

Long-Acting and Permanent Methods: Critical for Expanding Choice, Increasing Program Impact, and Saving Lives

FINDINGS AND RECOMMENDATIONS

December 2010



Core Assessment Team:

L. Bakamjian (Team Leader)
A. Adekunle
J. Holfeld
R. Leke
A. Randawa
L. Van Lith

© 2010
The RESPOND Project/EngenderHealth.
All rights reserved.

The RESPOND Project
c/o EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@respondproject.org
www.respondproject.org

This publication was made possible by the generous support of the American people through the Office of Population and Reproductive Health, U.S. Agency for International Development (USAID), under the terms of cooperative agreement GPO-A-00-08-00007-00. The opinions expressed herein are those of the publisher and do not necessarily reflect the views of USAID or of the United States government.

CONTENTS

Acknowledgments	v
Executive Summary	vii
I. Background	1
Why LA/PMs?	2
II. Assessment Purpose, Methodology and Framework	5
Purpose and Methodology of the Assessment	5
Assessment Framework	6
III. Findings	9
Secondary Analysis of Family Planning in Nigeria: Where Do LA/PMs Fit In?	9
Major Findings	11
A. Findings—Supply	11
B. Findings—Enabling Environment	14
C. Findings—Demand	18
IV. Strategic Approaches and Recommendations	23
Underlying Principles	23
Toward a National, Strategic Approach for LA/PM Programming	23
Strategic considerations regarding the Public and Private Sector programming for LA/PMs	25
Approaches for Expanding Access, Quality, and Use to Increase Supply	26
Approaches for Building an Enabling Environment	28
Approaches for Building Acceptability, Demand, and Proper Use	30
V. Coordination and Collaboration	33
VI. Actions for The Immediate Future	35
References	37
Annexes	
Annex I: Health Services Pyramid	39
Annex II: Advocacy Briefs	41
Annex III: Scope of Work, Protocol, Focus Group Discussion Guide	43
Annex IV: Secondary Analysis of the 2008 DHS	
Annex V: Donor Matrix	

ACKNOWLEDGMENTS

The assessment team extends its full appreciation to the U.S. Agency for International Development (USAID)/Nigeria for pursuing the important subject of long-acting and permanent methods of contraception (LA/PMs) in Nigeria. Worldwide experience indicates that LA/PMs must be included in the contraceptive method mix to assist couples in meeting their reproductive intentions and to realistically achieve national health and development goals. The team concludes that LA/PMs are critical to expanding choice, increasing program impact, and saving lives.

Special thanks go to Ms. Sharon Epstein, USAID/Nigeria Team Leader for Population, Health, and Nutrition, who put the subject on USAID's action agenda and who recruited the EngenderHealth-led RESPOND Project to do this in-depth assessment. The team is grateful for the leadership of Dr. Folake Olayinka, who interfaced with the team throughout the process, and to all of the USAID team members, who gave so willingly of their time and thoughtful input. The team appreciated the input of Ms. Epstein, Dr. Olayinka, and Mr. Kayode Morenikeji during the field visits.

The team particularly would like to express gratitude to the Ministry of Health officials, especially Dr. Bose Adeniran, Mrs. Olajumoke Ajayi, and Mrs. Nneka Oteka, who represented the Government of Nigeria in many meetings and who actively participated in visits to the field. Appreciation also goes to the many officials and individuals—State Commissioners of Health, state and local government area officials, and service providers and clients at health facilities—who helped the team gain a deeper understanding of what happens on the ground.

The team recognizes representatives of the donor agencies and the implementation partners who so willingly gave of their time and knowledge to share their work and ideas. Special credit must go to the United Kingdom Department for International Development (DFID) and to the United Nations Population Fund (UNFPA), who pledge collaborative action in the sector. Dr. Christian Ibeh of UNFPA must be singled out, as he devoted so much time and input to the core team that he was designated as an honorary member.

Finally, appreciation goes to the RESPOND Project for its organizational and financial support for this important assessment. Special kudos go to Dr. Iyeme Efem and the EngenderHealth/Nigeria team and for the New York RESPOND staff for the vital logistical, research, and program support provided to the team.

The authors' views expressed in this publication do not necessarily reflect the views of the United States Government or the U.S. Agency for International Development.

EXECUTIVE SUMMARY

The United States Agency for International Development (USAID) Mission in Nigeria requested the RESPOND Project partnership led by EngenderHealth to organize an assessment of long-acting and permanent methods of contraception (LA/PMs). The purpose of this strategic analysis was to: 1) assess the use of, unmet need for, trends in, and current programs for LA/PMs in Nigeria; and 2) develop strategic approaches for strengthening access to and availability, quality, and use of these services. Family planning has been identified as a pillar of safe motherhood in its ability to reduce the consequence of unintended pregnancy, including maternal and child deaths; yet one in five Nigerian women have an unmet need for contraception. In order to meet this need a wide range of modern and effective methods is required, including LA/PMs. LA/PMs are highly effective and safe. They are associated with longer-use and less discontinuation and, therefore, critical to ensuring choice, increasing program impact and saving lives. It is with this rationale in mind that this strategic assessment was commissioned by USAID.

The core assessment team¹ consisted of six international and Nigerian experts but expanded intermittently to allow full participation of officials from the Federal Ministry of Health (FMOH) and other international donors, including United Nations Population Fund (UNFPA) and the United Kingdom Department for International Development (DFID), as well as USAID technical staff. Prior to the team's arrival in Nigeria, RESPOND conducted a secondary analysis of the 2008 Nigeria Demographic and Health Survey (NDHS) and reviewed key background documents.

The team convened in Nigeria from September 10 to September 30, 2010 for a field review. This review allowed interviews with key government officials, key implementing partners, donor agencies, and USAID technical staff in Abuja; a stakeholders meeting was held and interviews conducted with key partners. The team visited seven states (representing all six zones), to permit site reviews at 47 institution and facilities representing all tiers of the health system (tertiary, secondary, and primary levels), as well as allow exchanges with officials, service providers, and clients at all levels of government (national, state, local government area [LGA], and ward).

The team organized the assessment using EngenderHealth's Supply-Enabling Environment-Demand (SEED) Programming Model for Family Planning/Reproductive Health, focusing on LA/PMs. This SEED programming model conceptually presents a logical framework positing that family planning with LA/PMs can be more successful and sustainable if it includes interventions that:

- Address quality services and other supply-related issues
- Strengthen the enabling environment to positively support the expansion of LA/PMs
- Improve knowledge of and the image of LA/PMs by cultivating knowledge of, demand for, and use of services.

This approach to programming also recognizes that these three program components—service supply, enabling environment, and demand—do not operate in isolation. These

¹ The team members were: L. Bakamjian (Team Leader); A. Adekunle, J. Holfeld, R. Leke, A. Randawa, L. Van Lith

three program areas are linked together; investments in one component can and will have an impact in another area, including quality client-provider interaction, capacity and systems building at all levels, and transformation of social norms for the acceptance and use of LA/PMs. Highlights of the key findings of the assessment are noted below.

The Key Findings

The team found that the environment and the health system in Nigeria are complex and diverse—politically, ethnically, culturally, and programmatically. The key observations and recommendations highlighted in this report focus on providing quality services, developing a supporting environment, and creating demand for LA/PMs. As detailed and documented throughout in this report, both **opportunities** and **challenges** exist to increase access to, quality of, and use of family planning, particularly for LA/PMs.

Opportunities: On the positive side, the climate for family planning programs is improving in great measure due to concerted efforts by USAID in coordination with DFID and UNFPA to revitalize FP programs in collaboration with the FMOH. USAID/Nigeria's HPN team commissioned DELIVER to work with the FMOH, state and local governments, NGOs, bilateral projects and other donors to produce a detailed 5-year forecast of contraceptive commodity needs. This process served as a means to generate increased commitment and funding to support commodity needs for 2010 and 2011. Other important initiatives by USAID include the support of studies on the ability to pay and cost recovery (along with a willingness to pay study by UNFPA) that will be used to make the case to the GON to address the cost barriers for FP clients and the support for private and NGO sector efforts to expand FP service delivery. This renewed attention makes the time ripe for addressing LA/PMs, methods which are often neglected when FP is diminished as a health priority.

There are family planning program champions at all levels, although they are few and aging. Good policies supporting family planning, even LA/PMs, have been promulgated at the national level. The FMOH has developed standards of care and protocols for all family planning methods, including LA/PMs. Analysis of the NDHS shows that 20% of women of reproductive age want to either limit or space their next pregnancy. The demand for family planning, and more especially for LA/PMs, exists in all parts of the country: For example, there is high unmet need in the South West, where family planning use is relatively higher; by contrast, in the North East, where family planning use is currently low; there is an almost equal extent of unmet need. The NDHS also shows that in all regions, actual fertility is higher than intended fertility.

Throughout the system, both in the public and private sectors and also with nongovernmental organizations (NGOs) and mission hospitals and networks, there are examples where family planning services, including LA/PM services, are available. Donors and their implementing partners have built expertise and models that provide a foundation upon which to build and expand service delivery: For example, former voluntary surgical contraception (VSC) efforts are remembered, and vestiges of these early programs are still in place in some states. There are successful models with private-sector providers that foster LA/PMs, such as those sponsored by the Society of Family Health (SFH) and Marie Stopes International (MSI). At the primary health care level, the

Midwives Service Scheme (MSS) shows promise as a springboard for expanding provision of the intrauterine contraceptive device (IUCD), hormonal implants, and injectables. There are some models of family planning education, counseling, and basic services included as a component of antenatal, delivery, and postpartum services, postabortion care, HIV counseling and testing, and child health and immunization clinics.

Further, there are examples of successful community mobilization models, including those supported by the Community Participation for Action in the Social Sector (COMPASS) project and the Maternal and Child Health Integrated Project (MCHIP). Traditional and religious networks exist, and it has been documented that these avenues can be effectively used for information dissemination. Many providers met during the assessment had received basic training in techniques of interpersonal counseling and communication. The assessment noted that there were cases where demand creation initiatives had led women to travel 150 km for family planning services and left others frustrated when supplies were not available.

In recent years, new funding sources have increased the potential financial support for health care, including available funding for reproductive health. These include the Millennium Development Goals (MDG) Fund (tied to debt relief), the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), and the National Health Insurance Scheme (NHIS). If the proposed health plan passes into law, as much as 2.0% of the national budget could be used for health care. To date, donors provide support for almost all family planning and LA/PM interventions, as well as contraceptive commodities, for the country.

Challenges: Sadly, almost every opportunity has a caveat. While opportunities exist, there are also considerable obstacles to increasing access to, quality of, and use of family planning, especially for LA/PMs.

As stated above, the national policies supporting family planning and LA/PMs are strong, but these are not adequately financed, appropriately backed with the human resources required, or effectively pushed down to the state and LGA levels for implementation. While champions do exist, an entire generation of stalwarts who can lead and be advocates for family planning and LA/PMs is lacking. Family planning is included in the pre-service training of physicians and nurses, but there is little practical training to adequately prepare providers to conduct LA/PM counseling and service delivery. Consequently, providers are not fully knowledgeable or skilled across the tiers of the health care system, especially at the primary health care level, and they require further in-service training to perform at required levels.

Despite the good news regarding improved forecasting and purchase in 2010 and beyond, LA/PMs continue to face a serious challenge in that equipment, commodities and supplies remain inconsistently available throughout the country, especially for LA/PMs. There are frequent stock-outs and an irregular supply of contraceptives, mainly at public-sector service sites, thereby narrowing the method mix to short-acting methods and limiting contraceptive choice, particularly for LA/PMs. Further, the public health system in many states provides free services for antenatal care, delivery, and postpartum care, as well as well/sick baby services, but charges fees for family planning services. The cost of hormonal implants is prohibitive (3,000–8,000 Naira per unit), as is that for female

voluntary surgical contraception (10,000–15,000 Naira), making cost a barrier to access to these methods.²

From the point of view of demand, there is little to no consistent social and behavior change communication (SBCC) focused on LA/PMs. Major misconceptions pertaining to LA/PMs are found nearly everywhere, with little coordinated effort made to counteract those myths. Side effects are often exaggerated, with fears outweighing reality. Many women know or perceive that their husbands are against family planning. While some solid community work has been done, few communities have been motivated to the point where there are strong advocates for services, nor do they fully support LA/PM use within the community.

Because of the lack of skilled and confident workers and the lack of available information and motivation, provider biases prevail. Providers often offer only those methods for which they have commodities available at a site. If services do exist, as in this scenario, the lack of skilled personnel, commodities, and necessary equipment and supplies, coupled with the inability to offer a choice, renders the service lacking in quality. Generally speaking family planning has not been a *priority* in either the public, private, or NGO service delivery systems—and certainly not LA/PMs.

During the field visits, three main themes emerged in all of the places visited and from most, if not all, of the key informants. When asked what can be done to revitalize or introduce LA/PMs, respondents highlighted the following as needed actions:

1. Increase the supply of skilled and confident personnel to provide the service
2. Increase awareness of these methods
3. Ensure a reliable supply of the commodities and supplies

The order of priority differed across sites, but these issues were given very consistent priority.

Implications for the Future

USAID asked the team to develop strategic options and approaches for strengthening access to and availability, quality, and use of LA/PM services. The USAID Mission in Nigeria has been concerned, as family planning services in general, and LA/PMs in particular, are *absolutely essential* to addressing the needs of couples to meet their reproductive intentions, and they are needed to realistically achieve national health and development goals. Respected demographers note that rapid and sustainable progress cannot be made in slowing population growth, meeting national development goals, or helping citizens to achieve their reproductive intentions, without LA/PMs being a substantial proportion of the contraceptive mix. In Nigeria, only 1.4% of married women use LA/PMs.³

To strengthen access to, quality of, and use of LA/PMs and to increase the share of the contraceptive method mix devoted to these more effective methods, in the context of choice, the assessment team recommends strategic options and specific interventions to

² These were variations in costs for LA/PMs observed during the team site visits.

³ This is based on the 2008 NDHS and the team's secondary analysis.

“fast track” the expansion of LA/PMs within the service menu. The team’s *major* recommendations to USAID as it prepares for future programming are as follows:

- Carefully articulate the “case for LA/PMs” as a means to reduce maternal and infant/child mortality, to be used as a key advocacy tool for policy and decision makers, service providers, and community leaders.
- Work with all three tiers of the health delivery system to introduce and provide the full choice of contraceptive methods, including LA/PMs. Prioritize those facilities where LA/PM services can be delivered rapidly, and concurrently prepare the terrain and build the capability of other primary health care facilities to deliver quality services.
- Provide a “state”-focused approach to scaling up LA/PMs, using public, private, and NGO partners, and strengthen relationships and coordination between implementing partners.
- Select states based on two strategic scenarios:
 - **Momentum-building:** states with a contraceptive prevalence rate (CPR) of 10% or higher and a foundation of existing demand, infrastructure, and program efforts to build upon
 - **Ground-breaking:** states with a CPR of 10% or less, characterized by less overall demand and awareness and more resistance to family planning in general

The team recognizes that some states have a mix of these characteristics and may not fit neatly into one category; however, this approach provides a starting point for discussing state selection.

- Phase efforts, making sure that services meet demand as quickly as possible (for example, place greater emphasis in the first phase on momentum-building opportunities; build on existing infrastructure and networks; work with high-volume service outlets; and work initially at the tertiary and secondary care levels, while strengthening services at the community and primary health care levels)
- Establish a basic package of interconnected interventions (with relative emphasis depending on the scenario) and go “deep” with key interventions:
 - **Supply:** Encourage services in public, private, and NGO facilities; upgrade and ready service sites; improve staff skills and performance through training and supervision; and strengthen service referrals and logistic systems to go the “extra mile.”
 - **Enabling Environment:** Develop a new generation of champions for LA/PMs; promote evidence-based policies and procedures and the dissemination of policies and guidelines to state and LGA levels; conduct advocacy with key leaders for greater awareness of and commitment for LA/PMs.
 - **Demand:** Support campaigns to enhance the image of services; disseminate accurate information, dispel myths and rumors, and generate awareness; produce/update counseling and other job aids; and link communities and clinics.
- Actively pursue the development and commitment of in-country resources, both financial and human, toward strengthening LA/PMs as an element of contraceptive choice.

- Encourage collaboration at all levels among donors, implementing partners, and host country institutions and organizations to obtain a more synergistic, coordinated, and unified approach to address the expansion of LA/PMs in Nigeria.

It is clear from literature and experience around the world that LA/PMs are critical for expanding choice, increasing program impact, and saving lives, particularly those of mothers and children. LA/PMs are highly effective, safe, and generally low-cost over time, and they do not require constant resupply. Long-acting methods are suitable for delaying, spacing, or limiting births and are appropriate for almost all women (e.g., young and older; once pregnant or never pregnant; interval, postpartum, or post abortion). Permanent methods are appropriate for couples whose reproductive intentions are to limit future births. LA/PMs are also used over longer period of time with less discontinuation. LA/PMs are critical to preventing unintended pregnancies and abortions and to contributing to the reduction of maternal and child mortality.

The narrative that follows assesses the use of, unmet need for, trends in, and current programs for LA/PMs in Nigeria, highlights work and accomplishments to date, identifies positive and negative findings, and makes specific recommendations for strengthening access to and availability, quality, and use of these LA/PM services. The sections that follow provide further details and data to support the major findings and recommendations.

