Gombe State Framework for the Implementation of Expanded Access to Family Planning Services 2013-2018

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The *Gombe State Framework for the Implementation of Expanded Access to Family Planning Services 2013–2018* was developed by the Gombe State Ministry of Health in July 2012. Financial Assistance for the framework was provided by the U.S. Agency for International Development (USAID) under the terms of the Cooperative Agreement GPO – A-00-08-00001-00 through FHI 360's Program Research for Strengthening Services (PROGRESS) project. The contents of this publication do not necessarily reflect the views of USAID or the U.S. government.

First published in 2012 by the Gombe State Ministry of Health, Nigeria, with support from USAID–PROGRESS

Citation: Gombe State Ministry of Health (SMoH). 2012. Gombe state framework for the implementation of expanded access to family planning services. Gombe (Nigeria): SMoH; 2012 Dec.

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FOREWORD

Family planning saves lives. Family planning prevents up to one third of maternal deaths and can reduce child mortality. In many states in Nigeria, including Gombe state, many women still die from childbirth. Infant and child mortality rates remain high. Most women have an average of seven children in their lifetime while the use of family planning services remains low. The shortage of skilled health care workers and a weak distribution chain have contributed to limited access to family planning services in rural areas.

To address these challenges, the Gombe state government developed the *Gombe State Framework for the Implementation of Expanded Access to Family Planning Services 2013–2018*. This framework builds on previous family planning efforts in Gombe state, particularly the 2008–2010 community-based access to injectable contraceptives pilot implemented in two local government areas. The pilot, implemented by the Association of Reproductive and Family Health (ARFH) and FHI 360 (formerly Family Health International), with funding from the U.S. Agency for International Development (USAID), demonstrated that community health extension workers could safely provide injectable contraceptives at the community level. This pilot provided the evidence for policy change.

The framework will ensure universal access to modern family planning methods across the state. This expansion framework identifies an overarching family planning goal, objectives, strategic intervention areas and key activities required to guide the scale-up of quality family planning services by all cadres of health workers at all service delivery levels across Gombe state.

This framework's success will depend on commitments made and fulfilled by relevant stakeholders, including the federal government, Gombe state government, donors, implementing partners, civil society nongovernmental organizations, religious and traditional leaders, the private sector and the citizens of Gombe state. Stakeholders will play a role in funding, organizing, managing and evaluating the framework.

It is my hope that the *Gombe State Framework for the Implementation of Expanded Access to Family Planning Services 2013–2018* will contribute to Gombe state's Millennium Development Goals 4 and 5 to reduce maternal child mortality and morbidity. I therefore encourage all stakeholders to support the endorsement of
this framework.

Kennedy Ishaya, MD
Honourable Commissioner
Ministry of Health
Gombe State

ACKNOWLEDGEMENTS

First, our sincere gratitude goes to the Almighty God who made it possible for us to achieve the feat of completing the *Gombe State Framework for the Implementation of Expanded Access to Family Planning Services 2013–2018*.

We thank the Honourable Commissioner of Health, the Permanent Secretary and our Director of Primary Health Care for all their advice and support.

We are equally grateful to all other line ministries who supported the framework's development. In particular, the Ministry of Economic and Budget Planning which made development possible through a concerted approach and efforts to have this framework finalized.

We register our special appreciation to FHI 360, who has been on the front line of all community-based access to family planning activities in Gombe state, for their unflinching support since the era of the pilot project through the post-pilot phase and now in developing our capacity to scale up the project.

Our special thanks also goes to participating organizations, including the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), Management Services for Health (MSH), Pact Nigeria, Save the Children and the Targeted States High Impact Project (TSHIP) led by John Snow, Inc. (JSI). We thank all our other development and commercial partners who worked very hard with us to make sure the framework development became a reality.

We also thank USAID for funding support that created a catalyst for implementing the project. We are also grateful for the commitment from FHI 360 as well as the consultant working on the project, Dr. Nnena Mba-Oduwusi. Their commitment to the process encouraged us to develop this framework for expanding access to family planning.

Finally, we commend the efforts of all those who participated in the 55th National Council of Health (NCH) held July 16–20, 2012, which led to a task sharing policy change to allow community health extension workers to provide injectable contraceptives as part of their extension services.

Alhaji Umaru Gurama

Permanent Secretary

Ministry of Health

Gombe

ACRONYMS

AGMPN	Association of General & Private Medical Practitioners of Nigeria
AIDS	Acquired immune deficiency syndrome
APHPN	Association of Public Health Practitioners of Nigeria
ARFH	Association of Reproductive and Family Health
B4H	Brothers for Health
BP	Blood Pressure
CB	Community-based
CBA	Community-based access
CBA TWG	Community-Based Access Technical Working Group
CBD	Community-based distribution
CBOs	Community-based organizations
CHEW	Community health extension worker
CHO	Community health officer
CHPRBN	Community Health Practitioners Registration Board of Nigeria
CLMS	Commodities and logistics management system
CPR	Contraceptive prevalence rate
CS	Contraceptive services
CSOs	Civil society organizations
CYP	Couple years of protection
DPHC	Director of Primary Health Care
FGD	Focus group discussion
FLE	Family life education
FLHE	Family life and HIV education
FMoH	Federal Ministry of Health
FP	Family planning
GATHER	Greet, Ask, Tell, Help, Explain, and Return
HF	Health facility
HIV	Human immunodeficiency virus
HMB	Hospital Management Board
IUCD	Intrauterine contraceptive device
JCHEW	Junior community health extension worker
JSI	John Snow Inc.
LAPM	Long acting and permanent methods
LGAs	Local government areas
LGSC	Local Government Service Commission
LMIS	Logistics management information system
LOE	Level of effort
M&E	Monitoring and evaluation
MCH	Maternal and child health
MDCN	Medical and Dental Council of Nigeria
MDG	Millennium Development Goal
MEC	Medical eligibility criteria
MNCH	Maternal newborn and child health
MoH	Ministry of Health

MoYD	Ministry of Youth Development
MoE	Ministry of Education
MoEP	Ministry of Economic Planning
MoF	Ministry of Finance
MSH	Management Services for Health
MSS	Midwifery service scheme
MVA	Manual vacuum aspiration
NCH	National Council of Health
NDHS	National Demographic Health Survey
NGOs	Nongovernmental organizations
NHMIS	National Health Management Information System
NID	National Immunization Days
NMA	Nigeria Medical Association
NMCN	Nursing and Midwifery Council of Nigeria
NPPSD	National Policy on Population for Sustainable Development
NURHI	Nigeria Urban Reproductive Health Initiative
PAC	Post abortion care
PAFP	Post abortion family planning
PHC	Primary health center
PPFP	Post-partum family planning
PPFN	Planned Parenthood Federation of Nigeria
PROGRESS	Program Research for Strengthening Services
QIT	Quality improvement team
RH	Reproductive health
RH TWG	Reproductive Health Technical Working Group
S4H	Sisters for Health
SACA	State Agency for Control of AIDS
SASCP	State AIDS and STI Control Programme
SMO	Social Mobilization Officer
SMoE	State Ministry of Education
SMoEP	State Ministry of Economic Planning
SMoH	State Ministry of Health
SMoLGA	State Ministry of Local Government Affairs
SMWASD	State Ministry of Women and Social Development
SOP	Standard operating procedure
SSHDP	State Strategic Health Development Plan
SSMO	State social mobilization officer
TFR	Total fertility rate
TSHIP	Targeted States High Impact Project
TWG	Technical working group
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VDCs	Village development committee
WDCs	Ward development committee
WHO	World Health Organization

EXECUTIVE SUMMARY

Prompt access to effective family planning (FP) is one of the major strategies for improving maternal and child health and is an avenue for promoting national development. Universal access, as stipulated in the Maputo Plan of Action, means the ability to have health services at affordable costs as near to the people as possible.

But according to the latest (2008) Nigeria Demographic and Health Survey[2], only 9.7 percent of married women of reproductive age nationwide use a modern contraceptive method and far fewer women in Gombe (5.3 percent).This low contraceptive uptake has contributed to Gombe state having some of the lowest maternal and reproductive health indices among women and children in Nigeria.

A 2008 task sharing pilot project implemented by FHI 360 and the Association for Reproductive and Family Health (ARFH) attempted to bridge the human resource and policy barriers to FP provision in Funakaye and Yamaltu Deba local government areas (LGAs) of Gombe state. The project, which ended in 2010, demonstrated that community health extension workers (CHEWs) could safely and effectively administer injectable contraceptives with minimal supervision.[1] Findings from this pilot provided evidence required by the National Council of Health in 2012 to decide to change policy and allow CHEWs to provide injectable contraceptives at the community level to increase access to FP for women in hard-to-reach areas.

It was in this context that the Gombe State Ministry of Health (SMoH), with technical assistance from FHI 360 through funding from USAID, developed this document, the *Gombe State Framework for the Implementation of Expanded Access to Family Planning Services 2013–2018*. This document was developed to guide the rollout of increased FP services at the community and facility levels and at a wider state level to accelerate efforts to achieve the state and national development goals and the Millennium Development Goals (MDGs). The SMoH will be the overall coordinating agency and work closely with the LGAs with support from partners.

The framework includes a goal, four objectives, targets and activities. The goal is to improve access to and uptake of FP methods in Gombe state such that the contraceptive prevalence rate (CPR) increases to 22.1 percent in 2018. This CPR goal is based on a projected baseline CPR of 8.82 percent in 2012 (see Appendix 1). The framework's four objectives are to:

1. Build the capacity of all CHEWs, doctors, nurses and midwives working in reproductive health (RH) and FP to provide cadre-appropriate FP services in Gombe state by 2018.
2. Expand the availability of FP commodities offered by cadre-appropriate providers in the wards, primary health centres, and secondary and tertiary facilities in Gombe state by 2018.
3. Increase the use of FP methods among men, women and young persons of reproductive age in Gombe state by 2018.
4. Increase the level of state and community support for FP services in Gombe state by 2018.

The first two objectives will strengthen the supply side of FP, whereas the last two objectives will ensure a supportive environment for increased demand and uptake of contraceptive methods. Each objective has specific targets or indicators and related activities that address eight strategic interventions areas identified by a national community-based access (CBA) technical working group (TWG). The strategic intervention areas for the activities include the following:

1. Advocacy and social mobilization for an enabling environment to support FP
2. Training and capacity building
3. Service provision and supportive supervision
4. Quality assurance
5. Commodities and logistics management
6. Finance and resource mobilization
7. Monitoring and reporting
8. Integration of FP with HIV/AIDS and maternal neonatal and child health (MNCH)

The framework also includes a "Plan of Action" that describes activities for each strategic intervention area, stakeholders responsible and costs. This "Plan of Action" offers defined opportunities for donors or partners to support the state government and public sector workers to provide quality FP services.

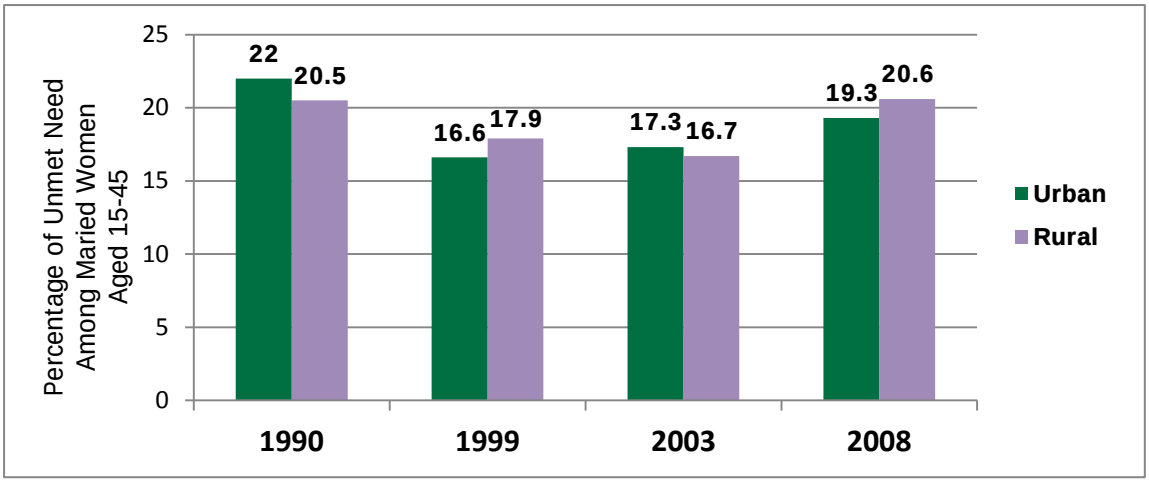
When implemented, this framework will ensure that women, men and youth have increased access to a broader FP method mix at the community and facility levels, more frontline health workers and clinicians are trained in FP and that the overall support for FP among community leaders and policymakers has improved.

