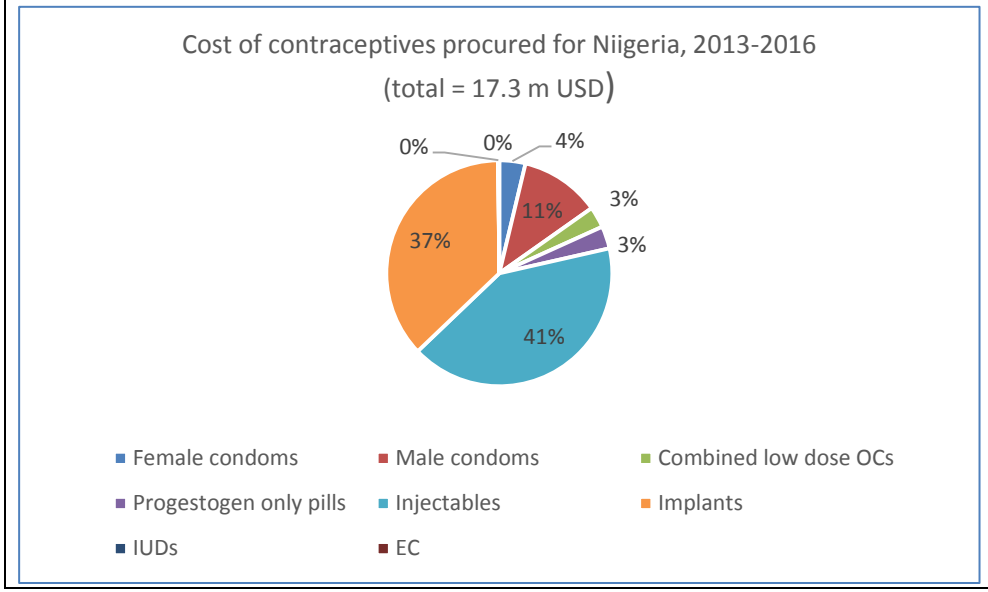
Question 3: Key Assumptions and Observations	Sources of Evidence
Assumption 3.1: UNFPA Supplies had **the necessary funding/resources made available** at the appropriate time in the 2013-2016 period to meet its mandate in procurement and supply of RH/FP commodities for focal countries.	
Trends in Funding for UNFPA Supplies in Nigeria	
Assumption 3.3: UNFPA Supplies actively participates in national commodity forecasting and planning processes and collaborates with national authorities to **provide appropriate commodities delivered on time to the 46 countries.** It also collaborates with national authorities and with other global and country-based partners, to ensure forecasting and supply functions are efficient and not duplicative.	
Forecasting and quantification of demand/need at country level	
• **Quantification and forecasting is the responsibility of the Family Health Department (FHD**) of the Federal Ministry of Health (FMoH). It is **undertaken annually with the support of UNFPA and partners** like the GHSC-PSM (Global Health Supply Chain – Procurement and Supply Management), PPFN (Planned Parenthood Federation of Nigeria), Marie Stopes and others. GHSC-PSM is the main implementing partner for USAID in the area of commodity security. They work closely with UNFPA and the FHD to manage procurement and supply planning for family planning commodities. This is done through annual stakeholder meetings where contraceptive needs are estimated, resources compared with needs, gaps identified and addressed by the FMoH and UNFPA. Before the annual quantification, INGOs like PPFN and Marie Stopes are sent forms which are used to identify their family planning commodity needs for the year. While the annual quantification is mainly for public health facilities, the needs of these INGOs, primarily their community intervention/outreach needs, are taken in to consideration during the exercise. Quantities procured depend on the funds available in the basket fund (to which the Nigerian government, UNFPA and other development partners contribute).	• Interview: GHSC-PHM Project Headquarters, Abuja
• The **"Review and Resupply" (R&R) model of distribution** from states to facilities (in which state family planning Coordinators, with support from the FMoH and UNFPA, meeting with facility coordinators at the cluster level to review consumption over the reporting period and verify the reported consumption before re-supplying facilities with more commodities) provides consumption level data down to the facility level. This method helps determine what volumes will be required to supply additional service delivery investments, which can then **guide the development of more accurate forecasts at the LGA level**. It has been in place since 2013 and is credited by UNFPA and USAID with **reducing stock-outs and improving reporting**.	• Interview: UNFPA CO Abuja and Kaduna
• Commodity quantification should be given specific attention, in order to replace the former review and resupply meetings in areas supported by UNFPA. Effort is needed to regain lost ground in terms of **commodity availability**, particularly as demand for these products grows.	• Appleford, G. and Ibeh, C.C., *Access to Family Planning Commodities Programme in Nigeria, Narrative Report,* 2016, p.14
• **At the state level, consumption is calculated every four months**. Providers compete the tally card every two months, then transfer the information to the yellow card while making sure that what comes in/what goes out matches. Facilities are expected to submit reports in the first week of the month following the bimonthly review period. **Collection of reports is**	• Interview: FCT family planning Store (Abuja)

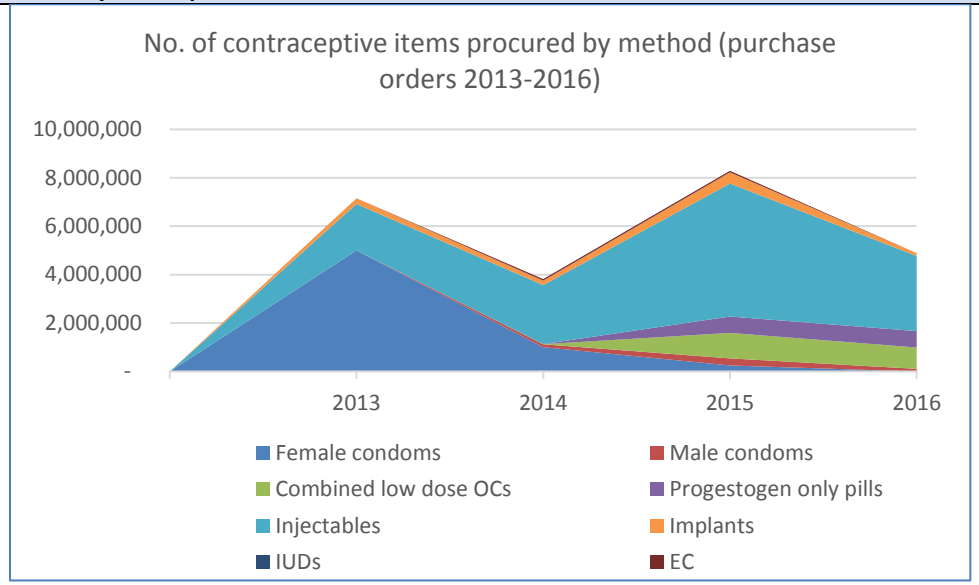
Question 3: Key Assumptions and Observations	Sources of Evidence
facilitated by cluster review meetings. Meetings are supposed to be held six times/year, but this year will only happen 3 times. World Bank (SOML) funded 1 meeting; UNFPA funded two. It costs 1.4 million Naira for each cycle. In FCT there are 9 clusters each covering 250 PHCs that offer family planning (out of a total of 500 PHCs in the FCT). Costs include transport/lunch for facility staff for one day. Clusters covering large areas could require 2 to 3-day cluster meetings because of travel and need for accommodation. Meetings include the FCT family planning coordinator, logistics manager, and M&E officer/data officer. The R&R system was introduced in 2011 when family planning services were made free of charge; prior to that, commodities were part of a revolving fund. Providers had to purchase commodities with money from client fees. • **Consumables remain an issue** as they are not part of the requisition process.	
• National level quantification exercises – **UNFPA coordinates the donor Basket Fund**. UNFPA leads the relationship – "We do nothing without UNFPA." It is a very good supply plan; UNFPA Nigeria team liaises with HQ to ensure smooth procurement. • There is no nationwide **end-to-end visibility** monitor at the moment. The NSCIP is expected to provide more visibility of programmes to state governments. **Navision** – a platform already in use in the vaccines programme introduced by UNICEF – is being used by the NPHCDA. There is no need for additional licensing and it is already compatible with DHIS which will enable synchronization of LMIS and HMIS data. However, funds are needed to develop modules for the other programmes. The plan is to rollout Navision in two phases: In phase 1, state LMCUs will input data for all PH programmes to provide visibility to both partners and the government. This phase began in October 2017 and will run for 18 months. Phase 2 will involve the SDPs, i.e., the last mile. In this phase SDP personnel will enter data directly to the system to order commodities and submit reports accordingly. One this happens, the R&R meetings will discontinue.	• Interview: USAID (Abuja)
• UNFPA is working closely with USAID technical support partner (JSI/USAID DELIVER Project from 2003 to 2016 and from 2017 Chemonics/USAID PSM Project) to develop forecasting projections however capacity issues remain, attributed to the **poor understanding of the Logistics Management Information System (LMIS) resulting in poor quantification and ordering problems at state leve**l.[34] The support by UNFPA through the DFID funded AFPC project has been critical. There are serious risks of a system collapse if the project were to end without clear exit arrangements in place.	• Horstman, R. et al, *Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report,* 2017, p.31
• In **Kaduna State**, BGMF is funding **The Transformation Project**, an integrated model of supply chain management for essential medicines not covered by one of the five major PH programmes. This system utilizes a PUSH system informed by LMIS based on a software platform or "control tower" being developed by the state. The Project started in 2017 and is being piloted in 28 health facilities across the state with over 1,000 SKUs (stock-keeping units)/products. Imperial Health Services (HIS) is the main 3PL in charge of warehousing and 3PL management.	• Interview: Health officials, Kaduna State
Procurement	
• **Supply plans** are developed after quantitation and procurement planning. A tracker is used to monitor what comes in to the country for UNFPA and USAID procured family planning commodities and received in to the CCW). The supply plans are	• Interview: USAID Abuja

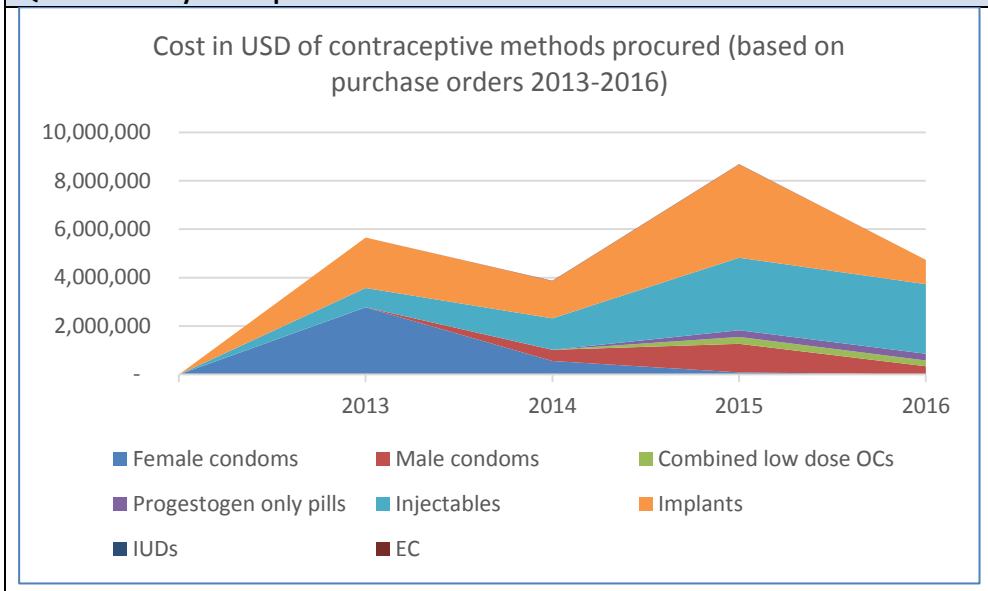
[34] UNFPA, 2017. FP-RHCS Business Case Midterm Report, draft 2.

Question 3: Key Assumptions and Observations	Sources of Evidence
presented at the national PSMTWG - whose members include FMoH, USAID, UNFPA, CHAI, NUHRI, SFH, and PPFN – for concurrence and comments.	
• **UNFPA procures family planning commodities using funds from the basket fund** (a fund set up to procure family planning commodities with donations from DFID, UNFPA, BMGF and GoN – Government of Nigeria). The commodities are procured **for public facilities for all 36 + 1 states** while USAID manages procurement for USAID-supported public health facilities in a few states. USAID also procures commodities for the private sector. USAID does not contribute directly to the basket fund but funds the gap –unmet needs- which goes directly in to the CCW. The GoN failed to fund their commitment; USAID provided 6.4m USD in commodities to fund the gap.	• Interview: USAID Abuja
• The integrity of the forecasting and quantification process is key. There was a brief window between 2013-2015 when there was consistency in the release of funds to the basket fund. **Funding has been a bit more erratic in the last two years** probably as a result of the recession. In the last few weeks there was a stock-out of Depo; USAID had to come in to restock the national stores. **Coordination has improved among partners**, including between the public and private sectors. The willingness of the Government to use UNFPA as the procurement agent has helped the supply situation in the country.	• Interview: SFH, Abuja
• UNFPA (and USAID) are working closely with the government in a coordinated fashion to support contraceptive commodity procurement in Nigeria. Development partners bring their contributions to the basket fund after the national quantification is conducted. The process to create a **basket fund brought the issue of commodities into national focus**. As a result, the GoN has committed funding; however, it hasn't released all the funds.	• Interview: FHD, Abuja
• *"**The number of family planning products distributed from national to state warehouses increased two-fold between 2014 to 2015**. **Family planning products primarily comprised short term methods however there was also significant growth seen in LARC, particularly implants**. Quantities of LARC issued to states using the requests and consumption from the previous reporting period, indicates a 100 percent increase from 308,987 (2014) to 748,779 (2015). Through-put of greater stock to states than what was procured in the year was possible by **utilisation of buffer stocks**. This came at a cost however as current stock levels for some products are below minimum levels in the national warehouse.* • *The **average procurement lead time declined from 222 days (7.4 months) in 2014 to 122 days (4.1 months) in 2015** **and 168 days 5.6 months) in 2016.** This was due to the use of multiple clearing agents as well as improved communication with the PSB to enhance delivery time.* • *In addition, the **clearing time reduced from 69 days in 2014 to 24 days in 2015** with clearing cost accounting for only 3 percent of total shipment cost. This was possible through the use of multiple clearing agents as well as improved communication with PSB to enhance delivery time. However, it was noted by UNFPA that, since Sept 2015, some products, notably Jadelle and male condoms, have been delayed in port awaiting clearance as a result of the new port clearance policy of the new government administration. The FMoH is aware and is working to unblock this.*	• UNFPA Nigeria, *Annual Review Summary Sheet, Access to Family Planning Commodities (AFPC Programme in Nigeria,* March Horstman, R. et al, *Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report,* 2017, p.222016, p. 7.