I. BACKGROUND

With more than 150 million people, Nigeria has the largest population in Sub-Saharan Africa. The country also has one of the highest maternal mortality ratios in the world. Total fertility rates have changed little over the past 20 years, and modern contraceptive use has increased by approximately 3.5 percentage points over the last decade. The total CPR rose faster than the modern-method CPR due to high use of traditional methods, highlighting a missed opportunity for the public-sector program to make modern methods widely available and educate the population about them (Goliber, Sanders, & Ross, 2009). Family planning has been identified as a pillar of safe motherhood in its ability to reduce maternal and child deaths, and yet little progress has been made in this arena in years. With one in five Nigerian women having an unmet need for contraception, it is clear that women are not getting the services they require. Part of Nigeria's MDG 5 is to reduce all current unmet need by 10% per year over the next few years; reaching this MDG target would require a large increase in CPR. Without a full method mix in which LA/PMs play an important role, these goals will not be met.

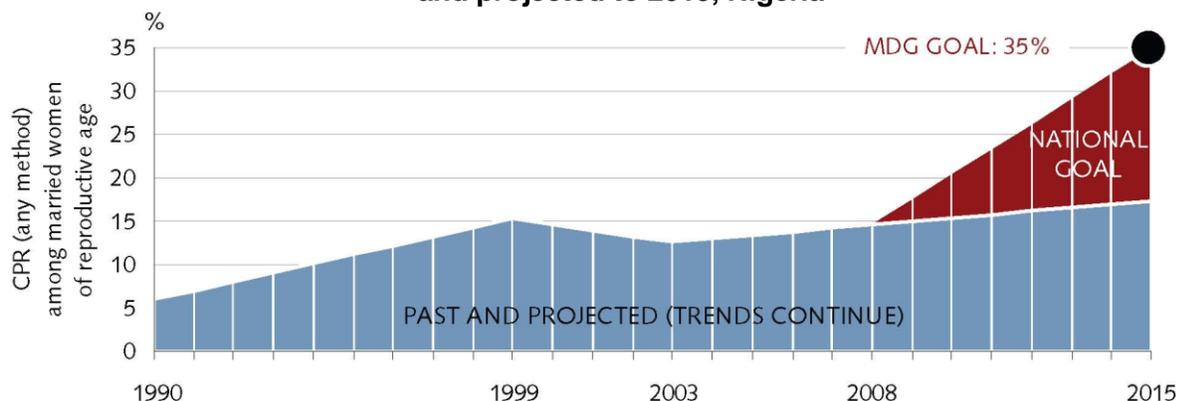
Notes on Nigeria

- Number of women of reproductive age: 35,400,000
- CPR: 14.6%
- Modern method CPR: 9.7%
- Unmet need for family planning: 20.2%
- Maternal mortality ratio: 545 maternal deaths per 100,000 live births
- Under-5 mortality rate: 157 under-5 deaths per 1,000 live births
- Infant mortality rate: 75 infant deaths per 1,000 live births

Source: NPC & ICF Macro, 2009

Figure 1 reviews CPR trends over time and posits that if current trends continue, contraceptive prevalence will rise only slightly between now and 2015, falling critically short of the 35% CPR needed to eliminate current levels of unmet need for family planning. The graph also shows how initial investments in family planning gained momentum through the late 1990s, but how the lack of continued progress led to decreases in overall CPR.

Figure 1. CPR among married women of reproductive age, 1990–2008, and projected to 2015, Nigeria



The need for effective, modern family planning in Nigeria has never been greater than it is today. More than 35.4 million women are moving through their reproductive years. Pregnancies are often among women at risk—too young or too old, and with high parity—and spacing intervals are inadequate to allow women to “rest” and prepare for another pregnancy. As previously noted, contraceptive use in Nigeria is low: Only 9.7% of married women in Nigeria are using any modern method, and only 1.4% are using the more effective LA/PMs (NPC & ICF Macro, 2009).

The consequences of low contraceptive use include a high occurrence of unplanned pregnancies: It has been estimated that in Nigeria, one in five pregnancies are unplanned, and that many of those pregnancies are terminated (CRR & WARDC, 2008). The 2008 NDHS statistics indicate that actual fertility rates are higher than stated intentions, with unmet need for family planning at 20% (NPC & ICF Macro, 2009). The consequences of unplanned pregnancy increase the likelihood of exposure to unsafe abortions and the risk of maternal mortality and morbidity. The current low rate of contraceptive use is without question a contributing factor to the high rates of maternal mortality (545 maternal deaths per 100,000 live births) (NPC & ICF Macro, 2009). Worldwide experience demonstrates that the use of contraceptives is a critical strategy to reducing maternal mortality and morbidity and that it has a significant impact on child mortality and morbidity. Family planning is one of the pillars of safe motherhood and is an essential component in reaching the MDGs. Research shows that with a vibrant family planning program, maternal and child deaths may be reduced by 25–30%. (Campbell 2006)

In addition to reducing maternal death and illness, data have shown that family planning and child spacing are critical to individual and family health and can help to improve families’ economic situation. Further, family planning can save the lives of children, reduce mother-to-child transmission of HIV, and enable couples to choose the number, spacing, and timing of their children. These outcomes reduce poverty, decrease strain on already fragile health care systems and economies, slow population growth, and spur development. Global experience confirms that without broad availability and use of effective modern family planning services, particularly LA/PMs, fertility levels will remain unsustainably high, maternal and child mortality will remain intractable, and national development will be slow.

The Population Reference Bureau’s *Family Planning Saves Lives* (Smith et al., 2009) clearly presents how family planning saves the lives of women, children, and adolescents and how family planning helps governments achieve national and international development goals. In the recent *State of the World’s Mothers* (Save the Children, 2010), Nigeria ranked 77th out of 77 less-developed countries, as one of the worst places in the world to be a mother.

Why LA/PMs?

Family planning services in general, and LA/PMs in particular, are needed to meet the needs of individuals and couples and to realistically achieve national health and

development goals. Respected demographers have noted⁴ that rapid and sustainable progress cannot be made in slowing population growth, meeting national development goals, and helping citizens to achieve their reproductive intentions without LA/PMs as a substantial portion of the contraceptive mix. In Nigeria, less than 15% of the modern method mix is from use of LA/PMs.⁵

LA/PMs are critical to the contraceptive method mix and choice, because they:

- Prevent unwanted pregnancies (including among HIV-positive women), avert abortions, and help to reduce maternal and child mortality
- Are highly effective, safe, and generally low-cost over time
- Do not require constant resupply
- Are suitable for a range of reproductive intentions (long-acting methods for delaying, spacing, or limiting births, and permanent methods for limiting)
- Are appropriate for almost all women (e.g., young and older; once pregnant and never-pregnant; interval, postpartum, and postabortion)
- Are useable when women are breastfeeding or not breastfeeding
- Can be used over a longer period of time, with less discontinuation
- Are popular when available

(See Annex II: Advocacy Briefs on LA/PMs)

⁴ J. Stover et al, Global Resources Required for Family Planning in Low and Middle Income Countries; presentation at Universal Access to Family Planning Conference in Uganda, 2009.

⁵ Secondary analysis by Nigeria assessment team (see Annex XX).

II. ASSESSMENT PURPOSE, METHODOLOGY AND FRAMEWORK

Purpose and Methodology of the Assessment

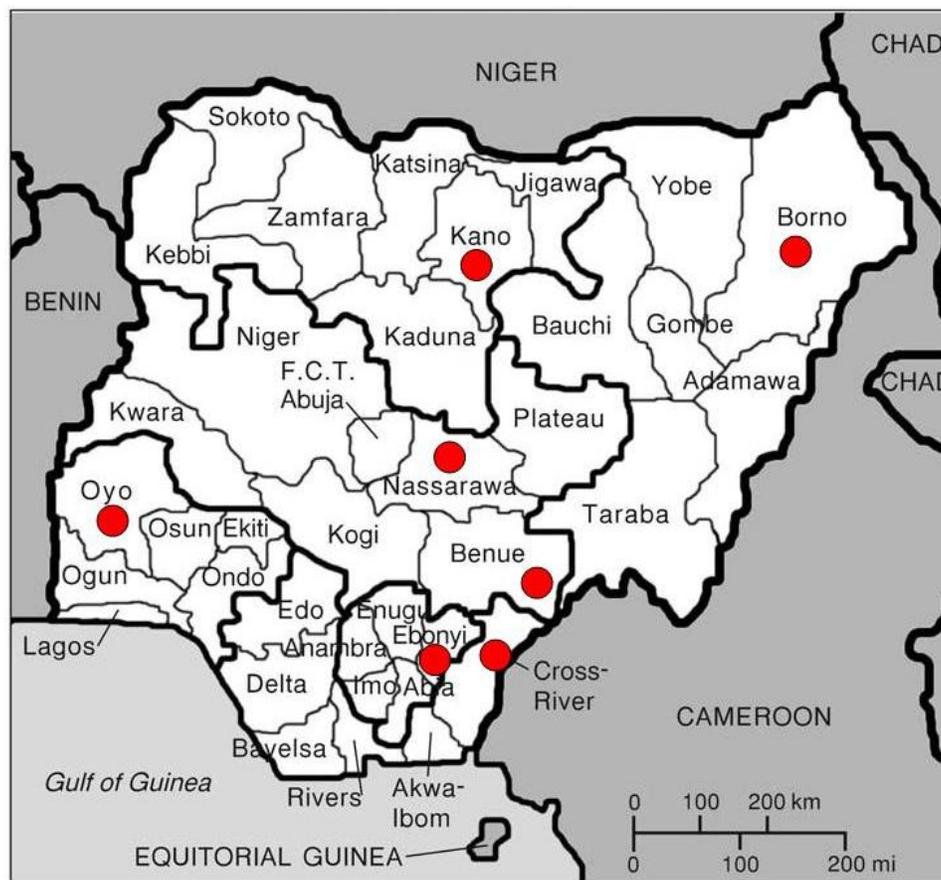
USAID/Nigeria requested the RESPOND Project, which is led by EngenderHealth, to organize and conduct a comprehensive assessment of LA/PMs in Nigeria. The purpose of this strategic analysis was to: 1) assess the use of, unmet need for, trends in, and current programs for LA/PMs in Nigeria; and 2) develop strategic options and approaches for strengthening access to and availability, quality, and use of these services. The in-country review took place from September 10 to September 30, 2010.

This assessment was organized to address issues of supply, demand, and the enabling environment for LA/PMs at the tertiary, secondary, and primary health care levels. For the purpose of this review, LA/PMs included long-acting methods (the IUCD and hormonal implants) and permanent methods (female sterilization and vasectomy). The review also took into consideration injectables, as they are used as “long-acting” methods by some women in Nigeria.

The core assessment team consisted of six technical experts, including two Nigerian obstetrician-gynecologists with deep knowledge of the national health system and the reproductive health and family planning situation in Nigeria. The team’s investigation was participatory and significantly involved government officials, key implementing partners, other donor agencies, and USAID technical staff. USAID and RESPOND convened a stakeholders meeting of a broad range of professionals, the FMOH, and State Commissioners of Health to seek advice on and insights into effective interventions for increasing the use of LA/PMs in Nigeria. In addition, the team conducted an extensive review of key technical documents and a detailed secondary analysis of the 2008 NDHS.

From September 19 to September 24, 2010, the core team divided into three subteams—each joined by governmental, USAID, and other donor representatives—and conducted field trips to ensure that the recommendations would be grounded in reality. The team visited seven states (Benue, Borno, Cross Rivers, Ebonyi, Kano, Oyo, and Nassarawa) in the six zones of Nigeria (see Figure 2) and visited 47 sites at the state, LGA, and community levels. During the visit, the team conducted six focus group discussions and interviewed clients. Throughout the assessment, the reviewers consulted literally hundreds of people.

Figure 2. Nigerian states visited as part of LA/PM assessment exercise



For further details, see Annex III for the following parts of the assessment:

- The detailed scope of work and schedule
- A list of key informants
- A bibliography of the documents reviewed
- The Assessment Interview Protocol
- The Focus-Group Discussion Guide

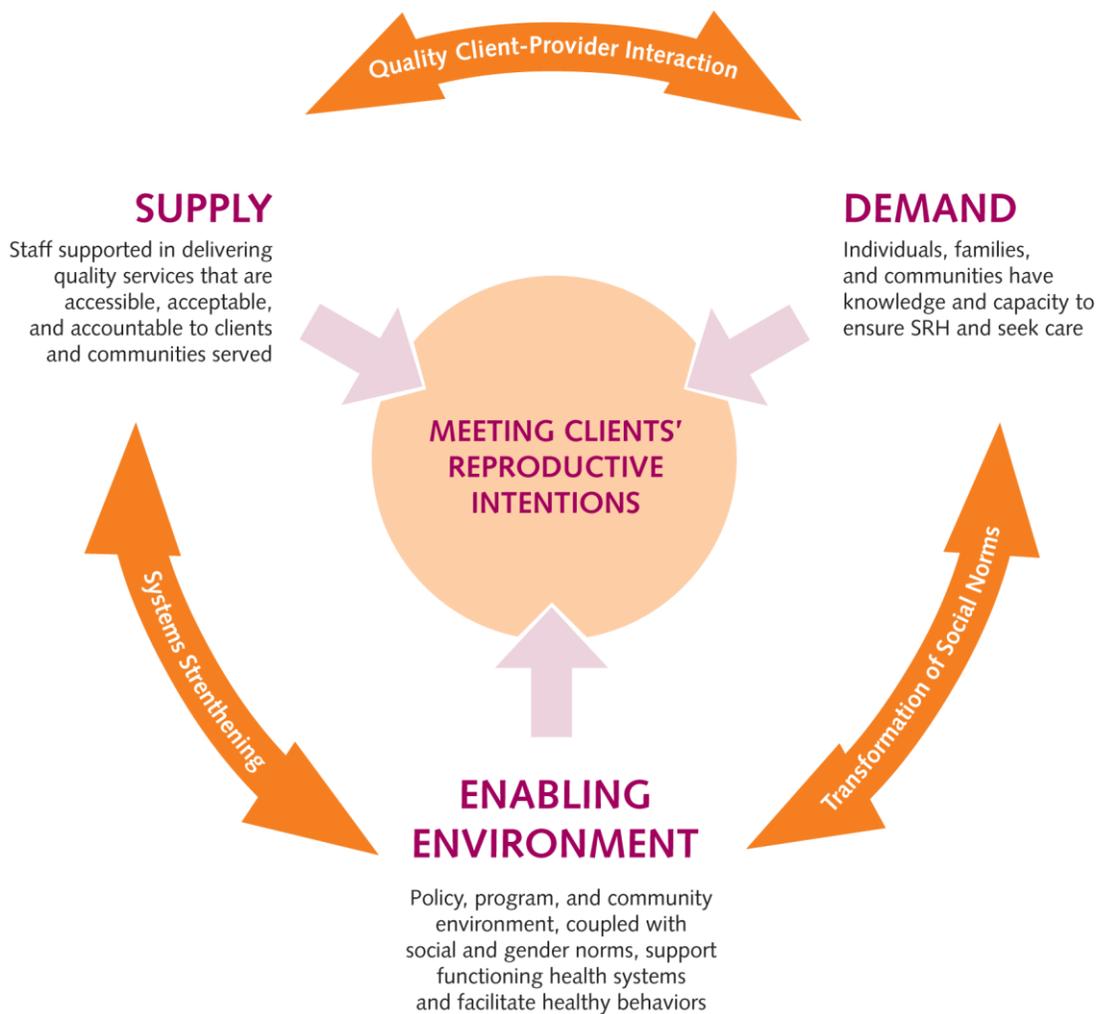
Assessment Framework

The team organized the assessment using EngenderHealth’s Supply-Enabling Environment-Demand (SEED) Programming Model for Family Planning/Reproductive Health, focusing it on LA/PMs. This SEED programming model conceptually presents a logical framework positing that family planning programming with LA/PMs can be more successful and sustainable if it includes interventions that:

1. Address quality services and other supply-related issues specific to LA/PMs
2. Strengthen the enabling environment to positively support the expansion of LA/PMs.
3. Improve knowledge of and the image of LA/PMs by cultivating knowledge of, demand for, and use of services

This approach to strong LA/PM programming also recognizes that these three program components—service supply, enabling environment, and demand—do not operate in isolation. These three program areas are linked together; investments in one component can and will have an impact in another area. The SEED model emerged from EngenderHealth’s decades of experience in family planning and reproductive health programming and evolved from an earlier model developed by the ACQUIRE Project. The SEED model is graphically represented in Figure 3.