1 INTRODUCTION

1.1 Family Planning in Nigeria

Reproductive health status in Nigeria has remained poor with only a marginal improvement over time as reflected in the high maternal morbidity and mortality rate, high infant mortality rate, and low contraceptive prevalence rate.

Figure 1: Trends in unmet family planning needs by area of residence: 1990, 1999, 2003 and 2008

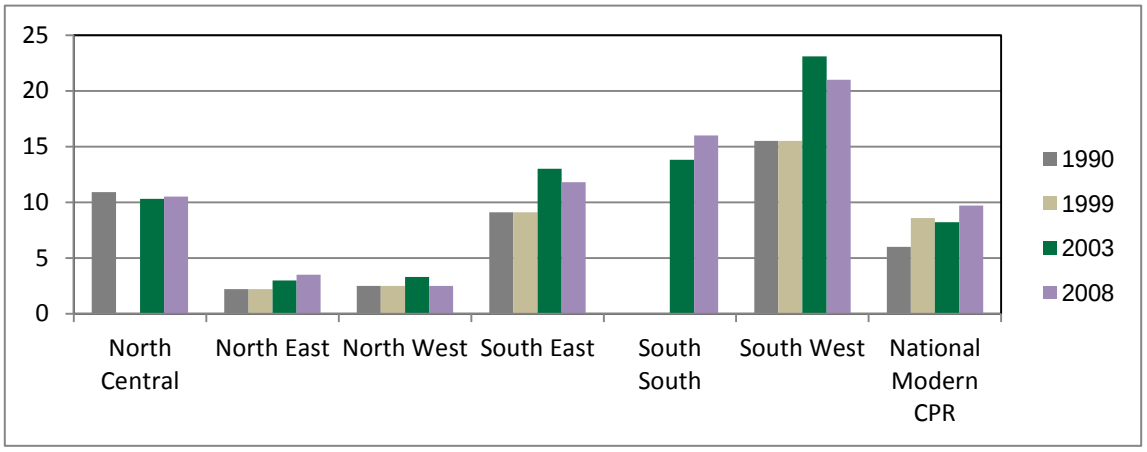


Source: NDHS: 1990, 1999, 2003 and 2008

Despite the knowledge of at least one contraceptive method by 72 percent of Nigerian women, the CPR for women who use any method (including traditional ones) is only 15 percent (and 9.7 percent for modern methods). This is one of the lowest such rates in Sub-Saharan Africa.[2] There is a wide urban-rural disparity in contraceptive use and the CPR varies greatly by geopolitical zone with the northern zones (where Gombe state is located) having only marginally improved CPRs over the years compared to the southern zones (Figure 2). Similarly, the total fertility rate (TFR) of 5.7 births per woman has not changed since the findings in 2003.[2]

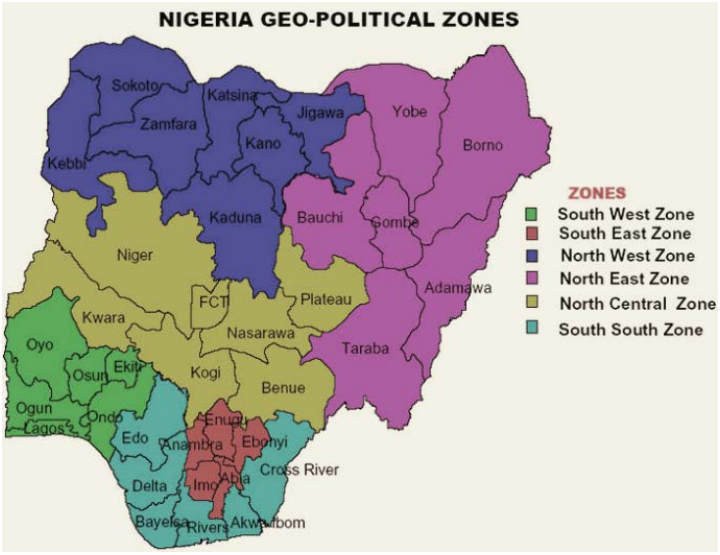
While the use of modern methods of contraception only marginally increased between 2003 and 2008 unmet need grew from 17% to 20% (Figure 1).[2,3] Factors associated with this unmet need are varied, ranging from the unavailability of services to cultural or religious barriers, rural residence, and lack of knowledge about family planning.[2,4] The shortage of skilled health care workers and a weak distribution chain further limits access to FP services.

Figure 2: Trends in modern contraceptive prevalence in Nigeria by zone: 1999, 2003 and 2008



Source: NDHS 1990, 1999, 2003 and 2008

1.2 Family Planning in Gombe State

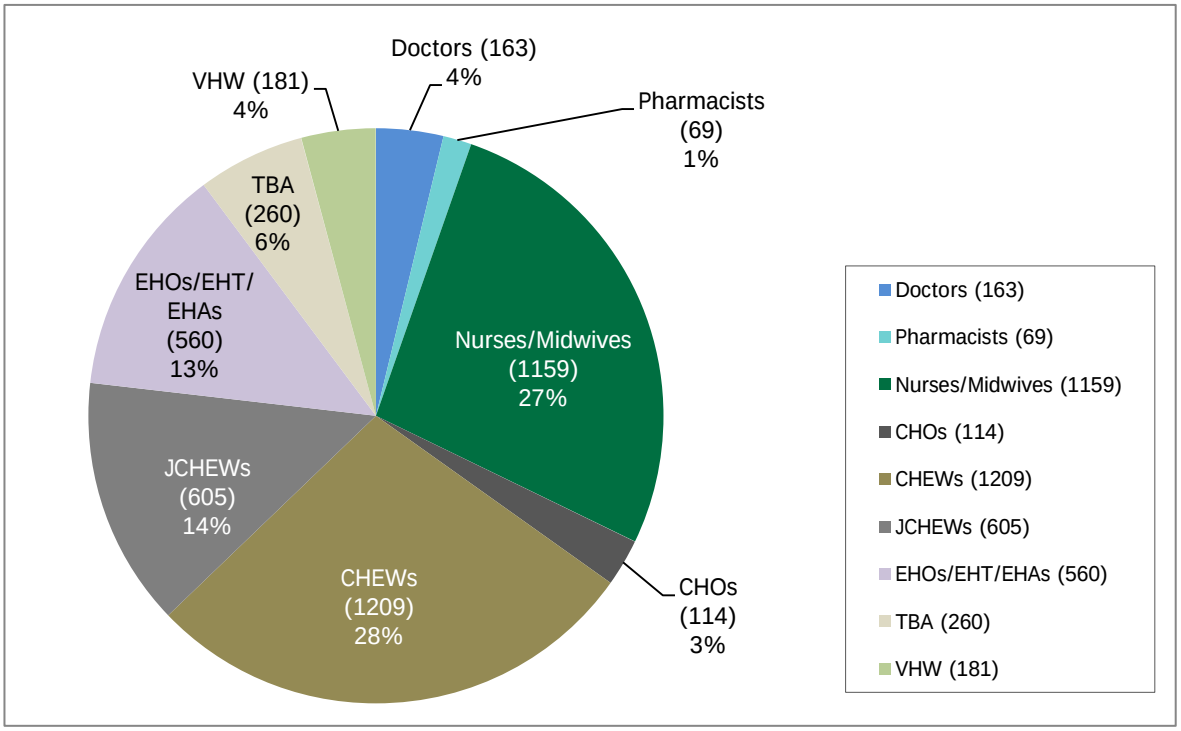


Gombe state is located in the predominately Muslim northeast geopolitical zone of Nigeria and has a population of 2.4 million. It was created on October 1, 1996, out of neighboring Bauchi state. It has a total fertility rate of 7.4 children per woman and a CPR for modern methods of 4.5 percent (see Table 1), both of which are worse than the national averages. In addition, the rural CPR (4.3 percent) is far higher than the urban rate (13 percent).[5] Contraceptive use is also very low among adolescents and young adults, which has resulted in a high prevalence of undesired pregnancies, unsafe abortions and hence high abortion-related deaths.[5] Gombe state has a high maternal mortality ratio of approximately 800 per 100,000 live births compared to 545 per 100,000 nationally and an under-5 mortality rate of 230 per 1,000 live births compared to 157 per 1,000 nationally.[2] There have been very few far-reaching initiatives to improve FP. From 2003 to 2007 the United Nations Population Fund (UNFPA) supported the implementation of existing reproductive health (RH) policies at all levels and improved availability of RH commodities. But since that time, there have been no large-scale FP efforts.

The majority (89 percent) of health care facilities in Gombe state are administered by the state government, while 7 percent are considered federal government facilities and the remaining 4 percent are private. There are 579 health facilities in the state with 4,320 health care personnel employed (see Figure 3).[5] The bulk of the health workforce in the state consist of lower cadre workers, such as CHEWs, junior

CHEWs (JCHEWS), environmental health officers, environmental health technicians and others. Most doctors in the state are employed by the Federal Medical Centre, which is located in the capital. Gombe state currently does not have a staff deployment policy, but those who are willing to work in high demand areas or rural settings are given incentives. Despite incentives, recruitment and retention problems persist.

Figure 3: Distribution of health personnel working in Gombe state by cadre



Source: Gombe SMoH, 2009

1.3 Rationale for Expanding Community and Facility-based FP Service Delivery

The Gombe state government identified the promotion of family planning as a key strategy for achieving the maternal and child health goals set forth in its State Strategic Health Development Plan 2010-2015.[5] It was with this outlook that the state government and stakeholders agreed to have two LGAs serve as pilot sites for assessing the safety and effectiveness of CHEWs providing injectable contraceptives at the community-level as a way to increase FP access and uptake between 2008-2010.

Injectables are the most commonly used FP method among married women in the state and nationally but are almost exclusively accessed in health facilities[2] because this method could not be provided at the community-level prior to the policy change in July 2012. FP clinic use in Nigeria is low,[6] and complementing it with community-based access will be beneficial for many reasons. Access to FP services will be increased for people living in rural areas where distance to health facilities is a key barrier to accessing services. In addition, in a conservative state such as Gombe, women are expected to have their male partners' permission before they use FP services. CBA allows women to access services in the privacy of their homes or the CHEW's home to avoid the stigma attached to FP use that is still common in many communities.

In addition, to demonstrating the feasibility of this practice in a culturally conservative setting the pilot findings suggest that community-based access appears promising in reaching men with FP services and more efforts should focus on community-based approaches to reach men.[1] The study showed that 13.9 percent of the clients who accessed FP services from community-based provision were males. Data were not available on the sex of all clients who accessed facility-based provision. But facility-based providers acknowledged that male clients do not normally access FP services in health facilities because such services are almost always provided in maternity clinics (including antenatal care, labour, postnatal care and family planning), which are patronized by women and children. Motivating men to attend FP clinics is difficult, so the proportion of males that accessed FP through CBA is encouraging.

In addition to CBFP service delivery, the SMoH also recognizes that facility-based service provision will need to be strengthened as well if FP access and uptake are to be increased. Facility-based providers, specifically the clinicians, will play a key role in providing long acting methods such as implants and IUDs that will substantially contribute to achieving the CPR goal. Therefore, the framework focuses on improving both community- and facility-based service delivery strategies.

2 METHODOLOGY FOR CREATING THE IMPLEMENTATION FRAMEWORK

This framework was developed under the leadership of the Gombe SMoH and the Gombe State Reproductive Health Technical Working Group (RH TWG) who referenced documents from the FMoH and the National CBA TWG. This section describes the series of meetings convened and activities implemented to draft and finalize the framework.

Community-Based Access Technical Working Group: The Road Map for Scaling Up Community-Based Access to Injectable Contraceptives

In September 2011, the National Community-Based Access Technical Working Group (CBA TWG) was convened by the FMoH. The CBA TWG developed a road map to guide the scale-up of community-based access to FP which included eight strategic intervention areas that must be addressed to ensure successful expansion (see Appendix 3).[7] Selection of these eight themes was influenced by the WHO Health System Framework's six building blocks (see Appendix 6)[8] and are therefore also applicable to strengthening facility as well as the community-based FP service delivery.

Baseline Assessment

To better understand the FP situation in Gombe state, in May 2012, FHI 360 supported the Gombe state RH TWG to conduct a baseline assessment of the readiness and capacity of the health system to provide FP services. The *Report of the Baseline Asessment of Community-based Access to Family Planning in Gombe State, North-East Nigeria* (Gombe State Ministry of Health, 2012)[9] used a simple random sample of two primary health care facilities from each of the 11 LGAs and a secondary facility for inclusion in the assessment. The examined components of the health system included the health workforce, service delivery, funding, commodities and logistics, supervision and health information system. Secondly, the FP knowledge, attitudes and practices among community leaders and men and women of reproductive age were also assessed using key informant interviews and focus group discussions. The results from this assessment informed several assumptions made in the framework and are noted where applicable.