Question 3: Key Assumptions and Observations	Sources of Evidence
• *While performance would suggest an A+, this grade is not possible due to s**hortfalls and delays in GoN contribution to the commodity basket**. In Dec 2015, the GON released Naira 196,000 million (approximately 1 million USD) towards its 2013 commitment."*	
• **UNFPA procured 26.6 million USD worth of commodities and equipment, the vast majority of which were contraceptives (22.9 million USD or 86.1 percent)**. 10.3 percent was for other pharmaceuticals, including medical kits and lab testing, with the remainder (4.6 percent) going for educational materials and transportation/handling.  • The amount **funding for procurement (based on PSB purchase orders) see-sawed during the period from 2013 to 2016**, going from 6.6 million USD (2013) to 4.9 million (2014) to 9.0 million (2015) and back down to 6.0 million (2016).	• Source: PSB purchase orders by country, 2013-2016
• The **largest share of funding for contraceptives** during the period 2013-2016 went to **injectables** (41 percent) and **implants** (37 percent), followed by **male condoms** (11 percent). • In terms of number of units, there was a **large procurement of female condoms in 2013** which diminished in later years, and an increase in the number of injectables which peaked in 2015. • Although **implants** make up a relatively small portion of the contraceptive commodities procured (4 percent); it accounts for a large percentage of funds allocated for procurement (37 percent).	• Source: PSB purchase orders by country, 2013-2016

Question 3: Key Assumptions and Observations	Sources of Evidence
• The number of implants procured peaked in 2015 (n=460,086), and was followed by 118,000 procured in 2016.  	

Question 3: Key Assumptions and Observations	Sources of Evidence
• 	

Question 3: Key Assumptions and Observations	Sources of Evidence
	

Improved access to quality RH/FP commodities and services	
Evaluation Question 4:	To what extent has UNFPA Supplies contributed to **improved security of supply, availability and accessibility of RH/FP commodities and services** in programme countries, especially for poor and marginalized women and girls, **in keeping with their needs and choices**, **including in humanitarian situations**?
Sub-Questions:	**a)** To what extent has UNFPA Supplies contributed to the **development of effective strategies and approaches** for making **high-quality RH/FP commodities and services available and accessible** for marginalized women and girls? b) To what extent has UNFPA Supplies been effective in supporting efforts to **strengthen the capacity of service providers for the delivery of quality RH/FP services and related commodities** and to integrate family planning into other services? c) Has UNFPA Supplies been effective in **brokering and managing partnerships that maximize the reach of efforts by all partners** to locate and provide a **secure and constant supply of high-quality RH/FP services and commodities** to poor and marginalized women and girls? d) To what extent has UNFPA Supplies worked effectively with national authorities, and other partners to provide a **timely, secure and constant supply** (and related services) of RH/FP **commodities to women and girls in areas affected by humanitarian crises**, using the MISP kits and guidance as well as other necessary commodities and services where appropriate?

Question 4: Key Assumptions and Observations	Sources of Evidence
Assumption 4.1: UNFA Supplies works effectively to ensure procured commodities match demand and help **address gaps in national supply chains** (including gaps resulting from crises), to enhance the secure flow and constant availability of **affordable RH/FP commodities that are accessible to marginalized women and girls.**	
Expanding Service Coverage	
• The Federal Ministry of Health in collaboration with partners embarked on **a number of interventions targeted at improving uptake of family planning services with technical support from UNFPA** Nigeria, including advocacy, coordination and management of several partners. These activities were "*across the spectrum from Policy and enabling environment – Access to Commodities, Demand Creation and Behavioural Change Communication using evidence and the "consumer lens", Improving Capacity of Nurses/Midwives on Long Acting Reversible Contraceptives (LARC) and Task shifting for provision of LARC to Midwives/Nurses*." UNFPA Nigeria provided technical support to FMoH to implement these interventions, which required advocacy, coordination and management of several partners.	• UNFPA West and Central Africa Regional Office, 2015, *SWOT Analysis: UNFPA Family Planning Interventions in West and Central Africa 2013-2015 (Nigeria)*, p.8
• Since 2014, **UNFPA has collaborated with MSIoN**: on-going collaboration to expand the **provision of LARC training** and supportive supervision in public sector health facilities in 14 states as of 2017. This support includes LARC training and supportive supervision in IDP camps in three states. • **UNFPA supports the Association for Reproductive and Family Health (ARFH) to promote injectable** contraceptives through task shifting to CHEWS in several states; this includes a pilot of Sayana Press in two states.	• Horstman, R. et al, *Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report,* 2017, p.34

Question 4: Key Assumptions and Observations	Sources of Evidence
• **UNFPA supports** the **Planned Parenthood Federation of Nigeria (PPFN)** for review and resupply meetings, training on youth friendly services in the public sector and peer educators. Support was extended to IDP camps in 2016.	
• **UNFPA is instrumental to family planning in Nigeria as the main provider of commodities**. PPFN participates in the stakeholder meetings where family planning resources are quantified, resources compared with needs and gaps identified to be addressed by FMoH and UNFPA. **PPFN also procures commodities that are not on the UNFPA list**, and has one of the warehouses (the "7th warehouse along with the other six zonal warehouses) for private sector needs. PPFN coordinates review and resupply meetings in UNFPA-supported states. UNFPA has assisted PPFN when there were delays in commodities from the IPPF procurement system. • **Per PPFN, R&R meetings are cost-effective**; ideally they should be bi-monthly but due to lack of funds they happen quarterly. When UNFPA funding is not available, other partner funds are mobilized. PPFN expressed scepticism about the integrated system, "Integration can only happen when review cycles are harmonized." • **PPFN** partnered with UNFPA in Benue, FCT and Kaduna to **train 310 CHEWs and 755 community mobilizers to do community-based distribution of Sayana Press** via outreach and door-to-door visits. Most users were new users (not existing Depo users). This was considered very successful as the services were free and CHEWs bring the service closer to the community. • **PPFN** also received UNFPA support to provide SRH services in Adamawa, Yobe and Borno, including **medical outreach to facilities where they still existed, or in an IDP camp** in Borno as the clinics were destroyed. PPFN deploys youth volunteers (Youth Action Movement) in Borno state to recruit IPD campmates to get services. While the major focus is on young people, adults receive information from the youth volunteers as well.	• Interview: PPFN, Abuja
• MSIoN has a large operation in Nigeria working through several service delivery different channels (clinics, franchised providers, outreach teams). **With UNFPA (and USAID) support, MSI has trained 3,000 public sector providers in LARCs**. It receives family planning commodities from government through UNFPA in support of its public sector training and outreaches. Other commodities come through the Marie Stopes store. Work with UNFPA started in 2013 to address weak public sector capacity on LARCs and the lack of a standardized training curriculum. MSI developed a standardized training manual for LARCs for training doctors, nurses and midwives; this has been adapted by the federal government. MSI also provides supportive supervision to these trained providers using a supervisory checklist. Each provider is visited at least once within a period of three to six months. • **Per MSI, IUDs are less successful**, although awareness and acceptance has increased. Demand creation issues for IUDs should address concerns that women have re IUDs (related to polygamous marriages, risk of infection from other partners, etc.). Other issues affecting IUD acceptability are lack of provider confidence, lack of ability to ensure privacy for insertion at facilities, and availability of ancillary equipment.	• Interview with MSIoN staff, Abuja

Question 4: Key Assumptions and Observations	Sources of Evidence
• UNFPA started working with **Nursing and Midwifery Council of Nigeria** in 2012. It assisted with conducting a gap analysis to inform the development of a **strategy for pre-service education for midwives**. UNFPA supported 12 institutions to upgrade capacity to conduct pre-service education, including the provision of anatomical models and books. It helped to launch the reaccreditation process and to conduct family planning training including a focus on LARCs in 80 midwifery centres. To be certified, a midwife must complete 20 insertions and removals. They introduced a Council exam. MSI assisted in training and monitoring. • UNFPA also supported International Day of Midwife • Mandatory modules for certification every three years. Modules on EmOC, Psychosocial, EMTCT, Rape, PPH FP. In Nigeria, 3000 MWs graduate annually; every MW required to recertify every three years; can choose from the 6 modules (has a choice so that they don't have to take the same course)	• Interview, NMCN representative, Abuja
• **UNFPA Nigeria supported MSIoN** to strengthen capacity of the Federal and State Ministries of Health to provide **LARCs** using a competency based curriculum in 13 States, resulting in 1,250 healthcare providers trained in 2013 and 2014. As part of the training, MSIoN conducted supportive supervision to ensure translation of skills acquired during the training is used to improve quality of service provision. • Also with technical support of MSIoN, UNFPA conducted a **Training of Trainers (TOT)** too. As part of its efforts to support pre-service training through midwifery schools to produce graduate midwives with capacity to provide on FP, UNFPA conducted Training of Trainers (TOT) **to train one midwife tutor from all the 98 accredited schools offering midwifery pre-service training programme in Nigeria and 5 staff of the midwifery regulatory body** in 2014. The adapted competency based curriculum used for training the midwifery schools on LARC allow practical demonstration sessions and enhance hands-on experience in counselling and provision of family planning services. Trained health care workers and tutors were provided with Implant/IUD insertion and removal kits to facilitate service provision post-training.	• UNFPA West and Central Africa Regional Office, 2015, *SWOT Analysis: UNFPA Family Planning Interventions in West and Central Africa 2013-2015 (Nigeria)*, p.14
• In 2015, UNFPA initiated bundling of **consumables for LARC**; these bundled packages are currently filtering through the pipeline and should be more readily available in facilities in 2016. This should reduce barriers to long acting reversible contraception (LARC), particularly for younger and poorer population segments. • UNFPA is also addressing **pre-service LARC orientation through midwifery training institutes**. UNFPA is encouraged to continue these efforts as well as the effective partnership with MSION as sustained, supportive supervision and public-private collaboration in service delivery will facilitate positive client-centred experience and access to LARC. This is critical given the fragility of family planning in many states, particularly in the north but also in other states where there is evidence of reliance on less effective methods (notably Lagos state).	• UNFPA Nigeria, *Annual Review Summary Sheet, Access to Family Planning Commodities (AFPC) Programme in Nigeria,* March 2016, p.3
• UNFPA Nigeria considered the following **key achievements/success stories in 2015 in family planning**: ○ "*The removal of user fees led to a surge in demand for contraceptives through the public sector by more than 150%, especially with regards to IUCD and implants.*	• UNFPA Nigeria, *Nigeria Saves Lives: Success Stories from*

<table>
<tr><th>Question 4: Key Assumptions and Observations</th><th>Sources of Evidence</th></tr>
<tr><td>

UNFPA supported the implementation of the National LARC Training Plan including development of standardized, Competency-based LARC Training Curriculum and training for staff in over 800 health facilities in 12 States (Lagos, Ondo, Adamawa, Kebbi, Kaduna, Cross River, Ebonyi, Bayelsa, Ekiti, Enugu, Kwara, Sokoto) and FCT
Six hundred and sixty-seven (667) Family Planning Service providers and 104 Master Trainers selected from public health facilities were supported by UNFPA to complete the 6 day LARC training between 2013 and 2014 to improve their counselling and service provision skills. The trained health care workers were also provided Implant/IUD insertion and removal kits to facilitate the provision of good quality services. In addition, 120 Midwives Tutors from all the 98 midwifery schools were trained on LARC and provided equipment. All these efforts have resulted in increased capacity in the states to provide family planning services to women and girls using the rights based approach
The number of public health facilities providing family planning services increased from 6,500 (2012) to 7,500 in 2014 thereby increasing access to family planning services especially in rural areas Over 100,000 CYPs were generated through the insertion of implants and IUDs as part of the competency-based training programme."

</td><td>UNFPA Nigeria, Abuja, March 2015, p. 30</td></tr>
<tr><td>
• Discontinuation rates are estimated below based on 2013 DHS data:
[Note: no data was available for implants given low use in Nigeria in 2013.]