Figure 3: The Supply-Enabling Environment-Demand (SEED) Programming Model for Family Planning/Reproductive Health



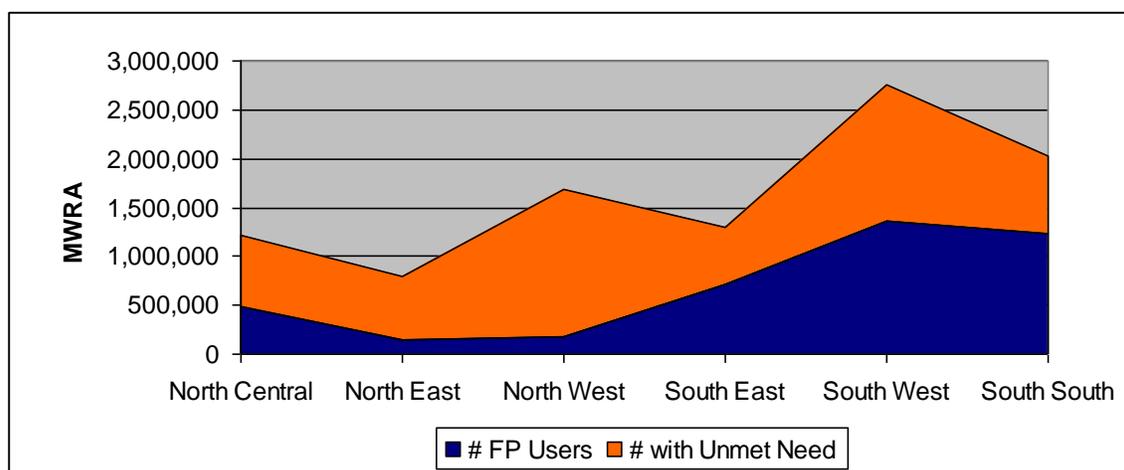
III. FINDINGS

Secondary Analysis of Family Planning in Nigeria: Where Do LA/PMs Fit In?

As noted above, current use of any family planning method in Nigeria is 14.6%. Based on secondary analysis of the 2008 NDHS, only 1.4% of married women of reproductive age are using an LA/PM. The projected actual number of women using an LA/PM, therefore, is a mere 483,000. Given the size of Nigeria, this number is shockingly low and represents a picture typical of a country with only an emergent family planning program. If Nigeria is to meet its MDGs, investments in building the country's family planning program with a strong LA/PM component must be scaled up rapidly.

When comparing met need with unmet need across the six zones in the country, a striking picture emerges. As seen in Figure 4, there are literally mountains of unmet need across all zones. What is striking is that the South West, an area with relatively higher family planning use, still has a high level of unmet need. The North West, by comparison, has low levels of family planning use, but also has an extremely high amount of unmet need. While both zones have a different starting point when it comes to current family planning use, both have extremely levels of high unmet need for family planning. Additional analysis by zone is provided in Annex IV.

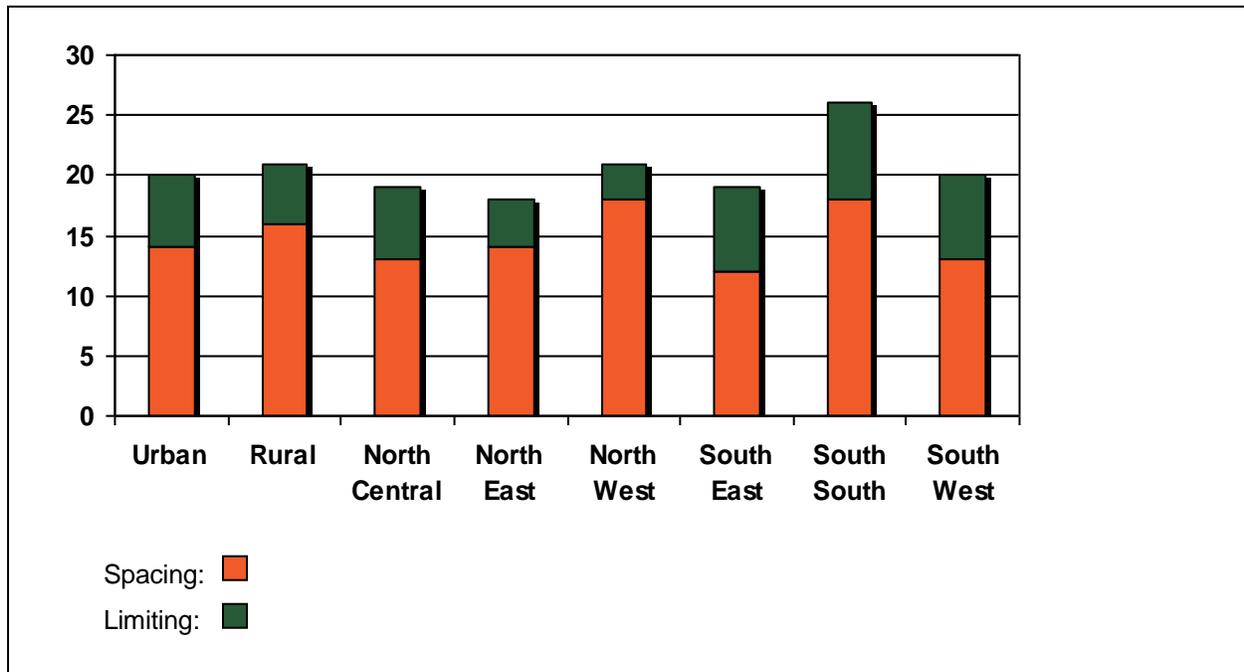
Figure 4. Met and unmet need, by zone, including all family planning methods, 2008 NDHS



When looking specifically at unmet need for spacing and limiting, more than half of all married women of reproductive age want to space or limit their next pregnancy (NPC & ICF Macro, 2009).⁶ When unmet need is broken down further by zone, it is clear that the large unmet need for spacing and limiting cuts across every zone in the country (Figure 5).

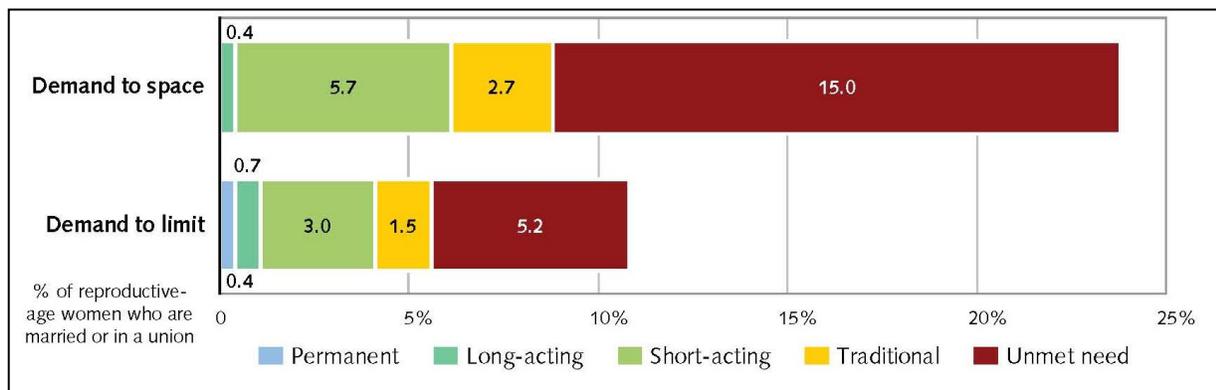
⁶ NDHS, 2008

Figure 5. Unmet need by spacing and limiting, 2008 NDHS



This reality is mirrored when examining desired fertility. According to the 2008 NDHS, actual fertility exceeds desired fertility in every zone (NPC & ICF Macro, 2009)—a clear indication that women’s need to limit deserves special attention, since they are having more children than they want. When reviewing demand for spacing and limiting by reported methods used, most women are not using the most effective methods. For example, nearly twice as many women have an unmet need to space births as are using contraceptive methods to space (Figure 6). Of those that are using family planning to space births, very few are using a long-acting method. For those who want to limit births, only one out of five are using the most effective methods.

Figure 6. Demand to space and limit births, disaggregated by method use and unmet need, 2008 NDHS



Data from the 2008 NDHS indicate that the greatest unmet need for spacing and limiting is in the North West and North East (NPC & ICF Macro, 2009). The zone with the highest IUCD use is the South West, the zone with the highest implant use is the South East, and

the zone with highest use of female sterilization is the North Central. Unfortunately, vasectomy use is too uncommon to appear in the NDHS.

This secondary analysis of the 2008 NDHS provides an evidence base and foundation for understanding current use of LA/PMs across the country, while clearly highlighting the need to increase LA/PM use if the high unmet need for delaying, spacing, and limiting births is to be met.

Major Findings

During the field visits, three main themes emerged in all places visited and from most if not all of the key informants at the facilities visited. When asked what can be done to revitalize or introduce LA/PMs, respondents highlighted the following:

1. Increase the supply of skilled and confident personnel to provide the service
2. Increase awareness of these methods
3. Ensure a reliable supply of the commodities and supplies

The order of priority differed across sites, but there was a very consistent priority given to these issues. The major findings of this assessment are enumerated below.

A. Findings—Supply

Context

During the field visits, the team observed a range of sites with some level of readiness to provide one or more LA/PMs in a quality manner. In general, those that had received some level of support from past or current donor-supported family planning projects were more likely to provide some level of services. Most of the tertiary and secondary facilities visited did offer IUCDs and implants, although when probed, some informants said that their facilities had issues with trained staff and/or commodities. Health centers may provide one or more long-acting method of contraception if a trained provider is in place and if commodities were available, but these elements were much more limited at the primary care level. As an example of the vast differences among zones, in the whole state of Borno, 26 nurses are trained in family planning. This compares to Benue, where there are five nurses trained in family planning per LGA across the state's 24 LGAs (though an irregular supply of commodities is common).

Female VSC was more likely to be available in tertiary and secondary hospitals; however, many were reported to be done in conjunction with cesarean sections for medical indications. It is not clear the extent to which these are done at the request of the women (for purposes of family planning) or on the basis of medical indication alone. In Benue, where female VSC prevalence is 4.3% (in a state where overall contraceptive prevalence is 12.5%), the team was hard-pressed to find a facility that accounted for a significant number of female VSC procedures though there was reference anecdotally to this being done in the federal medical centre and some secondary health facilities. Further, this number surprised many of the key informants we spoke to. Facilities visited that were once known as centers for minilaparotomy under local anesthesia are currently performing merely a handful of procedures each year (e.g., UCH-Ibadan in Oyo State, or NKST Mkar Hospital in Benue State).

The team received only a rare report of a vasectomy case within the last year or more (one at UCH-Ibadan and three at UTH in Kano).

1. **There are few skilled, confident providers who are trained in LA/PM service provision.** Findings revealed that in some states, there has been no recruitment of personnel for the last 5–10 years (e.g., Cross River State). The main reason given for not hiring is budgetary, as some states do not have allocations for health providers or family planning.

In many states, personnel were trained a long time ago and had not had any updates or enough practice to maintain their skills. The team heard many anecdotes about retirements among trained family planning staff.

Training of personnel continues for some categories of health personnel, such as community health extension workers and nurse-midwives, but in the absence of recruitment, many of these trained personnel never make it into the health system or are posted outside of FP services sections. There appears to be no systematic plan in place at the national level to address family planning training needs. In-service training is conducted “when funds are available” from donor projects and thus is more project-focused than strategically driven.

A dedicated operating theatre for VSC at the Teaching Hospital in Borno, for example, has been unused for almost 20 years due to the lack of a skilled provider or willingness to train one (nor has the OR been repurposed for other uses).

In the NGO sector, long-acting methods fare somewhat better. MSI has been operating mobile outreach services where skilled teams intermittently travel to rural areas that do not have a steady supply of family planning services and provide highly subsidized or free services (following community mobilization to announce service availability). The SFH, through the Women’s Health Project is supporting the strengthening of private and NGO service delivery points, while also conducting “event days,” an approach similar to mobile outreach. Neither group is focusing yet on female VSC or vasectomy; however, they have had great success with implants (MSI) and IUCDs (SFH), illustrating that when supply barriers are removed, use follows.

2. **Despite recent attention and gains in forecasting, the supply of commodities is inconsistent for long-acting methods.** In most states and LGAs visited, the major obstacle to LA/PM service delivery was the lack of commodities and supplies, particularly for implants. A long pipeline exists for contraceptive commodities, with LGAs requesting stock from the states and states requesting stock from the central stores. Where inputs for strengthening supply chain management were in place (for example, from DELIVER in Nassarawa State), there seemed to be fewer issues with supply. However, the working being done on forecasting and strengthening the supply chain is for contraceptive commodities alone. LA/PM services require other supplies and equipment, and these are not part of the equation at present.

- 3. Supply factors, including provider bias, limits client choice.** The unavailability of a range of methods in most PHCs due to supply issues or lack of trained personnel obliges most clients to accept the available method at the service delivery center rather than obtain her personal choice. The lack of skilled providers at the level of PHCs is another constraint to choice, as the client receives what the provider is qualified to offer, not necessarily the method she may want. The team heard providers say over and over, “We give clients what we have, not what they’ve come for.” Examples included the provision of injectables to clients who requested implants or IUCDs, the provision of the pill or condoms to those who requested injectables, and even the provision of Depo Provera when clients preferred Noristerat.

Moreover, providers can influence a client’s decision to use a method and the type of method and, if the power imbalance exists, women may feel they have no choice but to take the method they are given In Ebonyi (primarily a Catholic state), providers reported that some community health extension workers at PHCs in rural parts of the state often refuse to discuss family planning due to their religious beliefs. Clients have cited concerns over how health workers treat them in explaining their reluctance to seek family planning services, which may further exacerbate the problem. (Odumosu et al., 2002).

Biase PHC has not ordered IUCDs for the last four years, as they do not believe that their clients will want them.
--

- 4. High fees for implants and VSC are an obstacle.** Findings revealed that one of the obstacles to access to implants is the high cost, with implants being sold at prices as high as N 3,000 at some public-sector sites and as high as N 8,000 at some private clinics. Efforts to register Sino-implant (II) are currently underway; if successful, this method will contribute to reducing the overall cost of implant services. The same considerations apply to VSC, which is offered at N 5,000–N 10,000 in most tertiary hospitals where trained doctors and specialists are practicing. These high costs may explain the limited demand for interval female VSC in Nigeria. Beyond the commodities themselves, equipment (e.g., insertion kits, lamps, autoclaves, etc) and consumable supplies are another cost hindering access to family planning services, as reports exist of clients bringing their own cotton wool and other consumables to facilities.
- 5. There are many missed opportunities to link FP to other health services.** Family planning did not appear to be a major priority in the health services in most states visited. The other reproductive health activities on the ground may, however, be a port of entry for family planning. Family planning can and should accompany antenatal care, postabortion care, and HIV services, as well as immunization days, which take place regularly. At busy sites, such as the Adeoyo Specialist Maternity Hospital in Ibadan, there were no linkages between the surgery ward where manual vacuum aspirations and tubal ligations following cesarean deliveries occurred and the Family Planning Unit. It was clear this was a missed opportunity for women to receive family

planning counseling and services, particularly given the important link in Nigeria between maternal and child health and family planning.

Implications

Where efforts have taken place to improve readiness to provide services and to remove barriers, increased utilization has resulted. Unfortunately, these efforts are generally donor- or project-driven, and when the project ends, in many (but not all) cases, commitment and service availability soon diminish. The evaluation team's limited time at each service delivery point did not allow for a systematic assessment of equipment, commodity, and training needs; however, if LA/PM services are to be initiated or revitalized, there must be an effort to provide the basic inputs (clinical and counseling skills training/updating, facility upgrades, equipment and supply provision, quality assurance). Positive results in the short run are possible with systematic attention to strengthening capacity to supply quality services, coupled with a removal of access barriers (particularly those related to cost and distance).

B. Findings—Enabling Environment

Context

Political will, policy support, and sociocultural beliefs all influence the functionality and sustainability of any program interventions, but they are particularly important for those areas that might have sensitivity, such as family planning and LA/PMs. To determine what might be effective in future programming, the team looked at the enabling environment and what is required to remove obstacles and create a positive climate for implementation. The elements reviewed included level of political will, as evidenced by supportive policies and whether adequate resources—both human and financial—were allocated to family planning especially LA/PMs. The team considered the level of supporting leadership and management development by observing top-to-bottom decision makers, gate keepers, and providers, as they all make an enormous difference.

The Ebonyi First Lady has transformed MCH services statewide by prioritizing it as an essential issue affecting women and communities through her personal commitment and grassroots mobilization.

The findings below highlight the team's review of data and materials, interviews, and field trips regarding the status of the current enabling environment.

1. **A national policy base upon which to build family planning and LA/PM programs is extensive; however, these policies have not necessarily been adequately financed, staffed, or effectively pushed down to the state and LGA levels for implementation.** A large repertoire of policies, regulations, standards, and guidelines that support family planning, including LA/PMs, exists. A sample listing of such policies and guidelines includes the following:
 - FMOH Strategic Plan for Health (2010–2015), including corresponding plans at the state level
 - Strategy for Integrated Maternal, Newborn and Child Health (IMNCH) (2007)
 - Maternal Mortality Reduction Strategy (2005–2007)

- Guidelines to support the integration of HIV/AIDS with Reproductive Care (2007)
- National Youth Policy and Strategy Action Plan (2007)
- NPHCDA Minimum Ward Health Package (2007, currently being revised)
- National Clinical Service Protocol for Obstetric and Immediate Neonatal Care (2005)
- National Health Insurance Scheme (2005)
- National Policy for Sustainable Development, (2004)
- National Health Bill (currently before the legislature)
- National Reproductive Health Policy and Strategy (2001–2006)

All of the above policies in some way mention or support reproductive health, but not necessarily family planning or LA/PMs. While the number of these policies indicates some political will, many policies, strategies, and guidelines that could be used to support family planning, including LA/PMs, are “empty.” Some are outdated or have been left to expire; some are not drilled down to the state and LGA levels; and funding is not allocated to support the policies that are in place.