Framework Planning Meeting

A participatory planning session was conducted with representatives of the Gombe State MoH, Ministries of Economic Planning and Budgeting and representatives of the local governments, service providers, development partners and private sector. Also, key structures such as the Midwifery Council and Community Health Registration Practitioners Board of Nigeria were represented. Consultants were engaged to facilitate the session.

To better inform planning, projections for each year of the framework's implementation were developed with the aid of a health economist from FHI 360. The calculations and assumptions made for these projections are described in Appendix 1. Where feasible, Gombe state-specific data, particularly for CPR and method use, were used to inform the projections. Other data sources were the Nigerian DHS data 2008, National Census 2006 and reports on live births, deaths and stillbirths registration in Nigeria (1994–2007). Databases of the United Nations Development Program and International Organization on Migration as well as journal publications were also sources of other relevant demographic data. (Please see

a separate publication for more details: *Policy Analysis of Benefits and Program Requirements of Family Planning in Gombe State.*)[10] The projection exercise, using data from NDHS 2008,[1] generated scenarios and targets up to 2015, which is the duration of this plan. This exercise was informed by the overall goal, as determined from the extensive planning exercise above. The data from the projection exercise is reflected in expected outcomes and targets for this framework.

During an implementation planning meeting in July 2012, the stakeholders decided to focus the framework on providing the three FP methods that can be provided at the primary health centre (PHC) level (condoms, pills and injectables) and the five FP methods that can be provided at the secondary facility level (PHC level methods plus IUDs and implants). For that reason, surgical methods (such as vasectomy and tubal ligation) were not included in this framework, as they can be provided only at the tertiary level and only two tertiary facilities exist in Gombe state. The traditional methods, standard days method and lactational amenorrhea method, were not identified as formal methods for provision by the FMoH at the time and hence were not included in the framework.

In addition, the implementation timeline for the framework was discussed. Participants determined that it should be a three-year plan, 2013 to 2015, to align with Gombe's *State Strategic Health Development Plan* (SSHDP) 2010–2015,[5] which aims to increase the modern contraceptive prevalence rate from 4.5 percent in 2008 to 12 percent by 2015.

Review Meeting

Following the planning meeting held in July 2012, a review meeting was conducted in October 2012 with broader stakeholder participation to review the draft framework. Stakeholders at this meeting included the Gombe state RH TWG, implementing partners in Gombe state and the Community Practitioners' Registration Board of Nigeria.

Finalization of the Framework

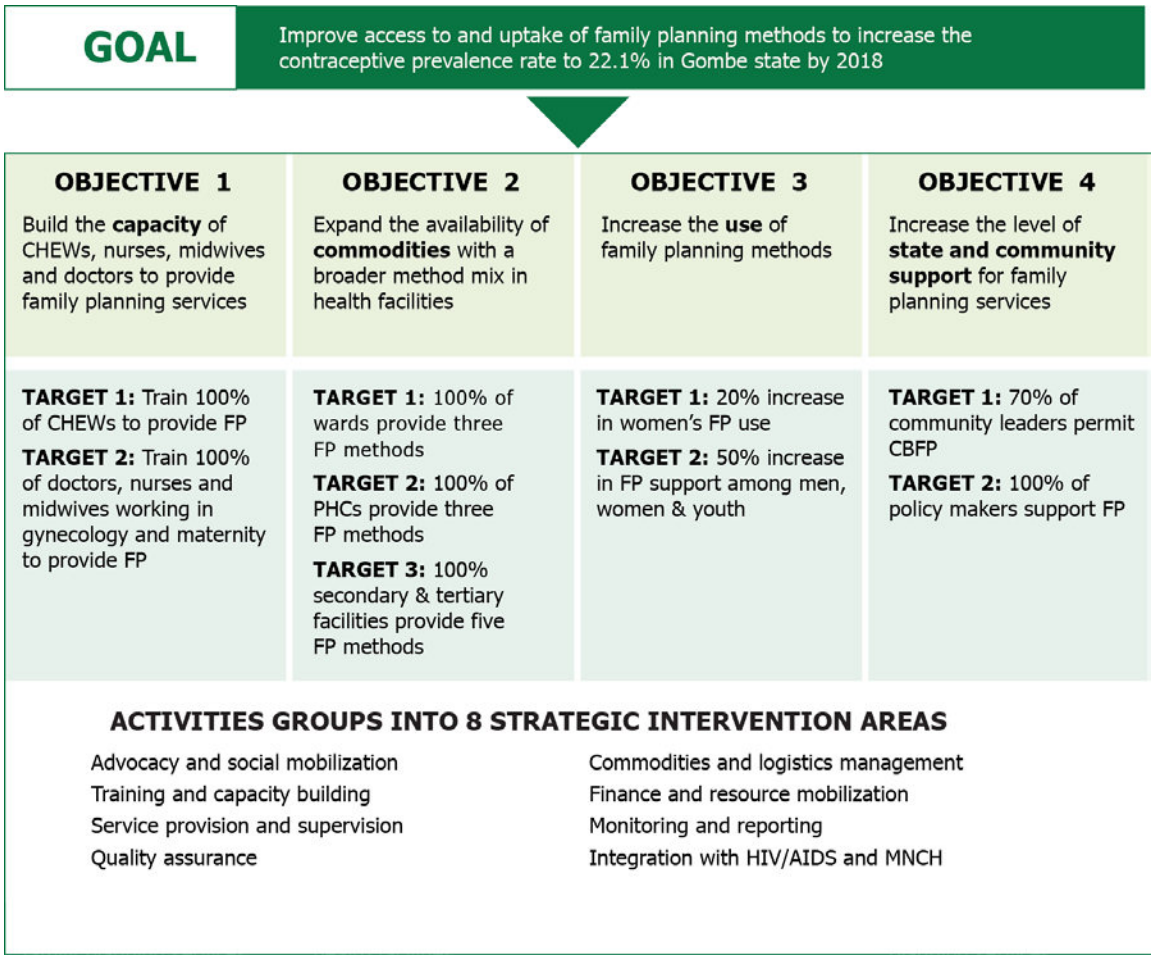
The framework's implementation timeline was initially aligned with the Gombe State Strategic Health Development Plan, which ends in 2015. However, in light of the Federal Government's commitment at the London Summit on Family Planning in July 2012 to achieve a CPR of 36 percent by 2018, the plan was amended to cover a period of six years and end in 2018 (DFID, 2012).[11]

In addition, this new implementation timeline for the framework now aligns with the FP goals outlined in the *National Policy on Population for Sustainable Development* (NPPSD) 2004.[12] This policy recognizes the adverse effect of rapid population growth on development and commits to increasing the national CPR by 2 percent each year through 2018 to reduce the current level of unmet need.

3 GOALS, OBJECTIVES AND STRATEGIC INTERVENTION AREAS

The implementation of this framework will result in improved FP service delivery by increasing coverage, training and support for FP across the state, and ultimately will improve the contraceptive prevalence rate. This framework is guided by its goal, four objectives and the activities categorized under eight strategic intervention areas, which are graphically depicted in Figure 4.

Figure 4: Goals, objectives and strategic areas of intervention



3.1 Goal

The goal of this framework is to improve access to and uptake of FP methods in Gombe State to increase the contraceptive prevalence rate to 22.1 percent in 2018. This goal is based on an assumed CPR of 8.8 percent in 2012, which was projected based on the Nigeria DHS 2008 CPR of 4.5 percent.[2] This goal may require updating if data demonstrating a change in CPR for Gombe state is made available during the implementation period for this framework.

3.2 Objectives and Targets

This framework includes four specific objectives and nine related targets that are described below. Annual progression towards these targets between the years 2013 and 2018 is depicted in Table 2. Further details about how each target was calculated and justification for its use as an indicator are provided in Appendix 1.

Objective 1: Build the capacity of all CHEWs, doctors, nurses and midwives working in RH and FP to provide cadre-appropriate FP services in Gombe state by 2018.

- **Target 1:** Train 100 percent of CHEWs to provide FP services in facilities and at the community-level in Gombe state by 2018.
- **Target 2:** Train 100 percent of all doctors in gynaecology and nurses and midwives in Maternity Services to provide FP services in Gombe state by 2018.

Objective 2: Expand the availability of FP commodities offered by cadre-appropriate providers in the wards, primary health centres, secondary and tertiary facilities in Gombe state by 2018.

- **Target 1:** Ensure the availability of a method mix of at least three FP methods (pills, condoms and injectables) in 100 percent of the wards in Gombe state by 2018
- **Target 2:** Ensure the availability of a method mix of at least three FP methods (pills, condoms and injectables) in 100 percent of primary health centres in Gombe state by 2018.
- **Target 3:** Ensure the availability of a method mix of at least five FP methods (pills, condoms, injectables, implants and IUDs) in 100 percent of public secondary and tertiary facilities in Gombe state by 2018.

Objective 3: Increase the use of FP methods among men, women and young persons of reproductive age in Gombe state by 2018.

- **Target 1:** Increase use of FP by 20 percent among women of reproductive age in Gombe state by 2018.
- **Target 2:** Increase support for FP by 50 percent among men, women and young persons of reproductive health in Gombe state by 2018.

Objective 4: Increase the level of state and community support for FP services in Gombe state by 2018.

- **Target 1:** At least 70 percent of community leaders permit the implementation of community-based FP in their communities in Gombe state by 2018.
- **Target 2:** 100 percent of policymakers at the state- and LGA-level support implementation of FP programmes in Gombe state by 2018.

Table 1: Annual Progression towards Targets by Objective

	GOAL	OBJECTIVE 1		OBJECTIVE 2			OBJECTIVE 3			OBJECTIVE 4	
		TARGET 1	TARGET 2	TARGET 1	TARGET 2	TARGET 3	TARGET 1		TARGET 2	TARGET 1	TARGET 2
Year	CPR (%)	CHEWs[1] trained in three FP methods (add55/year)	Clinicians trained in five FP methods[2]	Communities (i.e. wards) providing three FP methods	PHCs providing three FP methods	Secondary & tertiary facilities providing five FP methods	FP Users	% Increase in FP use	% increase in men, women & youth's support	Community leader support[3] (%)	Policy-maker support[4] (%)
2012 baseline	8.82	5% (83)	20% (41)	9% (10)	20% (101)	12.5% (2)	38,562	N/A	0	10	10
2013	9.90	30% (512)	30% (61)	30% (35)	30% (152)	30% (5)	44,483	15.4	5	25	25
2014	11.62	60% (1,058)	60% (121)	60% (69)	60% (303)	60% (10)	53,658	20.6	10	30	40
2015	13.64	100% (1,817)	100% (201)	100% (114)	100% (505)	100% (16)	64,730	20.6	20	40	55
2016	16.02	100% (1,872)	100% (201)	100% (114	100% (505)	100% (16)	78,131	20.7	30	50	70
2017	18.81	100% (1,927)	100% (201)	100% (114)	100% (505)	100% (16)	94,279	20.7	40	60	85
2018	22.10	100% (1,982)	100% (201)	100% (114)	100% (505)	100% (16)	113,837	20.7	50	70	100

[1] Includes Junior CHEWs. Justification for the targets is provided in Appendix 1.
[2] Clinicians include nurse/midwives and doctors. Justification for the targets is provided in Appendix 1.
[3] Community leaders are district heads and religious leaders. Justification for the targets is provided in Appendix 1.
[4] Policymakers are emirs, commissioners and permanent secretaries. Justification for the targets is provided in Appendix 1.

3.3 Eight Strategic Intervention Areas

Eight strategic intervention areas were identified by the National CBA TWG as key components of implementation that must be addressed to ensure successful community-based FP services and can also be applied to expanded FP services at the facility-level.[7] Therefore, all of the activities implemented under this framework address a strategic intervention area.

1. Advocacy and social mobilization for an enabling environment to support FP

The State Ministries of Health (SMoH), other ministries, LGAs, and traditional and religious leaders must be engaged continuously to mobilize political will to sustain buy-in for expanded provision of FP services, and especially the community-based provision of injectables by CHEWs, as this is a new task-sharing practice. Further, partnerships with civil society organizations (CSOs) and community-based organizations (CBOs) are strategic for community mobilization and demand creation. These entities have a role to play in increasing men's and women's awareness of FP, dispelling myths and misconceptions, as well as encouraging acceptance of and desire for FP. Community members must be engaged to gain an understanding of their concerns and information needs. The messages can be presented in a report, slide presentation, poster, video or other format.