Data accessible from:
http://www.track20.org/download/pdf/2017%20FP2020%20CI%20Handouts/english/Nigeria%202017%20FP2020%20CoreIndicators.pdf
<table>
<tr><th>Method/
Discontinuation rate (in percent)</th><th>IUD</th><th>Implant</th><th>Injectable</th><th>Pill</th><th>Condoms (male)</th></tr>
<tr><td>Discontinuation while in need</td><td>3.2</td><td>n/a</td><td>14.6</td><td>11.2</td><td>5.6</td></tr>
<tr><td>Discontinuation while not in need</td><td>5.2</td><td>n/a</td><td>6.7</td><td>12.5</td><td>11.3</td></tr>
<tr><td>Total discontinuation (all reasons)</td><td>9.1</td><td>n/a</td><td>23.1</td><td>26.1</td><td>20.1</td></tr>
<tr><td>Switching to a different method</td><td>0.5</td><td>n/a</td><td>1.8</td><td>1.8</td><td>1.6</td></tr>
</table>
</td><td>• Source: FP2020, The Way Ahead 2016-2017, Core Indicator Summary Sheet: 2017</td></tr>
<tr><td>• The Annual Review by DFID of the AFPC project recommended, "UNFPA should work with the federal and state MoHs as well as partners to gain a better sense of what is driving the high numbers of users discontinuing their contraceptive method. This could explore existing evidence, such as that generated from the "deep dive" landscaping work conducted in Lagos and Kaduna states in 2015 with support from the BMGF as well as guide research priorities so that client concerns and decisions related to discontinuation can be effectively addressed."</td><td>• UNFPA Nigeria, Annual Review Summary Sheet, Access to FP Commodities (AFPC) Programme in Nigeria, March 2016, p.3</td></tr>
<tr><td>• The national task shifting policy on family planning is expected to expand the number of health facilities providing family planning services in the country especially for injectables and LARC. It has however been very tasking for partners to train</td><td>• Appleford, G. and Ibeh, C.C., Access to Family Planning</td></tr>
</table>

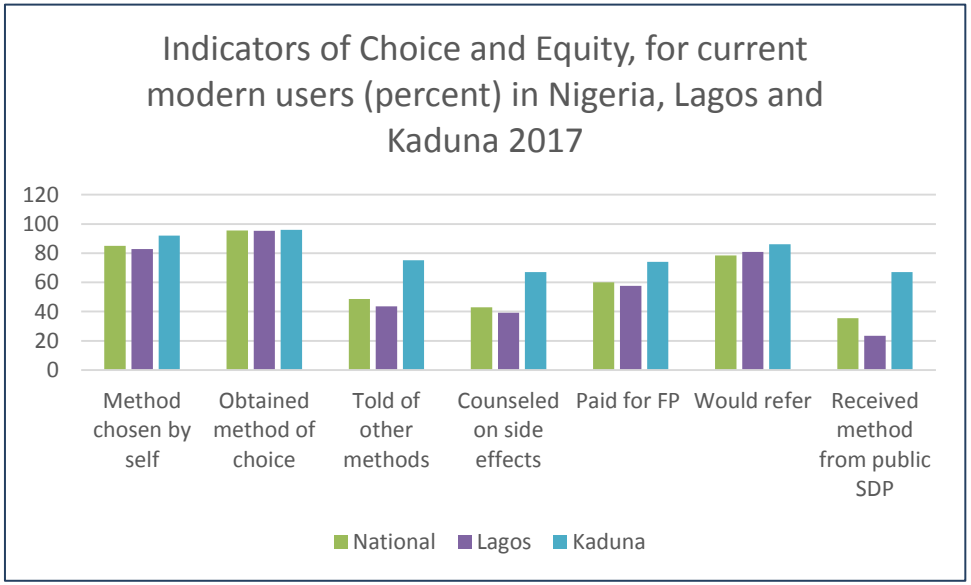
Question 4: Key Assumptions and Observations	Sources of Evidence
providers on family planning services as a result of the high cost of organizing training and sustaining the cost of the supportive supervision.	*Commodities Programme in Nigeria, Narrative Report,* 2016, p.11
• The **task shifting and sharing policy is being operationalized in an *ad hoc* manner** as it is left to **individual states** to implement and to prioritize aspects of the policy that best align with their situation (or the interests of respective development partners).	• Horstman, R. et al, *Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report,* 2017, p.16
• *"The **Nigeria 2012 London Summit commitment** included adopting **a task-shifting policy and training frontline health workers to deliver a range of contraceptives**. When Nigeria launched its Nigeria Family Planning Blueprint (Scale-Up Plan) for 2014–2018, the training of community health workers was highlighted as a priority. But the first rounds of training were delayed due to **resistance from nurses' unions**, who felt their profession could be threatened.* • *In 2015 Nigeria approved a **task-shifting policy** that would authorize trained community health workers to provide long-acting reversible contraceptives (LARCs). To jumpstart the process, FP2020 awarded an RRM grant to the Clinton Health Access Initiative (CHAI) for a pilot project. **CHAI trained 290 community health workers on LARCs in three states**, and successfully demonstrated to national stakeholders that task-shifting had no effect on the role of traditional providers such as nurses and doctors.* • *A year later FP2020 awarded a second grant, this time to **Marie Stopes Nigeria, to train 60 health extension workers on LARCs** and build a pool of competent master trainers in five states.* • *In 2017 the FP2020 focal points in Nigeria confirmed that **the task-shifting policy had been deemed a success**, and that the government was following through on its 2012 commitment to invest additional resources in training."* Accessible from: http://progress.familyplanning2020.org/en/fp2020-in-countries/connecting-with-fp2020-support#acceleration	• FP2020, *The Way Forward, 2016-2017*
• **UNFPA Nigeria supported the development of the National LARC strategy**, the main aim of which was to enable "*all Nigerian women who want implants or IUDs can safely and freely obtain quality counselling, insertion and removal services through the public sector."* (p.11) The strategy followed the key themes identified in the National RHCS Strategy, namely, capacity, commodities, client demand and utilization, context and coordination. This strategy led to a range of priorities, including (but not limited to) **establishing LARCs as a key component of the Midwife Service Scheme and including LARC in continuing medical education for doctors**. An important aspect of the plan was *"to work with UNFPA to update forecast plan based on service delivery increase and demand, work with partners in-country and through global mechanisms to*	• Source: FMoH, *Increasing Access to Long-Acting Reversible Contraceptives in Nigeria: National Strategy and Implementation plan (2013-2015)*

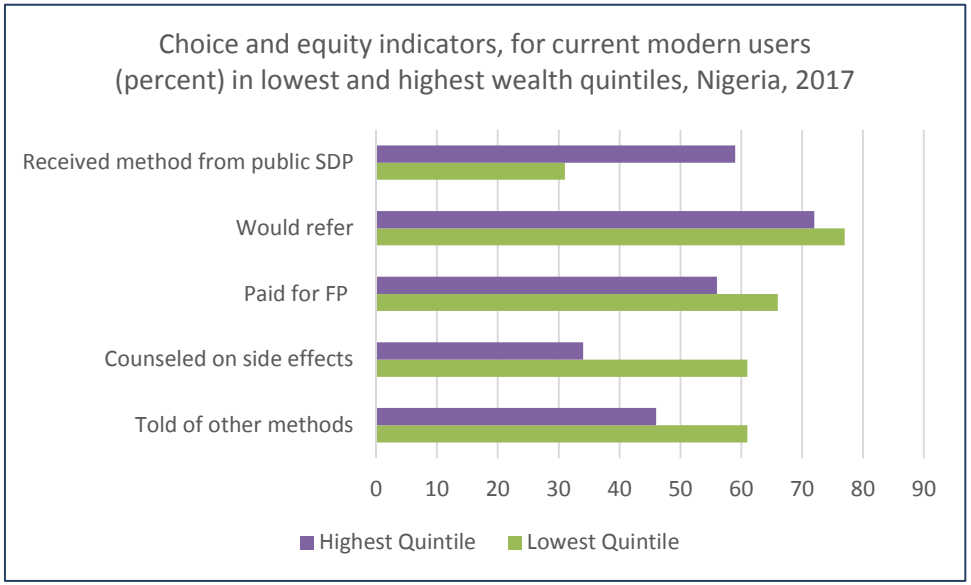
Question 4: Key Assumptions and Observations	Sources of Evidence
secure additional funds needed, build capacity of states to manage their own distribution plans and to continue Review and Resupply meetings to protect facilities from supply disruptions and ensure consumables needed for insertion and removal of implants are available." (p.13-18)	
• **UNFPA Nigeria supported the training of Service Providers on LARC from 10 States in 2013 and 2014.** Providers were trained to be able to understand the needs, culture and attitudes of family planning clients. This training focused on the importance of good client-provider interaction, high quality screening and counselling practices. Availability of updated Protocols, training manuals and method specific job aids is also needed in order to provide client centred care. The Federal Ministry of Health in collaboration with Partners in 2015 updated the National FP/RH Clinical Service Protocol, Standard of Practice using the WHO 2015 edition of Medical Eligibility Criteria (MEC). While competency-based training protocols are available at the national level, UNFPA Nigeria reported that there is a lack of availability of job aids and counselling tools at SDP level, and states do support adequate levels of training in FP.	• UNFPA West and Central Africa Regional Office, 2015, *SWOT Analysis: UNFPA Family Planning Interventions in West and Central Africa 2013-2015 (Nigeria)*, p. 13
General Strategies and Approaches to Targeting Poor and Marginalized Women and Girls	
• **UNFPA Nigeria CO staff indicated that there is no agreed upon definition for marginalized groups**. It can be defined in different ways for different groups. Populations identified in discussion included: women living with fistula, those in humanitarian situations (e.g., Borno in the North), marginalized youth (e.g., urban youth in Lagos).	• Interview: UNFPA Nigeria, Abuja
• In the **Kaduna CIP**, the expected results include *"improving access to family planning information and services for all users and potential users, especially those with difficulties in accessing services (e.g., rural residents, urban poor, adolescents through community mobilization" and " increase number of mobile and outreach SDPs to improve comprehensive rights-based family planning information and services for users and potential users with difficulties accessing services (e.g., rural residents, urban poor, adolescents)."*	• Source: Kaduna State Government Nigeria, *Costed Implementation Plan for Family Planning, 2016-2020,* 2016, p. 23, 25
Assumption 4.2: UNFPA Supplies and COs work effectively (with national authorities, and other partners) to **develop new approaches** to **address and resolve barriers preventing poor and marginalized women and girls** (including those in humanitarian crises) from accessing RH/FP commodities and services across the entire market (public, private, NGOs, etc.).	
Approaches to Providing RH/FP Services to the Disabled	
• No evidence identified	
Approaches to Reaching Adolescents: Especially Unmarried Women and Teenage Girls	
• The **DFID annual review of the AFPC project** recommended to make adolescent sexual and reproductive health (ASRH) a "cross cutting" issue of UNFPA advocacy and investment initiatives, given the weight carried by the organisation with national stakeholders, including federal and state MoHs. "*It is the opinion of the reviewers that the current approach to ASRH is not adequate (and lacks an evidence base). Distilling good practice from on-going UNFPA-supported investments should be undertaken however these need to be moved from small scale initiatives to those that can be scaled.* ***Greater understanding is required on adolescent contraceptive seeking behaviour****. In addition, the current configuration of public health facilities (at least those visited in Kebbi and Sokoto states) would suggest that these services (in terms of co-location*	• UNFPA Nigeria, *Annual Review Summary Sheet, Access to FP Commodities (AFPC) Programme in Nigeria,* March 2016, p.3

Question 4: Key Assumptions and Observations	Sources of Evidence
with maternal and child health services), a visible lack of privacy and confidentiality, and possible provider bias, limit adolescent patronage. In short, ***concerted effort to address the ASRH is needed.*** *This should be guided by the 2030 Agenda for Sustainable Development and the United Nations Global Strategy for Women's, Children's and Adolescents' Health."*	
• *"UNFPA Nigeria initiated a programme in* ***Kaduna State (Northern Nigeria) to integrate adolescent sexual reproductive health (ASRH) content to educational programme****. The programme worked with adolescent girls through safe spaces educational programmes for the integration of ASRH content in their curriculum. The core programme components—focused community engagement, mentored clubs, and reduced school fees—when combined have substantially increased girls secondary school enrolment, performance, and rates of graduation in Adolescent Girls Initiative (AGI) collaborating communities. The achievements of the interventions in the last year include:* 1. *Mentored Clubs: Attendance to the clubs resulted in quick enhancement of basic academic core competencies, improvement of school achievement and retention of the girls in school. Assessments show that in just eight months of participation, girls' scores in literacy doubled and numeracy triple.* 2. *97% of the first year girls are able to recall correctly the key messages on nutrition, puberty and menstruation, the danger signs of pregnancy, labour, after birth, benefits of antenatal care, use of cycle beads, and HIV prevention.* 3. *Community engagement resulted in changing of norms. Religious and traditional leaders are more involved in promoting girls' education and an increased number of girls are enrolled and retained in secondary school – 425 Girls enrolled in 2014 and retained in schools and safe spaces* 4. *Fourteen CGE mentors who worked with the girls in the clubs were trained on community acceptable and girl friendly ways of disseminating information on ASRH issues to the girls in the safe spaces. There was a significant increase in knowledge of the mentors on the use of cycle beads and also on general knowledge of ASRH issues and literacy."*	• UNFPA Nigeria, *Joint Thematic Trust Funds Annual Progress Report*, 2015 p.14.
• The 6th CP noted the **establishment of Youth Friendly Centres in selected states** with the aim of developing the skills of young people (both males and females) in different areas of specialization to improve their employability and productivity. The records showed that since the inception of the programme, the YFCs supported by UNFPA have trained 3000 youth in Carpentry, Barbing, Hair Dressing, Leather work and Tailoring. As an integral part of their activities, centres provide seminars on health matters to improve the knowledge of the youth on specific areas of health.	• UNFPA, UNFPA, *UNFPA Nigeria 6th Country Programme Evaluation, Final Report,* 2012, p.20
• There is an adjoining **youth friendly centre at the PHC Sango** called "Hello Lagos." Its activities are funded by UNFPA. About 70-100 unmarried young people visit the centre every day. Services on offer include skills acquisition, RH counselling, and family planning referrals. Young people who have been abused or raped are referred to the youth friendly centre in Lagos University Teaching Hospital, also funded by UNFPA. Facility staff have received training on counselling, skills provision. The centre was empty at the time the team visited, as it was in the morning and teens usually come by in the afternoon.	• Observations, PHC Centre Sango, Lagos