Guidelines and protocols are a bit more generous in supporting family planning, including LA/PMs. For example, in-service training for nurses and doctors include components on family planning. Preparations are underway for including reproductive health and family planning in the Extended Life Saving Skills curricula for physicians and medical officers and Life Saving Skills of midwives and junior community health extension workers. There are federal-level performance standards for all levels of service providers.

During the assessment, several policy changes that could make a difference in demand, service access, and availability, and in increased use of LA/PMs, were suggested:

- Task-shifting to allow lower-level trained/competent cadres (e.g., senior CHEWs) to provide injectables, implants, and IUCDs (Training, certification, and ongoing supervision and mentoring would be required.)
- Supporting the registration and availability of Sino-implant (II)
- Supporting increased funds for a contraceptive commodities line item in the budget at the national level and for logistics/management supply at the state and LGA levels
- Addressing the cost of family planning services, including LA/PMs (as all other maternal and child health services are free)

2. **Champions for family planning and LA/PMs exist, but there is a “missing generation” of new advocates.** In the late 1980s, there was a strong USAID involvement in and support for the inclusion of family planning in the Nigeria health system, both in the private sector (via social marketing), among NGOs (such as the Planned Parenthood Federation of Nigeria) and the public sector (primarily in teaching hospitals). For LA/PMs, champions were developed among senior teaching staff, and interested parties were inspired by the emphasis on pre-service training and service provision through the university teaching hospitals. Even today, there remain strong champions: FMOH and political leaders; professors at key university teaching

hospital (e.g., Oyo, Jos, Lagos, Zaria, Kano, Enugu, Calabar); NGOs (e.g., the SFH, the Association for Reproductive and Family Health, Planned Parenthood Federation of Nigeria, and the Development and Research Projects Center.

However, the development of the next generation of leaders has been piecemeal at best. At the teaching hospitals, interns have little opportunity for practical training in LA/PMs because of patient load; state family coordinators receive technical training, but they have little leadership or management training, particularly as it relates to LA/PMs. There is little exposure or opportunity for young professionals in the technical arena of LA/PMs.

Many traditional and religious leaders have received awareness training, but not at a systematic or deep level regarding LA/PMs. At almost all sites, it was suggested that religious and traditional leaders could be excellent champions if they received more thorough training, had greater involvement, and developed concrete action plans. The team identified several key religious networks that currently address social issues in Nigeria, including the Federation of Muslim Women's Associations, the Christian Health Association of Nigeria, and the local chapter of the Center for InterFaith Action, which combines Muslim and Christian networks for social actions (in malaria). In addition, a number of private voluntary organizations in Nigeria are available to work on social issues, and many have already adopted family planning and LA/PMs, such as the Planned Parenthood Federation of Nigeria, the Society of Women's Associations in Nigeria, the Country Women of Nigeria, Civil Society against HIV/AIDS in Nigeria, the Adolescent Health Information Project (AHIP), and the SFH. Several of these organizations are already USAID implementing partners.

“Traditional, religious, and civil society groups can be leaders and advocate at all levels.”

- 3. The Nigerian public health system is very complex and poses challenges for a coordinated family planning/LA/PM effort.** The federal level is responsible for setting policies, providing overall guidance, and managing and funding tertiary facilities and key research and development programs. The state level funds and manages the state-level hospitals and maternities, teaches colleagues, and provides higher technical staff for the SMOH and PHCs. The LGAs, with little technical expertise and insufficient funds, are responsible for basic staffing, management, and financing of primary health care within their jurisdictions. The private sector, while delivering a large portion of services, is generally under-regulated and not particularly interested in family planning or LA/PMs. (See Annex I for a schematic view of the health care system.)

This complexity affects the selection, hiring, supervision, and retention of skilled health workers who can support family planning and LA/PMs. Staffing, especially at the rural LGAs, consists of only a small percentage of the skilled providers that are needed. It is estimated that throughout the country, most health facilities operate with less than 50% of the needed trained staff.

The National Primary Health Care Development Agency has deployed (with special remuneration to aid in retention) over 2,000 midwives to primary health centers throughout the country via Midwives Services Scheme as a measure to assist states to address the acute shortage of skilled personnel. During the team site visit, it was reported that in Kano, a state of 10–12 million people, only 76 MSS midwives were assigned, only 56 reported for duty, and several of those left after just a few days on the job

New recruits to the rural areas arrive to find inadequate housing and receive no special hardship allowances. Retention of staff in the rural areas is difficult. It was repeatedly reported that many of the PHCs and comprehensive primary health care centers are manned with junior CHEWs—individuals with a secondary school education and one year of special training. The original design was for this cadre to be and health outreach workers—spending most of their time in the communities, not direct skilled service providers. The UTH and specialty and general hospitals (in Kano and Borno, for example) are overloaded, as the primary health care system is not staffed to capacity with nurses, community health officers or skilled senior CHEWs, and patients self-select and refer themselves to higher level facilities, bypassing the primary health care level, which lacks skilled providers for even basic services. Mandatory service of the Nigeria Youth Corps, which places new graduates, including physicians and nurses, in underserved facilities for a year, has helped alleviate the problem of staffing in some places. The Nigerian youth Corps is only required to serve in these posts for one year which is a constraint.

4. **Advocacy efforts for FP are limited to date with respect to making the case for LA/PMs.** There are organizations, networks, and professional association that could offer national- and state-level advocacy. In addition, USAID implementing partners could be strong advocates for ensuring that LA/PMs are seen as having an important role in family planning programs. To date, among the implementing partners, advocacy has been project-specific rather than coordinated, and advocacy messaging for LA/PMs has been limited. When an advocacy case has been made for “family planning,” advocacy has not drilled down to “why LA/PMs?” or how LA/PMs affect maternal mortality. Implementing partners can be an important constituency grouping for a concerted advocacy effort at the national and state levels.
5. **There are major new or increased internal and external funding streams for the health sector in Nigeria.** These include the MDG Account, as a result of debt relief reduction, and the Global Fund for AIDS, Malaria, and Tuberculosis. (Nigeria was included in Round Nine, although funds have not been released.) If the new Health Bill becomes law, a legislated amount of 2.0% of the national budget, such as exists for education, will be established for the health sector. The National Health Insurance Scheme allows reimbursement for counseling for LA/PMs, but not for commodities or services. During the visit to Kano Teaching Hospital, the team was told that in 2008, only 13% of the national budget allocated for health was actually released.

Because of these conditions, there is strong bilateral support in the health sector, with dramatic increases in funding from the United States, including the USAID health account and the President’s Emergency Plan for AIDS Relief; from Britain’s DFID, for capacity and systems building and essential drugs; and from the Canadian International Development Agency, for training and health structural development. Multilateral organizations such as the World Bank provide loans/grants for investing in health infrastructure. The United Nations organizations provide health funding through United Nations Children’s Fund (UNICEF), the UNFPA, and the World Health Organization (WHO). Several philanthropic organizations also work in Nigeria, such the David and Lucile Packard Foundation, the John D. and Katherine T. MacArthur Foundation, the William J. Clinton Foundation, and more recently the Bill & Melinda Gates Foundation. (See donor funding matrix, Annex V for more details.) USAID is working hard to coordinate with the other donors to rationalize and complement their support for FP programs so that each contributes where it has a decided comparative advantage.

Implications

Even though Nigeria is a complex setting and presents many challenges in terms of the enabling environment, the team was encouraged by the opportunities that do exist. There are policies that have strategic plans, guidelines, and protocols. Service delivery models exist, and with them come a core group of champions. Donor funds are available and could be used to leverage and press for the inclusion of internal domestic resources, specifically for the most effective family planning methods—one of the most important strategies for reducing maternal mortality. It is imperative that policies, especially those related to staffing, are drilled down to the state and LGA levels (to borrow a motto, “No trained provider, No LA/PM program”). A new generation of champions needs to be identified, trained, and mobilized to advocate and support family planning and LA/PMs. Systems for leadership development, financial and human resource management, and logistical and commodity management need to be strengthened, to create demand to change social norms and to deliver quality information and services for family planning, most importantly for the most effective methods of contraception.

C. Findings—Demand

Context

There are many barriers to people’s realization of their family planning intentions, especially with LA/PMs. Individuals, families, and communities need the knowledge, capacity, and motivation to seek, choose, and use family planning, and LA/PMs in particular. In Nigeria, several of the common predictors associated with contraceptive use (knowledge of three or more methods, discussion about family planning with spouse, belief that others approve, and intention to use) (Kincaid et al., 2007) are still far from ideal.

Secondary analysis of the 2008 NDHS indicates that of the seven states visited in this assessment, knowledge of *any* modern method was higher than the national average in Benue and Oyo among both men and women, while it was lower than average among both

sexes in Borno (NPC & ICF Macro, 2009). Kano, Ebonyi, Cross Rivers, and Nassarawa had lower knowledge among women but higher than average knowledge among men. While useful, this is only one measure of family planning knowledge, and it does not accurately reflect what men and women know about LA/PMs—or if LA/PMs were even one of the methods most people knew about. A likely assumption is that correct knowledge of LA/PMs may lag behind that of other family planning methods in many parts of the country.

Respondents in nearly all states reported that they had not heard family planning messages from any media channels, including radio, television, or newspapers (NPC & ICF Macro, 2009). Across the states visited, an overwhelming 84–97% of NDHS respondents had not discussed family planning with a field worker or at a health center. In this context, myths and misconceptions are pervasive.

As reported above, one of the three essential elements needed to expand access to, availability of, and use of LA/PMs is awareness creation. Across every state visited, whether the key informant was a service provider, policy maker, or client, all mentioned the need for greater demand generation activities. Some of the main findings include the following:

- 1. There is little to no consistent social and behavior change communication (SBCC) programming focused on LA/PMs.** While some projects include LA/PMs in their portfolio, the emphasis on these methods has been rather spotty across all communication channels and states. Given the large unmet need, many reported that there is limited information on what methods exist (LA/PMs in particular), where they can be obtained, and how they work. Moreover, few job aids or SBCC materials for counseling and education exist across all states visited. In most facilities, few posters were displayed, and few to no brochures or pamphlets existed. In addition, flipcharts and counseling tools were absent across most facilities, with the fewest resources reaching the lowest levels of care, including most PHCs.
- 2. Major myths and misconceptions pertaining to LA/PMs are found nearly everywhere and side effects are exaggerated, with fears outweighing reality.** In some parts of the country, some women believe that if they do not “use” all their eggs in childbearing, their stomachs will become bloated. Commonly held worries reported during the assessment about the IUCD were that a woman’s uterus might be destroyed during insertion or removal; that the IUCD might get lost in the body and travel to the heart, stomach, or other organs; that the IUCD causes infection; and that a husband will feel it during intercourse and object. For implants, some clients fear the insertion and removal process, at times believing that large cuts must be made in the arm. A cultural barrier exists relating to female VSC and vasectomy, given the belief in some parts of the country that if one’s

Fear of infertility when reincarnated after VSC was reported in Oyo, Cross Rivers, and Ebonyi.
Fear of IUDs causing infection was noted in Nassarawa, Ebonyi, and Cross Rivers.
IUDs cause infection (Nassarawa, Ebonyi, Cross Rivers)

private parts are “tampered with,” they will not have them when coming back in the next life and will therefore not be able to have children. Regarding side effects, feedback during the assessment trips to the seven states highlighted the need to address them through counseling and education. Clients worry about gaining weight if using hormonal methods, including implants and injectables. Bleeding is an issue for both the IUCD and the implant. For the IUCD, women have expressed concerns about discharge and heavy bleeding as reasons for discontinuation. If quality counseling exists to explain potential side effects, clients will know what to expect, and more women might accept long-acting methods as a suitable method while discontinuing use less frequently.

3. **Healthy timing and spacing of pregnancy (HTSP) messages are an acceptable entry point for discussing family planning, including long-acting methods.** There is a clear desire on the part of many women to space their children and have a “rest” between pregnancies. For those who argue that family planning is a sensitive issue, most also agree that talking about the benefits of family planning in the context of HTSP is acceptable. For example, work with religious leaders in northern Nigeria was successful, as imams felt that “healthy fertility” was an appropriate message for their communities (Blumhagen et al., 2009; Lane, C. No date).
4. **Many women know or perceive their husbands to be against family planning.** Men are often reported to be the “custodians of culture” and responsible for making final decisions about the number and spacing of children in many parts of the country. Studies have shown a high correlation between couples’ communication and family planning uptake in Nigeria (Ogunjuyigbe, Ojofeitimi, & Liasu, 2009; Barnes, Chandani, & Feeley, 2008). When men become aware of the benefits of family planning, many become highly motivated to support their wives in obtaining contraceptive methods. In places where strong counseling exists and there is greater use of family planning, providers place a greater emphasis on the concept of the individual clients’ choice. Couple counseling is seen as “nice to do” and not a necessity, unlike places where resistance to family planning is more the norm.
5. **Community mobilization is essential to increasing uptake of LA/PMs and has been effective in many settings.** Across the states visited, where community mobilization efforts had taken place, large numbers of women were obtaining both the implant and IUCD. SFH and MSI have had good success in reaching women with long-acting methods through event days. Under the Community Participation for Action in the Social Sector (COMPASS) Project, family planning uptake was vastly higher where community engagement was done than where there was none. In addition, some communities leveraged over \$1 million in one year alone to improve health infrastructure, with countless nonmonetary accomplishments as well (COMPASS Project Nigeria, 2007). The Maternal and Child Health Integrated Project (MCHIP) is currently

Household counselors in Kano MCHIP sites & community mobilization through the Maternal and Child Care Initiative in Ebonyi are examples of the potential of community engagement in Nigeria.

investing in community mobilization efforts and has already had results relating to family planning in Kano, among others.

6. Where quality family planning counseling exists, client choice is prioritized.

Provider bias, however, has a significant impact on family planning uptake. Where providers prefer certain methods over others, clients may end up with a method they do not desire—or

worse yet, none at all. Beliefs on the part of some providers that children are a gift from God and should not be interfered with were raised during the assessment; such attitudes keep some providers from even discussing family planning with clients. While these reports are anecdotal, similar descriptions emerged in most of the states we visited; these deserve further research and attention. In some cases, providers had not been trained in insertion/removal or knew little about these methods, making them reluctant to counsel on long-acting methods and their being a sound method for birth spacing. In other instances, providers had only a few methods in stock to offer and did not emphasize counseling on the long-acting methods that they did not have.

Evidence of quality family planning counseling was observed in Oyo and Nassarawa as an important consideration to ensuring that accurate family planning information reaches clients in a climate of choice.

Implications

Based on the above findings, it is critical that demand generation strategies be developed to raise awareness, dispel myths and misconceptions, and create community acceptance for LA/PMs. These efforts must of course be done in conjunction with supply and enabling environment interventions to ensure an adequate supply of commodities and quality services. As noted in other assessments, there have been cases where demand creation initiatives have led to frustrated clients when contraceptive supplies and services are not available, which can have devastating effects (Barnes et al., 2008). That said, as inputs into the supply and enabling environment are intensified, a concentrated focus on demand generation is essential in moving people from awareness to practice so that men and women may have children by choice, not chance.

IV. STRATEGIC APPROACHES AND RECOMMENDATIONS

The goal of the strategic approaches and recommendations in this report is to rapidly increase access to, quality of, and use of LA/PMs in Nigeria. Following the lines of the SEED Programming Model, the aim is to:

- Increase the access and availability of service facilities offering LA/PMs
- Increase the commitment and support for family planning and LA/PMs across all tiers
- Increase knowledge and acceptability of LA/PMs
- Increase the capacity and readiness of providers and sites to provide quality LA/PM services
- Increase the proportion of method mix attributed to more effective methods of contraception to support clients' reproductive intentions

Underlying Principles

Several guiding principles provide a foundation for the strategic approaches and recommendations expanded upon below. First and foremost, it is critical to apply a **holistic approach** and package across the supply, enabling environment, and demand domains, since focusing on any one without addressing the others will fail to have maximum impact. Because LA/PM services must be provided in the context of the general FP program, it is critical for the strategy to **implement client-oriented programming** as an essential element, so that all approaches focus on listening to women, men, and communities to ensure that quality LA/PM services are provided according to their perspective. In particular, a **gender lens** is needed to address women's status and its relationship to decision-making and health seeking behaviors. The strategy must also **build on existing strengths** and points of entry of other efforts and services so that momentum can be built from previous and current family planning projects, the work of local NGOs, and the efforts of champions throughout the system. Finally, a balance must be struck between achieving short-term results and longer-term gains, to ensure that efforts leave behind capacity for future action. This can be achieved by supporting principles of **local ownership and locally led** initiatives, to avoid creating parallel structures and to strengthen existing systems while building capacity.

Toward a National, Strategic Approach for LA/PM Programming

In a country the size and diversity of Nigeria, a strategic approach is needed for prioritizing areas of focus and intervention for improving access to, quality of, and use of LA/PMs. Given the limitation of any donor-funded project relative to the magnitude of need, strategic choices are required to ensure that program investments yield maximum return. The assessment findings highlight the fact that there is a need and an opportunity in all zones of the country. To the extent that resources allow, the program should cover a range of states with diverse cultural and religious characteristics, to support the concept of a national strategy that will build on efforts throughout the country.

Because there is a level of need for effective family planning programs throughout the country, decisions about allocating program effort and resources must be made. Each zone, and within the zone each state, has a distinct pattern of contraceptive use, knowledge, supply, and method mix. Over the past few years, allocations by USAID for

family planning have focused mainly in states in the northern regions of the country. However, given the magnitude of unmet need and total demand for family planning in other regions referenced earlier in the report, the LA/PM effort should include a broader geographic range of states.