2. Training and capacity building

Proper training is critical to ensuring the delivery of quality FP services. A training needs assessment will be conducted to understand learning needs that exist in FP service delivery in Gombe state. For example, a known need is training on community-based provision of injectables for CHEWs. With this information, a training plan will be developed for all health cadres. SMoH staff and representatives from the Community Health Practitioners Registration Board will be identified and trained as trainers using nationally validated curricula and job aids. This pool of master trainers in the state will be supported to step down the training to other health workers. Additionally, the SMoH will train health workers in logistics management systems to build their capacity in quantification and forecasting as part of the strategy to minimize FP commodities stock-out. In addition, to boost the pre-service training of CHEWs, the plan also includes activities to ensure the Gombe State School of Health Technology is reaccredited.

3. Service provision and supportive supervision

Once trained, health worker cadres will be provided with the necessary supplies to begin providing FP services and to expand access with guidance from their supervisors. Supervisors for each health worker cadre will need to conduct regular supportive meetings and report data to LGA and state health committees on the findings from these meetings. Safety, supportive supervision, monitoring and evaluation will be highlighted as critical factors in operationalizing the service delivery component.

4. Quality assurance

This will be a key strategy to ensure the delivery of high quality FP services. Appropriate quality assurance approaches will be introduced in areas of training and capacity building, as well as FP commodities security. These approaches would include the supportive supervision mentioned above, using a standard checklist on a regular basis; review of the referral and linkages system to minimize missed opportunity; on-site on-the-job refresher trainings and mentoring; and provision of standard operating procedures (SOPs), job aids and guidelines to standardize service quality.

5. Commodities and logistics management

Commodity stock-outs present a major challenge to facility-based services and CBD programmes. Therefore, this framework for expanded service delivery will be linked to the state's new plan for commodities and logistics management that will ensure a steady supply of commodities and other supplies such as auto-disable syringes. The commodities management plan will adopt the review and resupply meetings model already in use by UNFPA and several projects to ensure regular supply of FP commodities to facilities. The plan will also include contingency plans in the event of a stock-out. A sound logistics system will ensure that contraceptive commodities and other supplies are distributed smoothly, in good condition and on time.

6. Finance and resource mobilization, including private sector involvement

The additional financial, institutional and human resources needed to support expanded access to FP services will require Gombe state officials to seek out new partnerships with government, multilaterals, NGOs and the private sector and private donors. Linkages and partnerships among existing government programmes and implementing organizations' projects will be established to leverage funding. The Gombe SMoH will lead coordination of the expanded services effort to ensure these services are integral to their state financial, strategic and monitoring plans. Once donors and other resource providers have been engaged, a committed resource team can be formed to work on planning and allocating financial and human resources appropriately to support scale-up and sustained implementation.

7. Monitoring and reporting system

A Monitoring and Reporting Team composed of state and LGA staff already tasked with monitoring and evaluation (M&E) activities and staff from implementing partners who may be supporting expanded FP service delivery will assess the progress, lessons learned, outcomes and impact of the FP programme as it expands to serve new audiences. Key indicators will be determined for new services and routinely measured. Tracking forms and other M&E procedures will be reviewed to determine if updates are needed so the resulting data can be used to continually adapt and improve implementation. The Monitoring and Reporting Team will formulate effective mechanisms for ensuring that information is fed back to key stakeholders and used to continually adapt and improve implementation.

8. Integration of FP with HIV/AIDS and MNCH to address missed opportunities to curb the HIV epidemic

Integrated services are beneficial because clients can access more than one service during a single visit. Integrated services have the potential to be more efficient and effective. Integration enhances not only sharing of existing infrastructure or facilities and personnel, and it also maximizes the management of service delivery and simplifies logistics. Trainings to health workers will emphasize the importance of integrating the various services they provide and build their capacity to provide integrated services

3.4 Benefits and Impact of Expanded Family Planning Service Delivery

In addition to the overarching goal of achieving a CPR of 22.1 percent by 2018, broader health indicators can be measured to assess the impact of this framework's family planning achievements on Gombe state's population in 2018. This framework does not aim to measure these impact indicators but assumes that future demographic and health surveys will capture this information which can be used to monitor the framework's far-reaching impact.

Table 2: Family Planning Impact Indicators

YEAR	CPR (%)	CYP	PREGNANCIES AVERTED	BIRTHS AVERTED	INFANT MORTALITIES AVERTED	UNDER-5 MORTALITIES AVERTED	MATERNAL MORTALITIES AVERTED	ABORTIONS AVERTED	DISABILITY-ADJUSTED LIFE YEARS (DALYS) AVERTED
2012 baseline	8.82	41,470	23,697	17,232	1,675	3,253	190	4,329	10,227
2013	9.90	48,269	27,582	20,057	1,950	3,787	221	5,039	11,904
2014	11.62	59,022	33,727	24,526	2,384	4,630	270	6,161	14,556
2015	13.64	72,016	41,152	29,925	2,909	5,650	329	7,517	17,760
2016	16.02	86,855	49,632	36,092	3,508	6,814	397	9,066	21,420
2017	18.81	105,243	60,139	43,732	4,251	8,257	481	10,986	25,955
2018	22.10	127,612	72,921	53,028	5,154	10,012	583	13,321	31,471
Total	N/A	540,486	308,849	224,593	21,830	42,403	2,471	56,419	133,292

4 PLAN OF ACTION

This section of the framework was developed during consultations with the SMoH officials and the Gombe RH TWG to outline the activities that must be implemented to achieve each of the four objectives and related targets to ultimately lead to an increased CPR of 22.1 percent. The activities have been grouped into strategic intervention areas as described in Section 3.3. The stakeholders responsible, timeframe for implementation and resources required for each activity are also presented.

4.1 Objective 1

Objective 1: Build the capacity of all CHEWs, doctors, nurses and midwives working in RH and FP to provide cadre-appropriate FP services in Gombe state by 2018.

- **Target 1:** Train 100 percent of CHEWs to provide FP services in facilities and at the community-level in Gombe state by 2018.
- **Target 2:** Train 100 percent of all doctors in gynaecology and nurses and midwives in Maternity Services to provide FP services in Gombe state by 2018.

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
1. Advocacy and social mobilization for an enabling environment	1.1.1	Advocate for reaccreditation of the Gombe State School for Health Technology.	(1) Develop advocacy kit. (2) Conduct advocacy visits.	CHPRBN, FMoH, State Executive, School of Health Technology	2013 (Q4)	180,000
	1.1.2	Conduct advocacy visits to all LGAs to inform them of capacity development plans.			2014 (Q1)	360,000

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	1.1.3	Liaise with the SMoH and HMB to designate/brand the two tertiary and 11 secondary health facilities in Gombe state as referral sites.		MCH, FP, ARH coordinators and DPHC	2014 (Q1)	0[5]
2. Training and capacity building	1.2.1	Identify all eligible health care workers and assess training needs.			2013(Q4)	0
	1.2.2	Develop training plan.	(1) Review training needs assessment. (2) Quantify number and cadre of personal to be trained. (3) Document roll-out of training. (4) Budget training cost.		2013(Q4)	135,000
	1.2.3	Secure required approvals for training.	(1) Review training plan (see below). (2) Provide resources for training. (3) Provide permissions for public providers.	RH TWG, SMoH, SMoE, SMO, SMoLGA	2014(Q1)	0

[5] Costs of 0 naira indicate the expenses for these activities have been captured by related activities.

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	1.2.4	Conduct update trainings for master trainers including supportive supervision and HIV counseling and testing.	(1) Train the master trainers. (2) Review and adopt the national training manual for each cadre. (3) Identify training participants. (4) Prepare logistics for training. (5) Conduct training in phases for the cadres. (6) Incorporate CBA, infection control, CLMS and injection safety into FP training agenda.	RH TWG, LGAs, DPHC, development partners	2014 (Q1)	7,776,000
	1.2.5	Conduct cadre-appropriate step-down trainings for health workers on advocacy/sensitization, effective communication, CLMS, injection safety, HIV counseling and testing, waste management, overall knowledge and practical application of modern FP methods.	(1) Review and adopt the national training manual for each cadre. (2) Identify training participants. (3) Prepare logistics for training. (4) Conduct training in phases for the cadres. (5) Incorporate infection control CLMS and injection safety into FP training agenda.	RH TWG, SMoH, LGA and development partners.	2014 (Q2) - 2018 (Q3)	47,550,000
3. Service provision and supportive supervision	1.3.1	Adapt/develop culturally appropriate job aids and IEC materials to guide service provision at all service delivery levels.	Job aids (SOPs, clinical protocols, MEC wheels, MEC wall chart, GATHER charts, CBD algorithm for management of side effects) and IEC materials (such as posters)		2013 (Q4) - 2014 (Q1)	2,320,000
	1.3.2	Print job aids and IEC materials.			2014 (Q1)	60,000,000
	1.3.3	Distribute job aids.			2014 (Q2) -	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
					2018 (Q3)	
	1.3.4	Integrate on-the-job training and supervision of FP services into routine ISS, including CBA supervision	(1) Compile the list of public health personnel trained. (2) Develop a checklist.	PHC coordinators, M&E officer, state FP coordinators, CLMS officer, NHMIS desk officer	2014 (Q2) - 2018 (Q3)	0
	1.3.5	Conduct quarterly supportive supervision using performance standard, CLMS supervisory checklist and other tools at all service delivery levels.		DPHC, SMoH, LGAs and RH TWG, NURHI & FHI 360	2014–2018 (Quarterly)	0
	1.3.6	Conduct bi-monthly review meeting with MSS staff, CHOs, HF in-charges and LGA MCH coordinators.	(1) Identify training participants. (2) Prepare logistics for training. (3) Conduct training topics on CLMS tools for the MSS staff.	SMoH and FMoH	2014 - 2018(Bi-Monthly)	0
	1.3.7	Conduct quarterly review meeting with LGA MCH coordinators and State MCH, ARH and FP coordinators.	(1) Identify meeting participants. (2) Prepare meeting logistics. (3) Conduct the meeting.	FP, ARH, MCH Coordinators	2014 (Q2– 2018 (Q3)	0
	1.3.8	Institute waste management and infection prevention practices in health facilities of Gombe state.	Train providers on waste management and injection safety and universal	Quality improvement consultants	2014 (Q2) - 2018 (Q3)	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
4. Quality assurance	1.4.1	Assure quality of FP training.	(1) Maintain adequate FP trainer and trainee ration. (2) Implement competency based trainings. (3) Conduct pre- and post-tests before and after each training.		2014 (Q2) - 2018 (Q3)	0
	1.4.2	Conduct post-training follow-up supportive supervisory visits.	(1) Cross-check challenges with maintaining FP stock at facilities and community level. (2) Observe health workers providing FP services. (3) Document cases of adverse reactions or issues with injection safety.	SMoH, LGAs and RH TWG	2014 (Q3) - 2018 (Q3)	0
	1.4.3	Conduct post-training follow-up reviews with performance reviews in each LGA.		SMoH, LGAs and RH TWG	2014 (Q2) - 2018 (Q3)	0
	1.4.4	Adapt performance standards for FP service provision.		Consultants, SMoH, LGAs and RH TWG	2013 (Q4) – 2014(Q1)	0
	1.4.5	Print copies of performance standards for PHCs, secondary and tertiary health facilities.		SMoH, Implementing Partners	2014 (Q1)	1,000,000
	1.4.6	Conduct baseline study of primary and secondary health facilities in Gombe state to determine quality gaps.		Consultants, SMoH, LGAs and RH TWG	2013 (Q4)	16,500,000

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	1.4.7	Disseminate results and develop action plan towards improving service quality based on performance gaps.		SMoH, quality improvement consultants/resource persons, LGAs and RH TWG and HF staff	2014 (Q1)	900,000
	1.4.8	Form quality improvement teams to monitor implementation of quality improvement efforts.		Trainers and HF in-charges	2014 (Q2) - 2018 (Q3)	0
	1.4.9	Provide quarterly supportive supervision to monitor quality improvement effects using performance standards at all service delivery levels.		State, LGA MCH coordinator and RH TWG	2014 (Q2) - 2018 (Q3)	0
	1.4.10	Conduct midline evaluation in all health facilities participating in the quality improvement effort.		Quality improvement consultant	2016 (Q1)	1,500,000
	1.4.11	Continue to implement and monitor quality improvement efforts in health facilities of Gombe state.		HF staff, LGA FP coordinator, QITs and RH TWG	2014 (Q2) - 2018 (Q3)	0
	1.4.12	Conduct end-line evaluation of quality improvement efforts.		Consultants, SMoH, LGAs and RH TWG	2018 (Q3)	1,500,000
	1.4.13	Conduct recognition events and brand health facilities (HFs) as quality sites.		Consultants, SMoH, LGAs and RH TWG	2014 (Q2) - 2018 (Q3)	300,000