Question 4: Key Assumptions and Observations	Sources of Evidence
• **Okwu-Awo YFC is one of five centres supported by the UNFPA**. Facilities include The Young Moms Clinic for young unwed mothers. Classes provided include: SHUGA Tour, Health talk/drug abuse, ANC, Interactive session, Games and Fun activities, Counselling, Literacy Classes, and Show Your Talent. Adolescents from 10 and above; in-school youths and out of school youths – both married and unmarried, but mostly unmarried – attend. The centre sees more boys than girls, ratio of 3:2, boys: girls. 50-60 young people per day visit the centre; parents are often traders in the local market. It also offers career training/planning counselling on career paths. Other services offer include: Pregnancy testing, HIV/AIDS testing, malaria testing, and ANC. • Some are marginalized youth living in an unsafe environment, abandoned by parents/guardians. The centre provides skill acquisition services and helps with reintegration in to society. • SHUGA (based on a TV movie) –sponsored by UNFPA broadcast on MT Base Tour: Themes from the show include: abstinence is key, multiple partners not okay, sexual reproductive health and, STI prevention. • The centre refers cases it is unable to manage to higher level facilities. For instance, HIV positive are referred to the Comprehensive Health Centre. • Lagos State has a programme for sexual violence which provided the centre and other facilities with rape test kits. • There are also discussions around gender equality that help correct misconceptions about gender roles. • Centre has a Daily Register and a Monthly Summary report sent to the State. family planning Commodities available: Condoms, injectable, implants, IUDs. Some family planning commodities provided by Marie Stopes. The centre is almost never stocked out of any commodities. It is managed by the state and not as a PHC. Commodities are resupplied directly from the state CMS. • **Age of Consent**: The Policy on this does not seem to be clear and provision of family planning services to minors is left to the discretion of providers. Daily pills and condoms are provided without parental consent. Staff also seem to provide injectables without parental consent. • The Young Moms clinic provides ANC services to pregnant girls - 129 teenage pregnant girls and 68 deliveries since last year when programme started. • There are very few challenges as the centre networks with the State Ministries of Education, Youth and Women Affairs who can be called upon to provide help when necessary.	• Observations: Okwu- Awo Youth Friendly Centre, Lagos Island
Applying a Human Rights Approach to Family Planning Services and the Impact of Stock-outs on Efforts to Reach Marginalized Women and Girls	

Question 4: Key Assumptions and Observations	Sources of Evidence
GPRHCS/UNFPA Supplies Survey Findings on Exit Interviews: Nigeria (primary, secondary and tertiary; public and private) **2014** / **2015** Provided with the method of their choice: 93.5 / 96.6 Provider took clients preferences and wishes into consideration: 94.5 / 95.7 Client taught how to use the method: 93.9 / 97.0 Client told about common side effects of the method: 91.8 / 95.1 Provider informed client about what can be done re: side effects: 90.4 / 94.2 Provider informed client what to do in case of serious complications: 86.7 / 92.1 Client given date to return to the SDP for check-up and/or supplies: 91.4 / 92.8 Client satisfied with cleanliness of health facility: 88.1 / 93.6 Client satisfied with privacy of exam room: 89.8 / 94.0 Client indicated he/she was treated with courtesy and respect by staff: 94.1 / 96.4 Client would recommend SDP to friends and relatives: n/a / 97.0 **Client responded yes to "*forced to accept*" family planning method: n/a / 87.4** Note: Exit interviews weren't included in the 2013 survey report. The 2014 survey did not include the question about whether the client was forced to accept the family planning method.	• UNFPA/GPRHCS Facilities Surveys: 2014, and 2015
• CO staff expressed concern that Lagos will be required to support the bulk of the service results required to support the national family planning goal and	• Interview: UNFPA Nigeria CO, Lagos
• The **AFPC Annual review by DFID** recommended that *"UNFPA should work with the federal and state MOHs as well as partners to **gain a better sense of what is driving the high numbers of users discontinuing their contraceptive method**. This could explore existing evidence, such as that generated from the "deep dive" landscaping work conducted in Lagos and Kaduna states in 2015 with support from the BMGF as well as guide research priorities so that client concerns and decisions related to discontinuation can be effectively addressed."*	• UNFPA Nigeria, *Annual Review Summary Sheet, Access to FP Commodities (AFPC) Programme in Nigeria,* March 2016, p. 12
• Based on the Method Information Index developed by Avenir Health for FP2020, only 47 percent of women using family planning nationally received 1) information on other methods, 2) information about side effects, and 3) information about	• Source: FP2020 –Track20. *Exploring Subnational*

Question 4: Key Assumptions and Observations	Sources of Evidence
what to do in case of side effects. **There is wide variation in the Method Information Index by state, with nearly all states exhibiting an opportunity to improve the quality of services and counselling**. This ranges from a high of 90 percent in Ogun State and a low of 5 percent in Edo State. In the states visited by the evaluation team the index values are 75 percent for Kaduna and 37 percent for Lagos. • Accessible at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/11/Nigeria-Subnational-Opportunities-Handout-2.pdf	*Opportunities in Family Planning Programming*
• **Service integration, appears to be done by default given that many staff are "multi-tasking" in maternal health clinics**. Family planning was provided in the same location as ANC or immunization services. Due to spatial configurations, this often meant a lack of privacy, which has implications for confidentiality. The AFPC annual review recommended that advocacy needs to be sustained with states to improve the health facility readiness for family planning, including privacy, confidentiality and youth friendliness. UNFPA will be working with JHU/CCP and NURHI to explore use of the 72 hour makeover strategy to maximize spaces in health facilities in 5 -9 states in 2016.	• UNFPA Nigeria, *Annual Review Summary Sheet, Access to FP Commodities (AFPC) Programme in Nigeria,* March 2016, p. 11
• Data for the following chart is accessible at: https://pma2020.org/research/country-reports/nigeria  Analysis of above indicates that users in **Kaduna have a more positive experience as compared to nationally or in Lagos**. Note that it has the highest percent of clients receiving services from the public sector.	• PMA2020, 2017. *Key Family Planning Indicators, Kaduna R-4, Lagos R-4, National R-2*

Question 4: Key Assumptions and Observations	Sources of Evidence
• Data for the following chart is accessible at: https://pma2020.org/research/country-reports/nigeria  Analysis of the above chart indicates that **clients from the lowest (poorest) quintile are experiencing more effective counselling** (told of other methods, counselled on side effects) and are slightly more likely to refer others to the SDP. Interestingly, the lowest quintile clients are more likely to receive services from the public sector and also to pay for services.	• PMA2020, 2017. *Key Family Planning Indicators, Kaduna R-4, Lagos R-4, National R-2*
Assumption 4.3: UNFPA Supplies works effectively with national authorities, and other partners, to enhance availability and ease of access to RH/FP services and commodities using a **total market approach** (engaging a full range of public, NGOs, and private sector providers including social insurers and social marketing outlets and kiosks/dispensers for condoms, etc.).	
See observations and evidence sources provided under assumption 1.4 above.	
• The willingness of the government to use **UNFPA as its procurement agent has helped the supply situation in the country for both the public and private sector**. There has been great coordination among partners, good pricing, improved coordination between public and private sectors a well. UNFPA Supplies/GPRHCS has been instrumental in providing visibility to stock availability and has supported with forecasting and planning for family planning commodities. • **UNFPA has been supportive of the private sector** by providing 4 million female condoms and supporting demand creation for female condoms.	▪ Interview: Society for Family Health

Question 4: Key Assumptions and Observations	Sources of Evidence
• Society for Family Health (SFH) is a large non-governmental organization working on behaviour change and communication and social marketing. It manages its own procurement, but feeds into the national planning matrix. SFH is the largest procurer of condoms (2 million). SFH gets its noristerat from USAID.	
Assumption 4.4: UNFPA Supplies procures, packages and delivers **emergency RH/FP kits** and individual products with the **appropriate range, quantity and quality reaching populations in a timely way at the start of and during humanitarian crises**, to enable those affected to meet their RH/FP requirements.	
• Unable to find info regarding the number of kits provided.	
Assumption 4.5: UNFPA Supplies has provided **effective support to RH/FP services** as one element in **a national response to humanitarian crises** (not only through the provision of commodities).	
• See 4.1 above re UNFPA support to **PPFN** for serving **IDPs in Borno, Adamawa and Yobe States**.	•
• The North-Eastern region is affected by the Boko Haram Insurgency. Health facilities have been destroyed and deserted. This led to the suspension of routine resupply activities. UNFPA works with facilities in **IDP camps where commodities are provided, demand creation activities also implemented and providers are trained**. UNFPA also does outreach services using local NGOs like Royal Heritage Foundation. • The UNFPA **response to the humanitarian situation in the North East is multipronged**: Routine distribution/resupply + Service provision in IDP camps + Outreach services. • **Demand creation is the big challenge** as host communities are unaware of the availability of family planning services.	• Interview: UNFPA CO staff, Abuja
• According to a UNFPA case study of Nigeria, **for girls and women** fleeing from violence in the Boko Haram insurgency, **safe spaces in camps are an entry point for reproductive health** information and services including family planning and psychosocial counselling for gender-based violence (GBV). These gathering places also build resilience by offering women and girls opportunities to acquire livelihood skills and engage with others to rebuild community networks. With support from UNFPA, nine safe spaces were established in camps for the displaced in north-eastern Nigeria in August 2015. A total of 29,415 women and girls were reached by March 2016.	• UNFPA, *Adolescent Girls in Disaster and Conflict: Interventions for Improving Access to Sexual and Reproductive Health Services.* 2016. p. 40

Strengthened systems and capacity for Supply Chain Management	
Evaluation Question 5:	To what extent has UNFPA Supplies contributed to **improving systems and strengthening capacity for supply chain management** for reproductive health and family planning commodities in programme countries?
Sub-Questions:	a) To what extent has UNFPA Supplies enhanced the ability of programme countries **to move commodities** from their point of arrival through various supply channels to the **last mile and service delivery points?** b) To what extent has UNFPA Supplies strengthened supply chains for RH/FP commodities in areas affected by **humanitarian crises?**

c) To what extent has UNFPA Supplies contributed to strengthening the **capacity of supply chain managers and service providers** to forecast, order, receive, store, distribute and report on commodities? Has programme support addressed the capability, opportunity and motivation of supply chain managers and service providers?

d) Has UNFPA Supplies been effective in **improving systems (both computerized and manual) and procedures** for supply chain management (including LMIS) and systems for inventory management, distribution, tracking and tracing of products), by working with **public, NGO and private sector actors**? Have countries reported positive results in tracking and managing these products?

e) To what extent have UNFPA Supplies interventions incorporated a focus on **sustainability of supply** (to mitigate the potential risk of supply disruptions) through increased national ownership and support?

Question 5: Key Assumptions and Observations	**Sources of Evidence**
Assumption 5.1: UNFPA Supplies engages with national supply chain managers and development partners in countries to **discern key areas of supply chain management requiring support** (while seeking consensus among stakeholders regarding gaps and requirements to address them), and works to **supply targeted training, technology, and innovations to address the identified gaps**.	
Identifying elements of the supply chain that required support	
• Survey component: started in 2011 – makes use of mobile data technology (reports from 2011 up to 2016 available.) for facility surveys. These **facility surveys are seen as providing critical information** for stakeholders regarding family planning and RH service delivery access issues. These surveys contribute to the global measurement of three important performance outcome indicators: 1. Percentage of SDPs with at least three (3) modern methods of contraception 2. Percentage of SDPs where seven (7) life-saving maternal health/RH medicines from the WHO priority list is available in all facilities providing delivery services 3. Percentage of SDPs with no stock-outs of contraceptives within three months preceding the survey	• Interview: UNFPA CO, Abuja
• **Selected findings from the 2013 survey** include: 1. The **most common modern contraceptives** offered were oral contraceptives, injectables and male condoms, each available at 84 percent of facilities. Implants, female sterilization and EC can be accessed in one-third of facilities; vasectomy in 9 percent of facilities. 2. **51 percent of the facilities experienced no stock-outs of contraceptives**. The highest percentage of no stock-outs was in the North West political zone at 58 percent and the lowest in the North East geopolitical zone at 37 percent. 3. **Utilization of logistics forms was generally low** with only two-thirds reporting use, with substantial variation between primary (46 percent) and tertiary (81 percent) level facilities. Only 43 percent of staff reported they received training in logistics management of family planning commodities; 38 percent reported they never received a supervisory visit.	• FMoH, *Facility Assessment Reproductive Health Commodities and Services in Nigeria,* 2013, p. xi-xii
• **Selected findings from the 2014 survey** include: 1. **Seventy-eight percent of all facilities reported no stock-out of contraceptives** in the last three months, indicating that all managed contraceptive methods were in stock over the three months prior to the survey. 2. The **utilization of logistics forms** for reporting and/or ordering family planning supplies was somewhat **low at only 70%,** with evident variations between levels.	• UNFPA Nigeria, *Facility Assessment for Reproductive Health Commodities and Services in Nigeria, 2014 Survey Report,* 2014, p. 10-11.