To assist in making strategic choices, the assessment team proposes that USAID consider states that fall into one of the following two program classifications: **ground-breaking**, including states where overall family planning effort is at an earlier stage of development and LA/PM knowledge and use are very low or nonexistent; and **momentum-building**, where previous or current efforts by other projects and investments have resulted in a foundation of service delivery, awareness, and commitment. Some states will have a mixture of elements from both categories, since not all states will fit neatly into either category. More detailed characteristics are described in the table below.

GROUND-BREAKING	MOMENTUM-BUILDING
<ul style="list-style-type: none"> • Low overall CPR (10% or lower) • Low demand for family planning • Low awareness of family planning and especially of LA/PMs • Few service delivery points with readiness to provide LA/PMs. • Evidence of provider and community resistance 	<ul style="list-style-type: none"> • Relatively higher CPR (10% or higher) • Higher demand for family planning • Higher awareness and acceptability of family planning in general • Previous family planning or other program investments to build on: <ul style="list-style-type: none"> ○ Readiness of service delivery points ○ Community engagement ○ Identified champions ○ Evidence of resources committed
<p>Mixture of both ground-breaking and momentum-building</p>	

The CPR of 10% as the cut-off point for ground-breaking and momentum-building was based on review of all state CPR levels, whereby approximately half of the states were over or under a 10% modern method CPR. The other characteristics are qualitative (based on the findings during the assessment field visits) and may be refined further for state selection.

Evaluations of current and past programs and recommendations from key informants indicate that impact will be greater if efforts aren't "sprinkled" across LGAs without involvement and coordination at the state level. This is especially critical for a program focused on LA/PMs, so that efforts have a chance to be nurtured and take hold rather than fade when project support ends. Therefore, the team recommends a "state-focused approach," in which states are selected to satisfy a mix and balance between the two strategic scenarios (ground-breaking and momentum-building). To ensure that program efforts will be in a better position to yield quick results, the team proposes that the mix of states favors a higher proportion of states in the momentum-building category rather than the ground-breaking category. Moreover, state selection should be based on where there

is a high level of commitment for expanding family planning within the maternal and child health framework and not focus on one particular zone or section of the country.

The team defines a “statewide approach” as one that will work with all tiers within the state, including the tertiary, secondary, and primary facilities and ward structures. It is not possible or feasible to cover all LGAs within a state for LA/PMs. Targeting those facilities where it is possible to build on either past or current investments by other projects and donor efforts will yield greater results. Because an LA/PM effort generally requires a higher level of infrastructure and skilled provider, the emphasis **in the short term** should be placed on tertiary- and secondary-level institutions to enable a quick ramping up of service delivery. To reach the PHC level, the team recommends a mobile outreach service delivery model that twins expanding the provision of services with mentoring staff at host sites to strengthen family planning delivery. A state approach would:

- Select large, high-volume facilities, MSS facilities, placed in LGAs where political will and commitment exist in the first phase as a way to fast-track program activities.
- Utilize a balance of public, private, and NGO sector service delivery points
- Work with existing health and nonhealth networks, NGOs, such as FOMWAN, AHIP, ARFH, mission hospitals, and commercial entities as resources for awareness creation and advocacy activities.

Finally, the strategic approach should integrate important method-specific considerations as each method has a unique set of issues associated with them. For example, although implants tend to have higher overall acceptability among clients and providers, the cost barriers and access to removals are important considerations with programming. The IUCD has lost ground over the years because concern regarding HIV and STI infections and the lack of updated information about medical eligibility criteria. Injectables are increasingly popular; commodity security and counseling to support continuation are important issues. Female VSC and vasectomy require major effort to improve their image and acceptability as a contraceptive, with a focus on creating champions and normalizing these methods in pre-service education for physicians, nurses, midwives and CHEWs.

Strategic considerations regarding the Public and Private Sector programming for LA/PMs

Provision of contraceptive services in Nigeria is supported by both the public and the private health sectors. In general the private sector contributes 46% of health care provision, the public 47%, and others, 6%. However, the situation is different for family planning where the private sector is the dominant source of service delivery. The availability of LA/PMs in the private sector increases with the size of the facility given the greater likelihood of more highly trained providers. (Dutta A et al., 2009) An assessment using the 2008 NDHS data on unmet need and demand and a population of 37.3 million women estimated that the private sector could provide 35% of the demand for oral contraceptives, 29% of the demand for injectable hormonal contraceptives, 44% of the demand for the IUCD, and 8% of the demand for implants and tubal ligations (Ravenholt et

al., 2009). USAID/Nigeria is working to expand its support for social marketing, including a large BCC component as well as private sector services through the SHOPS project (led by Abt and Associates). Further, expansion of urban FP services through the private sector is a focus of the Gates-funded NURHI Project. Private sector participation is critical for supplementing the public sector by supporting quality and innovative FP services and by assisting with demand creation and training. The public sector is also very important given its reach and role in normative guidelines, education, training and service delivery at all levels of the health system. In considering the requirements for expanding access to quality LA/PM services in Nigeria, programs might consider the following roles for each sector:

Level	Potential Role:
PUBLIC SECTOR	
Tertiary	<ul style="list-style-type: none"> • In-service training for medical students, nurses, resident doctors • Short courses for all cadres of health workers for FP/LAPMs • Monitoring of services, including facilitative supervision and mentoring of service sites at the LGA level • Provision of all contraceptive methods, including VSC • Research, including introductory trials and intervention research
Secondary	<ul style="list-style-type: none"> • Provision of all contraceptive methods, including VSC • In-service training for nurses/midwives • Short courses for all cadres of health workers for FP/LAPMs • Monitoring of services and facilitative supervision at the PHC level
Primary	<ul style="list-style-type: none"> • Provision of short- and long-acting methods, depending on the availability of personnel
PRIVATE SECTOR	
Private/NGO hospitals/clinics	<ul style="list-style-type: none"> • FP counseling and provision of all methods, including VSC
Private Clinics/maternalities (staffed by nurse/midwives)	<ul style="list-style-type: none"> • FP counseling for all methods and referral for VSC • Initiate and resupply pills • Administer injectables • Insert and remove IUCDs and implants
Licensed pharmacies	<ul style="list-style-type: none"> • Sale of emergency contraception and oral contraceptives without prescription • Sale of injectable contraception and implants to licensed and trained nursing and medical professionals • Referral for VSC
Patent Medicine Vendors	<ul style="list-style-type: none"> • Sale of emergency contraception, oral contraceptives without prescription and refer for all other methods

Approaches for Expanding Access, Quality, and Use to Increase Supply

To achieve quality family planning and LA/PM programs, establishing effective training, supervision, logistics, and referral systems and ensuring medical safety and quality counseling are all needed. Organization of work and service linkages must be addressed and public-private partnerships explored. At the facility level, infrastructure upgrades are very likely to be needed, with attention to ensuring commodities, equipment, and

supplies. Given that little organized attention has been paid specifically to expanding family planning, and specifically LA/PMs, during the past several years in many states throughout Nigeria, the major recommendation is to systematically address the basic inputs required for service readiness in the states selected for intervention. The basic package will vary depending on the level of the service delivery point and what methods are appropriate for provision.

- 1. Ensure that integration efforts (antenatal care, postpartum services, Postabortion care, HIV services, immunization, fistula care, etc.) address and include LA/PMs.** Integration of services allows delivery of selected bundles of interventions in a cost-effective, impact-maximizing way to a large number of those who need them and will serve as an opportunity to meet women in numbers for dissemination of key LA/PM messages. By joining programs together, entry points for discussing family planning are maximized. Referrals from one service to another with the aim of providing comprehensive services make it easier for the client to meet his or her multiple needs. Integration as an approach can be used to strengthen the existing family planning component overall; to revitalize the family planning element within a care package (e.g., postabortion and postpartum care); and/or to create family planning linkages where they were lacking, as in fistula care and HIV services.
- 2. Utilize mobile service outreach approach to deliver services and build local capacity of sites.** Many women in remote areas cannot easily access the LA/PMs they need due to their distance from services and the nonavailability of services where they live. While some methods are available, choice is severely limited in many parts of Nigeria. Mobile service provision is therefore a viable choice in ensuring that women in hard-to-reach areas have access to family planning methods in general and LA/PMs in particular, since these methods require more skilled personnel and equipment than others. Mobile outreach has the benefit of satisfying existing demand for services in a short period of time and is currently used by NGOs to expand services. However, the approach can also be designed to provide an additional benefit in public-sector settings, to help build capacity (through on-the-job family planning clinical and counseling skills training and mentoring of service providers) while also quickly delivering services to the women and men who need them.
- 3. Strengthen referral between PHCs and higher level facilities, as well as within facilities.** One consistent finding is the lack of trained staff and equipment at lower levels of the health care delivery—i.e., PHCs. As a result, a significant portion of the population that these centers serve do not have access to LA/PMs. Strengthening referrals between these PHCs (especially for permanent methods) and the next highest level of care (including general hospitals and university teaching hospitals) will begin to address this unmet need. This approach, coupled with mobile services and service strengthening, will go a long way toward ensuring that clients have access and choice to meet their contraceptive needs. In some cases, women are willing to travel considerable distances for good quality services where they have access to a full range of family planning methods.

4. **Decentralize and strengthen service capacity to provide long-acting methods at lower levels.** The need for LA/PMs exists across every state in Nigeria, and yet most of these methods are currently only provided at higher level tertiary and secondary institutions. Most health facilities are located in urban areas (Kombe et al., 2009), and those that provide LA/PMs are almost always located in capital cities and major urban areas. For those women and couples outside major urban areas, little method choice exists, and LA/PMs are often not even discussed as an option, since commodities or trained providers are often unavailable. Over the long term, such services must be decentralized to the lower levels if clients are to access them easily at points near where they live. This will necessitate training service providers in remote areas and providing the necessary equipment and supplies to ensure that access is more widely available.
5. **Strengthen the capacity of family planning coordinators at the state and LGA levels to conduct performance monitoring, data for decision making, and facilitative supervision.** For the successful implementation of increasing supply of and demand for LA/PMs, it is critical to continually track the implementation of plans using a standard integrated tool. Monitoring and evaluation should be supportive to reinforce knowledge, skills, program management and quality implementation at all levels. There is a need to train those responsible for monitoring and supervision of reproductive health and family planning services. Training of the state and LGA reproductive health coordinators in facilitative supervision will improve their skill as supervisors and improve quality over time.
6. **Create stronger linkages between clinics and communities.** Several quality improvement processes should be used to link communities with the facilities serving them. Using tools such as Partnership Defined Quality (PDQ) and/or Community COPE, communities and providers together may identify and address problems relating to the provision of quality LA/PM services. These tools are developed around clients' rights and staff needs so that communities and providers work together to improve the quality of care through ongoing dialogue. Barriers to service, including long waiting times for clients, heavy workloads for providers, and limited or negative client-provider interactions, are some of the issues that may be addressed through such processes. Such methods have been used successfully in Nigeria in the past and should be expanded around the provision of family planning in general and LA/PMs in particular.

Approaches for Building an Enabling Environment

Building an enabling environment means establishing those conditions that will make it possible for the provision of services and creating a demand for family planning, especially LA/PMs. It means helping to develop systems to support service supply and changing social norms for behavior change. Strategies to create a positive environment will involve building a cadre of leaders and champions who will lead and manage the process. It will involve further refinement and implementation of policies and

development of guidelines and protocols. It will include drilling down those policies and guidelines to the operational level at the state, LGA, and community levels. It will mean advocating for and actively pursuing the mobilization of better capital resources and human resources for program implementation. Specific objectives and illustrative pathways are noted below:

1. Build a cadre of leaders/champions for LA/PMs. It is imperative that key champions are ready, willing, and able to lead, manage, and recognize the need for high-quality LA/PM programming in Nigeria. During the process of selecting states and sites for engagement, it will be important to identify persons who are enthusiastic, talented, and committed to family planning and to taking on the issues related to LA/PMs and to target these individuals for specialized training and mentoring. Some specific strategies for developing that next generation of leaders might be to:

- Develop an ongoing senior leadership management course specifically designed for the various implementation levels, but particularly for senior officers. The curriculum should lean toward skill development in visioning, strategic planning, and motivating individual team members.
- Provide, as necessary, “graduates” with leadership and management experience or tools (e.g., public speaking, techniques for motivating and nurturing staff, supportive supervision, etc.).
- Provide graduates with updated training, as needed, and give mentoring support.
- Among the graduates, mentor those most able to perform a higher “champion” role: by providing representative opportunities, facilitating meetings with high officials or visitors, getting exposure to different approaches by supporting presentation of papers at national or international conferences, or by supporting a special study leading to a published paper on what they are doing. As champions evolve, these individuals can serve as tutors/mentors to the next generation of professionals.
- Send champions on study exchanges to see successful programs in other countries.

2. Provide evidence-based support for the development of needed policies, procedures, and guidelines related to family planning/LA/PMs. In addition, push currently available policies/standards of care, etc., down the systems to the operational level. Specific approaches include:

- Identify key policies that should be supported. Those identified during the assessment include:
 - Task shifting to lower trained/competent cadres the authority to provide IUCDs, injectables, and implants
 - Seek the registration and use of Sino-implant (II)
 - Advocate for increasing funds for a contraceptive commodities line item at the national level and for commodities/management supply at the state and LGA levels
 - Address the cost to clients of family planning services (as all other reproductive health services are free)
- Engage the FMOH’s implementing partners forum (the Reproductive Health Working Group) in the development of a policy agenda that donors can support,

and identify key areas of help wanted and needed by the Ministry and throughout the health care system—both public and private.

- Provide support for fact-finding and consensus-building around policy issues (by means of studies, workshops, facilitation of consensus, and special research).
- Assist the FMOH to disseminate and “push” current policies and others developed down to the operational level at the state, LGA, and other levels.

3. Advocate, using NGOs, for family planning and LA/PMs at the national, state, and LGA levels. Specific approaches include:

- Develop a RAPID-type and/or Reality √ presentation on the benefits of family planning and the importance of LA/PMs that can be used at all levels for advocacy and sensitization of decision-makers at all levels.
- Research and develop a compelling rationale of why and how family planning and LA/PMs are a critical intervention for reducing maternal mortality in Nigeria.
- Use champions and develop their skills for advocacy at the national level and, particularly, at the state and LGA levels
- Build advocacy skills within selected states/LGAs for awareness building with key state leaders and stakeholders

4. Aggressively pursue increased Nigerian funding for family planning and LA/PMs

- Build a case for why LA/PMs are important for the local investment of funds
- Advocate for legislative budgeting and allocation of funds for procurement of commodities and supplies, particularly at the state and LGA levels
- Collaborate with policy-oriented projects and efforts to investigate alternative financing for family planning and LA/PMs, such as NHIS insurance, use of cost-recovery funds, and involvement of private companies in social responsibility activities
- Seek in-kind contributions for promotion of family planning and LA/PMs (as was done with COMPASS)

5. Test innovative approaches to address system barriers to LA/PM provision. Within the context of working through a statewide approach, illustrative ideas for strengthening the environment include the following:

- Investigate and document innovative ways to fill in the shortfall of skilled staff through the use of mobile clinics, use of locally hired retirees (along the lines of the MSS, but perhaps using local retired nurses or midwives)
- Investigate, build a constituency for, and promote re-tasking of skilled providers for specific tasks (such as IUCD insertion/removal, implant insertion and removal, and injectable distribution)

Approaches for Building Acceptability, Demand, and Proper Use

Communication interventions for LA/PMs must address social norms and barriers, as well as provider bias that inhibit family planning use in general and LA/PM use in particular. Interventions must be grounded in a socioecological framework that recognizes that individuals live and act within a complex system of family dynamics, norms, and social structure. These broader contextual factors can act as barriers to or

facilitators of healthy action. Any SBCC approach requires evidence-based, simple, and clear information to increase knowledge and self-efficacy and to encourage communication among communities, couples, peers, and within families to promote the use of family planning services. As individuals are exposed to a variety of SBCC interventions across multiple channels with repeated exposure, the cumulative effects on behavior are evident (Kincaid et al., 2001). A number of approaches for providing a supportive framework for increasing demand for LA/PMs have been identified.