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	1.4.14	Procure waste management equipment, infection prevention equipment and injection safety equipment (and consumables).		DPHC, SMoH, LGAs and RH TWG	2014 (Q2) - 2018 (Q3)	28,150,000
5. Commodities and logistics management	1.5.1	Procure CBA kits and injection safety boxes for eligible providers.		MCH, FP, ARH and state trainers	2014 (Q1) - 2018 (Q3)	4,000,000
	1.5.2	Distribute kits and injection safety boxes to CBA providers.		MCH, FP, ARH and DPHC	2014 (Q2) - 2018 (Q3)	0
	1.5.3	Procure and distribute HIV test kits to all FP clinics.		MCH, FP, ARH, SASCP and DPHC	2014 (Q1) - 2018 (Q3)	0
	1.5.4	Conduct quarterly supportive supervision at health facilities to determine adequacy of equipment and infrastructure by LGA supervisors.	Conduct periodic follow-up visits.	LGA, DPHC	2014 (Q2) - 2018 (Q3)	0
	1.5.5	Conduct quarterly supportive supervision of LGAs to determine adequacy of equipment and infrastructure by state.	(1) Develop a follow-up schedule. (2) Prepare logistics for the meeting. (3) Conduct meeting with the LGA supervisors.	SMoH	2014 (Q1) - 2018 (Q3)	0
	1.5.6	Conduct site assessments at all health facilities to determine renovation, commodity and equipment needs.		SMoH, LGA	2014 (Q1) - 2018 (Q1) (Annually)	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	1.5.7	Procure basic and specialized equipment for provision of FP services.	Procure basic equipment: weighing scale, sphygmomanometer, stethoscope, injection safety boxes, IUCD kit, MVA kit, insertion couch, angle poise lamp, autoclave, screen, instrument trolley, trays, gallipots, chaetae forceps containers and chaetae forceps, mosquito artery forceps, BP apparatus.	SMoH and LGAs	2014 (Q1) - 2018 (Q3)	84,450,000
	1.5.8	Distribute equipment to appropriate facility (by level of service provision).		SMoH and LGAs	2014 (Q2) - 2018 (Q3)	563,000
	1.5.9	Procure waste management equipment (dustbin, utility gloves, boots, mask, goggles and aprons).			2014 (Q1) - 2018 (Q3)	56,300,000
	1.5.10	Conduct renovation of approved FP clinics.			2014 (Q1) - 2018 (Q3)	140,750,000
	1.5.11	Conduct post-renovation inspection.			2014 (Q2) - 2018 (Q3)	563,000
6. Finance and resources	1.6.1	Allocate financial resources for human resource needs and capacity building.	(1) Enlist the HR materials needed. (2) Create a detailed budget on the HR materials needed.		2014 (Q1)	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	1.6.2	Engage development partners, NGOs, CSOs and private sector players towards supporting the provision of FP services to underserved communities and at-risk population.	(1) Enlist the development partners, NGOs and private organizations to be visited. (2) Develop proposals and budget for the resources.		2014 (Q1)	0
	1.6.3	Enlist additional CHEWs and JCHEWs; train and build the capacity of existing and enlisted CHEWs and JCHEWs.	(1) Enlist the additional CHEWs and JCHEWs. (2) Identify the participants of the training. (3) Prepare logistics for the training. (4) Conduct training. (5) Conduct periodical follow-up visits.		2014 (Q1)	0
7. Monitoring and reporting	1.7.1	Reprint and distribute copies of daily activity registers, daily consumption records forms, monthly summary and requisition forms.	(1) Review and compile the daily activity registers, daily consumption record forms, and monthly summary and requisition forms. (2) Reprint and distribute the documents.	SMoH, LGA, DPHC	2014 (Q1) - 2018 (Q2)	2,815,000
	1.7.2	Distribute copies of FP and HCT data collection tools to facilities as required.		SMoH, LGA, SASCP, DPHC	2014 (Q2) - 2018 (Q3)	0
	1.7.3	Develop indicators to track FP service provision and utilization across the state.	(1) Enlist the development partners, NGOs and private organizations to participate. (2) Conduct meeting.	SMoH, LGAs and development partners	2013 (Q4) – 2014 (Q1)	0
	1.7.4	Develop M&E reporting plan.	(1) Enlist the development partners, NGOs and private organizations to participate. (2) Conduct meeting.	SMoH, LGAs, and development partners	2013 (Q4) – 2014 (Q1)	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	1.7.5	Conduct quarterly data analysis and reporting (linked to quarterly review and resupply meetings).		SMoH, LGA	2014 (Q2) - 2018 (Q3)	0
	1.7.6	Develop and disseminate annual CLMS report for Gombe state.			2014-2018	600,000
8. Integration of FP with HIV/AIDS and MNCH	1.8.1	Conduct integrated PAC FP and Post-Partum FP) trainings into MCH services of secondary and tertiary health facilities in Gombe state (link with HW trainings).		MCH, FP, ARH and state trainers	2014 (Q2) - 2018 (Q3)	0
Subtotal Objective 1						**458,212,000**

4.2 Objective 2

Objective 2: Expand the availability of FP commodities offered by cadre-appropriate providers in the wards, primary health centres, and secondary and tertiary facilities in Gombe state by 2018.

- **Target 1:** Ensure the availability of a mix of at least three FP methods (pills, condoms and injectables) in 100 percent of the wards in Gombe state by 2018.
- **Target 2:** Ensure the availability of a mix of at least three FP methods (pills, condoms and injectables) in 100 percent of primary health centres in Gombe state by 2018.
- **Target 3:** Ensure the availability of a method mix of at least five FP methods (pills, condoms, injectables, implants and IUDs) in 100 percent of public secondary and tertiary facilities in Gombe state by 2018.

STRATEGIC INTERVENTION AREA	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
1. Advocacy and social mobilization for an enabling environment	2.1.1	Advocate for budgetary allocation for FP services at all levels in the state.	Review quantification (see section on commodity **and logistics** below) and allocate budgetary allocation.	State executive and legislative bodies, MoF, MoEP, SMoH, 11 local governments councils, donors, civil society organizations and faith-based organizations	2013-2018	225,000
	2.1.2	Conduct a one-day stakeholder meeting to mobilize political will and leadership for provision of quality FP services.	(1) Identify stakeholder categories. (2) Convene stakeholder meeting. (3) **Disseminate new** FP/RH policy guidelines to relevant stakeholders.	Chairmen of the MoH, Ministry of Women Affairs, Ministry for LG and Chieftaincy Affairs, LGSC, MoE, MoEP, MoF and LGA; House Committee on Health/Appropriation; religious leaders; and coordinators of the Gombe	2013 (Q4)	1,360,000

STRATEGIC INTERVENTION AREA	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
				SACA , CHPRBN, APHPN, MDCN, NMCN, NMA, AGMPN and PHC		
	2.1.3	Convene a one-day state RH TWG. (Link to quarterly review meeting)	Conduct quarterly meetings.	RH TWG members and other stakeholders	2013 (Q4) - 2018 (Q3)	0
2.Training and capacity building	2.2.2	Conduct a two-day training on supportive supervision for CLMS for RH TWG members).		MCH, RH and FP coordinator	2014 (Q1)	648,000
	2.2.3	Conduct training on CLMS for HWs (CHEWs, nurses, doctors). (Link to HW training)	(1) Identify training participants. (2) Review existing CLMS training curriculum. (3) Prepare logistics for training. (4) Conduct CLMS training.	SMoH, LGA	2014 (Q2) - 2018 (Q3)	0
3. Service provision and supportive supervision	2.3.1	Conduct supportive supervisory visit (ISS) to ensure availability of FP commodities and appropriate method mix at LGA level.	(1) Select facility to be visited. (2) Conduct the visit.	MCH coordinators	2014 (Q2) - 2018 (Q3)	4,752,000

STRATEGIC INTERVENTION AREA	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	2.3.2	Conduct one-day ISS training to ensure availability of FP commodities and appropriate method mix at state level.	(1) Select LGA and facilities to be visited. (2) Conduct the visit.	RH, MCH, FP, ARH coordinators	2014 (Q1)	1,584,000
	2.3.3	Conduct monthly review meeting with health facility staff and LGA MCH coordinators at the LGA level.	(1) Identify meeting participants. (2) Prepare meeting logistics. (3) Conduct the meeting.	FP providers, MCH coordinators	2014 (Q2) - 2018 (Q3)	11,880,000
	2.3.4	Conduct quarterly review and resupply meetings with LGA MCH coordinators and state MCH and FP coordinators at the state level (link with RH TWG meetings).	(1) Identify meeting participants. (2) Prepare meeting logistics. (3) Conduct the meeting	FP, ARH, MCH coordinators	2014 (Q2) - 2018 (Q3)	3,600,000
	2.3.5	Establish linkages and referral mechanisms among community-based providers**,** PHCs, secondary and tertiary health facilities to ensure availability of method mix.	(1) Use GIS to map service providers and service delivery points. (2) Draft service delivery directory.	MCH, FP, ARH and state trainers	2014 (Q2) - 2018 (Q3)	0
4. Quality assurance	2.4.1	Adapt SOPs and international standards for FP commodity management/CLMS.		Extended RH TWG	2014 (Q1)	1,620,000
	2.4.2	Print SOPs for CLMS.		SMoH	2014 (Q1) - 2018 (Q2)	3,000,000
	2.4.3	Distribute SOPs to all state and LGA stores.		SMoH, LGA	2014 (Q2) - 2018 (Q3)	0

STRATEGIC INTERVENTION AREA	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	2.4.4	Conduct routine inspection of FP commodities being supplied to the state.		FP coordinator	2013 (Q4) - 2018 (Q3)	0
5. Commodities and logistics management	2.5.1	Convene meeting to develop FP commodity management and procurement strategies to inform the state plan for commodities and logistics management.	(1) Identify the stakeholders involved. (2) Prepare meeting logistics. (3) Conduct stakeholders meeting.	RH TWG, SMoH, LGA and development partners.	2014 (Q1)	1,620,000
	2.5.2	Quantify commodity requirements and develop specific procurement plans (biannually).	(1) Review facility requisition and use. (2) Integrate targets from framework on commodity quantities required.	SMoH	2014 (Q1) - 2018 (Q2)	580,000
	2.5.3	Procure FP commodities.		SMoH	2014 (Q1) - 2018 (Q3)	500,550,000
	2.5.4	Procure FP consumables.		SMoH, HMB	2014 (Q1) - 2018 (Q3)	0
	2.5.5	Train health care workers on the LMIS tools (link with HW training).	(1) Identify training participants. (2) Prepare logistics for training. (3) Conduct training on LMIS tools for selected health workers.	SMoH, LGA	2014 (Q2) - 2018 (Q3)	0
	2.5.6	Conduct monthly review and resupply meeting with health facility staff and LGA MCH coordinators at the LGA level (link with supportive supervision).	(1) Send out invitations. (2) Prepare meeting logistics. (3) Conduct stakeholders meeting.	LGA, service providers	2014 (Q2) - 2018 (Q3)	0

STRATEGIC INTERVENTION AREA	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	2.5.7	Conduct quarterly review and resupply meetings with LGA MCH coordinators and state MCH and FP coordinators at the state level (link with supportive supervision.	(1) Send out invitations. (2) Prepare meeting logistics. (3) Conduct stakeholders meeting.	SMoH, LGA	2014 (Q2) - 2018 (Q3)	0
6. Finance and resources	2.6.1	Conduct a stakeholder meeting to agree on the scope of intervention, projected costs and commitments from stakeholders.	(1) Identify the stakeholders involved. (2) Prepare meeting logistics. (3) Conduct stakeholders meeting.	RH TWG, SMoH, LGA and development partners	2014 (Q1)	0
	2.6.2	Engage government, development partners, NGOs and the private sector to commit resources and take ownership of the program.	(1) Compile the development partners, NGOs and private organizations to be visited. (2) Develop proposals and budget for the resources.	RH TWG	2013 (Q4) – 2014 (Q1)	0
	2.6.3	Constitute a program management team that will track and coordinate resource mobilization and utilization (link with FP logistics procurement planning meeting)	(1) Identify the members of the project management team. (2) Track and coordinate resource mobilization and use.	SMoH, RH TWG, LGA, development partners.	2014 (Q1)	0
	2.6.4	Establish linkages and partnerships between CHPRBN, Schools of Technology, FMoH and implementing organizations to leverage existing funding.	(1) Conduct FGDs with the representatives of the stakeholders. (2) Explore the areas in which the stakeholders can be linked.	SMoH, RH TWG, LGA, development partners.	2013 Q4 - 2014 (Q1)	0
7. Monitoring and reporting	2.7.1	Constitute a monitoring and reporting team at both the LGA and state levels.	(1) Hold an inaugural meeting to constitute the M&E team. (2) Implement monthly meetings in the first year then quarterly meetings subsequently.	PHC coordinators, M&E officer, MCH , community representatives	2014 (Q1) - 2018 (Q3)	2,397,600