Question 5: Key Assumptions and Observations	Sources of Evidence
3. Results indicated a **deficiency in training in logistics management** of family planning commodities with only 54% of staff trained. 4. Many facilities reported **lack of any supervision** with 23% reporting they had never received a supervisory visit and only 28% receiving a visit within the last 3 months.	
• **Selected findings from the 2015 survey** include: 1. **Sixty-one percent of all facilities reported no stock-out of contraceptives** in the last three months, indicating that all managed contraceptive methods were in stock over the three months prior to the survey. There were variations in stock-out rates across facility level, ranging from 30% of facilities reporting a stock-out at the primary level to almost 50% at the secondary level. Male sterilization had the highest stock-out rate among all contraceptive methods in the last three months at 46%, followed by female sterilization at 29% and emergency contraceptives at 15%. 2. The **utilization of logistics forms** for reporting and/or ordering family planning supplies was **low at only 58%,** with evident variations between levels. 3. Results indicated a **deficiency in logistics management training** of family planning commodities with **only 53% of staff trained.** While training in the provision of family planning services and in insertion and removal of implants was generally higher overall, it was particularly high among tertiary level facilities, which is likely due to the availability of higher cadre staff at these higher level facilities. 4. Many facilities reported **lack of any supervision** with 32% reporting they had not received a supervisory visit in the previous year and only 33% receiving a visit within the last three months.	• UNFPA Nigeria, *Facility Assessment for Reproductive Health Commodities and Services in Nigeria*, January 2016, p. xi-xii.
• UNFPA plans to use the next MICS (Multiple Indicators Cluster Survey) or the midterm DHS planned in 2016 to inform the programme evaluation at the end of 2017. (p.5) • The reported **75 percent of SDPs reporting no stock-outs** of contraceptives in the last 3-6 months is attributed to **interventions by DPs, NGOs, Local and State Government entities coordinated and supported by UNFPA** and steered by the RHCS TWG chaired by the FMoH. *"Increasingly, supply chain challenges in the states are being met."* "*…the milestone (set last year) for new acceptors of family planning was more than doubled (150% increase above target). Review and re-supply (RRS) meetings sustained in 34 states, and regular distribution of commodities, funded by UNFPA, ensured their availability in LGAs and SDPs."* (p.13) • **Challenges** reported include: 1. **Resistance to sustainability measures**: States vary in assuming responsibility (financial, logistics, coordination) and most do not have an adequate response yet. In addition, the inadequate number of skilled providers for family planning services in states result in a limited number of SDPs that provide family planning services to clients. 2. UNFPA is increasingly having **difficulties in funding the R&R meetings** thereby limiting the number of SDPs that could be incorporated into the distribution network and the frequency of the meetings. 3. Stakeholders are relatively **slow in their reaction to expand training of Community Health Extension Worker** (CHEWS) on injectables and other family planning methods in order to rapidly scale up services in SDPs across the country. (p.8)	• UNFPA Nigeria, *Family Planning Annual Report (for DIFD Access to FP Commodities in Nigeria Project),* 2015

Question 5: Key Assumptions and Observations	Sources of Evidence
• In 2016, a report noted that UNFPA should continue to strengthen supply chain management, particularly at State level, in line with decisions taken based on the National Supply Chain Integration Project (NSCIP). The LMCUs will require on-going support with a range of functions including forecasting, warehousing, integrated last mile commodity distribution, reporting as well as data analysis. Commodity quantification should be given specific attention, in order to replace the former review and resupply meetings where this activity took place.	• UNFPA Nigeria, *Annual Review Summary Sheet, Access to FP Commodities (AFPC) Programme in Nigeria,* March 2016, p.2
Clearing at ports/warehousing	
• The **UNFPA sub-office in Lagos**, with guidance from the CO, **handles the clearing of imported family planning commodities** from the ports to CCW. The sub office works with clearing agents to ensure that goods are cleared on time. The paper work required to start the process moves through several agencies and departments: National Planning Commission, Ministry of Finance, Nigeria Customs Office and finally NAFDAC (National Agency for Food and Drug Administration and Control) for quality assurance. A blanket import waiver is required and if one is in place, it takes a month to clear a shipment of family planning commodities. The waiver lasts a year and is renewable after expiration, the renewal process takes about five months. UNFPA has diplomatic exemption and thus is exempted from duty payment and other port taxes. It does pay other charges associated with clearing. The sub office also works with other IPs like PPFN to help with clearing of family planning commodities. After clearing, commodities are moved to the CCW and then to the states. The main challenge with clearing is **bureaucratic bottlenecks** associated with getting import duty exemptions and other waivers from the federal government. The situation has worsened since the Ministry of Budget and National Planning took over responsibility from the Ministry of Finance, as the former doesn't yet have the institutional capacity to manage this responsibility. Delays in clearing also occur when conditions at the ports are suboptimal. The Lagos sub office cleared close to 100 containers of family planning shipments in 2017.	• Interviews: UNFPA sub-CO, Lagos
• **Commodities are stored at central, state and LGA stores before distribution to SDPs and community-based distribution (CBD)**. The CCW in Oshodi, Lagos houses the commodities that now go to state warehouses. Under the integration project, there will be seven "axial" warehouses: in Lagos (South West), Abuja (North Central), Gombe (North East), Anambra (South East), Sokoto (North West), and Cross River (South South). The warehouses in Abuja and Lagos are being renovated with state of the art facilities in prefabricated boxes, and are called **Warehouse-in-a-Box (WIB)** with funds from USAID and GF. The Abuja WIB features dust-free floor surfaces, temperature regulating systems, security systems, thermal insulated ceiling and warehouse handling equipment. WIB doubles the storage capacity of existing warehouses and will reduce the cost and time that the FMoH uses to buy, store, track and distribute commodities.	• Interview: USAID, Abuja
State-of-art Abuja WIB: • Prefabricated warehouse built in 2016 – operational since February 2017. Built by Imperial Health Science (HIS) • Same structure as WIB in Lagos; although overall premises in Abuja have larger office space and larger courtyard. The warehouses, however, are identical at 3800 square meters accommodating 4000+ pallets.	• Observations: Visit to Abuja WIB

Question 5: Key Assumptions and Observations	Sources of Evidence
• Government-owned facility ran by a public/private partnership (HIS also the builder, won the bid focused on maintaining optimum warehouse standards). The Government provided the land and the building was financed by USAID (70%) and Global Fund (30%) • In the warehouse: stock of HIV and malaria commodities only (Soon: TB) - 75% to 80% of the warehouse capacity is currently used. • Office area consists of: (i) Security room (screens connected to cameras in the warehouses and courtyard); (ii) Server room; (iii) large Board room; (iv) kitchen for staff • Staff: 32 staff in three categories: pharmacists; finance; operation. In addition: security guards and janitors • In the large courtyard: (i) Flammable Store (currently used to store boxes staff uses when they need to split units and repackage); (ii) Pump room and 8 tanks for water for domestic and fire use (the municipal water distribution system does not extend to the warehouse premises); (iii) Electrical room: 3 generators: 60 kva used exclusively for the cold room + 100 kva + 150 kva. • The warehouse: (i) dock leveller (to ensure trucks are at same level as warehouse); (ii) fire hoses; (iii) motion detectors for security purpose (complement camera system); (iv) cage area for incoming commodities; this is the receiving area where stock is off-loaded for a control consisting of: visual inspection (quantities, testing some pallets), entering data in the system, and placement; (v) industrial A/C (temperature must be 15-25 degrees); (vi) Narcotic cage: only pharmacists have the key; (vi) Battery charger area (for pallets jacks and forklifts); (vii) cold room: commodities that need to be stored at 2 to 8 C. (viii) out-going area: repackaging takes place in this area; (ix) Placement with bar codes system – note: all pallets used in warehouse are treated (to avoid presence of insects etc. in wood) • The warehouse is located in an area of Abuja that is not congested (traffic) and makes the in and out movement of trucks easy.	
• The **Kaduna State Central Medical Store was basic**. Contraceptive commodities were stored in two separate areas, and boxes were piled on top of each other with the most recent at the bottom (and the hardest to get to) in rooms that weren't temperature controlled. The Health Commissioner indicated that they are looking to relocate and develop a modern warehouse. He noted that they were working with the Transformation Project to support integrated LMIS and LMD in 28 facilities, relying on 3PLs. Using 3PLs is a stop gap measure, as they would prefer to use their own vehicles to distribute directly to the PHCs. This system doesn't include FP, as the R&R system is in place in Kaduna for contraceptive commodities.	• Observation: Visit to Kaduna State CMS • Interview: State Health officials, Kaduna
Working to strengthen different dimensions of the supply chain	
• In **2013, UNFPA implemented** a number of **measures to strengthen systems related to RHCS**, including 1. Mentoring FMoH staff on monitoring using tracking tools for procurement and supply chain management 2. Training on CHANNEL, including a study tour to Sierra Leone to support the development of a rollout plan	• UNFPA Nigeria, *Reproductive Health Thematic Funds Joint Report, Annual Progress Report, 2013,* p.6.

Question 5: Key Assumptions and Observations	Sources of Evidence
3. State-level distribution of contraceptives to SDPs in collaboration with FMoH and three NGOs (PPFN, CHAI and Axios Foundation; provided OJT for LGA MCH supervisors during review meetings and assisted in reviews of report. • Training of all 37 State family planning Coordinators on CLMS (co-funded with USAID Deliver Project.	
• In **2014, UNFPA implemented** a number of **measures to strengthen systems related to RHCS**, including 1. Mentoring FMoH staff on monitoring using tracking tools for procurement and supply chain management 2. Training on electronic LMIS system (CHANNEL Software) and deployment of computer hardware to manage Contraceptives LMIS data in 7 States 3. State level distribution of contraceptives to SDPs in collaboration with FMoH and three NGOsPPFN, CHAI and Axios Foundation. • OJT training for LGA MCH Supervisors from all the participating LGAs in the 34 States were provided on the job training during the review meetings and assisted in review of LMIS data and reports.	• UNFPA Nigeria, *Reproductive Health Thematic Funds Joint Report, Annual Progress Report, 2014, p. 22*
• In **2015, UNFPA supported 45 national and 350 state programme officers from 14 states to improve their knowledge of logistics management and last mile delivery** using integrated systems. A total of 70 service providers were trained in the streamlined CLMS and Logistics Management Information System in 3 states including capacity building for the Logistics Management Coordination Unit (LMCU) responsible for implementing integrated last mile delivery of public health commodities.	• UNFPA Nigeria, *Joint Thematic Trust Funds Annual Progress Report*, 2015 p.17
• The Final evaluation of AFPC in 2017 concluded that **UNFPA supported 9 states** (Lagos, Ondo, Ogun, Kaduna, Kebbi, Sokoto, Gombe, Benue, Adamawa and FCT) **as well as the Central Contraceptive Warehouse with computers and other IT equipment to facilitate the deployment of CHANNEL Software** to ensure logistics data capture of contraceptive commodities from 2012 to 2017. • In addition, **UNFPA supported FMoH to document logistics data from the states using the RIRF** database using automated Micro Soft Excel sheets. In addition, UNFPA supports the FMoH to conduct annual surveys on availability of essential medicines at service delivery points from 2011 to 2017. • Since 2016, UNFPA and other donors have been working with Government to **scale up the use of Microsoft Navision Electronics** System for end to end visibility of public health commodities including contraceptives.	• Horstman, R. et al, *Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report,* 2017, p.38
Towards an integrated supply chain for RH/FP commodities (2017)	
• Inefficiencies in parallel public health programmes supply chains led to integration project, started in 2015, following the establishment of the National Products Supply Chain Management Programme (NPSCMP) in 2012. **NSCIP is intended to accelerate the integration process through a three-year project designed to build buy-in and capacity**. The major issue being addressed by NSCIP is the "Paradox of Increased Investment" - Investments in the PH sector have marginal effect on health outcomes. Most PH programmes are funded donor-dependent and health workers are not accountable to their supervisors but to the individual programmes. In essence, the programmes/activities are not mainstreamed into the public sector. There is thus, a lack of accountability to the donor-programme (as a result of distance) and to government	• Interviews: NSCIP, Abuja

Question 5: Key Assumptions and Observations	Sources of Evidence
supervisors. The PH role should be mainstreamed in to the administrative system of the government. The integration project also tries to address this issue. • The NSCIP has established LMCUs in all 36+1 states. The LGAs – (774 in all) (Local Government Authorities) are also expected to have LGA LMCUs (LLMCU). • Each programme (malaria, HIV/AIDS, vaccines, TB and Leprosy and FP/RH) focal person is responsible for all supported facilities. The LGA LMCU Coordinator supervises these programme focal persons and reports to the Director of PH in the LGA. • About 700 LGA LMCUs inaugurated (and framework shared) but not strengthened to be effective yet. • Data quality from SDPs, LGAs affects forecasting quantification, and procurement at the national level. LLMCUs will need to be strengthened to ensure the quality of logistics data. **NSCIP Framework for LLMCUs** • The LGAs would be divided into clusters and each supervisor would be responsible for all facilities/programmes in that cluster. (Current programme-specific cluster review meetings are not sustainable.) • Partners/donors will continue to handle quantification and procurement. LMCU/integration project is needed to strengthen logistics activities and quality of service. • Partners are self-interested and exercise great control over logistics of health commodities. Managing the partners/donors for different programmes is critical and requires government leadership. • Warehousing, transport should be handled by partners/private companies but government must take the lead. • Vision of NSCIP is total issue and risk visibility leading to issue mitigation & resolution. Once LGA LMCUs are strengthened, R&R meetings no longer be funded by donors like UNFPA.	
• The integrated commodity distribution which has been adopted by states in Nigeria when fully functional will ensure that contraceptive and other health commodities are distributed to service delivery points. Continued advocacy to states on this new modality, assistance in capacity building and sustained supplementary funding need to be continued by partners until states assume complete ownership of the process.	• UNFPA Nigeria, *Annual Review Summary Sheet, Access to FP Commodities (AFPC) Programme in Nigeria,* March 2016, p. 2-3
• **JSI conducted a study comparing the different LMD distribution systems**, among them the R&R and DDIC systems. 1. **R&R system:** Service delivery point (SDP) facility staff attend meetings in clusters (usually a number of SDPs located in a few geographically contiguous LGAs) where information on consumption and inventory levels is collected or captured; in return, inventory is immediately provided to SDP personnel to be transported by them back to the SDP facilities. Here public transportation is the main mode of transport for facility staff. In Nigeria, facility workers bring their inventory	• Source: Watson, N. Noel, and J. McCord. 2015. *Evaluating Last-Mile Distribution Systems in Nigeria*. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 4, p. xiii-xx.