- 1. Use multiple channels for SBCC.** A cohesive and strategic set of communication interventions (community engagement, mass media, local-level advocacy, capacity building, interpersonal skills building among providers, etc.) must be implemented; they need to reflect an understanding of mutually reinforcing levels of influence and the social environment that may facilitate or hinder LA/PM use. With this holistic framework as a foundation, approaches must address the multiple dimensions (individual, family, peers, community, health facility, and society) that affect behavioral outcomes. A robust communication strategy closely interwoven with supply side activities is needed to ensure cohesion and continuity of messages across key audiences, including clients, providers, the community, and leadership across multiple levels.
- 2. Apply a life stage approach for audience segmentation.** Often, LA/PM programs are mistakenly oriented to those in the latter part of their reproductive life cycle. Reaching women, men, and couples at various points in their lives, when fertility intentions may vary, provides multiple opportunities for SBCC focused on LA/PMs. Breaking these life stages down into reaching (1) unmarried women, (2) young couples, (3) postpartum women, and (4) older men and women allows messages to be targeted to their respective needs at various stages of life. Within these various stages of life, long-acting methods are an option within a context of choice and are ideal methods for delaying and spacing, and the range of LA/PMs are ideal for limiting births.
- 3. Harmonize LA/PM messages across all family planning projects.** Several existing donor-funded projects include a focus on family planning. Some maintain a focus on LA/PMs (SFH, MSI, the Nigerian Urban Health Initiative, etc.) within their larger family planning or integrated health portfolio and may benefit from more consistent messaging around these methods. It would be cost-effective if messages were harmonized, if projects coordinated their messages, and perhaps if, where possible, they jointly produced, printed, and broadcast similar messages around LA/PMs to leverage funding and have greater reach and impact. Opportunities exist to build on the somewhat limited body of formative research available on the acceptability of LA/PMs. We also recommend that as part of the harmonization effort, the various projects collaborate to identify existing job aids and tools for providers and service sites and review/harmonize and make them widely available across all projects.
- 4. Use maternal and child health as foundation for family planning and LA/PM messages.** Further to the point above, a great deal of evidence supports the

acceptability of using maternal health as an entry point for discussing family planning in Nigeria. If messages are crafted around healthy timing and spacing of pregnancy, the links between the use of family planning and a reduction in maternal and child mortality can be made. Since many men and women perceive spacing as beneficial to avoid what is known in parts of the north as “kwanika”—a situation in which a woman becomes pregnant before she has weaned her child (Tsui & Williamson, 2008), another opportunity exists to support sound breastfeeding practices while also supporting women with contraceptive methods to space their next pregnancy.

5. **Engage communities to address myths and misconceptions and promote social normative change.** Implementing large-scale community outreach and mobilization efforts to address social and information barriers is critical for LA/PM expansion given that fear and misconceptions about these methods are powerful deterrents to their use. Community engagement through *existing* structures such as Ward Development Committees, who are responsible for supporting health promotion and related community mobilization efforts (NPHCDA, 2004), can both address family planning needs while also building the long-term capacity of communities to take action for their health. Seizing on opportunities such as the “New Yam” festival in August in Ebonyi, where people return to their village, hold community planning meetings, and conduct fundraising to meet the needs for the coming year, is another example of how information dissemination and community dialogue may increase family planning uptake in general and use of LA/PMs in particular. Local NGOs may also play an important role in supporting community mobilization efforts.
6. **Engage traditional and religious gatekeepers as change agents.** Building on the above point, it is critical to involve people who have influence and who are trusted resources of information and guidance, including traditional and religious leaders, community leaders, teachers, and others, to positively influence the behavior of others. Large mass media or even community-level radio campaigns are more effective when there are encouraging community and household-level discussions about the benefits of family planning. It is recommended to engage these gatekeepers to educate their communities using religious and culturally appropriate texts and practices that can be used to support FP and LA/PM uptake. The first step is to obtain their support; work with them to develop action plans to take forward with their constituencies; and involve them in speaking on local radio programs and at community events (such as drama performances) to reinforce messages about family planning and LA/PMs in locally appropriate ways.
7. **Encourage couple communication and male involvement.** Across Nigeria, many men’s knowledge and awareness about the benefits of family planning and correct knowledge about the various methods may be rather low. There is also evidence that men indeed desire to limit childbearing (Odumosu, et al., 2002). Any LA/PM effort must include outreach with men to reduce opposition to family planning, and increase their constructive participation in family planning to change attitudes and behaviors and advance LA/PMs and their role in delaying, spacing, and limiting births.

V. COORDINATION AND COLLABORATION

Given the size and diversity of Nigeria and the status of LA/PMs, the proposed recommendations are designed to build on existing efforts so that LA/PMs are not a stand-alone effort but become an integral part of the family planning efforts of others. Therefore, it is critical to have strong coordination and collaboration strategy to leverage resources and action; harmonize and align efforts and where possible, conduct joint planning to promote synergy and avoid duplication of effort. These efforts will be facilitated by the excellent coordination that already exists among the donors supporting family planning in Nigeria (especially among USAID, UNFPA and DFID).

The following are key areas and issues that will require proactive coordination related to LA/PMs:

- **Contraceptive Security:** USAID/N with the DELIVER project and in coordination with other donors has produced a five-year forecast of contraceptive procurement, delivery and distribution requirements in both the public and private sectors. This forecast should be updated to include requirements beyond the contraceptive commodities to address other areas of contraceptive security for LA/PMs including instruments and commodities. The RESOND Leader project is collaborating with JSI/DELIVER at the global level to support the expansion of the definition of contraceptive security to include these supplies.
- **Behavior Change and Communication:** Efforts should be made to share formative research findings (NUHRI, RESPOND's use dynamics study, any formative research from other projects, including the follow-on social marketing project), as well as to harmonize messages and campaigns where possible.
- **Policy Coordination:** The FMOH sponsors (although infrequently) coordination meetings with donors through the National RHCS Stakeholder Committee. A technical subcommittee of the RHFP meets periodically to discuss issues of common interest, such as forecasting of commodities and review and development of protocols and standing procedures. It is recommended to support policy dialogues around key issues related to LA/PMs (strategic planning and forecasting, dissemination of existing policies, task shifting, training) to strengthen the focus on family planning and LA/PMs at the national and state levels. Facilitate, to the extent possible and in coordination with other USAID policy partners, the FMOH to reactivate its coordination function and involve the FMOH to the extent possible (as was done for the LAPM assessment. Replicate coordination at the state/LGA to the extent possible.
- **Private sector:** Long-acting method provision is a major focus of two private organizations, Marie Stopes Nigeria (implants) and Society for Family Health (IUCDs). USAID is anticipating a new private sector project to expand the availability, quality and use of family planning through a range of clinic-based private sector providers. The Gate-funded NURHI project will have a significant private sector component. It will be critical for any LA/PM initiative to identify ways to both

collaborate and provide any needed technical input to strengthen the inclusion of LA/PM information, referrals and/or services as appropriate.

- **Knowledge Management:** Commission the development of a low-tech web site where relevant LA/PM-related materials and lessons learned (in Nigeria and worldwide) about family planning and LA/PMs can be loaded and shared between the implementing partners and the State Family Planning Coordinators. One idea may be to start with the Nigeria-specific articles collected electronically for this assessment and link them to existing web sites known for information on LA/PMs, such the LA/PM Community of Practice supported by RESPOND in collaboration with the Knowledge for Health project, which serve as a repository for family planning–related information (<http://www.k4health.org>).

VI. ACTIONS FOR THE IMMEDIATE FUTURE

Even though Nigeria offers a complex setting and many challenges, the assessment team is encouraged by the opportunities that exist. Donor funds are available to support Nigeria's strategies, and these resources coupled with potential domestic revenues could be considerable. Policies have been promulgated and service delivery models have been developed that can be refined, replicated, and brought to scale. There is a strong demand for family planning, including LA/PMs. Immediate strategic actions can be taken to strengthen access to and availability, quality, and use of LA/PMs so that they comprise a significant proportion of the contraceptive mix.

The team recommends that the USAID Mission in Nigeria, with technical assistance, develop an implementation framework to guide a more concerted effort for LA/PMs including the following illustrative actions:

- Triage the approaches and strategic options that have been identified by this assessment, determine priorities, determine cost implications, and develop a specific plan of action with an implementation schedule.
- Identify the level of program resources available so as to determine the number of states;
- Take an inventory (using specific criteria of the readiness of the states in Nigeria) to pinpoint potential states for initial investment and identify points of entry. And work with the FMOH to select states for a focused LA/PM effort.
- Use Reality \checkmark to set realistic family planning service goals, plan for resources needed, and generate data for evidence-based advocacy and strategic planning at national and state levels.
- Develop an advocacy plan, and articulate a strong Nigeria-specific case for LA/PMs' potential in expanding choice, increasing program impact, and saving lives, for use in advocacy.
- Identify potential champions that can be early advocates for the expansion of LA/PMs.
- Continue to systemically coordinate and engage in dialogue with the Nigerian government and public, private, and NGO stakeholders regarding commodity security and possibilities for expanding access to LA/PMs.
- Identify possible opportunities among implementing partners or other donors where LA/PMs can logically and immediately be incorporated into existing programs, recognizing points of entry and engaging implementing partners to take appropriate action. The purpose is to encourage more collaboration to obtain a more synergistic, coordinated, and united approach to addressing LA/PMs.
- Map proven strategies, approaches, materials, and tools that have already been developed that support LA/PMs, to avoid duplication and "reinventing the wheel." Those items identified can be "fast tracked" for quick dissemination.
- Ascertain possible resources (both donor and in-country) to develop critical backing for any significant effort to increase the access, acceptability and use of LA/PMs.

- Support research efforts that seek to better understand both providers' and clients' perceptions of LA/PMs, to inform client-centered programming.

REFERENCES

- ACQUIRE Project. 2008. *Save lives, alleviate poverty, spur development: Invest in long-acting and permanent methods of contraception*. Advocacy Brief No. 1. New York: EngenderHealth/The ACQUIRE Project.
- Africa Health Workforce Observatory (AHWO). 2008. *Human Resources for Health Country Profile: Nigeria*. Abuja.
- Barnes, J., Chandani, T., and Feeley, R. 2008. *Nigeria private sector health assessment*. Bethesda, MD: Private Sector Partnerships-One Project/Abt Associates Inc.
- Blumhagen, D., Barker, C., Oladosu, M., et al. 2009. *USAID/Nigeria maternal, child, and reproductive health program mid-term evaluation*. Washington, DC: Global Health Technical Assistance Project.
- Campbell, O.M.R., and Wendy J. Graham, W.J. 2006. Strategies for reducing maternal mortality: Getting on with what works. *Lancet* 368(9543):1284–1299.
- Center for Reproductive Rights (CRR) and Women Advocates Research and Documentation Centre (WARDC). 2008. *Broken promises: Human rights, accountability and maternal deaths in Nigeria*. New York and Abuja.
- COMPASS Project Nigeria. 2007. *A community empowerment success story: Nigerian communities taking action to improve health and education—Midterm assessment*. Abuja.
- Dutta, A., Kariisa, E., Osika, J., Kombe, A., Johnson Onoja, A., Lecky, M., Oyemakinde, A. June 2009. *The Private Health Sector in Nigeria – An Assessment of Its Workforce and Service Provision*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
- Fistula Care. 2010. *A strategy for engaging communities and involving men in fistula prevention*. New York: EngenderHealth/Fistula Care.
- Goliber, T., Sanders, R., and Ross, J. 2009. *Analyzing family planning needs in Nigeria: Lessons for repositioning family planning in Sub-Saharan Africa*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.
- Kincaid, D. L., Figueroa, M. E., Storey, D., Underwood, C. 2001. *Communication and behavior change: The role of ideation*. Baltimore: Johns Hopkins University Center for Communication Programs.
- Kincaid, D. L., Figueroa, M. E., Storey, J. D, and Underwood, C. R. 2007. *Communication, ideation, and contraceptive use: The relationship observed in five countries*. In *Proceedings of the World Congress on Communication for Development*. Washington, DC: World Bank.
- Kombe, G., Fleisher, L., Kariisa, E., et al. 2009. *Nigeria Health System Assessment 2008*. Washington, DC: Abt Associates Inc. Retrieved from: www.healthsystems2020.org/content/resource/detail/2326/, March 3, 2010.

Labiran, A., Mafe, M., Onajole, B., and Lambo, E. 2008. *Human resources for health country profile—Nigeria*. Abuja: Africa Health Workforce Observatory. Accessed at: www.hrh-observatory.afro.who.int/images/Document_Centre/nigeria_country_profile.pdf.

Lane, C. No date. *Reaching underserved youth with reproductive health and family planning services*. Washington, DC: Extending Service Delivery Project/Pathfinder International. Accessed at: http://www.esdproj.org/site/DocServer/ESD_Legacy_Youth_6_24_10.pdf?docID=3580.

National Population Commission (NPC) and ICF Macro. 2009. *Nigeria Demographic and Health Survey 2008*. Abuja.

National Primary Health Care Development Agency (NPHCDA). 2004. *Operational training manual and guidelines for the development of primary health care system in Nigeria*. Abuja.

Odumosu, O. F., Ajala, A. O., Nelson-Twakor, E. N., and Alonge, S. K. 2002. Unmet need for contraception among married men in urban Nigeria. Interregional Seminar on Reproductive Health, Unmet Needs and Poverty: Issues of Access and Quality of Service, Bangkok, November 25-30, 2002. Available: www.cicred.org/Eng/Seminars/Details/Seminars/Bangkok2002/27BangkokOdumosu_AjalaTwakor_Alonge.pdf

Ogunjuyigbe, P. O., Ojofeitimi, E. O., and Liasu, A. 2009. Spousal communication, changes in partner attitude, and contraceptive use among the Yorubas of Southwest Nigeria. *Indian Journal of Community Medicine* 34(2):112–116.

Ravenholt, B., Stene, A., Sulzbach, S., et al. 2009. *Assessing the commercial viability of long-acting and permanent contraceptive methods*. Bethesda, MD: Private Sector Partnerships-One Project, Abt Associates Inc.

Save the Children. 2010. *Women on the front lines of health care: State of the world's mothers 2010*. Westport, CT, USA.

Smith, R., Ashford, L., Gribble, J., and Clifton, D. 2009. *Family planning saves lives, 4th ed.* Washington, DC: Population Reference Bureau (PRB).

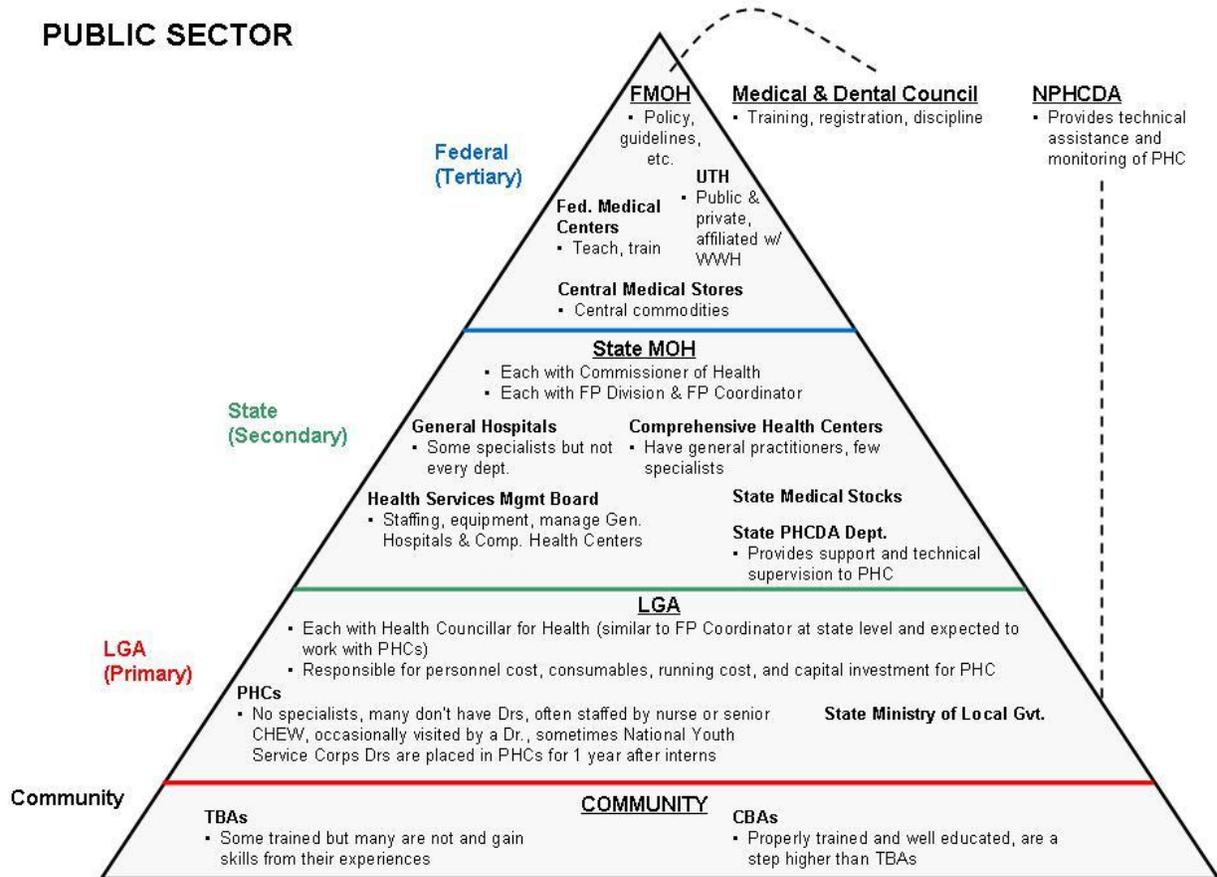
Tien, M., Ness, S., Amanyeiwe, U., et al. 2009. *Nigeria: Reproductive health commodity security situation analysis*. Arlington: USAID/DELIVER Project, Task Order 1. Accessed at: http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/NG_ReprHealCommSecuAnal.pdf.

Tsui, S., and Williamson, N. E. 2008. *Child spacing attitudes in Northern Nigeria: Part II: Formative research: Child spacing and family planning attitudes of young married men and women in selected areas of North West Nigeria*. Washington, DC: Family Health International and Contraceptive and Reproductive Health Technologies Utilization Program.