STRATEGIC INTERVENTION AREA	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	2.7.2	Develop indicators that will monitor availability of the method mix within the community (link with M&E inaugural meeting).	(1) Develop an inventory checklist to monitor the availability of the commodity in stock. (2) Support supervision to ensure above stated checklist.	PHC coordinators, M&E officer, MCH, state FP coordinators, CLMS officer	2014 (Q1)	0
	2.7.3	Integrate community-level FP data elements (particularly for injectables) into state level NHMIS (link with M&E inaugural meeting).	(1) Review state health information forms to capture services rendered at the community level. Provide NHMIS reporting forms in all centres. (2) Ensure prompt and proper recording and submission of all the FP services rendered.	PHC coordinators, M&E officer, MCH, state FP coordinators, CLMS officer, NHMIS desk officer	2014 (Q1)	0
	2.7.4	Update and adopt CBA activity sheets, community services register and report form to include injectables.	Implement a meeting to review the CBA activity sheets and capture the injectable services.	PHC coordinators, M&E officer, MCH, state FP coordinators, CLMS officer	2014 (Q1)	0
	2.7.5	Reprint copies of daily activity registers, daily consumption record forms**,** monthly summary and requisition forms (link with M&E in objective 2).		SMoH, LGA	2014 (Q1) - 2018 (Q2)	0
	2.7.6	Distribute M&E tools.		SMoH, LGA	2014 (Q2) - 2018 (Q3)	0
	2.7.7	Conduct monthly review meetings with health facility staff and LGA MCH coordinators at the LGA level (link with supportive			2014 (Q2) - 2018 (Q3)	0

STRATEGIC INTERVENTION AREA	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
		supervision).				
	2.7.8	Conduct quarterly review and resupply meetings with LGA MCH coordinators and state MCH and FP coordinators at the state level (link with supportive supervision,).		SMoH, LGA	2014 (Q2) - 2018 (Q3)	0
8. Integration of FP with HIV/AIDS and MNCH	2.8.1	Develop a framework to integrate these services.	(1) Conduct a review meeting. (2) Identify meeting participants. (3) Prepare meeting logistics. (4) Inculcate the agreement reached at the meeting into the framework.		2014 (Q1)	0
	2.8.2	Supply HIV test kits to FP clinics.			2014 (Q2) - 2018 (Q3)	0
	2.8.3	Support FP service provision during biannual MNCH weeks and NIDs.	(1) Conduct orientation meetings for staff involved in special events. (2) Mobilize resources for service provision: commodities and consumables. (3) Provide services.		2014 (Q2) - 2018 (Q3)	1,200,000
Subtotal Objective 2						**535,016,600**

4.3 Objective 3

Objective 3: Increase the use of FP methods among men, women and young persons of reproductive age in Gombe state by 2018.

- **Target 1:** Increase use of FP by 20 percent among women of reproductive age by in Gombe state by 2018.
- **Target 2:** Increase support for FP by 50 percent among men, women and young persons of reproductive health in Gombe state by 2018.

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
1. Advocacy and social mobilization for an enabling environment	3.1.1	Develop key FP (child spacing) messages for priority audience during advocacy, communication and social mobilization activities.	Develop messages and programs for media and print for priority audience.	SMoH, SMWASD, SSMO, CSO, ARH coordinators, MAP resource persons, CBO, community reps	2014 (Q1)	2,900,000
	3.1.2	Advocate to the SMoE to train young people on FP/RH component of FLHE using the approved national curricula.	Liaise with MoE to ensure availability of family life education (FLE) curriculum in all senior secondary schools.	MoH, ,MOE, MOYD,CSOs, development partners, ARH coordinator, state master trainers, resource persons	2013 (Q4) – 2018 (Q3)	0
	3.1.3	Conduct community-based demand creation meetings in all 11 LGAs.	Conduct community-based demand creation meetings at facility and communities: (1) Leverage support by engaging WDCs, VDCs, HFs, CBOs, FBOs, youth clubs and women groups for mobilizing target audiences in communities. (2) Develop community drama.	LGA SMO, CBOs, CSOs, SMoH	2014 (Q2) - 2018 (Q3)	1,188,000

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	3.1.4	Engage media outlets to create awareness of FP services.	Create awareness through media such as radio, postal, leaflets, billboards.	RH TWG, SMoH and development partners	2013 (Q4) - 2018 (Q3)	0
	3.1.5	Engage PHC facilities, NGOs and CBOs to provide youth friendly services (YFS) and increase access of young people to YFS.		SMoH, LGA and Partners	2014 (Q2) - 2018 (Q3)	0
2. Training and capacity building	3.2.1	Develop/adapt and distribute/disseminate IEC/BCC materials (posters, leaflets and booklets) and messages (jingles, TV spots, Bulk SMS, VOX Pop and PSAs) on FP.		FP coordinator, state social mobilization officers (SSMOs), LGA MCH coordinators	2014 (Q2) - 2018 (Q3)	0
	3.2.2	Distribute information materials.			2014 (Q2) - 2018 (Q3)	0
	3.2.3	Train men-to-men mobilizers as a Brothers for Health (B4H) initiative and develop action plans.		B4H resource persons, CS/RH coordinators, media to educate men on their role in child spacing	2014 (Q2) - 2018 (Q3)	660,000
	3.2.4	Train women community mobilizers as a Sisters for Health (S4H) initiative and develop action plans.	Provide BCC materials and job aids (motivational flip charts) to trained MAPs.	S4H resource persons, CS/RH coordinators, media to educate men on their role in child spacing	2014 (Q2) - 2018 (Q3)	660,000
	3.2.5	Conduct training ARH and YFS for health personnel at PHCs and NGO officials		ARH coordinator, state training teams, resource persons	2014 (Q2) - 2018 (Q3)	14,340,000

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
	3.2.6	Support CBOs, CSOs, NGOs to train in-school and out-of-school youths on peer health education activities.		ARH coordinator, state master trainers, resource persons	2014 (Q2) - 2018 (Q3)	0
	3.2.7	Provide ARH and YF IEC materials to trained young people in youth-based CSOs and CBOs.		ARH coordinator, state training teams, resource persons	2014 (Q2) - 2018 (Q3)	0
	3.2.8	Equip trained peer health educators with kits and IEC/BCC materials for implementation of PHED activities and referral.		ARH coordinator, state FP coordinators and NGOs,	2014 (Q2) - 2018 (Q3)	66,000
3. Service provision and supportive supervision	3.3.1	Distribute IEC materials to health facilities to facilitate the provision of health talks and home visits for counseling at facility and community levels.		FP coordinator, LGA MCH coordinators, HFs	2014 (Q2) - 2018 (Q3)	0
	3.3.2	Support CBOs to conduct community outreaches, such as house-to-house visits and mobile clinics/caravans targeted at hard-to-reach communities in Gombe state.		CHEWs, NGOs, CBOs, FBOs and WDCs and QIT members	2014 (Q2) - 2018 (Q3)	396,000
	3.3.3	Supervise community outreaches and other community-based activities.		LGA, SMoH	2014 (Q2) - 2018 (Q3)	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
7. Monitoring and reporting	3.7.1	Develop tools to track activities of MAPs, B4H and S4H at the community level (link with FP key message development).	Review existing community tools to ensure the inclusion of CB distribution of FP services.	SSMO, FP, ARH coordinators, FHI	2014 (Q1)	0
	3.7.2	Monitor media and community-based FP activities.			2014 (Q2) - 2018 (Q3)	0
	3.7.3	Conduct quarterly reviews of daily registers and daily consumption book.		M&E officer, FP coordinators (state and LGA), director of Planning, Research & Statistics, facilities in-charge officers, PHC coordinators	2014 (Q2) - 2018 (Q3)	0
	3.7.4	Conduct quarterly reviews of community mobilization and media outreaches/programming data.			2014 (Q2) - 2018 (Q3)	0
	3.7.5	Disseminate semiannual reporting of FP use data at LGA, state levels.	Routine compilation and reporting of service statistics at facility, LGA and state levels.		2014 (Q2) - 2018 (Q3)	0
	3.7.6	Integration of data into state HMIS system.			2014 (Q1)	0
	3.7.7	Conduct study to document attitudes towards FP.	Pre- , mid- and post-intervention RH TWG, SMoH and development partners	RH TWG, M&E TWG, SMoH, development partners	2013 (Q4)	0
	3.7.8	Document best practices.			2014 (Q2) - 2018 (Q3)	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF THE REQUIRED RESOURCES (NGN)
8. Integration of FP with HIV/AIDS and MNCH	3.8.1	Integrate FP messages into MNCH week mobilization activities.		RH TWG, MCH Coalition	2014 (Q2) - 2018 (Q3)	0
Subtotal Objective 3						**20,210,000**

4.4 Objective 4

Objective 4: Increase the level of state and community support for FP services in Gombe state by 2018.

- **Target 1:** At least 70 percent of community leaders permit the implementation of community-based FP in their communities in Gombe state by 2018.
- **Target 2:** 100 percent of policymakers at the state and LGA levels support implementation of FP programmes in Gombe state by 2018.

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF REQUIRED RESOURCES (NGN)
1. Advocacy and social mobilization for an enabling environment	4.1.1	Conduct a stakeholder meeting to mobilize political will and leadership for increased support for access to FP services (link with other stakeholder engagement efforts).	(1) Pay advocacy visit to concerned stakeholders. (2) Send out invitation letters.	Legislators, executives, LGA councils, traditional and community leaders, religious leaders, opinion leaders, RH TWG, CSOs, CBO development partners	2014 (Q1)	0
	4.1.2	Develop a partnership framework to strengthen engagement with policymakers, CSOs and community leaders.		SMoH, LGA, RH TWG	2014 (Q1)	900,000
	4.1.3	Engage with selected CSO and CBOs.		SMoH, LGA, RH TWG	2014 (Q1) - 2018 (Q3)	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF REQUIRED RESOURCES (NGN)
	4.1.4	Conduct sensitization meetings for community gatekeepers.		SMoH, LGA SMO, RH TWG	2014 (Q1) - 2018 (Q3)	1,188,000
	4.1.5	Support community dialogue among community members.		SMoH, LGA, RH TWG	2014 (Q1) - 2018 (Q3)	1,188,000
	4.1.6	Conduct bi-monthly review meeting with HF in-charges and LGA MCH coordinators.	(1) Identify the participants of the meeting. (2) Prepare the meeting logistics. (3) Conduct the meeting.	MCH, FP, ARH & DPHC	2014 (Q2) - 2018 (Q3)	0
	4.1.7	Conduct advocacy to line ministries and policymakers.	Pay solicitation courtesy visits to MoH, Ministry of Women Affairs, LGSC, LGCA, economic and budget planning and house committee on health.	RH TWG	2013 (Q4) - 2018 (Q3)	0
	4.1.8	Conduct advocacy and sensitization visits to gatekeepers, traditional and religious leaders and LGA council members.	Implement advocacy and sensitization to LG chairmen, traditional leaders and gatekeepers.	RH TWG	2014 (Q1) - 2018 (Q3)	1,188,000
2. Training and capacity building	4.2.1	Conduct a two-day training on advocacy and social mobilization strategies for CBOs, CSOs and SMOs to increase and improve method mix and funding for FP.		SMoH, LGAs, CSOs and CBOs	2014 (Q1) and 2016 (Q1)	1,728,000
	4.2.2	Conduct training on interpersonal skills and communication for CHEWs, nurses and doctors (link with HW training)	(1) Identify participants. (2) Conduct training. (3) Monitor activities post-training.	SMoH, RH TWG, LGA, development partners.	Q1–Q4	0

STRATEGIC INTERVENTION	ACTIVITY CODE	ACTIVITIES	SUBACTIVITIES	IDENTIFIED STAKEHOLDERS	TIME FRAME 2013–2018	COSTING OF REQUIRED RESOURCES (NGN)
7. Monitoring and reporting	4.3.1	Conduct a mapping of community leaders and policymakers and their levels of support for FP.	(1) Conduct baseline mapping and assessment of level of support of community leaders and policymakers. (2) Implement a post-intervention survey to document changes In the level of support for FP.	Community leaders, policymakers, LGA chairmen/representatives, M&E officers, PHC coordinators, Commissioner for Health, Supervisory Councilor for Health, Permanent Secretary of SMoH, Permanent Secretary of LG & Chieftaincy Affairs, chairman of Local Government Service Commission, development partners	2013 (Q1)	0
	4.3.2	Monitor statements of support or nonsupport for FP by policymakers and community and religious leaders.	Engage with media, CBOs and CSOs to assist in documentation.	CSOs, CBOs, Gombe RH TWG	2014 (Q1) - 2018 (Q3)	0
Subtotal Objective 4						**6,192,000.00**

5 BUDGET SUMMARY

The *Gombe State Framework for the Implementation of Expanded Access to Family Planning Services 2013–2018* has an estimated cost of 1.019 billion Naira over a six year implementation period. The resource requirements for the four objectives by each strategic intervention area are summarized below.