Question 5: Key Assumptions and Observations	Sources of Evidence
from the facilities to review meetings and information capture of inventory levels is based on physical counts of this inventory. 2. **DDIC: (Also known as the "moving warehouse")** involves a delivery truck and logistics personnel traveling to SDPs and performing physical counts of commodities to determine how much inventory should be given to the facilities, with the required inventory then pulled from the delivery truck. • **R&R systems are heavily dependent on SDP personnel and information capture from inventory counts**. There is a burden placed on health workers and takes their time away from patient care. R&R systems are hampered by the amount of inventory facility worker can carry on public transport; adding volumes eventually results in additional review meetings. The high number of review meetings drives the facility labour costs and general system support costs higher than for other systems lacking such dynamics. However, actual information capture, transport, and storage costs are lowest for R&R compared with other systems. DDIC was found to be more costly to start up, but more scalable than the R&R system	
• **GHSC-PSM** is a 9 billion USD global USAID project for which Nigeria accounts for about 1 billion USD. It is now managed by Chemonics; previously JSI managed the USAID DELIVER project with a similar scope. The programme **supports commodity procurement and technical assistance provision for HIV/AIDS, malaria, FP, MNCH and TB**. In Nigeria, its objectives are to ensure commodity availability for the five programmes, provide health system strengthening to USAID-supported states through collaboration with its consortium partners – Axios, Mckinsey, KHEUN+NAGEL (distribution company), IBM. There are about 11 consortium partners. • For the family planning programme, it **supports 5 states that are not covered by UNFPA** procurement: Bauchi, Sokoto, Ebonyi, Cross River, Kogi and Zamfara (movement of commodities only). There are plans to move to additional states – FCT, Kebbi, Plateau. Moving away from Kogi State because CPR has improved. • There is no overlap between states supported by UNFPA and USAID. • USAID plans to empower local manufacturers to produce family planning commodities. Short-term technical advisors from GHSC-PSM have travelled to the country to understand the context, prequalification issues etc. • **Regarding the Integration Project:** There has been a change in strategy for the supported states – moving to an integrated distribution model in the next couple of distribution cycles. DDIC mechanism will be phased out. • FP commodities will flow through axial warehouses – 4 zonal: Gombe, Anambra, Sokoto, Cross River and 2 central: Abuja and Lagos - and then directly to health facilities. • LMCUs coordinates collation of reports and submit same to programmes to inform resupply. LGA coordinators will no longer resupply health facilities. Efficiencies will be gained as levels are cut from the supply chain. • Integration of LMD of malaria and HIV commodities have already started, there are plans to add family planning commodities in USAID-supported states. LMD will be contracted to 3PLs like IHS.	• Interview: GHSC-PSM Project/Chemonics staff, Abuja

Question 5: Key Assumptions and Observations	Sources of Evidence
• Benefits of the Integration project include: improved cost efficiency, Commodity security, Shortening the pipeline which will affect shelf life of commodities. • There are challenges involved like change management issues; gaps in capacity etc. • Some states like Ebonyi do not know any other system besides DDIC. Data quality issues as a result of change are inevitable. But training of facility staff may address this. • **Re USAID/GHSC-PSM partnership with UNFPA on Procurement,** GHSC-PSM also supports the Family Health department (FHD)of FMoH, i.e., it supports FHD with UNFPA to manage procurement and supply planning of family planning commodities. It also participates in annual quantification exercises. Quantities procured depend on the amount in the basket fund. UNFPA manages procurement for donors like DFID, BMGF, GoN while USAID manages procurement for USAID facilities • **Re Supply Planning for family planning commodities,** a tracker is used to monitor what comes in to the country for UNFPA and USAID procured family planning commodities and received in the CCW. This provides visibility to the last mile. Supply plans are presented at the TWG (besides USAID and UNFPA, other members include CHAI, FMoH, NUHRI, SFH, PPFN). Issues data from state to facilities used as proxy consumption data. There is no nationwide end-to-end visibility at the moment. • UNFPA also moving to the NSCIP model of distribution • Implementation of **Navision** –good progress has been made with partners, government. Has yet to be tested at the LMCU level. Navision already works in the vaccines programme and can flag issues like stock-outs. • UNFPA has influence with the government and has been able to address some challenges with the government, e.g., Delay with release of family planning commodities from the CCW by FHD. There are, however, important issues to be addressed like: how UNFPA intends to fund distribution, who supplies ancillary family planning commodities like IUD kits, mini lab kits? How to address delays in procurement as a result of funding cycle issues. • There is a need for better coordination to cascade decisions to state level.	
• JSI is now providing technical assistance to UNFPA on logistics and in particular, in conducting the **annual facility surveys** that inform RHCS planning. The 2016 report is now available (though not yet on Google drive). • **Different models of distributing family planning commodities have been tried in Nigeria**. Different states have different LMD models. Funding of the LMD at the states remained an issue; states are waiting on the rollout of the integrated LMD. UNFPA-supported states are stuck the old LMD system and the new integration model and this has affected resupply. UNFPA should have a regular system of delivering commodities to the states regularly until integration is fully implemented. • **DELIVER conducted an assessment of the 4 states that use the R&R model and the DDIC model**. The R&R model is a good one as it facilitates OJT, experience sharing. People become more invested in the programme as a result of the meeting. However, staff have to leave the facilities to attend the meetings.	• Interview: JSI staff, Abuja

Question 5: Key Assumptions and Observations	Sources of Evidence
• **Regarding integration of the supply chain,** the government has not been very effective in implementing the project. Nigeria is a big country; technical assistance is required from partners. States need to be more in the integration. Directors of Pharmaceutical Services in the SMoH should take the leadership at the state level. The project requires large scale investment in funding and human resources. Capacity of staff needs to be strengthened. LMCUs also have to be strengthened to be effective in data management. Some LMCU members are staff of a different department of the government than the SMoH and may not report to the Director of Pharmaceutical Services who is the head of the unit. Also, clear lines of reporting need to be established. Political buy in by the commissioner of health and the permanent secretary is also important. Because of its influence, UNFPA is in a unique position to advocate for these and other issues.	
• **The Kaduna State LMCU** does not handle LMD for family planning commodities. The LMCU does manage family planning logistics data which is supplied by the State Family Planning Focal Person. Resupply of family planning commodities to SDPs is done through cluster review meetings. The LMCU hopes to handle supply chain functions for all programmes including the family planning programme. • There are issues with R&R resupply method: The LGA focal person in charge of handling the family planning commodities may lack funds to transport herself and the commodities to and from the review meetings. • LGA LMCUs are expected to assume responsibility for data collection after inauguration. • The Transformation project is a BMGF funded. Uses 3PLs for distribution of SKUs. State hopes to incorporate other programmes with time. • A standalone tool is used by the LMCU for LMIS data management. The national programme has plans to make it cloud-based thereby enabling use by two or more individuals at the same time, which is not the case at the moment. Plans to step down the use of the tool to the LLMCUs.	• Interview: State LMCU staff, Kaduna State
• **Integrated LMD (iLMD) has not taken off at the national level but has been piloted in Lagos State**. The initial plan was to include HIV/AIDS commodities. Discussion were opened with GHSC-PSM but the contractual issues prevented this from happening. The contract – between GHSC-PSM(Chemonics) and GF - for LMD of malaria commodities does not allow for other commodities to be transported along with malaria commodities. It is recommended that GF, NMEP, UNFPA should work on resolving this. • CRS is PR for malaria grant. LMCU determines the order, shares with CRS (state and national), CRS then shares with GHSC-PSM for LMD of malaria commodities. • UNFPA also supported the pilot of iLMD in Ogun and Ondo states. In the pilot, 3PLs had issues with picking and sorting at the state stores. This was resolved by getting experienced LGA managers involved in picking and packing. • There is the concern that while the Integrated LMIS tool will be useful at the state level, it might not work at the facility level due to capacity issues. At the SDP level, parallel tools will probably continue to be used.	• Interview: State LMCU staff, Lagos State

Question 5: Key Assumptions and Observations	Sources of Evidence
• **LGA LMCUs**: composed of individual programme managers for each of the disease programmes. Monitoring and supportive supervision visits (MSSVs) will be integrated, iMMSV tool already available and has components of each programme to leverage on resources of different programmes. For instance, when GHSC-PSM funds HIV/AIDS MSSV, the LMCU joins in and conducts MSSV for all programmes. • UNFPA supports post-LMD monitoring. The post-monitoring tool was also redesigned to enable monitoring of malaria, HIV/AIDS, TB etc. • Lagos has about 500 Public and private facilities. Conducting regular visits to all the facilities is out of the question but if public commodities are distributed to private facilities, it may be possible to conduct supportive supervision at such facilities. • UNFPA supported iSCM TOT training (5-day training on integrated supply chain management) at the state level. The state trainers are expected to step down the training to LGA staff. • **LMCU Challenges**: Funding is a challenge at the LMCU. Staffing is also a challenge at the LMCU. The integrated LMIS tool used at the LMCU is time consuming to fill, not cloud-based and not enabled for multiple concurrent users.	
• FP2020 reported in 2015, "*There has been a consistent and cohesive decision by the government at national levels to support states to take ownership of the last-mile distribution of contraceptives using integrated distribution. This includes using private sector contracting as third party logistics (3PL) and specific system wide strengthening efforts, such as the formation of a State Logistics Management Coordination Unit. There are also efforts to lower the regulatory barriers for importing contraceptives with expedited processing of waivers and product registration by NAFDAC. USAID/JSI and UNFPA are supporting the federal Ministry of Health to conduct last mile distribution of contraceptives across the 36 states and the Federal Capital Territory. The two models deployed are the Review and Resupply Meeting and the Direct Delivery and Information Capture Model. Implementation of last mile distribution over the years has resulted in more than 90 percent availability on contraceptives in health facilities and improved availability of logistic data for decision making.*" • Accessible at: http://www.familyplanning2020.org/entities/61	• Source: FP2020, *Government of Nigeria Official Update on FP2020 Commitment*, 2015.
• **Integration was conceived at national level and states' input was not considered**. For example, PHCs are not supervised by zonal authorities but by the state. Also, the states have different procurement systems from the national government. • **Another challenge is data management**. Each programme has its own data requirements. Different data tools/instruments used by different programmes, so better coordination between partners at the national level is needed to harmonize data management. Disaggregation of data also an issue. For instance, one programme may require information on clients ages 0-29 while another wants another 15-49. • Partners require a multiplicity of data points, it may be preferable to collect information on tracer commodities rather than on all commodities to reduce reporting burden. Some facilities staff are also unclear about the data to be collected.	• Source: Group discussion with Implementing Partners, Kaduna (Child Spacing TWG)

Question 5: Key Assumptions and Observations

- There is national family planning dashboard to capture mainly service data. CSTWG recommended that LMIS be reflected on the dashboard. The dashboard does have provision for LMIS data but is not utilized regularly. LGA staff lack the capacity to make informed decisions even where data is available.
- **Human Resource gaps are also a challenge**. Many RH coordinators are retired. The new ones need to be retrained, including for LMIS

Sources of Evidence

The prevalence of stock-outs and their effects

Percent of Service delivery points reporting a stock-out of a modern contraceptive method on the day of the survey (2013-2016)

- Horstman, et al, 2017, p. 24

Year	2013	2014	2015	2016
Male condoms	10.4	7.8	1.9	5.8
Female condoms	13.4	9.6	0.6	7.1
Oral contraceptives	5.2	4.4	7.8	2.9
Injectables	8.7	3.2	5.7	4.7
IUDS	5.7	5.2	6.2	5.0
Implants	10.4	5.1	6.5	4.5
Female sterilization	5.9	4.1	28.8	11.1
Male sterilization	10.0	5.3	46.7	11.5
Emergency Contraceptives	13.0	13.2	13.8	8.7

Percentage of SDPs (all levels) reporting no stock-outs of contraceptives in last 3-6 months, 2011-2016

- Horstman, et al, 2017, p. 23

2011	2012	2013	2014	2015	2016
Last 6 months		Last 3 months			
42	75	50	78	61	77

- **In 2016, the proportion of SDPs reporting no stock-outs in the last three months was 61% against a milestone of 80% for 2015 and the 78% achieved for 2014**. Increased stock-outs were most acutely felt in secondary health facilities. This increase was due to the transition to an integrated system from the previous approach of review and resupply. The new approach entails centralized distribution of all health commodities in the states with state ownership of the process and address the challenges of LMD. Support to this transition will remain a central focus for 2016.