UNFPA. 2005. *Country profiles for population and reproductive health: policy developments and indicators 2005*. New York. Retrieved from www.unfpa.org/upload/lib_pub_file/524_filename_country_profiles_2005.pdf, Dec. 29, 2009.

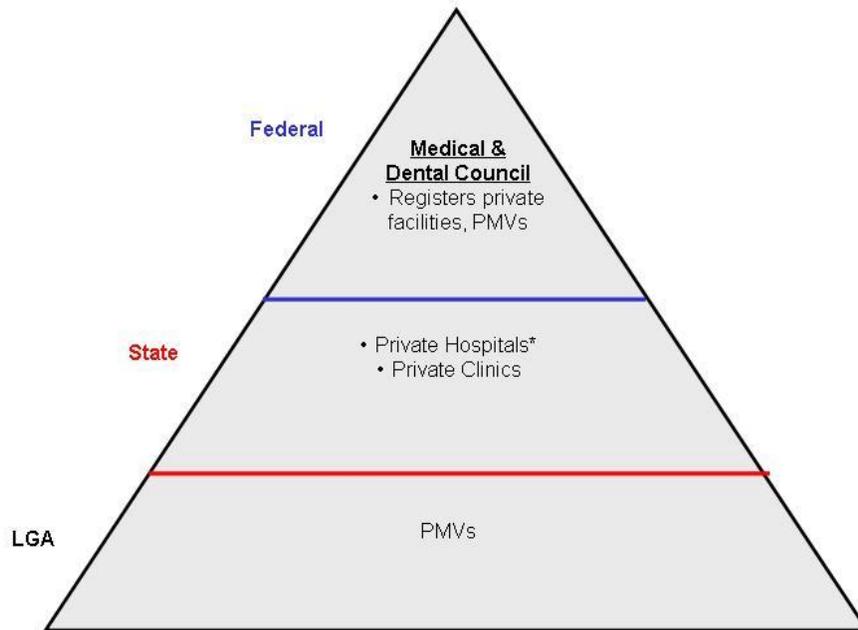
World Health Organization Statistical Information System (WHOSIS). 2010. *Core health indicators, Nigeria*. Geneva. Retrieved from www.who.int/countries/nga/nga/en/, March 3, 2010.

ANNEX I: Health Services Pyramid



PRIVATE SECTOR

See on previous page how it links with public sector pyramid



* Note that private hospitals are not accredited by FMOH

* Once a private hospital has enough specialists, they can train interns

ANNEX II: Advocacy Briefs

- 1. *Save Lives, Alleviate Poverty, Spur Development: Invest in Long-Acting and Permanent Methods of Contraception***
Advocacy Brief No. 1
- 2. *Long-Acting and Permanent Methods of Contraception: Without Them, a Country's Development Will Be Low and Slow***
Advocacy Brief No. 3
Roy Jacobstein, M.D., M.P.H., The ACQUIRE Project
- 3. *Nigeria Country Profile: Meeting National Goals and People's Needs with LA/PMs***
January 2010

ANNEX III: Scope of Work, Protocol, Focus Group Discussion Guide

- The detailed scope of work and schedule
- A list of key informants
- A bibliography of the documents reviewed
- The Assessment Interview Protocol
- The Focus-Group Discussion Guide

SCOPE OF WORK STRATEGIC REVIEW FOR STRENGTHENING LONG-ACTING AND PERMANENT CONTRACEPTIVE SERVICES IN NIGERIA

PURPOSE

The overall purpose of this strategic review is: 1) to assess the use, unmet need, trends and current programs for long acting and permanent methods (LA/PMs) in Nigeria; and 2) to develop strategic approaches for strengthening access to and availability, quality and use of these services. LA/PMs include long-acting methods (IUCD and implants) and permanent methods (female sterilization and vasectomy). In addition, the review will take into consideration injectables (as they are considered “long-acting” by some women in Nigeria). The strategic review will recommend program options for providing LA/PMs at the federal, state and local government authority (LGA) levels over the next five years in selected geographic areas in the country.

ISSUES FOR ASSESSMENT

The assessment will be organized to address issues at the different levels of the health system concerning LA/PMs according to three main program areas critical for improved access, quality and use of these services:

- **Supply-side** issues related to whether health workers are trained and supported, supplies and equipment are in place (including a range of contraceptive methods), sites and workers are mobilized and ready to provide services, and quality improvement mechanisms are in place.
- **Enabling environment** issues related to creating a socio-political and program environment that includes supportive policies that are made operational through the allocation of resources, use of evidence-based guidelines and protocols, and that fosters effective leadership and championing of family planning (FP) and more specifically LA/PMs at all levels of the health system, within communities and throughout other sectors.
- **Demand-side** issues that focus on increasing awareness and acceptability of LA/PMs among clients, couples and communities and on supporting health-seeking behavior through social and behavior change and communication (SBCC) to address knowledge gaps, correct misinformation, and address gender and other barriers that inhibit access to and use of services.

Within the broader assessment of LA/PMs, the Team will review the current state of LA/PMs in Nigeria and, to the extent possible, extrapolate who is providing LA/PMs and where, and what types of inputs or interventions are needed (from a supply, enabling environment and demand perspective) to revive efforts to support and expand these services. The Team will review past and current assistance for LA/PMs in Nigeria and how that program built up services, in order to determine how to revive the program and decentralize services as much as possible; and develop a strategic approach to increasing access, availability, quality of care and use of LA/PMs throughout Nigeria.

The Assessment Team will take into consideration current uptake of methods/method mix and geographical spread (based on the most recent DHS); public and private sector activities – ongoing or planned – that can or have the potential to stimulate increased use of LA/PMs by addressing access, availability and quality of care; the interest of other current and potential partners in strengthening LA/PMs; and the availability of RESPOND and USAID/Nigeria funding for these purposes. Specific information to be obtained during the assessment includes:

- Analysis of LA/PM use patterns, unmet needs and trends over time
- Current LA/PM program activities including geographical locations and extent of private or public sector involvement
- Initial assessment of service quality in facilities visited to inform a greater in-depth analysis of quality of services, placement of facilities and renovation and training needs in geographic areas selected for assistance
- Identification of types of facilities providing LA/PM, trained personnel and potential for expanding secondary and primary health care facilities to offer LA/PM
- Assessment of the enabling environment to determine if necessary policies, procedures and standards are in place to ensure quality services; and determine if the current social environment is conducive to an uptake in LA/PMs
- Identification of culturally acceptable approaches for Social and Behavior Change and Communication (SBCC) and demand creation for LA/PMs
- The interest of other donors in strengthening LA/PMs and identification of specific opportunities for collaboration
- Preliminary costing of approach options leading to development of budget estimates

The LA/PM Team will endeavor to answer such questions as: What types of scenarios/assumptions can be made and how to align facility, commodity and human capacity planning with potential increased demand? What is the best way to organize LA/PM interventions in areas both where there are other partners and where there are no partner programs; where services are emerging, and where there are programs to build upon? Where are the potential areas for program integration? What are the strategic and programmatic differences and in developing a new groundbreaking program or in building momentum for LA/PMs? What is the general state of facilities and what renovations or equipment might be needed to provide quality services? What training approaches are needed to ensure that skilled health workers can provide quality LA/PMs? How might SBCC approaches vary bearing in mind socio-cultural sensitivities? What might be the most effective SBCC messages/approaches for increasing acceptance of LA/PMs? How can constructive male involvement be integrated in such approaches? What levels of financial resources are needed to launch a reinvigorated program for quality LA/PMs in selected states in each of the geographical zones? Within the overall strategic plan, what are the use opportunities for RESPOND, USAID/Nigeria earmarked funds, and other donors for strengthening LA/PMs?

REVIEW APPROACH AND METHODOLOGY

The Team will use a variety of methods to collect both primary and secondary information for this assignment and to accurately determine the current situation of and potential for expanded programs for LA/PMs in Nigeria. The Team will propose

strategic, feasible and effective options for strengthening access to and availability, quality and use of these services. These methods include:

Conduct analysis of past and current situation regarding FP-LA/PMs in Nigeria. Prior to arrival, the Team will review and analyze existing data on FP-LA/PMs in Nigeria; survey the literature not only in Nigeria but experience in other countries that have successful LA/PM programs; review best practices for LA/PMs from world-wide experience; and generate some preliminary scenarios and projections to guide discussions with key stakeholders during the assessment visit. To facilitate the quick start up of the assessment and planning, preliminary analysis or briefings will be studied for the visit including but not limited to the following:

- Review of currently available resources on FP-LA/PM introduction and/or scale up in Nigeria
- Analysis of LA/PM use patterns, unmet needs, and trends over time in Nigeria
- Justification/Rational for LA/PMs in programming in Nigeria
- Identification of “best practices” regarding introduction or scale up of LA/PM programs and models of integration of LA/PMs with other service programs such as MCH antenatal/postpartum, fistula, AIDS, etc.
- Review of MacDonald/Bornbush mapping of services and update where FP-LA/PM services might be introduced or integrated within existing programs (This mapping will be further updated to include specifics on LA/PM activities)
- Update on the status of implant introductions (Sino-plant and others) in Nigeria and other African countries

Develop in advance assessment methodologies and protocol/assessment guides: The core RESPOND Team convened on July 21, 2010 for a one-day meeting in New York at EngenderHealth headquarters to finalize the schedule, review preliminary data, discuss key issues to be explored during site visit, and outline specific protocol and assessment guides to be used during the field visits. In addition, the Team will further develop a “core list” of questions to be asked of various informants during site visits and also have specialized modules for the specialty areas (i.e., clinical services, demand creation, and advocacy). Protocol guides and/or assessment tools will be sent to the USAID Mission prior to Team travel to Nigeria in September.

Conduct key informant interviews and stakeholder forums: During the visit, the Team will meet and interview key organizational officials and individuals involved in LA/PMs and/or that provide funding, including the Government of Nigeria (GON) and Ministry of Health (MOH) at federal, state, and LGA levels; private sector Nigerian organizations; Development Partners (DPs) and USAID Implementing Partners, including major donors/actors involved in MCH/RH/FP; and others as required.

To obtain stakeholders advice and to discuss issues/concerns regarding the scale of LA/PMs in Nigeria, the Team and USAID Mission will host “Stakeholders Meetings” prior to the field visits. Stakeholders will include representatives of organizations in the health sector including faith-based organizations, government officials at all levels,

and service providers in both public and private sectors. The key informant and stakeholder interviews will provide perspective on planning/implementation of future activities for LA/PMs, will identify potential areas of collaboration, and will indicate stakeholder perceptions of LA/PMs.

Field Visits: Three sub-Teams will travel to at least one state in each of the six major geographic zones to ensure that the strategic approach takes into consideration the diverse context for FP-LA/PM programming in Nigeria. The states proposed for the assessment (one state per zone) will be selected on the basis of the following criteria:

- population size
- zones/states representative of both emerging services and more established service programs
- some existing use of FP-LA/PM methods
- the potential for synergy with donor projects and cooperating agencies
- the existence of a University Teaching Hospital that can be used for training for LA/PM interventions
- previous or current EngenderHealth and/or JHU presence (to facilitate both the assessment and future programming)
- Proximity of locations to allow for better scheduling and better use of time
- Relative safety and good condition of roads for travel

As a basis for decisions regarding travel, the Team used the matrix of Family Planning Service Delivery Partners prepared by Patricia MacDonald and Alan Bornbusch during their January 2010 visit to Nigeria as well as Department of State information on security restrictions to inform and guide site selection, The aim is to guide the program strategy and not necessarily to confine the eventual strategic approach to these particular states.

The proposed states for field visits are noted below. The final selection of states to be visited will be determined in consultation with the Mission in early August so that travel arrangements can be finalized.

Sub: Team One	Sub-Team Two:	Sub-Team Three:
<ul style="list-style-type: none"> • North East Zone: Borno • North West Zone, Kano with stop in Zaria <p>Team Participants: Joyce Holfeld, Dr. Wandawa, Abdullahi Maiwada, and representatives of UNFPA, DFID, and others to be determined</p>	<ul style="list-style-type: none"> • South East Zone: <i>Ebonyi</i> • South South Zone: <i>Cross Rivers</i> <p>Team Participants: Lynn Van Lith, Dr. Robert Leke, Kayode Morenkyi, and representatives of UNFPA, DFID, and others to be determined</p>	<ul style="list-style-type: none"> • North Central Zone, Benue (with stopover in Nasarawa) • South West Zone: • Oyo (to explore national center of excellence) <p>Team Participants: Lynn Bakamjian, Dr. Adekunle, Folake Olayinka, and representatives of UNFPA, DFID, and others to be determined</p>

PROPOSED TEAM COMPOSITION

The Team will be led by two senior level health managers. All members of the Team are highly qualified in a broad range of skills (clinical, technical, advocacy, demand creation, and management) necessary for programming in reproductive health and family planning including LA/PMs and all have experience in Africa and/or in Nigeria. The Nigerian team members were chosen for their technical skills, knowledge of the Nigerian health system at all levels, senior level managers also knowledgeable of players and actors in the field in Nigeria. Confirmed Team members with proposed role and experience listed:

EngenderHealth Team Members:

- **Ms. Lynn Bakamjian, team leader, LA/PM service delivery expert:** Senior manager at EngenderHealth, Project Director of RESPOND, with broad based technical, program design and management skills relating to LA/PM service delivery.
- **Ms. Joyce Holfeld, co-team leader and enabling environment expert.** International consultant, champion for LA/PMs, recognized expert in family planning, MCH and health systems; extensive experience in program design, implementation and evaluation; knowledgeable of and experience with West Africa and Nigerian programs.
- **Ms. Lynn Van Lith, BBC/demand expert.** JHU-Center for Communication Programs, BCC specialist/Senior Technical Advisor for RESPOND also knowledgeable of the Gates Foundation Urban Health Initiative in Nigeria as well as HIV/AIDs programming and integration; strong skills in data for decision making.
- **Isaiah N'Dong, M.D.,** EngenderHealth, Senior Vice President of Programs will participate in the final strategic deliberations, and final presentation to the USAID Mission. EngenderHealth Team strongly believe to have direct involvement of its Senior Vice President for Programs will be important to secure long-term senior support of RESPOND and Engender Health in the future.

USAID Team Members:

- **Ms. Sharon Epstein, USAID Team Leader for Health, Population and Nutrition** a leader in the field of family planning with years of experience supporting such programs around the globe.
- **Dr. Folake Olayinka, clinical expert, USAID representative.** USAID/Nigeria Maternal and Child Health Program Manager; physician by training and public health specialist.
- **Mr. Kayode Morenkeji, USAID Representative,** USAID/Nigeria RH Program manager,

International and Nigeria Senior Consultants:

- **Dr. Robert Leke, internationally renowned clinical FP/RH expert.** Professor and Head of Department of OB-Gyn, University of Cameroon/Yaounde; RH specialist and Master Trainer for JHPIEGO (FP clinical skills, infection prevention, curriculum development); WHO collaborator; conducted needs assessments in several African countries; recently served as consultant to USAID/West Africa in design and development of West Africa RH Program (AWARE II).

- **Dr. AO Adekunle, Nigerian consultant** of the University College Hospital of Ibadan. He is an OB/GYN and professor with years working in family planning including LA/PM experience who has been a pioneer in the field in Nigeria.
- **Dr. Abdullahi Jabril Randawa, Nigerian Consultant** of Ahmadu Bello University Teaching Hospital in Zaria. He has direct family planning and LA/PM experience and will help in understanding the family planning context in the North and will complement the experience and expertise in LA/PM strategic programming assembled on the team.

The EngenderHealth Team in Nigeria, under the direction of Iyeme Efem, will provide logistical and travel support, as well as office space in Abuja. USAID, in conjunction with EngenderHealth, will help to facilitate appointments and other meetings. The Stakeholders meeting will be hosted by both USAID and EngenderHealth.

TIMING AND SCHEDULING

The in-country assessment is planned for three weeks immediately following Ramadan, from September 11 to September 30 2010. This in-country three week exercise will allow adequate time for key interviews with the Mission and stakeholders and the opportunity to visit sites in the six zones of Nigeria. The in-country visit also will permit time to review current activities and to analyze data and synthesize findings and to develop strategic options for the future. Agendas and meeting appointments will be made in advance of trip.

OUTCOME AND DELIVERABLE

Throughout the assignment period the Assessment Team will be analyzing materials, assessing findings, and developing hypotheses to be verified by data collected and informant interviews. The Team will meet informally daily to exchange information, assess notes, summarize meaningful data and formally move toward identification and documentation of solid findings and conclusions. During the final week, the Assessment Team will develop consensus on final conclusions and recommendations for an approach to strengthen the delivery of quality LA/PM services in Nigeria. It is anticipated that, depending on location of the proposed service sites, the strategic report will include approaches for ground breaking activities as well as for building momentum for services where there is already some foundation.

A specific deliverable of the exercise will be a draft report with a strategic approach to strengthen quality LA/PM services in Nigeria. The summary of assessment findings will reflect recommendations and provide some strategic choices regarding best program options, potential activities, management models, and a detailing of estimated costs for various scenarios for a robust LA/PM program as well as specific costs that RESPOND and the USAID/Nigeria/HPN country program may be able to meet with earmarked funding. The paper will also set out immediate next steps necessary to proceed with design and funding of the delivery of quality LA/PMs in Nigeria.