STRATEGIC INTERVENTION	OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	SUBTOTAL
Advocacy and social mobilization to create an enabling environment for FP	540,000	1,585,000	4,088,000	4,464,000	10,677,000
Training and capacity building	55,461,000	648,000	15,726,000	1,728,000	73,563,000
Service provision and supportive supervision	62,320,000	21,816,000	396,000	0	84,532,000
Quality assurance	49,850,000	4,620,000	0	0	54,470,000
Commodities and logistics	286,626,000	502,750,000	0	0	789,376,000
Finance and resources	0	0	0	0	0
Monitoring and reporting	3,415,000	2,397,600	0	0	5,812,600
Integration of FP with HIV/AIDS and MNCH	0	1,200,000	0	0	1,200,000
TOTAL (naira)	**458,212,000**	**535,016,600**	**20,210,000**	**6,192,000**	**1,019,630,600**

APPENDIX 1. CALCULATION JUSTIFICATIONS AND ASSUMPTIONS

This appendix provides the calculations and assumptions that support the goal, objectives and annual projections made throughout this framework. These calculations and assumptions were developed under the guidance of the Gombe RH TWG with technical assistance from a health economist and the assumptions were based on state-specific and national reports as well information acquired from Gombe state health officials and stakeholders.

Table A1.1. Number of Health Personnel Providing FP and Training in FP

YEAR	CPR (%)	CHEWS	ADDED CHEWS PER YEAR	CLINICIAN LOE	BASICS OF FP TRAINING	INJECTABLE PROVISION TRAINING
2012	8.82	1,652	n/a	13.4%	n/a	n/a
2013 *30% trained*	9.90	1,707	55	8.7%	$ 35,000	$ 16,000
2014 *60% trained*	11.62	1,762	55	3.2%	$ 42,000	$ 19,000
2015 *100% trained*	13.64	1,817	55	0.5%	$ 66,000	$ 30,000
2016 *100% trained*	16.02	1,872	55	0.6%	$ 22,000	$ 10,000
2017 *100% trained*	18.81	1,927	55	4.3%	$ 25,000	$ 11,000
2018 *100% trained*	22.10	1,982	55	10.7%	$ 28,000	$ 13,000

Assumptions: The 2012 baseline begins with the current projected CPR and number of health workers available.[5] CHEWs (including JCHEWs) will spend 20 percent (or 8 hours) of their effort delivering FP services including condoms, pills and injectables. An additional 55 CHEWs graduating from the state's school of health technology will be hired by the SMOH and trained on cadre-specific methods. Clinicians' (including doctors, nurses and midwives) level of effort (LOE) for providing FP services is estimated based upon two factors. First, the use of LAPMs (implants and IUDs) that only these cadres of health workers can provide and second, as well as the remaining work load for providing condoms, pills and injectables that the CHEWs are unable to support. Regarding training, the 2012 estimate assumes only 5 percent of CHEWs have been comprehensively trained in FP service provision. Trainings assume cadres of 40 trainees and that each year 10 percent of prior trainees will require retraining (primarily due to health worker turnover). Cost estimates are based on basic FP training and injectables-specific training expenses incurred during the pilot study.[1]

Table A1.2. Clinicians Required by Base Year

YEAR	NURSES/MIDWIVES	DOCTORS	TOTAL
2012	140	61	201
2013	140	61	201
2014	140	61	201
2015	140	61	201
2016	140	61	201
2017	140	61	201
2018	140	61	201

Assumptions: A total of 201 clinicians[5] (including nurse/midwives and doctors) are targeted for increasing the provision of LAPMs as this is the estimated number of providers who work in maternity clinics (i.e. antenatal care, labour, postnatal care and family planning) which are patronized by women and children and provide the vast majority of FP services. These calculations assume that each clinician can accommodate one LAPM (implants and IUDs) insertion per month and, therefore, that no additional providers will be required until insertion volume passes 2,400 per year. While the focus is on insertions, the percent change from clinicians in 2012 assumes removals of the LAPMs were also included in workloads. The number of clinicians does not change year to year because this is based upon staffing quotas and a fixed number of service points or facilities.

Table A1.3. Number of Wards with Access to CBFP and Health Facilities Providing FP

YEAR	CPR (%)	COMMUNITIES (I.E. WARDS)	PHC	SECONDARY AND TERTIARY
2012	8.82	9% (10)	20% (101)	12.5% (2)
2013 30% trained	9.90	30% (35)	30% (152)	30% (5)
2014 60% trained	11.62	60% (69)	60% (303)	60% (10)
2015 100% trained	13.64	100% (114)	100% (505)	100% (16)
2016 100% trained	16.02	100% (114	100% (505)	100% (16)
2017 100% trained	18.81	100% (114)	100% (505)	100% (16)
2018 100% trained	22.10	100% (114)	100% (505)	100% (16)

Assumptions: Gombe's 11 LGAs are further divided into 114 wards which represent communities or neighborhoods.[5] To reach the CPR targets wards must be provided with CBFP by CHEWs. The wards' access to FP (including injectables) will increase as more CHEWs are trained in CBFP and then maintained. The 2012 baseline for wards' access to FP only reflects the 10 wards that participated in the CBA2I pilot because others wards receiving outreach from the PHCs were only provided with condoms and pills but not injectables. [1,9] Similarly, the PHCs' and secondary/tertiary facilities' coverage of FP service provision will incrementally increase as more CHEWs, nurses/midwives and doctors are trained to provide cadre-appropriate methods.

Table A1.4. Requirements to Reach CPR Goal — Number of FP Users, Number of Commodities, Cost for Commodities and Logistics, Percent of Users by Method

	2012	2013	2014	2015	2016	2017	2018	TOTAL
CPR (%)	8.82	9.90	11.62	13.64	16.02.	18.81	22.10	
Condoms								
Users	657	948	1,372	1,931	2,336	2,826	3,420	13,489
Commodities	73,610	106,141	153,638	216,233	261,638	316,487	383,077	1,510,824
Price (naira)	549,868	792,869	1,147,679	1,615,257	1,954,435	2,364,158	2,861,582	11,285,851
Users by method (%)	1.7	2.1	2.6	3.0	3.0	3.0	3.0	N/A
Pills								
Users	6,438	6,733	7,284	7,776	9,013	10,426	12,045	59,715
Commodities	31,334	32,765	35,447	37,844	43,864	50,740	58,621	290,615
Price (naira)	846,005	884,663	957,068	1,021,795	1,184,325	1,369,972	1,582,778	7,846,609
Users by method (%)	16.7	15.1	13.6	12.0	11.5	11.1	10.6	N/A
Injectables								
Users	30,590	35,539	43,173	52,449	63,485	76,822	93,018	395,078
Commodities	148,873	172,958	210,111	255,253	308,963	373,866	452,688	1,922,711
Price (naira)	28,806,953	33,467,404	40,656,427	49,391,492	59,784,266	72,342,977	87,595,067	372,044,589
Users by method (%)	79.3	79.9	80.5	81.0	81.3	81.5	81.7	N/A
Implants								
Users	657	948	1,372	1,319	2,404	2,990	3,718	14,019

	2012	2013	2014	2015	2016	2017	2018	TOTAL
Commodities	398	509	740	1,010	1,071	1,329	1,652	6,711
Price (naira)	1,544,883	1,974,921	2,870,630	3,916,422	4,152,196	5,154,546	6,406,731	26,020,333
Users by method (%)	1.7	2.1	2.6	3.0	3.1	3.2	3.3	N/A
IUDs								
Users	219	316	457	644	892	1,216	1,636	5,379
Commodities	120	149	217	294	398	529	698	2,406
Price (naira)	18,947	23,519	34,223	46,305	62,762	83,297	109,861	378,971
Users by method (%)	0.6	0.7	0.9	1.0	1.1	1.3	1.4	N/A
Total users, all FP methods	38,562	44,483	53,658	64,730	78,131	94,279	113,837	

Assumptions: To meet the incrementally increasing CPR target each year, the number of FP users, number of commodities, cost for commodities and logistics will also increase. The estimates for users by method are based on the formula: *contraceptive prevalence* × *population.* [2,3] An annual % increase in # users ranges from 15.4% to 20.7% with an average annual increase of 19.8% from 2012 -2018.

The estimates for commodities by method are based on the formula: *number of users* × *volume of commodities per user per year* × *1.12* This formula also allows for 12% wastage. And the volume of commodities per user by method are: For condoms, assume 100/user/year; For pills and injectables, assume 4.35 units/user/year; For implants, assume 0.25 units/prior user/year (average expected use = 4/year) plus one unit for each new user; for IUDs, assume one-sixth unit for prior users (average expected use = 6/year) plus one unit for each new user.

The price for the commodities by method is described below in Table A1.5.

Additionally, the percent of users by method is provided to illustrate the changes in the method mix.

Table A1.5. Commodity Costs (US$)

	COMMODITY	LOGISTICS	TOTAL
Condoms $ per 100 condoms	4.15	0.83	$4.98
Injectables $ per vial	1.08	0.22	$1.29
IUD $ per unit	0.87	0.17	$1.05
Implants $ per unit	21.54	4.31	$25.85
Pills $ per pack	0.15	0.03	$0.18

Assumptions: These costs are based on international prices.[13] The logistic expenses are estimated at 20 percent of the cost of the commodity.

Table A1.6. FP Support by Men, Women, Youth, Community Leaders and Policymakers

YEAR	MEN, WOMEN, YOUTH (% INCREASE)	COMMUNITY LEADERS (%)	POLICYMAKERS (%)
2012	0	10	10
2013	5	25	25
2014	10	30	40
2015	20	40	55
2016	30	50	70
2017	40	60	85
2018	50	70	100

Assumptions: State health officials and stakeholders concluded that among men, women and youth of reproductive age, support for FP needed to increase and could be accomplished through FP education CHEWs will provide as part of their extension services and broader community-level advocacy initiatives that are planned. The baseline for FP support is unknown but perceived to be low given the state's low unmet need for FP (13.2%) and other FP indices.[2]

The majority of community leaders' (ward heads, religious leaders) and all policymakers at the state and LGA-levels (emirs, commissioners and permanent secretaries) will need to support FP as demonstrated by their participation in FP expansion planning meetings and the absence of clear opposition to advancing FP efforts.

Table A1.7. Family Planning Impact Indicators

YEAR	CPR (%)	CYP	PREGNANCIES AVERTED	BIRTHS AVERTED	INFANT MORTALITIES AVERTED	UNDER-5 MORTALITIES AVERTED	MATERNAL MORTALITIES AVERTED	ABORTIONS AVERTED	DISABILITY-ADJUSTED LIFE YEARS (DALYS) AVERTED
2012 baseline	8.82	41,470	23,697	17,232	1,675	3,253	190	4,329	10,227
2013	9.90	48,269	27,582	20,057	1,950	3,787	221	5,039	11,904
2014	11.62	59,022	33,727	24,526	2,384	4,630	270	6,161	14,556
2015	13.64	72,016	41,152	29,925	2,909	5,650	329	7,517	17,760
2016	16.02	86,855	49,632	36,092	3,508	6,814	397	9,066	21,420
2017	18.81	105,243	60,139	43,732	4,251	8,257	481	10,986	25,955
2018	22.10	127,612	72,921	53,028	5,154	10,012	583	13,321	31,471
Total	N/A	540,486	308,849	224,593	21,830	42,403	2,471	56,419	133,292

Assumptions: The couple years of protection (CYPs) based upon the latest USAID conversion factors [14] and estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.

The conversions coefficients for the other indicators are measured per CYP for Nigeria [15] include: number of pregnancies averted 0.571429, number of births averted 0.415539, number of infant mortalities averted 0.040390, number of under-5 mortalities averted 0.078454, number of maternal mortalities averted 0.004571, number of abortions 0.104386 and DALYs 0.246616.