- UNFPA Nigeria, *Annual Review Summary Sheet, Access to FP Commodities (AFPC) Programme in Nigeria,* March 2016, p.1

- In 2016, UNFPA reported that the **reasons for the stock-outs were delays from higher levels (State/LGA warehouses) to resupply the SDPs, delays by the SDP to request for supply of contraceptives and low or no client demand for contraceptives**. State managers of the Logistic Management Coordinating Unit (LMCU) are yet to take full control of the

- UNFPA Nigeria, *Annual Review Summary Sheet, Access to FP Commodities (AFPC)*

Question 5: Key Assumptions and Observations	Sources of Evidence
commodity distribution in the States (Sokoto, Kebbi States) with the result that there are gaps in the capacity to fully implement the centralized commodity distribution in the states. While the review and re-supply system of distribution has been phased out, the new system has not effectively taken its place, reversing some of the gains made in previous years.	*Programme in Nigeria,* March 2016, p. 10
Assumption 5.2: UNFPA Supplies (through COs) **collaborates effectively with country officials**, to enable **introduction and roll-out** (with requisite training) **of required new manual and automated supply chain management systems** and procedures **including LMIS**, inventory management, distribution to the last mile, track-and-trace mechanisms, etc.	
• **Distribution from federal to states relies on consumption (issue) data supplied by states**. Data is generated from the RIRF. Not all states use uniform software for data management (or, may not use any software at all). This is being addressed through periodic commodity review meetings. • See also evidence from implementing partner group discussion in Kaduna under Section 5.1.	• Interviews: Implementing partner group discussion, Kaduna
• In **Nigeria, the decision has been made to work with the government system (based on Navision)** rather than CHANNEL. • **CHANNEL is used at warehouses, but not completely rolled out to states ("didn't go to scale")**. It is also used at some R&R meetings where logistics focal persons enter data during resupply. Some higher-level facilities also make use of CHANNEL. UNFPA CO pushed for the adoption of CHANNEL in-country but because of the integration project and the agreement by all donors/partners to adopt a common LMIS software platform, this has been suspended. • **All public health programme development partners have agreed to use Navision, introduced by UNICEF** for the vaccine programme, which is owned by the Nigerian government. The module currently used in Nigeria is the warehousing module. Navision is compatible with the DHIS, and will enable synchronization of service delivery and commodity data. It will provide greater visibility to actual consumption (not issues) which would improve forecasting and quantification. Navision is meant to be a control tower; data from any LMIS software will feed into the platform (preferable to having all five programmes change the LMIS tools/software in use). • LMIS is partly paper-based now. • Partners are all contributing toward developing the software for the use up to facility level to ensure visibility to the last mile. • The first phase of Navision was flagged of in October 2017 and is expected to run for 18 months. • The second phase happens when data from the logistics end is linked to HMIS data • There is also the **Global Family Planning VAN (Visibility Analytical Network)** to be used to provide visibility in to RH commodities globally. Still at discussion phase by Reproductive Health Supplies Coalition. Nigeria has been selected to be one of the pilot countries for the Global VAN. • There is concern that the integrated LMIS tool will be useful at state level, but might not work at facility level due to capacity issues. At SDP, parallel tools are likely to continue to be used. The integrated LMIS tool used at LMCU is time consuming to fill; not yet could-based and not enabled for multiple concurrent users.	• Interviews: UNFPA Nigeria CO, Abuja, Kaduna and Lagos

Question 5: Key Assumptions and Observations	Sources of Evidence
• **In Lagos, State Government adopted CHANNEL among 7 different LMIS**.	
• **BMGF is funding the Kaduna State Transformation Project** to support integrated supply chain and LMIS for essential medicines. The project is different from Navision, and is for products that the State has jurisdiction over and are distributed from Kaduna warehouse to all PHCs using 3PLs.	• Interviews: Kaduna Health Officials
Assumption 5.3: UNFPA Supplies has access to **high-quality supply chain management systems and to capability/expertise**, and the **ability to convey these and to share technologies** (for example CHANNEL software) with the 46 programme countries.	
• While the CCW and some states use **Channel software**, this is stand alone and not connected online. For example, personnel in Abuja can only access the data when the staff in CCW Lagos or at the states prints it and sends it to them via email. Capacity is still needed at states, LGAs and facilities so that the data will be more reliable.	• Interviews: Implementing partner group discussion, Lagos
• In **2015, UNFPA supported 45 national and 350 state programme officers from 14 states to improve their knowledge of logistics management and last mile delivery using integrated systems**. A total of 70 service providers were trained in the streamlined CLMS and Logistics Management Information System in 3 states including capacity building for the Logistics Management Coordination Unit (LMCU) responsible for implementing integrated last mile delivery of public health commodities.	• UNFPA Nigeria, *Joint Thematic Trust Funds Annual Progress Report*, 2015 p.17
• *"UNFPA supported implementation of its Channel software (from 2015 onwards) and was adopted by the FMoH in 2016 as the standard to be used at national and state level as part of the NSCIP. UNFPA and partner have built the capacity of federal and state personnel to use the software as well as strengthen the LMCUs on a range of functions including forecasting, warehousing, integrated last mile commodity distribution, reporting as well as data analysis. Commodity quantification has been given specific attention in order to replace the former review and resupply meetings where this activity took place."*	• Horstman et al, 2017, p. 28
• **Channel was introduced in 2012 as a major improvement on the supply chain management system of public health commodities in Nigeria.** It has the capacity to manage and forecast for all the 34,000 public health facilities and for over 1000 commodities and supplies capturing the inflow and outflow including stock issuance data, stock expiry data, losses and adjustments and automated reports by health facility and by levels in the system. Channel helps to track the batching of products and eases the implementation of the principle of first expired, first out, to ensure that commodities with the nearest expiry dates get first distributed, despite they arrival dates in the warehouse. • UNFPA trained staff from the Central Contraceptive Warehouse.	• UNFPA Nigeria, *Nigeria Saves Lives: Success Stories from UNFPA Nigeria,* Abuja, March 2015, p. 36
Assumption 5.4: At the country level, UNFPA Supplies support **focuses on providing incremental value** (adding to the efforts of government and others without duplication), supporting **sustainability**.	
• See Section 5.1 for collaboration with USAID to collaborate and support the supply chain in Nigeria	

Improved programme coordination and management	
Evaluation Question 6:	To what extent have **the governance structures** (UNFPA Supplies Steering Committee) **management systems and internal coordination mechanisms** of UNFPA Supplies **contributed to** overall **programme performance?**
Sub-Questions:	a) To what extent have the UNFPA Supplies Steering Committee and UNFPA programme managers (HQ, Regional and COs) been effective in **providing strategic direction and oversight** to UNFPA Supplies as well as **internal programme coordination** at the global, regional and national level? Are Steering Committee members satisfied with the current governance structure? b) Have systems for **work programming, budgeting, review and approval** been effective at the global, regional, and country level? Has UNFPA Supplies been **effectively integrated into UNFPA country programmes**? c) Has UNFPA Supplies been able to assemble and deploy the **required human resources with the appropriate mix of skills and capabilities** to effectively support programme implementation at global, regional and national levels? d) To what extent have the **systems for results-monitoring, reporting and accountability** for UNFPA Supplies been effective? Have they contributed to **learning and knowledge management** and to ongoing programme management?

Question 6: Key Assumptions and Observations	Sources of Evidence
Assumption 6.1: Systems for work planning, budgeting, approval and review of UNFPA Supplies at the country level incorporate **meaningful participation by national health authorities, implementing partners and other key stakeholders**.	
• **UNFPA was described as a very responsive as well as visible and supportive partner**. Funds are regularly released for iLMD. In addition, UNFPA provided step-down training for SCM. UNFPA (sub-CO in Lagos) has also successfully advocated for getting counterpart funding released from the state.	• Interview: Lagos SMoH and Dir. of Pharmaceutical officials, Lagos
• The **UNFPA sub-office covers Lagos State and some other states in the Southern region** of Nigeria and works in partnership with IPs in the family planning space. UNFPA supported the Sayana Press pilot. NURHI trained service providers, mainly midwives on injection of Sayana Press. CHEWS did not receive the training on Sayana press as the midwives' association (which is quite influential in Lagos State) is resistant to the task-shifting policy and the idea of CHEWS administering LARCs. • Partnership with State Government: the **Lagos State government is a forward looking one and has been quite supportive of family planning** activities. There has also been continuity in programming because the commissioner for Health has been in the leadership of the SMoH for almost 12 years. The state is focused on supporting the achievement of the national CPR target (36%) of which Lagos State is expected to contribute toward achieving the target by 74%. Through the UNFPA supported Government Counterpart Cash Contribution, the government funds consumables, LMD, capacity building, demand creation and other activities. • In 2011, UNFPA, USAID and other partners advocated for **more investment in family planning programming**. That was a catalyst for the improvements recorded. FP2020 has also helped greatly especially with the establishment of targets. One UNFPA staff person indicated that it would be good to establish targets at LGA level and below.	• Interviews: UNFPA Nigeria CO, Lagos

Question 6: Key Assumptions and Observations	Sources of Evidence
• However, the **Lagos state government does not yet have ownership of the programme** even as it has provided funding for commodities. In terms of service delivery and demand creation, the funders and donors provide direction and leadership to the government. There are a few coordination forums at national and state levels.	
• **Coordination between IPs has been key to success**: this has resulted in harmonization of work plans, collaboration to avoid duplication of roles, and cost sharing. The TWG has sub-committees which handles different functions. • **Development of the CIP has also been key**. There are however parts of the CIP that remain unfunded. The government has allocated funds to address the identified gaps.	• Group discussion, Implementing partners attending Kaduna CSTWG, Kaduna State
• **UNFPA support has been crucial**. They helped advocate to the government on behalf of the SMoH staff for increased programme funding.	• Interview: State family planning official, Kaduna
• UNFPA supports **the partners' forum** to bring together all the stakeholders, donors, IPs, NGOs for state-level coordination of public and private sector activities. **FPTWG** meets regularly; the larger forum meets two times/year. Partner forum provides partners opportunity to share and exchange information to avoid duplication and competition.	• Interview: UNFPA CO staff, Lagos
Assumption 6.2: UNFPA Supplies has been able to access **appropriate and needed human resources** at the global, regional and national level.	
• No evidence collected regarding this assumption.	
Assumption 6.3: The systems and processes for the **governance of UNFPA Supplies** (including the UNFPA Supplies Steering Committee) have been effective in balancing the viewpoints of donor partners, programme country health authorities, programme managers and other key stakeholders in providing **strategic direction and over-sight** which is **responsive to differing contexts and changing conditions**.	

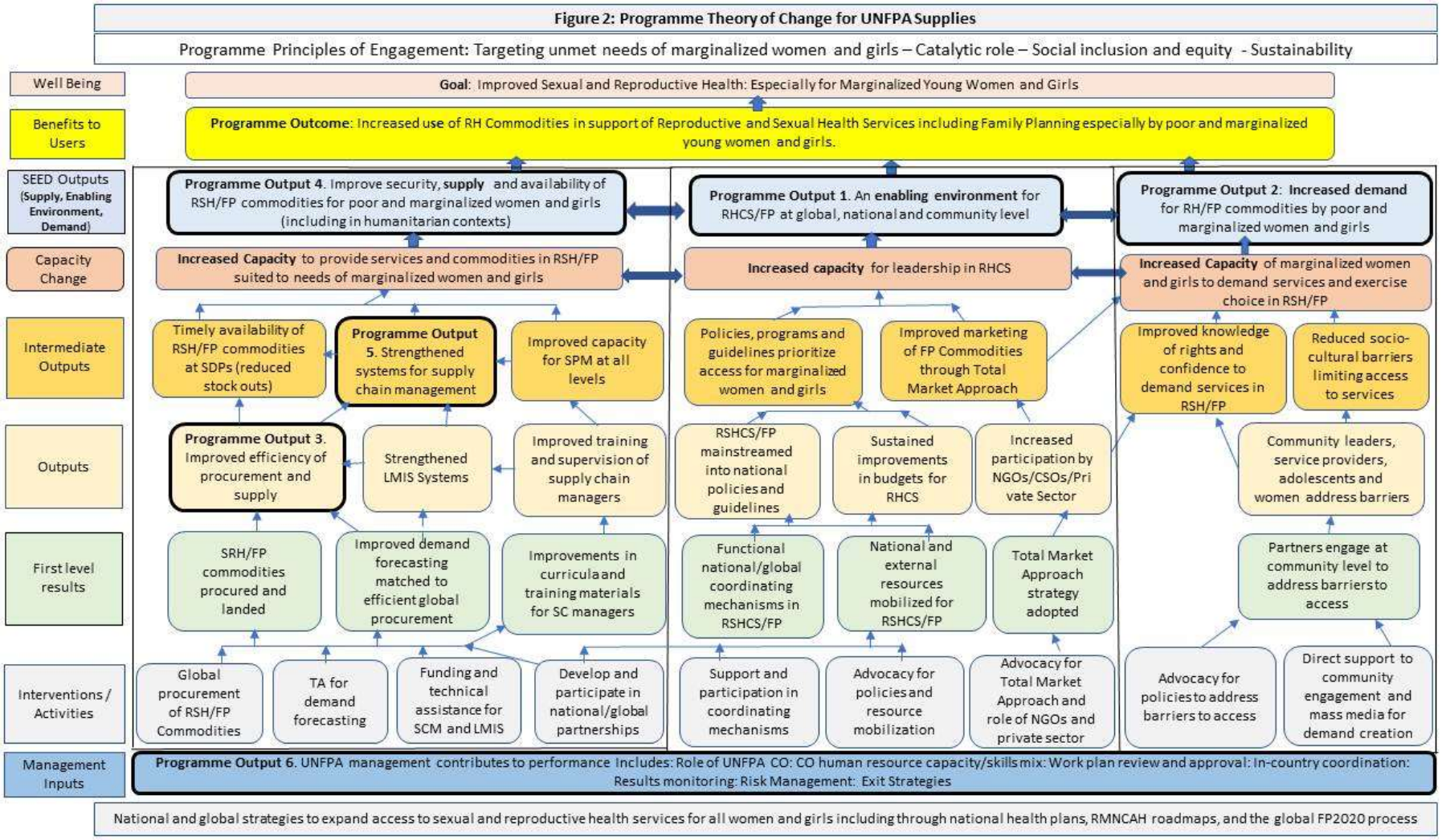
Cross Cutting Theme: The Catalytic Role of UNFPA Supplies	
Evaluation Question 7:	To what extent has UNFPA Supplies **played a catalytic role** by leveraging increased investment by other actors and supplementing existing programmes in RH/FP at global, regional and national levels?
Sub-Questions	a) To what extent has UNFPA Supplies been able to leverage increased investments and commitments by other actors in support of RH/FP commodities and services at global, regional and country level? b) To what extent has UNFPA Supplies programming been **sufficiently flexible and responsive to changing country needs and priorities**, including during and after humanitarian crises? c) To what extent has UNFPA Supplies supported **effective action to mitigate environmental risks** in procurement and disposal of RH/FP commodities?