The Team will submit a review draft of the report to the Mission on departure. Within two week the Mission will provide RESPOND with any comments or edits. RESPOND will incorporate the necessary changes, edits and prepare the final document and distribute as

required by the Mission. RESPIND will provide the Mission a final PDF electronic copy of the Report.

KEY REFERENCE MATERIALS

NIGERIA STRATEGIC LAPM ASSESSMENT SEPTEMBER, 2010

Blumhagen, D. et al. November 2009. *USAID/Nigeria Maternal, Child and Reproductive Health Program Mid-term Evaluation*. Washington, DC: The Global Health Technical Assistance Project.

Fertility, Proximate Determinates and Fertility Intentions – Nigeria DHS 2008 Powerpoint Presentation. Washington, DC: Macro International.

Goliber, T., Sanders, R. and Ross, J. December 2009. *Analyzing Family Planning Needs in Nigeria: Lessons for Repositioning Family Planning in Sub-Saharan Africa*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Holfeld, J. et al. June 2008. *An evaluation of the USAID/Nigeria Social Sector Projects: ENHANCE and COMPASS*. Washington, DC: The Mitchell Group Monitoring and Evaluation Management Services (MEMS).

Holfeld, J. and MacDonald, P. January 2007. *The “Ground is Softening” for the USAID/Nigeria Health Portfolio: Considerations for the Present and the Future*. Washington, DC: USAID.

MacDonald, P. and Bornbusch, A. January-February 2010. *Draft Trip Report, Nigeria*. Washington, DC: USAID. (Includes Appendix: Nigeria –Family Planning Service Delivery Partners)

Malakoff, S. March 2010. *Background Brief – Nigeria (internal report)*. New York: EngenderHealth.

Nigeria Country Profile: Meeting National Goals and People’s Needs with LA/PMs. June 2009. New York: EngenderHealth, RESPOND Project.

Nigeria Health System Assessment. 2008. Washington DC: Abt Associates, Health Systems 2020

Nigeria Private Sector Health Assessment. July 2008. Washington, DC: Abt Associates, PSP-One.

Nigerian Urban Reproductive Health Initiative – Project Overview, Powerpoint Presentation. January 2009. Baltimore, MD: Johns Hopkins Center for Communication Programs.

The Private Sector in Nigeria – An Assessment of its Workforce and Service Provision. June 2009. Washington DD: Abt Associates, Health Systems 2020.

Summary of Situational Analysis on Facility-based Interventions in Nigeria (internal report). New York: EngenderHealth. March 2010

USAID|DELIVER – Nigeria. *Reproductive Health Contraceptive Security Situation Analysis*. October 2009.

Tentative Schedule for Assessment and Strategic Review for LA/PMs in Nigeria

SEPTEMBER 2010						
SUN	MON	TUES	WED	THURS	FRI	SAT
SEPT 5	6	7	8	9	10 PM: Travel to Abuja	11 Arrive in Abuja
12 PM: Team members planning session	13 AM: Mtg with USAID: Team leader and those most concern with visit. PM Meeting with broader PHN staffers to seek input, especially re integration/ Collaboration	14 9:00AM (?) Facilitated mtg with donors re collaboration UNFPA, DFID, WHO, UNAIDS, World Bank, Global Fund	15 10:00AM Meet with NURHI (Dr. Moji & Bola Public Sector: MOPH Foundations: Gates, Packard Private Sector: Pharma-Fam, SFH, provider associations Policy makers NCA	16 8:30AM; Facilitated mtg. with Stakeholders (re rationale/ approaches)	17 AM: check in with Mission Syntheses of stakeholder meeting findings	18 Analyze, synthesize info for planning field visits
19 Travel to Initial Site Visit location	20 Assessment Team divides into at least three separate teams for field visit to six zones during field test: Sub-Team 1: Kano with stop in Zaria, and Borno Sub-Team 2: Cross Rivers, Ebonyi Sub-Team 3: Benue (with stop in Nasarawa and Oyo (pilot for female sterilization)	21	22	23	24 AM: Meetings and PM: Travel back to Abuja	25 Analyze/ synthesize; agree on approaches & major points
26 Write assigned section of report; Prepare presentation for Mission	27 Review initial findings w/ Mission on PPT; Continue with report narrative	28 Consolidate and make refinements on Draft Report	29	30 AM: Final Debrief with Mission Late PM: Depart	1 Travel to US	

Nigeria LA/PM Assessment Questionnaire

The RESPOND Assessment Team for Long Acting and Permanent Methods (LA/PM) will interview a variety of key informants. The list of questions that follow on pages 2-5 is basically a “standardized menu” of information that will be solicited from those individuals interviewed by the team. Those questions that are asterisked (*) will be standard questions asked of all interviewees. Additional questions from the menu will be tailored to the type of individual interviewed. This “menu” method allows some structure in data collected for the diversity found in the six zones and at different operational levels, but at the same time allows specific targeting of questions to specific interview groups. Interviews will be conducted at one-on-one site visits, during the stakeholder meetings, and by special appointments and group meetings with experts and special groups. The broad range of people to be interviewed during the assessment will include:

- Policy makers, opinion leaders, champions, community leaders who support (or not) RH/FP, particularly LA/PMs. These individuals may influence at the national, zonal, state or community level
- Government officials involved in health programming and service at the national (FMOH), state (SMOH) or community (LGA) levels
- Representatives from the non-governmental sector, including non-profit service organizations, faith-based organizations, health professional societies, the commercial sector, and university teaching hospitals faculties of medicine, nursing and midwifery
- Representatives from the commercial sector, including small private hospitals and clinics, pharmaceutical industry, health facilities within parastatal or private companies
- Representatives from the donor community including multilateral (e.g. UNFPA, UNAIDS), bilateral (e.g. USG official organizations and cooperating agencies USAID/ PEPFAR, DFID, GTZ), and other donors (Gates, Packard, MacArthur, Clinton Foundation)
- Public and private sector service providers primarily at community and state levels
- Clients and potential clients via quick-fire focus groups at clinics visited

Interview techniques and questions asked will vary by target group.

Nigeria LA/PM Assessment Questions

I. General Overarching Questions

1. What are the principle results and successes of LA/PM programming in the last five years? (How are these compared to results and successes in FP programming more generally?) *
2. What contributed to these successes (programmatic, political, cultural and social factors)? *
3. What were the major obstacles to increasing use of LA/PMs? *
4. How can these challenges be overcome?
5. What is most needed to revitalize LAs in this state/zone? PMs? *
6. What projects/NGOs are supporting the expansion of LA/PMs? Who should we be partnering and coordinating with?
7. Are government policies/practices supportive of **private sector** participation in FP (especially LA/PM) service provision? Give examples.*

II. Service Delivery

1. Is the status of the public (and private) health system and staffing within the state adequate to implement LA/PM programs?
2. What public service sites handle most LA users? PM users? *
3. What private service sites handle LA users? PM users? *
4. Which areas of the state are more difficult to serve with LA/PMs?
5. Which private sector agencies/groups provide LA service provision? PMs?
6. Are FP/LA/PM services integrated within workplace health services?

Questions below apply to both interviews at either public or private facilities

7. Do staff have access to adequate workspace, equipment and supplies to enable them to provide high-quality LA and PM services? How would you describe the “readiness” of the facility/ies to provide LA and or PM services? *
8. Are staff rewarded for providing quality care (e.g. recognition, bonuses, career development opportunities, and/or other nonfinancial rewards)?
9. Are salaries appropriately set to ensure highly-motivated staff?
10. Do providers have a tendency to promote some contraceptive methods over others? What are provider specific opinions of LAs? PMs? *
11. Please describe the level of supervision that most FP staff members receive.
12. Is there a fee associated with LA? PMs? If so, what is the cost to the client? (Obtain for both public and private sites)
13. Is FP counseling offered to both women and men?
14. Are female clients required to have permission from their husband to seek LA or PM services?
15. Where LAs and PMs are not available, are referral systems in place?
16. Is there coverage by workers whose primary task is to visit rural women in their homes to talk about FP?
17. Are FP services provided by mobile outreach? If so, how are these organized?
18. How many LA/PM users are there at the facility on average per month?

III. Enabling Environment

1. Are government policies generally supportive of LA/PMs? *
2. Does the state FP program have a long-range, 3-5 year plan in place? Does it include financing of FP commodities and services? *
3. Is FP included in national insurance policies/plans?
4. Do state-level policies correspond with national policies?
5. Do facility-level FP policies correspond with state-level policies?
6. Are there any FP champions in the state, LGAs, UTH, facilities?
7. Have state-level (or LGA level) coalitions been established or used to advance FP advocacy objectives? *
8. Do stakeholders including government, donors, service-delivery, and BCC organizations, etc coordinate their FP/LA/PM activities?
9. Do state government officials speak publicly and favorably about FP at least once or twice a year? In what form? (I.e. radio, TV broadcast, etc)?

IV. Demand

1. What is the image of LAs? PMs? Do these opinions vary by audience, e.g. married couples, communities, religious leaders, others? *
2. What are the most prevalent myths, rumors, biases that hinder LA use? PM use? *
3. Are clients satisfied with the quality of LA and PM services provided?
4. What are some of the biggest barriers to meeting demand? (service barriers, perceptions of the various methods, religious opposition, spousal opposition) *
5. Has formative research been done in recent years to explore perceptions of LA or PMs? Are any case studies or other data available?
6. What are the most useful channels of communicating FP messages to various audiences (i.e. married couples, communities, leaders) Radio, TV, journal, poster, billboard, etc.?
7. Have there been any BCC campaigns for FP/LA/PMs in the last year either at the state level or nationally?
8. How has the media been used to promote FP in the past? Was it successful?
9. Are job aids available to support providers in LA/PM service delivery and interpersonal communication with clients?
10. Are any BCC materials available that focus on LA/PMs? Are any available for low-literate clients?
11. Do facilities have BCC materials that promote male support of women/spouses in FP decision making? Any BCC materials that cater to men's FP needs?
12. Where would one obtain BCC materials on FP/LA/PMs? Please specify. (Govt, NGOs, produce own, websites/internet, etc.)
13. What channels are used to distribute BCC materials?
14. Do you know of any reports or evaluations of BCC activities related to FP/LA/PMs?
15. What types of tools and materials would be most helpful for LA/PM promotion activities (e.g. flip charts, leaflets, posters, cue cards, role play cards, drama scripts, etc.)?
16. Are any community engagement strategies in place in the state? LGA?
17. If they are in place, have communities been engaged in discussions about FP/LA/PMs in the state/LGA and if so, how? With what effects? *

18. What participatory approaches/tools are used to mobilize communities together for action around FP/LA/PM use?
19. How can communities become further engaged in the dialogue about FP? LA/PMs?
20. Is there a culture and history of community mobilization for health? Working with peer educators? Champions?
21. **IEC MATERIAL INVENTORY:** Collect or reference any FP/LA/PM BCC materials that might be available, E.g. Videos, flip charts, wall charts, counseling cards, demonstration materials, etc.

V. LA/PM Method Specific Questions

Female Sterilization:

1. Is female sterilization provided as a family planning option? If yes, are there special age/parity criteria or a medical/health rationale employed to discern?
2. What techniques are employed? (minilaparotomy or laparoscopy, what anesthesia regimens are followed?)
3. Who is allowed to provide the service?
4. Are services provided on interval or postpartum basis?
5. How is counseling and informed consent managed?
6. How is post-operative counseling and care managed?
7. Is there adequate OR time for scheduling elective surgery/TLs?
8. How are clients informed or referred to sites with capacity for female sterilization services? What are the characteristics of women receiving TL services (age, parity, wealth quintile, urban, rural)

Implants:

1. Have any contraceptive implants been introduced at this site? (Norplant, Jadelle, Implanon)? What has been the experience in terms of client acceptability and continuation?
2. How is the method being supplied? Who is paying for the commodity? Are there adequate supplies for the demand?
3. How is the method promoted? How are clients informed and referred for implant services?
4. Who is trained to insert/remove implants? How long ago were providers trained or updated?
5. Are clients able to get removal services on demand at the site? By referral? How is this managed?
6. What are the characteristics of the typical implant user (age, wealth quintile, spacer, delayer, limiter, etc.)
7. What are key messages provided in counseling? How are side effects (especially related to bleeding) discussed and managed?

IUD:

1. Is the IUD routinely provided as a FP option? If yes, do providers use any specific age, parity or other criteria for client selection?

2. If no, has the IUD ever been introduced previously and what were the reasons for no longer providing the method?
3. How are clients informed about the service and referred?
4. What are the key messages provided in counseling? How are side effects (especially related to bleeding) discussed and managed?
5. What cadre is allowed to insert IUDs? When were they last trained or updated?

Injectables:

1. What is the facility's experience with providing injectables and/or backing up community-based injectable services?
2. What are the reasons given for the method's popularity?
3. What is the facility's experience with continuation and discontinuation?
4. What injectables are provided? Who supplies and/or pays for supplies? Are stock-outs an issue?

Vasectomy:

1. Has anyone ever been trained in vasectomy? If so, when?
2. Have vasectomy services ever been available? If so, were there any men interested in receiving counseling and/or services? What was the experience in offering the service?

VI. System Strengthening and Cross Cutting

Contraceptive/Commodity Security

1. Are there sufficient LA/PM commodities/equipment/supplies in the state should promotion/revitalization efforts be successful?
2. To what extent do logistics systems support or hinder effective service delivery?
3. Do stock outs of LAs occur? If so, how often?

Performance Standards, Training and Supervision

4. Who/what entity manages in-service training needs? How are these linked to pre-service and/or supervision systems, if at all?
5. Are protocols/guidelines that support LA/PM service delivery in place? Are they used? How often are they updated?
5. What are some of the highest priority training needs for LA/PMs, i.e. Who needs to be trained in what skills? *
7. Are there training materials and curricula available on LA/PMs?
8. What are the general supervision methods for service providers?

Information Systems

9. Are LA/PM contraceptive reporting disaggregated on standard recording keeping in public facilities, private facilities?
10. Is there a timely national reporting system that captures both the public and private system for RH/FP, and specifically LA/PM?

VII. Options for Innovative Programming Strategies for Maximum Results

1. Do policies and programming support FP service integration with HIV services? MCH services? Postabortion care services? Postpartum care? *
2. What are the best measures that we can take to ensure that LA/PMs be incorporated into on-going MCH/HIV services*?
3. How can private sector best be used for delivery of LA/PMs? Can LA/PM be integrated into workplace services? *
4. Is there utility in supporting stage of development approaches (start-up program? acceleration/momentum building? Scale-up and replication?)
5. What are the advantages/disadvantages of going wide, or going deep?
6. In your opinion, what are the best strategies and approaches by LA/PM method for specific populations who want to space? (young women, newly weds, etc.) vs populations that want to limit (women who have had number of children they want, high parity women)*
7. What are the measures we can take to best ensure a full range of contraceptive choice and voluntarism?

Mini-Focus Group Discussion Guide LA/PM Assessment

The **purpose** of the mini-FGD is to better understand client and provider perceptions about FP and LA/PMs in particular. We are merely collecting information, not making any judgments, interjecting our ideas or contradicting responses. In assessing perceptions, there are no right or wrong answers.

Introduction

1. Self introduction (Be sure to identify a note taker)
2. Organization—RESPOND Assessment Team and purpose is to develop recommendations with the FMOH and USAID on child spacing/FP.
3. Information will inform the assessment but no names will be collected. Confidentiality will be kept.
4. Participants have the right to refuse to answer or participate in FGD
5. Informants will not get any immediate benefit by participating in the FGD.
6. Thank all participants in advance for their participation and cooperation.

For example:

“The discussion should take about 30min-1hr. Your participation is completely voluntary. You may decide not to participate or refuse to respond to any question at any time. You will not receive any direct benefit or money for your participation in the discussion. Your responses will be kept confidential. We will not share your information with anyone, nor will we identify you in any way.

Do you have any questions?

If you do not have any questions, do I have your permission to continue?”

Key themes include:

- The trajectory to the decision to use a LA/PM;
- Role of the spouse and other significant people;
- Perceived attributes of the method used (free listing?)
- Perceived attributes of the provider(s)
- Experience/satisfaction with the method
- Sources of advice and information about FP methods

Sample Questions:

Today I would like to discuss child spacing. Is this OK?

1. How do people come to know about spacing children in this area?
 - Which is the most trusted way to find information?
 - Describe some child spacing information you have seen or heard?
2. What do people say about child spacing?
 - What do they say about implants?
 - Why?
 - What do they say about IUCD?
 - Why?
 - What do they say about voluntary surgical contraception (female & male)?
 - Why?

3. Where do people go to get services to help them space their children?
 - Why?
 - What do people like most about these services?
 - What do people like least about these services?
4. What do providers think about the various child spacing methods?
5. In this locality what are the methods to space children that people use most?
 - Why?
 - What do people like most about these methods?
 - What do people like least about these methods?
6. Tell me about a time when someone had a negative experience with such a method. A positive one?
7. Who decides what child spacing methods a couple in this area uses?
 - Who else?
 - Why?
 - Tell me about a time a couple was choosing which method to use.
8. Who can persuade a woman to consider child spacing?
 - Why?
 - Can a wife persuade her husband to use a method to space their children?
 - Why?
 - Tell me about a time a wife talked to her husband about child spacing.
9. What do people in this locality say about women who use methods to space their children?
 - Why?

Finally, thank the participants again for their time and valuable contributions. Let them know that the information you have gathered today will be used to inform recommendations on how to improve child spacing/FP programs.