APPENDIX 2. SUMMARY OF STAKEHOLDER ANALYSIS

This appendix summarizes a rapid assessment conducted in Gombe in 2012 to understand state, LGA and community-level stakeholders' knowledge, support and ability to advance FP efforts. The assessment was conducted by staff from FHI 360 with approval and guidance from the SMoH.

STAKEHOLDER GROUP	STAKEHOLDER TITLE	STAKEHOLDER CHARACTERISTICS[6]							OUTCOMES
		Knowledge	Position	Interest	Resources	Alliance	Power	Leadership	
Govt. Ministries FMoH	Minister of Health	High	Supportive	High	High	High	High	High	Policy change allowing CHEWs to provide injectable contraceptives in communities
	Director, Family Health Department								
	RH Coordinator								
SMoH	Commissioner of Health	High	Supportive	High	High	High	High	High	Mandated and supported the RH TWG to hold meetings and panel discussions to develop the framework
	Permanent Secretary								
	Director PHC								
SMoLGA	Commissioner of Health	Medium	Supportive	High	High	High	High	High	Participated in developing the framework.

[6] Definitions of stakeholder characteristics assessed:

Knowledge: Level of understanding of FP. This was rated as high, medium or low.
Position: Support or opposition to FP. This was rated as support or oppose
Interest: Level of importance given to FP to improve maternal and child health. This was rated as high, medium or low.
Alliance: Access to groups that can influence FP. This was rated as high, medium or low.
Resources: Access to personnel and funds that can be used to influence FP. This was rated as high, medium or low.
Power: Ability to use their resources and alliances to influence CBA. This was rated as high, medium or low.
Leadership: Willingness to use their resources and alliances to support CBA. This was rated as high, medium or low.

STAKEHOLDER GROUP	STAKEHOLDER TITLE	STAKEHOLDER CHARACTERISTICS[6]							OUTCOMES
		Knowledge	Position	Interest	Resources	Alliance	Power	Leadership	
	Permanent Secretary State PHC Coordinator								Will support logistics and distribution of RH commodities
SMWASD	Commissioner of SWASD Permanent Secretary Director, Women Affairs Community Mobilization Officer	High	Supportive	High	High	High	High	High	Participated in the RH TWG meetings for developing the framework Will support FP community mobilization
SMoEP	Commissioner Permanent Secretary Director of Planning	High	Supportive	High	High	High	High	High	Participated in the RH TWG meetings for developing the framework Will support inclusion of the framework in the state budget
Local Government Service Commission	Executive Director Director PHC	High	Supportive	High	High	High	High	High	Participated in the RH TWG meetings for developing the framework. Committed to providing health workforce required to scale up community-based FP
Community Leaders	Emir of Kaltungo Emir of Yamaltu Emir of Deba Emir of Dukku	High	Supportive	High	High	High	High	High	Committed to support community mobilization activities to promote FP
Implementing Partners	SFH NURHI TSHIP UNICEF WHO UNFPA	High	Supportive	High	High	High	High	High	Participated in developing the framework Will support programme implementation of the framework

STAKEHOLDER GROUP	STAKEHOLDER TITLE	STAKEHOLDER CHARACTERISTICS[6]							OUTCOMES
		Knowledge	Position	Interest	Resources	Alliance	Power	Leadership	
Donors	USAID	High	Supportive	High	High	High	High	High	Funded efforts for policy change allowing CHEWs to provide community-based FP; funded the development of Gombe state's framework for expanding access to FP

APPENDIX 3. PARTICIPATION LIST: CBA TWG MEETING CONVENED SEPTEMBER 21–22, 2011, ON THE *ROAD MAP FOR SCALING UP COMMUNITY-BASED ACCESS TO FAMILY PLANNING FOCUSED ON INJECTABLES IN NIGERIA*

Venue
Vines Hotel, Durumi Abuja

Chair
Prof. Oladapo A. Ladipo — CEO Association for Reproductive and Family Health

FMoH
P. N. Momah — Head Family Health Department
Abosede Adeniran — Head Reproductive Health Division
Nneka Nkem Oteka — National FP Coordinator
Yemisi Akinkumi — National Programme Officer
Manuel Oyinbo
J. U. Ononose
Ralph Olayele
Pharm Alex Ugochukwu
Mrs. Bamigbe Osuntogun
Adesola Adesanwo
Omolola Oluyomi
Oluwayomi Ale
Temitope Bombata

National Primary Health Care Development Agency
Dr. Nnenna Ihebuzor — Director, Community Health Services
Dr. David Malgwi Pabar
Dr. Theodore Madike

Regulatory Bodies
Community Health Practitioner's Registration Board of Nigeria
Mr. Shiono Bennibor — Registrar

Nursing and Midwifery Council of Nigeria
Mr. Olaniyi Filade

States
Rejoice Bala — Gombe State FP Coordinator

Donor Agencies
United States Agency for International Development (USAID)
Folake Olayinka
Kayode Morenikeji

United Nations Population Fund (UNFPA)
Nasser Elkholy
Adeola Olunloyo

Implementing Partners
Advocacy Nigeria
Chinyere Ikenna
Ummulkhair Usman

FHI 360
Kwasi Torpey
Hadiza Khamofu
Lilian Anomnachi
Zubaida Abubakar
Michael Odo
Ignatius Mogaba
Rabiatu Hadi
Mariya Saleh
Tracy Orr
Laide Shokunbi
Ginikanwa Amauche
Mafo Yakubu

JHPIEGO
Lydia Airede

Planned Parenthood Federation of Nigeria
Ibrahim M. Ibrahim
Uduak George

Society for Family Health
Bartholomew Odio

TSHIP
Janet Ibinola
Julian Nathaniel
Hajiya Fatima Inuwa

APPENDIX 4. PARTICIPATION LIST: PLANNING MEETING CONVENED JULY 18–20, 2012, ON THE *GOMBE STATE FRAMEWORK FOR THE IMPLEMENTATION OF EXPANDED ACCESS TO FAMILY PLANNING SERVICES FRAMEWORK 2013–2018*

Consultants
Nnenna Mba-Oduwusi
Olayiwola Ogunjobi

FMoH
Dr. Bridget Okoeguale
Dr. Kayode Afolabi

Nursing and Midwifery Council of Nigeria
Mr. Olaniyi Filade

Gombe State Reproductive Health Technical Working Group

Gombe SMoH
Nuhu Kumangh — Director Primary Health Care, Gombe SMoH
Ibrahim Hassan
Abdu Abubakar — Deputy Director Primary Health Care
Rejoice Bala — FP Coordinator
Maryam Abubakar — Reproductive Health Coordinator
Hauwa Lauco — Adolescent Health and Development
Aishatu Haruna — Safe Motherhood Coordinator
Esther Tinjja Gabakau — Maternal and Child Health Coordinator, Funakaye LGA
Ahmed Maikano Bello — Social Mobilization Officer, Funakaye LGA
Ramatu Aliyu Kunde — Service Provider, Hashidu PHC Funakaye LGA

Other Line Ministries
Adamu Puma Mamman — Ministry of Women Affairs and Social Development, Gombe State
Stephen Nabuni Ayuba — Ministry of Economic Planning, Gombe State

Partners

FHI 360
Hadiza Khamofu
Mariya Saleh
Bridget Nwagbara
Muhammad Muhammad Saleh

Nigerian Urban Reproductive Health Initiative
Fatima Bunza

TSHIP
Julian Nathaniel
Hajiya Fatima Inuwa

APPENDIX 5. PARTICIPATION LIST: REVIEW MEETING HELD OCTOBER 4, 2012, ON THE *GOMBE STATE FRAMEWORK FOR THE IMPLEMENTATION OF EXPANDED ACCESS TO FAMILY PLANNING SERVICES FRAMEWORK 2013–2018*

Gombe State RH Technical Working Group
Alh Umaru Gurama — Permanent Secretary, SMoH
Dr Nuhu Kumangh — Director, PHC
Abdu Abubakar — Deputy PHC Coordinator, SMoH
Ibrahim Hassan — State AIDS Control Programme Coordinator
Rejoice Bala Aliyu — FP Coordinator, SMoH
Hauwa Lauco — Adolescent Coordinator, SMoH
Aishatu Haruna — MNCH Coordinator, SMoH
Amina Nuhu K. — Deputy MNCH Coordinator, SMoH
Maryam Abubakar — RH Coordinator, SMoH
Hassana Shegeth — FP Champion

Expanded RH TWG
Aishatu Ahmed — CNO, MCH Coordinator, Gombe LGA
Marina Bappa — MCH Coordinator, Shongom LGA
Nwese Apu — MCH Coordinator, Nafada LGA
Dija Ahmed — MCH Coordinator, Kwami LGA
Lewi Patriacia — MCH Coordinator, Billiri LGA
Aliyu Aishatu Adamu — MCH Coordinator, Dukku LGA
Yerima Comfort — MCH Coordinator, Y/Deba LGA
Ahmed Maikano — SMO, Funakaye LGA
Mary Sadi — CNO/APHCC-MCH, Akko LGA
Ajuji Bulus — MCH Coordinator, Kaltungo LGA
Subi Chapeh — MCH Coordinator, Balanga LGA
Esther Tinja — DPHC Coordinator, Funakaye LGA
Mairo Maigana — MCH Coordinator, Funakaye LGA
Aliyu Kunde Ramatu — CHEW representative, Funakaye LGA
Adamu Mamman Puma — Ministry of Women Affairs and Social Development, Gombe State

Regulatory and Professional Bodies
Community Health Practitioners Registration Board
Abubakar Wuda Goni — CHPRBN, North East

Society of Obstetricians and Gynaecologists
Melah G. Sule — Consultant, SOGON

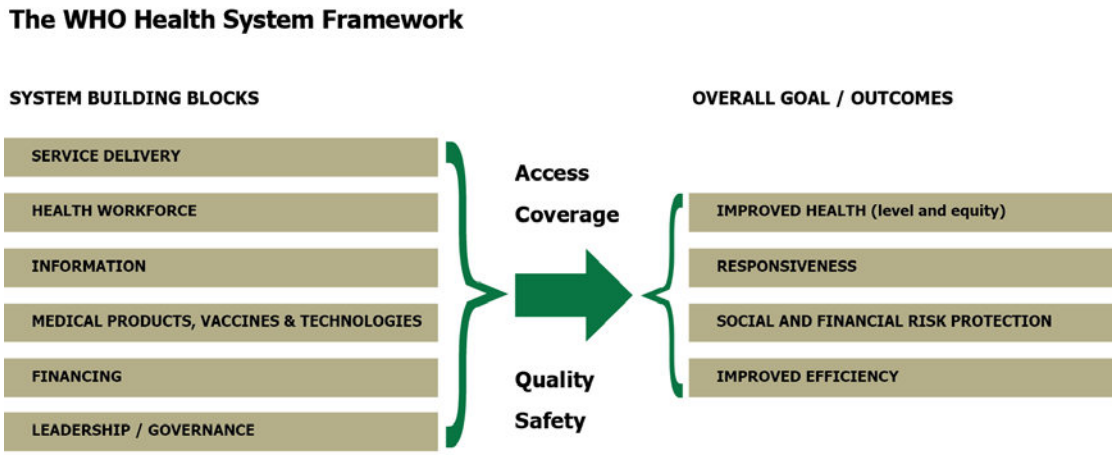
Civil Society Representatives
Abubakar Hassan — MCH Coalition

Partners
Mamman Sulaiman — UNICEF Assistant Coordinator
Maikano Paul .Y. — WHO, SE/LGF
Bathsheba Jonah Kalah — PPFN State Coordinator

FHI 360
Mansa Musa Adamu — SPC, Gombe
Muhammad Muhammad Saleh
Mariya Saleh
Bridget Nwagbara
Joy Hadiza Marcus
Joshua O.

Consultants
Nnenna Mba-Oduwusi
Olayiwola Ogunjobi

APPENDIX 6. WHO HEALTH SYSTEM FRAMEWORK



Source: WHO, 2007[8]

WHO defines the performance of each building block as follows:

1. ***Service delivery***: "Effective, safe, quality personal and impersonal health interventions" delivered to those who need them, when and where they are needed.

2. ***Health workforce:*** Personnel who are competent, responsive, fair, and efficient and who are equitably deployed in numbers and capacities sufficient to the need.

3. ***Information:*** A system that ensures the production, analysis, dissemination, and use of reliable and timely information about health determinants, health system performance, and health status.

4. ***Medical products, vaccines, and technologies:*** Products of assured quality, safety, efficacy, and cost-effectiveness.

5. ***Financing:*** A system with adequate financial resources for health such that people can access the services they need without fear of financial catastrophe or poverty associated with having to pay for medical services.

6. ***Leadership and governance:*** Strategic policies and frameworks existing in combination with oversight, regulation and accountability.

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