Question 7: Key Assumptions and Observations	Sources of Evidence
Assumption 7.1: The **design of UNFPA Supplies** as reflected in strategic documents and in systems and processes for programme planning, approval and review, takes account of the roles of other actors and sources of support to RH/FP and attempts to influence them in their programming and **leverage** their resources.	
• UNFPA assisted the FMoH to hold a **"Day of Dialogue" on family planning** in Nigeria: 1. To review the progress of Family Planning Programming in Nigeria with regards to concrete results, quality of service and resource mobilization 2. To provide updates on FP2020 developments and progress 3. To engage Stakeholders with regards to Family Planning activities and continue to build momentum	• FMoH and UNFPA, *Report of the Family Planning Stakeholders meeting of 30 April, 2013*
• **UNFPA continued its technical assistance to improve programme coordination and management at national level**. UNFPA supported the National Planning Commission (NPC), a federal government agency responsible for formulating and monitoring the implementation of national development plans as well as coordination and management of development cooperation. 1. In 2013 the CO had provided financial support to NPC to conduct the 2013 Resource Flow Survey (RFS) that generates data on resources utilized for "Population Activities" including Family planning services, basic reproductive/maternal/adolescent health services and basic research, data and population and development policy analysis. 2. The CO **also supported three states (Kaduna, Lagos and Cross Rivers) to domesticate the Family Planning Blue Print** in the States by supporting the development of costed implementation plans. The process included consultations with stakeholders in the selected States and review of existing data to produce validated situation analysis of family planning.	
Assumption 7.2: The process for planning, budgeting, implementing, reviewing and monitoring UNFPA Supplies at country level is **responsive to the needs of national stakeholders** (national authorities, development partners, NGOS, civil society and the private sector) including in humanitarian settings. It also contributes to **strengthened/increased action** to address needs.	
According to a SWOT analysis done in 2015 to review the period 2013-2015, UNFPA Nigeria reported the following: • UNFPA CO in Nigeria supports the Federal Ministry of Health (FMoH) and partners to initiate and implement evidence-based programming using the Nigeria Demographic Health Survey (NDHS) and other studies. • Examples of successes in UNFPA CO support to Government to **use data for evidenced- based programming and advocacy** are stated below: 1. Conduct of **Willingness to Pay Survey in 2010** which provided evidence on cost as a prohibition for access and led to Government Free Contraceptives Distribution policy in April 2011 2. Use of evidence on impact of contraceptives programme to persuade **Government to commit resources** to commodity procurement through the **basket funds** 3. The support to Federal Ministry of Health (FMoH) and National Population Commission to use evidence from **annual survey on availability of essential medicines at service delivery points** from 2011 to 2015 (with funding from UNFPA Supplies Programme).	• UNFPA West and Central Africa Regional Office, 2015, *SWOT Analysis: UNFPA Family Planning Interventions in West and Central Africa 2013-2015 (Nigeria)*

Question 7: Key Assumptions and Observations	Sources of Evidence
4. UNFPA Nigeria also supports conduction of the **National Demographic Health Surveys** and the **National Census** as well as other population based surveys like the **MICS** in collaboration with other partners. UNFPA Nigeria has also supported sub analysis of the 2003, 2008 and 2013 NDHS to documents the trends of **specific family planning indicators including CPR, unmet need, teenage pregnancy**, etc. UNFPA Nigeria uses the **convening collaborative advantage** to convene annual family planning Stakeholders' Consultative meetings in 2013, 2014 and 2015 which led to significant resolutions and contributed to re-strategizing the National Family Planning Programme and rallied support from sub-national government and other development partners.	
• **Challenges in Nigeria** are: 1. **Limited State-level buy-in led to funding gaps** regarding commodity security and training on LARC services provision 2. **Shortage of investments focused on demand generation** (large family sizes and low unmet need in the North) especially among young people 3. Need for additional **capacity building** to strengthen data analysis and performance management. • **Priorities** are to: 1. **Mobilize resources** for sustainable commodity security and supply chain; timely counterpart contribution from Government to basket funds for contraceptive procurement 2. **Enable a programming environment for greater uptake and delivery of family planning** services by implementation of State CIPs and a national BCC strategy. **Use data** to improve accountability and decision-making, especially with regard to return on investments in public and private sector channels.	• Source: PPT slide presented at FP2020 Reference Group Meeting, London June 29-30, 2016
• In **2016** UNFPA engaged consultants to work with the FMoH to draft a **Sustainability Plan for the Family Planning Programme** including incremental funding from Government at national and sub-national levels as well as innovative financing mechanisms. Ongoing efforts are underway to finalise the plans in 2017. A risk assessment of the sustainability of **the basket funds** was conducted in 2016. In addition, efforts were made to ensure family planning funding was included in the **GFF Investment case for RMNCAH**. The Federal Government has renewed its agreement to continue to contribute to the Basket Fund for the period 2017-2020 (this is done every four years). It is expected that this will also encourage partners to renew commitment to the basket fund in the next four years. • Through the **Family Planning Blueprint**, State Governments followed suit with State Blueprints or Costed Implementation Plan (CIP) that demonstrated significant support for family planning initiatives.	• Horstman, R. et al, *Access to Family Planning Commodities in Nigeria, 2011-2016, End of Programme Evaluation Report,* 2017, p.15-16
• The **regional focal point meeting for FP2020** was held in **November 2017**. According to the FMoH official who attended, several priorities were identified that build on the recent updated commitment made at the London Family Planning Summit in 2017. **Key actions** for acceleration include: 1. **Scaling up demand generation** interventions to promote family planning as a social norm 2. **Expanding access** through Task shifting policy and Community Based Distribution of family planning 3. **Increasing access to quality family planning services** through capacity building of Health Care workers 4. **Improving distribution to the last mile** to ensure reduction of stock-outs	• Interviews: FMoH officials, Abuja • FP2020, *Actions for Acceleration, 2018-2019, Nigeria*

Question 7: Key Assumptions and Observations	Sources of Evidence
• Revising the Family Planning Blue Print to include emerging issues and supporting drafting states CIPs **(**Embedding human rights based approach in the national and states CIP blue prints, including family planning in Humanitarian situations)	

5.2 Annex 2: Comprehensive theory of change for the UNFPA Supplies Programme



5.3 Annex 3: Persons Interviewed

Organization	Person Interviewed	Position
Abuja/FCT Interviews		
UNFPA Nigeria, Abuja	Keita, Diene	Representative
	Kongnyuy, Dr Eugene	Deputy Representative
	Adedeji, Olanike	National Programme Specialist FP/RHCS
	Anene, Amaka	National Programme Analyst
	Pistilli, Dr Sabrina	Maternal Health Advisor
	Anakhuekha, Emilene	Programme Associate
	Daura, Fatima M.	Reproductive Programme Analyst, Humanitarian Team
	Abubabakar, Zubaida	ASRH/HIV Officer
	Sageer, Rabiatu	National Programme Analyst, Maternal Health
	Dasogot, Dashe	National Programme Analyst, Demography
	Ezikeanyi, Dr Samson	Health Systems Specialist
	Musa, Elisha	Programme Officer
Federal Ministry of Health	Adebiyi, Dr Bimpe	Director, Family Health Department
	Afolabi, Dr Kayode Akintola	Head of Reproductive Health Division, Department of Family Health
	Adineran, Dr Bose	Former Director, Reproductive Health
National Primary Health Care Development Agency	Nelson, Mrs. N.C.	Deputy Director, Primary Health Care Systems Development
UK Department for International Development (DFID)	Anyachukwu, Dr Ebere	Health Advisor
	Hogan, Edem	Programme Manager, Human Development
USAID Nigeria	Ogwuche, Emmanuel A.	Logistics & Commodities Programme Manager, HPN Office
	Morenikeji, Kayode	Programme Manager, Reproductive Health, HPN Office
Global Health Supply Chain – Procurement and Supply Management (Chemonics)	Otto, Kenny	Deputy Country Director, Technical
	Ibeme, Antonia	Quantification Manager –forecasting and Supply Management team
	Askederin, Fatiya	Field Programme Management from warehouse to last Mile
	Urama, Bennett	Forecasting and Supply Planning Advisor
National Supply Chain Integration Project	Odoemene, Linus	NSCIP National Coordinator
Area 2 Clinic, Garki	Eniola, Awoniyi	Family Planning Focal Person

Organization	Person Interviewed	Position
FCT Family Planning Store, Area 2 Clinic, Garki	Alonge, Kikelomo	Store Keeper
Dutse Primary Health Care Clinic	Taiwo, Shola	Family Planning Focal Person
Association for Family and Reproductive Health (AFRH)	Ladipo, Professor O. A.	President and C.E.O.
	Osinowo, Kehinde A.	Director, Programmes
Education as Vaccine (EVA)	Alugh, Bem	Service Delivery and Information Sharing
	Enwerem, Patrick	Advocacy and Policy Planning
John Snow International	Igharo, Elizabeth	MEASURE Evaluation, Project Director
Marie Stopes International of Nigeria (MSIoN)	Palmer, Lucky	Director of Programmes
	Bello, Ademola J.	Inventory and Asset Management Coordinator
	Philips, Udeagbaja	Grant Accountant
	Samuel, Amade	
Nursing and Midwifery Council of Nigeria	Alheri, Yusuf	Deputy Registrar
Planned Parenthood Federation of Nigeria (PPFN)	Ibrahim, Dr. Ibrahim Muhammad	Executive Director
	Nenthok, Gokum	Supply Chain Manager
	Iluno, Ada	Programme Officer (DMPA SC)
	Awolaye, Abiola	Programme Officer (Humanitarian)
	Aku, Okai H.	Acting Director of Programmes
Society for Family Health (SFH)	Anyanti, Jennifer	Deputy Managing Director Programmes
	Idogho, Dr Omokhudu	Deputy Managing Director, Social Business Enterprise
Kaduna Interviews		
UNFPA Nigeria, Kaduna sub-Country Office	Darboe, Mariam	RH Representative
	Onoja, Dr Matthew	Monitoring and Evaluation Analyst
Kaduna State Ministry of Health and Human Services	Dogo, Dr Paul Manya	Commissioner of Health
	Zakari, Dr Ado Mohammed	Director of Public Health
	Marcus, Cecilia, J.	State Family Planning Coordinator
Drug and Medical Supplies Management Agency, Kaduna State	Abdulkadir, Ramatu	Executive Secretary
	Noma, Samuel T.	Programme Officer, Free Services
	Lekwot, Yohanna	Director, Logistics and Operations
Pamela Steele Associate Ltd.	Akut, Stephen	Country Representative
LMCU Office, Kaduna State Ministry of Health	Boyis, Mercy	LMCU Coordinator
	Tokan, Hope S.	LMCU Data Analyst
	Nzeto, Samuel	Logistics Interns (GHSC-PSM)

Organization	Person Interviewed	Position
and Human Services (workshop)	Bulus, Hope G.	Data Consultant, NSCIP
	Joshua, Alamide S.	Logistics Advisor (GHSC-PSM)
	Onwuegbusi, Sandra	CRS
	Dadogot, Agnes P.	CRS
	Eze, Juliet	Volunteer
	Malgwi, Helen	Volunteer
	Boyis, Abba	Volunteer
Child Spacing Technical Working Group – Kaduna (group discussion)	Bashir, Bashir Adamu	MNCH2 Project (Palladium) Kaduna
	Echu Friday	MNCH2 Project (Palladium), Kaduna
	Abubakar, Dr Sani Dahiru	CHAI, Kaduna
	Gutep, Emmanuel	PPFN
	Halid, Bathsheba	Voluntary Rights-based Family Planning Project (Palladium)
	Bello, Dr Sakina	Pathfinder
	Ewulum, Dr. Kenny	Pathfinder
	Tukur, D. Mansur	Palladium, BMGF/Technical Support Unit
	Mohammed, Dr. Amina	UNICEF
	Martins, Olaitan	Pathfinder Abuja
	Nuhu, Khadijah A.I.	NURHI 2
Sabon-Gari PHC, Kujama Chikun LGA	Emeanuru, Genevieve I.	Facility-in-charge
	Mairabo, Rebecca M.	RH Focal Point
Badarawa PHC	Abubakar, Asma'u	Facility-in-charge
Lagos Interviews		
UNFPA Nigeria Lagos sub-Country Office	Dr Omosemi	RH Representative
	Duro-Aina, Dr Titilola	National Family Planning/Maternal Coordinator
	Ayeni, Samson	Logistics Associate
Lagos State MOH	Adejumo, Dr Moyosore W.	Acting Permanent Secretary Lagos SMoH and the Director of Pharmaceutical Services
	Adedapo, Margaret	LMCU Coordinator
Lagos State Central Medical Stores	Olamide, Tayo-Olufemi Aderonke	State Logistics Officer
FP-TWG Lagos State (group discussion)	Vistor-Uadiale, Ify	NURHI-2
	Anebusoye, Ayo	Chairman PHSAI
	Kutelu, Evelyn	MSION
	Olufemi A. O., Tayo	Family Planning Logistics Officer
	Olaideyegun, Mariam	Palladium
Sango PHC, including youth friendly centre	n/a	
	Dare, Michael Oluwaseunfunmi	Youth Officer/Site Coordinator

Organization	Person Interviewed	Position
Okwu-Awo Youth Friendly Facility, Lagos Island	Ugwuezuoha, Catherine	Officer in Charge
	Sadiq, Aisha	Health Attendant
	Birch, Adeola	ASRHO/LSMoH

5.4 Annex 4: References

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